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INSIDE

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Hospices need to get involved in hospital-based palliative care

Despite lack of Medicare payment, hospices can get paid

As end-of-life and pain management advocates raised the volume on the end-of-life care discussion, some hospitals responded by developing palliative care units to address the needs of their patients. Suddenly, someone else was treading on the domain of hospices.

Hospices have been slow to respond. Some dismiss the foray by hospitals as something quite short of the hospice mission. They reason that while hospital programs focus on symptom management, they fail to address weighty matters such as emotional and spiritual care.

Still, other hospice leaders grumble that Medicare has allowed other types of care providers to invade hospice territory with its restrictive regulations and narrow definitions of which services are reimbursable. Certainly, if hospices were to be paid by Medicare for providing palliative care services in hospitals, then hospices would do so.

It seems, however, this kind of sentiment is turning around. The National Hospice Organization changed its name to include "palliative care" in large part to address the growing need for palliative care outside traditional hospice settings. And a number of hospices are embracing palliative care in hospitals by becoming visible partners in developing inpatient palliative care units.

The Mount Carmel Hospice in Columbus, OH, has helped three Columbus-area hospitals establish inpatient palliative care units since 1995. Since then, they have treated more than 3,000 patients. Many of those patients found their way to hospices. While Medicare doesn't provide reimbursement for the work it provides to the hospital, the partnerships translated into more timely referrals to the Mount Carmel Hospice and other area hospices.

In 1996, the Mount Carmel Hospice had an average length of service (LOS) of 38 days. With patients receiving hospice information sooner in inpatient palliative care units, an increasing number of patients are

being admitted sooner and, as a result, LOS this year has soared to 50 days.

"The continuum of care has to be developed," resolves **Mary Ann Gill**, RN, MA, director of hospice and palliative care medicine for Mount Carmel. "What we've learned is that when you give knowledge away, you get so much back. By partnering with area hospitals, we've created a system that moves patients along the continuum."

At the Hospice of the Florida Suncoast in Largo, FL, partnering with St. Anthony's Hospital is looked upon as return to what hospices did decades ago, before the industry became defined by what Medicare pays for.

"I think we're going back to the broader end-of-life care we used to provide . . . to before Medicare when we would provide consults for palliative care," **Mary Labiak**, president and CEO of the Hospice of the Florida Suncoast. "Palliative care is nothing new. It's a strength we have always had."

What both have helped create is an inpatient program that addressed the needs of the hospital's sickest patients; dying patients whose care requires high-tech equipment that cannot be provided in the home; home care patients whose disease has not progressed enough to make them hospice eligible; and residential facility patients who are not hospice eligible.

Established relationships come first

Both Labiak and Gill say that hospices should establish partnerships with hospitals to bring palliative care to hospital patients. From a moral perspective, hospices have a duty to reach out to patients who need their care, both say. From a business perspective, it makes sense to tear down existing barriers that prevent hospices from reaching patients who otherwise would not be exposed to hospice care.

Doing so isn't a simple proposition. It's a combination of building relationships and sharing the hospice philosophy. It's a delicate balance of competing hospital agendas and the hospice's need to manage patient care.

For Mount Carmel Hospice, its palliative care partnerships began five years ago when hospice leaders asked: "Why are so many people who die in hospitals not receiving hospice care?"

"Before we began our palliative care partnerships, it was like holding a net outside the hospital hoping for patients," Gill says.

Even before the hospice and hospitals began looking earnestly at developing an inpatient palliative care program, the foundation for such partnerships was set down by years of relationship building. As both interacted, the hospice taking on patients referred by the hospitals and the hospitals learning about palliative care from the hospice, they found common ground to build their palliative care programs upon.

"Almost every hospital deals with end-of-life issues," says Gill. "If you establish a relationship with them and help them deal with these issues, you can eventually help them with their palliative care program."

A long-standing relationship with area hospitals also was the precursor to the Hospice of the Florida Suncoast's program with St. Anthony's Hospital. In fact, the hospice had been providing palliative care to area hospitals, says Labiak.

"We have always worked with area hospitals," she adds. "Now instead of scattered beds, we're bringing them together in one place."

Hospitals and hospices that have nurtured their relationship have the inside track to establishing an inpatient palliative care unit. Now it is a matter of building a program that reflects the tenets of hospice care.

"Our greatest concern was that not only should the skills [needed for palliative care] transfer, but also the philosophy," says Labiak.

Left to their own devices, hospitals would likely implement palliative care programs that focus solely on symptom management. While a patient's pain may be treated better compared to traditional hospital care, hospital staff lack the expertise to provide emotional and spiritual care.

A hospice's role in developing an inpatient palliative care program is that of consultant. In essence, what hospices will be called upon to do is to provide training. Just as hospices would train new workers and volunteers, they will need to train hospital nurses and medical staff in treating the whole patient, how to recognize patients who would benefit from palliative care, and how to educate patients about their end-of-life options.

