

ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

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STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

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April 24, 1992

The Honorable Darrel J. Rexwinkel
Commissioner
Department of Revenue
P. O. Box 110400
Juneau, AK 99811

RE: Interpretation of Budget
Reserve Fund (Alaska Const.
art. IX, § 17)
Our File #'s: 663-91-0298
663-92-0189; -0256; -0107
Opinion No. 1

Dear Commissioner Rexwinkel:

This is in reply to your request for our views on several questions which you raise concerning Article IX, Section 17 of the Alaska Constitution. This constitutional provision, which became effective on January 2, 1991, following its ratification by the voters as an amendment to the Alaska Constitution, creates a budget reserve fund and requires that the proceeds of certain tax and mineral revenue disputes be deposited into the fund. This amendment also establishes limitations on the legislature's ability to spend money from the budget reserve fund.

The questions which you have presented to us and our views on them are as follows:

I. SUMMARY

1. Does the dedication required by the amendment apply to the proceeds received from the termination of administrative proceedings and lawsuits before the effective date of the amendment?

Yes. The amendment applies to all such proceeds received after July 1, 1990.

2. Does the amendment repeal the statutory budget reserve fund established by AS 37.05.540?

No. The preexisting statutory budget reserve fund remains a viable depository of public funds after the adoption of the amendment.

3. Does the amendment supersede other valid dedications of proceeds that are within the scope of the amendment?

No. Under the amendment, other dedications of revenue may apply to settlement proceeds prior to the dedication of revenue to the fund created by the amendment.

4. What is the meaning of the term "administrative proceeding" in the amendment as applied to tax disputes pending before the Department of Revenue?

"Administrative proceeding," in the amendment, means formal adjudicatory proceedings.

II. ANALYSIS

- A. Does the dedication required by the amendment apply to proceeds received by the state before the effective date of the amendment?

The amendment in pertinent part provides:

Except for money deposited into the permanent fund under Section 15 of this article, all money received by the State after July 1, 1990, as a result of the termination, through settlement or otherwise, of an administrative proceeding or of litigation in a State or federal court involving mineral lease bonuses, rentals, royalties, royalty sale proceeds, federal mineral revenue sharing payments or bonuses, or involving taxes imposed on mineral income, production, or property, shall be deposited in the budget reserve fund.

Alaska Const. art. IX, § 17 (emphasis added). The amendment expressly applies to revenues received before its effective date.

The Alaskan constitution provides that, "unless otherwise provided in the amendment, [the amendment] becomes effective thirty days after the certification of the election returns by the lieutenant governor." Alaska Const. art. XIII, § 1 (emphasis added). The state constitution is construed using the same rules that apply to the construction of statutes. 2 Norman J. Singer, Sutherland Statutory Construction § 41.04 (rev. 4th ed. 1986).

Under most circumstances, a constitutional amendment should be construed to avoid retroactive effects. Cf. AS 01.10.090 ("No statute is retrospective unless expressly declared therein").

However, "the electorate may nonetheless achieve retroactive effects by clear and unambiguous language." State ex rel. Maloney v. McCartney, 223 S.E.2d 607, 613 (W. Va. 1976) (citing 1 T.M. Cooley, Cooley's Constitutional Limitations (136-37 (8th ed.))); see also Matthews v. Quinton, 362 P.2d 932 (Alaska 1961), cert. denied, 368 U.S. 517 (1962) (constitutional provision may retroactively validate statute previously held unconstitutional, since constitutional provision contained reference to statute intended to be validated). Here, since the amendment clearly and unambiguously states that it applies to revenues received after July 1, 1990, it applies retrospectively to settlement proceeds received after the beginning of fiscal year 1991, even though the amendment did not take effect until January 2, 1991.

B. Does the amendment repeal the statutory budget reserve fund established by AS 37.05.54?

1. Status of the 1991 appropriation to the statutory fund

The same legislative session that adopted the constitutional budget reserve fund also purported to appropriate settlement revenues into a statutory fund established in AS 37.05.540. The statutory fund appropriation provided:

That portion of the money received by the state on or after the effective date of this Act as a result of the termination, through settlement or otherwise, of an administrative proceeding or litigation involving mineral lease rentals, royalties, royalty sale proceeds, or federal mineral revenue sharing payments or bonuses that is

The Honorable Darrel J. Rexwinkel
File #'s: 663-91-0298; 663-92-0189
663-92-0256; -0107

April 24, 1992
PAGE 5

not dedicated to the permanent fund under art. IX, sec. 15, Constitution of the State of Alaska, or to the public school trust fund under AS 37.14.150 is appropriated to the budget reserve fund (AS 37.05.540).

Ch. 194, SLA 1990. However, this appropriation was not obligated after it took effect. In fact, the appropriation was not encumbered or expended pending voter ratification of the budget reserve fund amendment. Upon ratification, all amounts covered by the appropriation were deposited in the fund created by the amendment.

Thus, the legislature did not intend to have the chapter 194 appropriation processed if the amendment was ratified by the voters. This appropriation was a backup measure designed to ensure that known settlement proceeds were reserved to cover future budgetary shortfalls.

2. Continued viability of the statutory budget reserve fund

The Department of Administration has asked whether the constitutional budget reserve fund operates to impliedly repeal the statutory fund. In deciding what constitutes a repeal in a conflict between a state statute and a state constitutional provision, we apply the same considerations as in conflicts between two state statutes. Fine & Son v. Hall, 21 P.2d 697 (Cal. App. 1933); see also 16 C.J.S. Constitutional Law § 41, at 117-20. In Alaska, a repeal by implication is not a favored construction.

Warren v. Thomas, 568 P.2d 400 (Alaska 1977). Where the provisions are irreconcilable, the later act, to the extent of conflict, constitutes an implied repeal of the earlier one. If the later act covers the entire subject of the earlier one and is intended as a substitute, it will operate to repeal the earlier act. Peter v. State, 531 P.2d 1263 (Alaska 1975).

Here no irreconcilable differences exist between the amendment and the statute. Moreover, no evidence has come to light that the framers of the amendment intended to subsume the statutory fund within the constitutional fund. Therefore, the statutory fund continues in effect until amended or repealed by the legislature.

C. Does the amendment supersede other valid dedications of proceeds that are within the scope of the amendment?

Although the amendment expressly allows dedications to the Alaska Permanent Fund, there are other dedications for which no provision is made by the amendment. Specifically, the amendment does not resolve conflicts with certain dedications of revenue established by statute to satisfy trust obligations imposed by federal law.

Under AS 37.14.150, one-half of one percent of state revenue derived from settlements subject to the amendment must be deposited in the public school trust fund (AS 37.14.110). They may also be subject to a conditional dedication in favor of the Mental

The Honorable Darrel J. Rexwinkel
File #'s: 663-91-0298; 663-92-0189
663-92-0256; -0107

April 24, 1992
PAGE 7

Health Trust Income Account (AS 37.14.011), if the settlement proceeds constitute "unrestricted general fund revenue." These two trust funds are statutory dedications of state revenue required by federal law. See, e.g., 1985 Inf. Op. Att'y Gen. (Aug. 13; 366-403-85). The state constitution permits dedications that existed before statehood or that are required for participation in a federal program. Alaska Const. art. IX, § 7.

The amendment must be construed to avoid conflict with other provisions of the Alaska Constitution. Abrams v. State, 534 P.2d 91 (Alaska 1975). Whenever reasonably possible, related provisions of an enactment should be harmonized and given their full meaning and effect. Park v. State, 528 P.2d 785 (Alaska 1974). Absent a clear expression of intent that the amendment must take precedence over other valid dedications required by federal law, these pre-existing dedications should be excluded from the reach of the amendment. Research into the history of the amendment reveals no evidence of such an intent.

Therefore, the amendment applies to proceeds net of dedications otherwise permitted under Article IX, Section 7.

D. What is the meaning of the term "administrative proceeding" in the amendment as applied to tax disputes pending before the Department of Revenue?

Dedicated to a budget reserve fund by the amendment are disputed mineral lease bonuses, rentals, royalties, royalty sale

The Honorable Darrel J. Rexwinkel
File #'s: 663-91-0298; 663-92-0189
663-92-0256; -0107

April 24, 1992
PAGE 8

proceeds, federal revenue sharing payments or bonuses, and the proceeds of taxes imposed on mineral income, production, or property received "as a result of the termination, through settlement or otherwise, of an administrative proceeding or of litigation in a state or federal court."

Dedications to the budget reserve fund from the termination of "litigation in a state or federal court" are readily identifiable. Since litigation is initiated with the filing of a complaint, the proceeds from a resolution of a mineral revenue dispute received following the filing of a complaint involving the disputed liability must be deposited in the budget reserve fund. As a general rule, litigation is the only formal vehicle for resolving disputes involving mineral revenues other than taxes, so normally money received by the state from these revenues will be dedicated to the budget reserve fund.

No ambiguity exists as to whether revenues received as the result of the termination of formal adjudicatory hearings conducted by the Department of Revenue pursuant to statute are dedicated to the budget reserve fund. They fall squarely within the ambit of the amendment. Whether the informal conference process established by AS 43.05.240 for the resolution of tax disputes is an "administrative proceeding" is a question which requires detailed analysis.

The Honorable Darrel J. Rexwinkel
File #'s: 663-91-0298; 663-92-0189
663-92-0256; -0107

April 24, 1992
PAGE 9

1. The conference process for tax disputes

Alaska Statute 43.05.240, enacted in 1976, provides both formal and informal mechanisms for the resolution of state tax disputes. The informal procedure furnishes the taxpayer an opportunity to present objections to a departmental official at an informal conference. AS 43.05.240(a). Corrections to the assessment or penalty are required to be made by the Department if, as a result of the informal conference, the Department determines that a correction is warranted. Taxpayers dissatisfied with the outcome of the informal conference may request a formal conference.¹

Under the formal hearing procedure, an adversarial hearing is held at which the taxpayer may present evidence and argument relevant to the amount of the tax and penalty owing the state. AS 43.05.240(b). The hearing officer is empowered to issue subpoenas, administer oaths, and make inquiries necessary to determine the amount of tax or penalty due, and, following the hearing, is required to issue a written, final decision adjudicating the taxpayer's liability. AS 43.05.240(c). Only after exhausting the formal hearing procedure may the taxpayer appeal to the superior court. AS 43.05.240(d).

¹ An aggrieved taxpayer may bypass the informal conference by immediately requesting a formal hearing. AS 43.20.240(b)(1).

2. Rules of construction to determine meaning of "administrative proceeding"

a. Common meaning of "administrative proceeding"

The Alaska Supreme Court recently noted that an "important right of the people implicated in all cases of constitutional construction" is the "right to have the constitution upheld as the people ratified it." Citizens Coalition for Tort Reform v. McAlpine, 810 P.2d 162, 168 (Alaska 1991). See also Thomas v. Bailey, 595 P.2d 1 (Alaska 1979). At issue in Citizens Coalition was the meaning of "rule" in the context of the constitutional provision defining the rule-making power of the Alaska Supreme Court. The proper approach to the analysis of constitutional provisions, the court explained, is as follows:

Because of our concern for interpreting the constitution as the people ratified it, we generally are reluctant to construe abstrusely any constitutional term that has a plain ordinary meaning. Rather, absent some signs that the term at issue has acquired a peculiar meaning by statutory definition or judicial construction, we defer to the meaning the people themselves probably placed on the provision. Normally, such deference to the intent of the people requires "adherence to the common understanding of words."

Id. at 169 (citations omitted). Applying this approach, the court looked to a standard dictionary to determine the common understanding of the word at issue.

This approach is appropriate here to ascertain the meaning the people themselves probably placed on the term "administrative proceeding" when they ratified the proposed amendment.² In a legal context, "proceedings" is defined in Webster's Third New International Dictionary at 1807 (Unabridged 1976) as "the course of procedure in a judicial action or in a suit in litigation: legal action . . . (2) a particular action at law or case in litigation"

Since this definition makes reference to "litigation," and "cases or actions at law," the plain, ordinary meaning of these words is important, too. "Litigate" is defined as "to carry on a legal contest by judicial process . . . to contest in law." Webster Ninth New Collegiate Dictionary at 698 (1987). Thus, in the legal context, the common understanding of the term "proceeding" leads to the conclusion that only those administrative actions which can be analogized to legal contests are within the amendment.

Informal conferences fall outside the ambit of the common understanding of litigation or legal contests. A conference, in the common understanding of the word, is inapposite to a legal

² Since the term "administrative proceeding" has not acquired a particular meaning by statutory definition or judicial construction, reference to a standard dictionary should be employed. See State v. Woods, 345 N.W.2d 457, 474 (Wis. 1984) "[t]he common and approved usage of [proceeding] in a statute may be ascertained by reference to a recognized dictionary".

The Honorable Darrel J. Rexwinkel
File #'s: 663-91-0298; 663-92-0189
663-92-0256; -0107

April 24, 1992
PAGE 12

contest. For example, Tormont Webster's Dictionary defines a conference as "a meeting for consultation or discussion." The Tormont Webster's Illustrated Encyclopedia Dictionary 367 (1990). This common understanding of the word squares with the statutory process for informal resolution of tax disputes. By regulation, the informal conference is a meeting between the taxpayer (or the taxpayer's representative) and a department "appeals officer." 15 AAC 05.020. The "appeals officer" at the informal conference is not a judicial or quasi judicial officer. The written decision of the appeals officer following an informal conference simply sets out the points of disagreement between the parties. Id. It is not a process which results in the protection of a legal right, or redresses or prevents a wrong, as does a judgment or other order enforceable by judicial process. Labeling the statutory conference as "informal" supports the conclusion that the "informal conference" is a process inherently different than a legal contest.

Application of well recognized tenets of statutory construction also yields the conclusion that the informal conference procedure is not an "administrative proceeding." Constitutional provisions are interpreted under the same principles as those applied in the interpretation of the statutes. See Citizens Coalition at 169 ("the basic principles of statutory interpretation apply to constitutions"). A "widely applied tenet of statutory interpretation [is] that if the legislative intent or

general meaning of a statute is not clear, the meaning of doubtful words may be determined by reference to their association with other associated words and phrases." State, Real Estate Commission v. Johnston, 682 P.2d 383, 386-87 (Alaska 1984) (quoting 2A C. Dallas Sands, Sutherland Statutory Construction § 47.16 at 101 (4th ed. 1973)). Another rule of statutory construction applicable here is that provisions relating to the same subject matter should be read as a whole so that a total scheme evolves which maintains the integrity of each provision and avoids ignoring one provision over another. Conner v. State, 696 P.2d 680, 682 n.3 (Alaska App. 1985). Since in the amendment the term "administrative proceeding" appears in association with the phrase "litigation in a state or federal court," the electorate must have understood that the term "administrative proceeding" referred to a process akin to litigation. This conclusion is supported by reference to the words "termination" and "settlement" used earlier in the amendment; these are words commonly used in reference to lawsuits, not conferences or meetings.

b. Harmonizing the amendment with the constitutional preference for unrestricted revenues

A preference for unrestricted revenues is implicit in the general prohibition against dedicated funds contained in the Alaska Constitution. Art. IX, § 7. However, under the amendment money required to be deposited into the budget reserve fund is dedicated,

and is not available for the unfettered exercise of the legislative power of appropriation. The divergence between these provisions is minimized by construing "administrative proceeding" to avoid an expansive interpretation of the budget reserve amendment. See Abrams, 534 P.2d at 95 (if possible, conflicting provisions of constitution should be harmonized).

