



HOSPICE/CBRF INTERFACE

**Guidelines for Care Coordination
For
Hospice Patients Who Reside In
Community Based Residential Facilities**

The Hospice Organization of Wisconsin wishes to thank the following persons who willingly gave of their time to serve on the Hospice/CBRF Interface Taskforce: Diane Gryskiewicz, Linda Grilley, Judy Mason and Rose Boron.

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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 individuals, their place of residence may be a Community Based Residential Facility (CBRF). In order to protect access to hospice care for CBRF residents in Wisconsin, a statewide task force was formed in 1998. This task force consisted of representatives of the hospice and CBRF industries across the state.

This comprehensive document is not intended to be a “blueprint” for providers, but rather a tool to facilitate care coordination in a consistent manner, while maintaining regulatory compliance. CBRFs and hospices engaging in collaborative arrangements are encouraged to structure their individual relationships in a manner that reflects their unique mission, community needs, and patient populations.

The Bureau of Quality Assurance reviewed this guideline and determined that it meets the intent of hospice and CBRF regulations in the State of Wisconsin.

SECTION II
REGULATORY REFERENCES

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

42 CFR Part 418, Hospice

Health Care Financing Administration (HCFA), State Operations Manual and Hospice Interpretive Guidelines

Wisconsin Administrative Code, Chapter HFS 131, Hospices

Wisconsin Administrative Code, Chapter HFS 83, CBRF Rule

Chapter 50, Wisconsin Statutes

SECTION III

CONTRACT CONSIDERATIONS FOR HOSPICES AND COMMUNITY BASED RESIDENTIAL FACILITIES (CBRF)

Introductions

The following list of key considerations is meant to assist hospice/CBRF providers in effectively coordinating provider services to the hospice patient receiving routine home care and/or continuous care in a CBRF. While not all-inclusive, these factors reflect many provisions found in the hospice and CBRF regulations and were compiled from comments and guidance distributed by authoritative state (Bureau of Quality Assurance) and federal (Health Care Financing Administration) sources.

The information which follows is specifically pertinent to the routine home care contract. It is not intended to address considerations for inpatient and respite care. 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

I. Administrative Concerns and Core Services Requirements

- a. The hospice/CBRF 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 care and (2) the CBRF responsibility for other services. (WI Adm. Codes HFS 131.35 (2) and HFS 83.34 (3)(a)(b))
- c. Hospice must provide the same services that would be offered if the patient was in a private residence, including necessary medical services and inpatient care arrangements.
- d. Identify a dispute resolution mechanism to be utilized in the event of disputes.
- e. Hospice may not discharge a hospice patient at its discretion, even if care promises to be costly or inconvenient.

Administrative Concerns and Core Services Requirements (continued):

- f. Statute/regulation prohibits a hospice from discontinuing care due to inability of the patient to pay for care.
- 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 “HCFA,” BQA,” etc.
- h. Admission criteria and requirements must be identical for all individuals regardless of pay source.
- i. Specify the exact services and extent of services that will be provided individually by the hospice and CBRF.
- j. Specify the exact responsibilities of each provider in the provision, and coordination, of care and services.
- k. Substantially all hospice 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, individuals under contract and volunteers under the jurisdiction of the hospice (see 42CFR 418.3, HFS 131.13 (7) and HFS 131.13 (33).)
- l. Hospice must provide the following core services through its own employees:
 - Physician services (may be contracted per federal Balanced Budget Act of 1997 and BQA memo #99-039)
 - Nursing services
 - Medical social services
 - Counseling services (Bereavement, Dietary, Spiritual and/or other Counseling)
- m. Hospice may not contract with the CBRF to provide core services.
- n. Services to be provided by the CBRF may include:
 - Personal care services
 - Assistance with activities of daily living
 - Assist with administration of medications under the direction of the hospice. (IV, IM meds are responsibility of hospice)*
 - Community/leisure time activities
 - Room cleanliness
 - Supervision/assistance with durable medical equipment use and prescribed therapies
 - Family/ Legal Representative contacts unrelated to medical/terminal conditions
 - Arrange transportation
 - Health monitoring of general conditions (ie: accuchecks /temps/blood pressure) and report to hospice
 - Nutritional meals/snacks

*CBRF staff may be limited to the type of medication administered based on training, competency and supervision.

Administrative Concerns and Core Services Requirements (continued)

- o. Hospice must include the patient's primary physician in the care planning process. The hospice medical director must also meet the general medical needs of the patient to the extent those needs are not met by the attending physician.
- p. Hospice certification and licensure does not require designation of a primary caregiver, although individual hospices can require this as a prerequisite to admission.
- q. Identify the terms and procedure for formal review and renewal of the hospice/CBRF relationship on a regular basis.

II. Coordination of Services

- a. At the time each hospice patient/resident is admitted to the facility, the CBRF must be provided with physician orders.
- b. All information relevant to the patient/resident care must be shared and contained in the patient care record compiled by both the hospice and CBRF. (Caution: The term "relevant" must be interpreted broadly enough to avoid inadvertently failing to share marginally relevant information.)
- c. 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.
- d. Specify a procedure for the prompt and orderly relay of general information, MD orders, etc., between the providers.
- e. Specify a procedure that clearly outlines the chain of communication between the hospice and CBRF in the event a crisis or emergency develops.
- f. Identify role/responsibility for collaborative practice, including patient assessment. Indicate source for provision of patient medications including self-administration. Packaging, expiration date and labeling requirements of HFS 83 must be satisfied. The hospice and CBRF must jointly coordinate, establish, and agree upon a single plan of care/individualized service plan to be used by both providers. This coordinated plan of care/individualized service plan must be implemented according to accepted professional standards of practice and address both the terminal and non-terminal needs of the patient.
- g. Delineates the role of hospice and CBRF in the admission process.
- h. Delineates the role of hospice and CBRF in the interdisciplinary group conference, including the encouragement of CBRF personnel to attend IOG meetings.
- i. The coordinated plan of care/individualized service plan must specifically identify the respective care and services which the CBRF and hospice will provide.

