

HOSPICE – NURSING HOME INTERFACE

Guidelines for Care Coordination
for Hospice Patients who Reside in
Nursing Homes



**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 chosen “home” is a skilled nursing facility. This document provides guidelines for hospice and skilled nursing home providers when jointly serving hospice patients who choose to reside in skilled nursing facilities.

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 nursing home providers in service to a common patient 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 132, Nursing Home Rules

DQA Memos

DQA Memo 09-042, “Palliative Care”

Federal

- 42 Code of Federal Regulation (CFR) Part 418, Hospice
- 42 CFR Part 483, Medicare and Medicaid; Requirements for Long Term Care Facilities
- Social Security Act Section 1861(dd)
- Centers for Medicare and Medicaid Services (CMS) State Operations Manual, Appendix M, Hospice Survey Procedures and Interpretive Guidelines
- Centers for Medicare and Medicaid Services (CMS) State Operations Manual, Appendix PP, Nursing Home Surveyor Protocols
- Centers for Medicare and Medicaid Services (CMS) Long Term Care Resident Assessment Instrument User’s Manual, Version 3.0

SECTION III CONTRACT CONSIDERATIONS

A. INTRODUCTION

The following list of key considerations during hospice/nursing home contract negotiations is meant to assist providers in effectively coordinating provider services to the hospice patient receiving routine home care who resides in a nursing home. While by no means all-inclusive, these factors reflect many provisions found in the hospice and nursing home 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 resident is not receiving inpatient, continuous, or inpatient respite care) contract. It is not intended to comprehensively address considerations for inpatient and respite care, which hospices and nursing homes 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. Complimentary proposed requirements for nursing homes have been published in the Federal Register (Vol. 75, No. 204 / October 22, 2010). The agreement specifies the provision of hospice services in the nursing home and must be signed by authorized representatives of the hospice and the nursing home before the provision of hospice services. Whether a hospice is allowed access into a nursing home 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 nursing home and the hospice are to communicate with each other and document such communications to ensure that the needs of patients are addressed and met 24 hours a day. § 418.112(c)(1)
- b. A provision that the nursing home immediately notifies the hospice if:
 - 1) A significant change in a patient'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 from the nursing home, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions; or
 - 4) A patient 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. An agreement that it is the nursing home's responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected § 418.112(c)(4) that include:
 - 1) Personal care services;
 - 2) Assistance with activities of daily living (ADLs);
 - 3) Administration of medications;
 - 4) Social activities;
 - 5) Room cleanliness; and
 - 6) Supervision / assistant with DME use and prescribed therapies.
- f. An agreement that it is the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the nursing home resident were in his or her own home. § 418.112(c)(5)
- g. Identification of the services to be provided by each provider. DHS 131.30(2)(b)1
- h. The manner in which the contracted services are coordinated and supervised by the hospice. DHS 131.30(2)(b)3
- i. A delineation of the hospice's responsibilities for all services delivered to the patient or the patient'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;
 - 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 resident's terminal illness and related conditions. § 418.112(c)(6)
- j. A provision that the hospice may use the nursing home nursing personnel where permitted by Wisconsin law and as specified by the nursing home to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family in implementing the plan of care.
§ 418.112(c)(7)

- k. 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
- l. 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 property by anyone unrelated to the hospice to the nursing home administrator within 24 hours of the hospice becoming aware of the alleged violation.
§ 418.112(c)(8)
- m. 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
- n. The qualifications of the personnel providing the services. DHS 131.30(2)(b)
- o. A delineation of the responsibilities of the hospice and the nursing home to provide bereavement services to nursing home staff. § 418.112(c)(9)

2. Reimbursement Issues

Providers must have a clear understanding of the financial ramifications of the partnership. This discussion should include the following:

- Specify which entity is responsible for billing the cost of specific services and determining to whom billing is directed. (See Reimbursement Mechanisms Chart.)
- Specify procedure for managing patient's liability payment when patient's nursing home care is covered by Medicaid or Medicaid programs.
- Discuss reimbursement surrounding the issues of bed-hold, discrepancies in payment to the hospice by Medicaid.
- Hospice is responsible for making the decision as to the level of care required and subsequent arrangements for the resident to receive the care.

REIMBURSEMENT MECHANISMS FOR HOSPICE CARE PROVIDED IN A NURSING HOME

The following chart briefly summarizes various reimbursement mechanisms for hospice care provided in a nursing home.