3. Legislative and electoral history

In determining the meaning of a term in the constitution, courts also scrutinize the history of the constitutional provision at issue. Citizens Coalition, 810 P.2d at 170. Unfortunately, here the history of the amendment provides little guidance for interpretation of "administrative proceeding."³

- a. The legislative history of the amendment provides no assistance in interpreting "administrative proceeding."

Article IX, section 17, was adopted by the 1990 legislature as Legislative Resolve No. 129. Although the vehicle for the Resolve was a Senate Resolution, SJR 5, that Resolution had

³ All tax disputes arising out of revenues from the development of the North Slope have been resolved through the administrative process. These informal conferences and formal hearings are confidential by law. AS 43.05.230. However, prior to enactment of the amendment, two settlements were publicly announced by the taxpayer and the state jointly because of the magnitude of the dollars involved. Both cases involved tax disputes with Atlantic Richfield Company. Both cases were administrative proceedings in formal hearing before the Department of Revenue. It appears that these settlements were part of the inspiration for the amendment.

The Honorable Darrel J. Rexwinkel
File #'s: 663-91-0298; 663-92-0189
663-92-0256; -0107

April 24, 1992
PAGE 15

earlier been drafted largely by the House Finance Committee as CSHJR 66 (Fin). An amendment adopted on the House floor essentially replaced the original Senate Resolution with CSHJR 66 (Fin), and the Senate later concurred with this amendment.

The original version of SJR 5 that came to the House from the Senate provided:

Except for money deposited into the permanent fund under Section 15 of Article IX, all money received by the State as a result of the termination through settlement or otherwise, of litigation in State or federal court involving mineral lease rentals, royalties, royalty sale proceeds, and federal mineral revenue sharing payments and bonuses shall be deposited in the budget reserve fund.

CSSSSJR 5 (Fin). The House Finance Committee modified this Resolution by, inter alia, including the reference to "an administrative proceeding" and adding "or involving taxes imposed on mineral income, production, or property."

The additional language was proposed to the House Finance Committee by Representative Kay Brown, and was drafted by the House Fiscal Policy Subcommittee in conjunction with the Office of Management and Budget. Mary Halloran, former Governor Cowper's budget officer, urged the committee to establish a budget reserve fund that included not only amounts received from pending litigation--including the Amerada Hess and the Dinkum Sands cases--but also amounts received for "back taxes still under consideration

The Honorable Darrel J. Rexwinkel
File #'s: 663-91-0298; 663-92-0189
663-92-0256; -0107

April 24, 1992
PAGE 16

in the Department of Revenue." House Finance Committee, Committee Tape 90-95, side 1 (May 1, 1990).⁴

These few historical items shed no light on the interpretation of "administrative proceeding," and nothing else in the legislative process shows that a committee, subcommittee, or legislator directly considered the question of what constitutes an "administrative proceeding."⁵

- b. The ballot summary provided to the electorate before ratification provides no assistance in interpreting "administrative proceeding."

When a proposed constitutional amendment is to be presented to the electorate for ratification, the official elections pamphlet must include the full text of the proposed amendment, the ballot title and summary of the proposal prepared by the director of the Division of Elections or the lieutenant governor, a neutral summary of the amendment prepared by the

⁴ Amerada Hess was a longstanding dispute in state court over the value of royalty oil to which the state was entitled; the original amount in dispute approached a billion dollars. Dinkum Sands, litigation in the United States Supreme Court, involves the location of the boundary between state and federal offshore mineral rights in the oil-rich Beaufort Sea; several hundred million dollars are at issue.

⁵ Subsequent pronouncements of legislators regarding the legislative intent in enacting a provision "are irrelevant to a determination of legislative intent." Lynden Transport, Inc. v. State, 532 P.2d 700, 716 (Alaska 1975).

The Honorable Darrel J. Rexwinkel
File #'s: 663-91-0298; 663-92-0189
663-92-0256; -0107

April 24, 1992
PAGE 17

Legislative Affairs Agency, and statements in support of and in opposition to the amendment. AS 15.58.020(6).

The ballot summary for the budget reserve fund amendment described the revenue source for the fund as "money the state receives from mineral revenue lawsuits or administrative actions." The neutral summary, prepared by the Legislative Affairs Agency uses the term "administrative proceeding" to explain one of the sources of potential funding. Neither summary described or defined the reach of the amendment with respect to "administrative proceedings." Nor did the statement in support of the amendment, authored by Senator Faiks and Representatives Brown and Phillips, distinguish between the two types of administrative processes involved in resolution of tax disputes.⁶ All statements in the voter pamphlet associate the terms "administrative actions" or

⁶ This statement in the voter pamphlet makes three oblique references to administrative proceedings:

Revenues from mineral or oil and gas legal settlements and administrative proceedings will be deposited into the Budget Reserve.

. . . .

Legal settlements involving mineral or oil and gas revenues received after July 1, 1990, will be deposited into the Budget Reserve. . . . If approved, the Budget Reserve Fund will help hold down spending by removing from the table the oil and gas revenue "windfalls" that result from pending litigation and tax disputes.

"administrative proceedings" with "lawsuits," providing additional support for the view that the "administrative action" referred to was a process in the nature of a legal contest or litigation.

c. The terms "windfalls" and "back taxes" are not helpful in resolving the issue

Although the terms "windfalls" and "back taxes" appear several times in the history of the amendment, they are of no real value to this inquiry. First, these terms do not appear in the text of the amendment, and cannot be grafted into it. See Gray v. State, 463 P.2d 897, 904 (Alaska 1970) (it is not for the court to rewrite statutes). Second, the amendment itself clearly places within the budget reserve fund proceeds of tax disputes that are neither longstanding nor "windfalls." For example, tax revenues arising from the early settlement of litigation initiated by the state to recover taxes cannot properly be called either "windfalls" or "back taxes."⁷ "Windfalls" are commonly understood to be sudden and unexpected pieces of good fortune in financial form.⁸ Recoveries of assessed taxes are not unexpected nor, generally,

⁷ It would not be permissible to exclude settlement proceeds clearly within the scope of the amendment merely because those proceeds did not spring from "back taxes" or represent a "windfall." The amendment clearly requires some tax recoveries for other than long-standing back taxes to be placed in the budget reserve fund.

⁸ According to William Safire, "'windfall' is a 400-year-old word that means an unexpected benefit, graphically describing the good fortune that falls to a passer-by when a piece of fruit is blown off a tree." William Safire, On Language 144 (1981).

sudden. "Back taxes" would encompass all assessed taxes not paid upon receipt of the tax bill, and surely the amendment was not intended to sweep within its purview all disputed taxes. If such were the case, virtually all major tax assessments would be required to be placed in the budget reserve fund. Further, patently clear is that the amendment snares "future taxes" as well as "back taxes."

In sum, there is no firm evidence that either the legislature or the public directly considered the question of what constitutes an administrative proceeding for the purposes of the amendment. Accordingly, no conclusions on the proper interpretation of the amendment can be drawn from its history.

4. Judicial decisions

While the interpretation of the amendment advanced here is based principally on an analysis of the text of the amendment, judicial decisions construing the phrases "administrative proceeding" and "proceeding" provide helpful guidance for its interpretation. Research has revealed cases adopting an expansive definition of these terms as well as cases adopting a narrow definition of them. Generally, the outcomes in these cases turn on the context in which the term "administrative proceedings" is used. No cases were found interpreting "administrative proceeding" in a context similar to that of the amendment.

The Honorable Darrel J. Rexwinkel
File #'s: 663-91-0293; 663-92-0189
663-92-0256; -0107

April 24, 1992
PAGE 20

The more persuasive view expressed in the judicial decisions supports the conclusion that, in this context, "administrative proceeding" means "adjudicatory proceeding." See, e.g., Telco Communications v. Carbaugh, 885 F.2d 1225, 1227-30 (4th Cir. 1989) (an informal administrative fact-finding conference that was not "judicial in nature" was not an administrative proceeding for purposes of the Younger abstention doctrine); Manders v. Oklahoma ex rel. Dep't of Mental Health, 875 F.2d 263 (10th Cir. 1989) (a state agency's internal grievance procedure was not an "action or proceeding" within the meaning of § 706(k) of the 1964 Civil Rights Act, 42 U.S.C. § 2000e-5(k), governing awards of attorney's fees); American Centennial Ins. Co. v. EEOC, 722 F. Supp. 180 (D.N.J. 1989) ("proceeding" under § 709(e) of the 1964 Civil Rights Act, 42 U.S.C. § 2000e-8(e), which prohibits the disclosure of EEOC-obtained information "prior to the institution of any proceeding" under Title VII, did not include the EEOC's informal conference, conciliation, and persuasion process, undertaken after a charge is filed); Roosevelt-Wabash Currency Exchange v. Fornelli, 364 N.E.2d 449, 452-53 (Ill. App. 1977) (judiciary will review only an "administrative decision," defined as a decision "which terminates the proceedings before the administrative agency").

The Honorable Darrel J. Rexwinkel
File #'s: 663-91-0298; 663-92-0139
663-92-0256; -0107

April 24, 1992
PAGE 21

5. Conclusion

The amendment applies only to the proceeds of disputes that have progressed to an adjudicatory stage of the dispute resolution process. The amendment does not apply to the proceeds of disputes settled at the informal conference stage.⁹

Very truly yours,



Charles E. Cole
Attorney General

CEC:JLB:SCS:pml

⁹ Nothing in this memorandum alters the previous advice given to the Department of Revenue concerning the power of the attorney general to approve the compromise of tax claims. In a 1990 formal opinion, we explained the extent of the attorney general's and the department's power to correct or compromise tax claims at various stages of assessment or administrative appeal. 1990 Op. Att'y Gen. No. 1 (Dec. 3, 1990) (the attorney general's approval of a settlement that has the effect of compromising a tax claim is mandatory, even if the settlement of the dispute occurs before the matter is considered an administrative proceeding for purposes of allocating the recovery to the budget reserve fund).



Alaska State Legislature

Please enter into the record my testimony to the HSS - House
committee name

committee on HB 156 4157, dated 3/2/93
bill/subject

I strongly urge you to support HB 156
& HB 157. The facts are simple - BP tax
settlement has generated \$630,000,000.
The backlog of school construction &
maintenance is enormous. Schools
need help now! Waiting jeopardizes children.
Appropriate use of these funds is critical!
Help support our schools & support future
Alaskan jobs now.

Signed: Kathy Jarvis
Testifier

Representing (Optional)
HC 32 Box 6631 Wasilla, AK 99654
Address

376-5308
Phone No.



Alaska State Legislature

Please enter into the record my testimony to the House Health, Education & Social Services
 committee name
 committee on HB 156 and HB 157 , dated March 9, 1993
 bill/subject

I'm not in favor of those bills as is, because they don't tell who will get the money or specifics of what it will be used for. Also, what plans does DOE have for it. Also, I'd like to see something in writing concerning the rural areas needing the funding.

Signed: Angela R. Roehring
 Testifier

Representing (Optional)
HC 100 Box 4660 Delta Jet, AK.
 Address
8954947
 Phone No.

99737



Alaska State Legislature

Please enter into the record my testimony to the House Health, Education & Social
committee name

committee on House Bills 156 & 157, dated March 2, 1992.
bill/subject

I support House Bills 156 & 157. In particular, I would like to see the renovation of Swanson Elementary in Palmer. It was built in 1955 and has capacity for 275 students. There are currently 400 students enrolled.

Signed: Patricia J. Walker
Testifier

Representing (Optional)

HCO1 Box 6028W Palmer 99645
Address

746-4912
Phone No.



OFFICE OF THE CLERK, LEGISLATIVE COUNCIL, BETHEL

LEGISLATIVE AFFAIRS AGENCY

DIVISION OF PUBLIC SERVICES

DATE: 3-9-93

Please accept the enclosed original(s) of written testimony for the HUES 76 HR 156 in a teleconference hearing that was scheduled on 3-9-93.

A copy of this testimony was transmitted to your committee via fax on 3-9-93.

March 9, 1993

I support HR 156 and 157. Our children are attending schools that are old and overcrowded. Investing this money in schools would send a clear message to all of Alaska's students and teachers that they are important today.

We shouldn't put the money into some nebulous rainy day fund. For many of Alaska's students, the rainy day is here.

I urge you to support these bills.
Thank you.

I'm sorry I couldn't stay for the duration of the conference today. I was here waiting from 3-5 last Tuesday.

Kappy Olson
Box 982
Bethel Alaska



Alaska State Legislature

Please enter into the record my testimony to the House Health, Education & Social
 committee name
 committee on House Bills 156 & 157, dated March 2, 1992.
 bill/subject

I support House Bills 156 & 157. In particular, I would like to see the renovation of Swanson Elementary in Palmer. It was built in 1955 and has capacity for 275 students. There are currently 400 students enrolled.

Signed: Patricia Orner
 Testifier

Representing (Optional)

HCO1 Box 6028W Palmer 99645

Address

746-4916

Phone No.

HB156
HB157



Alaska State Legislature

Please enter into the record my testimony to the Hess - House
committee name
committee on HB 156 & 157, dated 3/2/93
bill/subject

I strongly urge you to support HB 156
& HB 157. The facts are simple - BP tax
settlements has generated \$600,000,000.
The backlog of school construction &
maintenance is enormous. Schools
need help now! Waiting jeopardizes children.
Appropriate use of these funds is critical!
Help support our schools & support future
Alaskan jobs now. Kathy Jarvis
Signed: _____

Testifier

Representing (Optional)

HC 32 Box 6631 Wasilla, AK 99654
Address

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Phone No.

WALTER J. HICKEL
GOVERNOR



P. O. Box 110001
Juneau, Alaska 99811-0001
(907) 465-3500

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

SS HB 156

February 22, 1993

*The Honorable Ramona L. Barnes
Speaker of the House
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182*

Dear Speaker Barnes:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a sponsor substitute for HB 156 introduced at my request earlier this session.

This sponsor substitute more clearly reflects my intent to establish a statutory fund to be used for capital projects for Alaska public schools and for maintenance of University of Alaska capital projects. This bill establishes the educational facilities maintenance and construction fund to ensure a long-term source of money for appropriations for the design, construction, and maintenance of public school capital projects and for maintenance of University facilities.

A companion bill, introduced at my request, would appropriate the bulk of the February 1993 British Petroleum settlement to the educational facilities maintenance and construction fund. This bill, establishing that fund, provides for a July 1, 1993 effective date to correspond to the effective date of that appropriation bill.

