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## **INSTRUCTION MANUAL**

### **I. Introduction**

#### **A. Purposes of the Maryland Hospice Survey**

The Maryland Health Care Commission (MHCC) routinely conducts statewide surveys of health care facilities, providers, and their patients. The purposes of these surveys are to support policy development under the Maryland State Health Planning and Certificate of Need programs. For hospice services, the Commission requires annual data on hospice services to:

- Maintain an accurate inventory of hospice providers, including data on ownership, capacity, utilization, services available, and revenues;
- Analyze the composition of the population using hospice services, including demographic characteristics, length of stay, payment for care, and migration patterns;
- Analyze trends in the availability and utilization of hospice services;
- Monitor the impact of changes in reimbursement and other policies influencing the organization, delivery, and financing of hospice service;
- Provide a baseline for forecasting the future need for hospice services in Maryland.

#### **B. Programs Required to Report in the Maryland Hospice Survey**

The reporting requirements of the 2015 Maryland Hospice Survey are specified in COMAR 10.24.03. Under these regulations, long-term care providers, including hospice programs, are required to submit accurate, timely and complete data needed by the MHCC to support planning for hospice services. Hospices licensed for general or limited hospice services in Maryland are required to report annually to the MHCC under COMAR 10.24.03.

#### **C. How to Use the Instruction Manual**

A printer friendly version of this Instruction Manual is available in Adobe Acrobat format on the sign-in page of the Survey.

## **II. General Instructions for Completing the Fiscal Year 2015 Maryland Hospice Survey**

### **A. Organization of the Survey**

The survey is divided into two parts; **Part I** of the survey includes several sections requesting data on hospice operating characteristics, services, and utilization. In **Part II**, selected data from the Medicare Cost Report is requested.

#### **PART I:**

- Section A: Identification and Contact Information
- Section B: Program Demographics
- Section C: Patient Volume
- Section D: Patient Demographics
- Section E: Processes of Care
- Section F: Productivity (minus the Cost of Care section, F5)
- Section H and I: Inpatient and Hospice House Facilities **ONLY**

*If you respond **YES** to question B11a indicating that you have an Inpatient Facility, a new section, Section H, **will appear** on the menu. You will be required to complete this section for each Inpatient Facility you operate.*

*If you answer **NO** to B11a, Section H will **NOT appear** on the menu, as no data is required.*

*If you respond **YES** to question B11b indicating that you have a Hospice House Facility, a new section, Section I, **will appear** on the menu. You will be required to complete this section for each Hospice House you operate.*

*If you answer **NO** to B11b, Section I will **NOT appear** on the menu, as no data is required.*

#### **PART II:**

- Section F: Cost of Care (item F5)
- Section G: Level of Care and Pay Source and Revenue and Payer Mix

### **B. Completing the Survey**

The survey will be completed in two parts as described above. Part I **MUST** be completed before data entry on Part II can begin. Part I will be due 60 days after receiving notification of the online survey. Part II will be completed when your agency's Cost Report is complete, but no later than **June 6, 2016**. Part I and Part II will be certified separately *All data reported should represent your agency's **hospice services only**. Do not include data from a home health or other types of health care service.*

Each question on the Maryland Hospice Survey must be completed. The MHCC will not accept incomplete submissions. Both Survey Parts I and II require each agency to verify, correct, and certify the accuracy of the data entered prior to selecting the Certification button at the end of the survey. Instructions regarding verification, correction and certification of your data appear in the Certification Section of the survey. **The Commission does not consider your survey to be complete until your online certification has been accepted by the web-based data entry program.**

### **C. Survey Submission Date**

Part I of the survey must be completed by each hospice **within 60 days** of receipt of electronic notice that the survey is available for online data entry. This period begins on the day the survey begins, which this year is February 8, 2016. Notice was received in advance by email. The survey due date is **60 calendar days from that date, which is April 8, 2016.** The survey should be completed by the close of the business day (5:00 p.m.) no later than the 60<sup>th</sup> day.

As stated above, the survey is not considered complete until the data entered has been electronically certified by the individual authorized by the agency to do so. The certification rules, instructions, and submission button are available to you at the end of the survey. Please note that by certifying the authenticity of the data supplied, the electronic authentication of the data is immediate and permanent. The MHCC will receive electronic notices of each agency's Certification.

### **D. Questions**

If you have any questions regarding the reporting requirements for COMAR 10.24.03 or the instructions for completing the survey, please contact Linda Cole at [linda.cole@maryland.gov](mailto:linda.cole@maryland.gov) or at 410.764.3337.

### **E. Penalties for Non-Reporting**

The data requested in this survey must be provided by all licensed hospice programs in Maryland in accordance with Health-General Article §19-116(b), which authorizes the collection of data by the Maryland Health Care Commission, and COMAR 10.24.03 (Maryland Long Term Care Survey) which requires that hospice providers submit accurate, timely, and complete data needed by the MHCC to support planning for long term care services.

If a facility fails to provide accurate, timely, and complete data as required under Health General Article §19-116(b)(2), the Commission may:

1. Impose a penalty of not more than \$100.00 per day for each day the violation continues after consideration of the willfulness and seriousness of the withholding as well as any past history of withholding information;

2. Issue an administrative order that requires the facility to provide the information;  
or
3. Apply to the circuit court in the county in which the facility is located for legal relief considered appropriate by the Commission.

**F. Reporting Period**

All data submitted should be based on your agency's 2015 fiscal year.

**Please be aware that you can PRINT the entire Part I or Part II for your records once it is completed. A blank copy of both Part I and Part II of the survey may be printed from the Log-In Page.**

## IV. Error Notifications in Online Survey

### A. Error Notification

Errors are indicated with an asterisk or an error message, which will remain until they are fixed, and they must be corrected before you can continue with the survey.

**Please keep the following important notes regarding ERRORS handy as you enter data.**

There are three buttons at the bottom of the survey:

- “Menu”: this button on the bottom center permits you to return to the Main Menu but **DOES NOT VALIDATE OR SAVE**
- “Validate and Save”: this permits you to validate and save data!
- “Next Section”: this button on the bottom right permits you to go on to the Next Section but **DOES NOT VALIDATE OR SAVE**.