Coordination of Services (continued)

- j. Aside from responsibilities that are part of the core requirements, include a statement that the plan of care/individualized service plan must specify who is responsible for carrying out various individualized patient interventions.
- k. Specify the chain of communication to be followed between the hospice and CBRF whenever a change of condition occurs and/or changes to the plan of care are indicated.
- l. All changes in the plan of care/individualized service plan must be communicated to the other provider based on the specified time frames. Hospice must authorize changes to the plan of care.
- m. Each provider must be aware of the other's responsibilities in implementing the plan of care/individualized service plan.
- n. Hospice must ensure that hospice services are always provided in accordance with the plan of care/individualized service plan, in all settings.
- o. Hospice may involve CBRF nursing personnel in administration of prescribed therapies in the patient's plan of care/ISP only to the extent that hospice would routinely utilize the patient's family/caregiver in implementing the plan of care/individualized service plan.
- p. Hospice is responsible for making all inpatient care arrangements, including acute and respite care.

III. Employment Issues

- a. A key consideration for both the hospice and CBRF is the extent to which services will be directly provided by hospice with its own staff, since hospice receives the payment.
- b. A hospice may use contracted employees for core services only during:
 - Periods of peak patient loads
 - Extraordinary circumstances
(Exception: physician services)
- c. CBRF employees may also be employed by the hospice or volunteer to serve hospice patients during non-CBRF employment hours.
- d. For purposes of a hospice, "employee" is defined in 42 CFR 418.3, HFS 131.13(7) and HFS 131.13(33).
- e. Essential requirements for CBRF employees who are also employed by hospice to perform core services include:
 - Accurate time records.
 - Clear delineation of responsibilities (intent is to avoid allegations of dual reimbursement.)

- f. Specify how state and federal employment requirements will be met (criminal background check, employee health, etc.)

IV. Reimbursement Issues

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

Hospice Qualified	CBRF
<p>Medicare: Qualified patient has a right to elect hospice Medicare benefit, which pays for hospice services including routine homecare and continuous homecare in the CBRF.</p> <p>Medicaid: Qualified patient has a right to elect hospice Medicaid benefit, which pays for hospice services including routine homecare and continuous homecare in the CBRF.</p> <p>Private Insurance: Most private insurances cover hospice homecare services.</p>	<p>Directly bills patient and/or family for CBRF services.</p> <p>Community Option Program (COP) may be accessed for qualified patients. Patient pays co-payment. COP pays for room and board.</p>

**ESSENTIAL ELEMENTS FOR CONSIDERATION
IN A
HOSPICE/CBRF CONTRACT**

The following sample contract elements have been compiled for review or use by providers when developing the format of a hospice/CBRF contract. Since it is essential that the contract process be individualized to best meet the particular circumstances of the contracting parties, these sample elements 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 sections, 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.

SAMPLE ELEMENTS FOR INCLUSION IN A HOSPICE/CBRF CONTRACT

RECITALS

Definitions (particularized to individual needs and terminology):

Attending Physician	Informed Consent
Covered Services	Interdisciplinary Group
Community Based Residential Facility	Non-covered Services
Hospice	Other Pertinent Definitions as Identified by the Parties
Hospice Care	Plan of Care (Individualized Service Plan)
Hospice Core Services	Residential Hospice Patient
Hospice Medical Director	Room and Board Services
Hospice Services	
-Routine Homecare	
-Inpatient Respite Care	
-Continuous Care	
-Inpatient Acute Care	

Coordination of Services:

Admission Procedures (general process, written orders, authorizations advanced directive requirements, Code status and applicable aspects of HFS 155 and 154)

Assessment process of patient and family

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 Program

Drugs and Pharmaceuticals

Medical Equipment and Medical Supplies

Transportation and Ambulance

Family Services and Bereavement Care

Other Pertinent Sections As Identified By The Parties

Duties, Responsibilities and Services of Each Provider:

Services (including hours of services)

Compliance with Law (including licensure, staff qualifications)

Patient Care Management

Plan of Care/Individualized Service Plan

Medical Orders; Responsibilities of Attending Physician

Documentation (clarification of respective duties, location of original medical record)

Confidentiality of Patient Care Record

Orientation and Education

Other Pertinent Sections As Identified By the Parties

Financial Responsibility:

Responsibility of the Hospice

Responsibility of the Facility

Reimbursement

-Medicaid Patients

-Medicare Patients

-Medicaid/Medicare Patients

-Private Pay/Insurance Patients

Other Pertinent Sections As identified By The Parties

Insurance and Indemnification

Joint Review of Services (quality, appropriateness)

Compliance with Government Regulations

(see HFS 83.33, HFS 83.34 and HFS 83.21 (4)(n) 3.)

Relationship Between the Parties

Conflict Resolution Process

Term of the Agreement (length, renewals)

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

Amendments to the Agreement

Notice Requirements (form, method, delivery)

Miscellaneous (including Non-discrimination Policy)

Other Pertinent Sections As Identified By The Parties

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 as well as regulatory requirements are met, necessitates careful planning by both the CBRF and the hospice. The development of policies and protocols that define care coordination issues is essential to ensure consistent quality.

