For internal staff use:

MARYLAND HEALTH CARE COMMISSION

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MATTER/DOCKET NO.

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DATE DOCKETED

APPLICATION FOR CERTIFICATE OF NEED: HOSPICE SERVICES

for General Hospice Services in Prince George's County

Response to Completeness Questions

Applicant:

Montgomery Hospice, Inc.
1355 Piccard Drive
Rockville, MD 20850
301-921-4400

February 6, 2017

Part I – General Information

1. Will there be a local PG County office?

Yes, Montgomery Hospice plans to establish an office location in Prince George's County and has investigated specific locations. As a result of that investigation, we have used square footage and rental fee estimates appropriate to the likely location when preparing the project budget for this application.

Part III – Consistency with General Review Criteria at COMAR 10.24.01.08G(3)

A) State Health Plan: COMAR 10.24.13.05 standards
Admission Criteria.

2. The response provided to this standard is an explanation of reasons to discontinue services, not a description of eligibility limits. The standard asks for disclosure of any limits by age, disease, or caregiver.

Please see Attachment CA1, "Admission Criteria PFC.A10" for a description of Montgomery Hospice's eligibility policy. Montgomery Hospice does not limit hospice admissions by diagnosis in any way, and admits patients regardless of race, sexual preference, age, handicap, sex, communicable disease or religion. Montgomery Hospice serves patients of all ages, including children. It asks that patients without a caregiver in the home agree to assist the hospice in developing a plan of care to meet his or her future needs, but does not require an in-home caregiver as a condition of admission.

Minimum Services

3. The discussion of bereavement services does not address the standard's requirement of providing these services to the family for "at least one year following the death of the patient."

Please see Attachment CA2, "Bereavement Care Planning Policy PFC.B10", which describes Montgomery Hospice's policy of making bereavement services available for thirteen months following the patient's death. Upon a patient death, the interdisciplinary group (IDG) notifies the Bereavement counselor of the death and of any and all dynamics that happened at the death. A bereavement plan of care is developed to assess the needs of the bereaved and to offer services. The bereavement plan of care is followed for thirteen months following the patient's death, in accordance with the need assessed.

Impact

4. The application states that Montgomery Hospice expects the impact of its project on the hospice volumes at existing providers to be minimal in the short term. Please speak to your projection of longer term impact.

As stated in the original application, Montgomery Hospice expects the impact of its project on hospice volumes at existing providers to be minimal in the short term, and also in the long term (5 years out).

Although there are currently 8 hospices authorized to serve Prince George's County, combined they served only 2,349 patients in 2014. In 2015, the number of residents served by hospice fell further, to 2,251 patients according to the Maryland Hospice Survey. This meant that only 24% of county resident deaths received hospice services in 2015. Since this is far short of the number one would expect if hospice utilization rose to the level of the state average (40%), Montgomery Hospice believes that it can meet its forecast growth targets without cannibalizing patients or market share from existing providers, both in the short and longer term. Montgomery Hospice has developed its business plan to focus heavily on raising awareness and acceptance of hospice among underserved populations, such as African American residents. In addition, our established relationships with providers and professional referral sources in the county along border areas have contributed to the belief that culturally sensitive hospice care can make great inroads into underserved populations without disrupting other hospices' services.

If hospice utilization in Prince George's County had met the state average use rate of 40% in 2015, that would have represented 2,292 patient deaths (rather than the 1,400 actually served). Since historically the ratio of patient deaths to patients served in the county has been approximately 60%, that implies that there would have been about 3,800 patients served in the county had use rates been at a normal, or average, level. Even if all existing providers kept their current volume, that means that 1,569 patients who could have received hospice care went un-served by hospice. Montgomery Hospice intends to target that un-served population. Please see our model calculations below.

	Measure	**Data Source**
5,730	Resident deaths in Prince George's County	Maryland Vital Statistics, *2015 Preliminary Report*, Maryland Department of Health and Mental Hygiene
1,400	Resident deaths served by all hospices	MHCC Maryland Hospice Survey, 2015
2,251	Patients served by all hospices	MHCC Maryland Hospice Survey, 2015
62%	Percentage of PG County hospice patients that died during 2015	Calculated
24%	Percentage of all resident deaths served by hospice	Calculated
2,292	Number of hospice patient deaths if service rate met state-wide average (40%)	Modeled
3,820	Number of hospice patients if service rate met state-wide average (Modeled deaths/60%)	Modeled
1,569	Un-served potential hospice patients (*Montgomery Hospice target population*)	Modeled

Charity Care and Sliding Fee Scale

5. The charity care policy does not appear to contain a requirement to make a determination of probable eligibility for Charity Care within two business days following a patient's request for charity care services, application for medical assistance, or both, as specified in this standard. Please point out where this provision is covered, or amend the policy to include it.

It has always been the policy of Montgomery Hospice that no admission will be delayed during the determination of a patient's eligibility for charity care or financial aid. That being said, we have updated our former policy to incorporate a requirement that any Financial Assistance assessment will be completed within two business days following a patient's request for charity care services. Please see Attachment CA3, "Charity Care/Financial Aid Policy 8-006".

6. Your response states that Montgomery Hospice's policy on charity care is printed on most of the hospice's patient literature; please provide sample, as well as a copy of the notice regarding that policy that is posted in the business office.

Information about Montgomery Hospice's Charity Care policy is on its website under the "Patients and Families" page under the heading, "How is hospice paid for?" (See links below under the response to Question 7.) In addition, the Montgomery Hospice Patient and Family Handbook, given to all patients and their families, states on Page 79 under the heading "Costs, Benefits Coverage and Pre-authorization":

> *If you have problems paying our charges, please ask your hospice social worker to evaluate the situation. No person will be denied essential service because of inability to pay.*

Please see the relevant page on Attachment CA4, "Page 79 Handbook-Charity Care".

Below are some additional places where information about Montgomery Hospice's charity care can be found:

On the Q&A flyer printed by Montgomery Hospice:

Please see a PDF copy attached (Attachment CA5). This flyer is available on the Montgomery Hospice website at: http://www.montgomeryhospice.org/sites/default/files/docs/montgomery-hospice-educational-flyers/montgomeryhospiceqanda5718AB44AAA3.pdf?sfvrsn=2

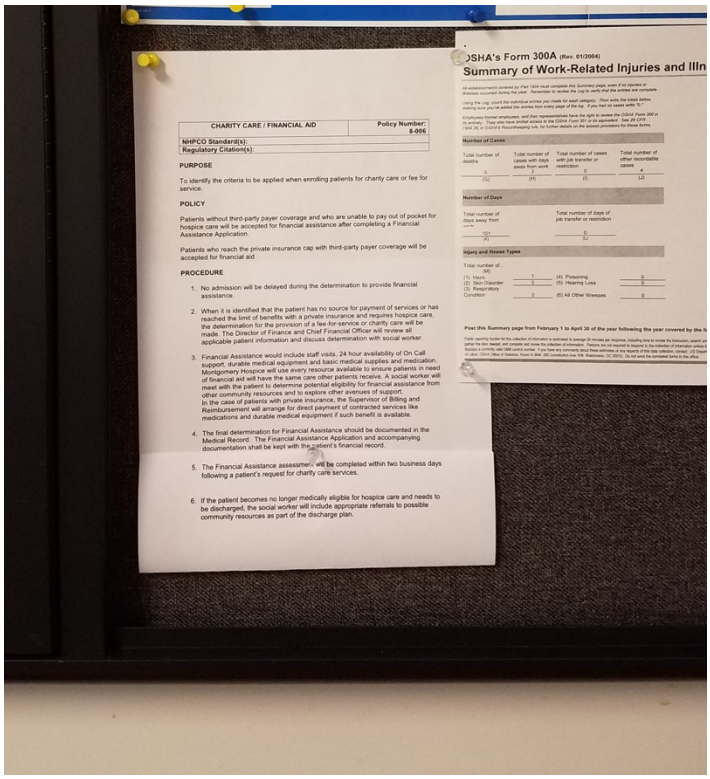
"Hospice services are paid for by:
• Medicare • Medicaid • most private insurance companies, or by
• Montgomery Hospice. We care for patients without insurance or any other way to pay."

This flyer is translated to Spanish, Chinese, Russian and French and available on the Montgomery Hospice website: **http://www.montgomeryhospice.org/education-resources/publications/educational-articles-flyers-and-brochures**

In the Montgomery Hospice brochure:

"If a patient is not covered by any of these programs and has no other way to pay, MH will pick up the cost."

Montgomery Hospice also posts its Charity Care/Financial Aid policy publicly at its offices at 1355 Piccard Drive Suite 100, Rockville, MD. For text of the policy please see Attachment CA3, "Charity Care/Financial Aid Policy 8-006". The photo below shows the policy as posted.



7. This standard requires that information on the hospice's charity care policy to be posted on the hospice's website. MHCC staff is unable to find this information on the site. Please provide a link and web address.

<u>Please see the following locations on the Montgomery Hospice Website:</u>

Hospice Services http://www.montgomeryhospice.org/health-professionals/hospice-services
"These services are provided by Montgomery Hospice to all patients, including the uninsured and under-insured".

Foundation Support http://www.montgomeryhospice.org/donate-support/foundation-support/foundation-support
"Foundations, faith groups and civic organizations award grants to Montgomery Hospice to support general operations and specific programs including: Charity care for the uninsured and under-insured."

How is hospice paid for? http://www.montgomeryhospice.org/patients-families/how-hospice-paid
"Charity care: Charity care for qualified patients is provided (based on the resources of the patient). For patients not covered by any of these programs and no other way to pay, Montgomery Hospice will pick up the cost of the care."

How your gift will help http://www.montgomeryhospice.org/donate-support/how-your-gift-will-help
"Provide hospice care to those who have no insurance or not enough insurance through our Charity Care Fund. We are proud to serve all who need our services. This would not be possible with contributions from the community."

Foundation support http://www.montgomeryhospice.org/donate-support/foundation-support/foundation-support
"Foundations, faith groups and civic organizations award grants to Montgomery Hospice to support general operations and specific programs including: Charity care for the uninsured and under-insured"

The website also contains the **Montgomery Hospice Donation form**:
http://www.montgomeryhospice.org/donate
On the donation form, donors can choose a "Gift Purpose" – one choice is Charity Care.

As noted above, our Q&A Brochures is available on the Montgomery Hospice website at:
http://www.montgomeryhospice.org/sites/default/files/docs/montgomery-hospice-educational-flyers/montgomeryhospiceqanda5718AB44AAA3.pdf?sfvrsn=2
"Hospice services are paid for by:
• Medicare • Medicaid • most private insurance companies, or by
• Montgomery Hospice. We care for patients without insurance or any other way to pay."

This flyer is translated to Spanish, Chinese, Russian and French and available on the Montgomery Hospice website:
http://www.montgomeryhospice.org/education-resources/publications/educational-articles-flyers-and-brochures

8. Please provide a copy of the sliding fee scale that is applied to eligible applicants.

Please see attached the Montgomery Hospice Financial Assistance Application (Attachment CA6). Montgomery Hospice uses a formula to determine eligibility for financial assistance based upon family income using federal poverty guidelines. See page 5 of the form for details. Under this formula:

Example 1: A patient with a family size of 4, with income of $21,458 would be eligible for a full write-off of their bill.
Example 2: A patient with a family size of 7 with actual income of $60,000 would be eligible for a 63% reduction.

Quality

9. This standard asks for documentation of Montgomery Hospice's compliance with all federal and State quality of care standards. Please report on your participation in the Hospice Experience of Care Survey and/or CAHPS Hospice Survey Quality Measures, including scores received and any peer comparisons. References are provided below.

Montgomery Hospice participates in CAHPS Hospice Survey Quality Measures, using Deyta National as its contractor to collect and benchmark its patients' responses. Please see the results of the most recent report available attached. (Attachment CA7: CAHPS Reporting December 2016).

10. This standard also requires an applicant's quality assurance and improvement program to be consistent with the requirements of COMAR 10.07.21.09. Please document that the Office of Health Care Quality has reviewed and approved Montgomery Hospice's QAPI.

Please find attached Montgomery Hospice's policies and procedures regarding QAPI (Attachment CA8, "MH Performance Measurement"). Montgomery Hospice also submits

notations to the table sent by Kevin McDonald, with responses in blue (Attachment CA9, "QAPI Documentation Table").

Please also find attached the Nov 2015 OHCQ letter stating that Montgomery Hospice is compliant with COMAR state licensure regulations which also proves that Montgomery Hospice is compliant with all State quality of care standards (Attachment CA10, "OHCQ Letter").

In addition, the attached letter from the Joint Commission provides proof that Montgomery Hospice is compliant with all federal quality of care standards, and established Montgomery Hospice's "deemed status" as a Medicare certified hospice provider surveyed for federal (Medicare) regulations in October 2016. An additional layer of rigorous external quality monitoring was given to Montgomery Hospice by the Joint Commission in 2016. See attachments CA11, "Joint Commission Deemed Status Letter, and CA12, "JC Accreditation Letter".

Patients' Rights

11. Please provide a copy of the written explanation of Patient's Rights that every patient admitted to Montgomery Hospice receives.

Every patient admitted to Montgomery Hospice received a Patient Handbook. On pages 67-68, a statement of Patient's Rights and the Complaint Procedure are included. Please see attachment CA13, "MH Patients' Rights".

B) Need

12. Montgomery Hospice (MH) states in its application that it has *made special emphasis on its plans to serve the African American and Hispanic populations of Prince George's County*, but provides no specifics regarding its outreach strategy or tactics. Please back up this statement with specifics that would differentiate you from other applicants.

Outreach to African American residents of Prince George's County will be critically important to the success of Montgomery Hospice's expansion into that jurisdiction. In 2015, 67% of all resident deaths in that county were identified as "Black" according to the state's Vital Statistics (*Maryland Vital Statistics, 2015 Preliminary Report*, Department of Vital Statistics, Maryland Department of Health and Mental Hygiene). Using the outreach techniques described below, Montgomery Hospice has been able to serve a patient population proportional to the demographics of its current service area in Montgomery County.

Montgomery Hospice has a long-established tradition of dedication to providing hospice care to residents of its service area from all walks of life, as demonstrated in the Mission, Vision and Values statements of the organization:

Our Mission

To gentle the journey through serious illness and loss with skill and compassion.

Our Vision

To bring comfort by providing the best care to our community's multicultural residents who are facing serious illness and loss.

To be the best workplace for staff and volunteers.

Our Core Values

The principles that guide our employees and volunteers are:

- Unconditional Compassion: Compassionate care, partnered with professional excellence, is the heart of our service.
- Dignity of the Dying: We affirm the right of our patients to be treated with respect, and to be honored as unique individuals.
- Dedication: We are committed and privileged to ease the burdens and challenges that our patients and families face.
- Collaboration: Mutual respect, empathy and trust unite us in providing care.

