Hospice/Nursing Home Partnership

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Over 25% of Americans dying from non-traumatic causes spend the "final chapter" of their lives in nursing homes. Approximately a half-million older adults die in U.S. nursing homes (NHs) each year which makes NHs increasingly the site of end-of-life care.¹ Nursing Homes are responsible to provide care for a more diverse, frail and clinically complex population of individuals. While providing high-quality end-of-life care to these diverse individuals is challenging for nursing homes, this challenge is intensified by the reimbursement and regulatory environments in which U.S. nursing homes operate.² This scenario creates the potential for the perfect partnership between hospice/palliative care programs, specialists with expertise in end-of-life care, and nursing homes, specialists in long term management of the frail elderly. This partnership however requires the successful negotiation of the complexities surrounding each industry's regulatory, reimbursement, philosophical/mission and operational challenges.

In 1982 the U.S. Congress passed legislation allowing payment for hospice care to terminally ill Medicare beneficiaries (i.e.; those with certified prognoses of 6 months or less [if the disease runs its normal course]),³ and in 1986 the benefit was extended to terminally ill Medicare beneficiaries residing in nursing homes.⁴ Nursing homes can offer Medicare hospice care by developing working relationships (including formal contracts) with certified Medicare hospice providers.⁵ Research attests to hospice’s positive impact on the care and outcomes for nursing home residents enrolled in hospice and suggest that hospices providing care in nursing homes instill the hospice philosophy and practices to the care of residents dying without hospice⁶.

Twenty-five percent of hospice beneficiaries resided in nursing homes in 2006. Approximately 1.4 million elderly and disabled nursing home residents are currently receiving care in nearly 16,000 Medicare and Medicaid certified Long-Term care facilities. In 2004, 78% of U.S. nursing homes contracted with hospice providers. Nursing home hospice patients tend to have higher rates of dementia and other non-cancer diagnosis compared to individuals in the community that use hospice⁷.

This technical assistance brief will be a resource tool for nursing homes as they partner with community-based hospices and for the staff and leadership of both the nursing homes and hospices as they seek to optimize the partnership.

² Miller S: A Model for Successful Nursing Home-Hospice Partnerships. J of Palliative Medicine, Vol 13, Number 5, 2010
⁶ Miller S: A Model for Successful Nursing Home-Hospice Partnerships. J of Palliative Medicine, Vol 13, Number 5, 2010
SECTION II: PHILOSOPHICAL AND MISSION PERSPECTIVES

Understanding Hospice Philosophy

The mission of hospice is to provide compassionate end-of-life care to patients and their family when a cure is no longer possible. Compassionate care is defined by hospice as care that focuses on the quality of the person's life rather than the quantity of days that they have to live. The hospice team focuses its goals of care on the end-of-life objectives as expressed by the patient and family. These end-of-life goals are defined by the patient and family in terms of “what is most important to them at this point in their life”. Care can focus on the physical, functional, emotional, social or spiritual aspects of their life which are hindering or helping them in meeting their “goals” or in other words, “what they define as important to them”.

Care is delivered by an interdisciplinary team of professionals and trained lay caregivers who bring their unique expertise to address the needs and desires of the patient and family. This team works cooperatively on the goals of the patient and family rather than only focusing on the professional goals of the discipline. Equally important in hospice is that the family is considered part of the unit of care, thus the needs, concerns and goals of the family are equally addressed by the team. The interdisciplinary team and the patient and family together function collectively to make the final days, weeks and months of a person's life more comfortable. In hospice, the patient and family “drive” the interdisciplinary team who follow the patient/family's lead in focusing on issues of physical, emotional or spiritual comfort.

Nursing Home resident and their families benefit greatly when the palliative care expertise of hospice staff is combined with NH staff’s expertise in providing nursing care to the frail elderly. This combination of skills can result in the alleviation of suffering for the patient and their family as they deal with the various issues they need to confront at the end of life. By addressing issues of pain, defining whether it is physical in nature or emotional/spiritual, the hospice is often able to isolate the factors that may be contributing to a poor quality of life for the resident and the agitated responses to this from the family and work in cooperation with the Nursing Home staff to achieve better end of life outcomes for all. When hospice patients can no longer remain in their own home, one solution is to transfer the patient into a nursing home or sometimes an assisted living facility. Likewise, residents of nursing homes who are approaching the end of life may be medically and emotionally ready to receive hospice services as an added benefit while they reside in the facility.

