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Partnership in Care:

Best Practices for Hospice Provider and Facility Collaboration

National Alliance for Care at Home

allianceforcareathome.org

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At the time of first publication, the National Hospice and Palliative Care Organization (NHPCO) has come together with the National Association for Home Care & Hospice (NAHC) to form the National Alliance for Care at Home (the Alliance). Any references to NHPCO throughout this document refer to legacy NHPCO resources or workgroups that will continue in a new name under the Alliance.

INTRODUCTION:

Providing patient-centered end-of-life care to residents of facilities is an important aspect of many hospice organizations' services. Facility residents represent a unique population and providing hospice services in a facility differs broadly from providing hospice care in the home setting. The goal of this resource is to facilitate collaboration between hospice and facility staff, and to provide a framework to guide provider conversations between hospices and offer their facility partners in order to establish best practices in caring for their shared patients.

This resource is intended to outline best practice recommendations to guide collaboration between hospices and their facility partners and, as such, does not represent prescriptive guidance for required aspects of facility education. The Alliance recognizes that hospice-facility agreements are unique and varied; this resource is broadly applicable to a variety of settings. While some aspects of this resource may apply most specifically to nursing facilities, it is intended to be adaptable for residents of a variety of additional congregate care settings, including assisted living facilities, residential care homes, and group homes.

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Hospices are encouraged to identify a responsible party to review the Partnership in Care: Best Practices for Hospice Provider and Facility Collaboration tool with an appropriate representative of the facility at the initiation of the agreement and on a regular ongoing basis. The Alliance recommends that hospices approach updates to this document as a team, including input from both the administration and clinical staff. This document should be updated at least annually, with review recommended on a more frequent basis.

The tool includes fillable space for hospice and facility representatives to note relevant information, as well as an outline of recommended topics to discuss. In addition, some aspects of the tool are marked with an asterisk, denoting items that should be prioritized in time-limited scenarios, such as admission of a facility patient very near the end of life.

Communication and Logistics

HOSPICE KEY PERSONNEL CONTACT INFORMATION	
Primary Hospice Contact	
Administrator	
Medical Director	
Director of Nursing	
Bereavement Counselor	
Volunteer Coordinator	
Facility Liaison	
Pharmacy Benefits Manager	
Incident Reporting	
Other	

FACILITY KEY PERSONNEL CONTACT INFORMATION	
Administrator	
Medical Director	
Director of Nursing	
Dietary Director	
Activities Director	
MDS Coordinator	
Social Worker/Director	
Admissions Coordinator	
Billing	
Pharmacy	
Unit Manager	
Unit Phone/Fax Numbers	
Incident Reporting	
Other	

HOW TO CONTACT HOSPICE	
Weekdays	
Evenings/Nights	
Weekends	
Holidays	

SECURITY	
Facility access after-hours	
24/7 phone numbers	
Parking	
Unit names/layout	
Security procedures	
Time of death procedures	
Visitation protocol	

PROVIDING EDUCATION TO FACILITY STAFF	
Who to contact	
Best time/dates	
Preference for live training, virtual, handouts, etc.	

STAFF COMMUNICATION

- **Reporting changes in condition**
  - Changes in status
    - New or changed symptoms
    - Behavioral changes
    - Change in diet or appetite
    - Death
  - Falls/incidents
  - New orders
  - Changes to the plan of care
  - Low on medications/need for refills
  - Low on supplies
  - Abuse/neglect reporting

- **Changes in responsible party or family dynamics**
  - Authorized representative
  - Family member sentinel events or circumstances (e.g., drug abuse by a family member, mental health considerations)

- **Facility changes**
  - Malfunctioning equipment
  - Room/location changes

- **Notable circumstances**
  - Infection precautions/outbreaks
  - Emergency events (e.g., active shooter, bomb threat, etc.)
  - Cybersecurity breach or incident
  - Surveyors on site
    - Hospice and facility survey best practices
    - Notify each other of surveyor presence

STAFF COLLABORATION

- **Charge nurse availability**

- **Shift change procedures**

- **Visit schedules**
  - CNA schedules and family preference for CNA care (i.e. priority for feeding, bathing, recreation, etc.)
  - Volunteers/activities
  - Coordinating personal care, wound care, etc.

STAFF EDUCATION

- **How can the hospice team support facility staff by providing trainings on topics relevant to end-of-life care and the hospice philosophy?**

- **Review trainings required by facility contract**

- **Required trainings for nursing facility staff** (42 CFR 418.112)
  - Philosophy
  - P&P re: comfort, pain control
  - Principles of death and dying
  - Patient rights
  - Recordkeeping

Medication Management

MEDICATION MANAGEMENT	
Hours of medication availability/ delivery?	
How to order medications?	
Comfort kits – procedures and limitations?	
Medication disposal procedures?	
Medication disposal responsible party?	
Medication disposal documentation?	