The hospice also will play a role in providing care. Arrangements will differ, depending on agreed-upon goals. One of the important details that needs to be ironed out is who will provide which services, such as whether hospice nurses will provide direct patient care in the palliative care unit or act as advisors, and the role other members of the interdisciplinary team will play. Involvement could range between acting as mere consultants to providing care in something similar to a hospice inpatient facility.

"It takes a lot of joint planning," says Gill.

According to the National Council for Hospice and Palliative Care Services, no matter what the structure or level of hospice involvement, hospital palliative care units should incorporate the following guidelines:

- The palliative care approach should be an integral part of all clinical practice, available to all patients with life-threatening illness.
- Appropriate management responsibility and consultative arrangements are required to ensure that key palliative care issues are addressed at trust level between patient and caregiver.
- Departmental policies should specify a minimum requirement of palliative care training for each category of staff, including nonclinical staff in contact with patients.
- All specialties should agree on clinical standards for palliative care; they should incorporate awareness of the psychosocial needs of patients and family/caregivers.
- There should be greater emphasis on the palliative care approach in both basic and post-basic education for all health care professionals

No matter the level of involvement, there will be cost incurred by the hospice. And while Medicare will not reimburse for palliative care outside the hospices, eligibility rules. Medicare rules are clear on covered benefits. Without a six-month terminal illness diagnosis, coverage is excluded. Further, services provided in a hospital are the billing responsibility of the hospital, because it is the hospital that owns the building, beds, equipment, and pays for staff who provide care.

But all this doesn't mean hospices can't get paid. "Where there is a will, there is a way," Labiak says.

One option is to charge hospitals a case rate for the palliative care it provides in its facility. If the rate isn't enough to cover costs, grants and charitable contributions can make up the difference. Hospices still must be careful not to run afoul of fraud and abuse regulations. They cannot give away their services or provide care for free, because the arrangement could be construed as a scheme to induce referrals.

Still, fair-market price might not be enough to cover costs. Gill points out the financial benefit of having patients referred to hospice sooner — allowing the hospice to spread out the cost of care over a longer period of time — is a payment of sorts. Gill says her hospice now accepts patients who will stay longer and benefit more from hospice care, rather than caring for them just days before they die, when care is most intensive and expensive.

"Palliative care units give us the opportunity to assess patients, and give physicians help in assessing patients to make better decisions. We can train hospital discharge planners about hospice referrals, talk with the patient to find out what their end-of-life wishes are, and explain to them the benefits of hospice," Gill says. "This is brand-new work being done. We're changing the culture of hospitals." ■

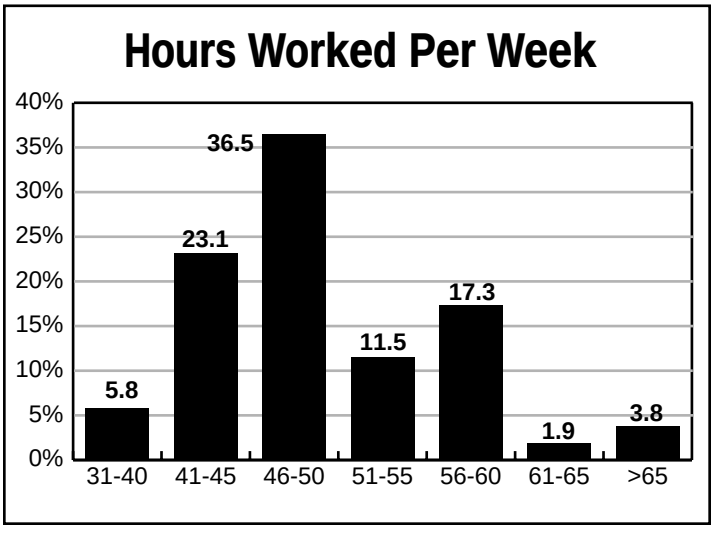
Hospice administrator salaries are on the rise