The Nursing Home’s Mission

As noted in the nursing home resident bill of rights, the Nursing Home's mission is to treat each individual with the honor and respect that is fitting.
to their dignity as a human being. Many nursing homes instill in their staff the philosophy of encouraging residents to remain as independent as possible, and help enable the resident to pursue activities that give them a sense of happiness and achievement. Many not-for-profit nursing homes especially include in their mission the need to provide an opportunity for residents to re-establish or strengthen their spiritual beliefs. The mission of the nursing home is to provide a safe environment that employs staff that is qualified, caring, considerate and respectful to the resident, their friends and family. Many not-for-profit nursing homes have also demonstrated a commitment to their communities, and they develop programs to ensure that the resident continues to feel that they are still an important part of the community.

Nursing Homes are especially focusing on building an environment of person-centered care. More and more Nursing Homes are incorporating culture change within their mission that encourages the individual needs and desires of the residents to direct and shape their life in the nursing home. The residents that nursing homes serve have diverse interests and physical, emotional and spiritual needs, and the nursing home must continually change to further improve the services that they provide to meet those needs.

Care is delivered by an interdisciplinary team of professionals who bring their unique expertise to address the needs and desires of the resident and family. This team works cooperatively on the goals of the resident and family. The resident and family are encouraged to actively participate in the interdisciplinary team meetings.

Nursing Homes have valued hospice care for the extra benefits that it provides the resident who is terminally ill. Hospice staff can help the Nursing Home staff with specialized treatments for pain and symptom management to assure maximum resident comfort. Hospice staff can augment the Nursing Home staff by providing services beyond the usual and customary services available within nursing homes. After the hospice resident dies, the hospice staff continues to help the family cope with their loss.

Mission and Reality Combined

While the Hospice and Nursing Home missions have similarities and have many common values, there are some issues inherent when combining the two industries to care for the patient/resident and family at the end of life. Consumer rights (referred to as patient and family rights in the mission statements) offer patient/residents the opportunity to select their providers of care. In doing so, there often are multiple NH and Hospice providers within the community. NHs often contract with multiple hospice providers in order to address this issue however this places additional burden on the NH facility to work with the individual policies and procedures of multiple hospice providers. While the intent is noble, the reality may cause
frustration on the part of the NH providers as each hospice educates the NH staff on end-of-life care (in accordance with the Hospice Medicare Conditions of Participation) and has different documentation policies and practices. Nursing Homes can encourage hospices contracting with the facility to work together to reduce duplication and excessive documentation replication.

Another challenge for the hospice and NH results when the consumer (patient/resident) utilizes all of the reimbursement avenues available to them which results in the termination of some services in order to access other services. A prime example of this is when the hospice patient residing in the NH is admitted to a hospital and discharged back to the NH and accesses their Medicare reimbursement upon discharge. This results in the patient having to revoke their hospice Medicare benefit and often the resident is not readmitted to hospice upon the termination of their Medicare NH benefit. This unfortunately causes the resident to die without the benefits of the hospice program, personnel and volunteers and the family to not reconnect with hospice for bereavement care and services.

The benefits of hospice and NH collaboration for the benefit of patients and families at the end of life far outweigh the burdens. This paper will address the optimal benefits of shared delivery of care at the end of life, while identifying operational challenges intrinsic to this relationship and possible recommendations to improve the partnership.
SECTION III: REGULATORY GUIDELINES

It is the nursing home’s responsibility to provide room and board, as well as the care unrelated to the terminal illness. Under the current Hospice Medicare Conditions of Participation the Hospice is responsible for all care as it relates to the terminal illness and coordination of all services for the patient. This includes developing and maintaining a system of communication and integration, ensuring the hospice interdisciplinary group maintains responsibility for directing, coordinating and supervising the care and services provided and that the care and services are provided in accordance with the plan of care and based on the assessments of the patient and family needs. Furthermore, the hospice is also responsible for the sharing of information between all disciplines providing care and services in all settings, whether provided directly or under arrangement. Hospice Medicare and Medicaid regulations mirror each other. This document will refer to Medicare regulations; however, this will often also apply to Hospice Medicaid recipients. Please check your State Hospice Medicaid regulations for clarifications.

