

HOSPICE/RESIDENTIAL CARE APARTMENT COMPLEX INTERFACE

**Guidelines for Care Coordination
For
Hospice Patients Who Reside In
Residential Care Apartment Complexes**

**Wisconsin Department of Health & Family Services
Division of Disability and Elder Services
P.O. Box 7851
Madison WI 53707-7851
608/266-2000**

May 2004

TABLE OF CONTENTS

	SECTIONS	PAGE
Section I	Introduction and Background	3
Section II	Regulatory References	4
Section III	Contract Considerations for Hospices and Residential Care Apartment Complex Facilities	5
Section IV	Clinical Protocol Development	13
	A. Priority Areas	
	B. Plan of Care	
Section V	Guidelines for Inservice/Education Planning	18
Section VI	Conclusion and Acknowledgments	20

SECTION I

INTRODUCTION AND BACKGROUND

This document is produced in collaboration between the Department of Health and Family Services, Division of Disability and Elder Services, Bureau of Quality Assurance (BQA), The Hospice Organization and Palliative Experts (HOPE) of Wisconsin and representatives from the Residential Care Apartment Complex (RCAC) industry. Questions on the content of this document for the Department of Health and Family Services can be directed to Kevin Couglin, Chief, Assisted Living Section at (920)448-5255. Questions for The Hospice Organization and Palliative Experts can be directed to Melanie Ramey, Executive Director, (608)233-7166.

Persons who are eligible to access their hospice entitlement benefits from Medicare and Medicaid have the right to receive those services in their primary place of residence. For some individuals, their place of residence may be a Residential Care Apartment Complex (RCAC). This document serves as guidelines for hospice and RCAC providers who jointly serve hospice patients who have chosen to reside in a RCAC.

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. RCACs 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.

SECTION II

REGULATORY REFERENCES

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

[42 Code of Federal Regulations \(CFR\) Part 418, Hospice](#)

Centers for Medicare and Medicaid Services (CMS), [State Operations Manual](#) and [Hospice Interpretive Guidelines](#)

Sections 50.034 and 50.90 to 50.98, [Wisconsin Statutes](#)

Wisconsin Administrative Code, [Chapter HFS 131](#), Hospices

Wisconsin Administrative Code, [Chapter HFS 89](#), Residential Care Apartment Complexes

SECTION III

CONTRACT CONSIDERATIONS FOR HOSPICES AND RESIDENTIAL CARE APARTMENT COMPLEXES (RCAC)

Introductions

The following list of contract considerations is meant to assist hospice/RCAC providers in effectively coordinating provider services to the hospice patient receiving routine home care and/or continuous care in a RCAC. While not all-inclusive, these factors reflect many provisions found in the hospice and RCAC regulations and were compiled from comments and guidance from state (Bureau of Quality Assurance - BQA) and federal (Centers for Medicare and Medicaid Services - CMS) sources.

The information that follows is specifically pertinent to the routine home care contract. It is not intended to comprehensively address considerations for inpatient and respite care, which hospice and RCAC providers may elect to include as part of the same contract or as separate contracts. Providers are encouraged to review the following contract considerations, but since the listing is not exhaustive, should also review their respective regulations, insurance and liability concerns, financial position and obtain their 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/RCAC 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 RCAC takes responsibility for other services. (WI Adm. Codes HFS 131.35 (2) and Ch. HFS 89)
- 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.
- f. State and federal regulations prohibit a hospice from discontinuing or diminishing care provided to a Medicare beneficiary 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 "CMS," 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 RCAC.
 - 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 [42 #CFR 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 RCAC to provide core services.
 - n. Services to be provided by the RCAC as part of the not more than 28 hours of care per week 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: blood glucose monitoring /temps/blood pressure) and report to hospice
 - Nutritional meals/snacks
- *RCAC staff may be limited to the type of medication administered based on training, competency and supervision.
- 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/RCAC relationship on a regular basis.