**For Sections H and I, the “Next Section” button is replaced with a button that says “Add Another Facility.”**

**If you need to stop survey completion, it is recommended that you click on the “Validate and Save” button at the middle bottom of the page and return to the survey and complete that page with the previously entered data intact.**

**As you move from page to page, you will be prompted with a Message that reads: “Reminder-No changes to this section are saved unless you validate.” This prompt has been added to assure that data is not lost.**

**When a section is complete and validated, a green arrow appears for that section on the log-on page. Each section must have a green arrow for the survey to be complete and submitted.**

## V. Survey Instructions by Section

### **Section A. Identification and Contact Information**

The name of your agency will appear in the name field once you have logged-in to the survey. **If the name of your agency has changed during Fiscal Year 2015, you will be required to update this information at the end of Section A per the instructions provided below.**

#### *Current Agency Name*

If your agency name has changed or is different from the name entered in this field, **Please remember to answer the last THREE questions on this page regarding the new agency name.** The first question in this group is, “Did your agency change name(s) during this reporting period?” Be sure to answer all subsequent questions regarding this name change. Error messages will result and final certification of your survey will not be possible if this information is not provided.

#### *Mailing Address*

Please enter your agency’s address in this space. **NOTE:** You can type in the first few letters of your county name in the county field and it should appear on the drop-down list. Otherwise, you can scroll through the list and select the correct county when it appears.

#### *Name of Administrator*

Please enter the name of your agency’s Administrator in this space.

#### *Agency Telephone Number*

Please enter the main telephone number of your agency in this space.

#### *Contact Person*

Enter the name of the person who completed the survey or the person. This is the person that MHCC’s staff, may contact with questions about the data submitted in this survey.

#### *Telephone Number and Email Address of Contact Person (person completing survey)*

Please enter the telephone number and e-mail address of the person who completed the survey. Please include the direct telephone number for the contact person.

**Section B. Program Demographics**

Please complete information as required.

**B 1. License Type**

Please indicate whether your agency has a general or limited hospice license. Use the license type that matches your State of Maryland license type designation.

**B 2. Agency Type**

Please indicate which type of agency listed best matches your organizational structure. Use the agency type that matches your Medicare agency type designation.

**B 3. Ownership**

Please indicate the type of ownership of your agency. **If your agency changed ownership during Fiscal Year 2015, you will be required to answer the 4 remaining questions after the question on ownership.**

**B 4. Tax Status**

Please indicate the type of tax status for your agency.

**B 5. Geographic Area Served**

Please indicate the type of community of your home office or where most of your clients are served in terms of population density. This is the designation Medicare has assigned to your agency.

**B 6. Multiple Locations**

Report multiple locations separately unless data is combined.

Indicate whether your agency has more than one location (this includes agencies outside MD) in the first part of question 6.

If you answered YES to this part of the question, please provide the addresses of these locations in the second part of question 6.

In the third part of question 6, please indicate which, if any, Maryland locations including headquarters report their data together in this survey.

**B 7. Medicare Certified for Hospice**

Indicate whether your agency is certified by Medicare. If you answered, YES to the first part of question 7, report your agency's Medicare number and National Provider Identifier (NPI) in the second part of question 7.

### **B 8. Medicaid Certified for Hospice**

Indicate whether your agency is certified by Medicaid. If you answered, YES to the first part of question 8, report your agency's Medicaid number in the second part of question 8.

### **B 9. Accreditation Status**

Please indicate whether your agency has received accreditation from any of the organizations listed. Check all those that apply.

### **B 10. Fiscal Year for Data Reporting**

Please provide the last day of your agency's 2015 fiscal year in question 10a. There is a drop down menu to select the month and date; 2015 is already in the year section. For example, if your agency fiscal year end is June 30, 2015, Select "June" and "30" and it will be shown as June 30, 2015.

In question 10b, indicate whether the data submitted in this survey represents a full 12-month fiscal year period.

If the data submitted in this survey does not represent a full 12-month fiscal year, please indicate the actual number of months that the data represents.

### **B 11. Inpatient and Residential Services**

Questions 11a and 11b refer to dedicated facilities or units. A **dedicated facility or unit is defined as:**

1. Consisting of one or more beds that are owned or leased by the hospice,
2. Staffed by hospice staff, and
3. Has major policies/ procedures set by the hospice.

For 11a, please indicate whether your hospice operates an inpatient facility licensed under COMAR 10.07.21.26 that provides inpatient, respite, and/or residential care. *If it is dually licensed as Inpatient and Hospice House, enter the data under Inpatient.*

For 11b, please indicate whether your hospice operates a Hospice House that provides only residential care.

**If you answered YES to question 11a** regarding inpatient facilities, please complete Section H before submitting your survey data. If Section H is incomplete when the hospice has a dedicated inpatient facility or unit, this will result in an uncertified and unacceptable survey. Section H will permit you to enter several inpatient units, if this is applicable.

**If you answered NO** to this question please proceed to Section C below. Section H will not be available to you on the menu.

**If you answered YES to question 11b** regarding Hospice House facilities, please complete Section I before submitting your survey data. If Section I is incomplete when the hospice has

a licensed Hospice House, this will result in an uncertified and unacceptable survey. Section I will permit you to enter several Hospice Houses, if this is applicable.

**If you answered NO** to this question please proceed to Section C below. Section I will not be available to you on the menu

### **Section C. Hospice Patient Volume**

#### **C1A. Patient Volume By County - *Background and Definitions***

This section of the survey contains many items regarding the number of carryovers, admissions, deaths, and non-death discharges by county and type of hospice care on admission. Columns C, D, E, F, and G are mutually exclusive, meaning that each of your agency's 2015 admissions should appear in only one of these columns, depending on their point of entry into hospice.

**Limited license hospices** should report only those patients who were not treated by a general license hospice concurrently with a limited license hospice stay. **General license hospices** should report patients in a limited license hospice setting for which the general hospice provides concurrent skilled hospice services.

