



**Hospice in the Facility Objectives**

1. Identify the mechanism for providing government regulated care in the facility.
2. Identify the Hospice policy and procedures involved in providing patient care in the facility.
3. Discuss symptoms of discomfort that may occur in the terminally ill.
4. Identify the documentation requirements to meet the state and federal rules and regulations.

***Understanding Hospice***

Hospice Brochure

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- Hospice Video

## **Facilities as a Place of Residence**

MCHS Hospice Program can provide hospice services in facilities where there is an established contract. When this occurs, both MCHS Hospice and the facility communicate, establish, and agree upon a coordinated plan of care. This plan reflects the hospice philosophy and is based on an assessment of patient needs and unique living situation.

A coordinated plan of care identifies the care and services that MCHS Hospice and the facility will provide to be responsive to the patient's unique needs and desire for hospice care. MCHS Hospice is responsible for implementing the plan of care related to the patient's terminal illness.

This Manual attempts to assist the facility and hospice care providers in their partnership by setting forth the responsibilities of the two providers including the recognition that many of these responsibilities must be considered as “joint.”

**Perhaps a more practical description of the role that hospice is to play in the facility setting is the fundamental understanding that hospice care is intended to supplement the care that is given routinely by the facility while the hospice team guides care decisions.**

From the viewpoint of the hospice, the facility should be considered no differently than would be the personal residence of the hospice patient cared for in a home setting. The facility staff should not be asked by the hospice to perform functions that the hospice staff would not be asking of the patient's familial caregivers in the home setting, yet, at the same time, the facility staff must satisfy all its requirements to provide room and board and other services to the resident.

## Admission to Hospice when Facility is Place of Residence

FACILITY STAFF	HOSPICE STAFF	JOINT
Identify potential hospice patients. *Approach physician for order for hospice care and for terminal diagnosis and DNR order	Respond to request to assist with initial evaluation. If referral generated from other than facility staff, hospice contacts appropriate person in a facility	
Approach patient/ representative. Educate regarding palliative care and hospice philosophy. Give hospice brochures, etc.	Provide hospice information for facility to give patients and families	
Contact MCHS	Contract for care in the facility must exist	
	Assess patient using hospice and regulatory guidelines to confirm eligibility	
Identify payer status (Medicare, Medicaid, private, HMO, etc.)	Verify patient financial status (Medicare, Medicaid, HMO, etc.)	
Notify PT/OT/Speech, etc., Departments of hospice status		Assess need for therapies
	Contact family to set appointment for education/ admission	
	Conduct intake process including complete patient assessment	
	Notify County Coroner of hospice status, per county procedure	
	Submit Medicaid paperwork if indicated	
	Secure needed DME and hospice related medications and supplies	
Modify Care Plan and MDS for change of status. Notify hospice of scheduled care conference	Develop hospice plan of care	Hold joint care conference and develop integrated plan of care
Continue to provide daily care, give medications on schedule, assess for breakthrough pain and other symptoms, call hospice with any change in condition, falls, medication errors, family/caregiver needs, death, etc.	Hospice assumes case management of patient	

## Continuity of Care

Each resident electing the hospice Medicare or Medicaid benefit may receive services according to four levels of care: routine home care, continuous home care, general inpatient care, or respite inpatient care.

FACILITY	HOSPICE	JOINT
	<p>Routine Home Care: Most residents electing to receive hospice care receive the “routine home care” level of care. The nursing facility is considered the patient’s home. Members of the hospice IDG visit the resident in the facility on an intermittent basis to assess the patient’s condition, or to deliver or supervise care.</p> <p>Continuous Care: During periods of crisis when the patient requires increased monitoring to maintain pain and symptom management, the hospice may intensify services in lieu of admitting the patient to an inpatient contracted hospital. With continuous care, the hospice provides a minimum of 8 hours and up to 24 hours of hospice care consisting primarily of nursing care.</p> <p>General Inpatient Care: When symptoms and pain becomes unmanageable at home, hospice may make arrangements for the patient to be admitted to a contracted hospital to meet the patient’s acute needs.</p> <p>Respite Inpatient Care: When family caregivers need a break from care giving, hospice programs may admit a patient to a contracted hospital or nursing facility for a period of up to five consecutive days.</p>	

## Core Services in a Facility

Core Services can be best described as people services. Core services as defined in the Federal Register includes nursing services, medical social services, physician services (medical director), and counseling services (spiritual, dietary, and bereavement), provision of medical supplies, DME, and drugs necessary for palliation of pain and symptoms associated with terminal illness and related conditions and all necessary hospice services for care of patient's terminal illness and related conditions. These services cannot be delegated to facility staff. These services are provided routinely by hospice employees. Hospice provides core services through a 24-hour, 7 days-a-week on-call system. In the partnership of the hospice and the facility, the resources of the hospice's interdisciplinary team are available not only to the patient and family, but to the staff of the facility, as well.