A. PRIORITY AREAS

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

Admission process	Hospice Core Services
Physician orders	Death Event
Supplies and Medications	Quality Assurance
Medical Record Management	Emergency Care

Admission Process:

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

Admission: Referral Of CBRF Resident To Hospice

- Significant health screening instruction (change of condition) form – DSL2370 (1-97) is completed by CBRF.
- Referral of resident made to hospice
- Consult/information provided by hospice
- Patient agrees to admission to hospice
- Hospice and CBRF collaborate to begin care planning process.
- Hospice secures orders from the physician and manages plan of care from this point.
- Establish that the CBRF has identified persons with terminal illness in their program statement.

HFS 83.07(2)(a)5 Client group served. If more than one client group will be served, an explanation shall be included of how the client groups are compatible with each other...If persons from any of the following client groups will be admitted, a full description of their special needs shall be provided...b. Persons diagnosed as terminally ill.

HFS 83.07(2)(b) Change. Any change in a program shall be documented in a revised program statement which shall be submitted to the department for approval at least 30 days before the change is implemented.

- Establish that the CBRF is licensed appropriate for the needs of the resident/patient. HFS 83.05(2) Classes of CBRF

Admission: Referral Of Hospice Patient To CBRF

- Establish that the CBRF has identified persons with terminal illness in their program statement.

HFS 83.07(2)(a)5 Client group served. If more than one client group will be served, an explanation shall be included of how the client groups are compatible with each other...If persons from any of the following client groups will be admitted, a full description of their special needs shall be provided...b. Persons diagnosed as terminally ill.

HFS 83.07(2)(b) Change. Any change in a program shall be documented in a revised program statement which shall be submitted to the department for approval at least 30 days before the change is implemented.

- Establish that the CBRF is licensed appropriate for the needs of the resident/patient. HFS 83.05(2) Classes of CBRF
- Referral to CBRF. The hospice may initiate contact with the CBRF and facilitate communication between the patient/family and the CBRF representative.
- Pre-admission assessment is done by CBRF
- CBRF agrees to admit patient to CBRF and determines admit date.
- Hospice and CBRF coordinate securing required admission paperwork (i.e., history and physical, TB screening, physician orders, etc.).
- Transfer of patient to CBRF. Hospice involvement continues on day of transfer.
- Collaboration in care plan process is begun to revise care plan/Individualized service plan.

Admission: Simultaneous Referral To CBRF And Hospice

- Establish that the CBRF has identified persons with terminal illness in their program statement.

HFS 83.07(2)(a)5 Client group served. If more than one client group will be served, an explanation shall be included of how the client groups are compatible with each other...If persons from any of the following client groups will be admitted, a full description of their special needs shall be provided...b. Persons diagnosed as terminally ill.

HFS 83.07(2)(b) Change. Any change in a program shall be documented in a revised program statement which shall be submitted to the department for approval at least 30 days before the change is implemented.

- Establish that the CBRF is licensed appropriate for the needs of the resident/patient. HFS 83.05(2) Classes of CBRF
- Referrals made to hospice and CBRF.
- Hospice and CBRF coordinate the admission process and required paperwork
- Transfer of patient to CBRF Hospice involvement begins on day of transfer.
- Initiation of joint care plan/individualized service plan and CBRF.

Physician Orders:

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

- All physician orders must be patient specific. Orders are obtained by the hospice and provided to the CBRF. These orders are initiated by the hospice according to patient need.
- All verbal, phone and written orders must be pre-authorized by hospice before initiated.
- Lab tests or other diagnostics related to terminal illness must be approved by hospice and specified on the plan of care/individualized service plan.
- CBRF may accept orders from a hospice nurse as prescribed by the physician.
- Contract should include timeline as to how CBRF will obtain a copy of signed physician orders.

Supplies and Medication/Contracted Services:

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

- Prescription medications related to the terminal illness (medications supplied by hospice must meet CBRF pharmacy labeling and packaging requirements HFS 83.33(3)(e)3 and not be unit dose).
- Durable medical equipment (DME), i.e. W/C, walker, bath bench, commode, oxygen, etc.
- Disposable medical supplies related to the terminal illness, as specified in the plan of care/individualized service plan.
- Provision of contracted services such as physical therapy, occupational therapy, speech therapy, dietary, etc., should be specified on the plan of care and clarified in the contract.

Patient Care Record Management:

- Copies of physician orders and coordinated plan of care should be on the medical records of both organizations. The location of the original orders should be according to the contract.
- The patient's record in the CBRF will be identified as a hospice patient.
- If specified in contract, both the hospice and CBRF retain copies of the other's record following death or discharge of a hospice patient.
- All clinical information, (as specified in the contract) obtained by both providers that are relevant to the hospice patient's care while a resident must be on both patients' records.
- Contract should state who should document where.

Hospice Core Services:

Core services as defined in the Federal Register includes nursing services, medical social services, physician services (medical director), and counseling services. These services are to be provided routinely by the hospice employees.

Nursing services

- Nursing care is a core service of hospice for assessment, intervention, and evaluation.
- The hospice may involve nursing personnel from the CBRF in assisting with the administration of prescribed interventions if specified in the plan of care.
- Hospice may involve CBRF nursing personnel in administration of prescribed therapies in the patient's plan of care only to the extent that hospice would routinely utilize the patient's family/caregiver in implementing the plan of care.