In addition, Montgomery Hospice's current strategic plan includes a key objective directed toward strengthening and enhancing multi-cultural service:

Strategic Objective E. Further enhance outreach and services which are culturally sensitive and reflect the economic and ethnic diversity within the community	1. Invest in additional support for diverse populations and underserved communities 2. Ensure adequate resources for diverse communities with language and appropriate cultural support 3. Identify additional underserved groups for outreach/service 4. Continue broadly sharing with other health care organizations, Montgomery Hospice's expertise in outreach and service to diverse communities

In Prince Georges County, Montgomery Hospice plans to pursue a strategy of outreach to African Americans and Hispanic residents using techniques that have worked successfully in Montgomery County:

- Provide quality services to the entire county's geography
- Develop relationships with members of the Prince Georges County community, and, as we did in Montgomery County, listen more than we talk.
- Develop relationships with area faith communities
- Provide educational opportunities and discussions
- Educate residents about the benefits of hospice services
- Tailor hospice services to the specific needs of individuals
- Invest resources in providing services that other hospices may not, including an extensive bereavement program and complementary therapies
- Conduct a preliminary study to assess educational needs, misconceptions, beliefs and potential barriers to hospice use
- Conduct focus groups in different faith communities throughout the county
- Conduct in-depth interviews with physicians in private practice (including oncologists, geriatricians and primary care doctors) and with hospitalists in all hospitals serving this county
- Form an advisory committee of professionals who can act as a sounding board and help promote Montgomery Hospice educational efforts
- Collaborate with professionals in the faith community, the Prince George's hospitals, doctors and extended care facilities and others who work with the aging community in the County
- Assign a clinical liaison to every hospital operating in Prince George's County. These clinicians are hospital liaisons and educators who are either nurses or social workers and are assigned to a hospital. Liaisons assist hospital clinical staff in presenting end-of-life care to eligible patients, and can facilitate admission if patient chooses hospice care.

By using the same outreach methods that we have used successfully in Montgomery County, we plan to work to increase the hospice utilization rate in Prince George's County. As evidence of Montgomery Hospice's long and successful history of working with minority populations in Montgomery County, please see attached CA14, "MH Outreach Materials." Among other activities, Montgomery Hospice has:

- Published multiple articles in the Montgomery Hospice newsletter, *Hospice Matters*, addressing barriers to hospice use and the advantages of hospice care for African Americans and Hispanic residents. *Hospice Matters* is mailed to more than 17,000 households quarterly. (See Attachment CA14, pages 1-6.)
- Sponsored research into African Americans' use of hospice that was conducted in 2003 by Dr. Robert Washington, who served as VP of Counseling and later as Chief Clinical Officer at Montgomery Hospice. (See Attachment CA14, pages 5-8, for the announcement of the study.)
- Hosted multiple interfaith conferences on end of life care for African American residents of Montgomery County.
    - "Ministering to Families Facing Illness and Death," held at People's Community Baptist Church, a large African American church near the eastern border of Montgomery County (four-hour instructional program for lay ministers), November, 2002

- Breakfast Meeting of the Black Ministers Conference of Montgomery County, hosted at Montgomery Hospice's Casey House facility, January, 2003
- *We've Come This Far by Faith: African-American Women, Cancer, and End-of-Life Care*, full-day conference, June 28, 2003
- "When Congregations Grieve," workshop for Gaithersburg Clergy Association, Summer 2004
- *Caring for Loved Ones with Memory Loss*, a free multicultural conference for members of ethnic minority communities to learn about caring for loved ones with Alzheimer's disease and other life-limiting illnesses, April 2007
- *The Need for Hospice Care in the African American Community*, full-day conference, October 27th, 2012
- *African Americans & End-of-Life Care*, full-day conference, November 19, 2013
- "Care for the Caregiver," Mt. Calvary Baptist Church, Rockville, workshop at an African American church, April 18, 2015
- *Different Voices, Shared Journeys: Providing Culturally Sensitive Care*, full-day conference, September 24, 2015

13. The application states that MH is "large enough to meet that annual need entirely, without additional providers," and that it "has developed its project budget and assumptions to meet the entire need once it achieves full utilization."

In a meeting with CON Chief Kevin McDonald on December 19, Montgomery Hospice representatives pointed out that this item is not phrased as a question, and requested clarification of MHCC staff's question. No further details were provided in time for inclusion in this Completeness Response.

C) Availability of More Cost-Effective Alternatives

14. MH states that it "anticipates a rapid and cost-effective start to providing service in the county, because it already operates in the county directly adjacent, and has extensive relationships with local providers and referral sources that can easily cross the county's borders." Given those advantages, and the economies of scale to be expected, please explain why MH suggests that it needs to be the sole entrant, requiring such high volumes, over $2 million in working capital, and 3 years before reaching profitability?

Montgomery Hospice has been a successful hospice provider in Maryland in the county adjoining Prince George's County since the beginning of the Medicare Hospice Benefit in 1983. In preparing the budgets and volume forecasts used in its application for a CON to serve that county, it has relied upon its decades of experience serving a population that is diverse racially, ethnically and economically.

It is clear from the continued low levels of service in Prince George's County that the actions and strategies of existing providers to date have been inadequate to "move the needle" and effectively increase the level of hospice service in that community. In 2015, despite ongoing

pressure from regulators on existing hospice providers, the number of hospice patients served in the county declined, rather than grew.

Montgomery Hospice leadership believes that in order to substantially increase acceptance and use of hospice in a community that has been underserved for so long, a significant upfront investment will be required in the early years of its service in the new jurisdiction. Success requires early investment in both clinical staffing and public outreach and education. Montgomery Hospice expects that investment will not be fully offset by patient revenue, at least at first. The effort to change public attitudes and to increase public acceptance of hospice will take time and a demonstrated commitment to service over the long term, and could well require multiple years to effect significant change. For that reason, Montgomery Hospice, a non-profit organization dedicated to public service, accepts that it will spend more than it will receive in billings for hospice care in the early years of the project.

In addition to the need for investment in outreach and education, Montgomery Hospice understands that the demographics of Prince George's County differ from its home service area in some important ways. Budget forecasts and staffing ratios have been developed with the assumption that referrals to hospice may occur later in the course of a patient's illness, and also that the condition of those patients may be more acute, requiring more expensive services. In recognition of this likelihood, Montgomery Hospice has built in an assumption for shorter lengths of stay and higher acuity of patient symptoms than for its patient population in Montgomery County.

Montgomery Hospice stands by its original budget and volume forecast in the belief that a high investment of effort, staffing and funding will be necessary to substantially increase hospice use in Prince George's County. That investment will ultimately pay dividends in the form of increased utilization of hospice throughout the county, but even after the first years of the project, larger patient volumes will be needed to help support ongoing investments in high-quality service.

D) Viability of the Proposal

15. The MH application states: "management's analysis makes clear that it is essential that the Maryland Health Care Commission should grant only one new CON during this round of review. The financial projections built into Montgomery Hospice's plans for the project assume that all existing hospice providers will continue to grow at their historic rates, and that all unmet need will therefore be available as potential hospice patients for the expansion of Montgomery Hospice into the new jurisdiction. Montgomery Hospice will be using reserves built through years of generous community contributions and efficient management, and believes that if it would be required to compete with one or more new hospice providers in addition to the existing eight approved providers, it would negatively affect the viability of the proposal." We have several questions probing that statement, immediately below.

    a) If this is true, how do the other hospices operating there manage to service such lower numbers and stay above water?

b) Does this statement imply that if another provider is also approved, MH would not be interested in providing services in Prince George's County?
c) Please provide an alternative operating budget (Tables 3 and 4) in which MH meets less than the total need (MH may choose its assumptions regarding proportion of need it might fill. It might make sense to model a scenario showing the minimum volume it would consider as feasible.

a)

The assumptions used by Montgomery Hospice in preparing the budgets and volume forecasts for its CON application build in an expectation of relatively low caseloads for the clinical staff, which is appropriate for a patient population expected to exhibit shorter lengths of stay and more-acute health conditions. In addition, the expense structure submitted in the original application assumes high investment in outreach and public education. Montgomery Hospice expects that in order to increase service to currently under-served populations beyond the levels now seen in that community a greater upfront investment will be necessary than would be required to serve populations already likely to accept and use hospice service at the end of life. (Please reference the response above to Question 14.) If such investment were not made, costs would naturally be lower, and hospice utilization would also continue to be low.

Montgomery Hospice also suspects that there may be a risk of "cherry picking" of naturally low-cost patients by hospices that are not well-equipped or funded to accept patients regardless of their health status or ability to pay. It is well established by independent research that patients with certain diagnoses (such as Alzheimer's Disease, Dementia and Parkinson's), cost less to care for than other populations.[1] It has also been demonstrated that patients residing in nursing homes and assisted living facilities have longer lengths of stay than patients who receive care at home, that longer lengths of stay are associated with higher profit margins, and further that both long lengths of stay and higher profit margins are more typical of for-profit providers.[2] Montgomery Hospice has written its budgets and business plans to permit it to care for patients with all levels of need, in all kinds of living situations.

b)

Montgomery Hospice did not mean to imply that if another provider is also approved that it would not wish to serve Prince George's County. The board of directors of Montgomery Hospice has fully committed to extending service to the neighboring county if approved, regardless of the Commission's decision regarding the number of providers to approve. However, the application section referenced related to "viability", not intent, and

[1] For reference, see Abt Associates Inc., *Medicare Hospice Payment Reform: Analysis of How the Medicare Hospice Benefit is Used* (HHSM-500-2005-00018I), Cambridge, MA, December 3, 2015, pages 24-27 and 30. This study was commissioned by the U.S. Department of Health and Human Services as mandated by the ACA of 2010.
[2] MedPAC, *June 2016 Data Book: Health Care Spending and the Medicare Program*, Medicare Payment Advisory Commission, Washington, DC, June 2016. "Section 11 Other Services: Dialysis, Hospice, Clinical Laboratory" includes a discussion of the relationship between hospice profit margins, hospice tax status, lengths of stay and certain patient characteristics, such as residence location and diagnosis. As a result of differing patterns of care, the average For-profit Medicare hospice margin in 2013 was **14.7%**, while the average Nonprofit hospice margin was **1.2%**. See pages 189-192; the complete document may be accessed at http://medpac.gov/documents.

Montgomery Hospice leadership does believe that fewer providers will positively affect the viability of the proposal, while a larger number approved will affect it negatively.

c)

As requested, Montgomery Hospice has developed an alternative operating budget which meets less than the total need, projecting an average daily census of 105 in year 2020, rather than the original projected census of 150 in that year. At that census level, if Montgomery Hospice maintains its anticipated clinical staff caseloads and outreach efforts, Montgomery Hospice projects an operating loss for the project through Year 4. This is true even recognizing that there would be somewhat-reduced requirements for clinical staff, equipment and medical supplies. Please see both the Alternative Budget and Original Proposal below for comparison purposes.

Table 3: Alternate Budget with Average Daily Census of 105 in Year Four (2020)

	Two Most Recent Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (circle)	2014	2015	2016	2017	2018	2019	2020
1. Revenue							
a. A. Inpatient services	2,904,957	2,947,459	3,159,784	3,566,608	3,848,690	4,067,413	4,324,351
b. Hospice at home services	19,116,426	20,654,590	22,830,425	25,503,206	28,106,435	30,099,401	32,441,517
c. Home care services							
d. Gross Patient Service Revenue	22,021,382	23,602,050	25,990,208	29,069,814	31,955,125	34,166,814	36,765,868
e. Allowance for Bad Debt	-306,853	-452,465	-320,354	-423,025	-479,327	-512,502	-551,487
f. contractual Allowance	-421,717	-447,377	-534,888	-634,651	-694,313	-740,364	-794,330
g. Charity Care	-407,481	-467,316	-711,133	-988,275	-1,102,508	-1,219,973	-1,361,113
h. Net Patient Services Revenue	20,885,331	22,234,892	24,423,833	27,023,863	29,678,977	31,693,975	34,058,938
i. Other Operating Revenues (Specify)	13,119	13,307	9,470	50,600	72,392	94,924	118,540
j. Net Operating Revenue	20,898,450	22,248,199	24,433,303	27,074,463	29,751,369	31,788,899	34,177,478
2. Expenses							
a. Salaried, Wages, and Professional Fees, (including fringe benefits)	16,951,065	17,434,086	19,437,009	22,869,247	24,501,151	25,825,390	27,319,551
b. Contractual Services	2,116,675	2,188,018	2,340,168	2,927,059	3,446,508	3,840,273	4,307,045
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation	344,425	298,115	229,124	227,256	228,392	229,534	230,682
f. Project Depreciation				25,000	25,000	35,000	40,000
g. Current Amortization							
h. Project Amortization							
i. Supplies	563,611	481,403	554,444	638,290	701,858	752,536	810,347
j. Other Expenses (Specify)	2,640,451	2,339,941	2,449,563	3,072,606	3,280,142	3,485,333	3,776,649
k. Total Operating Expenses	22,616,228	22,741,563	25,010,307	29,759,458	32,183,051	34,168,066	36,484,275
3. Income							
a. Income from Operation	-1,717,778	-493,364	-577,003	-2,684,995	-2,431,681	-2,379,166	-2,306,797
b. Non-Operating Income	2,601,422	1,893,693	1,878,103	1,983,126	2,171,811	2,301,912	2,452,824
c. Subtotal	883,644	1,400,329	1,301,099	-701,869	-259,870	-77,254	146,027
d. Income Taxes	0	0	0	0	0	0	0
e. Net Income (Loss)	883,644	1,400,329	1,301,099	-701,869	-259,870	-77,254	146,027

Table 3 Cont.	Two Most Recent			Projected Years			
	Recent Years -- Actual		Current Year Projected	(ending with first full year at full utilization)			
CY or FY (circle)	2014	2015	2016	2017	2018	2019	2020
4. Patient Mix							
A. As Percent of Total Revenue							
1. Medicare	84.3%	86.3%	84.4%	85.2%	84.6%	84.3%	83.9%
2. Medicaid	1.0%	1.3%	1.4%	1.7%	1.9%	2.0%	2.1%
3. Blue Cross	4.5%	5.0%	6.1%	5.1%	5.1%	5.0%	5.0%
4. Other Commercial Insurance	8.0%	5.4%	5.5%	4.5%	4.7%	4.8%	4.9%
5. Self-Pay	0.2%	0.1%	0.2%	0.2%	0.3%	0.3%	0.3%
6. Other (Specify)	1.9%	2.0%	2.4%	3.2%	3.5%	3.6%	3.7%
7. Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. As Percent of Patient Days/Visits/Procedures(as applicable)							
1. Medicare	85.3%	87.5%	86.0%	85.1%	84.6%	84.2%	83.9%
2. Medicaid	1.2%	1.2%	1.5%	1.7%	1.9%	2.0%	2.1%
3. Blue Cross	7.5%	4.8%	5.3%	5.2%	5.2%	5.1%	5.1%
4. Other Commercial Insurance	4.0%	4.8%	4.2%	4.7%	4.9%	5.1%	5.2%
5. Self-Pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6. Other (Specify)	2.0%	1.8%	3.0%	3.3%	3.5%	3.6%	3.7%
7. Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Sec. 1, line i includes Revenue from community Bereavement service and conference, advance care planning (starting 2017)

