

The Facts About Management of Hospice Patients in Long-Term Care Facilities

At the AMDA Annual Symposium last March, the program committee offered a session entitled “NHPCO and AMDA: Collaborating to Bring Hospice Care to the Nursing Facility.” Conference attendees came armed with detailed questions for AMDA and the National Hospice and Palliative Care Organization about the federal government’s Hospice Conditions of Participation, which took effect last December.

The regulations, from the Centers for Medicare & Medicaid Services (CMS), stress the need for hospices and long-term care facilities to collaborate, communicate, and thus provide optimal end-of-life care for long-term care residents who are eligible for hospice benefits.

An AMDA-NHPCO work group took key questions from the session and refined the answers in an effort to educate physicians and others about the new regulations on medical responsibility for hospice patients:

Who is responsible for patient management when the patient is receiving hospice services?

The long-term care facility (LTCF) attending has primary responsibility for all the medical care provided to the LTCF resident receiving hospice. For symptoms and care related to the terminal illness, the responsibility for the specific care plan would be by the hospice care team in collaboration with the patient’s attending physician. In the event that the LTCF attending or their designated covering provider can not be reached, that responsibility would be assumed by the LTCF medical director. The hospice medical director should be called to directly manage symptoms and care related to the terminal illness in the uncommon event that neither the LTCF attending or LTCF medical director is available.

When should the nurses call the attending physician or the hospice?

For symptoms related to the terminal illness: The final Medicare Hospice Conditions of Participation states that the hospice “must assume responsibility for professional management of the resident’s hospice services, provided in accordance with the hospice plan of care” (418.112(b)). The LTCF should notify the hospice immediately if:

- A significant change in the patient’s physical, mental, social, or emotional status occurs.
- Clinical complications appear that suggest a need to alter the plan of care.
- A need to transfer a patient from the SNF/NF or ICF/MR arises and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions (418.112(c) (2)).
- The patient dies.

The hospice nurse and the facility nurse should collaborate to determine the needs of the patient, update the plan of care, and call the LTCF attending physician, as necessary, to request medical input, including any physician orders. The hospice medical director is also available for consultation on pain and symptom management, as needed.

What care is related or unrelated to the diagnosis?

The written agreement between the hospice and the facility delineates the responsibilities of each provider.

Care related to the terminal illness is managed and covered under the Medicare or Medicaid Hospice Benefit. The benefit includes professional services of physicians, nurses, social workers, aides, and therapists, as well as medical equipment and supplies, medications and hospitalizations as necessary. The hospice is required to provide overall coordination of the hospice care with the staff of the facility, where ongoing communication is a must (418.112(e)(1)).

Care that is “unrelated to the terminal diagnosis” should be provided as if that patient were not receiving hospice benefits. The Medicare skilled nursing benefit is not generally available to the patient when he/she is a hospice patient. Hospitalizations may be questioned as “related to the terminal diagnosis,” so collaboration with the hospice is important.

Must the attending physician notify hospice if investigating or treating an acute symptom or illness?

The attending physician, LTCF, and hospice are partners in the care of the patient and should inform and consult with one another on every appropriate occasion, including plans of care. The hospice is available 24 hours a day, 7 days a week to provide relief to patients for acute pain as well as symptoms not related to pain and to serve as a resource to the attending physician in addressing these issues at any time of the day or night.

The LTCF and the hospice must reach an agreement on how to communicate concerns and responses 24 hours a day in order to work together to meet the needs of the patient identified in the patient's plan of care. The hospice must document that this communication has occurred, and it should be recorded in both the facility and the hospice charts.

Per the Medicare Hospice Conditions of Participation, the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of hospice services provided (418.112 (c)). The hospice is responsible for providing medical direction and management of the patient in relation to the terminal diagnosis, including interdisciplinary team management, counseling, spiritual care, dietary care plan, and bereavement. The LTCF attending physician should collaborate with the hospice in managing acute conditions related to the terminal illness.

If inpatient care is necessary and it is related to the terminal illness, the hospice must be a part of the decision-making process.

Medications: The Medicare hospice benefit provides for medications related to the terminal illness and related conditions. How medications are ordered, who provides them, and how they are paid for should be part of the written agreement between the hospice and the facility. The LTCF attending physician and LTCF medical director should communicate and collaborate with the hospice clinical team to determine the medications necessary to alleviate the symptom.

For conditions not related to the terminal illness, the LTCF attending physician and/or medical director should proceed as usual and communicate any changes or updates to the hospice.

May the attending physician initiate, change, or titrate a symptom-control medication?

Absolutely, as long as hospice is notified.

What services are covered by the hospice benefit?

The hospice interdisciplinary team includes the attending physician*, hospice medical director, nurse, hospice aide, social worker, chaplain, bereavement counselor, volunteers, pharmacist, nutritionist, and therapists. Other covered services in the hospice benefit can be provided when related to the terminal illness and specified in the plan of care. They include DME, medical supplies, pharmaceuticals, labs and diagnostics, special modalities (palliative chemo/radiation), ambulance, and other regularly covered Medicare services covered in the hospice benefit.

The new Medicare Hospice Conditions of Participation also mandate end-of-life care training for all LTCF staff. The training should focus on hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements. This can be accomplished by hospice involvement (possibly by way of a training video) in the orientation process for new LTCF staff and written information related to hospice philosophy and treatments available at each nursing station.

*Under written agreement with the hospice, attending physician may bill hospice for consultation (when requested for specific problem by team members) and technical component of medical services such as lab tests or radiology.

Should the LTCF medical director delegate supervision of wound care, chronic disease care, and weight loss to the hospice IDT?

No. However, the LTCF medical director and facility staff collaborate with the hospice to find the best course of management for the hospice patient, including evaluation of wounds, disease progression, and weight loss. These can be documented as expected outcomes of the terminal condition (which hospice supports) to explain deterioration of resident's condition and justify palliative focus of care. As an example, hospice can provide low-air-loss mattresses to prevent skin breakdown and facilitate healing of same, if the issue is addressed in the plan of care.

Is the medical director still "responsible" for events such as falls, fecal impaction, infections, unnecessary medications, etc. for hospice patients?

Yes. However, hospice can support the efforts of the LTCF medical director to eliminate these events by providing specialty medical equipment (i.e., high-low beds, Broda chairs, etc.), additional nursing assessments that include monitoring effectiveness of bowel regimen and looking for symptoms of infection, and reviews of

medications by a pharmacist and/or a hospice and palliative care certified physician or nurse.

Hospice services in the LTCF can provide benefits to the hospice patients in the facility as well as the other residents. Collaboration and communication among the physicians and staffs in both the LTCF and the hospice are key. Each provider retains responsibility for the quality and appropriateness of the care he or she provides in accordance with relevant laws and regulations. Both hospices and LTCFs must comply with their applicable conditions/requirements for participation in Medicare and Medicaid.

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