Medical Social Services:

- Social services are a core service of hospice for assessment, intervention, and evaluation related to the terminal illness.
- Other social/leisure interventions may be provided collaboratively by hospice and CBRF based on the plan of care.

Counseling Services:

- Counseling is a core service of hospice for assessment, intervention, and evaluation related to the terminal illness. Counseling services must be available to both the individual and family.
- Additional counseling interventions (spiritual/dietary/other counseling) may be provided collaboratively by the hospice and CBRF staff based on the individualized plan of care.
- Bereavement counseling services shall be provided based on an assessment of the family/caregivers' needs, the presence of risk factors associated with the patient's death and the family/caregivers' ability to cope with grief. The bereavement services shall be compatible with the core teams direction in the plan of care and provided for up to one year following the death of the patient.

Physician Services:

- Physician Services is a core service of hospice for assessment and evaluation.
- The medical director, the attending physician, a consulting physician, or their designees may provide physician participation.

Other Services:

- **Physical therapy, Occupational therapy and Speech-language pathology services** must be available and provided as determined by patient need identified in the individualized plan of care.
- CNA/HHA services should be provided collaboratively by the hospice and CBRF based on patient need and specified in the plan of care (clarified by the contract).
- Volunteer services are to be coordinated by the hospice but may be provided collaboratively by the hospice and CBRF as specified in the plan of care (clarify volunteer role in contract, especially related to hands-on care).

Death Event:

Protocols should be established that define mutual responsibilities at the time of death:

- The hospice must be notified.
- Review county, state and facility guidelines regarding coroner involvement, and follow protocol specified in contract for notification.
- CBRF and hospice coordinate notification of physician for pronouncement of death and release of body when heart rate and respirations have ceased.
- Medication disposal.
- CBRF/hospice identify closure experience with regard to other CBRF residents.

Quality Assurance:

- The CBRF and hospice are required to implement quality assurance activities per respective regulations.
- A collaborative approach to problem solving and outcome monitoring is encouraged for inter-related issues.

Emergency Care:

Emergency care is defined as unexpected and may be related or unrelated to the terminal illness.

- Care should be consistent with the patient's stated wishes in the advance directive, and the physician's order with regard to code status.
- CBRF staff provide immediate care in conjunction with facility policy and/or based on plan of care/ISP.
- CBRF staff call the hospice.
- Hospice completes further assessment, provides appropriate interventions and updates the plan of care/ISP as specified in the contract.

B. CARE PLAN PROCESS

1. Assessment

CBRF is required to complete a pre-admission assessment for residents prior to admission to the facility. Hospice completes the hospice initial, comprehensive and ongoing assessments.

When a patient changes from a maintenance/curative course of care to hospice palliative, the significant change-of-condition is the final change of condition for the CBRF. Upon the admission of the resident to hospice, the CBRF is no longer responsible for documenting change-of condition provided that the changes in condition are anticipated and documented as part of the progression of the terminal illness and/or dying process.

2. Plan of Care

The CBRF and hospice must coordinate, establish, and agree upon one plan of care/individualized service plan for both providers which reflects the hospice philosophy, and is based on the individual's needs and unique living situation in the CBRF. Each CBRF and hospice should develop policies and protocols to accomplish the care plan process. The care plan process is designed to fulfill hospice and CBRF (individualized service plan) regulations.

- a. It is essential that the hospice core team and the CBRF staff both derive patient care decisions from the same shared data.
- b. Ongoing revisions in the plan of care are done collaboratively. This includes the bi-annual reviews of the plan of care/individualized service plan.
- c. Chemical restraints, according to HFS 83.21, means psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms. The resident has a right to be free from all chemical restraints, including the use of an as-necessary (PRN) order for controlling acute, episodic behavior. The use of a chemical restraint for a terminally ill resident who is under the care of a hospice program under HFS 83.32(2)(a) shall be governed by the applicable provision in ch. HFS 131 for hospice programs. PRN meds must have approval or direction of RN coordinator.
- d. Physical restraints. The least restrictive use of physical restraints acceptable to the patient only is to be applied to enable the resident to maintain his or her highest level of functioning. The use of physical restraints requires a physician's order and department approval.

The Physical Restraint Protocol (Attachment A) may be used to document the collaborative care planning with regard to physical restraints. The CBRF may use the Physical Restraint Assessment Form to communicate with the State of Wisconsin, Department of Health and Family Services, Bureau of Quality Assurance for waiver purposes. The Physical Restraint Assessment Form is based on HFS 83 (Attachment B)

Note: Refer to DSL-BQA memo #97-015, use of physical restraints, HFS 83.21(4)(n)4 and HFS 131.21(1)(e).

- e. Change in condition related to the terminal illness. When a resident requires continuous care, the need for verbal or physical prompting to respond to a fire alarm or becomes semi-ambulatory or non-ambulatory due to the progression of the terminal illness, the CBRF may have additional requirements related to retaining that resident. The following codes may apply to the change in condition:
 1. When a resident requires continuous care, defined as "the need for supervision, intervention or services on a 24-hour basis to prevent, control and ameliorate a constant or intermittent mental or physical condition which may break out or become critical during any time of the day or night." Examples of persons who need continuous care are wanderers, persons with irreversible dementia, persons who are self abusive or who may become agitated or emotionally upset and persons whose changing or unstable health condition requires monitoring.