Medicaid	Medicaid Programs (Family Care, Partnership)	Reimbursement Medicare/Medicaid (Dual Entitlement)	Medicare	Private Pay / Insurance
<p>Medicaid (T19) pays hospice rate for routine home care plus room and board at 95% of nursing home's Medicaid rate.</p> <p>A hospice may reimburse up to 100% of the rate the nursing home would have received.</p> <p>The patient/resident remains responsible for liability payment.</p> <p>Hospice reimburses nursing home in accordance with contract. (Note: Hospice may contract with nursing home for services covered by hospice; e.g., supplies, pharmacy, OT, PT, ST)</p> <p>Medicaid will pay bed-hold for 15 days for a T19 nursing home resident while in the hospital if the nursing home meets minimum occupancy requirements. Medicare does not pay for bed-hold.**</p>	<p>Medicaid programs generally pay for routine home care plus room and board. The reimbursement rate may vary by program and county.</p> <p>Nursing homes bill Family Care directly for room and board.</p> <p>A hospice may reimburse the nursing home the difference between the Medicaid program reimbursement up to 100% of the rate the nursing home would have received.</p>	<p>Medicare (T18) pays hospice rate for routine home care.</p> <p>T19 pays hospice at 95% of the nursing home's Medicaid rate.</p> <p>A hospice may reimburse up to 100% of the rate the nursing home would have received.</p> <p>The patient/resident remains responsible for liability payment.</p> <p>Hospice reimburses nursing home in accordance with contract. (Note: Hospice may contract with nursing home for services covered by hospice; e.g., supplies, pharmacy, OT, PT, ST)</p> <p>Medicaid will pay bed-hold for 15 days for a T19 nursing home resident while in the hospital if the nursing home meets minimum occupancy requirements. Medicare does not pay for bed-hold.**</p>	<p>Patient must either elect the Medicare hospice benefit (Medicare pays hospice routine home care; nursing home bills patient or private insurance) or maintain Medicare Part A coverage for SNF.*</p> <p>Nursing home bills Medicare for SNF stay. Hospice may provide service and bill patient or private insurance but cannot simultaneously provide free care as this is seen as an inducement for referral.</p>	<p>Nursing home bills patient or private insurance. Hospice bills patient or private insurance.</p> <p>A nursing home resident who does not meet the Medicare hospice benefit criteria may receive palliative care in a nursing home. The hospice bills the patient or private insurance.</p>

* In rare cases, if it can be demonstrated that skilled nursing care as defined by Medicare is needed for care not related to the terminal illness, Medicare Part A will pay for nursing home care under normal Part A Medicare and Hospice services under the Medicare Hospice Benefit. In this section, SNF is used to distinguish a resident who is receiving care under the Medicare Part A Nursing Home Benefit.

** Refer to the 1995 DQA Memo DQA-95-010 at: http://www.dhs.wisconsin.gov/rl_dsl/publications/pdfmemos/95010.pdf and to DHS 107.09(4)(j).

SECTION IV CLINICAL PROTOCOL DEVELOPMENT

Effective coordination of care that assures patient needs and regulatory requirements are met necessitates careful planning by both the nursing home 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 and DME
- Medications
- 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 admission process. In all cases, the hospice determines eligibility for hospice admission and the nursing home determines eligibility for nursing home admission.

Admission: Referral of Nursing Home Resident to Hospice

- Referral of resident to Hospice made by nursing home or others
- Consult / information provided by Hospice
- Patient / resident meets hospice admission criteria and elects to receive hospice care. Hospice inter-disciplinary group (hospice team) conducts assessments and collaborates with the physician for any change in orders.
- If a current nursing home resident elects hospice, the nursing home must complete a significant change in status assessment which requires a new comprehensive assessment using the resident assessment instrument (RAI). A significant change must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure that a coordinated plan of care between the hospice and nursing home is in place. Refer to Chapter 2, pages 2-20, of the "Long Term Care (LTC) Resident Assessment Instrument User's Manual 3.0" related to significant change in status assessments.