I urge your favorable action on this important bill.

Sincerely,

A handwritten signature in cursive script that reads "Walter J. Hickel".

Walter J. Hickel
Governor

Governor's Transmittal Letter



ALASKA ASSOCIATION OF ELEMENTARY SCHOOL PRINCIPALS
ALASKA ASSOCIATION OF SECONDARY SCHOOL PRINCIPALS
ALASKA ASSOCIATION OF SCHOOL ADMINISTRATORS

• ALASKA COUNCIL OF SCHOOL ADMINISTRATORS •

326 Fourth St., Suite 404 Juneau, AK 99801-1101 (907) 586-9702 FAX (907) 586-5879

POSITION STATEMENT

SPONSOR SUBSTITUTE FOR HB 156 & 157

""Establishing the educational facilities maintenance and construct fund;""

The Alaska Council of School Administrators supports the establishment of a maintenance and construction fund for educational facilities.

As the educational leaders in our respective buildings and districts, we are keenly aware of the growing need to address the upgrading and repairs needed to our educational facilities for some time. We also must deal with over crowded schools and the location of portable facilities to house the many students needing classroom space. Since the 1986 reduction for general fund appropriations for the operation of educational programs, districts across the state have had to defer needed maintenance or the construction of needed facilities in order to fund continued general operations of the school's educational program. In the meantime, student populations continue to grow and facilities continue to become out dated.

There was a earnest attempt at addressing the issues of school construction through the passage of HB 37 in past years. However, because of the lack of capitol appropriations, many of the constructions projects will never be address

It does not appear fiscally sound to attempt to bond the school construction projects. The State of Alaska has access to several revenue sources which will permit such a construction fund to be established without obligating future legislatures to appropriate for bond payments of principal and interest.

School Facilities create the atmosphere for good education. A building that is well maintained, provides adequate space and has good lighting, contributes to every child's education.

We urge the Legislature to support the establishing of the educational facilities maintenance and construction fund outlined in HB 156 and 157


Stephen T. McPhetres
Executive Director

FISCAL NOTE

No. 2
 Bill Version: SSHB 156
 (H) Publish Date: 2/22/93

STATE OF ALASKA
 1993 LEGISLATIVE SESSION

Revision Date: _____ Dept. Affected: Revenue
 Title: Educational Facilities Maintenance and Construction Fund BRU: Revenue Operations
 Component: Treasury
 Sponsor: House Rules by Request of the Governor
 Requestor: _____ COMPONENT SERIAL NO. 121

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL						
---------	--	--	--	--	--	--

REVENUE FUND SOURCE:						
----------------------	--	--	--	--	--	--

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact: \$ _____

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Rod R. Mourant Phone: 465-2300
 Division: Commissioner's Office Date: 2/19/93
 Approved by Commissioner: Darrel J. Rexwinkel Date: 2/19/93
 Agency: Revenue

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COMMITTEE COPY

Fiscal Note - Revenue

HB

157



Alaska State Legislature

Please enter into the record my testimony to the H&SS - House
committee name

committee on HB 156 4157, dated 3/2/93
bill/subject

I strongly urge you to support HB 156
& HB 157. The facts are simple - BP tax
settlement has generated \$600,000,000.
The backlog of school construction &
maintenance is enormous. Schedules
need help now! Waiting jeopardizes children.
Appropriate use of these funds is critical!
Help support our schools & support future
Alaskan jobs now.

Signed: Kathy Jarvis
Testifier

Representing (Optional)
HC 32 Box 6631 Wasilla, AK 99654
Address

376-5308
Phone No.



Alaska State Legislature

Please enter into the record my testimony to the House Health, Education & Social Services committee name

committee on HB 156 and HB 157 , dated March 9, 1993 .
bill/subject

I'm not in favor of those bills as is, because they don't tell who will get the money or specifics of what it will be used for. Also, what plans does DOE have for it. Also, I'd like to see something in writing concerning the rural areas needing the funding.

Signed: Angela R. Koberly
Testifier

Representing (Optional)
HC 100 Box 4660 Delta Dist. AK.
Address
895 4947
Phone No.



Alaska State Legislature

Please enter into the record my testimony to the House Health Education & Social
 committee name
 committee on House Bills 156 & 157, dated March 2, 1992.
 bill/subject

I support House Bills 156 & 157. In particular, I would like to see the renovation of Swanson Elementary in Palmer. It was built in 1955 and has capacity for 275 students. There are currently 400 students enrolled.

Signed: Patricia Druehl
 Testifier

Representing (Optional)
HCOI Box 6028W Palmer 99645
 Address
746-4911
 Phone No.



LEGISLATIVE AFFAIRS AGENCY
DIVISION OF PUBLIC SERVICES

DATE: 3-9-93

Please accept the enclosed original(s) of written testimony for the HUEL 76, HR 156 & HR 157 teleconference hearing that was scheduled on 3-9-93.

A copy of this testimony was transmitted to your committee via fax on 3-9-93.

March 9, 1993

I support HR 156 and 157. Our children are attending schools that are old and overcrowded. Investing this money in schools would send a clear message to all of Alaska's students and teachers that they are important today.

We shouldn't put the money into some nebulous rainy day fund. For many of Alaska's students, the rainy day is here.

I urge you to support these bills. Thank you.

I'm sorry I couldn't stay for the duration of the conference today. I was here waiting from 3-5 last Tuesday.

Kappy Olson
Box 962
Bethel Alaska



Alaska State Legislature

Please enter into the record my testimony to the House Health, Education & Social
committee name

committee on House Bills 156 & 157, dated March 2, 1992.
bill/subject

I support House Bills 156 & 157. In particular, I would like to see the renovation of Swanson Elementary in Palmer. It was built in 1955 and has capacity for 275 students. There are currently 400 students enrolled.

Signed: Patricia M. [Signature]
Testifier

Representing (Optional)

HCOI Box 6028W Palmer 99645

Address

746-4916

Phone No.

HB156
HB157



Alaska State Legislature

Please enter into the record my testimony to the Hess - House
committee name
committee on HB 156 & 157, dated 3/2/93
bill/subject

I strongly urge you to support HB 156
& HB 157. The facts are simple - BP tax
Settlement has generated \$630,000,000.
The backlog of school construction &
maintenance is enormous. Schools
need help now! Waiting jeopardizes children.
Appropriate use of these funds is critical!
Help support our schools & support future
Alaskan jobs now.

Signed: Kathy Jarvis
Testifier

Representing (Optional)
HC 32 Box 6631 Wasilla, AK 99654

Address
376-5308

Phone No.

WALTER J. HICKEL
GOVERNOR



P. O. Box 110001
Juneau, Alaska 99811-0001
(907) 465-3500

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

February 22, 1993

*The Honorable Ramona L. Barnes
Speaker of the House
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182*

Dear Speaker Barnes:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a sponsor substitute for HB 157, introduced at my earlier request this session.

The sponsor substitute more clearly reflects my intent that an amount substantially equivalent to the February 1993 British Petroleum settlement be appropriated from the general fund primarily to capitalize a fund that is to be used for maintenance and construction of Alaska public schools and for maintenance of University of Alaska facilities. The settlement is expected to be received on June 30, 1993.

Additionally, the bill appropriates from the general fund an amount equivalent to six percent of that settlement, and places it in the mental health trust income account, consistent with AS 37.14.011.

The bill's July 1, 1993 effective date is contingent upon the educational facilities maintenance and construction fund being established in law. I have submitted a companion bill to accomplish that.

I urge your support of this bill.

Sincerely,

A handwritten signature in cursive script that reads "Walter J. Hickel".

Walter J. Hickel
Governor

Governor's Transmitted Letter

2

11

1

2

1

HOUSE COMMITTEE REPORT

(9)

Date Referred: February 22, 1993

FURTHER REFERRALS:

Finance

Date of Committee Action: 3-19-93

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HB 171

HOUSE BILL NO. 171

MEDICAID COVERAGE FOR HOSPICE CARE

"An Act providing coverage for hospice care under the Medicaid program; reordering the priorities given to optional services under the Medicaid program; and providing for an effective date."

- RECOMMENDATIONS: the same title
 be replaced with _____ a new title
 have attached amendments(s)
 do pass
 do not pass
 no recommendations
 individual recommendations
 additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): _____ (Dept)

APPROVES PREVIOUS: _____ (Dept/Date)

fiscal impact H+SS

fiscal note(s) _____

zero fiscal note _____

zero fiscal note(s) _____

SIGNING <u>DP</u> ASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
<i>[Signature]</i>	✓				
<i>[Signature]</i>	✓				
<i>[Signature]</i>	✓				
<i>[Signature]</i>	✓				
<i>[Signature]</i>	✓				
<i>[Signature]</i>	✓				

[Signature]

CHAIRMAN'S SIGNATURE



Alaska State Legislature
 House of Representatives
 COMMITTEE ON HEALTH, EDUCATION
 AND SOCIAL SERVICES

DATE: 3/19/93

PLACE: Capitol Room 106

SUBJECT OF MEETING:
 HB 171
 HB 178

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?	WHAT SUBJECT/ WHICH BILL?
Dave W. Williams	DHSS				465-5826	<input checked="" type="radio"/> Y <input type="radio"/> N	HB 171 HB 178
Quinn Mathis	Rep Larson				3878	<input type="radio"/> Y <input type="radio"/> N	
Ritchie Sonnen	Hospice + Home Care in Juneau				483- 3113	<input checked="" type="radio"/> Y <input type="radio"/> N	HB 171
						<input type="radio"/> Y <input type="radio"/> N	
						<input type="radio"/> Y <input type="radio"/> N	
						<input type="radio"/> Y <input type="radio"/> N	
						<input type="radio"/> Y <input type="radio"/> N	
						<input type="radio"/> Y <input type="radio"/> N	
						<input type="radio"/> Y <input type="radio"/> N	
						<input type="radio"/> Y <input type="radio"/> N	
						<input type="radio"/> Y <input type="radio"/> N	

LTN1100-R01
03/22/93

LEGISLATIVE TELECONFERENCE NETWORK

PAGE 01
18:11:59

TCN: 30416 DATE & TIME: 03/19/93 15:00 TO 16:00 STATUS:7 STATS. IN

**** ORDER SUMMARY ****

SPONSOR: HSES HOUSE HEALTH, EDUCATION AND SOCIAL SERVI CHAIRS: TOOHEY
PURPOSE: PUB PUBLIC HEARING BUNDE
CONTACT: LYNN TEL#: (907)465-6825
CHAIRING SITE: JUNEAU CAPITOL CAP106

SPONSOR REMARKS(PUB): TESTIMONY:Y ALLOWED 99 MINUTE LIMIT
TCN REQUESTED ON 03/19/93 AND HAS 1 UPDATES

**** AGENDA ****

1. HB 171 MEDICAID COVERAGE FOR HOSPICE CARE

**** PARTICIPATING LIOS ****

* JNU JUNEAU CAPITOL CAP106 LOCATION STAFF
MAT MATSU 165 E PARKS HWY. LOCATION STAFF

PARTICIPANTS IN:JUNEAU

JNU

1	REP	KOTT		TSFY. HB 171
			AK	(907)000-0000
2	REP	VEZEY		TSFY. HB 171
			AK	(907)000-0000
3	REP	G. DAVIS		TSFY. HB 171
			AK	(907)000-0000
4	REP	TOOHEY		TSFY. HB 171
			AK	(907)000-0000
5	REP	OLBERG		TSFY. HB 171
			AK	(907)000-0000
6	REP	BRICE		TSFY. HB 171
			AK	(907)000-0000
7	STAFF	STAFF		OBSV. HB 171
			AK	(907)000-0000
8	STAFF	STAFF		OBSV. HB 171
			AK	(907)000-0000
9	STAFF	STAFF		OBSV. HB 171
			AK	(907)000-0000
10	2	TESTIFY		TSFY. HB 171
			AK	(907)000-0000
11	2	TESTIFY		TSFY. HB 171
			AK	(907)000-0000
12	2	TESTIFY		TSFY. HB 171
			AK	(907)000-0000

PARTICIPANTS IN:MATSU

MAT

1 MS	DORIS	LUM	VALLEY HOSPITAL	TSFY. HB 171
	BOX 1687		PALMER	AK 99645 (907)376-1625

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. HB171

Revision Date: 02/22/93 Dept. Affected: Health and Social Services
 Title: An Act providing coverage for hospice care BRU: Medical Assistance Administration
 Component: Claims Processing
 Sponsor: Larson
 Requestor: _____ COMPONENT SERIAL NO. 00243

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	10.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	10.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	5.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	5.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	10.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)
 FY 94 funds are required to modify the Medicaid Management Information System to allow the payment of claims for hospice care.

Studies suggest that hospice care tend to be cost neutral or produce cost savings. Hospice care is already available to children covered by Medicaid and to Medicare-eligible adults. There are currently no Medicare-certified hospice providers in the state. We anticipate that only a small number of recipients will use hospice care as a result of this bill. Therefore, no other fiscal impact is projected.

Prepared by: Jon Sherwood, Program Coordinator *JS* Phone: 465-5826
 Division: Medical Assistance Date: 03/01/93
 Approved by Commissioner: Theodore A. Mala, MD, MPH *[Signature]* Date: 3/4/93
 Agency: Department of Health & Social Services

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FAX (907) 485-2293



Interim Address:
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PALMER, ALASKA 99645
(907) 748-1046 - Palmer
(907) 748-3560 - FAX
(907) 378-8628 - Wasilla

Representative Ronald L. Larson
District 27

MEMORANDUM

TO: Representative Cynthia Toohey, Co-Chairman
Representative Con Bunde, Co-Chairman
Health, Education & Social Service Committee

FROM: Representative Ron Larson *RL*

DATE: March 4, 1993

RE: HB 171 An Act providing coverage for hospice care

I respectfully request that HB171, An Act providing coverage for hospice care under the Medicaid program be scheduled for a hearing before the House H.E.S.S. Committee.

I have introduced HB171, in order that Hospice services can be made available to anyone who chooses this form of care. Hospice care allows a terminally-ill person to receive medical care and psychological, social, and/or spiritual counseling through a single agency, the hospice care provider. Without this option, an individual may require extensive hospital or nursing facility care or have to rely on community services, that can be interrupted or not readily available. This is a valuable option for terminally ill patients.

Attached you will a fiscal note, information and a position paper from the Department of Health and Social Services.



Sponsor Statement

Position Paper

The Department of Health and Social Services supports House Bill 171, which would include coverage of hospice care under the Medicaid program.

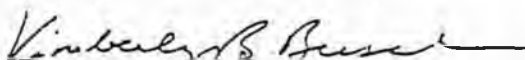
Hospice care is already a Medicaid-covered service for children and is available to people who qualify for Medicare. This bill would extend coverage of hospice service to Medicaid-eligible adults who do not qualify for Medicare. To qualify as a hospice care provider, a hospice care agency must be Medicare-certified. There are currently no Medicare-certified hospices in Alaska.

