



# LOUISIANA~MISSISSIPPI

## HOSPICE AND PALLIATIVE CARE ORGANIZATION

### CENTER PULLOUT SECTION

# PROVIDER MEMBERSHIP APPLICATION

Complete this application and return it with your membership dues.

ALL INFORMATION CONTAINED WITHIN WILL BE HELD IN THE STRICTEST CONFIDENCE AND ONLY USED FOR END-OF-LIFE CARE RESEARCH.

**Term of membership: January 1 - December 31, 2008**

The purpose of the Louisiana-Mississippi Hospice and Palliative Care Organization is to foster and promote quality hospice and End-of-life care, as defined by the National Hospice and Palliative Care Organization's Standards and Guidelines, for the terminally ill and their families. LMHPCO provides a network for the evolution and dissemination of communication, education, legislation, and standards of care related to end-of-life care in Louisiana and Mississippi. Members commit themselves to observance of these standards and support the goals and objectives of LMHPCO.

_____	_____
Hospice Name	Mailing Address
_____	_____
Location Address	City, State, Zip
_____	_____
Contact Person	Title
_____	_____
Telephone Number	FAX Number
_____	_____
Web site Address	Office/Staff E-mail Address
_____	_____
Name of Voting Member	Voting Member's E-mail Address

**LIST OTHER PHYSICAL OFFICES LOCATIONS (WITH THE SAME PROVIDER NUMBER)**

1. _____	_____
Hospice Name	Location/Mailing Address
_____	_____
Telephone Number / FAX Number	City, State, Zip
_____	_____
Contact Person	E-mail address
_____	_____
2. _____	_____
Hospice Name	Location/Mailing Address
_____	_____
Telephone Number / FAX Number	City, State, Zip
_____	_____
Contact Person	E-mail address

**INCLUDE ANY ADDITIONAL PHYSICAL OFFICE INFORMATION ON A SEPARATE SHEET**

<b>AFFILIATIONS:</b>	<b>MEMBERSHIPS:</b>	<b>CERTIFICATION/LICENSURE STATUS:</b>
<input type="checkbox"/> Hospital Administered (owned/operated)	<input type="checkbox"/> NHPCO	<input type="checkbox"/> (Louisiana) Medicare Certified
<input type="checkbox"/> Hospital/Home Health (dually licensed)	<input type="checkbox"/> HFA	<input type="checkbox"/> (Mississippi) Medicare Certified
<input type="checkbox"/> Freestanding	<input type="checkbox"/> HAA	<input type="checkbox"/> (Louisiana) Medicaid Certified
<input type="checkbox"/> In-Patient Facility	<input type="checkbox"/> Last Acts Partner	<input type="checkbox"/> (Mississippi) Medicaid Certified
<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Other _____	<input type="checkbox"/> JCAHO Accredited
		<input type="checkbox"/> CHAPS Accredited
Date Opened: _____	Date Licensed: _____	<input type="checkbox"/> For Profit
		<input type="checkbox"/> Not for Profit

PLEASE CONTINUE ON NEXT PAGE

## Calculation of Membership Dues

Provider Member dues are based on 3 items: 1) **Base fee for the primary office of the provider**; 2) **Number of additional physical locations** that are under the same state license number as the primary office; and 3) **Number of new admissions for the past year** under the same provider number.

First, the base fee is filled in for you. Second, multiply the number of physical locations that are in addition to the primary office times \$300.00. Third, list the number of all new hospice patients admitted under the same provider number in the previous calendar year, regardless of reimbursement, and multiply times \$4.00, up to a maximum of 500 new admissions per year.

Note: Each program's patient total information will remain confidential and will not be disclosed in any form.

Each separately State licensed provider must have a separate LMHPCO Provider Membership.

First-time Provider Member dues are \$400.00, instead of \$800.00, for the first year of operations or during the initial year of the formation of the hospice.