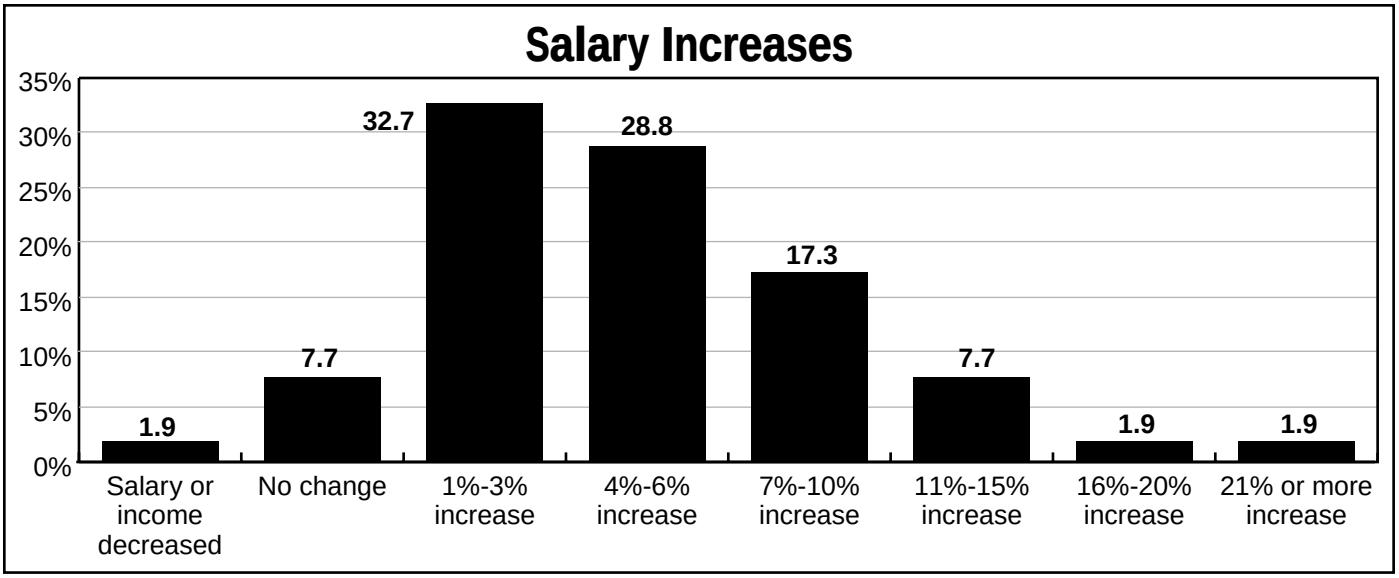
Increases represent industrywide norm

Hospice administrator salaries continue to increase, according to *Hospice Management Advisor*'s 2000 salary survey of its readers. The majority of *HMA* readers — mostly administrators, reported increases of 1% to 6% compared to the previous year.

Of those who responded to the survey, one out of every six people said they received a pay increase in the past two months. Of those who indicated raises in salaries, 32.7% were in the 1% to 3% range, and 28.8% were in the 4% to 6% range.

In June, 52 *HMA* readers responded to the salary questionnaire, which also looked at characteristics of the hospice and hospice administrators. While the small sample does not represent a statistically significant study, it does offer a glimpse of where *HMA* readers stand in comparison to their colleagues.





The majority of readers, 57.8%, indicated that their salaries were more than $65,000, with 25.6% falling between $65,000 and $74,999. About 15% of *HMA* readers' salaries this year ranged between $65,000 and $69,999, and 10.3% fell into the $70,000-$74,999 category.

The increases represent a norm in the industry, says **Lisa Spoden**, PhD, MBA, executive vice of Strategic Healthcare, a hospice consulting firm in Columbus, OH. But salaries themselves were a bit harder to pin down.

"We see a wide variety of salaries," says Spoden, whose company has done salary surveys of Kentucky hospices. "A lot of it has to do with the size of the hospice, the history, and its affiliation."

HMA readers also showed a wide variety of salaries. While one quarter of readers' salaries were concentrated in the $65,000 to $75,000 range, nearly 6% reported salaries in excess of $155,000, and 22.8% reported salaries between $40,000-$49,000.

The titles associated with those who reported their salaries to HMA were fairly consistent, representing top hospice administrators. Nearly 77% of respondents indicated their titles were either director of hospice (53.8%) or administrator (23.1%).

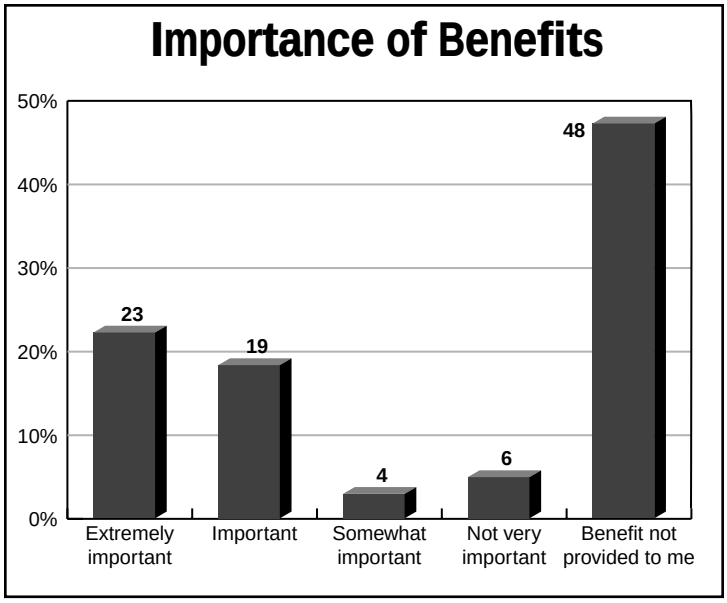
Spoden says administrators' salaries are likely driven by organizational characteristics. For example, hospital-based and for-profit hospices are likely to be paying administrators on the higher end of the pay scale, while smaller, nonprofit hospices are on the other end of the spectrum. The hospice's history may also play a role, Spoden says. Organizations whose roots date back to volunteer hospices may also pay on the low end. "It could be that the salary was never competitively set."