**Note that this section MUST be completed prior to completing Section D, since questions in Section D must match responses in C1a.**

#### ***Definitions:***

*County* – 1. For **home-based and residential hospice care**, county refers to the county where care was provided, and 2. for **inpatient hospice care**, county refers to the county of origin of the patient (patient's legal address).

*Carryovers* – the number of patients carried over from 2014 by county.

*Home-based hospice care* – patients admitted whose care is provided in a private home.

*In-patient hospice care* – patients whose care is provided in a general inpatient hospice unit or facility, or under a contract with a hospital.

*Hospice House care* – home-hospice care provided in a facility or unit to patients who cannot be cared for in a private home. *Exclude nursing homes and assisted living facilities.*

*Nursing home setting* – patients who are receiving hospice care while residing in a nursing home.

*Assisted living setting* – patients who are receiving hospice care while residing in an assisted living facility.

*Admission* – An admission to a **general license hospice** is a patient who was admitted to your program for whom you provided skilled hospice services. An admission to a **limited license hospice** is a patient who was admitted to your program and who did not receive general hospice services concurrently with the patient's stay in the limited license program.

**C1A. Patient Volume by County - Column Instructions:**

**Column B:** Enter the number of carryovers from 2014 by county. 1) Use the patient's county of origin for **inpatient carryovers**. 2) Use the county of care for **home-based carryovers**.

**Column C:** Enter the number of unduplicated, first time hospice admissions of a patient to your program, by county, residing in a private home. Home-based care is defined as care provided in a private residence, and excludes residential care provided in any other setting.

**Column D:** Enter the number of unduplicated, first time hospice admissions of a patient, by county of origin, to a facility providing general or respite inpatient care (including a GIP unit, facility or hospital contract). **Do not include patients who were admitted to the hospice program while a patient of an inpatient hospital**, but for whom your agency did not provide skilled services because of death prior to discharge from the hospital.

**Column E:** Enter the number of unduplicated, first time hospice admissions of a patient, by county of origin, to a hospice-owned Hospice House providing routine/continuous home care. **Exclude hospice admissions in a nursing home or assisted living setting.**

**Column F:** Enter the number of unduplicated, first time hospice admissions of a patient to your program, by county of care, residing in a skilled nursing home facility.

**Column G:** Enter the number of unduplicated, first time hospice admissions of a patient to your program, by county of care, residing in an assisted living facility.

**Column H:** Enter the sum of columns B, C, D, E, F, and G in column H.

**Column I:** Enter the number of deaths by county for all hospice settings within your program.

**Column J:** Enter the number of non-death discharges by county for all hospice settings within your program.

**The online format for this question was changed slightly beginning with the 2012 Survey. Select a jurisdiction from the drop down menu and complete columns B through J across the row. Then click the "ADD" button and the data will be entered in the table below. Make sure to click "add" after every jurisdiction is entered.**

**Important Note:** The answers provided in Section C1A columns H (minus B), I, and J must match the totals you will provide later as follows (you will receive an error message if these sections do not match):

1. Column H: Subtract Column B to get Total New Admissions. This number must equal Section D totals in items D1, D2, D3, D4, D6, and D7
2. Column I, Total Number of Deaths, must equal Section D totals in items D6 and D7
3. Column J, Total Number of Live Discharges must equal Section D totals in items D6 and D7

**C1B. Patient Volume by County**

Provide the number of readmissions and non-death discharges in FY 2015 for each of the categories listed. Include each discharge for patients who were discharged more than one time.

**Column Instructions:**

**Column B:** Enter the number of readmissions **during 2015** by county. This includes readmissions for patients who received services in 2015, were discharged, and readmitted in 2015. Include every readmission that occurred during 2015, no matter how many times a patient may have been discharged and readmitted.

1. Use the patient's county of origin for **inpatient re-admissions**.
2. Use the county of care for **home-based re-admissions**.

**Column C:** Enter the number of readmissions from years **prior to 2015** by county. This includes patients admitted for the first time any time prior to 2015, where discharged, and readmitted in 2015.

1. Use the patient's county of origin for **inpatient re-admissions**.
2. Use the county of care for **home-based re-admissions**.

**Column D:** Enter the number patients who were discharged due to an extended prognosis.

**Column E:** Enter the number patients who were discharged from the hospice program to attempt curative treatments.

**Column F:** Enter the number patients who refused hospice services.

**Column G:** Enter the number of patients who were discharged because they moved out of the hospice service area

**Column H:** Enter the number of patients who were transferred to another local hospice.

**Column I:** Enter the number of patients who were discharged by hospice for cause.

**Column J:** Enter the number of patients who were discharged from hospice for reasons other than those specified in this table.

**Again, select the jurisdiction and click "ADD" at the end of completing the row to enter data into the table below. Totals will be automatically calculated. Totals must equal non-death discharges column J from C1a.**

**C2. Referrals**

**Number of Referrals**

Enter the number of referrals received in FY 2015. The number of referrals does not include requests for general information. A referral is defined by one or more of the following and does not necessarily result in an actual admission.

**Important Notes:**

1. A request for assessment for possible admission to hospice from a physician, case manager, discharge planner, health care organization, or equivalent contact from a patient, or their family or friend that identifies a specific patient who may need hospice care.
2. The definition above is intentionally broader and is intended to capture all calls and contacts that identify a potential hospice patient.
3. For various reasons, hospices usually do not admit all patients who are referred for care. Therefore, the number of referrals is rarely the same as the number of admissions. A value entered for number of referrals that is the same, as the value entered for new admissions will be excluded from the data analysis.

**Referrals by Source**

Provide the number of referrals for each of the seven listed.

**C3. Average Daily Census and Length of Stay**

Calculate the average daily census and length of stay for your hospice program. Please review the definitions and calculation examples carefully before completing this data item for FY 2015.

*Average Daily Census (ADC)*

ADC is calculated by dividing all patient days for a given period by the number of days in that period.

EXAMPLE – Your agency provided a total of 12,775 patient days for all levels of care in 2015. 12,775 divided by 365 days equals an ADC of 35 patients per day.

