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INSIDE

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Inpatient palliative care is the next frontier for hospices

Collaboration must displace territorial attitudes regarding palliative care

Despite hospices' best efforts to reach those who would benefit from their end-of-life care, the fact of the matter is most terminally ill people either never receive hospice care or are admitted too late. Many of those underserved patients die in hospitals without the benefit of pain management and spiritual or emotional care.

For years, hospices have conceded that hospitals are a difficult referral source to tap. Patients either weren't aware of hospice care or clung to the hope that curative efforts would win out despite the bleakest of prognoses. Then, as the debate over end-of-life care began to heat up, some hospitals have begun to realize that their patients would benefit from palliative care, making their foray into a domain once exclusive to hospices.

As this trend continues, how should hospices react to this movement? Should it be one of disdain for hospitals that have paid little attention to the palliative care needs of their patients in the past? Or should hospices embrace their health care counterparts' newfound enthusiasm for principles hospices have championed for years?

According to **Larry Beresford**, a senior writer for the Alexandria, VA-based National Hospice and Palliative Care Organization (NHPCO) who has been on special assignment studying hospice and hospital palliative care collaborations, hospice administrators should see the development of inpatient palliative care programs as an opportunity to collaborate with their hospital colleagues.

The NHPCO and the New York City-based Center to Advance Palliative Care (CAPC) have charged Beresford, a former editor of *Hospice Management Advisor*, with the task of developing a monograph for that examines hospice-hospital collaborations in inpatient palliative care. The monograph is due out sometime this year.

In Birmingham, AL, the Birmingham-Area Hospice has been an enthusiastic supporter of the Balm of Gilead, an inpatient palliative

care center inside the city's Cooper Green Hospital.

"Cooper Green was a main referral source to our hospice," says **Gregory Townsend**, program director for the Birmingham-Area Hospice, which is run by the Jefferson County Health Department. "But we weren't capturing all the patients who could benefit from our care. The Balm of Gilead helped create a seamless network between the hospital, hospice, nursing home, and health department."

Hospice input can be essential in the development of a hospital program, while patient exposure to hospital palliative care can provide patients with timely and proper information about hospice care that could facilitate more appropriate hospice admissions.

It was Birmingham-Area Hospice Medical Director Frank Amos Bailey, MD, who championed the idea of bringing palliative care to patients admitted to Cooper Green Hospital and helped the hospital secure a three-year, $500,000 grant from the Robert Wood Johnson Foundation.

"Every palliative care program needs a physician champion," says **Edwina Taylor**, CRNP, palliative care specialist with the Balm of Gilead.

Hospices can help hospitals establish palliative care programs that emphasize the following attributes:

• physical, psychological, social, and spiritual support to help the patient and family adapt to the anticipated decline associated with advanced, progressive, incurable disease;

• incorporation of the full array of interinstitutional and community resources (hospitals, home care, hospice, long-term care, adult day services) and promotion of a seamless transition between institutions / settings and services;

• an environment that supports innovation, research, education, and dissemination of best practices and models of care.

While hospices bring a wealth of palliative care expertise, they need to cooperate with their hospital partners as they go through the process of establishing an inpatient palliative care program. To provide direction to hospitals and hospices, CAPC has outlined this step-by-step approach:

• **Identify institutional leaders and initiate a strategic planning process.** Strong, effective leadership is unquestionably the key ingredient for successful development of palliative care programs. Identify key stakeholders and champions among hospital / health system staff and from the community.

• **Conduct an institutional and community needs assessment for palliative care services.** Developing a new clinical service requires an organized process, convincing data, and demonstration of a compelling unmet patient need within the institution as well as the community. Begin this analysis by interviewing potential stakeholders. Assess their interests and needs. Elicit their support and identify opportunities for collaboration.

• **Survey the community for competitive palliative care services.** Evaluate the following characteristics: length of time in operation; reputation and ability to meet patient needs; gaps in existing palliative care services; potential collaborative opportunities.

Provide data on unmet needs

• **Profile hospital patient population and demonstrate an unmet patient need.** Profile the patient population that will benefit most from palliative care. For example, demonstrate the costs to the hospital for failing to institute appropriate services and discharge options for vulnerable, seriously ill patients, many of whom are dying. Graphically illustrate the scale of unmet patient need with data such as:

— total number of hospital deaths annually by age group and insurance status;

— causes of death by Medicare DRG;

— locations of deaths (eg, medical / surgical unit, ED, ICU, etc.);

— length of stay in hospital and in ICU by DRG among patients who die in the hospital;

— discharge information (destination);

— number of patients with advance directive, health care proxy, and / or DNR order.