Salary surveys done by Hospital & Healthcare Compensation Service, an Oakland, NJ, company that tracks salaries in the health care industry, show that hospice administrator salaries are on the increase, as well. 1999-2000 figures show a median salary of about $59,850 per year, says **Rosanne Cioffe**, director of reports for Hospital Healthcare Compensation Service. That represents a 6.8% increase from the 1998-1999 median salary of $56,035.

The average salary for hospice directors in 1997-1998 was $56,035, up 4.32% compared to the previous year's average of $53,713, Cioffe says.

The report, published by the Hospital and Healthcare Compensation Service and the Hospice Association of America, shows that directors' salaries have been increasing steadily for the past five years. Since

Annual Gross Income	
$20,000 to $24,999	0%
$25,000 to $29,999	0%
$30,000 to $34,999	0%
$35,000 to $39,999	3.4%
$40,000 to $44,999	17.2%
$45,000 to $49,999	24.1%
$50,000 to $54,999	17.2%
$55,000 to $59,999	10.3%
$60,000 to $64,999	24.1%
$65,000 to $69,999	33.3%
$70,000 to $74,999	25%
$75,000 to $79,999	8.3%
$80,000 to $84,999	12.5%
$85,000 to $89,999	12.5%
$90,000 to $94,999	0%
$95,000 to $99,999	0%
$100,000 to $104,999	0%
$105,000 to $109,999	8.3%
$110,000 to $114,999	0%
$115,000 to $119,999	0%
$120,000 to $124,999	0%
$125,000 to $129,999	0%
$130,000 to $134,999	0%
$135,000 to $139,999	20%
$140,000 to $144,999	0%
$150,000 to $154,999	0%
$155,000 to $159,999	60%
$160,000 or more	0%



1995, directors' average salaries have increased from a median of $48,309.

Researchers have noticed that hospice director salaries increased at a higher rate than their home care counterparts.

"In discussion with providers, we found that because home care has had some terrific problems, some are getting out of home care and going into hospice," says Cioffe. "This is because home health has had terrific problems with reimbursement the last couple of years."

Hospital and Healthcare Compensation Service expects to release its latest hospice salary report for 2000-2001 in November, Cioffe says. She expects the salary trend to continue, with 4% to 5% annual increases.

In 1998, the company also looked at hospice staff salaries. Wages for nurses and nursing aides were competitive compared to similar jobs in other health care settings. The average hourly rate a hospice RN in 1998 was $17.75, while LPNs earned an average of $12.70. Compared to their nursing home colleagues, hospice nurses, on average, earned $0.87 more per hour. On the other hand, aides in hospices earned an average of $0.18 less per hour.

The median home care nurse's hourly rate was $0.49 per hour more than a hospice nurse, and home care nursing aides had an average hourly rate that was $0.30 higher than hospice nursing aides. Hospice nurses earned an average of $17.75 per hour while home care nurses made an average of $18.24.

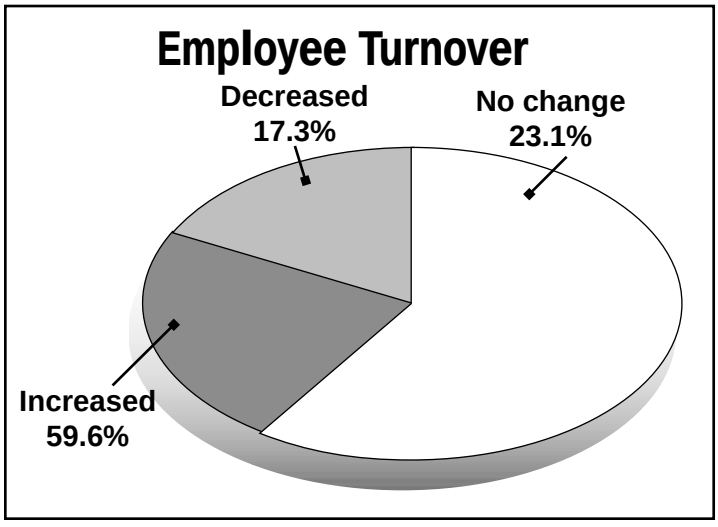
Compared to the previous year, the current difference represents a small step to closing the gap. In 1996, hospice nurses earned an average of $0.55 per hour less than home care nurses. In 1997-1998, the average hospice nurse's hourly rate was $17.30, while the average home care's hourly rate was $17.85.

The competitive salaries and wages help contribute to the stability of many hospices. As a whole, the hospice industry reported turnover rates lower than the home health sector. The position with the highest turnover in hospices was nursing aides. The report said one-quarter (25.5%) of nursing aides left their position in 1998. The lowest turnover rate was seen in respiratory therapists, which had a turnover rate of 14%.

The current salaries that administrators are making represent more than 13 years of experience in the health care industry, the *HMA* survey showed. One-third of administrators had held their current positions or similar ones with other hospices. Thirty-six percent of respondents said they have more than 25 years of experience in health care. Four out of 10 respondents said they have between 13 and 21 years of health care experience.

