STATE OF NEW YORK
DEPARTMENT OF HEALTH

161 Delaware Avenue Delmar, NY 12054-1393

Richard F. Daines, M.D.
Commissioner

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Chief of Staff

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DAL: HCBC 07–21
SUBJECT: Roles and Responsibilities When Hospice Provides Services in an Adult Care Facility

Dear Administrators:

The purpose of this letter is to clarify issues and concerns which have traditionally been brought to the Department of Health's (DOH) attention regarding the interaction between a hospice provider and an adult care facility (ACF). As you know, DOH policy permits adult home and enriched housing program (adult care facility) residents to receive hospice services within the ACF setting. No additional approvals or waivers are required.

The ACF and hospice must collaborate in the development of consistent policies and procedures to guide them in the care of each resident. When an ACF resident receives hospice services, the hospice is responsible for having the resident complete the election of hospice form, consent to hospice services and develop a hospice plan of care.

Hospice Responsibilities

- As with any hospice patient, a hospice plan of care must be established by the hospice medical director or physician designee, the interdisciplinary group (IDG) and, if appropriate, the resident's physician prior to providing care. This plan of care must be shared with the ACF.

- Hospice must designate an interdisciplinary group to provide or supervise the care and services provided to the hospice patient; to periodically review and update the plan of care for each hospice patient. The hospice plan of care must be reviewed and updated by the IDG at intervals specified in the plan, at the very minimum of every two weeks.

- Pursuant to 10 NYCRR Part 794, the hospice must have sufficient staff to implement the plan of care for each individual receiving hospice services. The interdisciplinary team is responsible for participating in the establishment of the plan of care, providing or supervising hospice care and services, periodic review and updating of the plan of care for each resident

receiving hospice care, and establishing policies governing the day-to-day provision of hospice care and services.

- The hospice plan of care must include an assessment of the resident's needs and identification of services to be provided (including the management of discomfort and symptom relief) and by whom (including the ACF). It must also detail the scope and frequency of services needed to meet the resident's and family's needs.

- The hospice must conduct an ongoing comprehensive, integrated self-assessment of the quality and appropriateness of care provided. The findings should be used by the hospice to correct an identified problem and to revise hospice policies if necessary.

ACF Responsibilities

Consistent with 18 NYCRR Parts 487 (adult home) and 488 (enriched housing program), ACF case managers are expected to work with hospice staff as part of an integrated approach to addressing the needs of the resident receiving hospice services. The ACF case manager should review the resident's hospice plan of care, review changes to this plan of care, and work with the nurse who is coordinating the hospice resident's plan of care as a representative for the IDG. The ACF continues to be responsible for the resident's case management and compliance with case management regulations. Hospice is responsible for coordination of the resident's health care. Hospice complements and is supplemental to the services of the ACF. Hospice should not replace or duplicate the services required to be provided by the ACF.

The core concepts of case management provide guidelines for good practices for the ACF case manager as follows:

- **Evaluation** – The facility should identify a system through which all staff and service providers (including ACF and hospice staff) communicate with one another to guarantee the hospice plan of care continues to be appropriate and responsive to resident needs.

- **Assistance Needed/Action to Be Taken** – The facility should develop a policy and procedure which describes the ways in which the resident's hospice plan of care is operationalized in the facility, mindful that any necessary actions should consider the resident's perspective, be resident-focused, include choice (whenever possible), be needs based, and be timely.

- **Collaboration/Linkages/Resources** – As the primary coordinator, the ACF case manager or other appropriate staff must arrange for the delivery of services for the resident. Hospice is responsible for coordination and provision of the health care service needs of the resident, and must work with the ACF case manager to assure that the resident's needs are met. Additionally, the case manager's role involves ensuring that the respective roles of the ACF staff and hospice staff are clear and appropriate. As such, the case manager should have a policy and procedure to resolve any disagreements which may arise between the ACF and hospice which might include when it is appropriate to contact the IDG.

- **Follow Through** – This can be viewed as the quality assurance component of ACF case management, wherein the case manager can assure that the highest level of quality case management is being achieved on behalf of the resident. For example, on-going communication with hospice staff will allow the case manager to monitor the hospice services being provided to the ACF resident, thereby ensuring a prompt response to changing circumstances within any given situation.

- **Re-Evaluation** – This is an ongoing process that should bring the work of all parties involved in the provision of services to the ACF resident "full-circle". During the re-evaluation process, the case manager, hospice staff and resident should reconsider the assistance that was originally needed and the actions that were to be taken. The re-evaluation process facilitates measurement of the outcome of those interventions, addresses the current status of the resident, and asks if the needs of the resident are being met appropriately.

Coordinated and Cooperative Role between the Hospice and ACF

While it is understood that family and significant others often become key in providing care to a family member and although the ACF is considered the resident's home, Social Services Law section 461-c and 18 NYCRR Parts 487 and 488 prohibit ACF staff from providing nursing and medical care to ACF residents.

This is a very important point with regard to the provision of hospice services to an ACF resident, and appears to be a point of confusion between hospices and ACFs – *ACF staff may not, and* are not trained as ACF staff to, *provide the following: total assistance with feeding, two-person transfers, administration of medication, or nursing tasks. An ACF staff person who is trained as a CNA or HHA may not function as such in their role as an ACF staff person.*

As a result, the ACF resident's hospice plan of care must be specific regarding necessary medications. *ACF staff can only assist a resident with medication, not administer the medication.* With regard to PRN controlled substances, the policy and procedures established between the hospice and ACF must address how the delivery of such medications are to be handled when the hospice nurse is unavailable. For a self-directing resident, a physician must attest that the resident is capable of making the determination of when a PRN medication is necessary in order for the ACF staff to assist with such medication. Both the hospice and ACF should be careful to avoid having expectations of each other for which there is no regulatory support.

Likewise, the resident's hospice plan of care must address who is providing the resident's personal care. Furthermore, there needs to be a discussion about transfer to an alternate level of care if the hospice and the ACF cannot manage the resident's care. Continued stay of the resident in hospice must be reviewed by the hospice after the initial 90 day period, a subsequent 90 day period and then an unlimited number of 60 day periods.

ACF Retention Standards

The ACF retention standards do not apply to residents in receipt of hospice services as they do to all other ACF residents; ***however,*** there must be a plan of care agreed upon between the hospice and the ACF to meet the increased needs of the resident. This plan must not only assure that the resident's care needs can be safely and appropriately met, but that the resident is able to be evacuated safely. To be evacuated safely means that there must be sufficient staff, whether staff of the ACF or hospice, to evacuate the hospice resident as well as all other residents of the facility.

The Department may prohibit a hospice from providing services in an ACF if it finds that either entity has failed in its obligation to establish and maintain a cooperative relationship and sound and timely communication which results in negative outcomes for the hospice resident.

For additional information about ACFs and hospice, kindly read the following previously issued documents:

- Office of Medicaid Management 02 OMM/ADM-6 issued November 22, 2002 which can be found on the internet at:

  http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/02adm-6.pdf

- Department of Health DAL HCBC 04-06 issued April 2004 which can be found on the HPN.

If you have questions about this letter please contact the program manager in your Regional Office (Enclosure A).

Sincerely,

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Enclosure

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