Message from UHPCO Past President – Lehi Rodriguez

I hope you are having a wonderful beginning of the year. It’s always a great opportunity to take a breath and reflect on the accomplishments and shortcoming of the previous year, identifying the things that are working good, changing the things that we need to change and then moving forward with more determination, energy and desire to do things better. Personally, I want to thank you for all your support and contributions to the UHPCO during 2012. It was a year full of opportunities and growth. I want to take the opportunity to welcome Robin Black our next President for 2013. Robin has a wealth of knowledge and experience in the Hospice industry. She is a dedicated individual with a great heart.

I’ve been thinking on the responsibility that we all have to follow up with the direction and all the great energy generated from last year’s participation and this thought came to mind:

In business, everybody always thinks it is about finding the ‘right’ idea, or the ‘right’ plan. The truth is that there are five ‘right’ ideas or plans. The real issue is getting oneself and others to be able to execute it and negotiate all of the people issues along the way”. Henry Cloud

Related to execution is integration. For example, if you’re a marketing person, the whole world becomes a marketing problem. Because of this, we need more integration. We need someone with a perspective, someone who understands various functions and parts of the industry, like Social Workers, Nurses, Chaplains, Marketing Directors, Administrators, Owners, etc. The ability to integrate is essential to execution.

That’s why I believe every one of you brings something unique to the UHPCO regardless of your position or title, we all can benefit much from your input and your ideas during this upcoming year.

Let’s make it a great one!
Lehi Rodriguez
Past President

Message from UHPCO Executive Director ~ Dan Hull

Dear Members,

I hope you are all enjoying the 40 degrees after a month of cold, snowy weather. We have a new website design. I am still uploading everything but please look at the site and let me know what we need to add.

We will be putting in UserNames and Password and forward them to you by the middle of February. Please review the website and complete your membership so that you will get a username and password for your agency. This website promises to be a great resource for you and your agency.

The online training program that we subscribe to has been greatly improved and they are holding a Webinar for the trainers of each agency on February 13. The information to attend the Webinar is the following:

Just a reminder there is still time to register for the webinar coming up on February 13. Participants will learn about the new features on RCTCLEARN.NET as well as discuss ideas on how to get staff started with the programs. Don’t forget, while designed for new users, existing agencies and training coordinators may benefit as well! Participants can sign-up at http://www..net/support/webinar/.

If you have any questions please contact:

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New CMS Edit on Hospice Claims

Today CMS released Change Request (CR) 8142 on the hospice monthly billing requirement. The CR instructs contractors to implement system edits to return hospice claims to the provider when there is more than one hospice claim per month per hospice beneficiary or when the provider submits claims that span more than one calendar month. The effective date of the CR is July 1, 2013. After this date claims not in compliance with the monthly billing requirement will be returned to providers. This is not new policy but is new enforcement.

The monthly billing requirement is found in the Medicare Claims Processing Manual, Chapter 11, Section 90. CR 8142 revised this section which will now read:

90 - Frequency of Billing and Same Day Billing
(Rev.2642, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

Hospices must bill for their Medicare beneficiaries on a monthly basis. Monthly billing must conform to a calendar month (i.e. limit services to those in the same calendar month if services began mid-month) rather than a 30 day period which could span two calendar months. Hospices submitting more than one claim in a calendar month for the same beneficiary will have claims returned beginning on dates of service July 1, 2013. The only exception to this requirement is in the case of the beneficiary being discharged or revoking the benefit and then later re-electing the benefit during the same month. The monthly billing requirement applies even if the patient is discharged, revokes, or expires on the first of the next calendar month. For example, if a patient is admitted to hospice on August 8th and revokes the benefit on September 1st, the hospice must submit two claims. A claim is submitted for dates of service August 8 to August 31 and a separate claim is submitted with dates of service September 1 to September 1.

Hospice claims should not span multiple months. Any hospice claim spanning multiple months will be returned to the provider for correction.

In cases where one hospice discharges a beneficiary and another hospice admits the same beneficiary on the same day, each hospice is permitted to bill and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission.

A corresponding MedLearn Matters article is expected to be posted soon.

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UHPCO Members for 2013

Provider Members
- Absolute Compassion Hospice
- Advocate Hospice
- Alpha Omega Hospice
- A-Plus Home Care & Hospice
- Aspire Home Health & Hospice
- A Step Forward Hospice
- Beaver Valley Hospice
- Community Nursing Services
- Curo Home Health & Hospice
- Encompass Hospice of Utah
- Envision Home Health & Hospice
- Good Shepherd Homecare & Hospice
- Gunnison Valley HomeCare & Hospice
- Harmony Home Health & Hospice
- Healing Hearts Hospice
- Heartwood Home Health & Hospice
- Horizon Hospice Specialists
- Hospice Care of Northern Utah
- Inspiration Hospice
- Integrity Home Health & Hospice
- Maple Creek Home Health & Hospice
- Millcreek Home Health & Hospice
- OneCare Home Health & Hospice
- Pine Mountain Home Health & Hospice
- PrimRose Home Care & Hospice
- Quality Solace Services Hospice
- Summit Home Health & Hospice
- Symbii Home Health & Hospice
- Tender Care Hospice
- Thatcher Brook Hospice
- Uintah Basin Home Care & Hospice
- Vista Care Hospice