Nineteen percent of hospice administrators have held their positions or similar ones for four to six years; 11.2% for seven to nine years; 13.5% for seven to nine years; 13.5% for 10 to 12 years. The survey also pointed to a new batch of hospice leaders. The survey showed that 21.1% of *HMA* readers have been in their current job for one to three years.

Readers indicated that their hospices are growing in the number of employees (59.6%). But Spoden says this is not due to increases in referrals, but rather a likely product of increasing regulations. "Hospices are having to deal with increased regulations," Spoden says. "All of those external forces create a need for more people. Hospices are just becoming more bureaucratic." ■



Improved orientation program reduces turnover

Hospice makes support group mandatory

For hospice workers, dealing with the death of someone close to them is an everyday occurrence. And while they provide compassionate care and support to patients and families, there is often little support for the hospice workers themselves, as they move from one death to the next.

Failing to provide adequate support to hospice workers often translates into burnout and high employee turnover. The stress of establishing a loving relationship with a patient and family, only to have it end with the patient's death, can take its toll if left untreated.

"All of my staff are important, and they deserve to be treated with the same hospice touch they provide to their patients," says **Jane Isbell**, BSN, RN, CRNH, administrator for the Hospice of Central Virginia in Richmond.

When it came to hiring and training nurses, the Hospice of Central Virginia was like a lot of other hospices around the country. As early as last year, the hospice was hiring nurses with unwanted regularity. New nurses were coming aboard not because they were adding new positions, but because they were losing nurses to the stress of the job. Prior to January 2000, a nursing staff of 15 was saddled with an average loss of five nurses per year.

Implement solid orientation program

That meant having to hire a handful of employees each year, incurring the cost of training them, all the while hoping they had the stuff that would allow them to be long-term successes. In addition, existing staff were handed the additional burden of making up the workload while the organization was brought to full staff.

"Our staff retention has increased dramatically," Isbell says. "I feel strongly that it is because of our orientation and support programs."

Isbell credits the hospice's new orientation program in reducing its average turnover of five nurses per year to one this year.

In the beginning of the year, the Hospice of Central Virginia implemented an improved orientation program, one that not only introduces new nurses to the organization, but also provides coping skills to help them deal with the emotional rigors of caring for the dying day in and day out. The hospice also conducts weekly support group meetings at which attendance is mandatory every other week.

Most hospices provide orientation programs for their new employees. There, they are shown a series of videotapes, listen to speakers from various disciplines, and learn about workplace safety. At the end of the process, a new nurse is sent out into the field with a caseload of a dozen or more patients.

To some extent, the Hospice of Central Virginia's orientation program isn't any different from those of other hospices. They, too, provide basic hospice information and show new employees how to properly lift heavy boxes. But the hospice also goes considerably farther. First, the orientation program is individualized and dependent on the new hire's ability to grasp concepts about death and dying, not only from a patient perspective, but also from their own perspective. All that means that new nurses aren't sent into the field in just two weeks, but in three or four, or not at all.

"They aren't sent into the field until they are comfortable," says **Cheryl Rodgers**, RN, BSN, staff development / quality assurance coordinator. "The nurse stays in the orientation program for as long as the nurse needs it. It also gives me a chance to determine whether being a hospice nurse is the right job for the person."

The orientation program includes the following topics:

- **Organizational philosophy:** Recently hired workers are schooled in the hospice philosophy and the hospice's mission.
- **Hospice basics:** For nurses who have never worked in hospice, there is a need to become familiar with ideas such as the interdisciplinary team, palliative care, spiritual care, advance directives, and other tenets of hospice that are critical to getting them oriented.
- **Communication:** New nurses are taught how to listen to patients and take clues from patient interaction.
- **Death and dying:** New hires are asked to explore their own feelings about death and dying, and perhaps revisit their own loss of a loved one.
- **Stress management:** The hospice stresses the importance of communication, not only for the sake of patient care, but also for the mental well-being of its nurses. New nurses are taught the importance of using resources available through

the interdisciplinary team, such as other team members who can provide additional support to the patient and alleviate the stress of having to support the patient on their own.

Learning to deal with death

Everyone has unique experiences with death. For hospice nurses who deal daily with death, these experiences can affect how they approach their work. New nurses who have gone through the pain of a loved one's death, can let their unresolved feelings affect how they relate to patients. For example, rather than remaining empathetic caregivers, they allow themselves to become too personally involved with their patients. If their own experience left them with feelings of guilt or anger, that could translate into poor care and higher job stress.

Some death experiences can leave some with the desire to help the dying in the same way their loved ones were helped or attempt to provide better care than their own loved ones received. While that may be the foundation for the type of commitment hospices are looking for, they still must work through unresolved feelings before being allowed to care for patients.

The Hospice of Central Virginia addresses those issues by making death and dying a focal point of their orientation. Orientation participants are asked to reflect upon their own experiences and are given skills that allow them to approach care from a patient perspective and not from their own viewpoint.

Yet, many of their new nurses are young and have yet to experience the death of a loved one. Their inexperience in caring for dying patients can have an adverse effect, as well. Young nurses, for example, can be overwhelmed by the needs of the patient. With little life experience, they could feel ill-prepared to answer lofty questions about life and death.

