COORDINATED TASK PLAN For Hospice Residents in Long-Term Care

Strategies & Tools to Improve the Coordination Process

July 1, 2009

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Overview

What is the Coordinated Task Plan of Care?

The Coordinated Task Plan of Care is a plan that will promote optimal hospice care to residents in long term care by increasing the communication between providers. The intent is to assist in establishing and agreeing upon a coordinated plan of care/service plan which meets the resident's individual needs, preferences and living situation.

This form is recommended for use in nursing homes, assisted living, and in the residential care setting for any residents receiving hospice care from a certified hospice agency. **The Section for Long Term Care Regulation and the Bureau of Home Care and Rehabilitative Standards within the Department of Health and Senior Services support this project.**

Why should I use the Coordinated Task Plan?

1. The Hospice and LTC provider will utilize a process to assure quality of care by use of the Coordinated Task Plan to communicate, establish and agree upon care.
2. It is the resident's right to access hospice services if the resident qualifies for that benefit.
3. CMS has identified the following four problem areas in providing hospice in the LTC setting:
    - Care and services do not reflect the hospice philosophy.
    - Poor coordination, delivery, and review of the care plan.
    - Ineffective systems to monitor effectiveness of the plan of care for pain management and symptom control.
    - Poor communication between hospice and LTC staff.

In Summary

Communicate!

Communicate!!

Communicate!!!

Objectives of Training for the Coordinated Task Plan

Training Points:

1. To introduce hospice and long-term care providers to the Coordinated Task Plan, including the purpose of the form and the correct way to complete and implement the form.

2. To show the benefits the Coordinated Task Plan creates for the hospice LTC resident when it comes to improving communication among providers of care by using example scenarios of two residents.

3. To establish how state and federal regulations regarding the management of hospice residents in the LTC setting are addressed through the Coordinated Task Plan.

Improving communication results in improved care.

Getting Started-Training Point One

The Purpose of the Coordinated Task Plan

The Coordinated Task Plan serves as a **crossover of the Hospice plan** for residents in the LTC setting.

The Coordinated Task Plan serves as a communication tool for **improving care** of hospice residents in the LTC setting.

The Coordinated Task Plan allows for **communication of care and information about changes in care.**

Policies of the Coordinated Task Plan

The Hospice provider will coordinate services with each LTC provider. The Hospice and LTC provider will jointly ensure collaborative efforts between them, by:

- ✓ documenting which services will be provided, by whom, and the schedule of services
- ✓ updates when changes occur
- ✓ dated signatures of both providers

The Coordinated Task Plan will be initiated by the Hospice provider upon start of care and updated with any changes. At a minimum, the Coordinated Task Plan will be reviewed with recertification of the hospice resident.

"Inaccurate information can occur in many ways, often putting a patient's health in serious danger."

_ Carolyn M. Clancy, M.D. Agency for Healthcare Research and Quality

Procedures for the Coordinated Task Plan

The Hospice provider will personalize the Coordinated Task Plan at the top of the form with its contact information and logo as desired.

The Hospice provider will complete the individual Hospice residents name, corresponding room number, and Hospice diagnosis at the top of the Coordinated Task Plan form and take it to the care plan meeting.

The Hospice staff member will ensure all dates correspond with the frequency of visits for each week with each discipline. The Hospice staff member who initiates any change of discipline frequency will update the Coordinated Task Plan, and sign and date each entry along with the LTC provider.

If a Hospice provider makes a change via phone call to the LTC provider, the Hospice provider will document the changes and with whom they discussed the changes on a progress note. Hospice staff will ensure that the updates have been made on the Coordinated Task Plan at the time of the next skilled nurse visit. The LTC staff should call the Hospice provider prior to calling the physician with changes.

Documentation on the Coordinated Task Plan will be monitored and updated by the Hospice RN case manager.

Responsibility for foley catheter changes and other treatments will be clearly documented by recording the planned frequecncy of interventions in the “responsible party” section for each provider.

Each new or changed intervention should have a start date, and each discontinued intervention should have an end date.

Medical supplies provided by the Hospice provider will be listed on the form. Therefore, supplies provided by the LTC provider will not be listed. The hospice provider will place a checkmark or list the appropriate DME provided by the hospice provider. DME provided by the LTC provider will not be listed on the form. Any change in the plan requires a representative from both hospice and LTC to sign and date at the bottom of the page to indicate they communicated and agreed upon the change.