Hospice care allows a terminally-ill person to receive medical care and psychological, social, and/or spiritual counseling through a single agency, the hospice care provider. Lacking hospice care, an individual may require extensive hospital or nursing facility care or have to rely on the sometimes fragmented or piecemeal provision of supportive services in the community.

The Department supports this effort to expand the availability of a valuable alternative for terminally ill people. It also concurs with the placement of hospice services on the Medicaid priority list. Under HB 171, in the case of a budget shortfall, hospice care would be eliminated before most other long term care services, but after most optional Medicaid services.

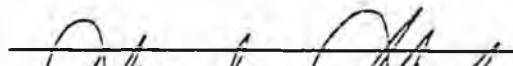
The Department recommends changing the effective date of the legislation to January 1, 1994. Because of other scheduled program changes, the Division of Medical Assistance will not be able to implement hospice services earlier.

Recommended by:



Kimberly B. Busch
Director
Div. of Medical Assistance

Date:



Approved by:

Theodore A. Mala, MD, MPH
Commissioner

Date:

3/4/93



February 22, 1993

Honorable Ronald L. Larson
State Representative
P O. Box V
Juneau, AK 99811

Dear Representative Larson:

Thank you for your support of the Medicaid Hospice option. We believe that Hospice care should be available to everyone with a terminal illness and we thank you for working toward making that possible.

Several features make Hospice care unique in a world of high cost, high tech, impersonal health care. Hospice care promotes quality of life. Hospice considers both the patient and family as the unit of care and serves both. Most important, attention is not just given to physical care, but also to the emotional, spiritual and social needs of the clients.

Hospice uses all its highly skilled medical care for promoting effective pain and symptom control for the patient, thereby maximizing the quality of remaining life. This skilled medical care is most often accomplished using user friendly, low-tech, low cost care that avoids as much as possible the automatic "sick" environment so much a part of traditional health care.

The benefits you would be making available to recipients of Medicaid considerably exceed the present services available. For management of a terminal illness, Hospice also provides the following:

- In addition to meeting physical needs, Hospice care offers a wealth of emotional, spiritual and practical supports to the patient and the family. Quality of life is maximized through an interdisciplinary team of physicians, nurses, physical, occupational and speech therapists, home health aides, social workers, chaplains, and volunteers. The patient and family are actually part of the team, helping to plan and prioritize care.
- It will be the role of Hospice to provide all medications, medical equipment and supplies necessary for management of the terminal illness.
- Bereavement care is also available to the family for a period of 13 months after the death. Hospice offers written resources, phone calls, visits from volunteers, a support group and, as needed, bereavement counseling.

Letter of Support

THE
FOLLOWING
DOCUMENTS
ARE
POOR
ORIGINAL
COPIES

- Most important are the trained Hospice volunteers who give a wide range of services from staying with a patient while the caregiver takes a break to nursing care, homemaking services, or a listening ear.

In addition to all the positive services that Hospice care can offer a family, crucial facts make the Medicaid Hospice option a wise decision. **Hospice is a budget-neutral program.** Hospice care is one of the few programs existing in our present health care structure that models fiscal responsibility and cost-effective quality care. Hospice offers the resources to allow terminally ill persons to spend the rest of their lives, or at least more of their lives, at home. **Quite often, the alternative to Hospice care is costly nursing home placement or frequent hospitalization.**

Valley Hospital is starting the first Medicare-certified Hospice in the state of Alaska. Many other communities are watching us to learn from our experience. If we can successfully manage a cost-effective Hospice program, other Alaska Hospice programs will also consider certification.

We will be a not-for-profit agency committed to providing services to all persons who are terminally ill and who choose to receive Hospice care. **We see the Medicaid Hospice option as being a crucial piece in running a fiscally solvent agency.**

Ability to pay has not traditionally been a criteria of admission to Hospices. We would like to continue this tradition in our community, but the proportion of Medicaid patients has the potential to tip the balance between solvency and program closure. **With the number of uninsured persons in our community, we consider it essential to request the enactment of the Medicaid option to ensure as much as possible the success of this endeavor.**

We do not have access to the latest statistics, but it is my understanding that few states remain that have not enacted the Hospice benefit.

Thank you for your support in this matter. I am forwarding some materials in the mail at Judy's request

Sincerely,

Gail Bayless

Gail Bayless, R.N.
Program Development

enclosed

WHAT DOES HOSPICE MEAN?

PHYSICIAN INFORMATION SHEET

WHAT IT MEANS TO THE PATIENT

When a patient elects the Medicare hospice benefit, they revoke their other part A benefits for treatment of their terminal illness? The hospice becomes the sole provider for their service needs, and whatever products are necessary for palliation and symptom control. This includes:

- professional services,
- pharmaceuticals
- DME
- in-patient respite
- in-patient care for symptom management

The hospice becomes a managed care program for the patient.

Benefit periods: 2 90-day periods, 1 30-day period,
Indefinite 4th period

The fourth indefinite period was recently enacted. They do not go off the benefit if they fail to die in 7 months.

Revocation of benefit is possible during any benefit period, but there are limitations regarding reelection of benefit.

Admission criteria:

- * Certified by physician that terminal illness with 6 months or less life expectancy.
- * Choose palliative care; treatment mode past

When a person has a terminal illness, consider Hospice as an information resource on options--to patient & physician. The ultimate choice regarding treatment options (including hospice enrollment) is made by client.

WHAT IT MEANS TO THE FAMILY

The family is included as client in the plan of care:

- Support
- Respite
- Bereavement program
- Assessment
- Care

WHAT IT MEANS TO THE HOMECARE PROGRAM STAFF

Philosophy of approach to care.

- Emphasis on living fully
- Self determination
- Palliation --complete
- Totality of care

Hospice Information

HOSPICE AND YOUR OTHER MEDICARE BENEFITS

Hospice under Medicare is designed to be more than just a collection of existing benefits with a new name. Many items and services are covered under hospice that are not covered through any other type of facility or provider.

This chart shows a comparison between hospice benefits and benefits available through hospitals and home health agencies.

SERVICE ITEM	MEDICARE COVERED IN		
	HOSPICE	HOSPITAL	HOME HEALTH AGENCY
Drugs for pain & symptom control to be used at home	YES	YES	NO
Services covered whether or not the patient is homebound	YES	---	NO
Deductibles waived	YES	NO	NO
Inpatient care to provide respite for family caring for the patient at home	YES	NO	NO
Continuous care at home during periods of crisis	YES	NO	NO
Counseling services at home for both the patient and the family	YES	NO	NO
Home Health Aides	YES	NO	YES
Bereavement Counseling	YES	NO	NO
Volunteers must be available	YES	NO	NO
Care must be continued if benefits run out	YES	NO	NO
Inpatient unit must have homelike decor	YES	NO	---

*Meeting the Challenge For
Quality Home Care*



Standards of a Hospice Program of Care Recommended by the National Hospice Organization

Standards for a Hospice Program

Standards For A Hospice Program

Standard 7: At a minimum, the hospice inpatient unit provides for: medical direction and coverage for all patients either directly or through agreement with the patient's personal physician; staffing coverage by an interdisciplinary team available to meet the needs of the patient/family on a 24 hour basis as needed; and, specific policies and procedures, as well as personal comfort amenities and courtesies that support and encourage a non-institutional, "home-like" environment for the patient/family. All hospice inpatient personnel must be appropriately trained in the provision of hospice interdisciplinary team care.

PATIENT/FAMILY AS THE UNIT OF CARE

Principle: Inclusion of the family in the hospice care program is essential. The wishes and desires of the patient/family are reflected in assessments and plans of care developed by the interdisciplinary team. The family members are seen both as primary caregivers and as needing care and support so that their own stresses and concerns may be addressed. Attention is also given to assisting with the development of a community support network when family and friends are not available and a patient needs and wants that support.

Standard 8: The patient/family is the unit of care in hospice and support is provided to both the patient and the family. The hospice program encourages patient/family participation in the development of the interdisciplinary team plan of care and in the provision of hospice services.

Standard 9: The hospice program acknowledges that each patient/family has its own values and beliefs and is respectful of them.

Standard 10: The hospice program seeks to identify, teach, coordinate and supervise those persons acting as primary caregivers for the patient. If a primary care person is not available, the hospice program seeks to develop a substitute network. If the hospice program does not accept patients without primary caregivers, then it must provide adequate information about community resources available to them.

PAIN AND SYMPTOM CONTROL

Principle: For the hospice program, the goal of all interventions is to maximize the quality of the remaining life through the provision of palliative therapies that control and symptoms and minimize the negative side effects of interventions. Hospice programs recognize that when a patient and a family are faced with terminal disease, stress and concerns may arise in many aspects of their lives. Optimum symptom control includes addressing these stresses and concerns, in addition to the use of appropriate therapies.

Standard 11: The goal of hospice care is to provide optimum relief of pain and control of symptoms through appropriate palliative therapies.

Standard 12: Symptom control includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

VOLUNTEERS

Principle: An essential component of hospice care is the direct personal support for the patient/family by volunteers. Volunteers provide important perspectives in developing the interdisciplinary team plan of care

and in the provision of significant hospice services.

Standard 13: A hospice program offers volunteer support to each patient/family admitted to its program of care.

Standard 14: A hospice program has an organized training program and procedures for the selection, supervision and continuing evaluation of volunteers.

HOSPICE INTERDISCIPLINARY TEAM

Principle: Hospice care is provided by an interdisciplinary team which includes at least the following members: patient and patient's family, physician, nurse, social worker, volunteer, and clergy. Ancillary staff are added to the team when appropriate. The team meets regularly to develop and maintain an appropriate plan of care.

Standard 15: The hospice identifies and maintains an appropriately qualified interdisciplinary team of health professionals and lay persons.

Standard 16: Emotional support for staff/volunteers is provided as an integral part of a hospice program.

Standard 17: Inservice training and continuing education are offered on a regular basis to both paid and volunteer staff.

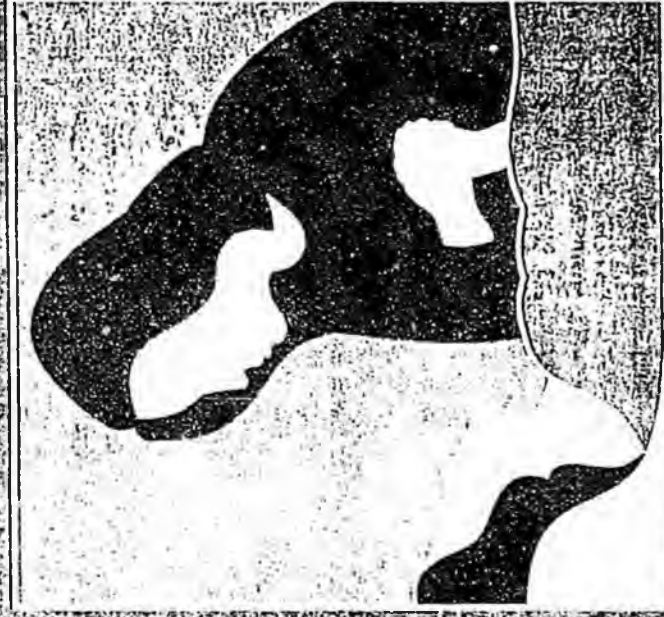
INTERDISCIPLINARY TEAM PLAN OF CARE

Principle: Documentation of services is necessary for the delivery of quality hospice care. Of critical importance is the development of an integrated plan of care which records assessments, proposed interventions by all

CORRECTION

**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**

*Meeting the Challenge For
the Home Care*



Standards for a Hospice Program of Care. Published by the National Hospice Organization

Standards for a Hospice Program

Standards For A Hospice Program

A DEFINITION

A hospice program is a coordinated program of palliative and supportive services provided in both home and inpatient settings which provides for physical, psychological, social and spiritual care for dying persons and their families. Services are provided by a medically directed interdisciplinary team of professionals and volunteers. Bereavement care is available to the family following the death of the person.

HOSPICE PHILOSOPHY

Hospice provides support and care for persons in the last phases of incurable disease so that they may live as fully and comfortably as possible. Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of remaining life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care, and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

ACCOUNTABILITY

Principle: The hospice operates as an integral part of the health delivery system at the community level and is accountable to the community it serves and the public at large. In order to provide care in this system, a hospice must meet the fundamental requirements for operation and delivery of health services, as regulated by local, state and federal laws.

Standard 1: The hospice program establishes and maintains appropriate reports, policies and procedures to assure that the hospice is accountable to the community for the services it provides.

Standard 2: The hospice program complies with applicable local, state and federal laws and regulations governing the organization and delivery of health care to patients and families.

ACCESS TO HOSPICE CARE

Principle: Admission to the hospice program is based on an assessment of the patient and family needs, their desire for services and the program's specific admission criteria. The level of care received, including the frequency and type of services provided, is based on both initial and subsequent assessments of the patient and family's needs. Care may be provided on either a part time, intermittent basis, a regularly scheduled basis, or a continuous basis, depending upon the needs of the patient and family as reflected in ongoing assessments.

Standard 3: Access to hospice medical and nursing services is available to identified hospice patients on a 24 hour basis, 7 days a week. During hours covered by on-call staff, hospices provide for at least a minimum of medical and nursing coverage, with visit capability should further assessment or treatment be needed. Provisions are made to assure that on-call staff are informed and updated regarding care plans and level of care. Reporting mechanisms are in place to assure continuity and coordination among members of the hospice interdisciplinary team.

Standard 4: The hospice program has admission criteria that reflect the patient/family's desire and need for hospice care; the extent and role of physician participation; and diagnosis and prognosis. To the maximum extent possible, the hospice program will admit patients regardless of their diagnosis or ability to pay for services.

CONTINUITY OF HOSPICE CARE

Principle: Hospice patients and their families may experience physical, social, emotional and spiritual concerns and problems. Hospice addresses these by providing a comprehensive and coordinated program of care which includes an ongoing assessment of needs and determination of the level of care and scope of services necessary. Continuity implies that services, whether provided directly or contracted for, are coordinated in both home and inpatient settings. Services are reflective at all times of patient/family needs, and that the hospice is accountable for its care and services in both home and inpatient care settings.

Standard 5: The hospice program organizes its services to respond to patient/family needs whenever they arise. It provides both structure and staff to ensure continuation of the hospice care plan in all settings.

ACCESS TO HOSPICE INPATIENT CARE

Principle: Not all patients can be maintained at home throughout their terminal illness; some may require short term inpatient care. When such a need arises, hospice care is provided in an inpatient hospice unit. The hospice provides access to hospice inpatient services which reflect the hospice philosophy and emphasizes symptom control and enhancement of a quality of life acceptable to dying patients and their families.

Standard 6: Access to hospice inpatient care is available either directly by the hospice or through contract or arrangement with an inpatient facility. This hospice inpatient unit must comply with all applicable local, state and federal regulations, including fire and safety code regulations.