2. When a resident requires the assistance of more than one staff, the CBRF shall have adequate staffing. HFS 83.15(1)(a).
 - a. HFS 83.15(1)(d). At least one qualified resident care staff shall be on duty in the CBRF and awake if at least one resident in need of continuous care is in the facility.
 3. When a resident needs verbal or physical prompting to respond to a fire alarm, the resident could be admitted or retained only in a class C facility.
 - a. HFS 83.05(2)(d), (e) or (f). Classes of CBRF – Class C: ambulatory, semi-ambulatory, non-ambulatory.
 4. When a resident becomes semi-ambulatory or non-ambulatory the resident could be admitted or retained only in a facility licensed for semi-ambulatory or non-ambulatory.
 - a. HFS 83.05 (2)(b), (c), (e) or (f). Classes of CBRF – Class A: semi-ambulatory, non-ambulatory; Class C: Semi-ambulatory, non-ambulatory
3. Expected Outcomes

Certain outcomes have a high probability of occurring as part of the progression of the terminal illness and/or dying process.

Dehydration and fluid maintenance – Changes in hydration status and fluid balance will occur as part of the progression of the terminal illness and/or dying process.

Psychosocial changes – Changes in lifestyle and interactions will 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 CBRF will become progressively more dependent for his or her activities of daily living as part of the progression 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 function – A decrease in visual function is anticipated with the dying process.

Other noted significant changes of condition.

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 the key regulations that govern both providers is essential for a successful CBRF/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, as well as ongoing educational efforts aimed at improving efficiencies and understanding of experienced and new staff.

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

Initial Orientation

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

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

- Discussion of hospice concept and philosophy, including reference to patient's entitlement.
- Informed consent and corresponding expectations/accountabilities.
- Services available – definition 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, record maintenance.
- Documentation practices.
- Symptom management practices common for hospice patients.
- Securing and processing of physician orders (including utilization of standing orders, if applicable).
- Reimbursement issues, For example medications, DME.
- Bereavement services available.
- Location of resource materials such as a hospice manual with accompanying quick references.
- DME, disposable supplies, oxygen, and ancillary services to be supplied by the hospice.
- Provision of pharmacy services.

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

- Tour of the facility, with introductions of key personnel, location of records, security system operation, and any information specific to the physical layout and daily routine.
- 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.
- Individual service plan, including resident/family involvement, etc.
- Documentation practices.
- Infection control issues, especially including biohazard waste disposal, location of PPE and blood spill clean-up kit, etc.
- Chemical/Physical restraints.
- Medication management, including regulations governing use of psychotropics, “unnecessary medications”, self-medication, etc.
- Patient levels of care and reimbursement scenarios.
- Pertinent facility policies (i.e., CPR, hydration, RN/Administration coverage, including any policies that explore ethical issues).

Ongoing Education

Periodic updates for contracted providers 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:

- Inservices on pain control and other symptom management protocols commonly used for hospice patients.
- Inservices on loss, grief and bereavement care.
- Quality assurance/improvement study results and recommendations.
- Practical issues related to communication with physicians, management of orders, etc.
- Care plan and individualized service plan coordination process.
- Volunteer involvement and utilization.
- Review and discuss mutual roles and responsibilities as appropriate.

Creative approaches that foster improved understanding and communications between the CBRF and hospice providers are encouraged. The use of various “mediums” is helpful to have available in the CBRF for staff. These might include audio/video tapes, self-learning modules, quick reference materials, and a manual containing pertinent protocols/policies.

SECTION VI

CONCLUSION AND ACKNOWLEDGEMENTS

The Hospice Organization of Wisconsin (HOW) and Community Based Residential Facility (CBRF) Forum have undertaken this statewide joint venture for the purpose of protecting quality hospice care for eligible CBRF residents.

Through the combined efforts of the task force, the intended outcome has been to develop guidelines and protocols for CBRFs and hospices that are:

- Flexible enough to meet individual patient needs;
- Predictable enough to ensure quality of care; and
- Consistent with the requirements that govern patient care as set forth in HFS 131, HFS 83, and federal regulations, 42 CFR 418 for hospices.

The measure of success for this collective effort is the question of access. It is hoped that access to hospice care for CBRF 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.

The CBRF Forum and HOW gratefully acknowledge the contributions of the individuals who have participated in this process and the support of their organizations. The shared commitment of the statewide CBRF Forum and hospice providers has set the tone for continued success in this collaborative process.

ATTACHMENT A

ATTACHMENT A

HOSPICE/CBRF PHYSICAL RESTRAINT PROTOCOL

SUBJECT: PHYSICAL RESTRAINT USE FOR TERMINALLY ILL RESIDENTS RESIDING IN A CBRF UNDER THE SUPERVISION AND CARE OF A HOSPICE PROVIDER.

I. PURPOSE:

- To protect the Resident's right to be free from the use of restraint.
- To provide for the Resident's right to have the least restrictive treatment which allow for the maximum amount of personal freedom.
- To promote a physical, social and cultural environment which allows for the least restrictive symptom management (i.e. physical restraints) that are clinically appropriate and adequately justified for CBRF hospice patients.
- To protect the Resident's health and safety, preserve his or her dignity, rights and well-being.
- To establish a standard for the care of a Resident who requires a physical restraint.
- To promote safe, proper and therapeutic use of physical restraints.

II. DEFINITION: PHYSICAL RESTRAINT

"Physical restraint" means any manual method of any article or device or garment interfering with the free movement of the resident, normal functioning of a portion of the body, or normal access to a portion of the body, and which the individual is unable to remove easily, or confinement in a locked room. (HFS 83.21 (4) (n) 1.c.)

