When Home is a Skilled Nursing Facility

It’s a Wild Ride!!!!
New Final Rule
The final rule reflects the Centers for Medicare and Medicaid Services' (CMS') commitment to the principles of the President's Executive Order 13563, released on January 18, 2011, titled “Improving Regulation and Regulatory Review.” It will improve quality and consistency of care between hospices and LTC facilities in the provision of hospice care to LTC residents.
Hospice and Nursing Home Partnerships

Potential perfect pair:

Hospice palliative care end of life experts.

Nursing Homes experts in caring for frail elderly and long term management of chronic illness.
The Numbers:

25% of Americans with a non-traumatic death die in nursing homes.
(500,000 people a year.)

In 2006 25% of Hospice patients lived in Nursing Homes.

1.4 million elderly (and younger disabled) live in the 16,000 US MediCare /Medicaid skilled nursing homes

1982 Congress authorized Medicare End of Life Hospice Benefit -living at home w 6 months or less anticipated life if disease runs its normal course.

1986 benefit extended to those living in nursing homes.

In 2004 78% of those nursing homes had contracts or agreements with Hospice Providers
Factoids

Nursing Home Hospice patients have a higher ratio of Dementia and other non-cancer diagnoses compared to Hospice patients who live in their own home.

Los Angeles leads the nation in Medicare spending on end-of-life care.

Spending in the last two years of life was about $112,000 per patient in L.A., (60% higher than the national average)

Dartmouth Atlas Project report.
Mission and Philosophy

**Hospice**

Provide compassionate end of life care to patients and family when cure is no longer possible.

Compassionate care is defined as focused on quality not quantity of life.

Focused on goals defined by patient and family.

Care focuses on physical, functional, emotional, social or spiritual aspects which are important to patient and family.

**Nursing Homes**

Achieve or maintain the Highest Practicable Level.

Safe environment- supervision.

Bill of Rights- treat each resident with dignity, respect and honor.

Remain as independent as possible.

Pursue activities – sense of happiness and achievement.

Many non-profit SNFs have additional spiritual goals.

Highly regulated industry.

Underfunded.
Turning everything upside down!
Mission and Reality: An Uneasy Partnership

Resident may choose their own providers.
Multiple Hospices providing services.
Additional burden on SNF—different procedures, protocols and approaches.
*Each* Hospice has education and orientation requirements.

NEW REQUIREMENT FOR AGREEMENT OR CONTRACT with each HOSPICE ORGANIZATION not for each patient.
Challenges

Reimbursement: no double dipping. Medicare will not pay for duplication of services.

Some services must terminate for Hospice to begin. (e.g. Med A SNF Coverage, PT/OT/SLP)

Delay in start of services due to myths and misapprehensions of patient, family and SNF staff.
Regulatory Guidelines

**Hospice**

- Provides all care as relates to terminal illness and coordinates all services.
- Develops and maintains system of communication and integration- Hospice Interdisciplinary Group (IDG) directs, coordinates and supervises care and services provided in accordance with Hospice Plan of Care based on individual needs of patient/family.
- Shares information among all disciplines-Hospice and SNF

**Nursing Home**

- Provides room and board and care unrelated to terminal illness.
- Responsible for decisions unrelated to terminal illness.
- Must have Interdisciplinary Team (IDT) develop and implement a comprehensive care plan.
- Communication – 3 shifts/7 days week, team
- Immediate Notification of Hospice certain circumstances.
- Requirements to notify attending physician and surrogates.
New Requirements

Delineate responsibilities more clearly between Hospice and SNF-specified roles and responsibilities for each.

Medicare/Medicaid regulations mirror each other.

Focus on coordination of services.

Prohibit duplication of services.
Regulations

OLD

SNF/NF may choose to have a written agreement with one or more hospice providers for Medicare-eligible residents electing benefits.

NEW

If SNF DOES NOT contract with at least one hospice they must help the resident find and transfer to a facility that does.

Specific provisions (15) required in agreement.

Seeking consistency in agreements.
Provisions in Agreement

Clarifies the roles and responsibilities of SNF and Hospice staff.

Signatures of authorized representatives of both Hospice and SNF are required in addition to the signatures of resident /surrogate decision maker.

SNF is now required to ensure that the Hospice services meet professional standards and principles and ensure the timeliness of the services!!!!!!!
Timeliness of Services

Means the SNF is required to ensure that, from the time the resident elects the Hospice benefit until the services are terminated, the Hospice will provide Hospice services meeting the resident’s needs in a timely manner, without any delay in the provisions of services for the resident.
Provisions

Hospice is responsible for making decisions related to the resident’s care for palliation and management of the terminal illness and related conditions.