Standards For A Hospice Program

Standard 7: At a minimum, the hospice inpatient unit provides for: medical direction and coverage for all patients either directly or through agreement with the patient's personal physician; staffing coverage by an interdisciplinary team available to meet the needs of the patient/family on a 24 hour basis as needed; and, specific policies and procedures, as well as personal comfort amenities and courtesies that support and encourage a non-institutional, "home-like" environment for the patient/family. All hospice inpatient personnel must be appropriately trained in the provision of hospice interdisciplinary team care.

PATIENT/FAMILY AS THE UNIT OF CARE

Principle: Inclusion of the family in the hospice care program is essential. The wishes and desires of the patient/family are reflected in assessments and plans of care developed by the interdisciplinary team. The family members are seen both as primary caregivers and as needing care and support so that their own stresses and concerns may be addressed. Attention is also given to assisting with the development of a community support network when family and friends are not available and a patient needs and wants that support.

Standard 8: The patient/family is the unit of care in hospice and support is provided to both the patient and the family. The hospice program encourages patient/family participation in the development of the interdisciplinary team plan of care and in the provision of hospice services.

Standard 9: The hospice program acknowledges that each patient/family has its own values and beliefs and is respectful of them.

Standard 10: The hospice program seeks to identify, teach, coordinate and supervise those persons acting as primary caregivers for the patient. If a primary care person is not available, the hospice program seeks to develop a substitute network. If the hospice program does not accept patients without primary caregivers, then it must provide adequate information about community resources available to them.

PAIN AND SYMPTOM CONTROL

Principle: For the hospice program, the goal of all interventions is to maximize the quality of the remaining life through the provision of palliative therapies that control and symptoms and minimize the negative side effects of interventions. Hospice programs recognize that when a patient and a family are faced with terminal disease, stress and concerns may arise in many aspects of their lives. Optimum symptom control includes addressing these stresses and concerns, in addition to the use of appropriate therapies.

Standard 11: The goal of hospice care is to provide optimum relief of pain and control of symptoms through appropriate palliative therapies.

Standard 12: Symptom control includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

VOLUNTEERS

Principle: An essential component of hospice care is the direct personal support for the patient/family by volunteers. Volunteers provide important perspectives in developing the interdisciplinary team plan of care

and in the provision of significant hospice services.

Standard 13: A hospice program offers volunteer support to each patient/family admitted to its program of care.

Standard 14: A hospice program has an organized training program and procedures for the selection, supervision and continuing evaluation of volunteers.

HOSPICE INTERDISCIPLINARY TEAM

Principle: Hospice care is provided by an interdisciplinary team which includes at least the following members: patient and patient's family, physician, nurse, social worker, volunteer, and clergy. Ancillary staff are added to the team when appropriate. The team meets regularly to develop and maintain an appropriate plan of care.

Standard 15: The hospice identifies and maintains an appropriately qualified interdisciplinary team of health professionals and lay persons.

Standard 16: Emotional support for staff/volunteers is provided as an integral part of a hospice program.

Standard 17: Inservice training and continuing education are offered on a regular basis to both paid and volunteer staff.

INTERDISCIPLINARY TEAM PLAN OF CARE

Principle: Documentation of services is necessary for the delivery of quality hospice care. Of critical importance is the development of an integrated plan of care which records assessments, proposed interventions by all

Standards For A Hospice Program

interdisciplinary team members and documents all services provided to the patient/family and their outcomes. Hospice clinical records reflect the full range of problems identified; services provided by level of care across both the home and inpatient settings; and progress notes documenting the care given on a day-to-day basis.

Standard 18: The hospice program has a written, interdisciplinary team plan of care for each patient/family unit that includes assessments, identified problems, proposed interventions, level and frequency of services and their outcomes.

Standard 19: The hospice program maintains accurate, current, integrated clinical records for all patient/family units and provides assurances for the confidentiality of these records.

Standard 20: These clinical records must include a signed informed consent form completed by the patient or a designated representative. The consent form must inform the patient/family of the palliative nature of hospice care; the avoidance, if at all possible, of injections, diagnostic testing and curative measures; and the non-use of heroic measures to prolong the dying process.

Standard 21: These clinical records must include specific, signed instructions regarding actions to be taken when life threatening situations occur to the patient. These instructions should be prepared by the physician and the interdisciplinary team, following consultation with the patient/family, and must be consistent with the patient/family's wishes.

BEREAVEMENT

Principle: Death of a family member may result in a wide range of physical, emotional, social, familial, economic and spiritual disruptions. Grief and bereavement are normal reactions to loss and death. Grief is the highly personal response to loss, bereavement is the extended period of deprivation following the loss of a loved one. Grieving may precede an anticipated death or may be delayed for a considerable period of time. Grief may manifest itself in emotional and/or physical distress and may affect family members in different ways at different times. Some persons can resolve grief with time and their own resources; others may require formal assistance and support over an extended period of time.

An important element of hospice care is an assessment of the needs of the bereaved family, and the development of a care plan that meets these needs, both prior to, and following, the death of the patient. Hospice encourages the expression of grief, recognizes social/religious and ethnic variables in bereavement and supports staff and family participation in meaningful funeral services and rituals.

Standard 22: The hospice program provides bereavement services to the surviving family members for at least one year after the death of the patient.

Standard 23: The hospice program maintains a process of risk assessment for surviving family members that identifies those individuals at risk of pathological grief. For those individuals at high risk, appropriate referrals are made to mental health professionals in the community.

QUALITY ASSURANCE AND UTILIZATION REVIEW

Principle: Hospice is committed to developing methods to measure and assure the quality of patient/family care and the appropriate utilization of hospice resources.

Standard 24: The hospice program has quality assurance and utilization review programs that include the following: statement of goals and objectives and established policies for conducting an ongoing assessment program that reflects the interdisciplinary nature of hospice services; designation of person(s) responsible for implementing policies and procedures; provisions for addressing specific problems identified in the quality assurance and utilization review processes.

Standard 25: At a minimum, the hospice program conducts on a regular basis the following activities: evaluation of services provided by both professionals and volunteers, audit of patient charts for outcomes of interventions, organizational review of hospice program, interdisciplinary team care plan review, evaluations provided by patient/families of care received, a review of appropriate/inappropriate use of services, facilities and personnel.

A Hospice Glossary

This glossary was prepared using a variety of source materials to provide definitions. These include: *NHO Standards of Care* (1983), *Joint Commission on Accreditation of Healthcare Organizations* (manuals, 1985), *Introduction to Health Education* (Bates, Wynder, 1984) and *Webster's New Collegiate Dictionary* (1986).

Ability to pay: A phrase used to describe a patient's capability to pay for health services received. Some health providers limit their services to patients who can pay for their services.

Access: An individual's or group's ability to obtain health care. Access has geographical, financial, social, ethnic and psychological elements. Many health programs have as their goal improving access to care for specific groups or equity of access for the whole population.

Accountability: To provide for an organization substantial reasons or convincing explanations for actions; to be accountable means to furnish a justification or detailed explanation of financial activities or responsibilities. Accountability entails an obligation to periodically disclose, in adequate, detailed and consistent form the purposes, principles, procedures, relationships, results, incomes, and expenditures involved in any activity, enterprise, or assignment, so that they can be evaluated by interested parties.

Accreditation: A voluntary process, generally developed and implemented by a non-governmental body composed of professionals within the field, with input from providers, and based on optimal standards of quality care.



Administration: The fiscal and general management of a hospice program, as distinct from the general policies and procedures of the hospice program.

Admissions: Numbers of patients/families that enter a hospice program and agree to accept the services provided by a hospice program.

Admission criteria: Guidelines or policies of a hospice program that specify the conditions under which a patient/family will be admitted. The purpose of the criteria is to control entry/admission to services, e.g. most hospices require a diagnosis of terminal illness by a physician as a prerequisite for admission.

Ancillary staff: Health professionals who provide additional services to support or supplement hospice interdisciplinary team services, including physical therapy, occupational therapy, speech therapy, nutritional counseling, respiratory therapy, and other services.

Appropriate: Descriptive of an action or policy that is suitable or compatible with a hospice program's objectives and philosophy.

Approved: Acceptable to the appropriate authority.

Assessment: Procedures by which strengths, weaknesses, problems, and needs are identified and addressed.

Audit, financial: An independent review of a hospice program's financial records that accurately reflects its financial status.

Bereavement: An important element of hospice care is an assessment of the needs of the bereaved family, and the development of a care plan that meets these needs, both prior to, and following the death of a patient. Hospice encourages the expression of grief, recognizes social/religious and ethnic variables in bereavement and supports staff and family participation in meaningful funeral services and rituals.

Bereavement services: The hospice program makes available bereavement services to the surviving family members for a period of at least one year after the death of the patient. They may include: cards to families; home visits; phone calls; group counseling; individual counseling; newsletters; and social activities.

Bylaws: The rules, regulations, or laws adopted by a hospice program for the regulation of its internal affairs and its dealings with other persons and the community at large.

Certification: A voluntary mechanism used to qualify organizations to receive public funds. If a provider chooses to participate in Medicare, for example, it must comply with a set of conditions of participation based on laws and regulations.

Chemotherapy: Provision of drugs (i.e., chemicals) taken orally, injected, inserted, topically applied, or otherwise administered to control pain and symptoms in hospice patients.

Clergy: A person who has met the requirements of a religious

A Hospice Glossary

organization or system to serve the constituency of that religious organization or system.

Clergy services: See spiritual services.

Clinical privileges: Authorization by the governing body to provide specific patient/family care and treatment services in the organization, within well-defined limits, based on the individual's license, education, training, experience, competence, and judgment.

Community: The individuals, groups, agencies, facilities, or institutions within the locality served by the hospice program.

Confidentiality: The relationship between the hospice staff patients/families in which information is shared and exchanged with the understanding that this information is used appropriately and with respect to the patient/families' wishes and rights to privacy.

Continuing education: Education beyond initial professional preparation that is relevant to the type of patient/family care delivered in the organization, that provides current knowledge relevant to the individual's fields of practice, and that is related to findings from quality assurance activities.

Continuity of care: Services that are organized, coordinated and provided in a way that is reflective at all times of patient/family needs, and which are structured to assure that the hospice is accountable for its care and services regardless of home or in-patient setting.

Continuous basis: Hospice care is provided in the home setting on a 24



hour basis until care is no longer needed. Usually this occurs when the patient/family goes into a medical crisis, but does not need or wish to return to an inpatient setting.

Contracted services: Services provided through a formal agreement with any organization, agency or individual. The agreement, which is approved by the governing body, specifies the services, personnel, and/or space to be provided to or on behalf of the hospice program and the consideration to be expended in exchange.

Counseling: A relationship in which a person endeavors to help another understand and cope with problems.

Curative: Medical interventions used to ameliorate the cause of a disease.

Dietetic services: Services that meet the nutritional needs of patients, with emphasis on patients who have special dietary needs.

Dietitian: A person who is registered by the Commission on Dietetic Registration of the American Dietetic Association or who has the documented equivalent in education, training and/or experience.

Discharge: The point at which the patient's active involvement with the hospice program is ended and the program no longer maintains active responsibility for the care of the patient.

The actual point of discharge is determined by the hospice program in accordance with the continuum of home care and inpatient services provided.

Documentation of services: The process of writing, recording and maintaining appropriate records of services that are provided by a hospice interdisciplinary team. This process is very important to assure continuity of services, high quality of care and to justify those services that have already been provided.

Dying: The progressive failure of body systems to retain normal functioning, thereby limiting the remaining life span.

Emotional: The feeling aspect of consciousness which is subjectively experienced and expressed by physiological reactions.

Emotional support: The provision of psycho-social services that assist and support the patient/family during that period of time when they cope with their feelings and responses to the loss, grief and change in their family structure which occurs when the patient dies.

Employees: Individuals who agree to work and provide their services under the administrative direction of the hospice program. Employees may receive wages and other compensation in exchange for their work, or they may provide their services without payment, as an in-kind contribution to the hospice program.

Facility: The building(s), equipment and supplies necessary for the

A Hospice Glossary

implementation of inpatient services for hospice patients/families.

Family: The relatives and/or other significantly important persons who provide psychological, emotional and spiritual support of the patient. The "family" need not be blood relatives to be an integral part of the hospice care plan.

Fiscal management: The policies and procedures used to plan and control a hospice program's overall financial operations.

Goal: An expected result or condition that takes time to achieve and is specified in a statement of relatively broad scope that provides guidance in establishing intermediate objectives directed toward attainment of that goal.

Governing body: The individual(s), group or agency that has ultimate authority and responsibility for the overall operation of the organization.

Grief: The highly personal response to loss. Grieving may precede an anticipated death or may be delayed for a considerable period of time. Grief may manifest itself in emotional and/or physical distress and may affect family members in different ways at different times. Some persons can resolve grief with time and their own resources; others may require formal assistance and support over an extended period of time.

Home: The patient's place of residence. Home is the place where most terminally ill patients choose to spend their remaining days.

Home care services: Formally organized services designed to provide and coordinate hospice interdisciplinary team services to

patients/families in the home.

Home health agency: An organization that provides services to individuals in their place of residence. Many home health agencies receive compensation for their services provided to Medicare beneficiaries. Some home health agencies operate a hospice program as a separate division of their total program.

Home health aide services: Personal care services provided in the home. Services may include assistance in the activities of daily living (e.g., helping the patient bathe, care for his or her hair or teeth, exercise and retain necessary self-help skills). Services may also include specific household tasks to maintain a safe environment in areas of the home used by the patient (e.g., changing the bed and doing laundry essential to the cleanliness of the patient).

Homemaker services: Services that are provided to assist patients to remain in their homes. Services may include assistance in personal care (e.g., assisting the patient to the bathroom or in and out of bed); maintenance of a safe and healthy environment (e.g., cleaning the patient's bedroom, bath and kitchen, doing personal laundry and preparing meals); and other services, as appropriate to the homemaker's responsibilities.

Hospice care: Care provided by a hospice program that is designed to meet the physical, social, emotional and spiritual needs of dying patients and their families.

Hospice program: A hospice program is a coordinated program of palliative and supportive services provided in both home and in-patient

settings which provides for physical, psychological, social and spiritual care for dying patients and their families. Services are provided by a medically-directed interdisciplinary team of professionals and volunteers. Bereavement care is available to the family following the death of the patient. Hospice provides support and care for persons in the last phases of incurable disease so that they may live as fully as comfortably as possible.

Hospice philosophy: Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

Hospice program director: The chief administrative officer of the hospice program who provides overall policy direction, is responsible for the fiscal operations, and implements work plans and procedures.

Incident report: Documentation of an event of action that is likely to lead to adverse effects and/or that varies from established policies and procedures pertaining to patient/family care.

Infection control program: Organized, on-going activities within a hospice program to control and monitor the spread of infectious diseases within the hospice, including both home and in-patient settings. Part of this program involves establishing and maintaining specific policies and procedures proper

A Hospice Glossary

procedures for proper disposal of human discharges and surveillance of staff and patients for infections acquired during their contact with a hospice program.