Sec. 2 line j includes program expenses of Volunteer and Bereavement services, Community Education expenses, Facility Cost of Casey House and

Sec. 3 line b includes Philanthropy and Investment income, net of fund raising expenses

Sec. 4 line A6 includes indigent care

Sec. 4 line B6 includes indigent care

Table 4: Alternate Budget with Average Daily Census of 105 in Year Four (2020)

New Budget, Lower Census	Projected Years			
	(with census of 105 in 2H of year 2020)			
CY or FY (circle)	2017	2018	2019	2020
1. Revenue				
a. A. Inpatient services	211,396	443,150	600,573	795,108
b. Hospice at home services	1,504,080	3,153,197	4,273,631	5,658,319
c. Home care services				
d. Gross Patient Service Revenue	1,715,476	3,596,347	4,874,204	6,453,427
e. Allowance for Bad Debt	-25,732	-53,945	-73,113	-96,800
f. contractual Allowance	-34,310	-71,928	-97,484	-129,068
g. Charity Care	-120,084	-251,745	-341,195	-451,740
h. Net Patient Services Revenue	1,535,350	3,218,729	4,362,412	5,775,819
i. Other Operating Revenues (Specify)				
j. Net Operating Revenue	1,535,350	3,218,729	4,362,412	5,775,819
2. Expenses				
a. Salaried, Wages, and Professional Fees, (including fringe benefits)	1,422,720	2,313,884	2,875,161	3,583,471
b. Contractual Services	391,348	772,981	1,042,023	1,372,444
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation	25,000	25,000	35,000	40,000
g. Current Amortization				
h. Project Amortization				
i. Supplies	32,147	62,771	83,635	108,852
j. Other Expenses (Specify)	870,094	1,064,817	1,257,131	1,535,506
k. Total Operating Expenses	2,741,309	4,239,453	5,292,950	6,640,274
3. Income				
a. Income from Operation	-1,205,959	-1,020,723	-930,537	-864,455
b. Non-Operating Income	130,000	260,000	350,000	460,000
c. Subtotal	-1,075,959	-760,723	-580,537	-404,455
d. Income Taxes				
e. Net Income (Loss)	-1,075,959	-760,723	-580,537	-404,455

Table 4 Cont.	Projected Years			
	(ending with first full year at full utilization)			
CY or FY (circle)	2017	2018	2019	2020
4. Patient Mix				
A. As Percent of Total Revenue				
1. Medicare	75%	75%	75%	75%
2. Medicaid	5%	5%	5%	5%
3. Blue Cross	4%	4%	4%	4%
4. Other Commercial Insurance	8%	8%	8%	8%
5. Self-Pay	1%	1%	1%	1%
6. Other (Specify)	7%	7%	7%	7%
7. Total	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures(as applicable)				
1. Medicare	75%	75%	75%	75%
2. Medicaid	5%	5%	5%	5%
3. Blue Cross	4%	4%	4%	4%
4. Other Commercial Insurance	9%	9%	9%	9%
5. Self-Pay		0%	0%	0%
6. Other (Specify)	7%	7%	7%	7%
7. Total	100%	100%	100%	100%

Sec. 2 line j includes program expenses of Volunteer and Bereavement services, Community Education
Sec. 3 line b includes Philanthropy income (net of fund raising expenses)
Sec. 4 line A6 includes indigent care
Sec. 4 line B6 includes indigent care

Table 3: Original Budget with Average Daily Census of 150 in Year Four (2020)

	Two Most Recent Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (circle)	2014	2015	2016	2017	2018	2019	2020
1. Revenue							
a. A. Inpatient services	2,904,957	2,947,459	3,159,784	3,622,095	4,056,033	4,546,687	4,751,969
b. Hospice at home services	19,116,426	20,654,590	22,830,425	25,898,001	29,581,764	33,509,885	35,484,647
c. Home care services							
d. Gross Patient Service Revenue	22,021,382	23,602,050	25,990,208	29,520,096	33,637,797	38,056,572	40,236,616
e. Allowance for Bad Debt	-306,853	-452,465	-320,354	-429,779	-504,567	-570,849	-603,549
f. contractual Allowance	-421,717	-447,377	-534,888	-643,656	-727,966	-818,160	-863,746
g. Charity Care	-407,481	-467,316	-711,133	-1,019,794	-1,220,295	-1,492,255	-1,604,065
h. Net Patient Services Revenue	20,885,331	22,234,892	24,423,833	27,426,867	31,184,969	35,175,308	37,165,256
i. Other Operating Revenues (Specify)	13,119	13,307	9,470	50,600	72,392	94,924	118,540
j. Net Operating Revenue	20,898,450	22,248,199	24,433,303	27,477,467	31,257,361	35,270,232	37,283,796
2. Expenses							
a. Salaried, Wages, and Professional Fees, (including fringe benefits)	16,951,065	17,434,086	19,437,009	23,380,771	25,380,157	27,599,866	28,940,589
b. Contractual Services	2,116,675	2,188,018	2,340,168	3,029,781	3,808,172	4,671,835	5,045,161
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation	344,425	298,115	229,124	227,256	228,392	229,534	230,682
f. Project Depreciation				25,000	25,000	35,000	40,000
g. Current Amortization							
h. Project Amortization							
i. Supplies	563,611	481,403	554,444	646,728	731,225	819,273	868,881
j. Other Expenses (Specify)	2,640,451	2,339,941	2,449,563	3,163,282	3,512,945	3,958,857	4,229,315
k. Total Operating Expenses	22,616,228	22,741,563	25,010,307	30,472,818	33,685,891	37,314,365	39,354,629
3. Income							
a. Income from Operation	-1,717,778	-493,364	-577,004	-2,995,352	-2,428,531	-2,044,133	-2,070,833
b. Non-Operating Income	2,601,422	1,893,693	1,878,103	2,013,126	2,281,811	2,571,912	2,692,824
c. Subtotal	883,644	1,400,329	1,301,099	-982,226	-146,720	527,779	621,991
d. Income Taxes	0	0	0	0	0	0	0
e. Net Income (Loss)	883,644	1,400,329	1,301,099	-982,226	-146,720	527,779	621,991

Table 3 Cont.	Two Most Recent		Current Year	Projected Years			
	Recent Years -- Actual		Projected	(ending with first full year at full utilization)			
CY or FY (circle)	2014	2015	2016	2017	2018	2019	2020
4. Patient Mix							
A. As Percent of Total Revenue							
1. Medicare	84.3%	86.3%	84.4%	85.0%	84.1%	83.3%	83.1%
2. Medicaid	1.0%	1.3%	1.4%	1.8%	2.0%	2.3%	2.4%
3. Blue Cross	4.5%	5.0%	6.1%	5.1%	5.0%	4.9%	4.9%
4. Other Commercial Insurance	8.0%	5.4%	5.5%	4.6%	4.9%	5.2%	5.2%
5. Self-Pay	0.2%	0.1%	0.2%	0.3%	0.3%	0.4%	0.4%
6. Other (Specify)	1.9%	2.0%	2.4%	3.3%	3.6%	3.9%	4.0%
7. Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. As Percent of Patient Days/Visits/Procedures(as applicable)							
1. Medicare	85.3%	87.5%	86.0%	84.9%	84.1%	83.3%	83.1%
2. Medicaid	1.2%	1.2%	1.5%	1.8%	2.1%	2.3%	2.4%
3. Blue Cross	7.5%	4.8%	5.3%	5.2%	5.1%	5.0%	5.0%
4. Other Commercial Insurance	4.0%	4.8%	4.2%	4.8%	5.1%	5.5%	5.6%
5. Self-Pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6. Other (Specify)	2.0%	1.8%	3.0%	3.3%	3.6%	3.9%	4.0%
7. Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Sec. 1, line i includes Revenue from community Bereavement service and conference, advance care planning (starting 2017)

Sec. 2 line j includes program expenses of Volunteer and Bereavement services, Community Education expenses, Facility Cost of Casey House and General Administrative expenses

Sec. 3 line b includes Philanthropy and Investment income, net of fund raising expenses

Sec. 4 line A6 includes indigent care

Sec. 4 line B6 includes indigent care

Table 4: Original Budget with Average Daily Census of 150 in Year Four (2020)

	Projected Years			
	(ending with first full year at full utilization)			
CY or FY (circle)	2017	2018	2019	2020
1. Revenue				
a. A. Inpatient services	266,883	650,493	1,079,847	1,222,726
b. Hospice at home services	1,898,875	4,628,526	7,684,115	8,701,449
c. Home care services				
d. Gross Patient Service Revenue	2,165,758	5,279,019	8,763,962	9,924,175
e. Allowance for Bad Debt	-32,486	-79,185	-131,460	-148,862
f. contractual Allowance	-43,315	-105,581	-175,280	-198,484
g. Charity Care	-151,603	-369,532	-613,477	-694,692
h. Net Patient Services Revenue	1,938,354	4,724,721	7,843,745	8,882,137
i. Other Operating Revenues (Specify)	0	0	0	0
j. Net Operating Revenue	1,938,354	4,724,721	7,843,745	8,882,137
2. Expenses				
a. Salaried, Wages, and Professional Fees, (including fringe benefits)	1,934,244	3,192,890	4,649,637	5,204,509
b. Contractual Services	494,070	1,134,645	1,873,585	2,110,560
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation	25,000	25,000	35,000	40,000
g. Current Amortization				
h. Project Amortization				
i. Supplies	40,585	92,138	150,372	167,386
j. Other Expenses (Specify)	960,770	1,297,620	1,730,655	1,988,172
k. Total Operating Expenses	3,454,669	5,742,293	8,439,249	9,510,628
3. Income				
a. Income from Operation	-1,516,315	-1,017,573	-595,504	-628,491
b. Non-Operating Income	160,000	370,000	620,000	700,000
c. Subtotal	-1,356,315	-647,573	24,496	71,509
d. Income Taxes				
e. Net Income (Loss)	-1,356,315	-647,573	24,496	71,509

Table 4 Cont.	Projected Years			
	(ending with first full year at full utilization)			
CY or FY (circle)	2017	2018	2019	2020
4. Patient Mix				
A. As Percent of Total Revenue				
1. Medicare	75%	75%	75%	75%
2. Medicaid	5%	5%	5%	5%
3. Blue Cross	4%	4%	4%	4%
4. Other Commercial Insurance	8%	8%	8%	8%
5. Self-Pay	1%	1%	1%	1%
6. Other (Specify)	7%	7%	7%	7%
7. Total	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures(as applicable)				
1. Medicare	75%	75%	75%	75%
2. Medicaid	5%	5%	5%	5%
3. Blue Cross	4%	4%	4%	4%
4. Other Commercial Insurance	9%	9%	9%	9%
5. Self-Pay		0%	0%	0%
6. Other (Specify)	7%	7%	7%	7%
7. Total	100%	100%	100%	100%

Sec. 2 line j includes program expenses of Volunteer and Bereavement services, Community Education expenses and General Administrative expenses

Sec. 3 line b includes Philanthropy income (net of fund raising expenses)

Sec. 4 line A6 includes indigent care

Sec. 4 line B6 includes indigent care

16. In the Project Budget, what is the nature of major and minor moveable equipment costing a total of $370,000? Provide an inventory.

Detail of major and minor movable equipment			
Office Renovation			50,000
Cubicles	1500	25	37,500
Conference room furniture and cables			15,000
IT Budget			
Laptops	2000	72	144,000
Desktop monitor	360	25	9,000
Laptops replaced every 3 years	2000	36	72,000
Cell phones	200	60	12,000
Air card	50	60	3,000
Phone apparatus	550	30	16,500
Voice and data cabling			6,500
Keri controller & Readers			4,600
Total			370,100

17. In Table 5, the Manpower Information, please confirm what year of implementation the Change in FTE column reflects.

Changes reported in Table 5 are over the life of the project, from Years 0 through 4.

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Ann Mitchell, MPH
CEO
Montgomery Hospice, Inc.

Date: 2/6/17

APPENDIX

Attachments to Completeness Response

for Montgomery Hospice in Prince George's County

CA1	Admission to Hospice – Criteria
CA2	Bereavement Care Planning Policy
CA3	Charity Care/Financial Aid Policy
CA4	Page 79 Handbook: Charity Care
CA5	Montgomery Hospice Q&A Brochure
CA6	Montgomery Hospice Financial Aid Application
CA7	CAHPS Reporting: December 2016
CA8	MH Performance Measurement Policies
CA9	QAPI Documentation Table
CA10	OHCQ Letter
CA11	Joint Commission Deemed Status Letter
CA12	Joint Commission Accreditation Letter
CA13	Montgomery Hospice Patient Rights
CA14	Montgomery Hospice Outreach Materials

ADMISSION TO HOSPICE - CRITERIA	Policy Number: PFC.A10
NHPCO Standard(s): PFC 2.1; IA 1.2; OE 2.1; CLR 2.2	
Regulatory Citation / Other:	

POLICY STATEMENT: Patients who meet the admission criteria are admitted to Montgomery Hospice regardless of race, sexual preference, age, handicap, sex, communicable disease or religion.

PROCEDURES:

1. During the referral process, hospice staff determine the patient's eligibility for hospice based on the following criteria:
    a. verbal or written certification by the patient's attending physician (if there is one) and the hospice Medical Director that the patient has a prognosis of 6 months or less if the disease follows its normal course;
    b. the patient resides in the geographic area served by the hospice program;
    c. the patient understands and accepts the palliative nature of hospice care and no longer seeks aggressive treatment;
    d. there is a capable primary caregiver living in the home or, if no caregiver is available, the patient agrees to assist the hospice in developing a plan of care to meet his or her future needs;
    e. the hospice has adequate resources and staffing to meet the needs of the patient; and
    f. the patient and/or caregiver wish to receive hospice services.

2. If it is determined that the patient does not meet the criteria for admission, reasons for non-acceptance are documented in the referral log and communicated to the referrer and patient/caregiver as appropriate.

3. Efforts are made to refer non-accepted patients to appropriate community resources or other health care providers.

BEREAVEMENT CARE PLANNING	Policy Number: PFC.B10
NHPCO Standard(s): PFC 17.1; PFC 19; PFC 19.1; PFC 19.3; PFC 19.4	
Regulatory Citation / Other: 42 CFR 418.54(c)(7) and 418.64(d)(1)(iv)	

POLICY STATEMENT: A bereavement care plan is developed for identified family members and other involved individuals after the patient's death.

PROCEDURES:

1. During the initial bereavement assessment, the IDG identifies family members, caregivers, or significant others who may be significantly impacted by the patient's death. The initial bereavement assessment is updated during IDG meetings throughout the course of the patient's care.

2. The Bereavement Counselor is notified of all deaths. The IDG notifies the Bereavement Counselor of any and all significant dynamics that happened at the death.

3. The bereavement plan of care reflects the assessed needs of the bereaved and notes the kind of bereavement services to be offered and the frequency of delivery.

4. The Bereavement Counselor ensures that the bereavement plan of care is followed for thirteen (13) months following the patient's death, appropriate to the level of need assessed.