**NOTE: This year you can use the Calculator Function to calculate ADC. Select “Use Calculator.” It will ask you to enter patient days. If you then click “Calculate”, it will automatically divide by 365 and enter the result in question C3a.**

*Average Length of Stay (ALOS)*

Calculate the ALOS by dividing the total days of care provided between admission and discharge to discharged patients by the total number of patients discharged.

EXAMPLE: 100 patients died or were discharged in 2015. Their total patient days from admission to discharge were 4,200. ALOS is calculated as follows:  $4,200/100=42$  days.

**NOTE: This year you can use the Calculator Function to calculate ALOS. Select “Use Calculator”, it will ask you to enter the total patient days, then it will ask you to enter the number of patients discharged, if you then click “Calculate” it will automatically calculate the ALOS and enter the result in question C3b.**

***Median Length of Stay (MLOS)***

If the LOS of all patients in 2015 were sorted in ascending order, the median is the midpoint, appearing halfway down the list. One half of patients have a LOS longer than the median and one half have a LOS shorter than the median.

Calculate the MLOS by arranging the LOS scores for all patients from lowest to highest (1, 2, 3, ...). The total number of LOS listed should equal the number of patients served. Find the score that falls in the exact middle of the list. This is the median length of stay.

EXAMPLE 1 – If you have an *even number* of patients served, calculate the MLOS as follows:

There are six (6) patients that stayed the following number of days: 11, 2, 9, 5, 8, 4. Arrange the LOS scores from lowest to highest: 2, 4, 5, 8, 9, 11. The median will fall between the third and fourth number, in this case, 5 and 8. Add 5+8 and divide the sum by 2. Therefore the median is 6.5 days.

EXAMPLE 2 – If you have an odd number of patients served, calculate the MLOS as follows:

There are five (5) patients with lengths of stay of 8, 22, 3, 10, and 22. Arrange the LOS scores from lowest to highest (3, 7, 8, 10, 22). The median length of stay is the middle number, 8 days.

**Number of patients who died or were discharged in less than or equal to 7 days**

Enter the number of deaths and discharges for all patients whose length of stay was 7 days or less.

**Number of Patients who died or were discharged in greater than or equal to 180 days**

Enter the number of deaths and discharges for all patients whose length of stay was 180 days or more.

**C4. Other Services Offered by Your Hospice**

This question asks whether your agency has a service delivery program outside the model of the Medicare Hospice Benefit.

***Definitions of Program Types:***

*Palliative Consult Team* – a hospice team that consults with non-hospice health care providers to provide advice on palliative care measures for symptom management of persons with a life-threatening illness.

*Home health agency serving primarily terminally ill patients* – palliative care provided to a terminally ill individual by a licensed home health agency that either is not certified for Medicare hospice reimbursement, or is serving terminally ill patients who choose to not enroll in a hospice program.

*Pre-hospice support program* – provides support care to a person with a life-threatening illness who may still be receiving curative treatment.

*Post-hospice support program for patients discharged alive* – non-clinical, non-hospice, volunteer support provided in-home to patients discharged alive.

*Grief counseling for non-hospice individuals* – bereavement support program that is open to the community and that may include, but is not limited to, individuals who independently contact the agency. This may include families or institutions dealing with the sudden death of a loved one or the death of someone who was not enrolled in a hospice program. This excludes bereavement services provided to clients and families of your hospice program.

*Other* – Please note that this includes music therapy, art therapy, and other alternative therapies.

If you have an existing program, please select YES (active program) from the dropdown list and indicate which program(s) you currently operate. Also include the number of admissions and deaths for each program for each program.

If you are PLANNING a program that is not yet operational, select “we are planning a program”. Indicate the type of program you are planning by selecting the box in the last column of the table. This is the only box you should select.

If you do NOT have or are NOT planning any of the programs listed or other possible unlisted programs, select NO and do not complete the rest of this question.

### **Section D. Patient Demographics**

**NOTE:** The totals for items D1 through D4 must match one another. ***YOU WILL RECEIVE AN ERROR MESSAGE, IF THEY DO NOT MATCH.***

**Also, the demographic information this year is collected on a jurisdictional basis. Note that the jurisdictions must match those selected in questions C1a and C1b. Again select the jurisdiction from the drop-down menu, enter the data, and click the add button.**

Report the number of unduplicated, new admissions during FY2015 for each category in this section. Count each patient only one time. This means patients with multiple admissions in 2015 are included only once. **Do not include carryovers or readmissions.** If your hospice did not serve persons in one or more of the age categories, enter “0”.

**The total admissions in this section should equal total admissions in Section C (Column H minus B). The number reported in Section C will appear in red on the top of this page to ease in data entry.**

#### **D 1. Age**

Report the number of unduplicated, new admissions by age at admission in FY 2015. Enter this data for each jurisdiction in which patients were served in FY 2015.

To obtain an accurate count of hospice patients less than 35 years of age, a detailed section for patients in this age group is provided for you to breakdown the 0-34 age group in greater detail. This is a subset of the 0-34 category.

Only Rows a through e, which excludes the individual numbers in the 0-34 subset, should be included in the Total of All Patients by Age.

**D 2. Gender**

Report the number of unduplicated, new admissions in FY 2015 by gender. Enter this data for each jurisdiction in which patients were served in FY 2015.

**D 3. Ethnicity**

Report the number of unduplicated, new admissions by ethnicity in FY 2015. Enter this data for each jurisdiction in which patients were served in FY 2015.

**D 4. Race**

Report the number unduplicated, new admissions by race in FY 2015. Enter this data for each jurisdiction in which patients were served in FY 2015.

**D 5a. Developmental Disability**

Report the number of hospice patients with developmental disabilities admitted by your agency in FY 2015. The developmentally disabled have problems with major life activities such as language, mobility, learning, self-help, and independent living. The definition of developmental disability according to Maryland Health General Article §7-403[e] is an individual who has a chronic disability that

1. Is attributed to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments;
2. Is manifested before the individual attains the age of 22;
3. Is likely to continue indefinitely;
4. Results in the inability to live independently without external support or continuing and regular assistance;
5. Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are planned and coordinated for that individual.
6. If you did not serve any patients with developmental disabilities, enter 0.