• **Conduct focus groups.** Further define your patient population and its needs by convening several small focus groups to reveal additional reasons for instituting a palliative care program. Focus groups to convene include physicians; nurses, social workers, pharmacists, and chaplains; patients in specific diagnostic groups; and family and caregivers.

• **Develop a mission statement, goals, and objectives for the palliative care program.** With your research completed, develop a compelling mission statement and goals and objectives that reflect and reinforce unmet need. Establish short-term (12 months) and long-term (three years) program goals that are as specific and measurable as possible. Goals to consider include:

— patient / caregiver satisfaction;
— physician and staff satisfaction;
— growth in patient volume;
— financial performance;
— impact on length of stay in hospital and ICU;
— innovation / research;
— awards / recognition.

• **Decide on the range of services to offer.** The range of palliative care services offered will depend on variables such as:
— gaps in existing community services;
— type of population to be cared for (e.g., complex tertiary-care referral populations vs. small community hospital populations of mostly elderly and chronically ill);
— location in the hospital where most patients die;
— inpatient hospital bed constraints.

• **Select a delivery model.**

• **Determine funding sources.** Medicare and Medicaid are the primary payers for palliative and hospice care. Medicare is the benchmark for rates paid by private insurers for these services.

• **Develop a public relations and communications plan.** Identify both internal and external audiences to promote the new service. Activities may include:
— program brochure and direct mail campaign;
— educational programs for referring physicians, families, and patients;
— local news and human interest stories;
— public relations and fundraising events.

• **Develop an operations plan.** Identify all the resources / costs required to put the program into operation, including:
— administration and management team;
— community advisory group;
— staffing;
— space renovation and rent;
— capacity (number of beds / patients per staff unit);
— medical and office equipment and supplies;
— medical records;
— quality assurance;
— public relations / communications.

• **Develop a financial plan.** Using cost estimates from the operations plan, develop a financial plan including a three-year proposed program budget of revenues and expenses. Project estimated revenues from all funding sources based on anticipated patient utilization and service volumes.

• **Recruit a skilled interdisciplinary team.** Once your program is approved, it is important to recruit a skilled interdisciplinary team from the outset. For a dedicated inpatient unit, the team should include a physician, a nurse, a social worker, and / or a bereavement or pastoral care counselor. If having a dedicated bereavement staff is not possible, the palliative care service should be able to refer families to affiliated bereavement program staff. Other experts who can make a significant contribution to the team include patient advocates, chaplains, pharmacists, pain experts, rehabilitation experts, and psychiatric consultants.

• **Develop a patient database to measure quality and outcomes.** Clinical data, patient and family assessments, and financial information should be collected in easily accessible and usable databases. It is also important to track and evaluate all program research and educational activities. Data such as these help quantify the importance of the program and are critical to demonstrating the program's benefit to the hospital's mission and reputation.

Side effect: Timely admissions

How hospitals and hospices work together can vary, says Beresford. Work arrangements should be dictated by local needs rather than adopting a cookie-cutter approach.

In most cases, however, hospices may act simply as consultants to hospital palliative care programs, providing education and training to hospital staff to help them recognize candidates for the hospital's palliative care programs.

The Balm of Gilead is a 10-bed dedicated inpatient unit where palliative care beds are clustered in a specific area of Cooper Green Hospital. This allows the hospital to concentrate patients with similar needs in one place where palliative care and consultative services can be provided. Supporters of this approach say a dedicated unit provides visibility and promotes acceptance of palliative care as an essential patient care service by hospital staff. As part of the program, a team composed of doctors and nurses, typically with a social worker and / or a bereavement counselor, sees patients with palliative care needs.

The Balm of Gilead has contracts with a total of seven hospices in the Birmingham area in which the hospices provide palliative care services and use four inpatient hospice beds. As Taylor describes it, the non-territorial approach of both hospital and hospices has paid off since the Balm of Gilead was launched in 1998. The program has served more than 700 patients.