Informed consent: A full understanding by a competent body of the risks and benefits of particular medical procedure or set of procedures. Prior to admission to hospice, the patient/family must sign an agreement that states they understand the nature and scope of hospice care, including the fact that hospice care is palliative and not curative, and that they agree to cooperate in the provision of care.

Inpatient services: Formally organized services designed to provide and coordinate hospice interdisciplinary team services to patients/families in an inpatient setting.

Inpatient settings: Services provided in a setting where the needs of acutely ill patients/families can be met. This care is provided on a 24 hour basis and involves the full hospice interdisciplinary team. During the last months of life, a dying patient may have episodes of acute illness that require the intensive services capability of an in-patient setting.

In-service education: Organized education designed to enhance the skills of interdisciplinary team members or teach them new skills relevant to their responsibilities and disciplines.

Interdisciplinary team: Hospice care is provided by an interdisciplinary team which includes at least the following members: patient and patient's family, physician, nurse, social worker, volunteer, and clergy. The team is coordinated by a qualified health care professional and is

medically supervised. The team meets regularly to develop and maintain an appropriate plan of care. (See Interdisciplinary team services.)

Interdisciplinary team conference: A meeting during which interdisciplinary team members review one or more interdisciplinary team care plans to update patient/family physical and/or psychological status and initiate any changes in the care plan.

Interdisciplinary team plan of care: Documentation of services is necessary for the delivery of quality hospice care. Of critical importance is the development of an integrated plan of care which records assessments, proposed interventions by all interdisciplinary team members and documents all services provided to the patient/family and their outcomes. Hospice clinical records reflect the full range of problems identified, services provided by level of care across both the home and inpatient settings, and progress notes documenting the care given on a day-to-day basis.

Interdisciplinary team services: A group composed of individuals from various professions and disciplines who interact on a regular basis and have a working knowledge of the assessment and care of the patient/family by each member of the team. The team services are characterized by the ability by all members and disciplines to allow their roles to overlap while simultaneously providing emotional support to each other and maintaining a respect for each other's skills, training and interventions.

Intermittent basis: Provision of hospice services at intervals as they are needed by the patient/family. During the final six months of life, the patient/

family may go through a number of crises that require a higher level of intensity of hospice services than at other times.

Interventions: Specific actions designed to interfere, stop or ameliorate the natural course of an illness or human disease. In hospice, interventions are limited to those that are palliative and not curative. These interventions may, however, address a range of patient/family needs, including physical, spiritual, social and emotional concerns.

License: Authorization to practice in the professional discipline by an individual may be mandated by state law. The state grants permission to a provider organization to operate or individual to practice. It is a matter of specific state law and violation imposes a penalty.

Licensure: Licensure standards are the minimum standards which must be met to provide service as a hospice. In contrast to accreditation and certification, licensure is mandatory if specified by state law. The state grants permission to a provider organization to operate or individual to practice. It is a matter of specific state law, and violation imposes a penalty.

Medical director: A fully licensed physician who is charged with the responsibility of acting as consultant to the interdisciplinary team and, as requested, to attending physicians with regard to pain and symptom management, as well as acting as liaison with physicians in the community.

Medical records: Specific records maintained by a hospice that document all services provided by the

A Hospice Glossary

interdisciplinary team to a patient/family.

Medical staff: A single organized body that is accountable to the governing body and has the overall responsibility for the quality of professional services provided by individuals with clinical privileges.

Medication: Any substance, whether prescription or over-the-counter drug, that is taken orally, injected, inserted, topically applied, or otherwise administered to the patient.

Nursing services: Patient/family care services pertaining to the palliative, curative, rehabilitative and preventive aspects of nursing, performed and/or supervised by a registered nurse pursuant to interdisciplinary team care plans.

Objective: An expected result or condition that takes less time to achieve than a goal, is stated in measurable terms, has a specified time for achievement and is related to the attainment of that goal.

Outcomes: The final results or consequences from specific interventions taken. In hospice, the death of the patient is anticipated and is not defined as an outcome. Appropriate hospice outcomes focus on control of pain and symptoms and quality of the remaining days that the patient/family spends together.

Pain and symptom control: For the hospice program, the goal of all interventions is to maximize the quality of the remaining life through the provision of palliative therapies that control pain and symptoms and minimize the negative side effects of interventions. Hospice programs

recognize that when a patient and a family are faced with terminal disease, stress and concerns may arise in many aspects of their lives. Optimum symptom control includes addressing those stresses and concerns, in addition to the use of appropriate therapies. Symptom control includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

Palliative care: Intervention that focuses primarily on reduction or abatement of the physical and psychosocial symptoms of terminal illness.

Patient/family as unit of care: The specific unit for whose needs hospice is organized. In hospice, this unit is the patient/family. Services are structured (e.g., record/keeping) and then delivered (e.g., visits at home with family members). In contrast, most health providers have, as their unit of care, the individual patient.

Personal care: Assistance rendered to the patient in bathing, dressing, mobility, or any other activities of daily living and personal hygiene.

Pharmacist: A person who has a degree in pharmacology and is licensed and registered to prepare, preserve, compound and dispense drugs and chemicals in the state in which he or she practices.

Physical: Relating to the body, its structure, characteristics and functions.

Physician: A doctor of medicine or doctor of osteopathy who is fully licensed to practice medicine in conformity with applicable law.

Physician, attending: The primary physician selected by the patient to be

responsible for his or her medical care.

Physician, hospice: Any licensed medical practitioner on the hospice staff (compensated or not) who is knowledgeable about hospice principles and active in the development and implementation of interdisciplinary team plans of care for patients and families.

Primary caregivers: The person designated by the patient to give emotional support and/or physical care to the patient. This person may be an individual who has personal significance to the patient but no blood or legal relationship (e.g., significant other), such as a neighbor, friend or other person. If the patient has no designated primary careperson, the hospice may, according to individual program policy, make an effort to designate a primary careperson.

Prognosis: The prospect of recovery, or a forecast of the natural history of a disease or illness. In hospice, usually prior to admission, a patient must have been given a prognosis by a physician of less than six months to live.

Program director: The person who has the authority and responsibility, as delegated by the governing body, to accomplish program-specific goals and objectives, implement program policy and manage personnel and resources.

Psychological/social work services: Counseling and/or therapy, as appropriate, that assists the patient/family in minimizing stresses and problems that arise from social, economic or psychological situations and assists the patient/family in maximizing positive aspects and opportunities for growth. Services are provided, as appropriate to the skills

A Hospice Glossary

required, by the persons who have education, training and/or experience in the care of hospice patients/families and demonstrated ability in counselling and casework.

Psychosocial assessment: The evaluation of a patient's/family's environment, religious background, financial status, and other pertinent psychosocial information that may contribute to the development of an interdisciplinary team care plan.

Qualified: Having the experience, education and demonstrated competence deemed appropriate by the hospice program to meet the requirements and fulfill the responsibilities of a specific function or duty.

Quality assurance: Ongoing assessment program that measures the quality of the interdisciplinary hospice services provided; It includes provisions for addressing specific problems identified and followup to determine the effectiveness of corrective actions.

Registered nurse: A nurse who is a graduate of an approved school of nursing and who is licensed to practice as a registered nurse.

Risk assessment: The hospice program maintains a process of risk assessment for surviving family members that identifies those individuals at risk of pathological grief. For those individuals at high risk, appropriate referrals are made to mental health professionals in the community.

Service: A functional division of a program or an interdisciplinary team. Also, the delivery of care.

Social: The interactions of persons with their families and communities.

Social services: See (Psychological/social work services.)

Spiritual service: Spiritual support provided by a member of the interdisciplinary team, community clergy, or a person identified by the patient/family as supportive with regard to spiritual or religious matters.

Staff: Paid or volunteer interdisciplinary team members who provide hospice services.

Staff support: Organized activities designed to provide psychological/social support to hospice employees as they respond personally to the loss, grief and change experienced by patients and their families.

Supervision: The direction of the provision of services and the individuals who provide the services, and the review of the services provided, in accordance with written program policies, procedures and job descriptions.

Terminal disease: An illness for which treatment directed toward cure or control of the disease process is no longer possible or effective.

Terminally ill: Individuals suffering from a disease with a prognosis of six months or less to live.

Transfer: Movement of the patient/family from one service or location to another (e.g., the patient and family or designated primary careperson).

Unit: A functional division of a facility or institution. Also, a person or group regarded as a whole (e.g., the patient and family or designated primary careperson.)

Utilization review: The process of using predefined criteria to evaluate whether the hospice's services and resources are necessary, cost efficient and effectively utilized.

Volunteer: An individual who agrees to provide services to a hospice program without monetary compensation. More specifically, a patient care volunteer is an individual who agrees to serve on an interdisciplinary team as a companion of the patient/family and provide psycho-social support to the patient/family during the remaining days of the patient's life. A bereavement care volunteer agrees to provide psycho-social support to the surviving family following the patient's death.

Volunteer support: Activities designed to assist and support volunteers as they work in their roles as patient care and bereavement volunteers.

Written agreement: A formal agreement with any organization, agency, or individual specifying the services, personnel and/or space to be provided to or on behalf of the hospice program, as well as the monies to be expended, if any, in the exchange. The agreement is approved by the governing body, in accordance with hospice program policy.



National Hospice Organization

Addendum to

Standards of a Hospice Program of Care
Recommended by the National Hospice Organization

Original Standard:

Standard 14

A hospice program has an organized training program and procedures for the selection, supervision and continuing education of volunteers.

Revised Standard:

Standard 14 (A)

The hospice program has an organized training program which covers at a minimum the following topics: introduction to hospice, concepts of death and dying, communication skills, care and comfort measures, understanding diseases and conditions, psychosocial and spiritual dynamics of death and dying, the hospice family, managing personal stress, the bereavement process, and the role of the volunteer in hospice.

Standard 14 (B)

The hospice program has established policies and procedures for the selection, retention and continuing education of hospice volunteers and volunteers are regularly evaluated using performance criteria defined by the hospice.

11/90





NATIONAL HOSPICE ORGANIZATION

ABOUT HOSPICE

Hospice is a philosophy and concept of care for the terminally ill that is now one of the most frequently used terms in discussions of innovative approaches to health care. In 1990, the American College of Physicians presented to the National Hospice Organization the Richard & Hinda Rosenthal Foundation Award in recognition of the "recent original approach in the delivery of health care or in the design of facilities for its delivery [which] will increase its clinical and/or economic effectiveness." However, most people are unaware that the significant recent growth of hospice in the United States and internationally is nurtured by ancient roots.¹

The modern hospice can trace its roots to the Irish Sisters of Charity who established St. Joseph's Hospice at London in 1905. The hospice most often recognized as the model of contemporary hospice philosophy and care is St. Christopher's in London. Started by Dame Cicely Saunders, M.D. in 1968, St. Christopher's laid the basis for a philosophy that emphasizes palliative care, i.e., pain and symptom control rather than curative care for the terminally ill.

A community based service, hospice care is provided by an interdisciplinary team of health care professionals and volunteers including physicians, nurses, counselors, therapists and aides. Using a comprehensive case management approach, hospice care is guided by a plan of care which is developed by the interdisciplinary team in conjunction with the patient and family. The goal of the plan is to care for the patient and family as the "unit of care," to provide an alert, pain-free life and to manage other symptoms so that individuals can "live until they die" with personal dignity and quality of life at home or in a home-like setting.

Responding to the directives of the Medicare Hospice Benefit Conditions of Participation², as well as the National Hospice Organization and JCAHO standards, most hospices offer the

¹ The first references to "hospice care" can be found in the ancient writings of Constantine in A.D. 335, and later with the sixth century Benedictine monks and in the ninth century under the emperor, Charlemagne.

² Congress first added the hospice benefit to Medicare in TEFRA 1982. In 1986, Congress made the Medicare benefit permanent and established hospice as an optional Medicaid benefit.

following services to terminally ill patients with a prognosis of six months or less: Physician and nursing services on an intermittent basis; social work services, physical, occupational and speech-language therapy; home health aides; volunteers; drugs and medical supplies; spiritual, dietary and other counseling; short-term inpatient care; continuous home nursing care during periods of medical crisis; and bereavement care for surviving family members. Most services are available, as needed, 24 hours per day, seven days per week.

HOSPICE REIMBURSEMENT AND SAVINGS

As noted, hospice care is a covered Part A benefit under Medicare. Additionally, hospice care is a covered Medicaid Benefit in thirty-three states. Medicare and Medicaid directly pay hospices an all-inclusive, prospective daily rate based on a particular level of care delivered on that day. The four levels of care are: Routine Home Care, Continuous Home Care, Inpatient Respite Care and General Inpatient Care. No more than 20 percent of a hospice's aggregate days may be furnished at the inpatient level of care, and there is an annual aggregate expenditure cap per hospice, calculated on a per patient basis, of \$11,551 (1992). For 1992, the Congressional Budget Office projected a \$600 million Medicare outlay for hospice care. Approximately 60 percent of all hospice patients are Medicare beneficiaries.

Estimated expenditures for hospice care are not available from private payers; however, according to the Health Insurance Association of America, more than 80 percent of employees in medium and large companies have hospice care as a covered benefit. In 1984, only 11 percent of such employees had coverage for hospice care.

Health Care Financing Administration (HCFA) research suggests that approximately 28 percent of annual Medicare expenditures are associated with services, many of which are inappropriate and unwanted, provided to Medicare beneficiaries in their last year of life. Medicare beneficiaries electing hospice services waive their right to standard Medicare benefits for treatment of the terminal illness although their attending physician continues to bill Medicare Part B directly.

A 1988 HCFA commissioned report by ABT Associates suggested a savings of \$1,248 per patient in the last year of life, when hospice care is elected. Kaiser Permanente, an Oakland, California-based HMO, conducted a hospice cost-effectiveness study in the late 1980's focusing on non-Medicare and non-Medicaid terminally ill patients who entered hospice care. The study showed an average cost savings per hospice patient of about \$1,430 to the HMO.

A STATISTICAL PROFILE OF HOSPICE CARE

- First Hospice in the United States, New Haven, CT. 1974
- Current number of U.S. hospices, 1830 including planned and non-comprehensive programs. NHO estimates 1700 comprehensive programs, as described above.
- Approximately two-thirds of the comprehensive hospices are Medicare certified.
- Over 90 percent of hospices are non-profit or government affiliated programs. Four percent are for-profit entities.
- Hospices served approximately 210,000 patients in 1990.
- The average daily census of the typical hospice program is 25 patients per day. The average length of stay is 59 days. Approximately 90 percent of all patient days were provided in the patient's home.
- Approximately two out of three patients served are over the age of 65. One percent are under the age of 18, representing 71 percent of pediatric cancer deaths.
- Eighty-four percent of hospice patients have cancer, accounting for approximately 33 percent of all cancer deaths as reported by the American Cancer Society. People living with AIDS and those with cardiovascular disease constitute the bulk of remaining hospice patient census.
- Over 20,000 people are employed nationwide in hospices and include physicians, nurses, social workers, administrators, home health aides, clergy, therapists and bereavement specialists.
- Approximately 68,000 people volunteer in hospice programs, contributing more than 5 million hours of service annually. Two out every three hours are direct patient care hours. The Medicare Hospice Benefit Conditions of Participation require that a minimum of five percent of patient service hours be provided by volunteers.