5. Bereavement services listed in a patient's bereavement plan of care may include, but are not limited to: bereavement visits and counseling, referrals to community resources, mailings and/or telephone contact.

6. Support groups, community education, and/or additional bereavement services are provided on an as needed basis.

7. A Memorial Service is offered annually.

CHARITY CARE / FINANCIAL AID	Policy Number: 8-006
NHPCO Standard(s):	
Regulatory Citation(s):	

PURPOSE

To identify the criteria to be applied when enrolling patients for charity care or fee for service.

POLICY

Patients without third-party payer coverage and who are unable to pay out of pocket for hospice care will be accepted for financial assistance after completing a Financial Assistance Application.

Patients who reach the private insurance cap with third-party payer coverage will be accepted for financial aid.

PROCEDURE

1. No admission will be delayed during the determination to provide financial assistance.

2. When it is identified that the patient has no source for payment of services or has reached the limit of benefits with a private insurance and requires hospice care, the determination for the provision of a fee-for-service or charity care will be made. The Director of Finance and Chief Financial Officer will review all applicable patient information and discuss determination with social worker.

3. Financial Assistance would include staff visits, 24 hour availability of On Call support, durable medical equipment and basic medical supplies and medication. Montgomery Hospice will use every resource available to ensure patients in need of financial aid will have the same care other patients receive. A social worker will meet with the patient to determine potential eligibility for financial assistance from other community resources and to explore other avenues of support.
   In the case of patients with private insurance, the Supervisor of Billing and Reimbursement will arrange for direct payment of contracted services like medications and durable medical equipment if such benefit is available.

4. The final determination for Financial Assistance should be documented in the Medical Record. The Financial Assistance Application and accompanying documentation shall be kept with the patient's financial record.

5. The Financial Assistance assessment will be completed within two business days following a patient's request for charity care services.

6. If the patient becomes no longer medically eligible for hospice care and needs to be discharged, the social worker will include appropriate referrals to possible community resources as part of the discharge plan.

Respite

Montgomery Hospice at Home patients covered by either Medicare or Medical Assistance can stay in a nursing home with which hospice has a contract for up to five days for respite when caregivers at home need time off from care giving. The payment per day from Medicare or Medicaid goes directly to the nursing home.

Continuous Care

This level of care is provided to patients who may need care up to 24 hours a day to maintain the patient at home during a pain or symptom crisis. The care provided is predominately nursing care to manage pain or other symptoms and is for a brief period of time until the crisis is resolved. When the symptoms are managed the patient resumes the previous level of routine home care.

Cost, Benefits Coverage and Pre-authorization

As a licensed and certified provider of hospice care, Montgomery Hospice is able to bill Medicare, Medicaid and insurance carriers such as Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs), Managed Care Organizations (MCOs) and traditional fee-for-service companies.

If there is no coverage for hospice services, the patient will be billed on a fee-for-service basis, which means there is a charge for each visit, as well as for supplies and medications.

Before any care is provided, a Montgomery Hospice representative will review charges for services and payment arrangements. You will be asked to sign the admission checklist and consent form stating that you have received this explanation. Signing this form also allows Montgomery Hospice to bill the insurance company and obtain medical and billing records concerning your condition.

If you have problems paying our charges, please ask your hospice social worker to evaluate the situation. No person will be denied essential service because of inability to pay.

Montgomery HOSPICE

Montgomery Hospice: what we do and how we help

What is hospice?

Hospice is care that focuses on medical and personal comfort for people living with a life-limiting illness.

Hospice care helps patients with physical symptoms like pain or nausea. Hospice staff members also comfort patients, families and friends by helping them feel emotionally and spiritually at peace. They work together with patients and families to bring dignity and well-being to anyone affected by illness and loss.

What is Montgomery Hospice?

Montgomery Hospice is a nonprofit organization that has been providing hospice care to people in Montgomery County for 30 years. We are the largest hospice in the county. Besides hospice services, we provide professional grief support for anyone who lives in the county. In 2010, Montgomery Hospice cared for more than 1,900 patients and their families, and provided grief education and support to 7,900 Montgomery County residents.

Who is Montgomery Hospice?

The people of Montgomery Hospice are professionals and volunteers who work together as a team to meet the needs of our neighbors who are living with a terminal illness. The professionals include doctors, nurses, nurse practitioners, spiritual counselors (chaplains), social workers, certified nursing assistants and grief counselors.

Is Montgomery Hospice a part of the Montgomery County government?

No.

Is Montgomery Hospice affiliated with a religious group?

No.

Whom does Montgomery Hospice care for?

Montgomery Hospice helps our seriously ill neighbors in Montgomery County who have decided (after talking with their doctors) to concentrate on living their lives as fully as possible rather than aggressively fighting a disease.

Is hospice only for people with cancer?

No.

Montgomery Hospice can help patients with any illness (including cancer, dementia, heart disease and others).

Do patients pay for hospice?

No.

Hospice services are paid for by:

- Medicare
- Medicaid
- most private insurance companies, or by
- Montgomery Hospice. We care for patients without insurance or any other way to pay.

Why do patients choose hospice?

Patients choose hospice when it becomes clear that a cure is no longer likely, and they want comfort care so they can live as fully as possible until the end of life. For some patients, hospice can be an alternative to staying in – or returning to – a hospital.

Where do patients receive hospice care?

Montgomery Hospice usually cares for patients and families in their own homes, wherever they live. Besides houses and apartments, we care for patients in assisted living facilities and nursing homes, and also at Casey House, the only health care facility in Montgomery County exclusively designed for hospice patients.

What services are provided by Montgomery Hospice?

- Expert pain and symptom relief
- Medications
- Medical equipment, such as oxygen, wheelchairs, walkers and hospital beds
- Medical supplies
- Nurses available by phone 24 hours a day, 7 days a week
- Assistance with patient personal care
- Grief support

Who cares for the patient?

The team of people that work together to care for the patient includes doctors, nurses, certified nursing assistants, social workers, spiritual counselors (chaplains) and volunteers.

Will the Montgomery Hospice doctor visit the patient?

Yes. If necessary, the Montgomery Hospice doctor will visit a patient's home.

What do Montgomery Hospice nurses do?

The nurses visit patients regularly to see how they are doing, teach caregivers how to take care of their loved ones, and coordinate the visits of other Montgomery Hospice team members.

What is a certified nursing assistant?

A certified nursing assistant is a trained nursing aide who has passed a state certification exam. Our CNAs visit patients periodically to help with things such as bathing and making sure patients can move around safely.

What does the Montgomery Hospice social worker do?

Montgomery Hospice social workers help patients and families learn coping skills and ways to keep patients comfortable in their homes. They also can help patients and families with difficult conversations or to work on practical tasks, such as arranging for help with chores.

What does a chaplain do?

For patients who are interested, Montgomery Hospice spiritual counselors (chaplains) are available to talk about spiritual concerns. Our chaplains help people find comfort and answers that fit their own beliefs. Chaplains offer spiritual support to people of any faith background, or no faith background, and help people find their own answers.

What do Montgomery Hospice volunteers do?

After a thorough three-day training, volunteers help in a variety of ways such as visiting with patients so caregivers can take a break, giving soothing hand massages to ease stress, running errands or helping patients and families with email, letters or memoirs. Volunteers are required to attend ongoing training during the year.

How are decisions made about the care of the patient?

Montgomery Hospice respects and honors the wishes of our patients. Their priorities guide us.

Are patients' family doctors still involved when a patient chooses hospice?

Yes. Patients can keep their own doctors while receiving hospice care.

Do Montgomery Hospice patients have to stop all medications?

No.

What happens if a hospice patient has an accident and breaks a leg, would that break be treated?

Yes.

Does hospice hasten death?

No. In some cases, hospice helps patients live longer.

What should patients or families do if they are considering hospice care, or if they have questions about hospice?

- Ask their doctor to discuss all their options, which may include hospice care
- Call Montgomery Hospice for information or ask us to visit them to provide information
- Call Montgomery Hospice back with more questions. Montgomery Hospice wants families to fully understand their options and will respect any decision made.

Can patients who sign up for hospice care change their mind?

Yes. Patients can stop hospice care whenever they want, for whatever reason.

Do patients ever leave hospice care?

Yes. Some patients improve and leave hospice.

What is Casey House?

Casey House is a warm, home-like facility designed for hospice patients. Patients who cannot be cared for at home may go to Casey House to get symptoms under control. Casey House also has doctors, nurses, certified nursing assistants, social workers, chaplains and volunteers.

How is Casey House different from other facilities?

Casey House has a highly skilled team of professionals who are experts in end-of-life care. Patients have private bedrooms with personal bathrooms. Adult, children and pet visitors are welcome 24 hours a day.

What is grief? What is bereavement? How does Montgomery Hospice help?

Grief is the intense feeling of sadness felt after the death of a loved one. The word "bereavement" is very similar, referring to that period of sadness. Montgomery Hospice has counselors with advanced professional degrees who support families for 13 months after their loved one dies. This free support includes phone counseling, groups, workshops and mailings.

How does Montgomery Hospice help the community with grief?

Montgomery Hospice support groups and workshops are free to anyone who lives in Montgomery County. Montgomery Hospice also provides education about grief to community groups, to employees in the workplace, and to students in high schools.

Montgomery HOSPICE

301-921-4400
www.montgomeryhospice.org

Patient Name _____ **Rec #** _____

Does the patient / family have a financial need?

***Please attach copy of Face sheet, Medication List, DME List**

See Resource Manual for related information

For specific needs, follow the options below and eliminate each possibility before moving on to the next step.

INSURANCE

Patient has no insurance, or inadequate insurance

☐ How have the Patient's medical bills been covered so far?
Specify: .....

☐ Is Patient a legal resident? (Has bearing on available resources)
☐ **Yes** ☐ **No**

☐ Is insurance available through another family member or employer
☐ **Yes** ☐ **No**
If Yes, specify: .....

☐ Is Patient eligible for **MEDICAID** - Community or LTC (Different Inc limits)
☐ **Community** ☐ **LTC**

☐ Explore Financial assistance available through **MCDHHS**
Specify: .....

☐ Financial assistance through other organizations:
Red Cross ☐ Yes ☐ No ☐ N/A
Salvation Army ☐ Yes ☐ No ☐ N/A
Church/Mosque/Synagogue ☐ Yes ☐ No ☐ N/A
Specify: .....
Other community organizations
Specify: .....

☐ Does Patient have **Long Term Care Insurance**?
☐ Yes ☐ No ☐ N/A

DME NEEDS

Patient needs medical equipment or supplies

☐ **Is the patient a Veteran?**
☐ Yes ☐ No ☐ N/A

☐ **Holiday Park Multiservice Senior Center**
☐ Yes ☐ No ☐ N/A

☐ **ALS Society**
☐ Yes ☐ No ☐ N/A

☐ **MS Society**
☐ Yes ☐ No ☐ N/A

☐ **American Cancer Society**
☐ Yes ☐ No ☐ N/A

CARE NEEDS

Patient needs help with food, housing, caregivers

☐ **Food and Friends / Meals on Wheels / Manna Foods** (groceries)
☐ Yes ☐ No ☐ N/A

☐ Emergency assistance through the county for housing or utility shut off
☐ Yes ☐ No ☐ N/A

☐ In Home Aide Support with MCDHHS - Sliding scale CNA's
☐ Yes ☐ No ☐ N/A

☐ Placement in a nursing home or other type of facility
☐ Yes ☐ No ☐ N/A

☐ Respite care with Montgomery County - ARC
☐ Yes ☐ No ☐ N/A

MEDICATION NEEDS

See list on attached facesheet

If a citizen, without insurance, they can apply for

☐ **Medicare Part D**

☐ **Maryland Pharmacy Assistance** (< $1,000 income for single person)

☐ **MEDBANK** (Financial Need, Clearinghouse for pharmaceutical companies)

☐ Individual Pharmaceutical companies

If NOT a legal resident, without insurance, try

☐ **MEDBANK**

☐ **FISH / HELP -**Also helps with emergency funds

Summary of Unresolved Issues: .....

.....

.....

If these steps do not alleviate the need, continue to explore community resources and collaborate with the Vice President of Social Work

If financial assistance is needed, complete the Financial Assistance Application
Please submit to the Director of Admissions

Financial Assistance Application

*Complete highlighted fields and attach Face Sheet

Page 2

Patient Name:		Date:	

Current MH Status: ☐ New Admit ☐ Hospice At Home ☐ Casey House

Household Monetary Income

GUIDELINES:

-Include pre-tax monetary income from all related household members
- Types of income listed below.
- Do not include Noncash benefits, such as Food Stamps or Housing Subsidies
- If unsure about nature of income, ask
- Poverty thresholds are indexed to size of household, age of patient and updated annually to adjust for inflation. They are not adjusted regionally.

Members of Household:

Patient:		**Age:**	
Spouse:		**Age:**	
Member:		**Age:**	

Please show relationship to patient (spouse, child, parent, etc.)

Household Size: **Include all family members living in home**

Sources of Monthly Income

All are Pre-Tax, Monthly Amounts

	Patient	Spouse	Family Member
Monthly Wages			
Unemployment Compensation			
Workers' Compensation			
Social Security			
Supplemental Security Income			
Public Assistance			
Veteran's Payments			
Survivor Benefits			
Pension or Retirement Income			
Interest and/or Dividends			
Rents and/or Royalties			
Income from Trusts and/or Estates			
Alimony and/or Child Support			
Support from outside the household			
Miscellaneous			

	Annual Family Income (A)
#DIV/0!	Sliding Scale Discount

Monthly Expenses

Indicate your monthly household expenses for the following:

	Household
Food	
Utilities (gas, electric, water)	
Auto, gas, or transportation costs (Bus/Metro fares)	
Telephone	
Child Care	
Prescription Drug Costs (all family members)	
Other Healthcare or Dental expenses	
Other - Describe:	
Other - Describe:	

Attach an additional sheet if necessary

	Total Monthly Expenses (B)

Creditors

Indicate the amount of all monthly payments and to whom they are made

* Documentation required		Household
Rent / Mortgage*		
Insurance (Auto)*		
Insurance (Other)*	Met Life	
Other Payment *- Describe:	Health Insurance	
Other Payment *- Describe:	Car Note	
Other Payment *- Describe:		

	Total Monthly Creditors (C)

Assets

	Patient	Spouse	Family Member
Bank Accounts:			
Savings			
Checking			
Other			
Stocks & Bonds			
IRA / Retirement Funds			
Life Insurance (Cash Value)*			
(Face Value)*			
Real Estate (other than homestead property):			
Home Value _____ (a)			
Mortgage Amount _____ (b)			
Home Equity _____ (a - b) →			
Trust			
Vehicles			
Other - Describe:			
TOTAL ASSETS			

	Total Assets

Total Family Monthly Income		(A)
Total Monthly Expenses	minus	(B+C)
Marginal Disposable Income	equals	

Required Supporting Documents:

_____ **Bank Statements**
_____ **Pay Stubs**
_____ **Receipts**
_____ **Latest Federal Income Tax Return Filed**

I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY MH AND SUBJECT TO REVIEW BY OTHERS AS REQUIRED. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Patient Signature **Date:**

Printed Name of Person Completing Form
(if other than patient)

Eligibility Criteria for the MH Financial Assistance Program

Based upon Federal Poverty Guidelines, Gross Income Levels, 2015

Family Size	Family Income	150% Guideline	300% Guideline
1		$17,655	$35,310
2		$23,895	$47,790
3		$30,135	$60,270
4		$36,375	$72,750
5		$42,615	$85,230
6		$48,855	$97,710
7		$55,095	$110,190
8		$61,335	$122,670

150% Test

Is Family Income greater than amount in 150% Guideline column?