After multiple changes and updates, it may be necessary to initiate a new Coordinated Task Plan form.

Getting Started-Training Point Two

Examples of Implementing Coordinated Plans of Care through Resident Scenarios

SCENARIOS

The following are examples of how to correctly complete the Coordinated Task Plan of Care.

RESIDENT #1 *SCENARIO*

An 81-year-old female assisted living resident is admitted to hospice on December 14th with a diagnosis of CHF.

The hospice nurse will visit 2x/week, hospice aide 2x/week and the social worker and chaplain will both visit monthly and prn.

The resident has nebulizer treatments, which the LTC provider will provide and administer (Because the equipment is provided by LTC, it is not on the form). The resident also requires oxygen and a wheelchair, which hospice will provide.

There are no other treatments added and the intensity of visits is not required to change.

Please refer to next page for the completed Coordinated Task Plan of Care.

Hospice/LTC Coordinated Task Plan of Care
Resident #1 Scenario

Just For You Hospice Care

Resident Name: Rose Wood	**Room #:** 1234 **Bed #:** 1	**Hospice Diagnosis:** CHF

Hospice Company: Just For You Hospice Care	
Daytime phone: (111) 222-3333	After hours phone: (111) 444-5555

RN Case Manager: Gary Gardener	Hospice Social Worker: Susie Sunflower
Hospice Aide: Helen Hose	Hospice Volunteer: Violet Valley
Hospice Chaplain: Charlie Chaplin	Other:

Date Start	Date End	**Hospice Nurse Visits**	Date Start	Date End	**Hospice Aide Visits**
12-14-09		Schedule S (M) T W (TH) F SA	12-14-09		Schedule S M (T) W TH (F) SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
12-14-09		Hospice Social Worker Frequency Monthly			
12-14-09		Hospice Chaplain Frequency Monthly			
		Hospice Volunteer Frequency			
		Hospice Other Frequency			

Date Start	Date End	**Wound Care Schedule**
		Hospice Wound Care
		Schedule S M T W TH F SA
		Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA

Date Start	Date End	**Treatments**	**Party Responsible & Frequency** Hospice	LTC
		Foley Catheter Care		
		Other Tx: (therapy, labs, trach care, ostomy care, etc.)		

Medical Supplies Provided by Hospice:		
[ ] Incontinence	[ ] Dressings	[ ] Foley catheter
Other	Other	Other
Other	Other	Other

DME Provided by Hospice:		
[✓] Oxygen	[ ] Commode	Other
[ ] Bed	[ ] Nebulizer	Other
[ ] Walker	[✓] Wheelchair	Other

Hospice Staff Signature	**Date**	**LTC Staff Signature**	**Date**
S Sanderger, RN	12-14-09	Pansy Palmer, RN	12-14-09

RESIDENT #2 SCENARIO

A 67-year-old female nursing home resident was admitted to hospice July 1st with a diagnosis of lung cancer.

The hospice nurse will visit 2x/week, hospice aide 2x/week, hospice social worker 2x/month, and hospice chaplain monthly.

The resident has a port-a-cath, and the hospice nurse will flush it monthly, but the LTC provider may flush it prn if there is any problem. She will have a CBC and PT done weekly by the hospice nurse, per port. She has oxygen, a walker, and a wheelchair – all provided by hospice.

August 5th a CADD PCA is started for pain management. The cassettes will be changed by either the hospice or LTC provider nurse as needed. The hospice nurse will manage the needle placement weekly and prn.

On August 12th, she develops a stage 1 decubitus on her right heel and right buttock. A hydrocolloid dressing is used, applied by the hospice nurse twice weekly when she visits. If it requires reinforcement or replacement between hospice nurse visits, the LTC provider nurse will do the dressing care.

On August 30th, the resident has skin breakdown on the right heel site. An ointment is ordered to be applied daily. The hospice nurse will apply the dressing on the days of a hospice nurse visit. There is no change to the right buttock dressing. Because the resident is declining, a volunteer will come weekly to sit with the resident and relieve the family members from daily visits.

On September 5th, the resident is declining significantly. A foley catheter is placed and will be changed prn by the hospice nurse and prn by the LTC provider. Also, the hospice nurse will begin visiting 3x/weekly and the aide will also visit 3x/weekly, but on alternating days from the nurse visits.

Please refer to next page for the completed Coordinated Task Plan of Care.