Individual Members
- David Bishop, DMB Ventures
- Chris Briggs, American Red Cross
- Frank Barton, Right at Home of Salt Lake
- Karla Johnson, Chaplain
- PJ Jennings, VA Medical Center

Associate & Palliative Care Members
- Larkin Mortuary
MedPAC Finalizes FY2014 Hospice Recommendations

Commission Intends Flat Payments between FY2013 and FY2014

The Medicare Payment Advisory Commission (MedPAC) on Jan. 11, 2013 finalized hospice recommendations for inclusion in its March Report to Congress. As reported in December, MedPAC will recommend a zero market basket update for hospice payments beginning Oct. 1, 2013. It is estimated that the recommendation would save $50 to $250 million over one year and between $1 and $5 billion over five years. MedPAC also will include in its report standing recommendations that were first included in its 2009 report:

- Payment Reform Recommendation:
  - Increase payments per day at the beginning of the episode and reduce payments per day as the length of the episode increases;
  - Provide an additional end-of-episode payment to reflect hospices' higher level of effort at the end of life;
  - Budget neutral payment system in the first year.
- Recommendation for focused medical review of hospices with many long-stay patients

Given uncertainties about whether or not the 2 percent cut in Medicare payments required under the sequester will be implemented as scheduled in March, Chairman Glenn Hackbarth clarified that MedPAC does not intend for its recommendation, in combination with the scheduled sequester, to result in reimbursement cuts over the FY2013 payment level, except that they do expect a continuation of the phase out of the Budget Neutrality Adjustment Factor (BNAF) to the hospice wage index. The BNAF phase out has an annual impact of -0.6 percent on payments.

For this year (2013), MedPAC estimates hospice financial margins to be 6.3 percent (as compared with 7.5 percent in 2010). MedPAC staff reported that supply of hospice providers, volume of services provided, and access to capital all seem to be adequate. The staff presentation slides, which contain additional data about the Medicare hospice program, are available online at the following location: http://www.medpac.gov/transcripts/hospice_January2013_percent20public.pdf. The transcript of the entire two-day meeting is available here: http://www.medpac.gov/transcripts/Jan2013_transcript.pdf; the hospice discussion begins on page 326.

Perhaps the most engaging part of the Commission’s discussion centered around potential options for future research, including:

- Shared decision-making;
- Including hospice in MA rather than current carve-out;
- Focused FFS demonstrations of broader hospice eligibility;
- Including hospice in bundled payments approaches for episodes;
- Potential end-of-life care quality measures.

Staff noted that shared decision-making was examined to some degree by the Commission a few years ago; a further update will be provided at a forthcoming spring meeting; the Commission is interested in engaging in additional discussions on how to improve the quality and timing of discussions between patients and physicians relative to care choices, including end-of-life choices. Relative to including hospice in MA, staff posited that such an arrangement might result in better integration. Discussion on demonstrations of broader hospice eligibility raised comments about the concurrent care demonstration authorized under the Affordable Care Act (but not yet funded by Congress) as well as mention of an AETNA program focused on a younger population that allows coverage of concurrent care without an increase in care costs. Commissioners commented that bundled payment approaches could raise practical problems in hospice.

KBYU Channel 11 Supporters for 2013

Advocate Hospice  A-Plus Home Care & Hospice  Aspire Home Health & Hospice
Community Nursing Services  Curo Home Care & Hospice  Dignity Home Health & Hospice
Good Shepherd Home Care & Hospice  Gunnison Valley Home Care & Hospice  Hospice Care of Northern Utah
Heartwood Home Health & Hospice  Hospice Care of Northern Utah  Inspiration Hospice
Integrity Home Health & Hospice  Intermountain Healthcare  Millcreek Home Health & Hospice
OneCare Home Health & Hospice  Quality Solace Services Hospice  Rocky Mountain Home Care & Hospice
Silverado Hospice of Utah  South Davis Home Health & Hospice  VistaCare Hospice
Health Information Privacy with Mobile Device Use in Home Health and Hospice

Home health and hospice providers are at ever increasing risk of Health Insurance Portability and Accountability Act (HIPAA) violations due to vulnerabilities related to the growing use of mobile electronic devices. The HIPAA Security Rule “requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.”

The recently posted final rule: Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules addresses electronic media and the transmission of protected health information through a web-based portal, e-mail, on portable electronic media, or other means, covered entities. According to the rule, covered entities should ensure that reasonable safeguards are in place to protect the information. This final rule defines electronic media as:

- Electronic storage material on which data is or may be recorded electronically, including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; and
- Transmission media used to exchange information already in electronic storage media. Transmission media includes, for example, the Internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media.