Rather than those patients receiving palliative care until their death, patients who would have died in the hospital actually thrived under care delivered at the Balm of Gilead. "Less than half of the patients here actually die on the unit," says Taylor.

That meant more patients were coming home and were in need of care. The increased awareness of hospice care as a result of inpatient palliative care increased the number of hospice admissions. The Birmingham-Area Hospice went from an average daily census of 25 patients in 1998 to 63 patients today, says Townsend.

"We have been able to meet the needs of patients not quite ready for hospice care and have been able to get them into hospice care when they were ready," Townsend says. ■

Baseline audit critical to compliance program

Determining weakness is the first step

So, your organization has committed to developing a compliance program. With such a daunting task ahead, where does one begin? A logical starting point would be to conduct a baseline internal audit of your hospice in order to gain valuable perspective on your hospice's strengths and weaknesses.

Baseline audits may seem like a logical step to skip so you can go straight to implementing standard policies that would help prevent a hospice from running afoul of any federal regulations in the future. But, experts warn, it would be shortsighted to ignore your organization's current performance.

"The whole point of a compliance program is to find out what your current weaknesses are — weaknesses that would allow fraud and abuse — and then make changes to prevent them," says **Mickey Pope**, RN, BSN, corporate compliance officer for the Hospice of the Bluegrass in Lexington, KY.

When conducting a baseline internal audit, hospices must consider the following:

— the scope of the audit;

— who should conduct the audit;

— what to do with the results of the audit.

Think of the baseline audit as a snapshot of your hospice's policies and procedures to be held up against guidelines set forth by the Office of the Inspector General (OIG).

Specifically, the OIG is concerned with hospice policies regarding documentation, billing, and marketing, to name a few. The OIG wants to be assured that employees and hospice agents and contractors, such as physicians and therapists, uphold the hospice's commitment to comply with federal and state standards, with a particular emphasis on preventing fraud and abuse.

In its own guidance, OIG recommends that hospices creating a compliance program include appropriate training and educational programs to avoid risk areas, such as uninformed consent and improper admission.

Policies and procedures should include:

• timely documentation of clinical factors that qualify a patient for the Medicare hospice benefit;

• instruction on who has the authority to make entries in the patient record;

• an emphasis on admission only when documentation supports applicable reimbursement eligibility criteria;

• an indication that the diagnosis and procedure codes for hospice services reported on the reimbursement claim are based on a patient's clinical condition as reflected in the medical chart and other documentation;

• a provision that compensation for hospice billing and admission staff not include any incentive to bill for hospice care regardless of whether proper criteria are met.

These are all matters that hospices must consider as they begin to put together the elements of the compliance programs. Hospices must take specific steps, including appointing a compliance program officer and educating employees on the purpose and procedures of the compliance program. The baseline audit is one of a number of exercises that hospices should perform to ensure smooth implementation and organization improvement.

The Alexandria, VA-based National Hospice and Palliative Care Organization (NHPCO), recognizing the importance of an effective compliance program, published a resource for hospices seeking direction in the formation of their own compliance program. In *The Compliance Program Toolkit*, the NHPCO advises hospices not to confuse their compliance programs with accreditation standards. The fact that a hospice scored well

on accreditation standards does not guarantee it is compliant with federal regulations and laws.

While there is some overlap, accreditation focuses on processes that affect quality of care, while a compliance audit focuses on asking the question: What are the potential areas where laws may be broken?

Hospice of the Florida Suncoast in Largo added another reason to conduct a baseline audit. After a string of reviewers conducted their own audits of the organization, including the OIG (which found no evidence of fraud and abuse), hospice officials felt that they needed to conduct an audit of their own and annually review their performance to identify areas that can be improved upon.

"We wanted to be in a constant state of readiness," says **Betty Oldanie**, RN, BSN, MS, vice president of planning, and the ethics and compliance officer for the Hospice of the Florida Suncoast. "We felt that we have had so many people looking at our organization that we had already gathered a lot of the information needed to do a baseline audit."

Oldanie says hospices should begin by looking at information that has already been gathered as a result of reviews done by other organizations, including insurers and accrediting organizations.