II. Coordination of Services

- a. At the time each hospice patient/tenant is admitted to the facility, the RCAC must be provided with all physician orders.
- b. All information relevant to the patient/tenant care must be shared and contained in the patient care record compiled by both the hospice and RCAC. (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, physician orders, etc., between the providers.
- e. Specify a procedure that clearly outlines the chain of communication between the hospice and RCAC 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.

The hospice and RCAC 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. Delineate the role of hospice and RCAC in the admission process.
- h. Delineate the role of hospice and RCAC in the interdisciplinary group conference, including the encouragement of RCAC personnel to attend interdisciplinary hospice meetings.
- i. The coordinated plan of care/individualized service plan must specifically identify the respective care and services that the RCAC and hospice will provide.
- 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 RCAC 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 RCAC nursing personnel in administration of prescribed therapies in the patient's plan of care/individualized service plan(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 RCAC is the extent to which services will be directly provided by hospice with its own staff, since hospice receives the payment.
- b. RCAC employees may also be employed by the hospice or volunteer to serve hospice patients during non-RCAC employment hours.
- c. For purposes of a hospice, "employee" is defined in 42 CFR 418.3, HFS 131.13 (7) and HFS 131.13 (33), Wis. Admin. code.
- d. Essential requirements for RCAC employees who are also employed by hospice to perform core services include:
 - Accurate time records.
 - Clear delineation of responsibilities to avoid perception or allegations of dual reimbursement.
- e. 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 RCAC:

Medicare	Medicaid	Private Pay/ Insurance	Community Option Program (COP)
A qualified Medicare patient has a right to elect hospice Medicare benefit that pays for hospice services including routine homecare and continuous homecare in the RCAC.	A qualified Medicaid patient has a right to elect hospice Medicaid benefit that pays for hospice services including routine homecare and continuous homecare in the RCAC.	Most private insurances cover hospice homecare services.	Community Option Program (COP) may be accessed for qualified patients. Patient pays co-payment. Facility must be certified by the state.

**ELEMENTS FOR CONSIDERATION
IN A
HOSPICE/RCAC CONTRACT**

The following sample contract elements have been compiled for review or use by providers when developing the format of a hospice/RCAC contract. Developing a contract between providers should be an individualized process that best meets 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/RCAC CONTRACT**

RECITALS

Definitions (particularized to individual needs and terminology):

Attending Physician	Informed Consent
Covered Services	Interdisciplinary Group
Residential Care Apartment Complex	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 the physician when a change of condition occurs, 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 89](#), [HFS 131](#), [42 CFR 418.3](#), and [HIPAA](#))

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, tenant transfers and single-case continuation agreements, tenant 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 that both patient needs and regulatory requirements are met necessitates careful planning by both the RCAC 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 RCAC tenant to the hospice program, admitting a current hospice patient to the RCAC or for the simultaneous admission of a patient that is new to both the hospice and the RCAC. Depending on the type of admission, the following are the suggested protocols to follow to ensure coordination of care:

Admission: Referral of RCAC Tenant to Hospice

- RCAC makes referral of tenant to hospice.
- Hospice provides consultation and/or information.
- Patient/tenant meets hospice admission criteria and agrees to admission to hospice.
- Hospice and RCAC collaborate to begin care planning process.
- Hospice secures orders from the physician and manages plan of care from this point.
- Hospice verifies that the RCAC is licensed appropriately to meet the patients needs under Ch. HFS 89, Wis. Admin. code as an RCAC.

Admission: Referral of Hospice Patient to RCAC

- Hospice establishes that the RCAC setting is registered or certified under Ch. HFS 89, Wis. Admin. code and is appropriate for the needs of the patient.
- Hospice makes referral to RCAC. The hospice may initiate contact with the RCAC and facilitate communication between the patient/family and the RCAC representative.
- RCAC performs pre-admission assessment.
- RCAC agrees to admit patient to RCAC and determines admit date.
- Hospice and RCAC coordinate securing required admission paperwork (i.e., history and physical, tuberculosis screening, physician orders, etc.).
- Hospice transfers patient to RCAC. Hospice involvement continues on day of transfer.

