HOSPICE/NURSING HOME INTERFACE

GUIDELINES FOR CARE COORDINATION FOR HOSPICE PATIENTS WHO RESIDE IN NURSING HOMES

Jointly prepared by the
Hospice Organization and Palliative Experts (HOPE) of Wisconsin;
Wisconsin Department of Health and Family Services (DHFS),
Division of Supportive Living (DSL), Bureau of Quality Assurance (BQA);
The Wisconsin Health Care Association; and
The Wisconsin Association of Homes and Services for the Aging

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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 serves as guidelines for hospice and skilled nursing home providers when jointly serving hospice patients who choose to reside in skilled nursing facilities.

The collaboration of hospice and skilled nursing facility providers takes careful planning. In 1995, a task force consisting of representatives of the hospice and nursing home industries published the first edition of this document. The Bureau of Quality Assurance reviewed the guidelines, and found it did not conflict with the intent of hospice and nursing home regulations. The first edition was widely distributed on a state and national basis.

Since 1995, the hospice and nursing home industry has learned a great deal about developing and refining the process to maximize the expertise available through a collaborative partnership. Based on our collective experience, the second edition of the Guidelines for Care Coordination for Hospice Patients Who Reside in Nursing Homes was created. Hospice and nursing home provider representatives edited this second edition of the guidelines.

The Wisconsin Department of Health and Family Services, Division of Supportive Living, Bureau of Quality Assurance, assisted in reviewing and editing the guidelines. These guidelines are 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 Hospice Organization and Palliative Experts (HOPE) of Wisconsin has made this edition of the Guidelines available to providers for reproduction as needed. This guideline will also be made available on the Department of Health and Family Services (DHFS) web site at:

http://www.dhfs.state.wi.us/rl_DSL/Hospice/HospiceIntro.htm

SECTION II

REGULATORY REFERENCES

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

References include:

- Wisconsin Statute, Chapter 50
- Wisconsin Administrative Code, Chapter HFS 131, Hospices
- Wisconsin Administrative Code, Chapter HFS 132, Nursing Home Rules
- Bureau of Quality Assurance Memo BQC 96-025, "Waiver of Chapter HSS132, Wisconsin Administrative Code, for Nursing Home Residents Electing Hospice Services."
- 42 Code of Federal Regulation (CFR) Part 418, Hospice
- Social Security Act Section 1861(dd)
- Centers for Medicare and Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA), State Operations Manual (Transmittal 265, dated 12/1994 and transmittal 23, dated 12/8/2000) and Appendix M, Hospice Survey Procedures and Interpretive Guidelines.
- 42 CFR Part 483, Medicare and Medicaid; Requirements for Long Term Care Facilities
- HCFA Long Term Care Resident Assessment Instrument User's Manual, Version 2.0 (Wisconsin Edited: April 1998/October 1999/August 2000) PSL-3109

SECTION III

CONTRACT CONSIDERATIONS

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 (Bureau of Quality Assurance) and federal (Centers for Medicare and Medicaid Services) sources.

The information that follows is specifically pertinent to the routine home 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.

CONSIDERATIONS FOR THE HOSPICE "ROUTINE HOME CARE" CONTRACT

1. Administrative Concerns and Core Services Requirements

a) The hospice/nursing home agreement must be in writing.

b) The written agreement must specify that (1) the hospice takes full responsibility for professional management of the patient's hospice cares, and (2) the nursing home provides room and board.

c) Hospice must provide the same services that it would otherwise offer if the patient was in a private residence, including necessary medical services and inpatient care arrangements.

d) The written agreement should identify a dispute resolution mechanism to be utilized in the event of conflict or disagreement.

e) Hospice may not discharge a hospice patient at its discretion, even if care promises to be costly or inconvenient.

f) Statute/regulation prohibits a hospice from discontinuing care to a Medicare beneficiary due to inability of the patient to pay.

g) References to specific government agencies can often be misleading and should be omitted from contract language, refer more generally to "state" (or "federal") regulations, rather than "CMS," "BQA," etc.

h) Admission criteria and requirements must be identical for all individuals regardless of payment.

i) The agreement should specify the exact services, and extent of services, that will be provided individually by the hospice and nursing home.

j) The agreement should specify the exact responsibilities of each provider in the provision, and coordination, of care and services.