When all is said and done, the following risk areas should be included in the audit:

Clinical areas that should be audited:
Eligibility
Levels of Care
Revocations / discharges
Timely physician signatures
Interdisciplinary group patient review
Length of stay and recertification
Falsification of records
Volunteer coordination
Verbal orders

Billing areas that should be audited:
Coordination of payments
Levels of care / accurate billing
Inadequate / substandard care
Unlicensed staff
Location of service delivery
Provider certification numbers
Overpayments

Marketing areas that should be audited:
Anti-kickback
High-pressure marketing
Patient solicitations
Sales commissions
Late referrals
Nursing home areas that should be audited
Utilization of services
Professional management
Written agreements
Incentives

Internal reviewer vs. external reviewer

Depending on the resources available to a hospice, the audit can be conducted by internal or external sources. For example, the Hospice of the Florida Suncoast, one of the largest hospices in the country, uses an audit firm to conduct a financial audit and internally assesses its compliance efforts each year.

In addition, consultants, lawyers, and accountants can also serve as external consultants. According to the NHPCO, attorney-directed baseline audits are beneficial because the work provided by the attorney may be protected under attorney-client privilege laws.

The common denominator among the internally and externally conducted audits is knowledge of hospice regulations and conditions of participation needed by those conducting the audit.

More important, however, than who conducts the audits is ensuring that the person or team assigned to the task is independent and objective. Appointing someone with a potential bias — such as a department supervisor who has an interest in proving that his or her department is meeting federal regulations — can put the integrity of the entire process into question.

Managers at Haven House Hospice in Atlanta, a hospice with an average daily census of 100, realized that their limited resources prevented them from hiring external auditors to examine their financial records and their regulatory compliance performance. But that didn't prevent them from conducting an independent review.

"I think it's easily done," says **Cheryl Watts**, RN, CPHQ, compliance officer and performance improvement director for Haven House.

An accurate assessment of current policies can be done internally by hospice personnel as long as the person assigned to conduct the audit maintains independence. This can be achieved by removing the layers of management between the reviewer and the hospice's board of directors.

Allow the reviewer to report his or her findings directly to the board or a subcommittee of the board in charge of reviewing audit findings.

"Any areas that needed work were taken to the board and an action plan was developed," Watts says.

In the weeks that it takes to compile the data gathered from the audit, a number of items may prove to be weaknesses that must be improved upon. For example, the audit may reveal a number of instances in which physician signatures were missing or delayed.

What a hospice does with these kinds of results — a deficiency in a risk area that could lead to regulatory problems — is obvious: Correct the problem by implementing policy and educating staff and contractors so the deficiency is abated.

Both the Hospice of the Florida Suncoast and Haven House Hospice did not uncover any major problems. The problems they did reveal were addressed by reporting them to the hospices' boards of directors and doing strategic planning to eliminate similar problems in the future. Also, procedures were put into place to monitor problem areas and track improvement.

What if an audit reveals more than routine problems that can easily be fixed, such as evidence of Medicare overpayments, fraud, or just plain human error on a grand scale?

According to the NHPCO, several factors must be considered:

- the extent of the problem;
- the amount of money involved;
- whether it is an isolated incident caused by human error or intentional fraud.

The bottom line may be that the audit revelation may require hospice officials to report the compliance problem voluntarily, which is also known as "self-disclosure." In this case, an attorney is essential, says the NHPCO. There are several levels of disclosure. Overpayments should be reported to the hospice's fiscal intermediary, whether the problem was caused by human error or fraudulent activity. The hospice may also report its findings to the OIG in addition to the fiscal intermediary or allow the fiscal intermediary to decide whether the OIG should be informed.

The OIG has developed protocols that dictate self-disclosure. The disclosing provider is required to provide basic information regarding the hospice's findings, including a description of the matter and the reason why the provider believes regulations have been disobeyed. The provider also should provide a report to the OIG identifying the cause and the officials involved; describing the time period in which the incident or incidents occurred; and estimating its financial impact. ■

GUEST COLUMN

Raising funds in a softened economy

Focus on fundraising basics

By **Dee Vandeventer**
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With a significant rise in unemployment, a drop in the stock market, and consumer confidence at a four-year low, it seems logical that people are more likely to focus on their own economic situation and less likely to focus on yours.

However, this is not necessarily true. While the current economic situation doesn't paint a pretty picture for hospices trying to raise funds, now is not the time to pull back on your fundraising efforts.