Admission: Referral of Hospice Patient to Nursing Home

- Hospice makes referral to nursing home; the hospice may initiate contact with the nursing home and facilitates communication between the patient / family and the nursing home representative.
- Hospice and the nursing home coordinate securing required admission paperwork (i.e., history and physical, TB screening, physician orders, etc.)
- Reference DQA Memo 96-025, dated May 2, 1996, Waiver of DHS 132, Wisconsin Administrative Code, for nursing home residents electing hospice services.
- Transfer of patient to nursing home; the provision of hospice services continues in the nursing home on day of transfer.
- RAI process and subsequent care plan developed by nursing home / hospice

Admission: Simultaneous Referral to Nursing Home and Hospice

- Referrals made to hospice and nursing home
- Hospice and nursing home coordinate the admission process and required paperwork.
- Hospice services may begin on day of admission to nursing home.
- Initiation of the RAI process, assessments, and care planning process by the nursing home and the hospice

2. Medical Orders

- Orders should be consistent with the hospice philosophy and in line with the patient's goals and plan of care.
 - At the time each hospice patient/resident is admitted to the nursing home, a decision is made as to the role of the hospice physician, nursing home physician, and attending physician, if any.
 - Specify a procedure for the prompt and orderly communication of general information, MD orders, etc., between the providers.
 - Hospice nurse has the authority to communicate the order(s) to the nursing home nurse. Nursing home nurse has the authority to communicate the order(s) to the hospice nurse.
 - Clarification of the process of obtaining and implementing orders is defined. Both providers may document orders. Orders are to be dated and signed in accordance with Wisconsin laws.
 - Both providers do not need to obtain a physician signature for an order. Once an order is signed, the other provider may copy the order for their medical record.
- Individualized orders for symptom management are obtained by the hospice and provided to the nursing home. These orders are initiated by the hospice according to patient need and as identified in the comprehensive plan of care.
- Nursing home patient specific standing orders may be utilized, if hospice determines that the orders are consistent with the hospice philosophy and the order is specified on the plan of care.

- In the event the nursing home receives new orders or changes to orders, the nursing home will coordinate implementation of the orders with hospice.
- All orders, including medication, laboratory tests, and other diagnostic procedures related to terminal illness, must be pre-approved by hospice and specified on the plan of care.
- The nursing home coordinates the scheduling of routine physician visits (and/or physician extender visits) that relate to nursing home regulations. Under state and federal law applicable to nursing homes, a physician extender (e.g., nurse practitioner or physician assistant) may be utilized after the first 30 days and every 60 days thereafter.

3. Supplies and Durable Medical Equipment (DME)

Supplies and DME related to the management of the terminal illness are the responsibility of the hospice. The nursing home and hospice should coordinate obtaining and monitoring supplies and services according to the terms of their contract. Routine DME and supplies are provided by the nursing home as part of room and board. A current list of what is included in room and board can be found at:

<https://www.Forwardhealth.wi.gov/WIPortal/Default.aspx> DME and supplies not covered in the room and board payment which is related to the terminal illness is the financial responsibility of the hospice.

- A hospice may contract with a nursing home for non-routine DME if the nursing home meets the hospice state and federal regulations related to provision of DME.
- Disposable medical supplies related to the terminal illness, as specified in the plan of care.

4. Medications

- Administration of medications is the responsibility of the nursing home and is included in the room and board payment.
- Prescription medications related to the terminal illness (medications supplied by hospice) must meet nursing home pharmacy labeling and distribution requirements.
- The hospice is responsible for assessing the need for and obtaining medications related to the terminal illness in a timely manner.
- Medications related to the terminal illness are billed to the hospice provider, even if the resident has Medicare Part D coverage.
- The nursing home is responsible for accounting for medications and ensuring access to emergency 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

5. Medical Record Management

- Copies of hospice informed consent, Medicare Hospice Benefit election, current physician certification and recertifications, advance directives, plan of care, medications, and physicians orders must be on the nursing home chart.
- 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 nursing home medical record and not be thinned.
- Original MDS information stays with nursing home record and may be utilized by the hospice.
- The patient's record in the nursing home will confidentially identify the person as a hospice patient.
- The records of a patient residing in the nursing home must include clinical information that is relevant to the care of the patient (orders, data assessment, etc.), whether obtained by the hospice or the nursing home.