Trailways Hospice

Trailways Hospice/LTC Coordinated Task Plan of Care
Resident #2 Scenario

Resident Name: TINY TIM	Room #: 789 Bed #: 2	Hospice Diagnosis: LUNG CANCER

Hospice Company: Trailways Hospice care	
Daytime phone: (333) 444-5555	After hours phone: (333) 666-7777

RN Case Manager: Paul Path	Hospice Social Worker: Wendy Walker
Hospice Aide: Tim Track	Hospice Volunteer: Randy Route
Hospice Chaplain: RON Roads	Other:

Date Start	Date End	Hospice Nurse Visits	Date Start	Date End	Hospice Aide Visits
7-1-09	9-5-09	Schedule S (M) T W (TH) F SA	7-1-09	9-5-09	Schedule S M (T) W TH (F) SA
9-5-09		Schedule Change S (M) T (W) TH (F) SA	9-5-09		Schedule Change S M (T) W (TH) F (SA)
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
7-1-09		Hospice Social Worker Frequency 2 x MONTH + PRN			
7-1-09		Hospice Chaplain Frequency 1 x MONTH + PRN			
8-30-09		Hospice Volunteer Frequency weekly			
		Hospice Other Frequency			

Date Start	Date End	Wound Care Schedule
		Hospice Wound Care
8-12-09	9-5-09	Schedule S (M) T W (TH) F SA
9-5-09		Schedule Change S (M) T (W) TH (F) SA
		Schedule Change S M T W TH F SA

Date Start	Date End	Treatments	Party Responsible & Frequency: Hospice	LTC
9-5-09		**Foley Catheter Change**	PRN	PRN
		Other Tx: (therapy, labs, trach care, ostomy care, etc.)		
7-1-09		Porta Cath Flush	Monthly	PRN
7-1-09		CBC + PT Per Port	weekly	
8-5-09		CADD PCA cassette change	PRN	PRN
8-5-09		Needle Placement	weekly/PRN	

Medical Supplies Provided by Hospice:		
[ ] Incontinence	[✓] Dressings	[✓] Foley catheter
Other Porta Cath supplies	Other	Other
Other	Other	Other

DME Provided by Hospice:		
[✓] Oxygen	[ ] Commode	Other CADD pump
[ ] Bed	[ ] Nebulizer	Other
[✓] Walker	[✓] Wheelchair	Other

Hospice Staff Signature	Date	LTC Staff Signature	Date
Paula Path, RN	7-1-09	L. Long, RN	7-1-09
Tony Tracker	8-5-09	L. Long, RN	8-5-09
Tony Tracker	8-12-09	L. Long, RN	8-12-09
Paula Path, RN	8-30-09	L. Long, RN	8-30-09
S. Stott	9-5-09	L. Long, RN	9-5-09

Getting Started-Training Point Three

Addressing State and Federal Regulations

State and Federal laws and regulations impact the care hospice residents receive in the nursing home, assisted living and residential care settings. The laws and regulations on the following pages are provided to assist you in understanding the requirements and responsibilities of hospice care.

HOSPICE PHILOSPHY

"*Hospice care* is intended to meet the physical, emotional and spiritual needs of patients and their families facing life ending illnesses. The goal of hospice care is to provide comfort to the patient by assisting with pain and symptom management and to enhance the quality of life for both the patient and the family."

Hospice – State Regulations 19 CSR 30-35		Hospice – Federal Regulations 42 CFR Part 418	
TAG	**STATEMENT**	**FEDERAL CITATION**	**STATEMENT**
ML153	Such contracts shall not relieve the hospice of the primary responsibility for ensuring patient care or otherwise complying with these regulations.	418.112 (b)	(b) *Standard: Professional management.* The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice--related inpatient care in a participating Medicare/Medicaid facility according to § 418.100 and § 418.108.
ML252	(K) **Facility Resident.** 1. When the hospice patient resides in a nursing facility, the hospice collaborates with the nursing facility providing care to the patient/family to ensure coordination of services.	418.112 (a) (e)(2), (3)	**§418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.** In addition to meeting the conditions of participation at §418.10 through §418.116, a hospice that provides hospice care to residents of a SNF/NF or ICF/MR must abide by the following additional standards. **(a) Standard: Resident eligibility, election, and duration of benefits.** Medicare patients receiving hospice services and residing in a SNF, NF, or ICF/MR are subject to the Medicare hospice eligibility criteria set out at §418.20 through §418.30. (e) *Standard: Coordination of services.* The hospice must: (2) Ensure that the hospice IDG communicates with the SNF/NF or ICF/MR medical director, the patient's attending physician, and other physicians participating in the provision of care to the patient as needed to coordinate the hospice care of the hospice patient with the medical care provided by other physicians. (3) Provide the SNF/NF or ICF/MR with the following information: (i) The most recent hospice plan of care specific to each patient; (ii) Hospice election form and any advance directives specific to each patient;