### Dues Formula for Provider Member:

A.	Annual Fee for Provider Member	\$800.00
B.	Additional Physical Locations (\$300.00 per location)	_____
C.	Total number of new admits in previous calendar year (Max 500)	
D.	Assessment per Patient	\$ 4.00
E.	Multiply patients x \$4.00 to calculate your Dues (Cx D=E)	
F.	Total LMHPCO Membership Dues (A+B+E=F)	_____

While the remaining questions in this application are not required for membership with LMHPCO, your responses to these questions are vitally important to our research and advocacy efforts related to end-of-life care in Louisiana and Mississippi. If an individual question cannot be answered due to limitations in your reporting capabilities, please indicate this and move into the next question. LMHPCO encourages all members to provide as much information as possible.

## Average Daily Census and Length of Stay

Please review the definitions and calculation examples carefully before completing the following data for the last 12-month period:

**Average Length of Stay (ALOS):** \_\_\_\_\_

Divide the total days of care provided to discharged patients in 2006 by the total number of patients discharged in 2006. EXAMPLE: 100 patients died or were discharged in 2006. Their total patient days from admission to discharge were 4200.  $ALOS = 4200 / 100 = 42$  days.

**Median Length of Stay (MLOS):** \_\_\_\_\_

The midpoint of all discharged patients in 2006 (same populations as for ALOS, above). Half of the patients has a LOS longer than the median and half of the patients have a LOS shorter than the median. Calculate the MLOS by arranging the LOS scores for all patients for all patients from lowest to highest (1,2,3...). Find the score that falls in the exact middle of the list. This is the median length of stay. EXAMPLE 1: Even number of patients. You have six patients that stayed the following number of days: 11, 2, 9, 5, 8, 4. When you arrange the numbers lowest to highest, the middle numbers are 5 and 8. the median is the average of these two numbers, which is 6.5. EXAMPLE 2: Odd number of patients. You have five patients who stayed the following number of days: 10, 7, 3, 8, 22. When you rearrange the numbers lowest to highest, the middle number is 8, which is your MLOS.

**Average Daily Census (ADC):** \_\_\_\_\_

ADC is computed as follows: Take all patients days for a given period and divide by the number of days in that period.

**Total Number of Death:** \_\_\_\_\_

Number of patients Who Died in 7 days or less: \_\_\_\_\_ Who Died in over 180 days: \_\_\_\_\_

## Level of Care and Pay Source

Provide number of patients days for all patients served for the 12 month time frame.

Payment Source	# of Patients Served	Days of Routine Home Care	Days of Inpatient Care	Days of Respite Care	Days of Continuous Care	Total Patient Care Days
Medicare						
Medicaid						
Private Insurance						
Self Pay*						
Other**						
Totals:						

\*Self Pay is to include indigent care and foundation assistance. \*\*Other payment sources may include but are not limited to VA, Worker's Compensation, or other sources of payment.

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## Admissions

\_\_\_\_\_ Unduplicated Admissions  
 \_\_\_\_\_ Readmissions  
 \_\_\_\_\_ Veterans

## Discharges

\_\_\_\_\_ Death discharges  
 \_\_\_\_\_ Transfer to another hospice  
 \_\_\_\_\_ Revocation discharges  
 \_\_\_\_\_ No longer met hospice criteria

## Referral Sources

Data should reflect all hospice admissions during the last 12-month period regardless of pay source. Count individuals referred from two sources only once, under the initial referral source. An affiliated agency is defined as an agency that is co-owned or operated by the same principals and/or shares resources with the hospice agency. A non-affiliated agency is defined as an agency that has no co-ownership or common resources with the hospice agency.

Referral Source	# of Patients Admitted
Hospital (discharge planner, etc.):	_____
affiliated Home Health Agency:	_____
Non-affiliated Home Health Agency:	_____
Physician:	_____
Family or Self:	_____
Community Service Organization:	_____
Nursing Facility	_____
Assisted Living Facility:	_____
Other (Please specify):	_____
TOTAL PATIENTS:	_____

## Admissions and Deaths by Location

Please document the number of admissions and deaths in each location during the last 12-month period. Admission location is the actual site where the patient was on the first day of care.