III. PHYSICAL RESTRAINT/SIDERAIL ASSESSMENT IMPLEMENTATION

Prior to the use of a Physical Restraint/Siderail, a Pre-Restraining Assessment must be completed.

The Pre-Restraining Assessment must adequately assess all areas of the Resident's well being (physical, mental, emotional, environmental, and social considerations) prior to the use of the Restraint/Siderail in order to identify the least restrictive intervention.

The Hospice RN Case Manager will complete the Pre-Restraining Assessment.

The Hospice staff will secure physician order for physical restraint(s).

The plan of care/ISP will include physical restraints and frequency of resident checks.

The hospice staff will provide in-service related to appropriate use of restraints.

The CBRF will request Department of Health and Family Services approval (include pre-restraint assessment form), obtain resident/legal representative approval. HFS 83.21(4)(n).

ATTACHMENT B

ATTACHMENT B
HFS 83.21
Subchapter III – Resident Rights

HFS 83.21 RIGHTS OF RESIDENTS

1) LEGAL RIGHTS

- a) Section 50.09, Stats., establishes specific rights of CBRF residents and describes mechanisms to resolve complaints and to hold the CBRF licensee accountable for violating those rights. Other statutes, such as s. 51.61, Stats., and chs. 55.304, and 880. Stats., and ch HFS 94 may further clarify or condition a particular resident's right, depending on the legal status of the resident or a service being received by a resident. The licensee shall comply with all related statutes and rules.
- b) The licensee shall protect the civil rights of residents as these rights are defined in the U.S. Constitution, the Civil Rights Act of 1964, Title VIII of the Civil Rights Act of 1968, Section 504 of the Rehabilitation Act of 1973, the Fair Housing Amendments Act of 1988, the Americans with Disabilities Act of 1990, and all other relevant federal and state statutes.

2) EXPLANATION OF RESIDENT RIGHTS AND HOUSE RULES

- a) Before or at the time of admission, the CBRF staff shall explain resident rights, the grievance procedure under sub. (5) and the house rules of the facility to the person being admitted, that person's guardian, or agent, family members when involved in the placement, and any designated representative of the person, except that when an admission is being made on an emergency basis the explanation of resident rights, grievance procedure and house rules may be done within 5 days after admission. The resident or the resident's guardian or agent shall sign a statement to acknowledge having received an explanation of resident rights.
- b) Before the admissions agreement is signed or at the time of admission, whichever comes first, the licensee shall provide copies of the house rules and resident rights to the resident, and to the resident's guardian, agent or the resident's designated representative.
- c) Copies of the house rules and resident rights shall be posted in each facility in a prominent public place accessible to residents, staff and guests.

3) CORRECTIONAL CLIENTS. The rights established under sub. (4) do not apply to a resident in the legal custody of the department of corrections except as determined by the department of corrections.

4) RIGHTS OF RESIDENTS. Individuals have basic rights, which they do not lose when they enter a CBRF. Any form of coercion to discourage or prevent a resident or his or her guardian or designated representative from exercising any of the rights under this subchapter is prohibited. Any form of retaliation against a resident or his or her guardian, agent or designated representative for exercising any of the rights in this subchapter, or against an employee who assists a resident or his or her guardian, agent or designated

representative to exercise any of the resident rights in this subchapter, is prohibited. Except as provided under sub. (3), each resident shall have all of the following rights.

- a) **Copies of rights and house rules.** To receive from the facility, before admission, a copy of the rights established under this section and a copy of the rules of the facility. Copies shall also be offered to the resident's guardian, agent or designated representative, prior to the person's admission.
- b) **Mail.** To receive and send sealed, unopened mail, including packages. Correspondence of residents with legal counsel, the courts, governmental officials, the department, private physicians or licensed psychologists shall not be opened by staff. As a condition of receipt of correspondence believed to contain contraband, the CBRF may require the correspondence be opened by the resident in the presence of staff. The evidence shall be documented in the resident's file. Mail which cannot be delivered immediately shall be held securely by the CBRF until it can be delivered to the resident. Any resident who is without available funds and is not expected to receive additional funds for at least 3 days shall, upon request, be provided with up to 2 stamped non-letterhead envelopes each week and with a sufficient supply of non-letterhead stationery and other letter-writing materials to meet the resident's writing needs.
- c) **Telephone calls.** To make and receive telephone calls within reasonable limits and in privacy. The facility shall provide at least one non-pay telephone to which the residents have access and may require that long-distance calls be made at the resident's own expense. Any resident who is without available funds for at least 3 days shall be permitted to make at least one long-distance telephone call without charge to an attorney, the department or another source of help such as the resident's guardian, designated representative, a family member, a psychiatrist, a psychologist, a licensed therapist or a counselor.
- d) **Visits.** To have private visitors and adequate time and private space for visits.
- e) **Financial affairs.** To manage the resident's own financial affairs as provided in s. 50.09 (1)(c), Stats.

Note: Sec. HFS 83.17 for the duties of a CBRF which accepts responsibility to manage a resident's funds.