Now is the time to strengthen your efforts. The best way to do that is to get back to the basics: Stay in touch with your donors; maintain your image of honesty and trustworthiness; and develop a planned giving proposal for future economic slowdowns.

Treat your donors well

A study released in March by the Association of Fundraising Professionals (AFP) found that nearly 40% of people who quit giving did so because of what they perceived as poor communication on the part of the charity. Nearly half of those who hadn't made recent charitable donations cited negative experiences with the charity's fundraising practices or staff.

In contrast, donors who have given many times to the same charity said receiving follow-up information on how their money was used and the courteousness of the charitable organization's staff and volunteers were factors in their gift giving.

In short, times may be difficult, but you don't have to be difficult when it comes to asking your donors for money.

Maintaining a high level of quality will also ensure that people continue to give. Nurture

those relationships; be honest about where the money goes. Donors need to feel there is value in what you're doing. Honesty also means being accountable to those people and organizations you exist to serve, to those who support your work, and to society.

A softening economy makes it all the more important that you persuade donors their dollars are being used to the fullest benefit. Those donors who have the longest relationship with you are the ones who will stick with you when times are tough.

Although very generous donors aren't typically affected by an economic downturn, those who usually give gifts of stock may now decide on gifts of cash, trusts, real estate, or insurance policies. Don't take their giving for granted; it's more important now that you provide them with flexibility and choices to make their commitment. And don't ignore the less generous donors. Last year, the American Cancer Society received $94.2 million in receipts in the last quarter, a 7.4% increase over the same period in 1999. The average gift was $61.

Always let your donors know how much you appreciate their gifts. A "Thank You" should be timely and appropriate to the gift. A fundraising rule of thumb: Find creative ways to thank your donors — particularly your best donors — seven times.

Donors said being frequently asked to give and being asked to give large sums of money was a deterrent to giving.

What influences giving

A recent article in *The Chronicle of Philanthropy* cited four basic lessons that have more impact on gift giving than the state of the economy:

• People give to organizations whose values mirror their own.

• People give to organizations they trust, and how much they know about them influences how they give.

• Generosity is stimulated by passion about an issue, idea, or movement.

• People are more generous when they're involved in the issue or idea and they understand the results of their giving. Make your donors feel like venture capitalists.

While conventional fundraising wisdom says the key lies in repeated solicitations, the AFP study found that donors who choose how often and how much to give are more likely to give. Donors said being frequently asked to give and being asked to give large sums of money was a deterrent to giving.

Hospices can benefit from allowing donors to determine how they are approached — whether it's a monthly newsletter, being approached only during a holiday fundraiser or other event, an e-mail reminder, or being removed entirely from a mailing list.

Many philanthropic organizations now use the Internet to provide donors with another way to give. It allows potential donors to immediately access information about your organization and make a pledge with a simple transaction. This is something to consider if you're looking to incorporate more flexibility for your donors.

If you don't already have a program in place for planned giving, you need to establish one. Planned giving, one of the basic supports of fundraising, is beneficial — not only for future economic slowdowns, but also for your long-term success.

Planned giving provides donors with opportunities for deferring their gifts. It falls into three categories:

• bequests or gifts;

• invested funds, with the principal going to the charity and the income going to the donor or to the donor's family;

• invested funds, with the principal going to the donor and the income going to the charity.

For smaller hospices, this may be too ambitious. Start with something as simple as adding a line to your newsletter or direct mail piece stating you accept bequests. Then establish relationships with attorneys and accountants to provide the technical assistance needed to manage planned gift giving.

Also essential is training your staff and volunteers so they can better inform prospective donors about the benefits of planned giving.

No matter what the economic situation, remember that giving is a personal thing. Ultimately, people give to people. Establishing a good relationship with current and potential donors will ensure your long-term success.

(Editor's note: Dee Vandeventer is president and partner of Mathis, Earnest and Vandeventer, a fundraising and integrated marketing communications consultancy.) ■

Speed up MCO payment by educating staff

Planning and communication are key

Is billing managed care plans for care a frustrating experience topped off by delayed or denied payments? If the answer is yes, then it's likely that you blame the managed care organization (MCO) for withholding payment and choking off your cash flow. But there is a good chance that your hospice is a major contributor to the problem.

While MCOs have their own processes that can lead to delays in payment, the main reasons payment is delayed are poor claims, denials, and appeals, says **Lisa Spoden**, MS, partner in Columbus, OH-based consulting firm Strategic Health Care.