MEDICATION COORDINATION AND ADMINISTRATION

- **Pharmacy coordination**
  - Acquiring medications
    - Family responsibilities
    - Hospice Pharmacy Benefits Manager (PBM)

- **Controlled medications or psychotropics**
  - Availability/limits
  - Risk vs benefit forms
  - Other required documentation
  - NHPCO Regulatory and Compliance Center: Opioids https://www.nhpco.org/rg-new/rg-opioids-2/

- **Medication administration**
  - Bubble packs/pre-filled syringes
  - PRN vs routine
  - IV medications – staff comfort with pumps

- **Relatedness/coverage**
  - How should hospice communicate relatedness?
  - Formulary/preferred medications
  - Regulatory and Compliance Center: Relatedness: Conditions, Medications, Drugs, Services https://www.nhpco.org/rg-new/rg-conditions-medications-drugs-and-services/

Coordinating the Plan of Care

DOCUMENTATION AND PLAN OF CARE	
Where should hospice staff document?	
Where should hospice documents be filed?	
Can hospice staff have EMR access?	
How does hospice staff access patient records (medications, input/output, nutrition logs)?	
How are incident reports documented?	
How are incident reports shared between hospice and facility?	
How should hospice staff communicate regarding patient's advance directives?	
Where are advance directives located?	

CARE PLAN MEETINGS	
Frequency	
Scheduling contact	
How hospice staff can attend (in-person, virtual, etc.)	

REPORTING REQUIREMENTS	
Does the facility require any specific reports/documentation from the hospice (ex. quarterly quality reports)?	

PHYSICIAN COLLABORATION

- **Patient choice of attending physician**
- **Outside physician groups**
- **Hospice physicians**
  - Privileges and credentialing procedures
- **Requirements for facility physicians**

ANCILLARY SERVICES

- **Services to coordinate with hospice in advance**
  - Wound care
  - Podiatry
  - Physical therapy
  - Occupational therapy
  - Speech language pathology
    - Swallow evaluations
  - Behavioral health consults and services
  - Durable medical equipment (DME)
  - Imaging
  - Specialist medical appointments
  - Transportation to medical appointments
  - Lab draws
  - Dietary/nutrition consults

Clinical Considerations

DEATH OF THE HOSPICE PATIENT	
Who can pronounce/verify?	
Who will call family/responsible party?	
Who notifies funeral home?	
Who is responsible for generating the death certificate?	

ETHICAL CHALLENGES AND COMPLAINTS	
Is there a facility contact or committee to collaborate on ethics concerns?	
What is the facility procedure for complaint management?	

DME, SUPPLIES, AND WOUND CARE

- **DME**
  - What DME is allowed or restricted
    - Bed rails (full/half)
    - Hoyer/other lifts
    - Pumps
    - Wound Vacs
    - Fall prevention devices (alarms, fall mats, etc.)
  - What should hospice provide and what is provided in-house?
  - Ensuring that DME and supplies are given to correct patient

- **Wound care**
  - Ensure coordination of wound care
    - Wound care as related to terminal illness is responsibility of hospice, facility should coordinate all wound care treatment, including by outside parties, with hospice
  - Reference patient goals for wound management (i.e. healing vs. emphasis on relief of pain/symptoms, dignity, etc.)
  - Identify any limitations on wound care for facility staff (i.e. are staff onsite permitted to change wound dressings?)

SAFETY AND INFECTION CONTROL

- **What/when to report**
  - Patient death
  - Falls
  - Sentinel events
  - Medication errors
  - Abuse/neglect

- **Protocol for sending patients to the Emergency Room**
  - Consideration of advance directives
  - Communicating with hospice prior to the transfer

- **Emergency Preparedness**
  - Facility plans
  - Evacuation procedures

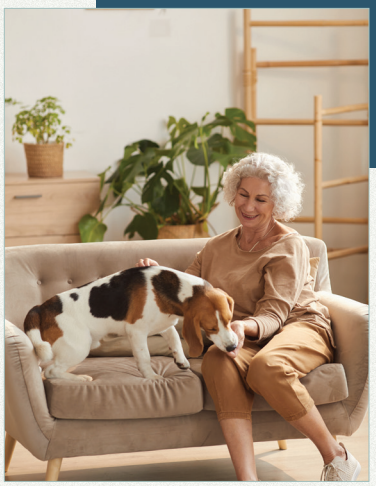
- **Infection Control**
  - Facility/hospice protocol
  - Availability of PPE

SYMPTOM MANAGEMENT AND CLINICAL PROTOCOL

- **Common symptom challenges**
  - Pain
  - Constipation
  - Agitation
  - Nausea
  - Shortness of Breath/Dyspnea
  - Terminal Restlessness
  - Fever