- Hospice/RCAC begins collaboration in care plan process to revise care plan/individualized service plan.

Admission: Simultaneous Referral to RCAC and Hospice

- Hospice establishes that the RCAC is appropriate for the needs of the tenant/patient and is licensed under Ch. HFS 89, Wis. Admin. code as an RCAC.
- Providers make referrals to hospice and RCAC. (Let each provider know that referrals are being made to the other provider.)
- Hospice and RCAC coordinate the admission process and required paperwork.
- RCAC transfers patient to RCAC Hospice - involvement begins on day of transfer.
- Hospice/RCAC begins initiation of joint care plan/individualized service plan.

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 RCAC. 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.
- RCAC may carry out orders from a hospice nurse as prescribed by the physician and as delegated by the RCAC RN.
- Contract should include timeline as to how RCAC 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 RCAC 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 RCAC pharmacy labeling and packaging requirements in Ch. HFS 89, Wis. Admin code.
- Durable medical equipment (DME), i.e. wheelchair, 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 RCAC will be identified as a hospice patient.
- If specified in contract, both the hospice and RCAC retain copies of the other's record following death or discharge of a hospice patient.
- The records of a patient residing in the RCAC must include all clinical information that is relevant to the care of the patient (orders, data assessment, etc.), whether obtained by the hospice or the RCAC.
- Contract should indicate the proper medical record area for documentation by the RCAC and the hospice staff.

Hospice Core Services:

Core services as defined in the Federal Register (418.80) include 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 RCAC in assisting with the administration of prescribed interventions if specified in the plan of care.
- Hospice may involve RCAC 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 RCAC 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 RCAC 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 team's 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.
- **Certified nursing assistants and home health aide services** should be provided collaboratively by the hospice and RCAC 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 RCAC 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.
- Hospice/RCAC should review county, state and facility guidelines regarding coroner involvement, and follow protocol specified in contract for notification.
- RCAC and hospice coordinate notification of physician for pronouncement of death and release of body when heart rate and respirations have ceased.
- Medication disposal.
- RCAC/hospice facilitate closure experience for other RCAC tenants.

Quality Assurance:

- The RCAC 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 cardio-pulmonary resuscitation.
- RCAC staff provides immediate care in conjunction with facility policy and/or based on plan of care/individualized service plan.
- RCAC staff calls the hospice.
- Hospice completes further assessment, provides appropriate interventions and updates the plan of care/individualized service plan as specified in the contract.

B. CARE PLAN PROCESS

1. Assessment

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

2. Plan of Care

The RCAC 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 RCAC. Each RCAC and hospice should develop policies and protocols to accomplish the care plan process. The care plan process is designed to fulfill hospice and RCAC individualized service plan regulations.

- It is essential that the hospice core team and the RCAC staff both derive patient care decisions from the same shared data.
- Ongoing revisions in the plan of care are done collaboratively. This includes the bi-annual reviews of the plan of care/individualized service plan.

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 RCAC will become progressively more dependent for his or her activities of daily living as part of the progression of 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 RCAC/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 RCAC 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 RCAC 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 including confidentiality of medical records.
- 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 RCAC needs to be balanced by a corresponding effort to educate hospice staff on the regulations and protocols of the RCAC. 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 Tenant 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 tenant/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., cardio-pulmonary resuscitation, 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:

- In-services on pain control and other symptom management protocols commonly used for hospice patients.
- In-services 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 RCAC and hospice providers are encouraged. The use of various resource tools and media is helpful to have available in the RCAC 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

These guidelines were developed for the purpose of protecting quality hospice care for eligible RCAC tenants.

Through the combined efforts of those preparing this document, the intended outcome has been to develop guidelines and protocols for RCACs 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 Chs. HFS 131, HFS 89, Wis. Admin. code 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 RCAC tenants 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 contributions of the numerous individuals who have participated are gratefully acknowledged. The shared commitment of the statewide RCAC and hospice providers has set the tone for continued success in this collaborative process.