(Hospice is (Already required § 418.58 to establish and maintain a written plan of care for every Hospice client.)

SNF is required to make decisions unrelated to the terminal illness. (§483.20(k) requires facilities to develop a comprehensive care plan for each resident.).)
Requirements

SNF is responsible for communicating changes in care plan to Hospice.

Define in writing which services are provided by Hospice and SNF staff respectively according to their care plans.

Define how the facility and Hospice will communicate.

Conditions under which the facility would need to IMMEDIATELY contact Hospice.
Immediate Contact Requirements
Include:

- Significant change of condition/status.
- Clinical complications that would alter the care plan.
- Need for transfer for any condition not related to the terminal condition.
- Resident Death.
Provisions Must State:

Hospice assumes responsibility for determining the appropriate course of hospice care, including changing the level of services as necessary.

Facility provides 24 hour room and care and meets the resident's personal and nursing care needs in coordination with Hospice.

Hospice provides medical direction and management of the hospice care, nursing, counseling (including spiritual, dietary and bereavement) social work, medical supplies, durable medical equipment and drugs needed for palliation of pain and symptoms associated with the terminal illness and related conditions.
Provisions Must State:

Hospice is responsible for all other Hospice services necessary for the care of the terminal illness and related conditions.

Nursing Homes are required to report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual and physical abuse including injuries of unknown origin and misappropriate of patient property by Hospice staff to the Hospice Administrator immediately upon facility awareness of alleged violations.
Provisions of Agreement

Delineate the responsibilities to provide bereavement services to facility staff.

SNF/NF must designate a member of the IDT to coordinate with Hospice.
SNF IDT Designee

The SNF InterDisciplinary Team member must have a clinical background, function within their State Scope of Practice Act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident
SNF IDT DESIGNEE

Is responsible for: Collaborating with hospice and coordinating facility staff participation in the hospice care planning process.

Communicating with hospice and other providers participating in care for the terminal illness, related conditions, and other conditions.

Ensuring the LTC facility communicates with the hospice medical director, attending physician, and other practitioners participating in care as needed to coordinate hospice care with that provided by others.
SNF IDT Designee MUST

Ensure that the LTC facility staff provides orientation to hospice staff.

Obtain from the hospice:
- The most recent hospice plan of care specific to the resident.
- Hospice election form.
- Physician certification and recertification of terminal illness.
- Names and contact information for hospice staff involved in the resident's care.
- How to access the hospice's 24-hour on-call system.
- Hospice medication information specific to the resident.
- Hospice physician and attending physician (if any) orders specific to the resident.
NEW REQUIREMENTS

Facility provides orientation to its policies and procedures to Hospice Staff (for each Hospice Organization with whom they contract)

Each resident’s plan of care would include Both the Hospice Plan of Care and the SNF Comprehensive Plan of Care.
What could go wrong?
SNFs providing hospice care must ensure that each resident's plan of care includes the most recent hospice plan of care and a description of the services furnished by the SNF to ‘attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being’ [483.25-Quality of Care].
Challenges yet to be solved:

CMS is still determining how SNFs can provide quick efficient orientation to Hospice staff that is sufficient to protect residents.

§483.75(r)(2)(ii)(J) now requires facilities to report all alleged violations by Hospice staff to Hospice administrator immediately upon becoming aware of allegation.

Hospice is already required (§418.112(c)(8) to report the same allegations to the SNF administrator if they suspect facility staff.
“Turf Wars”
“Professional Disagreement”

Terminal Illness and related conditions - what is NOT related to terminal illness?
Opiate induced constipation vs. Constipation
Medication Discontinued
Pain vs. Anxiety
Sedation vs. Least Medicating
Black Box Warnings – Psychototropic Medications
Evidenced –based interventions
Infections
Schedules: Showers, Meals, Activities, Visitors
Potential for Increased Conflict
Hospice vs. SNF Staff

Many challenging operational issues:
  SNF or Hospice provider assumes the role of primary decision maker?
How do providers handle disagreements between hospice staff and SNF staff?
Avoiding serious negative outcomes if/when hospice providers change orders unrelated to palliative care for a patient's terminal diagnosis.
What is related to the Terminal Condition and what is not?
Coordinate care...

Home Health Aide / CNA schedule and clarification of duties.
Frustrations include: I just gave the shower and now the HHA shows up wanting to shower my resident.

Discontinue Meds vs. Palliation of symptoms
Frustrations include thyroid medication, CHF medication, antidepressants etc.

Liberalized regular diet-altered texture risks /benefits
Thin vs. thick liquids risks and benefits.
Hospice Social Worker vs. SNF Social Services Designee
Chaplains seldom conflict but...
Outings and visitors – when is Hospice coming?
Meal time sacrosanct or?
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