II. Studies Showing Savings and Benefits of Hospice Care:

Through the national hospice demonstration projects conducted by the federal government, it was learned that not only was hospice care a more humane alternative of care but it resulted in cost savings as well. As a result of its cost effectiveness, the Medicare hospice benefit was created by the Tax Equity and Fiscal Responsibility Act of 1982 as a more humane alternative to the hi-technology care traditionally provided to the terminally ill. In 1986, hospice was made an option under Medicaid and the number of states offering the hospice benefit rose to 34 states by 1992.

- Savings can be realized by substituting the high cost of conventional care with the home-oriented approach of hospice care. A study by Abt Associates (Medicare Hospice Benefit Program Evaluation, Final Summary Report, July 21, 1989) stated that comparisons of hospice benefit and conventional care expenditures in the last month of life showed that conventional care was 30% higher in FY85 and 43% higher in FY86. The hospice savings were even more significant for non-cancer beneficiaries who cost \$3,135 for hospice care in the last month of life compared to \$4,730 for conventional care.

- Major savings in the cost of providing care to the terminally ill are directly related to the percentage of time patients are at home during the final months of life. Based on 1986 mortality data from the National Center for Health Statistics, an article in the Health Care Financing Review/Fall 1990, stated that there was an increase of 10% in the shift in place of death for cancer patients from hospitals to patients homes, and because about 94% of all hospice patients have cancer, the data suggests a possible impact of hospice use.

- A survey of hospital based hospices conducted by the American Hospital Association in 1986 identified a major reduction in the number of inpatient days for those patients cared for under the Medicare hospice benefit: the average

patient on the Medicare hospice benefit spent 68 days at home and 7.7 days in the hospital; the traditional Medicare patient spent an average of 58.1 days in home care and 21.3 days in the hospital; and the non-Medicare patient spent an average of 53.4 days at home and 13.8 days in the hospital.

- According to the most recent statistics gathered from Medicare certified hospice programs by the Health Care Financing Administration, the average length of stay was 48.38 days in a hospice program in 1990, and 96% of all patient days were spent in the home rather than in conventional health care settings. Additionally, the number of Medicare certified hospices in the country increased to 1,072 by April of 1992.

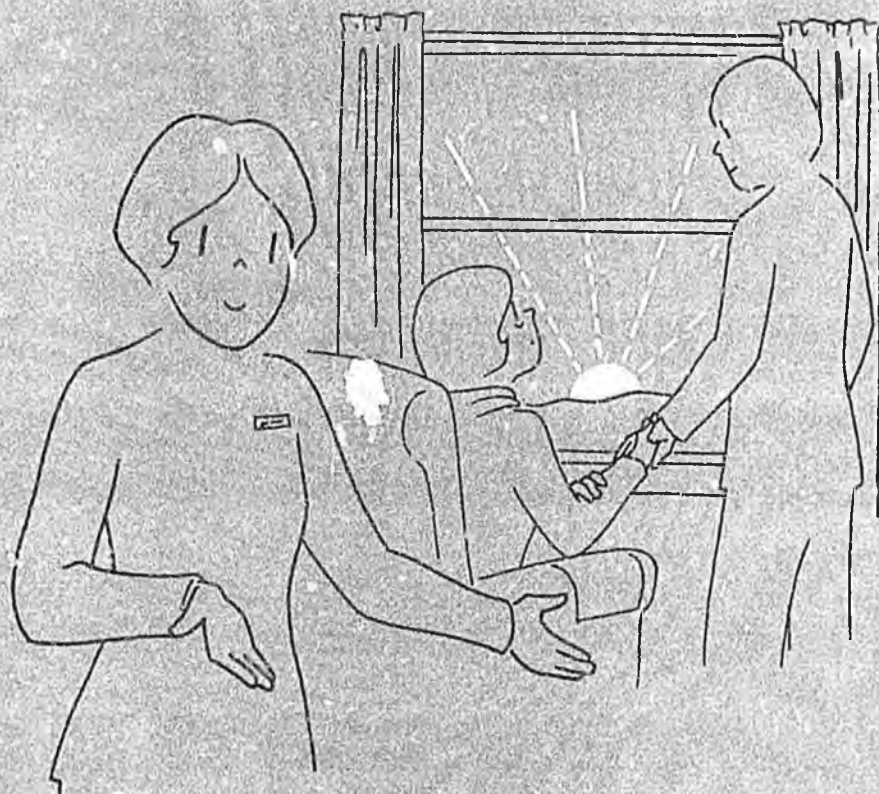
- Employee benefit packages surveyed by the Bureau of Labor Statistics showed 23% carrying hospice coverage in 1985 and 31% in 1986.

- General Motors Corporation covers hospice care on a per diem basis for all of its employees (Blue Cross is the intermediary for this reimbursement) and Metropolitan Life Insurance Company also uses a per diem system for all of its subscribers.

- Sixty-nine percent of Health Maintenance Organizations (HMOs) offer hospice care as surveyed by the Group Health Association of America in 1988.

- A survey conducted by Foster Higgins & Company, a benefits consulting firm, showed that 80% of major employers nationwide included hospice as an employee benefit in 1989. The survey represented over 12.5 million employees of 1,943 public and private-sector employers.

ABOUT HOSPICE



What is
HOSPICE
?

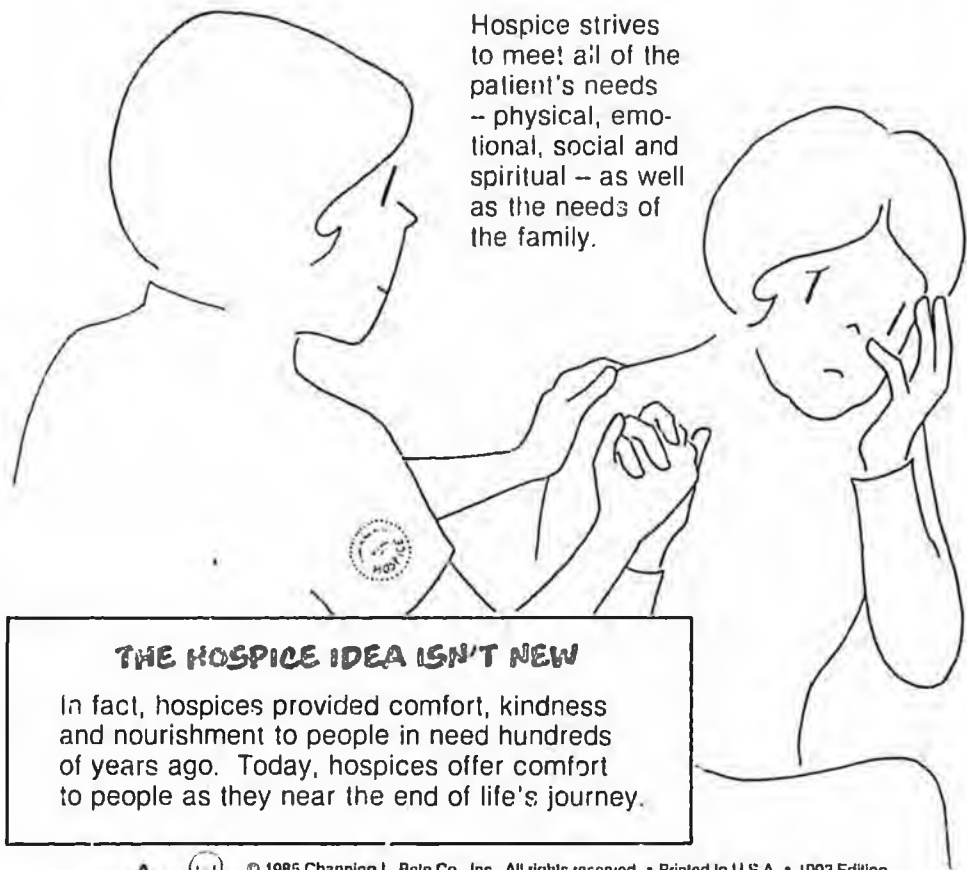
It's a special way
of caring for people
with terminal illnesses
and for their families.

HOSPICE TREATS THE WHOLE PERSON

A terminal illness can cause many reactions,
including:

- pain and discomfort
- concern about family and friends
- fear and loneliness
- anxiety about what lies ahead.

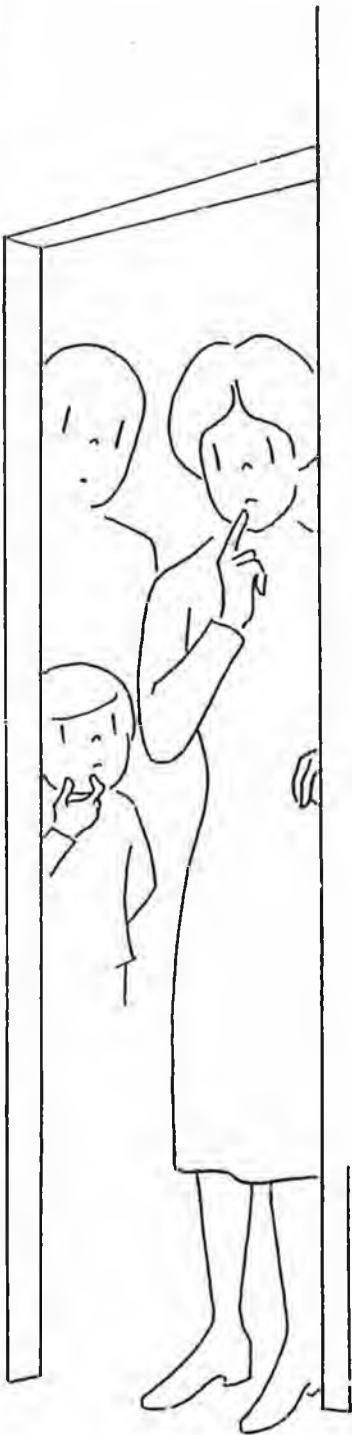
Hospice strives
to meet all of the
patient's needs
– physical, emo-
tional, social and
spiritual – as well
as the needs of
the family.



THE HOSPICE IDEA ISN'T NEW

In fact, hospices provided comfort, kindness
and nourishment to people in need hundreds
of years ago. Today, hospices offer comfort
to people as they near the end of life's journey.





Because it provides many benefits that aren't possible in a traditional health-care setting. Hospice means:

A COMING TOGETHER WITH FAMILY

Through hospice, the family is directly involved in making decisions and in helping a person they love.

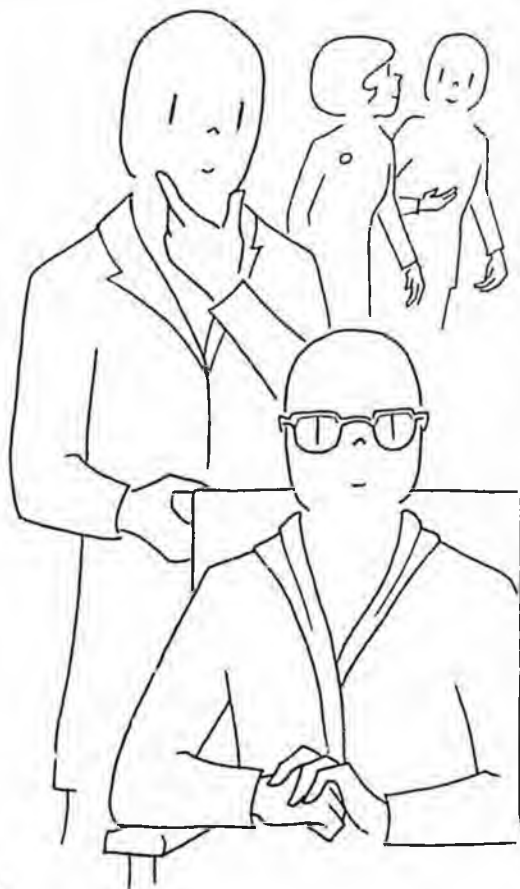
Hospice serves the family as a unit and is sensitive to any special needs.

GREATER CONTROL FOR PATIENTS

Hospice enables people with terminal illnesses to make decisions about how and where they want to spend the rest of their lives and to make advance directives (see p. 14).

HOSPICE FOCUSES ON THE UNIQUE NEEDS OF PATIENTS AND FAMILIES

Special attention is given to:



PHYSICAL NEEDS

For many patients, relieving pain through medication is an important part of hospice care. Patients are also made more comfortable through:

- frequent changes in body position
- back rubs
- proper care of teeth and gums
- personal cleanliness
- attention to many other important details.

A goal of hospice is to help patients use their physical abilities as fully as possible.

SOCIAL NEEDS

Sometimes little things make all the difference. Though seriously ill people may not be as active as they used to be, most still enjoy:

- eating favorite foods
- listening to music
- sharing time with family and friends
- being well-dressed and well-groomed.

Hospice can help make these things happen, as well as provide assistance with practical issues, such as putting financial matters in order.

EMOTIONAL NEEDS

Hospice helps patients cope with loneliness, isolation and the fear of being abandoned. Patients are:

- treated so that they know they're still important to others
- given honest, compassionate answers to their questions
- encouraged to express how they think and feel.

Hospice also helps families and friends express their emotions.

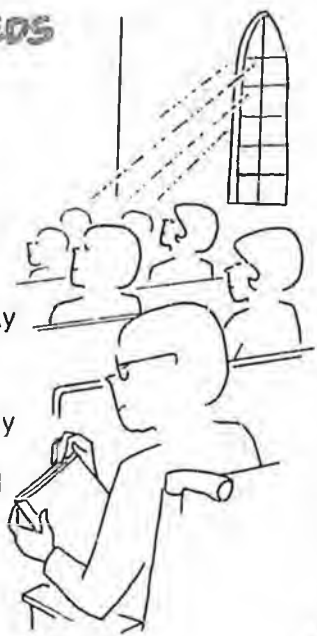


SPIRITUAL NEEDS

Hospice recognizes the importance of spiritual matters. Patients can share their feelings with:

- their own minister, priest or rabbi
- a chaplain, who may be part of the hospice team.

Members of the clergy can also help family and friends who need support.



WHAT
makes hospice
SPECIAL
?