**D 5b. Veterans**

Report the number of hospice patients admitted who served in the U.S. armed forces (i.e., Veteran). It is not necessary for a patient to receive hospice services through Veterans' benefits to be counted as a veteran.

If your hospice did not admit any veterans in 2015, enter 0.

**D 6. Number of Admissions and Deaths by Location of Care by Level of Care—New in 2013.**

Report the number of unduplicated, new admissions in FY 2015 and deaths and non-death discharges, regardless of admission year, and patient days for patients who died or were discharged in each location during FY 2015. Do not include carryovers or readmissions.

Count the admission location on the first day of care. *Please note that the settings are now grouped into: Home Care, Respite Care, GIP Care, and Continuous Care in the table. This should provide information on location of care as well as level of care.*

Total admissions in this section should equal total admissions in Section C (Column H minus B). Number appears in blue.

Total deaths should equal the total deaths in Section C1a (column I). Number appears in blue.

Total non-death discharges should equal the total non-death discharges in Section C1a (column J). Number appears in blue.

*Total patient days should be reported by location and level of care for all patients who died or were discharged during FY 2015. Total patient days should equal the Total Patient Days reported in Section D7.*

**Results from data entered in Section C for admissions, deaths, and non-death discharges will appear in blue in this section to aid in data entry.**

**D 7. Number of Patients by Primary Diagnosis**

Report the number of unduplicated, new admissions, deaths, non-death discharges, and total patient days by principal major diagnostic category. Do not include carryovers or readmissions.

All hospice patients admitted during FY 2015 should be reported regardless of payment source. Each patient should be reported only once under the correct primary diagnostic category on admission. Deaths, non-death discharges and patient days should include all patients regardless of their admission year and should be categorized by their primary admitting diagnosis, not cause of death.

Admissions: Report the number of unduplicated new admissions in FY 2015. Count each patient only one time. Total admissions in this section should equal total admissions in Section C (Column H minus B).

Deaths: Total deaths in this section should equal total deaths in Section C (Column I). Count each discharge for those patients who were discharged and re-admitted one or more times in 2015.

Non-Death Discharges: Total non-death discharges should equal the total non-death discharges in Section C (Column J).

Patient days: Include the total number of days services were provided for all patients who died or were discharged in 2015. Count ALL days for each patient, including days in years other than 2015. **Total patient days should match total patient days reported in Section D6.**

**Results from data entered in Section C for admissions, deaths, and non-death discharges will appear in blue in this section to aid in data entry.**

### **Section E. Processes of Care**

#### **E1. Volunteers**

The number of volunteers should be an unduplicated count, with no individuals included in more than one category, even if they engage in more than one type of volunteer service.

Sometimes volunteers participate in multiple types of activities, such as spending time with patients *and* assisting with fundraising mailings. If any of the activities performed by a volunteer involve direct contact with patients or families, the volunteer should be counted in the direct care category for the purposes of the survey, regardless of the proportion of time spent providing direct care.

Do not include volunteer medical director hours when entering responses in this section. Medical director's volunteer hours should be entered in Section F: Productivity and Cost of Care. The table for Question F1 includes a category specifically for volunteer physicians.

#### ***Definitions of Volunteer Types:***

*Direct Patient Care Volunteers* - are defined as volunteers who spend time with patients and families.

**Note:** Direct Patient Care, Clinical Support, and General Support are separate categories of volunteers. The number and hours in the three categories should total to All Hospice Volunteers.

*Clinical Support Volunteers* - are defined as volunteers who provide services such as clerical duties, answering the phone, or organizing supplies, that support patient care and clinical services.

*General support volunteers* - provide services, such as help with fundraising and serving as members of the board of directors, which make an overall contribution to the hospice.

**NOTE:** *Direct Patient Care Volunteer* hours and *Clinical Support Volunteer* hours combined meet the Medicare Condition of Participation (COP) requirement for volunteer time equal to 5% of patient care hours. *General Support Volunteer* hours do not contribute to the 5% requirement. The number of volunteer hours entered in *Direct Patient Care* plus the number of volunteer hours entered in *Clinical Support Volunteer* should equal the number of hours documented by your hospice for the volunteer hours COP requirement.



**Number of Volunteers, Hours and Visits**

The number of volunteers reported in the number column should be an unduplicated count of volunteers -- no individual should be counted twice during the year. Direct Patient Care, Clinical Support, and General Support are separate categories of volunteers. The number and hours in the three categories should total to All Hospice Volunteers. For volunteers who contributed hours in more than one volunteer service category, provide the number of hours for each category.

Please report the number of volunteers by volunteer category.

Please report the number of hours by volunteer category

Please report the number of visits (where applicable) by volunteer category.

**Total All Hospice Volunteers**

For All Hospice Volunteers – The TOTAL of All Hospice Volunteers should equal the sum of Direct Patient Care Volunteers, Clinical Support Volunteers, and General Support Volunteers.

**E2. Bereavement Services**

**A. Total Number of Contacts by Visit by Member Category**

Please report the number of bereavement contacts, mailings to the bereaved, and individuals served by your program in FY 2015. **NOTE:** Include any face-to-face one-to-one contact with individuals, regardless of setting. Do NOT include support group or camp services.

The **Total Number of Contacts by Visit**, located in the third column, should equal the sum of Visits to **Hospice Family Members** and **Community Members**.

Information entered under Community Members should include bereavement services provided to individuals in the community who were **NOT** associated with a family member or friend admitted to hospice.

**B. Total Number of Contacts by Phone Call**

Please enter the total number of bereavement contacts by phone to the bereaved and individuals. The **Total Number of Contacts by Phone Call**, located in the third column, should equal the sum of **Phone Calls to Hospice Family Members** and **Community Members**.

**C. Total Number of Mailings to the Bereaved**

Please enter the total number of bereavement mailings to the bereaved and individuals.

The **Total Number of Contacts by Mail**, located in the third column, should equal the sum of **Contacts by Mail to Hospice Family Members** and **Community Members**.

**D. Total Number of Individuals who Received Bereavement Services**

Please enter the total number of individuals who received bereavement services. Include all individuals enrolled for bereavement, including those served through support groups and camps.