Hand in hand with helping new nurses come to terms with their perceptions of life and death comes the need to teach stress management, says Rodgers. Caring for the dying requires a special type of commitment. Effective hospice nurses must walk the fine line between being caring and compassionate caregivers and becoming too emotionally invested in the patient and family. Hospice nurses feel compelled or called to their line of work. While that stands out as an admirable trait, it also can lead to higher stress levels among nurses.

In their zeal to care for their patients, they run the risk of neglecting their own well-being. This can manifest itself in a number of ways. A common example is one where the nurse tries to provide the lion's share of the care and support to the patient and family.

"They have a hard time leaving the visit," Rodgers says. "Rather than fostering independence and teaching the family and patient how to deal with certain situations, they fall into the trap of trying to do everything for them."

New nurses are taught to rely on others to keep stress to a minimum. Rather than shouldering all the care a patient needs, nurses are encouraged to call upon other members of the interdisciplinary team to provide specific types of care.

For example, when a patient questions the purpose of his or her life as he or she approaches death, a nurse might feel uneasy about trying to tackle such a delicate subject. Although the nurse can play a role in encouraging the patient's spiritual explorations, he or she might be more comfortable calling upon a chaplain to take the conversation further.

"We try to tell them: 'You're not alone. The interdisciplinary team will support you. Everyone makes mistakes — you're not going to have all the answers. "I don't know" is an acceptable answer. You shouldn't be expected to have all the answers.'"

Encouraging nurses to care for themselves

The overall message new nurses are given, says Rodgers, is that if you don't take care of yourself, your work will suffer and that there are resources available to help them. "If you feel overwhelmed, tell someone," Rodgers says. "Take the day off. People need space from work."

"You need to take the time to care for yourself, just like you teach families to do," adds Isbell.

Even the mundane aspects of the job can cause stress. Providing documentation to ensure Medicare reimbursement is a good example. According to Rodgers, the orientation program addresses that by not glossing over the importance of providing detailed information regarding documentation and required forms. According to Rodgers, program participants are not allowed to graduate from the program until they are proficient at gathering the needed information and completing required paperwork. Aside from the obvious benefit of clean claims, the rule is rooted in the belief that the stress of patient care will not be compounded

with the tedium of administrative red tape.

After new nurses have completed the orientation program, stress is still a threat. The continuous loss of patients can take its toll. Perhaps, the death of particular patients can trigger strong emotions. For this, the Hospice of Central Virginia has established support group meetings for its workers.

Many hospices do the same. Heavy caseloads among their staff often preclude them from attending support group meetings. Rather than allowing workers to attend the groups sessions voluntarily, the Hospice of Central Virginia requires its workers to attend two meetings a month. Attendance is scheduled according to the interdisciplinary team. To keep up with the daily slate of visits, one team covers scheduled visits of the team attending the support group.

The support group is facilitated by an outside psychologist. Isbell says it was important to bring in an outside facilitator rather than rely on an in-house chaplain. "Our chaplain needs to be able to express his grief, too," Isbell says.

In addition, the support group meetings are for staff only, and administrators are excluded from attending. Isbell says this allows staff to speak freely. ■

Teach physicians how to use CPO codes

Overlooked codes represent increased income

As hospices try to encourage physicians to refer patients to their care, one of the hurdles standing between physicians and a timely referral is reimbursement. While not the most significant problem, physicians' loss of reimbursement as a result of referring patients outside their care is an obstacle that affects hospice referral.

Hospices can remind their referring physicians that Medicare allows some reimbursement for physicians' involvement in their patients' care in hospices. Medical directors and administrators should instruct physicians to bill for care plan oversight each time they call to follow up on patient care.

Documenting each call is a tedious process, one that leaves physicians unwilling to go through the trouble. Two oncology practices that work with hospice and home care use a tracking system that makes it easier to keep track of care plan oversight and garner reimbursement. Their advice is one that hospices can pass along to referring physicians.

Log systems that track the time physicians spend on *care plan oversight provided to patients admitted to home health or hospices* (CPT 99374-99375) can help make the paperwork hurdle more manageable for physicians who refer patients to hospices, advises **Sharon Grimes**, CPC, insurance and billing manager for West Clinic in Memphis, TN.

All too often, physicians are unwilling to take time away from their patients in hospices care to gather the documentation necessary for care plan oversight (CPO) billing, she says. Many end up providing their services for free, Grimes says. The CPO codes are among the least used by oncology practices, adds **Nancy Cothern**, business manager at Baptist Regional Cancer Institute in Jacksonville, FL.

Tracking how physicians spend their time

At the heart of the problem is the time it takes to keep track of each three-minute to five-minute phone call in 30-minute increments, to locate corresponding notations in the patient record, and to gather them up every 30 days to submit a bill. Setting up a log system that tracks how physicians are spending their time can help, Grimes advises.