As a positive choice to a traditional nursing home, hospice has proven to provide quality end-of-life care that has resulted in reduced hospitalizations and improved pain management. The involvement of hospice in long-term care has also proven to benefit non-hospice residents. Many believe it is the bereavement and spiritual nature of hospice which provides this indirect benefit.
SECTION IV: PROPOSED RULE WITH REVISED REQUIREMENTS FOR THE PROVISION OF HOSPICE IN LTC

Background: The Center for Medicare and Medicaid Services believes that there are not definitive regulations that delineate responsibilities of providers in caring for Nursing Home residents who receive hospice care from a Medicare-certified hospice provider, which could lead to duplicative or missing services. The proposed rule in the Federal Register would create a regulation that would revise the requirements Nursing Homes have to meet in arranging provision of hospice care. CMS states “We are proposing these requirements to ensure that long-term care (LTC) facilities (that is, SNFs and NFs) that choose to arrange for the provision of hospice care through an agreement with one or more Medicare-certified hospice providers would have in place a written agreement with the hospice that specified the roles and responsibilities of each entity.”

- Under current regulations, a SNF/NF may choose to have a written agreement with one or more hospice providers to provide hospice care to a Medicare-eligible resident who elects the hospice benefit. If the facility does not contract with a Medicare-certified hospice, the facility is responsible for assisting the resident in transferring to a facility that will arrange for the provision of such services, as requested by the resident. (See State Operations Manual; Appendix PP; 42 CFR 483.12(a)(2)(i), Transfer and discharge requirements.)

- CMS believes “there is a lack of clear regulatory direction regarding the responsibilities of providers in caring for LTC facility residents who receive hospice care from a Medicare-certified hospice provider, which could result in duplicative or missing services…” and that “…this problem would be remedied by a regulatory requirement for a written agreement between the two types of entities when they are both involved in the care of a Medicare beneficiary.”

Overview/Provisions

- Section 418.112(e) in the Hospice Conditions of Participation (CoPs) specifies what is included in a written agreement between a Medicare-certified hospice provider and a LTC Facility. CMS states that, to make the requirements for LTC facilities consistent and to ensure equal responsibility for the written agreement, the language in this proposed...
rule mirrors the hospice final rule to the degree possible.

- The proposed rule “…seeks to clarify the role of the LTC facility and the Medicare-certified hospice by requiring clear delineation of each provider’s responsibility for maintaining continuity of care.” The agreement requirements would apply even when the hospice and Nursing Home are under common ownership and/or control.

- CMS is proposing a new requirement at 42 CFR 483.75-Administration (r), entitled “Hospice Services.”

- Under the written agreement the Nursing Home would be required to ensure that the hospice services met professional standards and principles, and to ensure the timeliness of the services.

- “Timeliness of services” is defined to mean that the facility “…would be required to ensure that, from the time the resident elected the hospice benefit until the services were terminated, the Medicare-certified hospice would provide hospice services meeting the resident’s needs in a timely manner, without any delay in the provision of services for the resident.”

- The signatures of authorized representatives of the hospice and the Nursing Home would be required.

- Under the agreement the hospice would be responsible for making decisions related to a resident’s care for the palliation and management of the terminal illness and related conditions [Sec. 418.58 of the hospice Conditions of Participation requires a hospice to establish and maintain a written plan of care for every individual admitted to its hospice program].

- The Nursing Home would be responsible for making decisions unrelated to a resident’s terminal illness, re: 483.20(k) that requires the facility to develop a comprehensive care plan for each resident. The LTC facility would be responsible for informing the hospice about changes to the resident’s care plan.

- Written agreements would need to define (1) the services to be provided by hospice and the Nursing Homes, respectively, in accordance with the care plans; (2) how the facility and hospice would communicate; and (3) conditions under which the facility would need to contact the hospice immediately (including significant changes in condition/status; clinical complications that would alter
the care plan; need for transfer for any condition not related to the terminal condition; or resident death).