### Interaction of Hospice in a Facility

SERVICE	SKILLED NURSING	FACILITY	HOSPICE JOINT
Nursing Services	RNs, LPNs and aides in role of the daily caregivers.  Continue provision of care as with all patients	RN coordinates & reviews care plan. Makes intermittent visits, based on patient need. Educates staff and families. Reviews record. Assigns and supervises hospice aides as needed	Maintain communication to fulfill plan of care and inform each other of changes in care plan
Physician Services	Attending physician and facility medical director will continue to follow facility state and federal regs for visitation schedules	Complements attending physician's care as a resource on palliation. Provides for unmet medical needs related to terminal diagnosis. Part of the interdisciplinary team	Each provider shall identify lines of communication for medical care
Medical Social Services, Spiritual Counseling, Dietary Counseling, Bereavement Counseling, and other Counseling	Performs these services as agreed upon in the plan of care and/or by contractual agreement with the facility in accordance with facility state and federal regulations	Performs these services as indicated in the plan of care in accordance with Hospice Medicare Conditions of Participation. Medical social services, pastoral care, dietary are part of interdisciplinary team	Maintains open communication between hospice and facility for services performed and for status changes that affect the plan of care

## Patient Care Management

The hospice retains overall professional management responsibility for implementing the plan of care related to the terminal illness.

FACILITY STAFF	HOSPICE STAFF	JOINT
<p>Create initial plan of care or revise current plan of care at time of admission to hospice (no longer than 24 hours after admission) to assure that immediate patient needs are met</p>	<p>Determine that resident is hospice appropriate. Plan of care must be established within 2 days following assessment with input from physician, nurse, social worker, chaplain, and patient; must be consistent with hospice philosophy; and must be updated as necessary to reflect resident's changing status</p>	<p>Assure, via mutually agreed upon method, that care plans are integrated and congruent with one another and that responsibilities are clearly communicated</p>
<p>Assure that MDS is in place within 14 days of admission to facility or of significant change</p>	<p>An initial plan of care is developed at the time of an admission to hospice care based on the limited information obtained, or the priorities identified during the initial assessment, which is consistent with the resident/family's immediate care needs and desires. The initial plan of care may be developed by the hospice nurse or hospice physician in consultation with the resident's attending physician and one other member of the hospice interdisciplinary team. Each of the hospice interdisciplinary team's core services (nursing, medical, social services and counseling) must review the initial plan of care and provide input into the process of establishing the plan of care within two calendar days following the assessment. The input may be provided through telephone consultation</p>	<p>Create and maintain a mutually acceptable communication system, which includes the established conference, that maximizes the flow of information for enhanced care delivery</p>
<p>Assure plan of care is in place within 7 days of MDS</p>	<p>Update integrated plan of care at least every 2 weeks, or more frequently, as needed Assure Hospice POC is completed by all core disciplines within 5 days</p>	<p>Periodic assessment and review of care plans by both teams to ensure that the rapidly changing needs of the patient/family facing life limiting illness are met</p>
<p>Assure that hospice team always has available a current version of the facility's interdisciplinary care plan and that changes to the care plan are communicated in a timely manner to the appropriate staff</p>	<p>Assure that facility team always has available a current version of the hospice interdisciplinary care plan and that changes to the care plan are communicated in a timely manner to the appropriate facility staff</p>	

## **Integrated Plan of Care**

***In this Manual, when the term “integrated plan of care” is used, it refers to the one or more documents that the hospice and facility have determined constitute the integrated plan of care.***

Care planning in any setting is the cornerstone for the delivery of individualized care and treatment. The care plan provides for communication between caregivers and promotes continuity by establishing resident/patient goals and objectives. Care planning sets the stage for implementation and evaluation of care provided to the patient. In addition, care planning provides an opportunity for the patient and his or her significant other to be involved in and make decisions about care.

The purpose of the care plan is to provide a structure for the delivery of individualized care for the patient and family through the use of measurable objectives and timelines.

The structure incorporates the identification of problems, goals, and interventions, and designates the role of each team member. While long term care plans generally focus on functional status, rehabilitation/restorative nursing, health maintenance, and daily care needs, hospice plans to a greater extent address pain and symptom management, preparation for death and bereavement, and end of life tasks. The challenge herein lies in incorporating the two modalities to enhance the quality of services provided to the patient. When successfully integrated the long term care team members come together in a synergistic way.

The Facility staff and the hospice team shall communicate, establish and agree upon a collaborative, interdisciplinary care plan for both providers which reflects measurable objectives and time lines to meet a resident’s medical, nursing, physical, psychosocial and spiritual needs as well as the needs of the resident’s family/caregivers, as identified in a comprehensive assessment.

## Managing Physician Orders, Medications and DME

Protocols for communications between the staff and the hospice staff shall be developed to address all medical orders. The primary physician (either the patient's attending physician and/or the hospice medical director) shall participate in the development of the plan of care with the hospice interdisciplinary team and the patient.