CPT 2000 uses the clinical example of a 58-year-old woman with advanced intra-abdominal ovarian cancer. The care plan includes home oxygen, intravenous diuretics for edema and ascites, and pain control management through the use of intravenous morphine. As part of CPO, the physician contacts the nurse, family, and social worker by phone to discuss care, and the social worker indicates the patient wants to withdraw from supportive measures. In order for the physician to be able to properly bill for this care, he or she must document review and modification and certifications from nurses, social workers, pharmacists, and durable medical equipment suppliers.

The first step to tracking CPO services is understanding the billable components to the service, says Reynolds. CPO must be accrued in 30-minute increments. The CPT 2000 provides minimal direction in this area. Payers will provide better detail as to their requirements. For example, Palmetto Government Benefits Administrator, a fiscal intermediary, offers the following directives to its Medicare providers:

• The beneficiary must require complex or multidisciplinary care modalities requiring ongoing

physician involvement in the patient's plan of care.

• The beneficiary must be receiving Medicare-covered home health agency (HHA), hospice, or nursing facility services during the period in which the CPO services are furnished.

• The physician who bills CPO must be the same physician who signed the home health or hospice plan of care.

• The physician must furnish at least 30 minutes of CPO (see details of services that may be included below) within the calendar month for which payment is claimed, and no other physician has been paid for care plan oversight within that calendar month.

• The physician must have provided a covered physician service that required a face-to-face encounter with the beneficiary within the six months immediately preceding the provision of the first CPO service (a face-to-face encounter does not include EKG, lab services, or surgery).

• The CPO billed must not be routine post-operative care provided in the global surgical period of a surgical procedure billed by the physician.

• For beneficiaries receiving Medicare-covered home health services, the physician must not have a significant financial or contractual interest in the HHA.

• For beneficiaries receiving Medicare-covered hospice services, the physician must not be the medical director or an employee of the hospice or providing services under arrangements with the hospice.

• CPO services must be personally furnished by the physician who bills them.

• Services provided "incident" to a physician's service do not qualify as CPO and do not count toward the 30-minute requirement.

• The physician may not bill CPO during the same calendar month in which he or she bills the Medicare monthly capitation payment for the same beneficiary.

• The physician billing for CPO must document in the patient's record which services were furnished, and the date and length of time associated with those services.

Services that can be counted as part of CPO include:

• Review of charts, reports, treatment plans, or lab or study results, except for the initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.

• Telephone calls with other health care professionals (not employed in the same practice) involved in the care of the patient.

• Team conferences (time spent per individual patient must be documented).

• Telephone or face-to-face discussions with a pharmacist about pharmaceutical therapies.

• Medical decision making.

• Activities to coordinate services may be counted toward CPO time if the coordination activities require the skills of a physician.

Services not included

Services that physicians may not include in CPO billing include:

• Services furnished by nurse practitioners, physician assistants, and other nonphysicians cannot be billed under the CPO service. This includes the time spent by staff getting or filing charts, calling HHAs or patients.

• The physician's telephone call to a patient or family, even to adjust medication or treatment. The physician's time spent telephoning prescriptions into the pharmacist may not be counted, since those activities do not require physician work or meaningfully contribute to the treatment of the illness or injury.

• Travel time, time spent preparing claims and for claims processing.

• Initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.

• Low-intensity services included as part of other evaluation and management services.

• Informal consults with health professionals not involved in the patient's care.

• The physician's time spent discussing the patient with his/her nurse, and conversations the nurse had with the HHA do not count toward this 30-minute requirement. However, the time spent by the physician working on the care plan after the nurse has conveyed the pertinent information to the physician may be counted toward the 30 minutes.

• Only one physician per month will be paid for CPO for a patient. Other physicians working with the physician who signed the plan of care are not permitted to bill for those services.

• The work included in *hospital discharge day management* (99238-99239) and *discharge from observation* (99217) may not be counted toward the 30 minutes per month of CPO. Physicians may bill for work on the same day as discharge, but only for those services separately documented as

occurring after the patient is actually physically discharged from the hospital.

While Reynolds' current practice has yet to implement a log system, she shares how a previous employer handled CPO billing. Physicians there used their hospital cards as a way of documenting CPO while out of the office and as a phone log while in the office.

The hospital card, which the physicians carried with them to keep track of the patients they need to see at each facility, allowed them to jot down the time they spent on CPO and other services. Each physician was assigned a billing staff person who was responsible for collecting the card at the end of the day, she says.

In the office, physicians noted the length of call, the patient being discussed, the facility or agency that was caring for the patient, and made brief notes describing the nature of the CPO.

The billing staff assigned to that physician were responsible for reviewing the cards and phone log and counting the minutes each physician spent on CPO. The physician was notified when he or she had spent 30 or more minutes doing CPO for any patient, clearing the way for a billing.

Remind physicians not to make the mistake of thinking a log system can replace patient chart notes. Physicians still have to make the proper notations in the patient chart, she stresses. It does, however, eliminate the time physicians have to spend pouring over the chart to recall each instance they performed CPO, Reynolds adds. ■

News From the End of Life

AMSA to review med school curriculum

The American Medical Student Association (AMSA) plans to evaluate end-of-life and palliative care curriculums used in U.S. medical schools. The best will be honored with the AMSA's Paul R. Wright Award for Excellence in Medical Education in March 2001.