NO Then patient qualifies for a full write-off of charges

YES Go to Sliding Scale Test

SLIDING SCALE CALCULATION

Over Income Amount	150 % Guideline	300 % Guideline
0		

Sliding Scale Discount	#DIV/0!

Calculation Process:

- If patient is at or below the 150% guideline, they will receive a full write-off of charges

- If a patient exceeds the 150% guideline, but does not exceed the 300% guideline, a sliding scale will be used to determine the percent reduction that will apply.

Formula:

Family Income - 150% Guideline = Over Income Amount

(1 - Over Income Amount / (300% Guideline - 150% Guideline)) x 100 = Percent Reduction

Example 1: A patient with a family size of 4, with income of $21,458 would be eligible for a **full write-off of their bill.**

Example 2: A patient with a family size of 7 with actual income of $60,000 would be eligible for a **63% reduction**.

$60,000 - $43,695 = $16,305

(1 - $16,305 / ($87,390 - $43,695)) x 100 = 63% Reduction

CAHPS

Reported December 2016

Please Note: August and September responses are still "open" and may be subject to change.

RETURN RATE

2016 (January – September)

MH return rate 33%

Deyta national rate 32%

RATING OF CARE

Rating of patient care (9/10 and 10/10)

2016 MH 82%

Deyta national avg 85%

Would recommend Montgomery Hospice

2016 MH 88% (Jan – Sept (Aug and Sept still "open")

Deyta national avg 87%

January through September 2016

Received help as soon as wanted

	MH	Deyta National
Always	77%	72%
Usually	18%	22%
Sometimes	3%	5%
Never	1%	1%

Provided training about if/when to give more pain medication

	MH	Deyta National
Yes, definitely	77%	81%
Yes, somewhat	15%	12%
No	8%	7%

Patient received help for trouble breathing

	MH	Deyta National
Always	71%	75%
Usually	22%	15%
Sometimes	7%	10%

Amount of religious/spiritual support for caregiver

	MH	Deyta National
Right Amount	95%	94%
Too Little	3%	5%
Too Much	2%	1%

Amount of emotional support in weeks after death

	MH	Deyta National
Right Amount	88%	87%
Too Little	8%	10%
Too Much	4%	1%

Amount of help received from volunteers

	MH	Deyta National
Less Than Wanted	5%	4%
Right Amount	91%	95%
More Than Was Wanted	4%	1%

PERFORMANCE MEASUREMENT (PA)

TABLE OF CONTENTS

PATIENT / CAREGIVER SATISFACTION	Policy Number: PM.P10
NHPCO Standard(s): PM 5; PM 5.1; PM 5.3	
Regulatory Citation(s):	

POLICY STATEMENT: Montgomery Hospice routinely collects data related to patient/ caregiver satisfaction with the care and services provided in order to identify performance improvement opportunities.

PROCEDURES:

1. The CAHPS is used to collect data related to the patient's and family's experience of the care provided by the hospice.

2. The survey is sent to primary caregivers (by a contracted vendor) who were cared for by the hospice program according to CMS Guidelines.

3. Surveys results are reviewed by the QAPI Committee and the results are analyzed and aggregated to identify trends and issues.

4. Performance improvement opportunities are identified from the data and performance improvement projects are initiated when appropriate.

5. Data from CAHPS is used for benchmarking purposes and is analyzed in conjunction with state and national initiatives.

QAPI - BENCHMARKING	Policy Number: PM.Q10
NHPCO Standard(s): PM 6; PM 6.1; PM 6.2; OE 3.2	
Regulatory Citation(s):	

POLICY STATEMENT: To further the goals of the hospice industry and evidence-based research, Montgomery Hospice participates in the development, collection and submission of hospice benchmark data.

PROCEDURES:

1. The QAPI Committee determines which data are most appropriate for submission to state and national benchmark initiatives.

2. Mechanisms for the collection of appropriate data are developed and implemented.

3. Members of the QAPI Committee review and incorporate standardized and validated tools to measure outcomes.

4. The results of internal data collection are analyzed in order to identify performance improvement initiatives.

5. The results of data analyses by state and national initiatives are reviewed and utilized by the QAPI Committee to determine the position of Montgomery Hospice with respect to the data and to identify performance improvement activities as appropriate.

QAPI – PERFORMANCE IMPROVEMENT ACTIVITIES AND PROJECTS	Policy Number: PM.Q15
NHPCO Standard(s): PM 3; PM 3.1; PM 3.2; PM 3.3; PM 7; PM 7.1; PM 7.2	
Regulatory Citation(s): 42 CFR 418.58(c); 418.58(d)	

POLICY STATEMENT: Performance improvement activities and projects are consistent with and reflective of the size, complexity and past performance of the hospice's services and operations.

PROCEDURES:

1. The planning, development and implementation of performance improvement activities and projects is comprehensive and collaborative.

2. The QAPI Committee makes recommendations for potential performance improvement activities and projects that reflect areas of weakness, as identified through data analysis and the needs of the organization.

3. Performance improvement activities and projects are selected that:
    a. focus on high risk; high volume and problem prone areas;
    b. consider incidence, prevalence and severity of problems in high risk; high volume and problem prone areas; and
    c. affect palliative outcomes, patient safety and quality of care.

4. The QAPI Committee involves members of appropriate departments, disciplines and programs in the planning, implementation and evaluation of selected performance improvement activities and projects.

5. All performance improvement projects conducted, the reasons for selecting specific projects and the measurable progress achieved of all activities and projects are documented in QAPI Committee meeting minutes and communicated throughout the hospice and to the organization's governing body.

6. Progress achieved through selected performance improvement activities and projects is continually evaluated and sustained over time.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPI)	Policy Number: PM.Q20 Page 1 of 2
NHPCO Standard(s): PM 1; PM 1.1; PM 1.2; PM 1.3; PM 1.4; PM 1.5; PM 1.6; PM 2; PM 2,1; PM 4; PM 4.1; PM 4.2; PM 7; CES 15.1; OE 2.1	
Regulatory Citation(s): 42 CFR 418.58	

POLICY STATEMENT: Montgomery Hospice develops, implements and maintains an effective, ongoing, hospice-wide and data-driven quality assessment and performance improvement (QAPI) program that reflects the complexity of the hospice's organization and services.

PROCEDURES:

1. The QAPI program includes processes for measuring, analyzing, and tracking quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, services and operations.

2. The hospice collects data that is used to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement.

3. Performance improvement activities focus on high risk, high volume or problem-prone areas that affect palliative care outcomes, patient safety and quality of care with a consideration of incidence, prevalence and severity of problems in those areas.

4. Performance improvement activities track adverse patient events, analyze their causes and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.

5. As a result of its performance improvement activities, the hospice takes actions aimed at performance improvement and measures and monitors improved performance to ensure that improvements are sustained.

6. The number and scope of performance improvement projects conducted annually reflects the scope, complexity and past performance of the hospice program.

7. Documentation of the QAPI program includes:
    a. all performance improvement projects being conducted;
    b. the reasons for conducting these projects;
    c. measurable progress achieved during performance improvement projects; and
    d. evidence that demonstrates the operation of the hospice's QAPI program.

Policy Number: PM.Q20 p.2

8. The hospice's Board of Directors ensures that the QAPI program is developed implemented and maintained and delegates coordination and management of the program to the President/CEO.

9. The President/CEO assures the overall implementation of the program and regularly reports activities and findings to the Board of Directors that are documented in Board meeting minutes.

10. All hospice employees and contracted staff are responsible for the quality of care and services within their respective departments and are expected to participate in the hospice's QAPI program.

11. The QAPI Committee, Chaired by the Director of QAPI, which includes representatives from all disciplines, assists in the management of the on-going performance improvement process through regularly scheduled meetings.

12. Improvements in processes or outcomes as a result of the QAPI program are communicated throughout the hospice.

QAPI – PROGRAM DATA	Policy Number: PM.Q25 Page 1 of 2
NHPCO Standard(s): PM 1.3; PM 1,4; PM 3.1; PM 5; PM 5.1; PM 5.2; PM 5.3; OA 2.2; EBR 2.2	
Regulatory Citation(s): 42 CFR 418.58(b)	

POLICY STATEMENT: As a component of the hospice's information management program, performance and outcome data is routinely collected and analyzed.

PROCEDURES:

1. Through the comprehensive assessments and use of satisfaction surveys and HIS data, data is collected regarding patient and family care outcomes related to the following measures:
    a. safe and comfortable dying;
    b. self-determined life-closure;
    c. effective grieving; and
    d. satisfaction with care, treatment and services provided by the hospice program

2. Data from the comprehensive assessments of all patients is aggregated and included in the hospice's quality assessment and performance improvement program.

3. When data is collected and aggregated, individual patient confidentiality is protected.

4. The QAPI Committee is responsible for reviewing and analyzing routine data that is collected by the hospice program. Data areas may include:
    a. average and median lengths of stay;
    b. utilization of levels of care;
    c. referral patterns and delays in admission and or provision of services;
    d. complaint and incident report logs;
    e. infection surveillance data;
    f. staff and volunteer surveys;
    g. CAHPS satisfaction surveys; and
    h. clinical record review monitoring data.

5. The QAPI Committee utilizes the results of the data analyses to monitor the effectiveness and safety of services and the quality of care and to identify performance improvement opportunities.

6. The President/CEO utilizes the results of the data analyses to identify negative trends and for reporting to the Board of Directors.

Documentation	State regulation reference	Location/citation in Applicant's QAPI
Develop, implement and maintain an effective, ongoing, hospice-wide data driven QAPI program	**10.07.21.09A & B**	Policy PM.Q20 Pg 1
Policy Statement: Montgomery Hospice develops, implements and maintains an effective, ongoing, hospice-wide and data-driven quality assessment and performance improvement (QAPI) program that reflects the complexity of the hospice's organization and services.		
Maintain documentary evidence – able to demonstrate operation	**10.07.21.09D(2)**	Policy PM.Q20 Pg 1 #7
Documentation of the QAPI program includes: *1. all performance improvement projects being conducted;* *2. the reasons for conducting these projects;* *3. measurable progress achieved during performance improvement projects; and* *4. evidence that demonstrates the operation of the hospice's QAPI program.*		
Program capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services	**10.07.21.09C(2)**	Policy PM.Q20 Pg 1 #5 Policy PM.Q15 Pg 1 #6
As a result of its performance improvement activities, the hospice takes actions aimed at performance improvement and measures and monitors improved performance to ensure that improvements are sustained. *And* *Progress achieved through selected performance improvement activities and projects is continually evaluated and sustained over time*		
Must measure, analyze and track quality indicators including adverse patient events	**10.07.21.09C(3)**	Policy PM.Q20 Pg 1 #4
Performance improvement activities track adverse patient events, analyze their causes and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.		
Must use quality indicator data in design of program to: monitor effectiveness and safety of services and quality of care; identify opportunities for improvement	**10.07.21.09D(3)**	Policy PM.Q20 Pg 1 #2
The hospice collects data that is used to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement.		
Frequency and detail of data collection must be approved by governing body	**10.07.21.09E**	Policy PM.Q20 Pg 2 #8 and #9 Policy PM.Q15 Pg 1 #5
The hospice's Board of Directors ensures that the QAPI program is developed implemented and maintained and delegates coordination and management of the program to the President/CEO.		

And *The President/CEO assures the overall implementation of the program and regularly reports activities and findings to the Board of Directors that are documented in Board meeting minutes.* *And* *All performance improvement projects conducted, the reasons for selecting specific projects and the measurable progress achieved of all activities and projects are documented in QAPI Committee meeting minutes and communicated throughout the hospice and to the organization's governing body*.		
Must focus on high risk, high volume or problem prone areas		Policy PM.Q15 Pg 1 #3 Policy PM.Q20 Pg 1 #3
Performance improvement activities and projects are selected that: *1. focus on high risk; high volume and problem prone areas;* *2. consider incidence, prevalence and severity of problems in high risk; high volume and problem prone areas; and* *3. affect palliative outcomes, patient safety and quality of care.* *And* *Performance improvement activities focus on high risk, high volume or problem-prone areas that affect palliative care outcomes, patient safety and quality of care with a consideration of incidence, prevalence and severity of problems in those areas.*		
PI activities must track adverse patient events, analyze their causes and implement preventive actions	**10.07.21.09D(3)**	Policy PM.Q20 Pg 1 #1 and #4
The QAPI program includes processes for measuring, analyzing, and tracking quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, services and operations. *And* *Performance improvement activities track adverse patient events, analyze their causes and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.*		
Must measure success and track performance to ensure improvements are sustained		Policy PM.Q20 Pg 1 #5
As a result of its performance improvement activities, the hospice takes actions aimed at performance improvement and measures and monitors improved performance to ensure that improvements are sustained.		
Number and scope of PIP (performance improvement projects), conducted <u>annually</u> based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity and past performance of the hospice's services and operations	**10.07.21.09C(1-6)**	Policy PM.Q.20 Pg 1 #6 and #7 Pg 2 #9 and #11

The number and scope of performance improvement projects conducted annually reflects the scope, complexity and past performance of the hospice program.

And

Documentation of the QAPI program includes:

5. *all performance improvement projects being conducted;*
6. *the reasons for conducting these projects;*
7. *measurable progress achieved during performance improvement projects; and*
8. *evidence that demonstrates the operation of the hospice's QAPI program.*

And

The President/CEO assures the overall implementation of the program and regularly reports activities and findings to the Board of Directors that are documented in Board meeting minutes.

And

The QAPI Committee, which includes representatives from all disciplines, assists in the management of the on-going performance improvement process through regularly scheduled meetings.

Governing Body- responsible for ensuring that one or more individual(s) who are responsible for operating the QAPI program are designated	**10.07.21.09D(4)**	Policy PM.Q.20 Pg 2 #8 and #11

The hospice's Board of Directors ensures that the QAPI program is developed implemented and maintained and delegates coordination and management of the program to the President/CEO.

And

The QAPI Committee, Chaired by the Director of QAPI, which includes representatives from all disciplines, assists in the management of the on-going performance improvement process through regularly scheduled meetings.

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

November 13, 2015

Ann Mitchell, Administrator
Montgomery Hospice Inc
1355 Piccard Drive, Suite 100
Rockville, MD 20850

PROVIDER # 211503
RE: NOTICE OF COMPLIANCE WITH
HEALTH COMPONENT REQUIREMENTS

Dear Ms. Mitchell:

On November 4, 2015, a Complaint Survey was conducted at your facility by the Office of Health Care Quality to determine if your Montgomery Hospice Inc Facility was in compliance with Federal participation requirements for Hospices Services participating in the Medicare and/or Medicaid programs. The survey was also conducted for the purpose of State licensure.

