



IHO Update

IHO - Quality Home Care for Hospice Professionals in Iowa

December 14, 2007

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Happy Holidays!

From the IHO staff, we wish you a wonderful holiday season! There will be no *IHO Update* on Friday, December 28. The *Update* will resume after the first of the year where it will be distributed in conjunction with the *Legislative Update*.

IHO Wants to Hear From You

We know there are plenty of Internet resources out there to further your hospice knowledge, however, IHO wants to make our Web site (www.iowahospice.org) number one on your list!

With a new year and changing technology, comes the opportunity to evaluate the Web site and make sure that it is user friendly, accessible and helpful for our members.

The link below is to a short, on-line evaluation. Please take a moment to fill it out so we can help to better meet your needs. Deadline to complete the survey is Friday, December 21.

Click Link Below to Access Survey:

https://www.surveymonkey.com/s.aspx?sm=MLfb42o_2bc_2bLYPPHVXPgcUg_3d_3d

Join the Cahaba ListServ

As the Regional Home Health and Hospice Intermediary (RHHI), Cahaba Government Benefit Administrators[®], LLC believes communication with your hospice agency and your staff is a critical part of staying informed of updates, clarifications and changes made to the Medicare program and the Medicare hospice benefit. As you know, in the next year, there

will be many changes occurring that directly affect your hospice agency; Change Request 5567, National Provider Identifier (NPI) and Medicare Contracting Reform, to name just a few. We want to make sure that you are prepared and informed.

One of Cahaba GBA's primary means of communication with our providers is through the Cahaba GBA ListServ. The ListServ is a free email notification service that can provide you with prompt notification of Medicare news including policy, benefits, claims submission, claims processing and education events. Enrolling for this service means that you will receive information as soon as it is available, and plays a critical roll in ensuring you are up-to-date on all of the coming changes.

When considering whether you should subscribe to the Cahaba GBA's ListServ, remember the following: it's free, there is no cost to subscribe or to receive information; you only need a valid e-mail address to subscribe; and multiple people/e-mail addresses from your facility can subscribe.

This is Cahaba's primary means of sharing important information with you in a timely manner.

To subscribe to the Cahaba GBA ListServ, go to https://www.cahabagba.com/part_a/whats_new/email_service.htm and click on the 'Subscribe Now' link.

CMS Visit Reporting Guide

CMS is moving forward with a phased increase in data required of hospices, in order to improve hospice benefit payment accuracy and analyze the services provided in this evolving and growing benefit. With a Change Request to the Medicare billing requirements (CR 5567), CMS has begun the second phase of expanding required line level details on hospice claims. CR 5567 requires additional data to describe services provided for each hospice level of care, mandatory beginning July 1, 2008.

The CMS Visit Reporting Guide summarizes the new requirements, provides direction regarding interpretation challenges and implementation priorities, and lists additional resources for information. Discussions with CMS on behalf of hospice providers are ongoing and the regional home health intermediaries (RHHHIs) are refining their specifications for CR 5567.

For more information, see the CMS Visit Reporting Guide enclosed in this week's issue of the *IHO Update*. Updated links to the (CR) 5567 Web site are also listed below:

NEW—CR 5567 Additional Frequently Asked Questions – Published by CMS
http://www.cms.hhs.gov/PropMedicareFeeSvcPmtGen/downloads/Questions_and_Answers_About_CR5567v2.pdf

NHPCO’s Quality Partners Initiative

Inclusion and Access: How Can We Serve Everybody?

In this issue of the *IHO Update*, we will continue to examine the components of NHPCO’s Quality Partners Initiative by focusing on the fourth component of the initiative’s “10 Components of Quality in Hospice Care.”

“Inclusion and access” are often discussed in terms of diversity, primarily racial/ethnic diversity. Historically, America’s hospices have had greater success reaching white, middle-class patients. The need to reach out and respond to the changing ethnic face of our communities is recognized as one of hospice’s biggest current challenges and priorities — even though the path to connecting with other populations may take us outside of our comfort zone.