Hospice is special because it concentrates on care -- not cure. Hospice emphasizes:

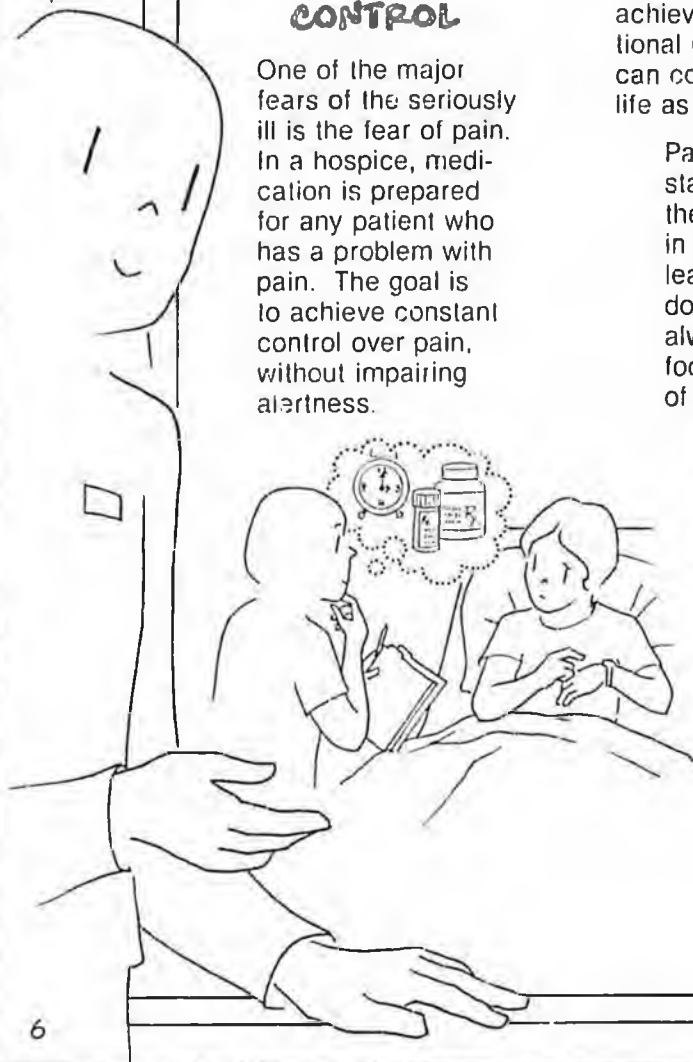
PAIN CONTROL

One of the major fears of the seriously ill is the fear of pain. In a hospice, medication is prepared for any patient who has a problem with pain. The goal is to achieve constant control over pain, without impairing alertness.

LIVING LIFE FULLY

Hospice helps patients achieve physical and emotional comfort so that they can concentrate on living life as fully as possible.

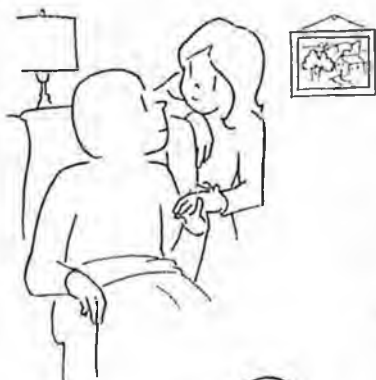
Patients are urged to stay active for as long as they're able -- to take part in activities they enjoy, to learn something new, to do something they've always wanted to do, to focus on the quality of life.



CARE AT HOME.

Whenever possible, family or friends care for patients at home, amid familiar surroundings and loved ones.

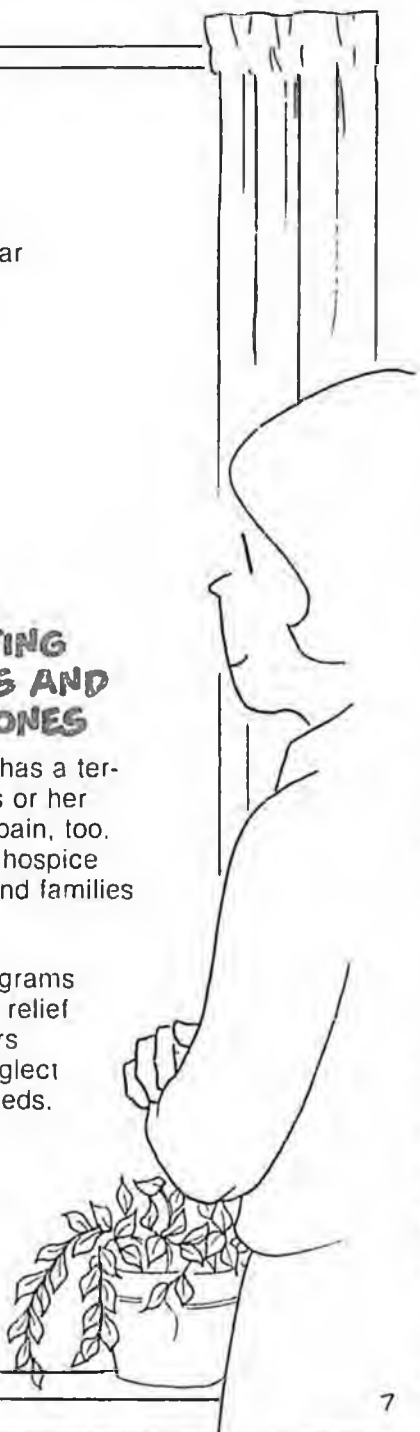
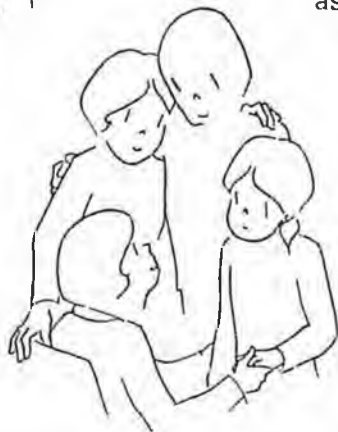
Care at home can help patients and families draw closer and enrich their lives. It can also help relatives and friends become less frightened about facing death themselves someday.



TREATING PATIENTS AND LOVED ONES

When someone has a terminal illness, his or her loved ones feel pain, too. For this reason, hospice treats patients and families as a unit.

Hospice programs also provide relief to care givers who may neglect their own needs.

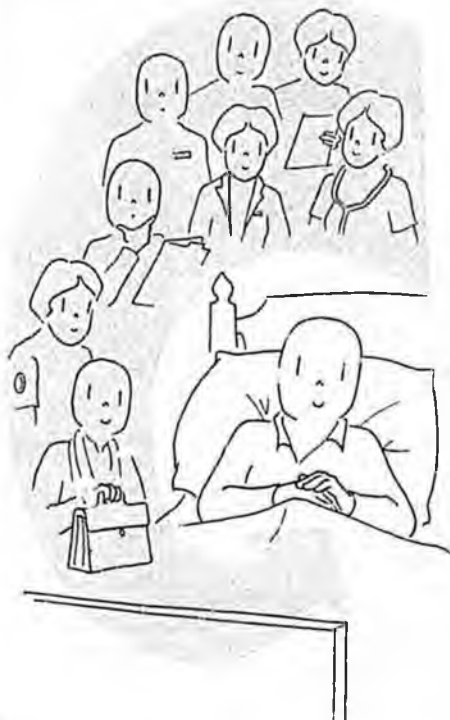


MORE ABOUT HOSPICE SERVICES

A "TEAM" PROVIDES CARE

Realistically, it's just not possible for one person to meet all of the needs of a seriously ill person.

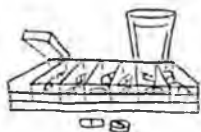
For this reason, hospice uses a team approach. This means that many people with many different skills work together for the good of the patient and the family. The team holds meetings to coordinate care.



FAMILY AND FRIENDS LEARN CARE TECHNIQUES

Those people who provide care for a patient at home may be specially trained to:

- give medications



- help the patient to stay as mobile and active as possible

- listen and respond to the patient's needs



- take certain steps in specific types of situations.

Sharing in the care of a loved one can be hard work, but it certainly has its rewards.

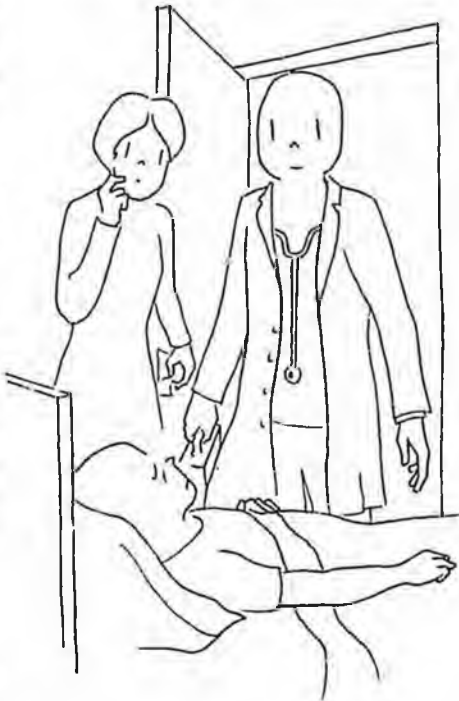


HELP IS ALWAYS AVAILABLE

Family or friends providing care in the home can call for help at any time --

- 24 hours a day
- 7 days a week.

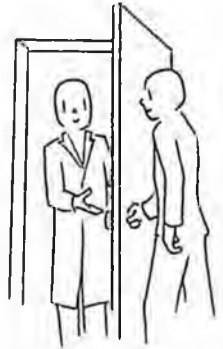
A member of the hospice team will come to the patient's home whenever needed.



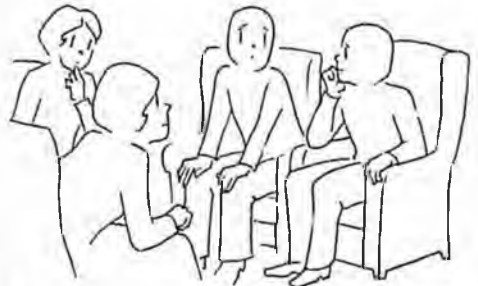
BEREAVEMENT COUNSELING IS PROVIDED

Though hospice helps prepare family and friends for the loss of a loved one, additional support is often needed after the loss occurs. Hospice can help people deal with their grief through:

- individual and family counseling
- volunteer visits
- holiday programs
- support groups
- learning about loss and grief.



(Some hospices help with funeral arrangements.)



WHO
are the
members of the
hospice team

?

They're specially
trained people who
help patients to be
as comfortable as
they can be.



**MEMBERS OF THE
TEAM MAY DIFFER**

from hospice to hospice, but
generally they include:

- A hospice coordinator or director
- Physicians
- Nurses
- Psychiatrist
- Psychologist
- Clergy
- Social worker
- Dietitian
- Pharmacist
- Therapists (physical, occupational, etc.)
- Volunteers.

Patients, families and
friends are important
members of the team, too,
since it is their needs that
hospice seeks to serve.

WHERE

is care
provided



In a setting
that best suits
the needs of the
patient and care givers.
Care may be provided at:

HOME

Home is the usual care setting for hospice patients.

A family member, friend or community volunteer assumes the role of primary care giver. This person receives support from hospice personnel, whenever necessary.



INPATIENT FACILITIES

In some areas, inpatient services may be provided in a:

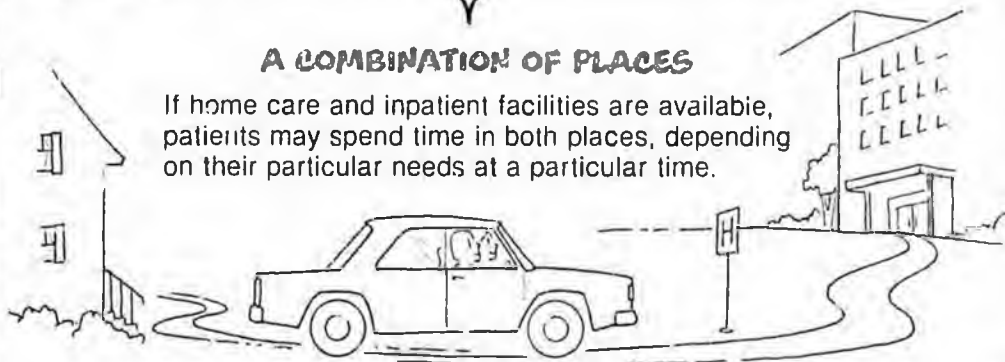
- hospital-based unit
- free-standing, independent facility
- nursing home.

These facilities may be used if there's no primary care giver or if the patient needs medical attention that can't be given at home.

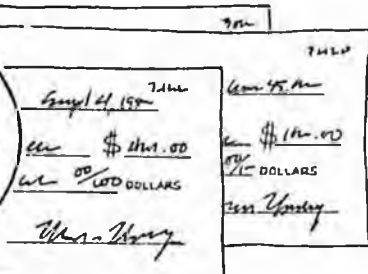


A COMBINATION OF PLACES

If home care and inpatient facilities are available, patients may spend time in both places, depending on their particular needs at a particular time.



WHO PAYS for hospice programs ?



Sources of funding may vary from one hospice to another.

INITIAL FUNDING

for a hospice may come from:

- grants
- contributions from private foundations
- local government funds
- individual contributions.



ONGOING FINANCIAL SUPPORT

is often received through:

- local fund-raisers
- memorial gifts
- voluntary contributions
- fees for patient services.



REIMBURSEMENT FOR SERVICES

may come from:

- Medicare
- Medicaid
- private insurance carriers.

Some patients don't qualify for reimbursement and are charged for services. But, it's reassuring to know that patients are accepted into a program based on their health needs – not their ability to pay. (Some hospices provide free services.)



HOW TO LOCATE A HOSPICE PROGRAM

To find out if there's a hospice
in your area, contact:

LOCAL SOURCES

These include:

- your physician (who is usually the person who makes the referral to a hospice)
- the nearest hospital
- your area health department
- your state hospice organization
- members of the clergy
- a home health agency
- the visiting nurses' association.

THE NATIONAL HOSPICE ORGANIZATION

Write or call:

National Hospice
Organization
1901 North Moore St.,
Suite 901
Arlington, VA 22209
1-800-658-8898

Information is also
available from the Cancer Infor-
mation Service. Call toll free,
1-800-4-CANCER.

SOME QUESTIONS AND ANSWERS

Are hospices only for **ELDERLY PEOPLE** ?

No. People of all ages may receive hospice care. Some hospices provide special services to children who have terminal illnesses.

What are **ADVANCE DIRECTIVES** ?

They're documents that allow you to state what kind of medical treatment you want – and don't want – in the event that you become unable to communicate your wishes.

What are some of the **SERVICES** that volunteers provide ?

Volunteers may assist patients and families directly by helping with household chores, errands, transportation, personal care, etc. Providing companionship and support is also a very important part of being a hospice volunteer.

How can I become a hospice **VOLUNTEER** ?

Contact your nearest hospice (see p. 13). You may be required to:

- have an interview
- fill out a questionnaire that shows your feelings toward terminally ill people
- complete a training program.

Soo--

HOSPICE CARE FOCUSES ON THE QUALITY OF LIFE



If you or someone you
care about is seriously ill --

✓ **FIND OUT**
if there's a hospice
in your area

✓ **CONSIDER THE
BENEFITS**
of hospice care.

**Hospice is helping make life --
and its loss -- easier for many people.**