To speed up payment and improve cash flow, a hospice must examine its own processes.

"When we investigated what slowed down payment, we found that it goes both ways, both sides are to blame," Spoden says.

Spoden suggests a couple of fixes that could immediately result in faster payment:

- Submit bills more often than once or twice a month.
- Achieve electronic billing capability.

But changes in the process — the way hospices communicate with MCOs, for example — are where the most significant changes will occur. What many hospices will find is that within the hospice walls, very little is known about managed care. So, before processes can change, staff need to be educated about managed care, followed by an education in the managed care contracts the hospice has with MCOs.

Experts suggest that hospice leaders explain to staff the different types of MCOs and the various relationships with them that can occur. For example, elaborate on the kinds of plans that exist, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and Medicare risk, to name a few. Explain the subtle financial relationships that can occur, such as a physician group being the payer for services provided to patients enrolled in an HMO.

Having explained the basics of managed care, the next step is to familiarize staff with the contracts your hospice has with MCOs. If a hospice is negotiating a contract with an MCO, key staff should be kept abreast of the requirements the contract specifies. A billing department manager, for example, can provide the necessary input to help facilitate error-free claims.

Whoever negotiates contracts with a hospice may not be aware of what the hospice's billing capabilities are. The negotiator might wind up obligating the billing department to to follow procedures it's unable to follow.

If a hospice's billing capabilities don't meet the requirements of the MCO, the hospice could be left with having to make costly revisions or bill manually, which could lead to errors.

Billing staff must become familiar with each contract's language. They should also be involved in contract negotiations by questioning the payer about specific claims submission requirements. For example, billing staff should find out whether an HMO requires claims to be submitted on a Uniform Bill 1992 (UB92) or if the HMO has its own form, and what documentation must accompany the claim.

Keep admissions staff informed

After the contract has been signed, the billing representative should meet quarterly with the payer to discuss any system changes, address changes, and personnel changes that could lead to a claims error.

Admissions staff are key personnel who should be included in negotiations. Information from negotiations will provide admissions nurses with information such as whether the hospice is at risk for the cost of care, whether that risk is shared with another provider, and whether the managed care company is assuming financial risk.

In other words, the admissions staff will better understand the relationship between the hospice and its managed care payer and avoid the following scenario, which is a common occurrence that leads to payment delays:

Hospice A has a contract with Physician Group B to provide services to patients they refer to the hospice for end-of-life care. The patients, however, are enrolled in Health Plan C, which has entered into a capitation arrangement with the physician group to provide prepaid care to its enrollees. In this situation, Physician Group B becomes the payer, because they have assumed financial risk for the care of the patient.

Unfamiliar with the physician group contract, the admissions nurse assumes that because the patient is an enrollee of Health Plan C, the MCO

is the payer. She calls the MCO case manager for approval of services, and because the services fall under the health plan's coverage guidelines, they are approved and the patient is admitted. But when the time comes to submit the bill, it is rejected by the health plan because reimbursement staff there know that the physician group is at risk and has already received a per member per month payment for that patient.

In this situation, the claim should have been sent to the physician group. On top of the already delayed payment, the hospice faces further delays from the physician group because proper authorization for services was not obtained from its case manager.

Sending the claim to the wrong payer and other billing errors can be avoided if everyone understands the benefits and requirements of each MCO. To aid in informing staff of requirements of each MCO, experts recommend developing a payer matrix that can be used by all staff members, especially the admissions nurse. This is a chart that lists each contracted MCO at the top of each column and important contract topics in the far left of each row. Topics might include authorization contacts, billing addresses, and reimbursement type. Billing staff should receive a similar document with more detailed information.

The admissions staff should then obtain a copy of the beneficiary's insurance card. The back of the card will identify the payer and the address to which the claim should be sent. The admissions staff can check the matrix to determine whom to contact for authorization. With both parties properly notified of a patient's admission along with agreed-upon care, the hospice has a made a solid first step to a clean claim.

Case manager takes over

Once a patient has been admitted for care, the hospice's case manager begins overseeing patient care and must keep in constant contact with the case manager from the MCO. Case managers are nothing new, but hospices should add a managed care case manager to their interdisciplinary team.

"There should be someone on the interdisciplinary team assigned to act as a liaison between the hospice and the MCO," says Spoden.