- f) **Service charges.** To be fully informed in writing before or at the time of admission of all services and charges for the services. Throughout the time a person is a resident of a facility, to be fully informed in writing of any changes in service and related charges.
- g) **Fair treatment.** To be treated with courtesy, respect and full recognition of the resident's dignity and individuality by all employees of the facility.
- h) **Privacy.** To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs. Persons not directly providing care and treatment or participating in group sessions shall not be present during such care and treatment except with the express spoken or written consent of the resident. Privacy in toileting and bathing shall be provided. The resident's room, any other area in which the resident has a reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without his or her permission, or permission of the guardian, except when there is a reasonable cause to believe that the resident possesses contraband. The resident has the right to be present for the room search.

i) **Confidentiality.**

1. To have all treatment records kept confidential. The resident or his or her guardian, agent or designated representative may inspect, copy and challenge the accuracy of the resident's records. For the purpose of coordinating care and services to the terminally ill resident, the licensed hospice program or home health care agency which is the primary care provided under s. HFS 83.34 (2) (a), shall have access to the resident's treatment records. For purposes of licensing and administration, staff of the department or the licensee may access resident treatment records without the resident's consent, but may not disclose the information except as permitted by law. Case discussion among staff shall be conducted discreetly, and staff shall not disclose treatment information about one resident to another.
2. The facility shall comply with 42 CFR Part 2 if the resident is in the CBRF because of alcohol or other drug abuse, and with s. 51.30, Stats., and ch. HFS 92 if the resident is in the CBRF because of mental illness, developmental disability, or alcohol or other drug abuse. Written informed consent shall be obtained from the resident or the resident's guardian for all other disclosures.

Note: Section 51.30 (4) (b) 5 and 15, Stats., permits sharing of limited information in certain circumstances between the department and a county department established under s. 46.215, 46.22, 51.42 or 51.437, Stats.

- j) **Labor.** To not be required by the facility to perform labor which is of any financial benefit to the facility. Personal housekeeping is an exception and may be required of the resident without compensation if it is for therapeutic purposes and is part of the resident's individualized service plan. This responsibility shall be clearly identified in the house rules of the facility.
- k) **Activity choice.** To meet with and participate in the activities of social, religious and community groups at the resident's discretion.
- l) **Clothing and possessions.** To retain and use personal clothing and effects and to retain, as space permits, other personal possessions in a reasonably secure manner.
- m) **Abuse.** To be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property.
- n) **Seclusion, restraints.**
 1. In this paragraph:
 - a. "Chemical restraint" means a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms.
 - b. "Seclusion" means physical or social separation from others by actions of the staff but does not include separation in order to prevent the spread of a communicable disease or cool down periods in an unlocked room as long as presence in the room by the resident is voluntary.

- c. "Physical restraint" means any manual method or any article, device or garment interfering with the free movement of the resident or the normal access to a portion of the body, and which the individual is unable to remove easily, or confinement in a locked room.
- 2. To be free from seclusion.
- 3. To be free from all chemical restraints, including the use of an as-necessary (PRN) order for controlling acute, episodic behavior. The use of a chemical restraint for a terminally ill resident who is under the care of a hospice program or a home health agency under s. HFS 83.34 (2) (a) shall be governed by the applicable provisions in ch. HFS 131 for hospice programs or ch. HFS 133 for home health agencies.
- 4. a. To be free from physical restraints except upon prior review and approval by the department and upon written authorization from the resident's primary physician. The department may place conditions on the use of a restraint to protect the health, safety, welfare and rights of the resident.
- b. Upon approval to use a physical restraint under subpar. a., only resident care staff trained in the proper use of the restraint may apply the restraint to the resident. Staff trained in the proper use of the restraint shall check the physically restrained resident according to conditions specified by the department on the use of a restraint.
 - c. Any use of a physical restraint approved under subbed. 4, a., shall be recorded, dated and signed in the resident's record. A record shall be kept of the periodic checking required under subbed. 4, b., on a resident in a restraint and of any adjustments to the restraint made by resident care staff, any adverse effects on the resident from the restraint and any complaints from the resident.
- o) **Medication.** To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, while being free from unnecessary or extensive medication and the use of medication as punishment for the convenience of staff as a substitute for treatment or in quantities that interfere with treatment. The resident has the right to refuse medication unless there has been a court finding of incompetency. Medication shall not be forcibly administered unless there is an appropriate court order.
- p) **Prompt and adequate treatment.** To receive prompt and adequate treatment appropriate to the resident's needs.
- q) **Choice of providers.** To exercise complete choice of providers of physical and mental health care, and of pharmacist.
- r) **Treatment choice.** To receive all treatments prescribed by the resident's practitioner, and to refuse any form of treatment unless the treatment has been ordered by a court. The written informed consent of the resident or the resident's guardian or agent is required for any treatment administered by the CBRF. General non-intrusive treatments typically provided by the CBRF may be provided to the resident under a written general informed consent agreement.

- s) **Religion.** To be permitted to participate in religious activities of his or her choice, to entertain visits from a clergy person or lay representative of his or her choice and to obtain the help of staff, if needed, to contact such clergy person or lay representative. No resident may be required to engage in any religious activities.
- t) **Incompetency.** To not be treated as mentally incompetent unless there was a court determination under ch. 880, Stats. A resident who has been adjudicated incompetent has a right to have his or her guardian fully informed and involved in all aspects of his or her relationship to the CBRF. The guardian may exercise any and all rights to consent or refuse which the resident is granted under this section. A resident who has been adjudicated incompetent shall be allowed decision-making participation to the extent possible as agreed to by the guardian and facility.
- u) **Least restrictive conditions.** To have the least restrictive conditions necessary to achieve the purposes of admission to the CBRF. Each CBRF shall help any resident who appears to be ready for more independent living to contact any agencies needed to arrange for it. No curfew, rule or other restriction on a resident's freedom of choice shall be imposed.
- v) **Recording, filming, photographing.** To not be recorded, filmed or photographed for promotional or advertising purposes without his or her written, informed consent. A photograph may be taken for identification purposes. The department may photograph, record or film a resident pursuant to an inspection or investigation under s. 50.03 (2), Stats., without his or her written informed consent.
- w) **Safe environment.** To live in a safe environment. The CBRF shall safeguard residents who cannot fully guard themselves from the environmental hazard to which it is likely that they will be exposed, including both conditions which would be hazardous to anyone, and conditions which are hazardous to the resident because of the resident's condition or handicap.

