DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

Ref: S&C-02-29

DATE: **May 10, 2002**

FROM: Director
Survey and Certification Group
Center for Medicaid and State Operations

SUBJECT: Promising Practices for Implementing the Medicare Hospice Benefit for Nursing Home (NH) Resident

TO: Associate Regional Administrator, DMSO
State Survey Agency Directors

The purpose of this memorandum is to inform you that the Centers for Medicare & Medicaid Services has developed several promising practices for the successful implementation of the Medicare Hospice Benefit for nursing home residents. The following practices were developed after consultation with the long-term care and hospice industry representatives and are part of our commitment to assure that nursing home residents who elect the hospice benefit receive the needed care and services from providers. These guidelines are not a regulatory requirement, but they are consistent with Federal requirements if properly implemented. They are intended to offer a framework to structure a collaborative relationship between the hospice and nursing home when they are providing care to common patients and their families at the end of life. We hope that they will be helpful for providers and assist them in promoting quality care to nursing home residents who have elected the hospice benefit.

Development of Partnership

1. Hospice and NHs providing services to common residents develop a written contract before services begin that addresses at least the following issues:
   - Resident eligibility, desire, and election of hospice;
   - Resident rights and confidentiality;
   - Orientation and continuing education of staff caring for the resident;
   - Financial responsibility for "room & board;"
   - Financial responsibility for medications, supplies, medical equipment, and ancillary services;
   - Professional management responsibility of the hospice; and
   - Liability and insurance.

2. In addition, the hospice and NH negotiate and include in the contract, how they will coordinate their services. These issues include, but are not limited to, the following areas:
   - Hospice staff access to and communication with NH staff;
   - Development of coordinated plan of care;
   - Documentation in both respective entities' clinical records or other means to ensure continuity of communication and easy access to ongoing information;
   - Role of any hospice vendor in delivering supplies or medications;
   - Ordering, renewal, delivery and administration of medications;
   - Role of the attending physician and process for obtaining and implementing physician orders;
   - Communicating resident change of condition; and
   - Change in level of care and transfer from facility.

   The hospice and NH review this contract as appropriate for needed changes and/or improvement in the working relationship between the two entities and/or the care and services provided to residents electing the hospice benefit.

3. Hospice and NH managerial staff should share common philosophical values in end-of life care. Both facilities should include key managerial staff in contract and procedural negotiations.

4. Hospice should provide on going training to the applicable NH staff, as needed, regarding the hospice philosophy and implementation of the individual's coordinated plan of care. Educational information is given to and understood by all direct care staff before care is provided to residents.

Coordination of Care Practices

5. Hospice and NH keep the resident/family needs first and keep the lines of communication open with each other related to these needs.

6. Hospice and NH communicate, establish, and agree upon a coordinated plan of care that reflects the hospice philosophy and is consistent with both the hospice and NH requirements, and is based on an assessment of the individual's needs and unique living situation in the NH.

7. All services necessary to meet the physical, psychosocial, medical and spiritual needs of the resident/family are reflected in the plan of care.

8. Coordinated plan of care identifies the discipline and provider to be held responsible/accountable for each intervention. For example, the hospice aide visits on Tuesday and Thursday to bathe the resident. The NH aide bathes the resident on Monday, Wednesday, and Friday. If there is an unanticipated need to change the schedule, notification must be given to the other provider and resident to assure that the resident’s needs continue to be met.

9. Coordinated plan of care reflects the hospice philosophy and resident's wish for palliative care.

10. The coordinated plan of care includes directives for the responsibilities of both entities regarding the assessment and management of pain and discomfort.

11. Procedures are in place to assure that the patient receives timely medication and treatments for optimal palliation. The hospice provides education to the NH on the hospice resident's pain management regime.

12. The hospice works with the NH to monitor the effectiveness of treatments related to pain and symptom control. The hospice and NH coordinate care to assure that the patient does not experience a delay in receiving needed drugs and treatment.

13. The hospice and NH may continue to utilize their individual processes/forms for care planning. Hospice and NH care plans reflect common resident problems, complimentary interventions, and same palliative goals.

14. The hospice and NH determine a process by which information from the hospice interdisciplinary team and the NH team will be exchanged when developing, and evaluating outcomes of care and updating the plan of care to make any necessary revisions to assure that the resident receives the necessary care and services. The teams actively seek input from the resident/family on desired goals.

15. The regulatory requirements for each provider are unique. Each provider should be knowledgeable of the basic requirements of the other provider. Each provider orients the other to its requirements (such as the NH orients hospice on its assessment/care planning and significant change in condition requirements; hospice orients NH on palliative care and hospice philosophy.) Education is ongoing to meet the needs of staff for both providers.

16. Hospice and NH maintain compliance with all applicable Federal, state and local laws and regulations.

Hospice Specific

17. Hospice provides all core services (nursing, physician services, medical social services and counseling) to the hospice resident.

18. Hospice assumes full responsibility for professional management of the patient's care with input from NH staff.

19. The hospice RN coordinates the implementation of the plan of care for resident.

20. The hospice interdisciplinary group (doctor of medicine or osteopathy, RN, social worker, pastoral or other counselor) participates in establishing the coordinated plan of care; provides or supervises hospice care and services; and reviews and updates the plan of care with the NH staff. Hospice explains each discipline's role, including the role of the dietary counselor, volunteer, spiritual counselor and bereavement counselor to the NH.

21. Hospice is responsible for providing, in a timely manner, all supplies, medications, and durable medical equipment that are needed for the palliation and management of the terminal illness and related conditions. Hospice financial responsibility for all medical supplies, appliances, medications and biologicals related to the terminal illness is established and documented.

22. The hospice provides orientation on hospice care to key NH staff (such as the Director of Nurses, Educational Coordinator or Nursing Unit Manager) on hospice philosophy and practices and assures that NH staff caring for the hospice patient have an understanding of hospice.

23. Hospice determines the appropriate level of care to be given (routine homecare, inpatient, or continuous care) and makes arrangements for any necessary transfers from the NH in consultation with the NH staff.

NH Specific

24. Financial responsibility for items that are included in "room & board" payment under Medicaid is established and documented. (Items included under Medicaid may vary from state to state.)

25. The NH conducts a significant change in condition assessment when the resident elects the hospice benefit.

26. Hospice care supports the resident's well being and allows the NH to meet the requirement that the resident receive desired care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being within the limits of the disease process.

27. NH notifies hospice when the resident experiences a change in condition. The NH must continue to meet the requirements for notifying the attending physician and family of significant change in condition. As part of a coordinated plan of care, procedures will be identified and addressed.

28. NH informs hospice of new NH staff and facilitates orientation by the hospice.

We are considering incorporating the content of these practices more formally into the regional office and state agency surveyor guidance, in addition to the information that is currently available in Appendix P and section 2082 the State Operations Manual.

We would be interested in your comments on these practices and on any other ideas you may have to promote quality care to our residents in nursing homes who elect the hospice benefit. You can send your comments to Mavis Connolly of my staff at mconnolly@cms.hhs.gov. Thank you very much for your interest and cooperation.

/s/
Steven A. Pelovitz