Transmissions of protected health information via paper, facsimile, and voice via telephone, are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.

The U.S. Department of Health and Human Services (DHHS) offers extensive guidance on privacy and security considerations when using mobile devices for the storing and transmission of protected health information. This information can be accessed at: http://www.healthit.gov/providers-professionals/your-mobile-device-and-health-information-privacy-and-security .

For purposes of the Mobile Device Privacy and Security, “a mobile device is a handheld transmitting device with the capability to access, transmit, receive, and store health information, and the provider has control over the mobile device. Examples of mobile devices include smartphones, tablets, and laptops.”

The DHHS site provides details on the following tips for protecting and securing health information when using a mobile device at How Can You Protect and Secure Health Information When Using a Mobile Device?

- Use a password or other user authentication.
- Install and enable encryption.
- Install and activate remote wiping and/or remote disabling.
- Disable and do not install or use file sharing applications.
- Install and enable a firewall.
- Install and enable security software.
- Research mobile applications (apps) before downloading.
- Maintain physical control.
- Use adequate security to send or receive health information over public Wi-Fi networks.
- Delete all stored health information before discarding or reusing the mobile device.

Also, guidance is available for healthcare organizations that allow their staff to use mobile devices for work at You, Your Organization and Your Mobile Device, such as:

- Decide whether mobile devices will be used to access, receive, transmit, or store patients’ health information or be used as part of your organization’s internal network or systems, such as an electronic health record system.
- Understand the risks to your organization before you decide to allow the use of mobile devices.
- Conduct a risk analysis to identify threats and vulnerabilities.
- Identify a mobile device risk management strategy, including privacy and security safeguards.
- Develop, document, and implement your organization’s mobile device policies and procedures to safeguard health information such as:
  - Mobile device management
  - Using your own device
  - Restrictions on mobile device use
  - Security or configuration settings for mobile devices
  - Conduct mobile device privacy and security awareness

Bums Magleby Scholarship Recipient

Erika Torres, Caregiver Support Network
For Kristy Chambers, chief executive officer of Salt Lake City’s Fourth Street Clinic, the memory is still troubling — and motivating. “We had a gentleman who came to us who was in the latter stages of his life,” she said softly, her upbeat demeanor noticeably shifting at the memory. “He knew he was dying, and he seemed to be at peace with it.”

The clinic, located on the southwest corner of 400 South and 400 West, exists to provide a wide variety of medical services to Salt Lake City’s growing homeless population. Its effectiveness and capability are the envy of other homeless service providers around the country, and the full resources of the facility were employed on behalf of the man Chambers was talking about.

“We did the best we could to care for him,” she said. “We even tried to help him reconnect with his family. That’s what he needed at this point in his life, but that didn’t happen.”

That isn’t unusual among the chronically homeless, she observed. Often family ties have been so severely severed that there is no reconnection to be made.

“He reached the point where he was close to the end, and what he needed was hospice care,” she said. “But he had no insurance, and he wasn’t covered by Medicaid, and he had no family. He died in a hospital emergency room — alone, in that sterile environment, without any love or peace or dignity.”

Chambers paused for a moment, then looked up.

“Nobody should die alone like that,” she said. “These folks deal with enough indignity in their lives. They should at least be allowed to die with some degree of dignity. But everything is extended out to the extreme when you’re dealing with our homeless individuals.”

That will soon change, if Deborah Thorpe has anything to say about it. Thorpe is an advance practice nurse at the Huntsman Cancer Institute and is experienced in end-of-life care. As a volunteer she has been working closely with Chambers and her staff as well as the Salt Lake City interfaith community to create a much-needed hospice for the homeless that will eventually include a home and surrogate families to surround dying residents with love, faith and dignity.

“We call it the Inn Between,” Thorpe said. “It will be for those who fall in between the cracks of the health care system.”

It will also be a place where people of faith can come to serve — which is exactly how the idea of a hospice for the homeless got started in the first place.

“I was working one Saturday at the food bank at St. Paul’s Episcopal Church,” Thorpe said. “We see a lot of sad situations among the people who come to the food bank, including some who are clearly getting close to the end of their lives. Some of us who were working there that Saturday started worrying: What happens to these people? Who is there for them?

“Taking care of people at the end of life is part of my profession,” Thorpe continued. “But I know that hospice care costs money, and it relies on the cooperative efforts of medical professionals, hospice care providers and family and friends. Usually it happens in the home. But what happens when you are homeless, and you have no money, no insurance, no family, no friends?”

Eventually Thorpe brought her concerns initially to the now retired Fourth Street Clinic Founder, Allan Ainsworth, whose staff was already wrestling with the problem as a result of too many experiences like the gentleman who died in the hospital emergency room alone.

“We’ve had problems getting homeless people placed in hospice care,” Chambers said. “We knew we needed to do something about this.”

And so the Fourth Street Clinic did what the Fourth Street Clinic does best: It collaborated.