6. Hospice Services

Hospice services are defined in the Code of Federal Regulation (CFR) and include nursing services, medical social services, physician services, medical director, and counseling services. These services are to be routinely provided directly by hospice employees and cannot be delegated to the nursing home staff. All covered hospice services must be available as necessary to meet the needs of the patient for the terminal illness and related conditions. Additional hospice services include aides and volunteers.

a. Nursing Services

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

The hospice may involve nursing personnel from the nursing home to assist with the administration of prescribed interventions as specified in the plan of care. This involvement would be to the extent that the hospice would routinely utilize the patient'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 nursing home 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 nursing home as identified in the bereavement plan of care.

Additional counseling interventions may be provided collaboratively by the hospice and nursing home 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. Attending physician services may be provided by the hospice or nursing home medical director, the patient's attending physician, or their designees. The patient has the right to choose her/his attending physician.

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 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

Aide services should be provided collaboratively by the hospice and nursing home based on patient need and as specified in the plan of care. The nursing home is responsible for providing hospice patients the same level of services provided to non-hospice residents. (Reference "Nursing Home Surveyor Protocols, Appendix PP.") The hospice is responsible for providing nursing home patients the same level of services provided to hospice patients in their own homes. Hospice aides must have successfully completed hospice orientation addressing the needs and concerns of residents and families coping with a terminal illness.

g. Hospice Volunteer Services

Volunteers may be asked to provide patient care services. The service 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 nursing home prior to any patient care.

7. Death Event

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

- At the time of death, the nursing home 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 nursing home guidelines regarding coroner/medical examiner involvement, and follow the protocol.
- The hospice nurse coordinates notification of physician for release of body.
- Medication disposal is the responsibility of the nursing home.
- Specify hospice and nursing home role in supporting the resident's family/caregivers and nursing home staff.

8. Quality Assessment Performance Improvement

The nursing home and hospice are required to implement quality assurance/performance improvement activities per respective regulations.

A collaborative approach to problem solving and outcome monitoring is encouraged for inter-related issues.

9. 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 stated wishes in the advance directive and with the physician's orders, including cardiopulmonary resuscitation.

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

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

Nursing home staff immediately notifies the hospice if:

- A significant change in a patient'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 from the nursing home arises and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions; or
- A patient dies.

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

10. Employment Issues

- A key consideration for both the hospice and nursing home 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 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 hospice volunteers.
- Nursing home employees may be employed by or volunteer for a hospice during non-nursing home 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 nursing home 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.
- Criminal background checks will be completed per contract.

B. Patient / Resident Assessment and Plan of Care

The nursing home and hospice must develop a coordinated plan of care for each patient that guides both providers. The coordinated plan of care must identify which provider (hospice or nursing home) 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 nursing home 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; and
- Patient goals

When a patient is admitted, both providers are responsible for establishing 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 nursing home staff, the attending physician (if any), and the patient or representative.
- The nursing home may use the hospice IDG's assessment of the resident in completing the required Minimum Data Set (MDS) for nursing home residents and completing the nursing home portion of the plan of care. The nursing home is responsible to assure that the MDS is complete and submitted in accordance with the nursing home requirements.

The nursing home is required to update its plan of care in accordance with any federal, state, or local laws and regulations governing the particular nursing home and the hospice is then responsible for updating the plan with the nursing home, the attending physician and patient or representative (to the extent possible) as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.

- The providers must have a process in which they can exchange information from the hospice IDG plan of care reviews and assessment updates and the nursing home team, patient, and family (to the extent possible) conferences, when updating the plan of care and evaluating outcomes of care to assure that the patient receives the necessary care and services.

The provision of care by each provider for the 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 nursing home nursing personnel in the administration of prescribed therapies, as they would use the patient's family/caregiver in implementing the plan of care. Hospice remains responsible for arranging, providing, and ensuring availability for patient 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 nursing home remains responsible for arranging, providing, and ensuring for patient use of the medications, medical supplies, and/or DME not related to the terminal illness and related conditions. The nursing home'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 the nursing home to perform.

The providers must have a procedure that clearly outlines the chain of communication between the hospice and nursing home 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.

1. Use of the Resident Assessment Instrument, including the MDS, in the Care Plan Process

General Framework for Decision-Making

Nursing homes are required to use the Resident Assessment Instrument (RAI) that includes the Minimum Data Set (MDS) for all nursing home residents, including residents who choose

hospice. The MDS is completed at the time of admission and periodically throughout a resident's stay. A new comprehensive assessment is required when there is a significant change in status that meets the definition in the RAI. A significant change in status assessment (SCSA) is required to be performed when a terminally ill resident enrolls or discontinues hospices and remains a resident at the nursing home (RAI Manual, May 2011, pp. 2-21).