**NOTE:** Rows **A, B, and C** will **NOT** total **D** as the number of bereaved and individuals served through support groups and camps are included in row D, but nowhere else.

## **Section F. Productivity and Cost of Care**

### **F1. Staffing**

Review the definitions and calculation examples carefully before completing the Productivity and Cost of Care data for FY 2015.

#### **F1a. Staffing by Discipline**

**NOTE:** Do NOT include inpatient staff when completing Section F, with the exception of Question F4. Data for inpatient staff should be entered in Section H or I.

Complete Table F1a using the following definitions and calculation instructions:

#### ***Row Definitions***

*Nursing-Direct Clinical* – Includes RNs and LPNs. Include on-call and after hours care. Do **not** include supervisors or other clinical administrators unless a portion of their time is spent in direct care. Direct Care includes all activities involved in care delivery, including visits, telephone calls, charting, team meetings, travel for patient care, and arrangement or coordination of care. When a supervisor provides direct care, estimate the time involved in direct care, as distinct from supervision of other staff or program activities.

*Nursing- Indirect Clinical* – Include intake staff, educators, quality improvement, managers, and liaison nurses with clinical background, but who do not provide direct care.

*Social Services* - Includes medical social services staff as defined by CMS for the cost report. Do not include chaplains or bereavement staff.

*Hospice Aide* - and homemaker services such as dressing and bathing that address the patient's personal needs. Hospice Aides are considered Clinical Staff. Includes both aides and homemakers. Note: In previous surveys this was referred to as Homs Health Aides.

*Physicians-PAID*- include visits made by medical directors and other physicians providing direct care to patient. Exclude volunteer physicians and put in *Physicians-Volunteer* row.

#### *Chaplains*

*Other Clinical* – include any paid staff in addition to those captured above who make visits as part of direct care to patients or families. Include therapists and dietitians. Do not include volunteers, chaplains, or bereavement staff.



*Bereavement*- include all paid staff providing bereavement services, including pre-death grief support. Do NOT include volunteers.

***Column Definitions:***

*FTE* - One full time equivalent (FTE) is 2080 hours per year (40 hours per week times 52 weeks). Provide actual FTEs utilized, not the budgeted number of FTEs.

*PRN Employees* - also called “per diem” employees, are called upon to work when necessary without a commitment to work a specific number of hours for your agency. They may be available all of the time or they may be only available for certain days or times. However, they are not the same as part-time employees, even though they may routinely work on the same day or number of hours each week. A part-time employee is expected to work a certain number of hours each week, but there is no expectation for number of hours for a PRN employee.

*Separations* - a voluntary or involuntary termination of employment.

***Calculations***

*Total FTEs* - Divide paid hours by 2080. Include vacation, sick leave, education leave, and all other time normally compensated by the agency. Categorize your FTEs as you do for the Medicare Hospice Cost Report. Include hourly, salaried, and contract staff. **Include On-Call in direct clinical nursing.**

*Separations* - Do not include PRN employees in the calculation of total separations.

**F1b. General Staffing**

Complete Table F1b, General Staffing Time, using the following definitions and calculation instructions:

***Definitions:***

*Clinical* - Includes all direct care, which includes all activities involved in care delivery, including visits, telephone calls, charting, team meetings, travel necessary for patient care, and arrangement or coordination of care. When a supervisor provides direct care, estimate the time involved in direct care, as distinct from supervision of other staff or program direction activities. *This is the total of Direct Clinical, Social Services, Hospice Aides, Physicians, Chaplains, and Other Clinical.* Do not include bereavement services or indirect clinical.

*Non-Clinical* – Includes all administrative and general staff or contracted staff. Do not include indirect clinical here.

*Total:* Clinical plus Non-Clinical plus Indirect Clinical, plus Bereavement

**F1c. Visits by Discipline (Do not include inpatient staff)**

Please provide the numbers of visits made by the following disciplines for FY 2015: nursing, social services, hospice aides, paid physicians, volunteer physicians, chaplains, and other clinical.

Please count ALL visits regardless of setting (hospital, nursing home, residential facility, etc.) or number of visits per day using the definitions above and the additional ones below. Do not count phone calls.

**F2. Caseloads**

Caseload is the number of patients for which a staff member has responsibility or to which she/he is assigned at a time. *This question must be completed by both general and limited license hospices.*

Some disciplines, such as chaplains and social workers, may be responsible for contacting all patients and families, but visit only a proportion of them. In this situation, include ONLY those patients who receive visits in determining caseloads.

Please provide average caseloads (NOT RANGE) for the four disciplines listed.

**F3. Admission Model**

Indicate whether your agency uses a dedicated admission staff for the majority of initial admission visits.

**F4. Physician Involvement**

Complete the table based on FY 2015 using the following definition and calculation instructions:

**Definition:**

*Direct care* - includes all activities involved in care delivery, including visits, telephone calls, charting, team meetings, travel for patient care, and arrangement or coordination of care.

**Calculation**

Calculate the percentages based only on physician time devoted to hospice. If your hospice has more than one physician, consider all of their time combined as the base for the calculation. Percentage of Time column should add up to 100%.

**F5. Costs**

Note that this section is in Part II of the survey. These data items may be completed after your agency's fiscal year end and the completion of your fiscal year annual report. The submission due date for these data items is no later than 60 days after receipt of the survey, however, if your agency's fiscal year ended before December 31, 2015, you may complete this data item



whenever your cost report data is available. The data reported should be consistent with your agency's cost report.

Please provide a summary of cost data you submitted in your FY 2015 Medicare Cost Report. Enter the data for each line number (at left) from your Medicare Cost Report Worksheet and Column noted at the top of each column below. Freestanding, hospital-based and home health-based hospices cost reports request the same information, but have different worksheet, column and line references.

This survey contains references for the **Free-standing Hospice Cost Report** If your costs are submitted to CMS on a hospital or home health cost report and you are having difficulty identifying the appropriate spaces for your responses, please contact MHCC staff.

Enter the data for each line number (at left) from you Medicare Cost Report Worksheet and Column noted at the top of each column below.