This survey found that your facility is in compliance with the health component of the requirements.

If you have any questions, please call me at (410) 402-8288 or by fax at (410) 402-8277.

Sincerely,

Roslyn Tyson, Program Coordinator
Ambulatory Care Programs
Office of Health Care Quality

Enclosure: CMS 2567L

The Joint Commission

December 21, 2016

Re: # 5353
CCN: #211503
Program: Hospice Agency
Accreditation Expiration Date: October 15, 2019

Ann Mitchell
President/CEO
Montgomery Hospice, Inc.
1355 Piccard Drive, Suite 100
Rockville, Maryland 20850

Dear Ms. Mitchell:

This letter confirms that your October 12, 2016 - October 14, 2016 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospice agencies through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on December 02, 2016 and December 19, 2016, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of October 15, 2016.

The Joint Commission is also recommending your organization for continued Medicare certification effective October 15, 2016. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location(s):

Montgomery Hospice, Inc.
1355 Piccard Drive, Suite 100, Rockville, MD, 20850

Montgomery Hospice, Inc.
6001 Muncaster Mill Road, Rockville, MD, 20855

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 3 /Survey and Certification Staff

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

December 21, 2016

Ann Mitchell
President/CEO
Montgomery Hospice, Inc.
1355 Piccard Drive, Suite 100
Rockville, MD 20850

Joint Commission ID #: 5353
Program: Home Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 12/21/2016

Dear Ms. Mitchell:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Home Care**

This accreditation cycle is effective beginning October 15, 2016 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

Reference

Patient Rights and Responsibilities

As a patient of Montgomery Hospice you have the right to:

- be cared for by a team of professionals who will provide high quality, comprehensive hospice services as needed and appropriate for you and your family (including extended and alternative family);
- appropriate and compassionate care, regardless of diagnosis, race, color, religion, gender, sexual orientation, national origin, handicapping condition, marital status, type of residence, or the ability to pay for services rendered;
- exercise your rights as a patient of Montgomery Hospice and be free from discrimination or reprisal for exercising your rights;
- receive information about the scope of services that Montgomery Hospice will provide and specific limitations on those services;
- privacy;
- receive effective pain management and symptom control;
- be involved in developing your plan of care by being fully informed regarding your health status. (The hospice team will assist you and your family identifying which services and treatment will help you reach your goals.)
- be fully informed regarding the potential benefits and risks of all medical treatments or services suggested, and to accept or refuse those treatments and/or services as you wish. (The hospice team will provide you with information and work with you on ways to make your wishes known to those caring for you.)
- be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, and misappropriation of patient property;
- choose your attending physician;
- have your cultural and personal values, beliefs and preferences respected;
- have your property and person treated with respect;
- be informed of short-term inpatient care options available for pain control, management and respite;
- confidentiality with regard to information concerning your health status as well as social and/or financial circumstances, and confidentiality in all aspects of service or treatment. (Patient information and/or records will be confidential and released only on your, or your agent's written consent, or as permitted or required by law.)

- formulate advance directives as provided under state law;
- be informed of our discharge policy;
- receive information about the services covered under the hospice benefit;
- be informed orally and in writing, before care is initiated, of any fees or charges for which you may be responsible. (You have the right to access any insurance or entitlement program for which you may be eligible.)
- have unlimited access to visitors and others you choose, and to keep and use personal clothing and possessions if you are at Casey House;
- voice complaints or grievances regarding treatment or care and/or the lack of respect for property by Montgomery Hospice staff without threat or fear of retaliation.

Patient and Family Complaint Procedure

If at any time you have a concern or problem regarding your care, hospice staff members or safety, please call us at 301-921-4400. Please ask to speak with someone from the Senior Leadership. Or you may write to us at:

Montgomery Hospice
1355 Piccard Drive, Suite 100
Rockville, MD 20850

All complaints received by Montgomery Hospice are recorded and investigated. If we receive a complaint, you will be notified about the outcome within 10 days. We will work with you to answer your concerns.

If you prefer not to report a problem to us, you may call the Maryland State Toll Free Hotline at 1-800-492-6005, or write them at:

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center - Bland Bryant Building
55 Wade Avenue
Catonsville, MD 21228-4663

Or you may also contact the Joint Commission (an independent non-profit organization that accredits and certifies health care organizations). Montgomery Hospice is proud to be accredited by The Joint Commission. The Joint Commission can be reached by calling 800-994-6610 if Senior Leadership of Montgomery Hospice cannot resolve your concern. More information can be found at www.jointcommission.org.

HOSPICE MATTERS

CA14-1

A Newsletter for Family and Friends of Hospice

Fall - 2010

Montgomery HOSPICE

Why You, An African American, Should Choose Hospice Care

by Robert A. Washington

Robert A. Washington, Ph.D., MDiv.
Vice President of Counseling Services
Montgomery Hospice

Your last days are sacred

Whether you view them as transitional or the final chapter, your last days hold unique promise for both you and those who love you. That is why the very first question on the spiritual assessment at Montgomery Hospice asks the patient and/or family member what is most meaningful in life at this point. Your answer to this question will help us co-create with you the best opportunity to have your desires met. Our goal is to make you as comfortable as possible and, thereby, maximize your ability to live as you choose.

Your choices are sacred

We are patient centered at Montgomery Hospice, which means we take direction and get permission from you. It is our responsibility to ensure that you receive all the information you need to make informed decisions about your care, even if you decide hospice is not what you want at this point. We know that African Americans are more inclined to want life prolonging treatments at life's end. We will give you honest feedback about your desires, but we will always honor your decisions (in accordance with regulations and the law). For example, if being resuscitated and re-hospitalized is what you want, despite medical projections of futility, then those options will remain available to you. We will always discuss with you the benefits and side effects of pain medication needed to relieve your distress but then follow your direction. It's okay if you choose not to sleep in a hospital bed, but it is our duty to explain the advantages to both you and those who care for you who must safely reposition, lift and help you to the bathroom. Additionally, we cannot make you call us in the middle of the night when your concern is heightened, but we can certainly come when you call. At Montgomery Hospice we know that belief is a powerful medicine, which is why we would never stand in the way of your choices and why the choice we offer is the opportunity for a better quality of life.

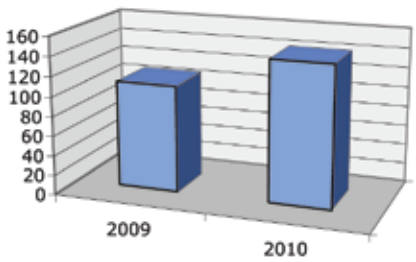
> "We know that trust is a sacred gift that must be earned, so we invite your questions and concerns as we work to gain your confidence."

Your trust is sacred

Some African Americans have little knowledge of hospice; the overwhelming desire to support their own makes exploring hospice care unnecessary. At Montgomery Hospice we want you to know that hospice is a supplement, not an alternative to family care. Other African Americans may have misconceptions about the definition of hospice. For example, some may think of hospice as a place where one goes to die rather than a host of treatments and services provided wherever the patient resides. Still others may think hospice is all about morphine when, in fact, hospice personnel use many tools (medicinal and otherwise) to ensure comfort. We know there are African Americans who mistrust the practice of medicine; the infamous Tuskegee Study is very well known and contributes to fear that treatment will be

(continued on page 4)

Increasing numbers of African Americans are receiving services from Montgomery Hospice.



African American patients increased 31% in 2010

comparing numbers from January through September of each year

From Ann's Office

Doing More with Less

For the last five years, the level of reimbursements we receive from Medicare, Medicaid and other private insurance companies has remained essentially flat. Consequently, the provision of high quality care has been most challenging since we have been strained by the rising costs of gas, supplies, therapies and pharmaceuticals, as well as the cost of retaining competent staff.

During these five years, we have expanded the types of therapies and medications we are able to provide in patients' homes. Due to developments in portable technology, we can provide more sophisticated aggressive pain and symptom management and honor patients' wishes to remain in their homes. We have started a complementary therapies program, which includes comfort touch, music by the bedside and aromatherapy for both patients and caregivers. Also, we have established a Montgomery Hospice educational enterprise that offers an increased number of informative programs to the public.

Because 75 percent of our care is delivered in the home, our professionals (including our Medical Director) are on the roads during the day and deployed as needed at night. Our care is available 7 days a week, 24 hours a day. In the last five years the number of people we care for has nearly doubled and so has the number of uninsured families we serve. We are providing much more, but our insurance payments have not even kept up with the yearly inflation rate.

One of our biggest challenges is to keep Casey House functioning at the highest level of care. This home-like environment with fourteen beds, where hundreds of families finally feel at ease, is the only standalone end-of-life care facility in Montgomery County. At Casey House, Montgomery Hospice is doing more with a reimbursement rate that only covers 75 percent of the cost of the care.

To tackle these challenges, the Montgomery Hospice Board of Directors decided to embark on a three-year fundraising campaign to raise 8 million dollars. Half of the funds raised during the *"Gentle the Journey: the Campaign for Montgomery Hospice"* will go to the creation of an endowment to support nursing care at Casey House and the other half will support bereavement services and the care we provide in patients' homes.

Montgomery Hospice has shown that its care improves the quality of life of patients and their families. For the last 30 years we have provided hospice services to one in four people in need of end-of-life care in this region. Furthermore, the trend of increased usage of our services is expected to continue as we meet the needs of an aging generation of baby-boomers who are caring for their parents and for themselves. We trust that the community we love and serve will help us raise the funds we need to ensure the continued provision of high quality care as we "gentle the journey" for our neighbors and their families.

Ann Mitchell, MPH
President & CEO

Montgomery Hospice's new Medical Director

Geoffrey Coleman M.D., M.H.A. has joined Montgomery Hospice as Medical Director. In this position, Dr. Coleman will be responsible for the medical oversight of the Montgomery Hospice clinical team. Dr. Coleman has been a hospice physician since 2003 and is certified in Hospice and Palliative Care Medicine, as well as in Family Medicine.

Dr. Coleman is looking forward to serving patients and families in Montgomery County, saying "I am honored to be joining an organization known as an expert and leader in end-of-life care." Ann Mitchell is pleased to welcome Dr. Coleman. "His medical experience combined with his passion and caring will make Dr. Coleman a valued asset and team leader. "

Remembering Sylvia Shapiro

Sylvia Shapiro with her daughter Lyn Chiet

It was just three years ago in March when my world came to a screeching halt when I learned that one of my most favorite people was going to be taken away from our family. In just three short weeks, a rare and undetected case of gall bladder cancer took my mother-in-law Sylvia Shapiro's life. To this day, it still hurts to think about losing her.

It took a lot of effort to convince me that there was nothing I could do to save her. However, I quickly learned that there was one thing we could try to do, and that was to give this classy woman the dignity that she deserved by spending her last few days in a place of comfort.

A good friend of mine, Bill Schlossenberg from The Gazette, had recommended Montgomery Hospice to me. I remembered hearing about Montgomery Hospice and seeing their ads in The Gazette but never really understood what they were all about. After I called them and they moved mountains to help Sylvia relocate to the beautiful Casey House, then I began to understand.

I clearly remember the day she was moved… it was the first time I saw her beautiful smile in days, with her knowing that she was going to be leaving the hospital to go to a peaceful and warm home-like environment. She was especially pleased to be reunited with her best buddy, her golden Hemingway cat.

The staff at the Casey House welcomed us with open arms, like a family would be welcomed into their home. All of Sylvia's family and grandchildren were present and we were treated with such warmth.

Sylvia passed away the next morning, but there was peace in knowing that we did right by her in coming to the Casey House.

Sylvia's daughter, my wife Lyn Chiet, and I both appreciate Montgomery Hospice and Casey House and the gift they brought in honoring a special person's life.

Cliff Chiet

Vice President of Sales, and Publisher of The Gazette Montgomery, Prince George's and The Gazette of Politics & Business

Why You, An African American, Should Choose Hospice Care

(continued from page 1)

denied, causing premature death if hospice is chosen. At Montgomery Hospice we regard your suspicions as healthy; it ensures that you are well informed and vigilant. We know that trust is a sacred gift that must be earned, so we invite your questions and concerns as we work to gain your confidence.

The desires of your heart are sacred

Working with your physician we address the ailments of your body so you are as free as possible from pain and physical distress; then you can focus on the concerns of your heart. We fervently pray for healing with and for you if that is your heart's desire, and if your body progressively fails we support you as you grieve the losses. We understand fear and anger however they are expressed and can help you to a more peaceful place if that's what you really want. We hear your concerns about loved ones, can help find them when estranged, and provide ongoing care for them well beyond your death. Most importantly, we understand that what many African Americans desire most is to know God, the "author and finisher" of one's fate, for when all else fails, God remains trustworthy and will get you through. At Montgomery Hospice we walk the final journey with you and support you as you stand on the tenets of <u>your</u> faith.

Your experience is sacred

Montgomery Hospice staff is well aware of these cultural underpinnings, historical facts and research findings; we keep them uppermost in our minds as we strive to ensure that your expectations for quality care are exceeded. Those who have utilized our services frequently wish that hospice had been engaged sooner. Our teams of nurses, chaplains, home health aides, social workers, bereavement counselors and volunteers are continually upgrading their skills and knowledge to ensure that the care you receive is state-of-the-art. Montgomery Hospice has almost thirty years of experience that have taught us that we must honor your last days, your choices and the desires of your heart to gain your trust and afford you an experience worthy of your sacred humanity.

African-Americans & End-of-Life Care

a personal story by
Gloria Thomas Anderson, LMSW

When one of my older relatives was rushed to the hospital with a serious illness, she wasn't ready to deal with the business of her healthcare issues. Her memory was starting to fade and she was calling us other people's names without knowing it.

Since 1991, the Federal Patient Self Determination Act has required all healthcare providers to ask patients if they have an "advance directive," and give them the choice to complete one if they don't.

My relative got VERY upset when the nurse tried to tell her about this, shouting, "What y'all trying to do with me? Ain't nobody gon' put me in no nursing home!" Her piercing words stayed in my mind as we hoped for the best and prepared for the worse. She calmed down once she was assured that no one was going to make any decisions without her input. She then agreed to give one of her children Durable Power of Attorney for both her healthcare and financial decisions.

When I learned that she had not been to a doctor in many years because of fear and mistrust, I realized that she was not alone in her rationale. Some people of color still experience healthcare disparity, in light of much improvement in healthcare service delivery. Racial disparity in healthcare has caused many people of color to lose trust in doctors or proposed treatment options. End-of-life decisions are also impacted by African Americans' unique history, culture and generational values. Ethical end-of-life decision- making encompasses far more than medical dimensions, often extending to include individual personal experiences and belief systems.

Regardless of ethnicity, age or socioeconomic status, the ability to make good decisions in healthcare and end-of-life care is often based on understanding and effective communication. Miscommunication can be a barrier, especially in these kinds of situations. My relative's fears were significantly decreased once she understood that she was in control of her own life and that her wishes would be respected.