- **Recommendation 1**

The initial RAI is very important and includes the MDS, as well as the periodic reviews. Sharing of information and collaborating in this process is strongly encouraged. It is essential that the hospice core team and the nursing home staff both derive patient care decisions from the same core set of patient data.

Many of the patient-change criteria that can trigger the need for generation of a new MDS for terminally ill or dying patients are, in fact, changes that are a natural, expected outcome of the progression of a terminal illness and/or the dying process. The key in determining if a SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual (RAI Manual, May 2011, pp. 2-25). In these situations, the patient care benefits of generating a new MDS are minimal at best, and are far outweighed by the intrusion to the patient that the process of developing a new MDS entails.

- **Recommendation 2**

If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for a SCSA, a new assessment is required (RAI Manual, May 2011, pp. 2-25). Periodic reviews (quarterly and annually) are still required. Illustrated as a process, this statement would look as follows:

Trigger	Change in Patient Condition (after hospice election).
Notify and Review	The nursing home reports the change to hospice and initiates a joint review of the Care Area Assessments (CAA).
Decision	The hospice and nursing home staff make a two-fold determination: (a) Is the change in condition related to the progression of the terminal illness? (b) Was the change already anticipated and documented on the MDS?
Action	<p style="text-align: center;">If "yes," to both questions: No new comprehensive assessment; hospice and nursing home staff address changes through the plan of care.</p> <p style="text-align: center;">If "no," to one or both questions: New comprehensive assessment by the nursing home staff and hospice is completed to determine changes to the care plan.</p>

2. Patient Change of Conditions

Various elements of the nursing home MDS/RAI relate to the progression of the terminal illness and/or dying process. When supported by hospice philosophy and experience, elements

subject to a change in condition are divided into three categories, detailed below. Guidelines to govern the decision-making process for determination of whether a new MDS is to be generated are outlined in the following chart.

Category	Problem Area
<p>Potential Expected Outcomes of the Progression of the Terminal Illness and/or Dying Process</p>	<ul style="list-style-type: none"> • Delirium • Use of Psychotropic Drugs • Pressure Ulcers • Dental Care • Urinary Incontinence (including catheter) • Behavior Problems • Falls (patient at risk for) • Cognitive Loss/Dementia • Communication • Pain
<p>Expected Outcome of the Progression of Terminal Illness and/or Dying Process</p>	<ul style="list-style-type: none"> • Dehydration and Fluid Maintenance • Psychosocial Changes • Activities of Daily Living (ADL) • Mood Status • Activities • Nutritional Status • Visual Function
<p>Special Circumstances</p>	<ul style="list-style-type: none"> • Physical Restraints • Feeding Tubes • Return to Community

3. Potential Expected Outcomes

Certain changes in patient condition are potential, expected outcomes of the progression of the terminal illness and/or dying process. While they may not be present in every terminally ill or dying patient, these changes are **not unexpected** and are routinely addressed by hospice staff in the regular course of care. The occurrence of one of these changes should not trigger a change of condition MDS, if the change is related to the terminal illness and/or dying processes, is anticipated, and is documented.

In evaluating the change of condition, the elements of the change should be reviewed by the nursing home staff with the hospice staff. This process will necessarily involve the expertise of the nursing home staff and underscores the importance of the review being a joint effort. The focus of the review is based on the resident's condition regardless of the cause.

The following grid provides sample statements that include elements to be reviewed under each Care Area Assessment (CAA) listed. Additional elements should be included based on an assessment of individual patient circumstances.