			(iii) Physician certification and recertification of the terminal illness specific to each patient; (iv) Names and contact information for hospice personnel involved in hospice care of each patient; (v) Instructions on how to access the hospice's 24-hour on-call system; (vi) Hospice medication information specific to each patient; and Hospice physician and attending physician (if any) orders specific to each patient.
ML253	2. Collaboration activities shall include the following: A. There shall be a coordinated single plan of care in the nursing facility which may be multiple documents, that: (I) Reflects coordination and input from both the hospice and the nursing facility; (II) Identifies the care and services which each shall provide; and (III) Is updated to reflect changes in patient/family condition, needs and care.	418.112 (d)	**(d) Standard: Hospice plan of care.** In accordance with §418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care. (1) The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care. (2) The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible. Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be approved by the hospice before implementation.
ML254	Services usually identified as hospice services shall remain the responsibility of the hospice, and are provided or arranged by the hospice to meet the needs of the patient at the same level that the hospice normally furnishes to patients in their homes.	418.112 (b)	**(b) Standard: Professional management.** The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §418.100 and §418.108.

ML255	A registered nurse is designated from the hospice to coordinate the implementation of the plan of care and to respond to questions and concerns from the nursing facility.	418.112 (e)(1)	**(e) Standard: Coordination of services.** The hospice must: (1) Designate a member of each interdisciplinary group that is responsible for a patient who is a resident of a SNF/NF or ICF/MR. The designated interdisciplinary group member is responsible for: (i) Providing overall coordination of the hospice care of the SNF/NF or ICF/MR resident with SNF/NF or ICF/MR representatives; and Communicating with SNF/NF or ICF/MR representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family.

Long-Term Care Regulations and Expectations of Hospice Services

State Operations Manual (SOM) – Appendix P

F Tag 309 – 42 CFR 483.25 Quality of Care

When a facility resident has also elected the Medicare hospice benefit, the hospice and the nursing home must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy, and is based on an assessment of the individual's needs and unique living situation in the facility. The plan of care must include directives for managing pain and other uncomfortable symptoms and be revised and updated as necessary to reflect the individual's current status. This coordinated plan of care must identify the care and services which the SNF/NF and hospice will provide in order to be responsive to the unique needs of the patient/resident and his/her expressed desire for hospice care.

The SNF/NF and the hospice are responsible for performing each of their respective functions that have been agreed upon and included in the plan of care. The hospice retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions.

For a resident receiving hospice benefit care, evaluate if

The plan of care reflects the participation of the hospice, the facility, and the resident or representative to the extent possible;

The plan of care includes directives for managing pain and other uncomfortable symptoms and is revised and updated as necessary to reflect the resident's current status;

Medications and medical supplies are provided by the hospice as needed for the palliation and management of the terminal illness and related conditions;

The hospice and the facility communicate with each other when any changes are indicated to the plan of care;

The hospice and the facility are aware of the other's responsibilities in implementing the plan of care;

The facility's services are consistent with the plan of care developed in coordination with the hospice, (the hospice patient residing in a SNF/NF should not experience any lack of SNF/NF services or personal care because of his/her status as a hospice patient); and

The SNF/NF offers the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The resident has the right to refuse services in conjunction with the provisions of 42 CFR 483.10(b)(4), Tag F155.

FORMS AND GUIDELINES

"to cure sometimes,

to relieve often,

to comfort always"

Dr. Edward Livingston Trudeau

Hospice/LTC Coordinated Task Plan of Care

Resident Name:	**Room #:** **Bed #:**	**Hospice Diagnosis:**

Hospice Company:	
Daytime phone:	After hours phone:

RN Case Manager:	Hospice Social Worker:
Hospice Aide:	Hospice Volunteer:
Hospice Chaplain:	Other:

Date			Date		
Start	End	**Hospice Nurse Visits**	Start	End	**Hospice Aide Visits**
		Schedule S M T W TH F SA			Schedule S M T W TH F SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
		Hospice Social Worker Frequency			
		Hospice Chaplain Frequency			
		Hospice Volunteer Frequency			
		Hospice Other Frequency			

Date		**Wound Care Schedule**
Start	End	**Hospice Wound Care**
		Schedule S M T W TH F SA
		Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA

Date			**Party Responsible & Frequency**	
Start	End	**Treatments**	Hospice	LTC
		Foley Catheter Change		
		Other Tx: (therapy, labs, trach care, ostomy care, etc.)		