It is possible to view inclusiveness more broadly, however, to simply mean serving the whole community. That would mean being recognized and called upon as the end-of-life resource for the needs of everyone who lives in the community — in all of their varied groups, categories and pie charts.

Besides ethnicity, other important distinctions include religion, age, the growing needs of veterans of military service, socio-economics, place of residence, disease and treatment, and the various disabled communities, such as the developmentally disabled, reaching the end of their life spans. In some communities, an aging prison population may be biggest frontier of unmet need. Inclusion doesn’t just refer to patients, but also to the hospice’s staff, volunteers, board members, partnering community agencies, and the other consumers of its services, including grievors, schools and workplaces.

Misleading Assumptions

For groups that have not been well-served by hospice, it is easy to make assumptions about their lack of need for hospice care — assumptions that may not be borne out by the facts, says Betsy Murphy, business relations representative for Capitol Hospice in Falls Church, VA. “We’ve been in this business for 25 years, and it is amazing how many ‘aha moments’ we continue to have” about previously underserved groups.

For example, pediatric hospice patients typically cost more than any available reimbursement source pays, but taking care of these kids can have significant implications in terms of community donations. When hospices discovered that many patients with Alzheimer’s and other dementias were also terminally ill and in need of hospice care, opening their doors to these patients resulted in increased overall lengths of stay. Other hospices have had success building bridges to the African-American community, despite the widespread assumption that African-Americans would be suspicious of this kind of outreach.

“The first thing you need to do is look at the demographics of your own community and how it has changed,” Murphy says. “Are you as administrators aware of what’s really happening in your community?”

A neighboring hospice recently targeted the local Korean community and all of the physicians who serve it, Murphy says. “Has anybody actually quantified what are the outcomes of that kind of outreach in bringing in more patient referrals — and not just from the targeted community?” she wonders.

“If you think you’re already serving the whole community, check that assumption against the facts.” Your county’s planning department may already have a planning document projecting population trends and health care needs for the next five years. “Then, is there a grant out there to support your agency in responding to the unmet needs you identify?”

Hospices may be driven by mission and a desire to better meet the community’s needs, or by the bottom line and financial calculations. Even by the latter standard, however, inclusiveness can be good business. Hospices may be short-sighted in their calculations if they fail to take advantage of opportunities to grow their census, increase their length of stay, and reach new populations with diversified services and product lines. In other words, Murphy says, the hospice needs a belief system that the expense of reaching out to a more diverse patient population will be offset by long-term gains, both for the agency’s mission and for the bottom line.

Where We’ve Been, Where We’re Going

Pat Gibbons, director of the Beacon Place residence for Hospice and Palliative Care of Greensboro, NC, wants to remind hospices of what they have already achieved, and use that accomplishment as a springboard for future advances. The fact that hospices cared for 1.2 million terminally ill Americans last year points to their collective ability to create access.

Take as another example, Gibbons says, the proportion of hospice patients who do not have cancer as their primary diagnosis. Ten years ago, NHPCO published guidelines for determining prognosis in non-cancer diagnoses, which were then adapted by Medicare fiscal intermediaries — although not without some angst and growing pains for the field. But today, more than half of patients served by hospices have non-cancer diagnoses.

“Take that achievement and let the enthusiasm invigorate your whole organization.” Gibbons adds that hospices need to not forget about HIV patients. Although many of them are living longer — and better — thanks to advances in medical treatment, a significant proportion will eventually need hospice care.

Other hallmarks of a commitment to improving quality in the realm of inclusion and access include: performing periodic community needs assessments; exploring barriers to quality end-of-life care in your community; continuing to work on increasing the cultural competence of the agency and its staff; pursuing collaborative marketing and community relations initiatives; and paying attention to conversion rates (the proportion of referrals that result in hospice admissions) and response time to referrals.

Visit nhpco.org/quality for detailed information, tools and resources for this and the other nine components of Quality Partners.

Enclosures

CMS Visit Reporting Guide