- Agreements would have to state that the hospice assumes responsibility for determining the appropriate course of hospice care, including changing the level of services, if necessary; that the facility provides 24-hour room and board and meets the residents’ personal and nursing care needs in coordination with the hospice. Agreements would also have to delineate hospice’s responsibilities, including providing medical direction and management of the hospice care; nursing; counseling (including spiritual, dietary and bereavement); social work; medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services necessary for care of the terminal illness and related conditions.

- Nursing Homes would be required to report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the facility becomes aware of the alleged violation.

- Agreements would have to include a delineation of the responsibilities of the hospice to offer bereavement services to Nursing Homes staff.

- Nursing Homes would be required to designate a member of the facility’s interdisciplinary team to be responsible for working with hospice representatives to coordinate care provided. This individual would be responsible for communicating with hospice representatives and other healthcare providers; ensuring the facility communicates with the hospice medical director, the attending physician, and other physicians participating in the provision of care; obtaining pertinent information from the hospice; and ensuring the facility provides orientation in its policies and procedures to hospice staff.

- Each resident’s written plan of care would include both the hospice plan of care and the services provided by the Nursing Homes.

Notes

CMS is still determining how Nursing Homes can provide orientation for hospice staff that is quick and efficient but sufficient to protect residents who receive hospice care. CMS efforts to mirror exist-
ing hospice requirements notwithstanding, some differences occur. For example, 483.75 (r)(2)(ii)(J), the facility would be required to report all alleged violations by hospice personnel to the hospice administrator immediately when the facility becomes aware of the alleged violation. However, the hospice is required at Sec. 418.112(c)(8) to report these same violations within 24 hours of the hospice becoming aware of the alleged violation.

CMS is also still determining whether the differences between the requirements that are found in the proposed rule would create a barrier to forming agreements between Nursing Homes or interfere in coordination of residents’ care between nursing homes and hospices.
Medicare will only reimburse one provider of care at a time, thus a resident of a Nursing Home can either receive skilled Medicare or Hospice Medicare, but not both. (*There are some circumstances which can result in both services—if the Medicare skilled nursing care is unrelated to the terminal condition.) Many times, newly discharged hospital patients will move to a Nursing Home and utilize their skilled Medicare benefit, which pays for room and board as well as skilled nursing care for the term of the benefit. Upon reaching the term of that benefit they can access their Medicare Hospice benefit for care related to the terminal illness and private pay/Medicaid for the room and board. Care required for services unrelated to their hospice diagnosis would also be billed to traditional Medicare.

Medicare pays the hospice according to the care level provided, and the Medicare beneficiary or a third party payer pays the room and board costs.

In the case of a nursing home resident who is covered under Medicaid, Medicaid pays the hospice, and hospice then pays the nursing facility.

Medicare Hospice provides four levels of care within a nursing home.

1. Routine Home Care includes, care delivered by an interdisciplinary team including but is not limited to nurses, hospice aides, medical social work, chaplains and trained volunteers (91% of claims are billed under this level of care)

2. Continuous Home Care is care delivered during periods of crises for palliation or management of acute medical symptoms

3. Respite Care is defined as short term care for the relief of the caregiver delivered in a nursing home for not more than five consecutive days

4. General Inpatient Care is for pain control and symptom management that cannot be provided in an alternate setting.

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Goals of Care

- Resident and family centered care is of paramount importance in order to keep the resident’s and family’s needs and wishes as the primary focus in a unified goal development.

- Allowing the resident to age in place utilizing the Hospice Medicare General Inpatient benefit during intermittent acute care phases of the terminal disease is often underutilized. This results in residents emergently transported to an acute care setting resulting in an unwanted hospital admission. Regularly reviewing the resident/family care and treatment goals by both Nursing Home and Hospice is sometimes overlooked or placed at a lower priority.

- Both care providers are focused on different care goals. The Nursing Home typically develops resident care goals centered on restorative or rehabilitative care. Hospice works with the terminally ill resident and their family in developing goals that promote palliation of symptoms.