Medical Supplies Provided by Hospice:		
[ ] Incontinence	[ ] Dressings	[ ] Foley catheter
Other	Other	Other
Other	Other	Other
DME Provided by Hospice:		
[ ] Oxygen	[ ] Commode	Other
[ ] Bed	[ ] Nebulizer	Other
[ ] Walker	[ ] Wheelchair	Other

Hospice Staff Signature	**Date**	**LTC Staff Signature**	**Date**

6-18-09 DC

COORDINATED TASK PLAN – INSTRUCTIONS

(back of form)

Policy

1. The Hospice agency will coordinate services with each LTC provider. The Hospice and LTC Provider will jointly ensure collaborative efforts between the LTC provider and the Hospice, by documenting which services will be provided, by whom, the frequency of services, updates when changes occur, dated signatures of both LTC provider and Hospice staff.
2. The Coordinated Task Plan will be initiated by the Hospice provider upon start of care in the LTC and will be continuously updated with any changes as needed.
3. At a minimum, the Coordinated Task Plan will be reviewed with recertification of the hospice resident.

Procedure

1. Complete the Hospice resident name, corresponding room number, and Hospice diagnosis at the top of the Coordinated Task Plan form.
2. Complete the name of the Hospice agency, phone numbers and staff assigned for each discipline.
3. Circle the days of the week the hospice nurse plans to visit. Update any on-going schedule changes on the next line.
4. Circle the days of the week the hospice aide plans to visit. Update any on-going schedule changes on the next line.
5. List the frequency of visits planned for the social worker, chaplain, volunteer or other staff. Update this section by marking through the previous schedule with one line and listing the new schedule with current the date.
6. For the wound care schedule, circle the days of the week that hospice will provide the wound care. Update any on-going schedule changes on the next line. The LTC provider will be responsible for wound care on all other days.
7. List frequency of foley catheter care under each party responsible.
8. List each treatment planned and document frequency under each party responsible.
9. Indicate by check mark or record the medical supplies provided ONLY by the hospice agency.
10. Indicate by check mark or record the DME provided ONLY by the hospice agency.
11. Document a start date for each new or changed intervention and an end date for each discontinued intervention.
12. Indicate at the bottom of the page, signatures and dates of both LTC representative and the Hospice staff member making the changes.

After multiple changes and updates, it may be necessary to initiate a new Coordinated Task Plan.

Collaboration Between LTC and Hospice Staff

Objective: Hospice, LTC staff, resident/family, and physician set clear palliative care goals AND communicate them to all parties.

- Hospice service retains overall professional management of the plan of care related to the terminal illness.
- LTC provides daily care and communicates to hospice any change in condition or need.

Planning for Hospice Care

- Decide where hospice documentation should be in the chart.
- Establish a contract according to regulation.
- Determine best method to communicate to all disciplines that resident has elected hospice.
- Establish a method to clearly identify hospice contact information.
- Devise system to thin charts.
- Establish mutually acceptable procedures for timely Medicaid billing and reimbursement.

For Resident Care

- Establish date and time to meet and formulate initial plan of care.
- 24-48 hours from admission to hospice.
- Collect data, encourage patient/family participation.
- Determine patient's DME, medication and treatment needs
- Designate discipline responsible for care.
- Identify payer source of items/treatments.
- Develop and implement an integrated plan of care.
- Create and maintain communication system

Coordinated Task Plan History

The Missouri Association of Homes for the Aging and the Missouri Hospice and Palliative Care Association developed the Hospice in Long Term Care Workgroup to address various hospice and LTC issues. The taskforce consisted of: hospice, nursing home, residential care and assisted living providers, and representatives of the Section for Long Term Care Regulation and the Bureau of Home Care and Rehabilitative Standards within the Department of Health and Senior Services.