It will become the hospice case manager's responsibility to communicate with the MCO case manager. Keeping the lines of communication open between the internal hospice case manager and the external MCO case manager ensures that both parties are in agreement about care, which will help prevent disputes over unauthorized care when the claim is submitted. Just as important, it allows the hospice to develop working relationships with the MCO.

Just as admissions staff need an education in current contracts, case managers must also have a working knowledge of contracts. The case manager acts as a link between clinical activity and financial requirements of the MCO.

Key points an internal case manager must know about each contract include:

- **Authorization process.** The case manager should be clear on whom to call and when in the event a patient requires care that is outside the agreed-upon care. Changes in care may occur when a physician, after consulting with a therapist, orders therapy services after admission.
- **Required information.** What information or documentation does the HMO or MCO require? Making sure a claim is accompanied by the proper documentation will also prevent delays in payment.

Improve communication

By now it should be obvious that there is a common theme running through the above advice: communication. From the time of admission, admission staff need to communicate to the case manager which payer is responsible for paying for the patient's care, what level of care the provider was authorized to deliver, and whom to contact for further authorization.

Meetings between internal case managers and external case managers should occur regularly, normally through weekly utilization review meetings in which cases are discussed individually. These meetings also should include other clinicians, such as RNs, therapists, social workers, and chaplains to provide needed background when discussing the change to a patient's care.

How many case managers does a hospice need? Depending on the level of managed care in one's market, the number of case managers needed might range from several full-time case managers to none. Hospices should be aware that as managed care becomes a larger part of their business, there will be a greater need for a full-time case manager. The old model of using the director of nursing to track patients will only leave the leader of your nursing staff awash in paperwork in addition to supervisory duties. ■

Health system requires info from advance directives

Policy aims to prevent confusion among family

Dying patients who have advance directives and are seeking care in the Owensboro (KY) Mercy Health System will now be required to include details of their advance directives on a form until the actual advance directive can be produced.

This revision in the health system's policy is aimed at preventing confusion from arising when families disagree among themselves over treatment decisions, which could result in provision of care that is against the patient's wishes, Owensboro Mercy Health System officials say.

"Sometimes unexpected things happen, and you have a situation where all the siblings aren't agreeing with how to deal with the parent's illness," says **Lisa Jones**, vice president of patient services. "It gives us a consistent place to go to find out exactly what the patient wants."

In addition to stating what medical treatment the patient wants, such as resuscitation, nutrition, and hydration, the advance directives may name someone to make decisions about treatment if the patient is unable to do so. As long as the patient is able to give informed consent, advance directives will not be used. They also can be changed at any time.

In the event a patient is admitted who has advance directives but didn't bring them, the patient will be given a form to list instructions contained on the advance directive. The form, signed in the presence of a witness, instructs the hospital to carry out the orders until the original directives are brought in. The form also allows patients to name someone to make decisions concerning medical treatment and gives permission to donate organs. ▼

Study: Don't cut back on social work services

Increase in social services results in lower costs

As hospices try to scale back their costs, some may find that cutting back on social work is an easy place to save money. But according to a University of Arkansas study, those same hospices may be setting themselves up for a financial loss.

"The original vision for hospice consisted of an interdisciplinary team of professionals who would make visits to the home to provide not only for the patient's physical needs but also to offer social services and psychological and spiritual counseling," said **Dona Reese**, assistant professor of social work at the University of Arkansas in Fayetteville. "But across the country, we've seen the nonmedical services — including social work services — minimized under the rationale that it's more important to provide for the patient's physical needs."

In addition, the national study of hospice programs shows that providing adequate social work services in conjunction with physical care significantly reduces overall hospice costs. Additional benefits include fewer hospitalizations for the patient, decreased nursing costs, and higher client satisfaction.

Taking a random, stratified sample from the membership of the National Hospice and Palliative Care Organization in Alexandria, VA, the study assessed 66 home hospice programs and examined 330 individual patient cases. Initial findings showed that nurses outnumbered social workers three to one in the average hospice. The researchers also documented five times as many nursing visits as social work visits to each hospice patient.

Participating hospice programs contributed information through three steps. First, the social worker with the greatest experience in hospice filled out a social work questionnaire that described the qualifications of social workers employed at the hospice, the duties of those social workers, the overall functioning of the

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hospice team, and the demographics of the clients they served.