Apportionment Statistics are included in the summary data you submitted in your FY 2015 Medicare Cost Report. Refer to the worksheets, columns and lines listed below that correspond to your Cost Report.

Enter the Apportionment Statistic for each of the following categories. The line from Worksheet S-1 Column 6 of your Cost Report is provided next to each category.

Line 11 - General Inpatient Days

Line 10 - Inpatient Respite Days

Line 12 - Total Patient Days

Please enter the Apportionment Statistic for Continuous Care HOURS reported in your FY 2015 Medicare Cost Report Worksheet S-1 Column 1.

## **Section G. Revenue and Payer Mix -- Part II**

### **G1. Level of Care and Pay Source.**

#### **Hospice Medicaid MCO**

Please enter Medicaid Managed Care here. Do not include Medicaid Managed Care in the Hospice General Medicaid category. Managed Care Organizations are health care organizations that provide services to Medicaid recipients in Maryland. These organizations contract with a network of providers to provide covered services to their enrollees. MCOs are responsible to provide or arrange for the full range of health care services.



### **Total Managed Care or Private Insurance**

Do NOT include any form of Medicare or Medicaid, or Blue Cross Managed Care Insurance in this category.

*Subcategory 1: Commercial Managed Care Insurance* – This form of Commercial Managed Care provides coverage through a specified network of providers in a specified service area. Non-network providers (i.e., providers who do not have a contract with the commercial managed care plan) may or may not require a referral from a managed care provider for out of the HMO network services.

*Subcategory 2: Commercial Non-Managed Care* - This form of Commercial Non-Managed Care Insurance is commonly known as traditional, fee-for-service, or indemnity insurance, as well as Preferred Provider Organization (PPO) and Point of Service (POS) plans. They all cover a defined set of benefits; various degrees of freedom in provider selection; facilities available; and the reimbursement, deductible, and co-pay amounts vary depending on the type of non-managed care insurance. There is considerable variability in the forms of Commercial Non-Managed Care Insurance.

Enter the total number of patients served, the number of routine days of home care, the number of inpatient days of care, the number of respite care days, and the number of continuous care days for **Commercial Managed Care Insurance**.

Enter the total number of patients served, the number of routine days of home care, the number of inpatient days of care, the number of respite care days, and the number of continuous care days for **Commercial Non-Managed Care Insurance**.

On the line above these subcategories labeled **Total Managed Care or Private Insurance**, enter the total of **Commercial Managed Care and Non-Managed Care**.

### **Total Blue Cross**

The definitions for Commercial Managed Care and Non-Managed Care also apply to the Blue Cross Insurance Program. Please use the same definitions as above for Blue Cross patients only. Do not include Medicare or Medicaid in these subcategories.

Enter the total number of patients served, the number of routine days of home care, the number of inpatient days of care, the number of respite care days, and the number of continuous care days for **Blue Cross Managed Care Insurance**.

Enter the total number of patients served, the number of routine days of home care, the number of inpatient days of care, the number of respite care days, and the number of continuous care days for **Blue Cross Non-Managed Care Insurance**.

On the line above these subcategories labeled **Total Blue Cross**, enter the total of **Blue Cross Managed Care and Non-Managed Care**.

Enter the total number of patients served, the number of routine days of home care, the number of inpatient days of care, the number of respite care days, and the number of continuous care days for **the remaining payers listed, including other payers.**

**Please note that Uncompensated Care has been separated this year from Charity Care. They are defined as follows:**

***Charity Care* means care for which there is no means of payment by the patient or any third party payer. This includes ONLY unpaid charges for which payment is not anticipated at the time of service. Charity Care does not mean uninsured or partially insured days of care designated as deductibles or co-payments in patient insurance plans, nor that portion of charges not paid as a consequence of either a contract or agreement between a provider and an insurer, or a waiver of payment due to family relationship, friendship, or professional courtesy.**

***Uncompensated Care* means care for which payment was anticipated when care was rendered, but for which payment was not collected. This includes bad debt. This excludes other unfunded sources of care such as underpayment from Medicare or Medicaid.**

**Note:** A patient whose care is paid for by more than one payer should be counted in all appropriate payer categories. Allocate this patient's days of care according to the number of days paid by each separate payer source.

## **G 2. Revenue source**

These data items may be completed after your agency's fiscal year end and the completion of your fiscal year annual report. The submission due date for these data items is the same as for Part I. The data reported should be consistent with your agency's cost report.

Report the amount of revenue and expenses for fiscal year 2015 for hospice service, total agency fund raising, and other revenue and expenses.

For Total Agency Fundraising Revenue: Include contributions for patient care, grants, fundraising, bequests, memorial donations, United Way and other community support, as well as transfers from your hospice foundation, if applicable. Interest/investment income should be included with Other Agency Revenue.

If you are a **limited license hospice** you may skip the 1<sup>st</sup> table in G2, but you must enter total revenue and total expenses in the 2<sup>nd</sup> table. **General license hospices** must answer the 1<sup>st</sup> table in G2 but may skip the 2<sup>nd</sup> table. All types of agencies may complete both tables.

## **3. Receivables Management**

These data items may be completed after your agency's fiscal year end and the completion of your fiscal year annual report. The submission due date for these data items is the same as for Part I. The data reported should be consistent with your agency's cost report.

Report the average number of days that revenue was outstanding in fiscal year. The formula is as follows: Multiply the total accounts receivable on the last day of your fiscal year by 365 and divide by your total Hospice Service Revenue.



**Section H. Inpatient Hospice Facilities**

This section requests detailed information describing the physical location of inpatient hospice facilities or units the agency operates.

Multiple inpatient hospice units or facilities can be reported in this section. Be sure to include data for all inpatient facilities separately. If your agency is planning a program that is not yet operational, please indicate this in Comments Section of this survey.

**1. Facility Name, County, and State**

Provide the name and county the inpatient hospice facility.

**2. Where is the facility sited?**

Check the response that best describes the location or site of the facility.

***Definitions:***

*Freestanding Hospice* – an inpatient hospice facility located in a stand alone building, not in a nursing home, hospital or other health care facility.

*In Hospital* – an inpatient hospice facility located in an acute care hospital setting.