The review of medical schools comes after strong criticism of end-of-life curriculum and the absence of palliative care education in textbooks. A study published in March detailed how leading medical textbooks generally don't include enough information on how to care for patients at the end of their lives. Previous studies have concluded that many patients unnecessarily die in pain or in hospitals rather than at home. Inadequate training in that area is to blame for this deficiency in care.

"We feel that it is important to critically examine medical school curricula in this area, determine which programs are successful, and promote these ideas so that all medical schools incorporate this important topic in medical education," says **Sindhu Srinivas**, MD, AMSA's national president.

AMSA's Paul R. Wright Award in Excellence in Medical Education was established in 1993 to recognize a medical school whose exemplary achievements in medical education foster the development of socially responsive physicians. Past topics have focused on medical student well-being, medical technology, and the recruitment of minority students.

Founded in 1950, AMSA is the nation's largest independent medical student organization, with more than 30,000 members at more than 150 medical schools nationwide. Visit www.amsa.org for more information. ▼

MedicAlert starts repository for DNR, others

The MedicAlert Foundation, the nation's leading emergency medical information service, has launched its national repository for end-of-life medical preference documents, including directives concerning life support, resuscitation, organ donation, living will, and power of attorney.

"This new service responds to the unmet need for fast and confidential access by medical personnel to an individual's directives for end-of-life care," says **Tanya J. Glazebrook**, president and

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CEO of MedicAlert Foundation. "It is a natural extension of the foundation's services because we already store and transmit emergency medical information for millions of members around the world, and are universally recognized within the health care community."

The repository's comprehensive services include support from the MedicAlert 24-hour call center that is staffed by professionals, referral service for advance directives forms and assistance, verification of completed forms for all required signatures and contact information, physician and health care agent notification upon enrollment and during medical events, family notification service, and safe storage and transmission of advance directives regardless of the health care setting.

Timeliness of communication will improve

Glazebrook says the new service will dramatically improve the timeliness of advance directive communication, as well as ensure that the documents are secure and available when and where they are needed. "Regardless of age or health status, it makes good sense for people to plan ahead for future medical care needs."

"Unfortunately today, a person's end-of-life preferences are often not available when they are needed," says **Cherie Morrison-Davis**, MedicAlert Foundation's director of advance care planning. "Sometimes, it's a problem of not knowing where the written directives are kept, and frequently a person's physician and designated decision maker don't even know they've been named in these instructions. All of this can lead to confusion on the part of caregivers at the time of need. This new service resolves these problems and takes care of the paperwork, so others can take care of the patient." ▼

New journal explores range of pain issues

The American Pain Society (APS), a multidisciplinary educational and scientific organization dedicated to advancing pain-related research, education, treatment, and professional practice, has announced its new peer-reviewed scientific journal *The Journal of Pain*. The summer 2000 issue contains a review and commentaries on pre-emptive analgesia, along with a survey of pain attitudes, a study on the stages of pain processing throughout the adult lifespan, and a report on muscle hyperalgesia in post-exercise soreness. Published quarterly, the journal provides a forum for clinical researchers and other medical professionals to publish original research. The journal will soon be available on-line at www.jpain.org. ■

News From Home Care

Home care workers are making more

Home care salaries increased in 2000, according to Hospital & Healthcare Compensation Service's 2000-2001 salary and benefits report

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released in September. The following median salary figures from its 380-page report were released:

- executive director — $63,882;
- occupational therapist — $45 per visit;
- physical therapist — $45 per visit.

The executive director median salary increased 3.04% from $62,000 in 1999. Occupational therapists' median per-visit rate increased 4.65% from $43 per visit in 1999. Physical therapist median per-visit rate increased 2.27% from $44 per visit in 1999.

The report points out that the therapists per-visit rate increases represent a recovery from decreases the previous year. Personnel activity during 2000 for executive departments showed that 4.7% were expanded, 13.3% were reduced in size, and 82% remained the same. Respondents also reported 41.1% of nursing departments were expanded, 42.2% remained the same, and 16.7% were reduced in size.

The report involved 1,475 home health agencies whose employment consisted of nearly 52,000 employees. The report was conducted in cooperation with the National Association of Home Care in Washington, DC. ▼

Add care for the dying to your continuum toolbox

Too often, dying patients suffer unwarranted pain, run a high risk for unwanted procedures, and endure unreliable care systems, according to RAND's Center to Improve Care of the Dying.

Hospice employees who want to provide more support for patients at the end of life will find useful guidance in the book *Improving Care for the End of Life: A Sourcebook for Health Care Managers and Clinicians.*

The book chronicles the experiences of 47 health care organizations that participated in a collaborative project on improving end-of-life care co-sponsored by the Center to Improve Care of the Dying and the Institute for Healthcare Improvement in Boston.

The sourcebook shows readers how to apply changes in care patterns to their own practice settings. Ordering information and excerpts from the sourcebook can be found on-line at www.medicaring.org/refer. The sourcebook costs $35, which includes shipping and handling. ■