k) Substantially all core services must be routinely provided "directly" by hospice employees, and must not be delegated. (Interpretation of "directly" is that the person providing the service for the hospice is a hospice "employee." "Employee" includes paid staff and volunteers under the jurisdiction of the hospice (see 42CFR 418.3).

l) Hospice must provide the following core services through its own employees:
   - Physician services (DSL-BQA-99-039, Variance of HFS 133.43 (2) (a) 1)
   - Nursing services
   - Medical social services
   - Counseling services

m) Hospice may not contract with the nursing home to provide core services.

n) The nursing home may provide <u>non-core</u> services based on the contract. Hospice MUST assume the overall professional management responsibility for the services and assures that these services are performed in accordance with hospice policy and the hospice plan of care.

o) Routine room and board services to be provided by the nursing home including:
   - Personal care services
   - Assistance with activities of daily living (ADLs)
   - Administration of medications
   - Social activities
   - Room cleanliness
   - Supervision/assistance with DME use and prescribed therapies

p) Hospice must include the patient's attending physician in the care planning process.

q) Hospice certification and licensure requirements do not require designation of a primary caregiver, although individual hospices can require this as a prerequisite to admission.

r) Identify the terms and procedure for formal review and renewal of the hospice/nursing home relationship on a regular basis.

2. Coordination of Services

a) At the time each hospice patient/resident is admitted to the facility, the nursing home must have physician (attending and/or hospice medical director) orders for the recipient's immediate care.

b) Both providers must specify who is responsible for obtaining, administering and controlling medications. This includes access to emergency medications. If self-administration is indicated, the contract must delineate the provider responsible to ensure that medications are labeled appropriately and have not expired. (HFS132)

c) Contract must specify that patient confidentiality will be maintained and that hospice staff have access to nursing home records and vice-a-versa.

d) All information relevant to the patient's care **must be shared and contained in the** medical records compiled by both the hospice and nursing home. (**Caution:** The term "relevant" must be interpreted broadly enough to avoid inadvertently failing to share marginally relevant information.)

e) Except where dictated by state or federal regulations, identify which provider will retain "originals" and which provider will retain "copies" of pertinent documents in the medical record.

f) Specify a procedure for the prompt and orderly communication of general information, MD orders, etc., between the providers.

g) Identify who will be responsible for completing various parts of the MDS document. The hospice provides information about the patient/resident for completing the required Minimum Data Set (MDS) for nursing home resident assessment and care plans. The nursing home is responsible to assure that the MDS is complete and submitted to the state in accordance with the nursing home requirements.

h) The hospice and nursing home must jointly coordinate the development, implementation and evaluation of the comprehensive plan of care. This comprehensive plan of care must be implemented according to accepted professional standards of practice.

i) The comprehensive plan of care must clearly delineate each provider's responsibility for the patient specific care and services.

j) Aside from hospice responsibilities that are part of the core requirements, include a statement that the comprehensive plan of care must specify the individual responsible for carrying out each intervention.

k) Specify 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 plan of care are indicated. Hospice must authorize all changes to the plan of care prior to the change being made.

l) Each provider must be aware of the other's responsibilities in implementing and updating the plan of care.

m) Hospice must ensure that hospice services are always provided in accordance with the plan of care, in all settings. The nursing home must ensure that its services are provided in accordance with the plan of care.

n) 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.

o) Hospice is responsible for making all inpatient care arrangements (symptom control and respite).

p) Specify bed hold requirements.

3. Employment Issues

a) 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.

b) A hospice may use contracted employees for core service only during:
- periods of peak patient load
- extraordinary circumstances

c) For a hospice, "employee" is defined in 42 CFR 418.3 and HFS 131.13 (7).

d) Nursing home employees may be employed by the hospice during non-nursing home employment hours. Essential requirements for this to occur include:
    - accurate time records and wage and hour compliance issues
    - clear delineation of responsibilities (intent is to avoid allegations of dual reimbursement) or confusion. For example: nursing home staff might assume that aide or RN providing hospice care is providing nursing home care as well.

e) 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.

f) Specify orientation and ongoing training requirements.

4. Reimbursement Issues

a) Specify which entity is responsible for billing the cost of specific services and determining to whom billing is directed.

b) Specify procedure for managing patient's social security liability payment when patient has elected the Medical Assistance hospice benefit.