*In Nursing Home* – an inpatient facility or unit located in a nursing home.

*Other* – please use this space for inpatient units located in any other setting. Please specify the type of facility.

**3. What level of care does the facility predominantly provide?**

Check the response that reflects the level of care your facility predominantly provides. ***NOTE that these have been rewritten to be consistent with the Medicare levels of care.***

***Definitions:***

*Routine Home Care* – care to an individual, who has elected to receive hospice care, who is at home and is not receiving continuous home care as defined below.

*Continuous Care*—care provided to an individual, who has elected to receive hospice care, is not in an inpatient facility, and receives hospice care consisting predominantly of nursing care on a continuous basis at home.

*Respite Care* – short-term inpatient care provided to an individual who has elected to receive hospice care when necessary to relieve the family members or other persons caring for the individual.

*General Inpatient Care* – care provided to an individual, who has elected to receive hospice care, and received general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

**4. How many beds by level of care does the inpatient facility have?**

Enter the total number of licensed beds that were operational on the last day of the fiscal year.

**5. Patient Care Services.**

For each level of care listed, please report the number of:

- Total admissions/transfers in
- Deaths
- All Live discharges or transfers out \*
- Patients served
- Patient days for patients who died or were discharged by each level of care occurring in FY 2015.

**NOTE:** \* Count each individual occurrence, even if a patient is in and out of the facility more than once in FY2015. Count transfers between levels of care.

**6. First month of operation for new hospice facilities.** This data item should only be completed by hospices opening a new hospice inpatient facility in their fiscal year 2015. Indicate the month the facility first accepted patients using the drop down menu. For example, if your facility opened in April of 2015, select “April” from the drop down menu.

*To enter another facility, click on Add Another Facility at the bottom of the page.*

**H7. Facility Staffing by Discipline**

Complete the table using the following definition and calculation instructions:

***Definition:***

**FTE:** One full time equivalent (FTE) is 2080 hours per year (40 hours per week times 52 weeks). Provide actual FTEs utilized, not the budgeted number of FTEs. Include ONLY those disciplines providing visits in the Inpatient facility.

***Calculation:***

**Total FTEs:** Divide paid hours by 2080. Include vacation, sick leave, education leave, and all other time normally compensated by the agency. Categorize your FTEs as you do for the Medicare Hospice Cost Report. Include hourly, salaried and contract staff.

**At the end of the Section you can save the data and add another inpatient facility if applicable.**

## **Section I. Hospice House Facilities**

This section requests detailed information describing the physical location of Hospice House facilities or units the agency operates. Multiple Hospice House facilities can be reported in this section. Be sure to include data for all Hospice House facilities separately. If your agency is planning a program that is not yet operational, please indicate this in Comments Section of this survey.

### **1. Facility Name, County, and State**

Provide the name and county of the Hospice House.

### **2. Where is the facility sited?**

Check the response that best describes the location or site of the facility.

#### ***Definitions:***

*Freestanding Hospice* – a Hospice House located in a stand alone building, not in a nursing home, hospital or other health care facility.

*In Hospital* – a Hospice House located in an acute care hospital setting.

*In Nursing Home* – a Hospice House located in a nursing home.

*Other* – please use this space for Hospice House facilities located in any other setting. Please specify the type of facility.

### **3. How many beds does the Hospice House have?**

Enter the number of beds for which the Hospice House was licensed on the last day of the fiscal year.

### **4. Patient Care Services**

Please report the number of:

- Total admissions
- Deaths
- All Live discharges
- Patients served
- Patient days for patients who died or were discharged in FY 2015.

**NOTE:** \* Count each individual occurrence, even if a patient is in and out of the facility more than once in FY2015.



**5. First month of operation for new hospice facilities.** This data item should only be completed by hospices opening a new Hospice House facility in their fiscal year 2015. Indicate the month the facility first accepted patients using the drop down menu. For example, if your facility opened in April of 2015, select “April” from the drop down menu.

*To enter another facility, click on YES at the bottom of the page.*

### **I6. Facility Staffing by Discipline**

Complete the table using the following definition and calculation instructions:

*Definition:*

FTE: One full time equivalent (FTE) is 2080 hours per year (40 hours per week times 52 weeks). Provide actual FTEs utilized, not the budgeted number of FTEs. Include ONLY those disciplines providing visits in the Hospice House.

#### **Calculation:**

Total FTEs: Divide paid hours by 2080. Include vacation, sick leave, education leave, and all other time normally compensated by the agency. Categorize your FTEs as you do for the Medicare Hospice Cost Report. Include hourly, salaried and contract staff.

**At the end of the Section you can save the data and add another Hospice House facility if applicable.**



**Comments**

This section is optional. Include any comments to explain the data provided or about the survey content itself.

**Certification**

Once the survey is complete (Part I or Part II), and the check boxes on the Log-In Page all have green arrows, the button on the bottom that reads “Submit Hospice Survey Part I/ (or II)” will darken and can be clicked. That will take you to the Certification Page. After reading the information, click on “Certify Part I (or II) Survey. You will then get a message that the survey is certified and you can continue with Part II or log out.

To complete the survey, you must certify the information provided by reading the following and selecting **Certify Survey** at the bottom of the page. All of the boxes for Sections A through I (G if no inpatient or Hospice House units) must have a green check mark indicating that they have been successfully completed. You should have **NO** \* errors remaining at this point in the survey process.

**Contact MHCC** you have any problems with certification.

By selecting the **Certify Survey** button you certify that:

You are authorized to complete the Maryland Health Care Commission Hospice Survey;

All information contained in the Hospice Survey is true, correct and complete to the best of your knowledge and belief;

No information, data, report, statement, schedule or other filing required to be filed or filed hereunder contains any medical, individual or confidential information personally identifiable to a patient or consumer of health services, whether directly or indirectly;

You understand that the Fiscal Year 2015 Hospice Survey is required to be filed with the Maryland Health Care Commission and is considered a public record which is available for public inspection, unless such disclosure conflicts with the Maryland Health Care Commission’s then existing data disclosure policy.

After your data is certified, you will still be able to view your data, but you will **NOT** be able to add to or edit the data.