Optimally, we all should have conversations about healthcare decision-making before an emergency situation. Although questions such as "What would your wishes be if you were no longer able to speak or do for yourself?" are difficult to answer, they are important ones to consider so that we can remain in charge of our lives, right up 'til we reach Heaven's gate.

Life isn't promised to anyone. Nobody wants to think about leaving here, but the reality is everybody is going to—someday. Having dignity in dying can be just as valuable as having dignity while living. Making personal healthcare decisions is rarely an easy thing to do, especially when it pertains to end-of-life. My relative's response need not be a common one. By choosing to gain a better understanding of one's options and taking charge of one's own health decision-making, those whom you care about and love most can honor your wishes if you are unable to speak for yourself. When people choose to talk about these subjects, they gain greater peace of mind, as well as provide comfort to those they love most during such times as our family experienced.

Gloria Thomas Anderson is a licensed master's social work educator and the author of "The African-American Spiritual and Ethical Guide to End-of-Life Care-What Y'all Gon' Do With Me?" This patient educational resource helps to increase awareness and understanding about end-of-life care options.

Montgomery Hospice Center for Learning presents
African-Americans & End-of-Life Care

Silver Spring Civic Building
1 Veterans Place Silver Spring, MD 20910

Tuesday, Nov 19, 2013
8:30 am to 12:00 pm

Speaker: Gloria Thomas Anderson, LMSW

An interactive, educational, informative and fun event that will bring awareness to the unique cultural, historical and spiritual values that may influence African-American healthcare decision-making. This workshop will help to identify prominent barriers to culturally appropriate healthcare provision, while simultaneously providing self-awareness assessments to enhance and improve communication between providers, caregivers and patients.

Come and be a part of the conversation. Let's talk about it!

cost: $20 ($25 with CEUs) 2.5 Social Work CEUs available
registration: http://GAnderson.eventbrite.com/
information: call Terrie James-Taylor at 301 637 1900

New Partnerships, Programs in African-American Community

There has been concrete progress in Montgomery Hospice's effort over the past 18 months to forge new partnerships with influential institutions in the African-American community.

Montgomery Hospice chaplain Paulette Stevens with Rev. Chester L. Burke, pastor of Pilgrim Baptist Church and president of the Montgomery County Black Ministers Conference, at the Casey House clergy breakfast.

There is clear reason to work together. Compared to other ethnic groups, African Americans are at higher risk for diseases such as cancer and are less likely to use the comfort care of hospice. This amounts to needless suffering that burdens patients, families and communities.

In November, Montgomery Hospice staff designed and taught a four-hour instructional program for lay ministers at the People's Community Baptist Church, a prominent African-American church in Silver Spring. The program was called "Ministering to Families Facing Illness and Death."

Casey House nurse Dorothea Gonzalez led with a presentation on the health risks facing African Americans. Chaplain Paulette Stevens' instruction on spiritual care at the end of life followed. Comments from lay ministers in attendance were extremely positive. One remarked, "Can we do this again and make it mandatory for all ministries?"

The lay minister training was funded by the county and the state's Cigarette Restitution Fund (CRF) program. Montgomery Hospice is a chief organizer of CRF efforts among hospices and has used CRF funding to enhance cancer education among African Americans and provide in-home cancer screening for all Montgomery Hospice patients.

State and local officials have been pleased with Montgomery Hospice's stewardship and have extended CRF funding through June 30, 2003.

The first Saturday of the new year saw a special breakfast meeting at Casey House of the Black Ministers Conference of Montgomery County. This influential assembly of clergy toured Casey House and learned how inpatient hospice care can relieve physical, emotional and spiritual suffering.

For clergy with parishioners coping with serious illness, this was valuable information. Again, response was enthusiastic and brought calls for more ways that Montgomery Hospice and local leaders can work together to improve the health of African Americans.

Contact Montgomery Hospice to:

- Learn about caregiver education programs for your church
- Participate in Montgomery Hospice's study of African Americans and end-of-life care
- Receive in-home cancer education and screening if you have or had a family member in Montgomery Hospice's care

A Study of Root Causes

To help healthcare professionals everywhere understand African Americans' low use of hospice care, Montgomery Hospice is conducting a study of how African Americans facing terminal illness make decisions about their care.

Throughout 2003, Montgomery Hospice psychologist and chaplain Robert Washington will interview family members and other close caregivers of African Americans who were eligible for hospice care in 2000 and 2001. The goal is to distinguish the criteria and decision-making of African Americans who chose hospice from those who did not.

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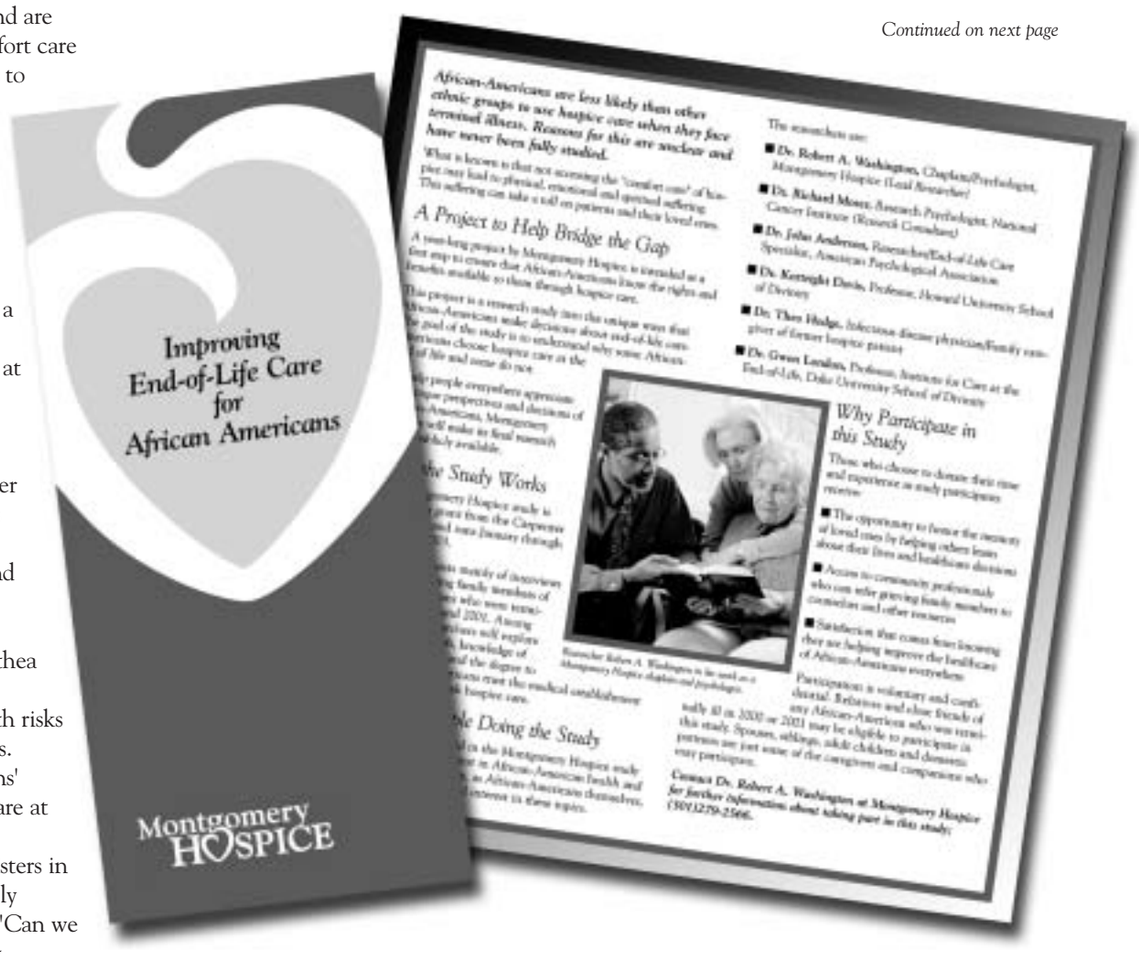


Recruitment materials for Montgomery Hospice's study of African Americans and end-of-life care.

Continued from previous page

To enhance partnerships between hospices and African Americans everywhere, Montgomery Hospice will make its report findings publicly available upon completion of the study.

Building these new bridges would be impossible without dedicated partners. From caregivers taking part in our year-long study to our colleagues in the clergy and lay ministries, we are grateful to all those who make this energizing and rewarding work possible.

Black Ministers Conference breakfast meeting at Casey House, January 3, 2003

Breakfast in the Casey House Great Room.

Touring Casey House

Bereavement Counselor Takes to the Air Waves During Sniper Attacks

That reassuring, informative guest you may have seen on Channel 9 Morning News during October's sniper crisis was our own Elaine Tiller, Montgomery Hospice's Bereavement Coordinator.

Channel 9 learned of an essay Elaine wrote for parents during the attacks called "Creating Safety in the Midst of Fear." The station invited her for a live interview on bereavement care and how to support children during the crisis.

Elaine's essay has helpful tips for families coping with the stressful news of any public crisis. Copies are available by calling (301)279-2566 or by visiting the Resources/News&Events section at www.montgomeryhospice.org.

(Top) Montgomery Hospice Bereavement Coordinator Elaine Tiller discusses bereavement care and how to support children in the context of sniper attacks.

(Bottom) In a light moment, Elaine reacts to the interviewer's comment that area residents would "all need a hug" at the conclusion of the sniper crisis.

Investing in Community: Stocks, Bequests, Matching Corporate Gifts

Many friends of hospice prefer to make charitable gifts of stock rather than cash. To enable that kind of contribution, Montgomery Hospice has an account with Salomon Smith Barney in Bethesda. Our broker there, Tom Fahey, can assist you or your broker in handling the transaction. The tax-deductible value of such gifts is based on the shares' high/low mean value on the date they are transferred.

Many area companies have matching gift programs. Check with your employer to find out if your company matches charitable contributions.

Planned giving helps Montgomery Hospice provide care according to need, not insurance status. If you are interested in including Montgomery Hospice in your estate planning but are not sure how to go about it, please contact Maureen Dimont at the Montgomery Hospice Foundation at (301)279-2567 ext. 110, or email mdimont@montgomeryhospice.org.

Free brochures on the following topics are also available at the Foundation office:

- Tributes: Creative Ideas for Remembering Others
- Giving Gifts of Securities
- How a Will Works for You
- Giving Through Your Will
- An Estate Planning Quiz

FOR IMMEDIATE RELEASE
June 24, 2004

Contact: Andy Reynolds, Montgomery Hospice
(301) 921-4401, Ext. 186

Study by Former DC Commissioner of Mental Health Finds Hospice Care Benefits Black Families

Research By Howard, Harvard Alumnus Into African Americans' Views on End-of-Life Care Raises Issues of Religion, Race and Class

A year-long study of how African Americans make decisions about end-of-life care reveals strong support for hospice care and indicates intriguing areas of future research that would benefit African Americans' health. All findings are based on interviews conducted in 2003 with the primary caregivers of African Americans who died in the care of Montgomery Hospice, based in Rockville, Maryland, between January 1, 2000 and June 30, 2002. The study's author is available for media interviews.

Challenging Conventional Wisdom
In several respects, the report's findings do not support common beliefs about how African Americans make medical decisions about end-of-life care. For example, the study did not support the prevalent view among healthcare professionals that African Americans tend to wait until death is imminent to engage hospice service. The median length of stay in hospice of patients in the study was twice that of all Montgomery Hospice patients. This difference suggests that African Americans in the study were more likely, not less, to engage hospice service early in an illness.

Two questions raised by the research affect end-of-life care for African Americans in that they concern fundamental questions of spirituality and racial equality:

1) What's Faith Got to Do With It? – Caregivers in the study reported that spirituality was important to themselves and to patients. Both groups were frequent churchgoers and were often involved in other religious pursuits. However, religious concerns did not influence the decision to engage hospice services and pastors were rarely consulted while the issue was under consideration. This finding may be at odds with theories that African Americans are less inclined to accept hospice care and engage in other end-of-life planning because of their religious beliefs. More study would be helpful.

2) Do Economics & Education Outweigh Race? - The majority of interviewees reported that race played no role in their assessments of patients' medical care and in the decision to engage hospice services. However, study participants had relatively high incomes and educational levels: 83% had more than high school education. The author notes that it would be interesting to research whether lower-income African Americans feel differently about race as a factor in assessing their medical care, as well as their perceptions of how much control they have in choosing medical providers.

African Americans & Hospice Care
For reasons that researchers have never clearly identified, African Americans are underrepresented as hospice patients. By not accessing the "comfort care" of hospice, terminally ill African Americans may be more likely to suffer physically, emotionally and spiritually in their final weeks or months.

(CONTINUED)

June 24, 2004 **(301) 921-4401, Ext. 186**

In the study, 92% of caregivers said hospice services met or exceeded their expectations and 96% said they would recommend hospice services to other African Americans.

The study showed particular benefits of hospice care to patients' families. Half the caregivers reported that their experience with hospice had reduced their own anxieties about death by, in effect, showing them that dedicated professionals could care for them and their loved ones should they become terminally ill.

The availability of Montgomery Hospice's inpatient care facility, Casey House, seemed particularly beneficial to families in which caregivers work full-time in middle or low-paying jobs. The percentage of patients using Casey House exclusively or in combination with home care (46%) significantly exceeded that of the general Montgomery Hospice population (roughly one third). Eighty-three percent of those who used Casey House exclusively and 80% of those who used a combination of home care and Casey House said their expectations for care were exceeded. One-hundred percent of those who used Casey House exclusively worked full-time.

Who Conducted the Study and How

Among other positions held in his long career in counseling and public health, psychologist and chaplain Robert A. Washington was DC Commissioner of Mental Health from 1987 until 1992. He received his Ph.D. in Clinical Psychology and Public Practice from Harvard University in 1974. He studied at the Howard University School of Divinity and became an ordained minister in the United Church of Christ in 2003. A DC resident, Dr. Washington has cared for terminally ill patients and their families as a full-time Montgomery Hospice chaplain and bereavement counselor since July 2001.

Dr. Washington's study, which was funded by the Carpenter Foundation, consisted of in-person or phone interviews with the 24 primary caregivers of 24 African Americans who died between January 1, 2000 and June 30, 2002 while receiving care from Montgomery Hospice. The sample represents almost one-quarter of African Americans cared for by Montgomery Hospice during those 30 months.

All caregivers interviewed were African American. All interviews took place in 2003 and consisted of identical questions about demographics, faith and impressions of hospice care's impact on the patient and family.

Montgomery Hospice & African Americans

Studies such as Dr. Washington's and educational partnerships with black churches help ensure that Montgomery Hospice meets its mission of caring for all Montgomery County residents who need care. From 2000 through 2002, Montgomery Hospice tripled its percentage of African American patients to mirror the approximate overall death rate of African Americans due to illness in the county.

Montgomery Hospice is independent, nonprofit, and cares for patients regardless of their ability to pay. Every year, more than 1,000 Montgomery County residents and their families get the help they need though Montgomery Hospice's *Hospice at Home* service, *Casey House* inpatient facility, and affiliated physician practice, *Palliative Medicine Consultants*.