Objectives of the Hospice in LTC Workgroup:

- Identify obstacles that prevent coordination of quality end-of-life care;
- Develop strategies to assure mutual understanding of the hospice resident needs, preferences, goals of care and plans;
- Identify necessary components for a coordinated plan of care/service plan;
- Develop tools for improving communication among providers of care; and
- Empower providers to maximize coordination of the plan of care/service plan by the utilization of tools and implementation of solutions.

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The workgroup realized, that for numerous years coordinating care for LTC hospice residents was very important and challenging and that the key was communication. Having that in mind, the workgroup set out to create a form that would be universally used by Hospice and LTC providers.
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Hospice in LTC Workgroup Participants

Denise Clemonds, Co-chair MO Assoc. of Homes for the Aging 573-635-6244	**Cindy Baird, Co-chair** MO Hospice & Palliative Care Assoc. 816-524-9505
Barbara Elder Owens Village Hospice 816-347-2574	**Joy Neupert** Alexian Brothers 314-544-1111
Betty Marko St. Agnes 314-965-7616	**Joan Devine** Lutheran Senior Services 314-968-9313
Brenda Lovelady Liberty Hospital Hospice 816-407-2200	**Lenda Wachter** La Plata Nursing Home 660-332-4315
Carol Scott DHSS, MO LTC Ombudsman 573-526-0727	**Lisa Coots** DHSS, Home Care & Rehab. Standards 573-751-6336
Cheryl Pappas DHSS, Home Care & Rehab. Standards 573-751-6336	**Lisa Erickson** Village Hospice 816-347-2584
Christine Crouch Bethesda Southgate 314-846-2000	**Kelly Shipley** Regional Hospice 417-343-3386
Gerry Ann Wagner DHSS, Home Care & Rehab. Standards 573-751-6336	**Mary Dyck** Riverways Hospice 417-256-3133
Jamie Aukskalnis Bethesda Hospice Care 314-446-0623	**Roxanne Reed Wilson** Missouri River Hospice 573-814-7100
Jan Pearson John Knox Village – Valley View 816-347-2701	**Shelly Williamson** DHSS, Section for LTC Regulation 573-526-4872
Janet Gard Community Hospices of America 417-335-2005	**Yvonne Schwandt** Pathways Community Hospice 636-733-7399

RESOURCES

Association Websites

Missouri Association of Homes for the Aging	www.moaha.org
Missouri Hospice and Palliative Care Association	www.mohospice.org
Missouri End-of-Life Coalition End of Life Manual	www.mo-endoflife.org http://www.dhss.mo.gov/showmelongtermcare/EndofLifeManual.pdf

Federal Laws and Regulations

Hospice: Federal Regulation	42 CFR 418.10-418.405
CMS LTC SOM Transmittal 41	
Nursing Home: F 500 – Use of outside resources F 309 – The hospice and nursing home must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy, and is based on the individual's needs and unique living situation in the facility. ……. The plan of care must include……..	http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf

State Laws and Regulations

Hospice: MO Law	http://www.moga.mo.gov/STATUTES/C197.htm
Hospice: MO Regulations 19 CSR 30-35.010 Hospice Program Operations 19 CSR 30-35.020 Hospice Providing Direct Care in a Hospice Facility19 CSR 30-35.030 State Certification Management	http://www.sos.mo.gov/adrules/csr/current/19csr/19c30-35.pdf

Residential Care: MO Regulations Chapter 86.042 (28) and (30) and 86.043 (25) and (27) reference ability to make pathway to safety and not admitting or continuing to admit those whose needs cannot be met. Nothing about Hospice specifically. NOTE: (per DHSS) If a resident is on hospice in an RCF and can not meet the path to safety. The facility must move the resident or request an exception. The exceptions committee has only been approving path to safety in RCF's if either the facility is providing 24/7 care in addition to the required staffing or the family is providing a caregiver 24/7. Caregivers have to be awake all hours. If the facility can no longer do this or the family cannot do this then the resident must be moved.	http://www.sos.mo.gov/adrules/csr/current/19csr/19c30-86.pdf
Assisted Living: MO Regulations Chap 86.047 (30) references Hospice and refers to 86.047 (29).	http://www.sos.mo.gov/adrules/csr/current/19csr/19c30-86.pdf

Coordinated Task Plan

Coordinating Hospice Care in the Long-Term Care Setting

For more information, contact Denise Clemonds at the Missouri Association of Homes for the Aging at 573-635-6244 or by e-mail at denise@moaha.org or the Missouri Hospice and Palliative Care Association at 573-634-5514.

6/09