- Physicians have difficulty or are reluctant to determine prognosis resulting in delayed or no referral for hospice services.

- DNR orders (or the lack of them) may create confusion about care goals.

Development of Plan of Care

Both the Nursing Home and Hospice are required to coordinate a “unified” collaborative care plan in order to provide seamless interdisciplinary care at the end of life. Many times the Nursing Home and the Hospice do not understand one another’s regulatory mandates. Probably the most significant area of coordination and collaboration needs to be evident in the care planning process. This lack of knowledge can add to the likelihood of one or both partners receiving statements of deficiency following a survey.

Care Coordination

- The Nursing Home may lack an understanding about hospice admission criteria or enrollment process.

- Difficulty coordinating the involvement of both providers in care plan meetings due to staff scheduling conflicts leads to ineffective and disjointed approaches to care.

- In some cases, an ineffective care plan is a result of arrogance by the care plan staff and a lack of understanding and
appreciating one another’s area(s) of expertise.

Documentation

- Hospice must update assessments and care plans in response to changes in the resident’s condition.
- It is imperative that both the Nursing Home and Hospice share documentation. With the emergence of the EMR (electronic medical record) both nursing homes and hospice are challenged to share documentation. Future successful partnerships will necessitate coordinated efforts in developing technology that speaks to each other.

Communication

- Lack of communication between the Nursing Home staff and the Hospice care team is frequently noted as an added burden to a successful relationship. Timely and effective communication pertaining to disease progression and symptom management is often inconsistent and superficial. Care partners may lack the ability or grasp the importance of coordinating services that promote physical, psycho/social, and spiritual well-being of residents.
- Knowing the best person to collaborate with regarding residents at the nursing home can be a challenge for Hospice staff. Staffing turnover issues add to the confusion and inconsistencies of collaboration.
- Nursing Homes often times do not designate specific members of their care team to act as a resident care liaisons with Hospice staff.

Service Delivery

- Coordination of care provided by both partners is necessary to avoid duplication of efforts and services. The Nursing Home staff is often unclear what the objectives and utilization expectations are for each member of the Hospice Interdisciplinary team. There is always the potential for the Nursing Home staff to question their ability to provide quality care to their residents or feel de-valued when another professional enters the picture.
- The Nursing Home administration is often times reluctant to partner with Hospices due to a potential perception that having Hospice involved could be viewed by some as an area of weakness with their staff’s ability to provide care at the end of life.
• The Nursing Home administration has a disincentive to recommend hospice care over the skilled Medicare benefit.

**Billing Clarification**

• Ineffective and misunderstood billing processes for the Nursing Home and Hospice can result in late or lower reimbursement and in some unfortunate cases no reimbursement at all.

• Understanding and delineating payment responsibilities for supplies and treatment modalities in nursing homes has and continues to be a challenge for both the Nursing Home and Hospice staff. This organizational challenge is another area where communication and collaboration is extremely important and tends to create barriers for reimbursement.

• Nursing Home and physician billing often times is challenging, usually due to a lack of communication and understanding of coding practices.

• Perception of “double dipping” of Medicare benefits can be confusing to the resident, the family and sometimes the Nursing Home staff.
The professional relationships and strong partnerships between nursing homes and hospice are crucial to developing and maintaining best care practices in the Nursing Homes setting. Both partners must understand their roles and how to incorporate their areas of expertise in providing end-of-life care to nursing home residents. Promoting and maintaining consistent, thorough collaboration standards will ensure resident’s care choices are recognized and honored.

Hospice staff must become familiar with the regulatory expectations of their contracted Nursing Homes. A lack of understanding can open the facility up for survey deficiencies. Conversely, Nursing Home staff must be willing to change their “rehab” centered mindset in order to better understand and accept a resident’s terminal condition and the provision of palliative care. It is important to the success of this partnership to continually support each other as valued members of the same team. Role modeling the highest standards of care and service by both providers will result in resident/family satisfaction.

Partnering with Hospices can also provide NH residents with additional integrative therapies. Palliative arts including Massage Therapy, Music Therapy, Aroma Therapy, and Lifetime Legacies are just a few examples of added value services that can be utilized by residents to promote comfort and pain management.