"We collected so much data because we wanted a comprehensive look at how social work services impact hospice outcomes," Reese said. "Knowing exactly how these services benefit hospice programs can help administrators design hospice care so that it fully meets patients' needs while still being cost-conscious."

A key finding of the study holds that an increase in social work services actually lowers overall hospice costs. This alone constitutes a good reason to stop cutting social work from the protocol, Reese said. But the statistics also revealed specific correlations that prompted researchers to recommend changes that will help hospice programs run more effectively and economically.

For example, the presence of a social worker at the patient's first interview with hospice representatives contributed to lower hospice costs, lower labor costs, lower home health aide costs, and improved functioning of the hospice team.

According to Reese, early participation provides an opportunity for the social worker to evaluate factors such as family dynamics, social support systems, and personal beliefs, customs, and concerns, among other things. Such information enables the social worker to identify problems that the patient will likely encounter and begin building support networks that will address the problems in a preventive manner. ▼

Funding end-of-life care education for social work

Graduate students will learn care skills

Current social work education does not produce social workers trained in end-of-life care. A new initiative in California is hoping to correct this shortcoming by establishing course work in four Southern California graduate social work programs.

The new initiative will support the development of curriculum to educate graduate social work students about end-of-life care skills in the classroom and in training sites throughout Southern California.

"Neither a well-defined end-of-life care education program nor an end-of-life care specialization in social work exists in our region, and field experience is not available to MSW students," says **W. June Simmons**, president and CEO of Partners in Care Foundation in Burbank, CA, one of eight recipients of The Project on Death in America's Social Work Leadership Development Award. "This project has enormous potential to ease suffering and enhance quality of life through educated social work interventions."

Simmons will lead field work conducted in four social work agencies and eight social / medical service providers representing the area's enormous ethnic and racial diversity. In addition, the initiative hopes to answer the questions, "Who will care for our aging parents as they approach the end of their lives? How will they be trained? By whom and where?" ▼

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Chronically ill patients not getting proper care

A Harris Interactive survey of 1,663 adult Americans has found that Americans fear the 125 million people living with chronic diseases are not getting the care they need. The survey found that:

• 72% of Americans say it is difficult for people living with chronic conditions to get necessary care from their health care providers.

• 74% say it's difficult to obtain prescription drug medications.

• 89% say it's difficult to find adequate health insurance.

• 78% say it's difficult to get help from their own family.

The study also found that nearly two-thirds of those polled who do not currently have a chronic condition believe they will develop one during their lifetime, and they fear that when they do, they will be unable to afford needed medical care and will become a burden to their families. The survey also found that, on average, family caregivers provide care for their loved ones for 4.5 years, with the unpaid help of four friends or family members. ▼

Upper-level hiring in health care looks strong

People looking for executive and professional positions in the health care field should have little trouble finding a job, according to a recent hiring survey conducted by search and recruitment firm Management Recruiters International of Cleveland. The survey reported that 54.3% of health care executives with responsibility for hiring said they plan to increase their staffs in the first half of this year, up 8.5% from the 45.8% level of the second half of 2000.

Another 42.5% of those surveyed said they plan to maintain current staff size, up 10.3% from the second half of 2000, while only 3.2% plan staff decreases, a decline of 18.8% from last year's second half. Across all industries, 58.8% of hiring executives projected new hires during the current half, 35.2% plan to maintain current levels, and 5.9% plan decreases. ▼

JCAHO releases home care manual

The Joint Commission Resources, a subsidiary of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), has released its 2001-2002 Comprehensive Accreditation Manual for Home Care. The manual is divided into two main sections. The first contains common standards that apply to all types of home care organizations; the second provides specific standards for home health (including personal care and support services), hospice, pharmacy (including home care and long-term care pharmacies and non-physician-based ambulatory infusion centers), and home medical equipment (including respiratory therapy and rehabilitation technology services). Also included are segment-specific standard intent statements, as well as a separate section on compliance tips. Cost for the publication is $225. Cost for an electronic version of the manual and a traditional print version is $550. When ordering, use code CAHC-01XY.

To order, call the Customer Service Center at (630) 792-5800 between 8 a.m. and 5 p.m. Central Time M-F, or go on-line to www.jcrinc.com. ■