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

Medicaid	Reimbursement Medicare/Medicaid (Dual Entitlement)	Medicare	Private Pay/Insurance
Medicaid (T19) pays hospice rate for routine home care plus room and board at 95% of nursing home's Medicaid rate. The patient/resident remains responsible for liability payment, in which the reimbursement is 95% minus resident liability. Hospice reimburses nursing home in accordance with contract. (Note: Hospice may contract with nursing home for services covered by hospice, e.g., supplies, pharmacy, DME, OT, PT, ST, CNAs). Bed hold may be reimbursed if the SNF meets criteria. Reimbursement is at bed hold rate for the SNF.	Medicare (T18) pays hospice rate for routine home care. T19 pays hospice at 95% of the nursing home's Medicaid rate. The patient/resident remains responsible for liability payment, in which the reimbursement is 95% minus resident liability. Hospice reimburses nursing home in accordance with contract. (Note: Hospice may contract with nursing home for services covered by hospice, e.g., supplies, pharmacy, DME, OT, PT, ST, CNAs). Bed hold may be reimbursed if the SNF meets criteria. Reimbursement is at bed holding rate for the SNF.	Patient must either elect the Medicare hospice benefit (Medicare pays hospice routine home care, and nursing home bills patient or private insurance); or, maintain Medicare Part A coverage for SNF.* Nursing home bills Medicare. Hospice may provide service and bill patient or private insurance. If the patient does not meet criteria for hospice Medicare benefit or skilled Medicare, the patient is the same as a private pay/insurance patient.	Nursing home bills patient or private insurance. Hospice bills patient or private insurance.

* 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.

SAMPLE PROVISIONS FOR INCLUSION
IN A HOSPICE/NURSING HOME CONTRACT

Initially developed for the first edition by:
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The following sample contract provisions are provided for use when developing the format of a hospice-nursing home contract. Since it is essential that the contract process be individualized to best meet the particular circumstances of the contracting parties, these sample provisions are intended for general reference only.

This document does not purport to be all-inclusive or "model" in nature. It will likely need to be changed in at least several respects to accurately conform to the intentions of each party. For example, exact terms used in the "Definitions" section will probably vary among providers, and certain other sections might be more easily addressed in combination under one general topic heading. In addition, providers may prefer to include additional provisions and section, which are not included among the samples in order to provide greater detail and clarity to their agreement. Therefore, while providers should feel free to review these **sample** provisions (as well as others) during preliminary contract negotiations, the format of their **actual** contract should always reflect the individuality of their specific relationship.

1. Recitals

2. Definitions (particularized to individual needs and terminology)

Attending Physician	Informed Consent
Care Manger	Interdisciplinary Group
Covered Services	Non-covered Services
Facility	Nursing Home Medical Director
Hospice	Patient Care Management
Hospice Care	Plan of Care
Hospice Medical Director	Residential Hospice Patient
Hospice Services	Respite Care
- Routine Home Care	Room and Board Services
- Inpatient Respite Care	Other Pertinent Definitions as Identified by the Parties
- Continuous Care	Bed hold
- Inpatient Acute Care	

3. **Eligible Residents** (criteria)

Medicaid Eligible
Medicare Eligible
Medicaid/Medicare (dual eligibility)
Private Insurance or HMO
Private Pay
Other Pertinent Sections As Identified by the Parties

4. **Coordination of Services**

Admission Procedures (general process, written orders, authorizations)
Patient Care Management (decision process, delegation of responsibility)
Continuity of Care (transfers between levels of care, actions requiring patient notice)
Communication Process (detail the process generally and for emergencies)
- notification of MD (change of condition, death, etc.)
- notification of hospice

Interdisciplinary Team Meetings
Quality Assurance/Performance Improvement
Drugs and Pharmaceuticals
Medical Equipment and Medical Supplies
Transportation and Ambulance
Family Services and Bereavement Care
Other Pertinent Sections as Identified by the Parties

5. **Hospice Duties, Responsibilities and Services**

Hospice Services (general coverage under Routine Home Care), Access and Availability
Provision of Core Services
Compliance with Law (including licensure, staff qualifications)
Hospice Patient Care Management
Management of the Terminal Illness: Plan of Care
Medical Order: Responsibilities of Attending Physician
Medical Order Procedures
Documentation (clarification of respective duties, location of original medical record)
Confidentiality of Medical Record
Orientation and Education
Other Pertinent Sections as Identified by the Parties