The inclusion of hospice in a nursing home benefits the nursing home resident, as well as the nursing home staff and non-hospice nursing home residents by incorporating the bereavement and end-of-life care into the nursing home. Hospice could also act as a catalyst for culture change within the nursing home. The partnership benefits the hospice provider by allowing them to serve patients that are not in the community, the most prevalent location for hospice services.

Section VII: Why Optimize the Nursing Home/Hospice Partnership?
The article, A Model for Successful Nursing Home Partnerships by Susan C. Miller, Ph.D., M.B.A. in the Journal of Palliative Medicine in November 2010 focuses on the following domains as critical components of a successful Nursing Home–Hospice collaboration:

- Administering the Collaboration
- Interdisciplinary Practice
- Communication
- Education
- Care Planning
- Care Provision
- Support to Resident/Family/NH Staff

Administering the Collaboration

The key to a successful partnership is when both organizations have similar missions and philosophies of care. When there are regular meetings between CEOs and key staff, there tends to be a more efficient collaboration that results in better care for the NH resident receiving hospice. The difficulty occurs on an administrative level because the regulations for nursing homes and hospice are different. Nursing Homes have a model of care that promotes maintaining functioning levels. Hospices have a model of care that focuses on palliative care and the quality of life for individuals who are terminally ill. It is important that the Administrator and staff of both the nursing home and hospice understand both the nursing home and hospice regulations, and how they will proceed if there is a conflict between the nursing home and hospice staff concerning disease modifying versus palliative care. The CEO must also have mechanisms in place to periodically assess the partnership.

In order to have an effective nursing home / hospice collaboration, it is important to develop a model text for the election statement. The election statement ensure that the nursing home resident receiving hospice is fully aware of the types of services that they will be receiving as well as the treatments and services that they may be relinquishing under the hospice benefit. It is important that the election statement mirror federal regulations that address the hospice patient's rights if they are admitted to the hospital. A hospice patient does not rescind the hospice benefit when he or she is admitted to the hospital without authorization from the hospice. At that point the individual must sign a statement that eliminates hospice benefits for that election period. The causes for discharge from hospice should be clearly delineated in the election statement.

The nursing home and hospice billing staff must have a system in place to assure an effective, accu-
rate billing process. The nursing home and hospice need to have a formal mechanism concerning how to identify potential referrals to hospice.

**Interdisciplinary Practice**

Systems must be in place to facilitate communication between hospice and nursing home staff at all levels. It is important to instill the philosophy of “we” care for the resident. It is important from the beginning of the working relationship to have in place a system of conflict resolution. The CEOs and Directors need to cultivate personal relationships between hospice nurses and nursing home nurses, as well as all the members of both teams. The Quality Improvement program for the nursing home and hospice should be addressing the palliative care issues.

**Communication**

There needs to be open and frequent communication between nursing home and hospice staff. It is important that both the hospice and nursing staff have contact information and are familiar with who to contact in the organization concerning specific issues. Systems must be in place to facilitate communication between hospice and nursing home staff at all levels - independent of individual personalities. Lack of communication between the facility staff and the Hospice care team is frequently noted as an added burden to a successful relationship. Timely and effective communication pertaining to disease progression and symptom management is often inconsistent and superficial.

Care partners may lack the ability or grasp the importance of coordinating services that promote physical, psycho/social, and spiritual well-being of residents.

Along with the importance of communication and coordination of services between the nursing home and hospice, there should be a system in place to address any areas of duplication of efforts and services. Hospice can not provide services under the Hospice Medicare benefit that are a provision of the NH contract with the resident. Thus services provided as a part of the NH room and board, such as housekeeping, dietary, basic healthcare and aide services, to name a few, can not be duplicated by the hospice.

Knowing the best person to collaborate with regarding residents at the nursing home can be a challenge for Hospice staff. Staff turnover adds to the confusion and inconsistencies of collaboration. Nursing Homes often times do not designate specific members of their care team to act as resident care liaisons with Hospice staff.