FACILITY	HOSPICE	JOINT
		Both staff will be knowledgeable of the hospice patient's medical plan of care. Predetermine plan for physician communication, as reflected in integrated plan of care. Timely inform each other of changes in physician orders. Establish and abide by protocol for provision and maintenance of supplies, drugs, and DME

## Medical Record Management

In accordance with accepted principles of practice, the hospice and facility must establish and maintain a clinical record for every individual receiving care services. Clinical records must be retained as required by state and federal law documenting all services furnished directly or by arrangement. The facility and the hospice should decide what areas of the clinical records should be copied and which agency retains the original forms.

**Confidentiality of the clinical record must be maintained.**

FACILITY	HOSPICE	JOINT
Facility will establish and maintain a clinical record of the MDS and Care Plan of the resident in accordance with long term care regulations	Hospice will maintain a clinical record of the resident receiving hospice services in accordance with hospice regulations	Decide where hospice documentation is located in the facility chart. Decide which documents are part of both Hospice and clinical records. Decide who retains original forms, who retains copies. Retain clinical records as required by state and federal law. Document all services furnished directly or by arrangement

## Emergency Care in a Facility

Emergency care should be consistent with the patient's stated wishes in the advance directive, and the physician's order with regard to code status. Facility must notify Hospice immediately if a significant change in patient's physical, mental, social, or emotional status occurs, clinical complications appear that suggest a need to alter the plan of care, or a need to transfer the patient from the facility. Hospice will make arrangements for and remains responsible for any continuous or inpatient care related to terminal illness and related conditions.

**All emergency care related to the terminal illness requires approval and coordination by hospice.**

FACILITY	HOSPICE	JOINT
Staff member will call hospice in a timely manner for any significant change of condition, reassessment and revision of the plan of care. Staff will not transfer the hospice patient to another care setting without hospice consultation	Unless otherwise agreed upon, the hospice nurse or on-call nurse will call the ambulance or other transport in transferring the hospice patient to another care setting	Both staff will know the resuscitation status of the resident. Both staff will know the patient's advance directives, if applicable. Both staff will be aware of and communicate to each other a transfer to the ER or other acute care setting

## Conflict Resolution in a Facility for Clinical Decisions

FACILITY	HOSPICE	JOINT
		<p>Make commitment to problem solving and resolution for the sake of excellent end-of-life care for the patient.</p> <p>LEVEL ONE: facility and hospice staff will problem solve directly</p> <p>LEVEL TWO: facility clinical supervisor will problem solve with hospice clinical supervisor</p> <p>LEVEL THREE: facility administrator will problem solve with hospice administrator</p>

## Shared Benefit Coverage

There are some services provided by facility which are not covered hospice services, such as : room and board services, including but not limited to, telephone, guest trays, and television hook-up. When a patient chooses interventions that are not in the hospice plan of care, unauthorized intervention may not be a covered benefit.

Type of Care	Medicaid	Medicare	Dual Entitlee	Private Pay/ Insurance
Place of Residence	<p>Hospice receives payment for routine day. Room and Board</p> <ol style="list-style-type: none"> <li>1. Nursing Facility bills Hospice their skilled nursing daily rate (MA rate, not charge)</li> <li>2. Hospice pays Nursing Facility 100% of the MA rate.</li> <li>3. Hospice bills MA and receives 95% of the rate.</li> </ol>	<p>Patient must <b>either</b>*</p> <p>A. Elect the Medicare Hospice Benefit</p> <ol style="list-style-type: none"> <li>1. Hospice receives payment for routine day.</li> </ol> <p>B. Room and Board</p> <ol style="list-style-type: none"> <li>1. No Medicare Benefit</li> <li>2. No Hospice obligation</li> <li>3. Nursing Facility may bill patient or private insurance</li> </ol>	<p>Hospice receives payment for routine day from Medicare Room and Board</p> <ol style="list-style-type: none"> <li>1. Same as Medicaid Room and Board</li> </ol>	<p>Hospice bills patient or private insurance. Nursing Facility bills patient or private insurance.</p>

## Orientation and Education

FACILITY	HOSPICE	JOINT
		There is an expectation that orientation and continuing education occur for both hospice and facility staff that ensure that the clinical caregivers are aware of and are guided by the integrated plan of care

## Pronouncement of Death

FACILITY	HOSPICE	JOINT
Contact the hospice nurse	Pronounce Initiates Notice of Removal (NOR) form Contacts the coroner, if necessary	Hospice provides direction to facility regarding family notification if they are not present, as well as the funeral home.
Facility staff dispose of the hospice patients medication according to facilities protocol	MCHS staff document	
	MCHS will arrange for removal of DME	

Policies: 336, 3301, 3307, 3336, 3339, 3340, 3341, 3342, 3345, 3347, 3349, 3354, 3355, 3358, 3359

*A Hospice Team Member  
is just a phone call away.*

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