6. **Facility Duties, Responsibilities and Services**

Facility Services (generally, room and board, specific services, plan of care, cooperation with hospice in identified areas, bedhold policy)
Compliance with Law (including licensure, staff qualifications)
Availability of Nursing Home Care (hours of care, adequate services, personnel)
Documentation (clarification of respective duties, location of original medical record)
Facility Staff Privileges: Hospice Medical Director
Access to Documents (medical/business records, federal record retention requirements for facility, subcontractors)
Orientation and Education
Other Pertinent Sections as Identified by the Parties

7. **Financial Responsibility**

Responsibility of the Hospice
Responsibility of the Facility
Reimbursement

- Medicaid Patients
- Medicare Patients
- Medicaid/Medicare Patients
- Private Pay/Insurance Patients
- Purchase of Services by the Hospice from the Facility
- Other Pertinent Sections as Identified by the Parties

8. **Insurance and Indemnification**

9. **Joint Review of Hospice Services** (quality, appropriateness)

10. **Compliance with Government Regulations** (caregiver background checks, nurse aide registry, corporate compliance, etc.)

11. **Relationship Between the Parties**

12. **Conflict Resolution Process**

13. **Term of the Agreement** (length, renewals)

14. **Termination of the Agreement** (for cause/without cause, events precipitating regulatory implications, resident transfers and single-case continuation agreements, resident notice timeframes)

15. **Amendments to the Agreement**

16. **Notice Requirements** (form, method, and delivery)

17. **Miscellaneous** (Including Non-discrimination Policy)

18. **Other Pertinent Sections as Identified by the Parties**

19. **Appendices** (if desired, may include references to provider policies, clinical protocols and procedures; see also: "Clinical Protocols" and "Educational Planning" documents for possible policies and protocols.

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.

1. PRIORITY AREAS

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

Admission Process	Hospice Core Services
Physician Orders	Death Event
Supplies and Medications	Quality Assurance/Performance Improvement
Medical Record Management	Emergency Care

a) Admission Process

Protocols should be developed that clarify the process of admitting a current nursing home resident to the hospice program, a current hospice patient to the nursing home, and lastly for the simultaneous admission of a patient who is new to both the hospice and the nursing home.

- **Admission: Referral of Nursing Home Resident to Hospice**

  Referral of resident made to Hospice made by nursing home or others.

  Consult/information provided by Hospice.

  Patient/resident meets hospice admission criteria and chooses to pursue admission to Hospice Care.

  Hospice conducts assessments, secures orders from the physician and manages orders from this point.

  Nursing Home assesses if significant change of condition has occurred that requires a new comprehensive assessment using the resident assessment instrument (RAI). Refer to Chapter 2, page 2-8 of the “Long Term Care (LTC)-Resident Assessment Instrument User’s Manual” 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 BQA memorandum 96-025, dated May 2,1996, Waiver of HFS 132 Wisconsin Administrative Code for NH 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.

  Transfer of patient to nursing home-hospice involvement begins on day of transfer.

  Initiation of the RAI process, assessments and care planning process by the nursing home and the hospice.

b) Physician Orders

Hospice is responsible for securing medical orders and assuring they are consistent with the hospice philosophy.

Individualized standing orders for symptom management are obtained by the hospice from the attending physician and provided to the nursing home. These orders may be 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 (based on contract), if they are consistent with the hospice philosophy and specified on the plan of care.

All verbal, phone and written orders must be authorized by hospice before initiated.

Laboratory tests or 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 nurse practitioner visits). Under state and federal law applicable to nursing homes, a nurse practitioner may be utilized after 30 days of the first 90 days, and after 60 days thereafter. "Certified Registered Nurse Hospice" (CRNH) does not qualify as an advanced practice nurse.

Hospice nurse may communicate the physician order(s) to the nursing home nurse.

c) Supplies and Medication/Contracted Services:

Supplies and medications related to the management of the terminal illness are the responsibility of the hospice. The nursing home and hospice should coordinate obtaining and monitoring the following supplies and services according to the terms of their contact:

Prescription medications related to the terminal illness (medications supplied by hospice must meet nursing home pharmacy labeling and distribution requirements).

Durable medical equipment (DME), i.e., wheelchair, walker, bath bench, commode, oxygen, etc. that are related to the terminal illness.

Disposable medical supplies related to the terminal illness, as specified in the plan of care.

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

d) Medical Record Management

Copies of physician orders and coordinated plan of care should be on medical records of both organizations. The location of the original orders should be based on the contract.