(END)

African Americans & End-of-Life Care:

What Y'all Gon' Do With Me?(Let's Talk About It)

Three Key Factors in African-American Healthcare Decision-making

by Gloria Thomas Anderson, LMSW
www.hearttones.com

Why The EOL Guide?
Why The Work? (a family conversation…)

1) To provide an easy to read, culturally sensitive resource for African American patients and families to talk about what their wishes would be if they were not able to speak for themselves due to life threatening illness or accident.

2) To help increase awareness about cultural influences that may contribute to African American healthcare decision-making through a contextual perspective.

Workshop Objectives:

- To examine the unique cultural, historical and spiritual values that may influence African-American decision-making.
- To identify prominent barriers to culturally appropriate healthcare provision.
- To participate in a self-awareness exercise that explores how personal values can impact communication with diverse others.

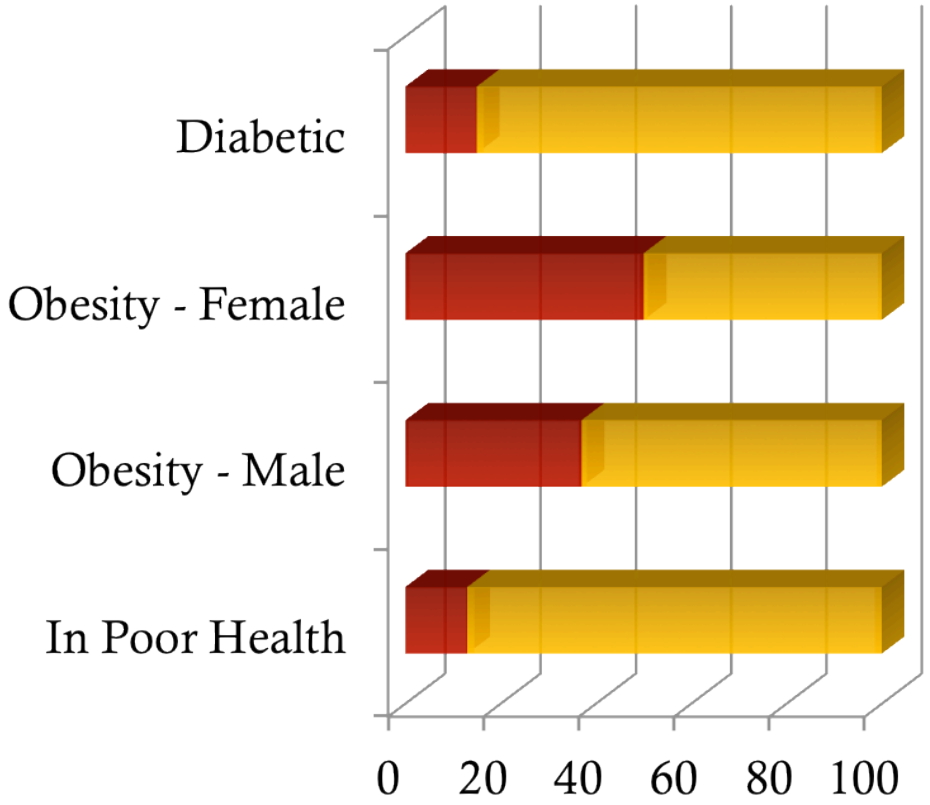
PART I

Key Historical & Spiritual Influences in African-American Healthcare Decision-Making

Why The Historical Mistrust in Healthcare Research?

- Racial disparity in medicine
- The Tuskegee Syphilis study. (Chadwick, 1997)
- Less use of cardiac procedures, reduced access to renal transplants, and fewer surgeries for lung cancer (Peterson,et al., 1997; Chen, et al.,2001; Bach, et al.,1999; Schulman, et al., 1999, Ayanian, et.al.,1999)

Some Chronic African-American Health Conditions



- 13% of African Americans of all ages report they are in fair or poor health.
- 37% of men and nearly 50% of women are obese. Adult obesity rates for African Americans are higher than those for whites in nearly every state of the nation.
- 15% of African Americans have diabetes as compared to 8% of whites. African Americans have higher rates of diabetes, hypertension, and heart disease than other groups.
- African Americans experience higher incidence and mortality rates from many cancers that are amenable to early diagnosis and treatment. African-American adults with cancer are notably underrepresented in cancer trials and are much less likely to survive prostate cancer, breast cancer, and lung cancer than their white counterparts.
- Leading causes of death among this group are heart disease, cancer, and stroke.

Source: Center for American Progress | Fact Sheet: Health Disparities by Race and Ethnicity

Four Prominent Barriers That Can Hinder Culturally Responsive Care

1) Racial disparity in health care

2) Mistrust of doctors and proposed treatment options

3) Miscommunication

4) Cultural Competency "Miss-steps"

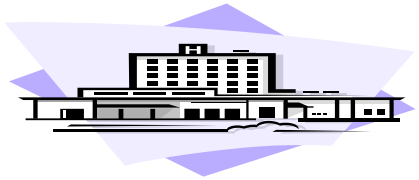
Some Attitudes and Beliefs that Contribute to Healthcare Disparities & Service Delivery

- Biases
- Prejudice
- Stereotyping
- Discrimination
- Fear
- Ignorance
- Deception

Prejudices:
Inclinations to dislike or like certain people, places and things because of a real or perceived discriminating factor.

Historical: Social and Economic Factors Affect African-American EOL Decisions

Dr. Rodney Hood noted twice in history when health reform improved African American health outcomes:



Engrained Institutionalized Racism

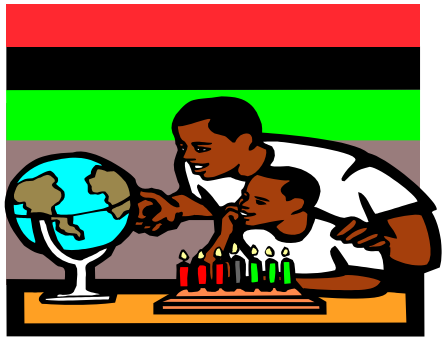
1865-1872

1965-1975

The imbalance remains…

Cultural Influence of Spirituality and Religion

- West African backgrounds
- Slavery
- A Spiritual People
- The Church



Religion vs. Spirituality

- **Religion**—a particular set of institutionalized belief systems and standards that provide direction and instruction for one's life

- **Spirituality**—a personal expression and/or connectedness with something or someone greater than one's self that gives meaning and purpose to one's life.

Differing Spiritual & Religious Views To Consider: Traditional vs. Western Healers

Traditional	Western
Holistic	Separate dimensions/ Physical, Spiritual and Mental
Spiritual basis to well-being and health Spirituality and religion has a central role	Cognitive and Emotional Spirituality and religion does NOT have a central role
Healers more active/take more responsibility	Helpers more passive in interventions
Emphasizes multidimensional sources for possible causes	Emphasizes cause and effect

Source: Adapted from Cultural Diversity, A Primer for the Human Services, Jerry V. Diller, 1999

Recurrent Themes in African American Spiritual Beliefs

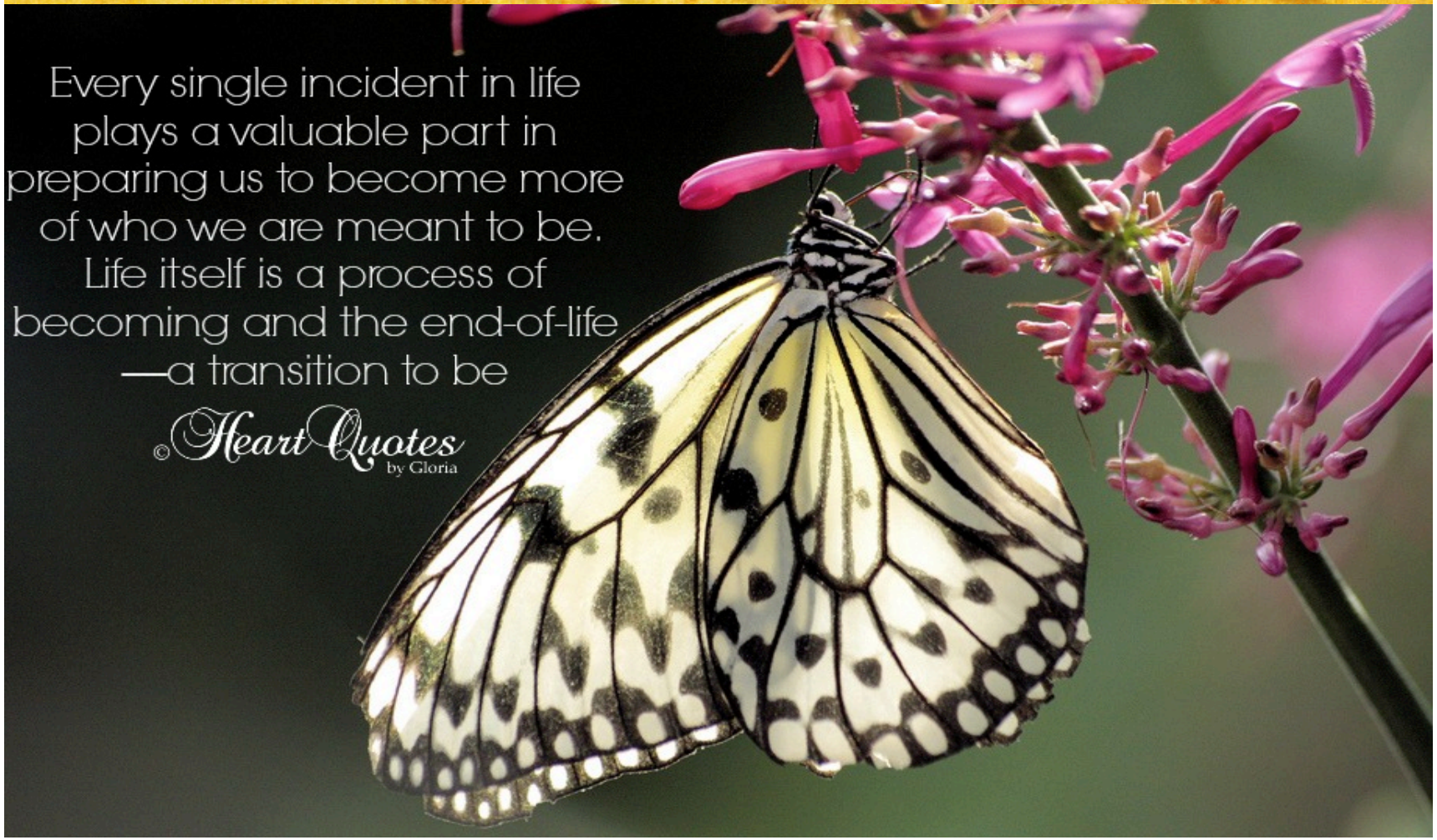
- A source of comfort, coping and support
- An effective way to influence healing
- God is responsible for physical and spiritual healing
- The doctor is God's instrument

(Johnson,Elbert-Avila & Tulsky, 2005)

Universal Spiritual Values: Issues of the Spirit

- *Why me?*
- *What will happen to me?*
- *What has my life meant?*

Break Time!



Part II

Key Generational & Family Values in African-American Healthcare Decision-Making

Personal Values & Beliefs

Some Traditional African American Values: A Cultural Context of Underlying Principles

- **Faith: Spirituality and Religion**
- **Strength: Self-Determination**
- **Family: Children/Extended Family/Fictive Kin**
- **Cooperation: Community-Centeredness/ Interdependent**
- **Responsibility: Resourceful/Creative**
- **Unity: Collective Identity/Groups**
- **Heritage: Belief Systems /Traditions**

Understanding Cultural Communication Differences

African-American Cultural Communication Style	Western-European Cultural Communication Style
Collectivism—The belief that one's identity is in large part a function of one's membership and role in a group; interdependence and harmony of group members are valued.	*Individualism—The belief that the needs of the individual should be satisfied before those of the group; independence and self-reliance are valued.*

Some Southern African-American Generational and Family Values That Influence Decision-Making

- Sacrificing one's own needs
- Family directed care
- Relying on their spirituality and faith, including prayer (passed down generationally)
- Relief from physical and financial stress (Born, et.al, 2004)
- Focusing on "life" rather than "death" (bad omen)

Self-Reflection Questions to Ponder

1. Am I seeking to better understand different cultural groups in the context of their own lives?

2. Do I engage different others with intentional respectfulness and appreciation of their knowledge, time and trust?

3. Am I mindful to the fact that all people are first human beings with their own story and life experiences*? (People are the best experts on themselves.)*

4. Am I aware of the *(sometimes)* unconscious thoughts to stereotype, judge or make quick assumptions about different others?

5. Am I willing to listen and learn from different others with empathy and genuine concern for their best interest?

Personal Values & Beliefs Assessment Activity

Healthcare Personal Values Exercise
(Small Group Activity)

What do you believe is true about…?

Discussion: Personal Values & Communication

Your Legacy—Your Life

What's really important at the end of life?

- Building memories
- Leaving a legacy to be remembered by

Embracing Life…
Releasing Life.

Tomorrow's Hope

Hope is the substance of renewal and strength that

gives courage to go on.

Hope is the quiet stillness comforting the soul

as a broken heart mourns.

Hope is the light that merges with faith,

a new beginning to be born.

Such is the precious gift of tomorrow's hope—

a treasured jewel to adorn.

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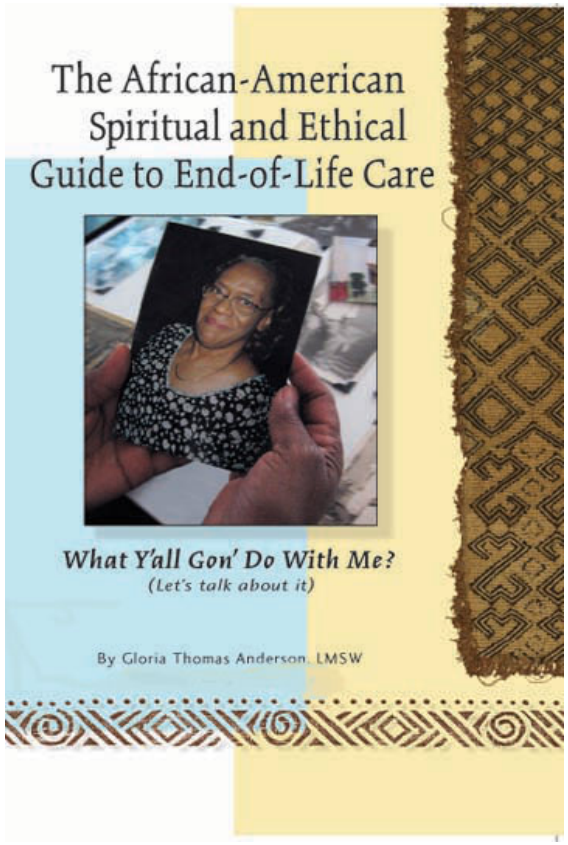

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