- **Hospice clinical protocol**
  - Wound care/dressing change schedule
  - Catheter/ostomy care
  - Skin Breakdown
  - Pressure Sores
  - Depression
  - Fecal impaction
  - Dehydration

HOSPICE PHILOSOPHY AND INTERDISCIPLINARY TEAM



- **Hospice philosophy**
  - Nutrition
    - Voluntary stopping of eating and drinking
    - Patients unable to swallow
    - Feeding tubes
    - Management of weight loss
  - Activity decline/staying in bed
  - Prioritizing comfort

- **Myths and misunderstandings**
  - Use of morphine
  - Comfort vs curative treatment

- **Advance Directives**
  - Power of Attorney
  - MOLST/POLST
  - Guardianship

- **Hospice Interdisciplinary Team (IDT)**
  - Hospice aide responsibilities
  - Volunteers
    - Types of volunteers offered
  - Bereavement
    - Hospice support for facility staff
    - Memorial services
  - Veterans' services
  - NHPCO Regulatory and Compliance Center: Interdisciplinary Team (IDT/IDG) and Care Planning https://www.nhpco.org/regulatory-and-quality/regulatory/interdisciplinary-team/

- **Additional hospice services**
  - Music therapy
  - Massage therapy
  - Pet therapy
  - Aromatherapy
  - Energy work/therapeutic touch
  - Art therapy
  - Death doula

Administrative Considerations

LEVELS OF CARE	
What levels of care are provided in the facility?	

BILLING AND ADMINISTRATIVE PROCEDURES	
What reports are available for hospice to review (pharmacy invoices, DME charges, etc.?)	
When is the last time the hospice-facility agreement was reviewed?	
Who is responsible for review of the hospice-facility agreement?	
When is the hospice-facility agreement set to expire? Does it auto-renew?	

COMPLIANCE

- **Levels of Care**
  - Definitions of the different hospice levels of care
  - When would each be appropriate
  - Review eligibility criteria for each hospice level of care
  - NHPCO Regulatory and Compliance Center: Levels of Care https://www.nhpco.org/regulatory-and-quality/regulatory/levels-of-care/

- **Bed holds**
  - Discuss facility bed hold protocol in the unusual event that a hospice patient leaves the facility
  - Note: bed hold requirements may vary by state law
  - NHPCO Regulatory and Compliance Center: State-Specific Resources https://www.nhpco.org/regulatory-and-quality/regulatory/state-specific-resources/

- **Live Discharges**
  - Reasons for hospice live discharge
  - Coordination of care
  - Implications for service-connected patients (e.g., patients with VA service-connected benefits)
  - Implications for patients who are no longer Medicaid-eligible
  - NHPCO Regulatory and Compliance Center: Discharges, Transfers, and Revocations https://www.nhpco.org/regulatory-and-quality/regulatory/discharges-revocations-transfers/

- **Hospice-Facility Agreement/Contract**
  - Schedule/process for review
  - Review components of the agreement for mutual understanding
  - Compliant/timely billing practices
  - Medicaid room and board considerations
    - When is the hospice responsible for paying the facility, e.g., after Medicaid payment is received or before?
    - Who is responsible for tracking the patient's Medicaid eligibility?
    - Who is responsible for submitting the patient's Medicaid eligibility renewal paperwork (if applicable)?
    - Who collects the patient's Medicaid cost share?

- **Legal considerations for nursing facilities**
  - Kickbacks and inducements
    - Hospice is supplemental to nursing home services, hospice services should not be utilized to replace care provided by the facility
    - **Example:** Hospice is able to provide hospice aides, but should not replace, but is rather supplemental to Certified Nurse Aide (CNA)/ General Nurse Aide (GNA) care provided by the facility.

BILLING

- **The Medicare Hospice Benefit** is intended to cover "virtually all" of the items, services, and medications needed by the beneficiary electing the benefit

- **Unless there is clear evidence** that a condition is unrelated to the terminal prognosis, all services would be considered related. It is also the responsibility of the hospice physician to document why a patient's medical needs would be unrelated to the terminal prognosis.

- **The determination** of what is related or not related to the patient's terminal prognosis and related conditions is a hospice determination, not the facility's determination.