Copies of hospice informed consent and current physician certification must be on the nursing home chart.

Original RAI/MDS information stays with nursing home record and may be copied to hospice based on the contract.

The patient's record in the nursing home will confidentially identify the person as a hospice patient.

If specified in the contract, both the hospice and nursing home retain copies of all or parts of the other's record following death or discharge of a hospice patient.

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

The clinical information must be included in the records maintained by each provider.

If admitted to the hospital, copies of transfer bed hold agreement if indicated.

e) Hospice Core Services

Core services as defined in the Code of Federal Regulation (CFR) include nursing services, medical social services, physician services (medical director), and counseling services. These services are to be provided routinely directly by the hospice employees and cannot be delegated to the nursing home. All covered hospice services must be available as necessary to meet the needs of the patient.

1) Nursing services

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

The hospice may involve nursing personnel from the nursing home to assist with the administration of prescribed interventions if 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.

2) Medical Social Services

Social services constitute a core service of hospice for assessment, 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.

3) **Counseling Services (Bereavement/Dietary/Spiritual/other)**

Counseling is a core service of hospice for assessment, 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 Wisconsin Administrative Code, HFS 131.42 (3) (d).

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

4) **Physician Services**

Physician Services are a core service of hospice for assessment and evaluation. The Hospice Medical Director provides this service.

Attending physician services may be provided by the Hospice or Nursing Home Medical Director, the patient's attending physician, or their designees.

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

5) **Other (non-core) services**

CNA/HHA should be provided collaboratively by the hospice and nursing home based on patient need and as specified in the plan of care (clarify in contract).

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.

Volunteer services are to be coordinated by the hospice but may be provided collaboratively by the hospice and nursing home as specified in the plan of care (clarify volunteer role in contract, especially related to hands-on care).

f) Death Event

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

The hospice must be notified, make a visit and coordinate the death

pronouncement.

Review state, county, and facility guidelines regarding coroner/medical examiner involvement, and follow the protocol specified in contract for notification.

Nursing home and hospice coordinate notification of physician for release of body when heart rate and respiration have ceased.

Medication disposal.

Specify hospice and nursing home role in supporting the resident's family/caregivers and nursing home staff.

g) Quality Assurance/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.

h) Emergency Care

Emergency care is defined as unexpected and **may or may not be related or unrelated** 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 facility 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.

2. PLAN OF CARE:

The nursing home and hospice must coordinate and establish a plan of care for both providers which reflects the hospice philosophy, and is based on the individual's needs within this unique living situation. For further information related to care planning for the resident who has a terminal illness, please refer to the care planning 2000 guidelines distributed via BQA memorandum 00-022. Each nursing home and hospice should develop policies and protocols to accomplish the MDS/RAP care plan process.

a) 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 MDS, for all nursing home residents, including residents who choose hospice. The MDS is completed at the time of admission and periodically through out 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. The RAI definition addresses end stage disease and the need for significant change of condition (SCOC) assessment. (Refer to RAI manual for specifics).

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. 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:

Refer to the Center for Medicare and Medicaid Services (formerly Health Care Financing Administration's) RAI Manual, page 2-11 for information related to End-Stage Disease Status.

When a patient changes from a rehabilitation/curative course of care to palliative care, the initial change-of-condition minimum data set (MDS) may be the final change of condition MDS. In this situation, the changes in condition are anticipated and documented as part of the progression of the terminal illness and/or dying process. 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	**Nursing home reports change to hospice and initiates a RAP review jointly with hospice staff**
DECISION	**The hospice and nursing home staffs make a two-fold determination: (a) is the change in condition related to the progression of the terminal illness, and (b) was the change already anticipated and documented on the MDS?**
ACTION	**If "YES" to both questions: No new comprehensive assessment; hospice and nursing home staff address changes through the plan of care.** **If "NO" to one or both questions: New comprehensive assessment by the nursing home staff and/or hospice and shared by the two agencies.**

Revisions could be made in the nursing home's approach to the RAI/MDS process that would protect quality of care for patients by forcing a review of the patient's condition against the changes expected and documented as part of the progression of the terminal illness and/or dying process. Additional triggering a SCOS assessment is a clinical decision at the nursing home level, and in many instances, is of little value in the care of the terminally ill hospice patient electing hospice.

b) Patient Change of Condition:

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 paragraphs.