Care Area Assessment (CAA)	Elements of Review
Delirium	Assess medication, psychosocial state, and sensory loss.
Use of Psychotropic Drugs	<ul style="list-style-type: none"> • Assess medications (drug review) and side effects. • Adjuvant drug therapy will be utilized to provide palliative symptom management. • The risk-benefit ratio evaluation regarding drug initiation and continued use, including use outside the guidelines, will be assessed by the hospice IDT / IDG and nursing home staff. • Documentation will be recorded in the clinical record by nursing home staff. • Reference DQA Memo 10-37, Informed Consent for Psychotropic Medications.
Pressure Ulcers	<ul style="list-style-type: none"> • Assess pressure versus stasis ulcer. • Assess skin integrity.
Dental Care	<ul style="list-style-type: none"> • Dental care to increase comfort may be undertaken. • Preventative dental care is not an expected part of the plan of care.
Urinary Continence (including catheter)	<ul style="list-style-type: none"> • Reduced output may occur given the progression of the terminal illness and dying process. • Assess UTI, fecal impaction, UA, diabetes, medication.
Behavior Problems	Assess volatility of mood, medications, and cognitive status.
Falls (patient at risk for)	<ul style="list-style-type: none"> • Safety issues can be anticipated because of physical deterioration with a terminal illness and associated adjuvant drug therapy. • Assess medications, appliances, and environment.
Cognitive Loss / Dementia	Assess functional limitations, sensory impairment, medication involvement factors, and failure to thrive.
Communication	Assess components of communication, including strengths and weaknesses and medication.
Pain	Assess whether the resident is on a scheduled pain medication that controls discomfort as reported by the resident.
Terms <ul style="list-style-type: none"> • IDT = Interdisciplinary Team • IDG = Interdisciplinary Group • UA = Urinalysis • UTI = Urinary Tract Infection 	

4. Expected Outcomes

Certain changes in patient condition are expected outcomes with a high probability of occurring as part of the progression of the terminal illness and/or dying process. There are no identifiable benefits of triggering a change-of-condition MDS on these criteria, provided that the hospice and nursing home staffs have (1) jointly reviewed the criteria and determined that the change of condition is linked to the terminal illness and/or dying process and (2) this review and determination have been documented in the clinical records.

Seven of the CAA problem areas are expected outcomes of the progression of the terminal illness and/or dying process. The following sample statements address the respective CAA problem area listed.

- **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 residing in the nursing home 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.

5. Special Circumstances

Changes in patient 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 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 resident, may be used only under the order of a physician. If used, the restraint must enable the resident to maintain his or her highest level of functioning. Restraint usage must be consistent with the guidelines set forth in the CMS State Operations Manual and state/federal nursing home/hospice regulations. Refer to the clinical guidelines distributed via DQA Memo 00-021, Quality Improvement Information: Providing a Quality Life While Avoiding Restraints.” These guidelines are available on the DHS web site at: http://www.dhs.wisconsin.gov/rl_dsl/publications/Restraint.pdf

- **Feeding Tubes.** A normal part of the dying process is the body's decreased need and the patient's decreased desire for nutrition and hydration. The hospice is responsible for discussing the use of feeding tubes with the patient/family as the terminal illness progresses and will initiate enteral/parenteral feeding at patient/family request, as consistent with the philosophy of the individual hospice. Nursing home staff is involved to the extent that the hospice would routinely utilize the patient's family/caregiver in the provision of enteral/parenteral feedings.
- **Return to Community.** Occasionally a resident may have the desire to die in his/her private home. This requires coordination to assure that the resident has enough support to meet their needs and those of the caregiver. Hospice is responsible for making the transfer arrangements in collaboration with the nursing home.

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 nursing home/hospice partnership. Achieving quality outcomes for patients 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 facility. It is also the hospice's responsibility to determine how frequently training needs to be offered in order to ensure that the facility staff furnishing care to hospice patients are oriented to the philosophy of hospice care. Facility 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 nursing home 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 nursing home staff (i.e., meeting with business office and clerical staff separately from direct patient care staff to allow for questions and discussion specific to the expertise of the group).*

- Discussion of hospice concept and philosophy, including patient'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 needs, family support, and record maintenance
- Symptom management practices common for hospice patients
- 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 nursing home needs to be balanced by a corresponding effort to educate hospice staff on the regulations and protocols of the nursing home. 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 nursing home
- Discussion of resident rights
- Life Safety Code, 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 regulations governing use of psychotropic, “unnecessary medications,” self-medication, etc.
- Patient 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 nursing homes 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. Likewise, nursing homes may want to provide similar opportunities for hospice staff to share current trends and industry standards. Suggested topics for these periodic updates include:

- Pain control and other symptom management protocols commonly used for hospice patients
- Loss, grief, and bereavement care
- Quality assurance/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 discuss mutual roles and responsibilities, as appropriate

Some hospices hold regular conferences in the nursing home on a prearranged schedule to communicate patient related issues. Others conduct occasional IDG meetings in the nursing home and encourage nursing home 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 nursing home and hospice providers are encouraged. The use of various “mediums” is helpful to have available in the nursing home 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.