- **While certain services,** items and drugs may be separately billable if they are totally unrelated to the patient's terminal prognosis, CMS believes that virtually all care should be covered by the hospice. Illustratively, hospices are "responsible for providing any and all services indicated in the plan of care as reasonable and necessary for the palliation and management of the terminal illness and related conditions." Medicare Benefit Policy Manual, Chapter 9, Section 40.1.9
  - NHPCO Regulatory and Compliance Center: Relatedness: Conditions, Medications, Drugs, Services https://www.nhpco.org/rg-new/rg-conditions-medications-drugs-and-services/
  - NHPCO Regulatory and Compliance Center: Terminal Illness and Related Conditions, Prognosis, and Eligibility https://www.nhpco.org/regulatory-and-quality/regulatory/determining-terminal-prognosis/

- **Part A**
  - CMS has indicated that "Medicare services for a condition completely unrelated to the terminal condition for which hospice was elected remain available to the patient if he or she is eligible for such care." Medicare Benefit Policy Manual, Chapter 9, Section 10.
  - CMS has further specified that "[a]ny covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider using professional or institutional claims for non-hospice Medicare payment." Medicare Claims Processing Manual, Chapter 11, Section 50

- If a hospice determines that certain services, such as skilled nursing facility (SNF) care offered by the facility, is totally unrelated to the patient's terminal prognosis and related conditions, then the facility may provide these services, provided the care is both reasonable and necessary. In these cases, any institutional claim submitted by the facility to Medicare for these services should be coded with condition code 07 "Treatment of Non-terminal Condition for Hospice."
- In these instances, the facility would be paid by Medicare Part A from the date the patient qualifies for SNF care unrelated to the terminal condition. In these instances, the facility must complete required Medicare- assessments from the of care for the unrelated condition.
- Hospice Beneficiary Election Statement Addendum Frequently Asked Questions (FAQs) (Updated: FY 2022 Hospice Final Rule Effective 10.1.2021)

- **Part B**
  - When a patient elects hospice services under Medicare, they waive all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, which may include a nurse practitioner or physician assistant.
  - Medicare only provides coverage for medically necessary services of a non-physician practitioner (NPP), such as a nurse practitioner or physician assistant, for a hospice patient when the patient has designated that NPP as their hospice attending - no exceptions. This applies regardless of whether they are an employee or contracted with the hospice. Medicare Benefit Policy Manual, Chapter 9, Section 40.1.3.2
  - Medicare regulations for nursing facilities require a physician visit for a nursing home resident "at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter." 42 CFR 483.30(c)(1)
  - Relatedness/coverage of medical visits
    - Considerations for physicians rounding in facilities
    - Determination of relatedness
    - Any professional claims for Medicare Part B-covered services should be coded with the GW modifier "service not related to the hospice patient's terminal condition."
  - NHPCO Regulatory and Compliance Center: Billing and Reimbursement https://www.nhpco.org/regulatory-and-quality/regulatory/billing-reimbursement/

- **Part D**
  - NHPCO Relatedness Process Flow https://www.nhpco.org/wp-content/uploads/NHPCO-Relatedness-Process-Flow_Revised-Version-2.0-2020vFINAL.pdf
  - NHPCO Regulatory and Compliance Center: Relatedness: Conditions, Medications, Drugs, Services https://www.nhpco.org/rg-new/rg-conditions-medications-drugs-and-services/

The National Alliance for Care at Home gratefully acknowledges the work of the Hospice and Facility Partners Workgroup, composed of members of the NHPCO Quality and Standards and Regulatory Committees, for making this resource possible. This guide has been developed by the Alliance for informational purposes only. It should not be viewed as official guidance from CMS. It is always the provider's responsibility to determine and comply with applicable regulatory requirements. Further, this guide does not constitute legal advice and is not intended to take the place of legal advice.

References

Medicare Benefit Policy Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

Medicare Hospice Conditions of Participation
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418

Hospice Care Code of Federal Regulations Subpart G
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-G/section-418.302

Nursing Home Conditions of Participation
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

NHPCO Regulatory and Compliance Center: Facility Based Care (SNF, NF, and ALF)
https://www.nhpco.org/rg-new/facility-based-care-snf-nf-and-alf/

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https://www.nhpco.org/rg-new/rg-opioids-2/

NHPCO Regulatory and Compliance Center: State-Specific Resources
https://www.nhpco.org/regulatory-and-quality/regulatory/state-specific-resources/

Hospice Care Code of Federal Regulations 42CFR 418 Subpart D 418.112 Condition of Participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/MR
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#418.112

State Operations Manual Appendix M – Guidance to Surveyors: Hospice
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_m_hospice.pdf

CMS Hospice and End of Life Care and Services Critical Element Pathway
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes

Office of the Inspector General (OIG)
Compliance Program Guidance for Hospices (64 Fed. Reg. 54031; October 5, 1999)

Office of the Inspector General (OIG)
Compliance Program Guidance for Nursing Facilities (65 Fed. Reg. 14289; March 16, 2000)

Room and Board Statute under Social Security
http://www.ssa.gov/OP_Home/ssact/title19/1905.htm

National Alliance
for Care at Home

228 Seventh Street, SE
Washington, DC 20003

tel. 703.837.1500 • allianceforcareathome.org