Category	Problem Areas
Potential expected outcomes of the progression of the terminal illness and/or dying process	**Delirium** **Use of psychotropic drugs** **Pressure ulcers** **Dental care** **Urinary incontinence (including catheter)** **Behavior Problems** **Falls (patient at risk for)** **Cognitive loss/dementia** **Communication**
Expected outcome of the progression of terminal illness and/or dying process	**Dehydration and fluid maintenance** **Psychosocial changes** **Activities of daily living (ADL)** **Mood status** **Activities** **Nutritional status** **Visual function**
Specials	**Physical restraints** **Feeding tubes**

c) Potential, Expected Outcomes:

Certain changes in patient condition are potential, expected outcomes of the progression of the terminal illness and/or dying process. That is, 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.

The value of the information generated through a change of condition MDS may be of limited value in reshaping care provided to the terminally ill or dying patient.

At the time a change in condition presents in the hospice patient residing in the nursing home, a determination should be made as to whether the change is related to the terminal illness or dying process, and whether it has been documented. If so, a

new MDS would not be triggered. Instead, the hospice interdisciplinary team in collaboration with the nursing home would address the change of condition through the plan of care.

The federal RAI manual, page 2-11, provides the following guidance. *"In an end-stage disease status, a full reassessment is optional, depending on a clinical determination of whether the resident would benefit from it. The facility (nursing home) is still responsible for providing necessary care and services to assist the resident to achieve his or her highest practicable well being. However, provided that the facility identifies and responds to problems and needs associated with the terminal condition, a comprehensive re-assessment is not necessarily indicated."*

In evaluating the change of condition, the elements of the change as set out in Appendix R, Resident Assessment Instrument for Long Term Care Facilities, of the CMS State Operations Manual 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 RAP problem area listed. Additional elements should be included based on an assessment of individual patient circumstances.

RAP Problem	Elements of Review
Delirium	Assess medication, psychosocial state and sensory loss.
Use of Psychotropic drugs	Assess medications (drug review) and side effects. Adjuvant drug therapy will be utilized to provide palliative symptom management. The risk-benefit ration 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.
Pressure Ulcers	Assess pressure versus stasis ulcer, assess skin integrity.
Dental Care	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)	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)	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.

Terms:

IDT - Interdisciplinary Team
IDG - Interdisciplinary Group
UA - Urinalysis
UTI - Urinary Tract Infection

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

- **Dehydration and fluid maintenance -** Changes in hydration status and fluid balance occur as part of the progression of the terminal illness and/or dying process. If the change noted in the patient is related to that progression, the benefits of generating a change-of-condition MDS are minimal in terms of patient care, and do not outweigh the intrusion of conducting the MDS.

- **Psychosocial changes -** Changes in lifestyle and interactions 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 generally becomes 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 is expected in a terminal illness.

- **Visual functions -** A decrease in visual function is anticipated with the dying process.

e) 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 DSL-BQA-00-021 memorandum related "Quality Improvement Information: Providing a Quality Life While Avoiding Restraints". These Guidelines are available on the DHFS web site at:
  http://www.dhfs.state.wi.us/rl_DSL/NHs/NHnodMemos.htm

- **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/perenteral feedings.

  If the need for use of physical restraints or feeding tubes is driven by the progression of the terminal illness and/or dying process, the task force believes that these changes should not alone trigger a change-of-condition MDS.

SECTION V

GUIDELINESS 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.

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

1. 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.
- 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.

  - 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.

  - 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).

2. 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. Suggested topics to include in these periodic updates.

- 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 inservices. These might include audio/video tapes, self-learning modules, quick reference materials, and a manual containing pertinent hospice protocols/policies.

SECTION VI

CONCLUSION AND ACKNOWLEDGMENTS

These guidelines were developed for the purpose of promoting access to quality hospice care for eligible nursing home residents throughout Wisconsin.

The second edition is issued to offer updated guidelines that:

- Clarify contract considerations,
- Promote hospice care in the nursing home setting,
- Encourage constancy with the requirements that govern patient care as set forth in HFS 131, HFS 132, and federal regulations for hospices and nursing homes.

The measure of success for this collective effort is the question of access. It is hoped that access to hospice care for nursing home residents may be protected and expanded through diligent efforts to maintain clear communication while striving to meet the unique needs of patients and their families. Collaboration is the key.

The contributions of the numerous individuals who have participated are gratefully acknowledged. The shared commitment of the statewide nursing home and hospice providers has set the tone for continued success in this collaborative process.