From the first day of hospice care, there must be an understanding by the attending physician, nursing home and hospice medical directors, nursing home nursing staff and hospice staff concerning when residents receiving hospice should be transported to an acute care setting. There also must be clarity in the physician’s prognosis for the resident. There should be Do Not Resusitate orders that align with both the goals of the hospice and nursing home.
plans of care.

It is recommended that hospices and nursing homes designate liaisons to facilitate communication across hospice and nursing home staff. Also, hospices may dedicate a specially trained team that would only be assigned to nursing homes. The hospice team members would check in with their nursing home counterparts as a routine for their visits. It is important that when they check in both the nursing home and hospice staff share information on what is currently happening with the patient. Sometimes it is helpful for the assigned nursing home staff to have previous hospice experience, and perhaps the hospice nurse may have previous nursing home experience.

**Education**

The staff of the Nursing Home should be required to be trained about relevant regulations in the hospice conditions of participation, and the hospice staff needs to be aware of nursing home regulations. The Nursing Home staff should understand the basics on hospice admission criteria and the enrollment process. This training could be done as part of the initial staff orientation process, as well as annual training programs. The training of Hospice and Nursing Home Staff must address relationship building and conflict resolution. The Hospice should provide formal in-services for NH staff on palliative and hospice care for all shifts. The hospice staff needs to participate in training on issues related to Nursing Homes. Part of the joint education program should include conducting mock surveys in the nursing home that include both nursing home and hospice staff to assure quality of care and accurate documentation.

**Care Planning**

It is imperative that both the nursing home and hospice share documentation. The sharing of information may require that the two providers are using electronic medical records that are compatible. Hospice staff should always be invited to the care plan meetings for their client. The intervals that the plan of care should be reviewed and updated should be person-centered and reflect the progression of the terminal illness. We suggest developing a checklist of what information should be included in the plan of care for a hospice patient. The plan of care helps to ensure that the hospice and nursing home personnel all are aware what needs to be done, by whom, at what time, and for what reason. Besides the hospice registered nurse, it is important to include the pastoral or other hospice counselor plan of care in the interdisciplinary plan of care. Plans of care that include home health type services must include the scope of these services. Also, the frequency of each service must be included in the plan of care. It is important that if a scope of service is noted in the plan of care that both the hospice and nursing home staff are compliant with documenting these services when they are provided for the patient. Both the Nursing Home and Hospice are required to coordinate a “unified” collaborative care plan.
in order to provide seamless interdisciplinary care at the end of life. Many times the Nursing Home and the Hospice do not understand one another’s regulatory mandates. Probably the most significant area of coordination and collaboration needs to be evident in the care planning process. This lack of knowledge can add to the likelihood of one or both partners receiving statements of deficiency following a survey. “For instance, the Minimum Data Set/Quality Measure surveys for the nursing home’s record issues with dehydration and weight loss, and those symptoms can be part of the typical dying trajectory”.

**Care Provision**

It is critical that when there are multiple hospices providing services in a Nursing Home, that there is a consistency in how the hospice teams work with the nursing home staff. Hospice must be visible in off hours when needed. The hospice can assist the nursing home with end of life care by suggesting and help implement supplemental services for the individual in hospice. These nursing home services could include making available a private room for dying residents and their families, providing comfort carts for families of dying residents, and showing respect for residents who died through gestures such as not filling a resident’s bed for a specified period of time after death.

**Support to resident/family and nursing home staff**

A collaborative hospice and nursing home relationship can improve the quality of life for the resident and family by enhancing the emotional and spiritual services that are available for the individual that is terminally ill. The hospice could offer to arrange for Memorial services, as well as answer special requests with transformational and inspirational experiences, such as providing patients with recorded messages, stories and memories from loved ones.

**SECTION IX: CONCLUSION**

As the baby-boomer generation continues to age and seek alternatives to care that include nursing home and hospice services the necessity of both organizations to work in harmony for the sake of all Americans is paramount. The responsibility of developing a working partnership between hospice and nursing home care far outweighs the alternative to do nothing collaboratively. Residents of nursing homes and their family members will be the beneficiaries of combining the strengths of both organizations in providing quality end-of-life care. Through this collaboration, end-of-life care with dignity can be attainable for all people regardless of where they reside.

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