Location	# of Admissions	# of Deaths
<b>Home</b> - Private residence of patient or caregiver	_____	_____
<b>Nursing Facility</b> - A licensed facility providing nursing and supportive services (may be Skilled Nursing Facility or Intermediate Care Facility)	_____	_____
<b>Hospice Inpatient Unit</b> - (operated by the hospice or another licensed hospice)	_____	_____
<b>Hospital</b>	_____	_____
<b>Residential Care Setting</b> - (assisted living facility, Group home, etc.)	_____	_____
<b>TOTALS:</b>	_____	_____

## Number of Patients by Diagnosis

Please provide the number of hospice patients admitted during the last 12-month period regardless of pay source. Count the patient only under the primary diagnosis at admission, for which care is provided. Report each patient only once.

Diagnosis	Comments	# of Admissions
Cancer	Include all cancers (ICD-9 codes 140-239)	
Heart Disease	All patients with heart disease including CHF & Primary Sclerotic Heart Disease (ICD-9 codes 390-459 - not including 436)	
Dementia	Include Alzheimer's, vascular dementia etc., (ICD-9 codes 290-319, plus 331.0)	
Pulmonary Disease	COPD (emphysema) and other non-cancer lung diseases (ICD-9 codes 460-519)	
Renal Diseases	End stage renal disease (ICD-9 codes 580-629)	
Liver Disease	Cirrhosis, Advanced Hepatitis, and other non-cancer liver disease (ICD-9 codes 520-579)	
HIV	All AIDS and HIV related conditions (ICD-9 code 042)	
Stroke/Coma	Stroke-CVA (ICD-9 code 4360; Coma (ICD-9 code 780.01)	
Neurological Disease	Include ALS, Parkinson's, Huntington's, MS (ICD-9 codes 320-389, except 331.0)	
Other Disease Process	Include Terminal Debility, Failure to Thrive (ICD-9 codes 780-799, except 780.01)	
	<b>TOTAL:</b>	

## Patient Demographics

For the last 12-month period, report the number of patients admitted that falls into each category below:

GENDER	RACE/ETHNICITY	AGE (Years)
Male: _____	American Indian: _____	0-17: _____
Female: _____	African American: _____	18-34: _____
	Hispanic: _____	35-64: _____
	Asian: _____	65-74: _____
	Caucasian: _____	75-84: _____
	Other race: _____	85+: _____
TOTAL: _____	TOTAL: _____	TOTAL: _____

# Staffing Levels

List Full Time Equivalents for each discipline.

STAFFING	EMPLOYEE	VOLUNTEER	CONTRACT
PHYSICIAN			
RN			
LPN			
MSW			
HOMEMAKER			
HHA			
COUNSELOR			
PT			
OT			
SLP			
OTHER			

E-MAIL CONTACTS FOR YOUR AGENCY (\*monthly e-newsletter, The Journal recipient):

Medical Director(s) \_\_\_\_\_  
 Administrator: \_\_\_\_\_  
 Office Manager: \_\_\_\_\_  
 DON/PCC: \_\_\_\_\_  
 Social Worker: \_\_\_\_\_  
 Chaplain: \_\_\_\_\_  
 Volunteer Manager: \_\_\_\_\_  
 Pharmacist: \_\_\_\_\_  
 Marketing: \_\_\_\_\_  
 Educators: \_\_\_\_\_

## Volunteers

	# of Volunteers	Volunteer Hours	Visits
Direct Patient Care Volunteers	_____	_____	_____
Patient Care Support Volunteers	_____	_____	N/A
General Support Volunteers (i.e., board members, fundraising volunteers)	_____	_____	N/A
<b>ALL HOSPICE VOLUNTEERS</b>	_____	_____	_____

## Bereavement Contacts

	Family Members	Community Members
Total Number of Contacts	_____	_____
Total Number of Individuals who received bereavement services	_____	_____

## Type of Control

NON-PROFIT	FOR PROFIT (PROPRIETARY)	GOVERNMENT
____ RELIGIOUS AFFILIATION	____ INDIVIDUAL	____ STATE/PARISH
____ PRIVATE	____ PARTNERSHIP	____ LOCAL GOVERNMENT
____ OTHER	____ CORPORATION	____ COMBINATION
	____ OTHER	

**PLEASE MAIL COMPLETED APPLICATION AND PAYMENT TO:**

**LMHPCO, 717 Kerlerec, New Orleans, LA 70116**

Telephone: (504) 945-2414 Toll Free: (888) 546-1500 Fax: (504) 948-3908

www.LMHPCO.org Email: LMHPCO@AOL.com