5. GRIEVANCE PROCEDURE.

- a) **Requirement.** All CBRFs shall have a written grievance and shall provide a copy to each resident and the resident's guardian or agent. The grievance procedure shall specify all of the following:
 1. Any resident or the resident's guardian or agent or designated representative may file a grievance with the facility, the department, the resident's case management, if any, the state board of aging and long term care, the Wisconsin coalition for advocacy for persons with mental or physical disabilities, or any other organizations providing advocacy assistance. The resident or the resident's guardian, agent or designated representative shall have the right to advocate assistance throughout the grievance procedure. The written grievance procedure shall include the name, address and phone number of organizations providing advocacy assistance for the client groups served by the facility, and the name, address and phone number of the department's regional office that licenses the facility.
 2. Any person investigating the facts associated with a grievance shall not have had any involvement in the issue leading to the grievance.

3. Any form of coercion to discourage or prevent a resident from filing a grievance or in retaliation for having filed a grievance is prohibited. Any form of coercion or retaliation against an employee who assists a resident in filing a grievance or otherwise obtaining assistance or referral for a grievance is prohibited.
 4. If the grievance is filed with the facility and the resident believes the grievance is not resolved within 15 days after filing, the resident may file the grievance with the CBRF's corporate office, if any, with the department, the resident's case manager, if any, the state board on aging and long term care or, for mentally or physically handicapped persons, the Wisconsin Coalition for Advocacy, or any other organization providing advocacy assistance.
 5. A written summary of the grievance, the findings and the conclusions and any action taken shall be provided to the resident or the resident's guardian, agent or designated representative and the resident's case manager, if any, and shall be inserted in the resident's record.
 6. If a resident is placed or funded by a county department of social services under s. 46.21 or 46.22, Stats., a county department of human services under s. 46.23, Stats., or a county department of developmental disabilities services under s. 51.437, Stats., the county grievance procedure under s. HFS 94.29, shall be used.
- b) **Assistance and referral.** A CBRF shall assist its residents as needed with the resident grievance procedure and provide access to a resident's case manager, if any, the department, advocacy organizations and the court on matters having to do with residence in the CBRF, treatment by the facility, the resident's legal status and the resident's disability. Assistance shall include finding and giving information about service agencies, helping residents express their grievances and appeals and finding an attorney.

History: Cr., Register, July, 1996 No. 487, eff. 1-1-97

PHYSICAL PRE-RESTRAINT ASSESSMENT CBRF/HOSPICE

This form has been developed in order to ensure the residents right to live in a safe environment. The CBRF and Hospice shall safeguard residents who cannot fully guard themselves from an environmental hazard to which it is likely that they will be exposed, including situations which would be hazardous to the resident because of the residents condition, disease progression or disability.

PHYSICAL AND MENTAL CONSIDERATIONS

MENTAL STATUS	YES	NO	PARALYSIS/PARESIS (If present)		
Alert			Arm Right Hand Right Leg Right Foot Right Left Left Left Left		
Short attention span					
Disoriented					
BALANCE (When sitting)	YES	NO	POTENTIAL MEDICAL FACTOR AFFECTING BEHAVIOR	YES	NO
Falls Forward			Medication change or addition in past month		
Falls/leans sideways			Possible infection		
Right Left Both			Dehydration		
Slides down			Respiration status insufficient for activity		
Slumps			Change in baseline vital signs		
AMBULATION	YES	NO	Progressive weakness		
Unable to ambulate			Other: _____		
Unsteady on feet			_____		
Loses balance			_____		
History of falls					
Foot problems			HAS RESIDENT EXPERIENCED A RECENT	YES	NO
Steps on own feet			Transfer		
Leans			Caregiver or staff change		
Other: _____			Other: _____		
_____			_____		

EMOTIONAL, ENVIRONMENTAL AND SOCIAL CONSIDERATIONS

POTENTIAL CONTRIBUTING BEHAVIORAL FACTORS	YES	NO	POTENTIAL CONTRIBUTING BEHAVIORAL FACTORS	YES	NO
Glasses available			Doesn't understand what is being said		
Hearing aid malfunctioning			Cannot comprehend surroundings		
Poor lighting or flickering lights			Affected by environmental noise level		
Needs to go to the bathroom			Loss of self-control		
Is hungry or thirsty			Experiencing feelings of anger, fear, abandonment		
Needs position changed; is cold/warm			Experiencing feelings of loneliness or isolation		
Misinterprets words, sounds			Other: _____		
Feels threatened by other residents			_____		
Is searching for a missing item					

RECOMMENDATIONS

CBRF/ HOSPICE COLLABORATION

Recommendations: _____

Rationale for use of restraints (full bilateral siderail)

___ Guardian/family request ___ Patient Security ___ Comfort Measure ___ Feeling of Safety ___ Presence of Dignity

___ Other: _____

Describe alternatives to restraints that have been tried or considered: _____

Summary: _____

Date ___/___/___ Signature (physician) _____

Date ___/___/___ Signature (patient/legal representative) _____ Relationship _____

Date ___/___/___ Signature (department) _____ Title _____

Approved _____ Disapproved _____