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INSIDE

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Are honest providers victims of zealous investigators?

Some say honest billing mistakes are interpreted as fraud

There are signals the federal government's attempts to crack down on fraud and abuse are working. The latest figures from the Office of the Inspector General (OIG) show overpayments to Medicare providers at the lowest point since the federal government began auditing Medicare claims three years ago.

Buoyed by the recent success, the Department of Health and Human Services, along with the Department of Justice and the American Association of Retired Persons, launched a national fraud and abuse initiative, "*Who Pays? You Pay,*" aimed at encouraging Medicare beneficiaries to call a toll-free number to report suspect claims.

No one in the hospice industry argues that providers who engage in defrauding the government should be allowed to participate in Medicare or Medicaid. But many are wondering whether investigators' zeal to root out criminal behavior ends up hurting those whose only crime is making an innocent mistake.

"HCFA has the distinction of being the new IRS," says **Eric Sokol**, JD, assistant director of government affairs for the National Association of Home Care in Washington, DC. "There is a failure to differentiate between fraudulent acts and innocent billing mistakes."

Pay now or pay later

Sokol characterizes federal investigators as bullies who threaten providers, most of whom lack the resources to mount an adequate defense, with long, intrusive, and disruptive investigations. Rather than fight accusations of wrongdoing, many agencies simply agree to pay the amount investigators say was overpaid to the provider plus additional fines to avoid expensive legal fees.

"Investigators go in and audit a sample of claims, and they may spot 10% to 15% errors in billing and come back and say, 'You owe us $100,000. You can pay this amount, or we can go back and look at all your records,'" Sokol says.

David Queen, JD, a Baltimore-based attorney who has defended a number of providers in fraud and abuse cases, corroborates Sokol's description.

"I've got letters that have been sent to clients saying, 'Pay the amount they have determined from their comprehensive audit or face a full audit,' Queen says. "The terms I hear from my clients are 'extortion' and 'adversarial.'"

Sokol admits that home health agencies endure the bulk of this type of treatment, but warns that hospices are also starting to see aggressive behavior from federal investigators.

Hospices have been on the list of targeted Medicare providers since mid-1997 when Department of Health and Human Services Secretary Donna Shalala announced that Operation Restore Trust would expand its scope to include hospices. Joining the list of targets was nursing home, durable medical equipment (DME), and home health. **(See *Hospice Management Advisor*, June 1997, pp. 61-63.)**

Guilty until proven innocent

Two years prior to that announcement, one home health and hospice provider found itself mired in a nightmare that would take more that two years to awake from.

After investigators released Home Health and Hospice Care Inc. (HHHC), a nonprofit provider in Goldsboro, NC, from their grip, the agency had lost $5 million in referrals and at least two potential joint ventures with area hospitals.

The experience serves as an example of what can go wrong when investigators become overzealous in their attempt to root out fraud and abuse only to cause harm to an honest provider. "[HHHC] had the fortitude to stand up and fight," Sokol said. "Think how many others couldn't do that."

It was still dark on the morning of Jan. 19, 1995, when nearly 100 FBI agents descended upon HHHC's offices. While the sun eventually rose, it was a gloomy day in what would be the beginning of a dark period for the rural home health and hospice provider.

During the search of HHHC's 10 offices scattered throughout eastern North Carolina, agents searched through closets, behind ceiling tiles, and employees' personal property. By day's end, they would gather five million documents and computer files, enough to fill 500 boxes that were loaded into borrowed Postal Service trucks.

Working with the testimony of three confidential informants, federal investigators launched one of the biggest raids on a home health agency the state had ever seen. Information provided by the three informants, which documents suggested were HHHC employees, provided the basis for investigators' request for a search warrant.

Federal investigators were accusing HHHC of billing for services that it had not rendered and falsifying records to meet government billing standards. Informants, federal investigators told a magistrate judge, had told them as much. The judge granted the government's request for the warrant that was used to search HHHC offices that January day.

As it turns out, one of the informants was the special programs director at the agency. Two months prior to the seizure of documents and computer files, the employee met with investigators at his home. For two hours, he answered their questions. His answers and how federal officials interpreted them would play a major role a year later.

From the start, HHHC officials decried the allegations. To anyone who would listen, they proclaimed that no wrongdoing took place in their organization. But it seemed few were listening.

Beverly Withrow, HHHC president, told the *Raleigh News & Observer* at the time that HHHC employees were asked why they would work for a company that cheats the government, and one physician openly accused her of taking money from the poor and elderly.

"Our referrals went down sharply during that time," Withrow tells *HMA*. "We estimated that we lost about $5 million worth of business. At the time, we were also working with area hospitals on joint ventures. Understandably, when the news hit they decided to go in another direction. By the time we had cleared our name it was too late."

In addition, there was the immeasurable amount of productivity lost because HHHC had to reallocate staff to focus on the investigation. Because investigators had seized their patient records, HHHC staff was forced to obtain copies at investigators' convenience. HHHC staff had to travel to Raleigh and copy records at investigators' offices.

In order to clear the company, Withrow and its team of lawyers faced a daunting task: prove that the information that federal investigators were using to go after HHHC was indeed false. They would also prove that the information was not only false; and the federal investigators knew the

information was false and recklessly disregarded the truth.

The defense of HHHC focused on the legality of the search warrant. HHHC lawyers argued that federal investigators illegally obtained a warrant through misrepresented evidence.

At a hearing in 1996, in front of the same U.S. magistrate judge that granted the government's earlier request for a search warrant, HHHC attorneys questioned federal agents and hammered on discrepancies between the search warrant and a memo prepared a day after agents interviewed the hospice's special programs director.

After hearing the testimony, the judge determined the agents knowingly and recklessly gave false information. As it turns out, the employee never told agents that records were falsified. The agent testified that the warrant falsely stated that HHHC billed for services not rendered and that agents misrepresented Medicare and Medicaid rules. In addition, the employee told agents he did not have personal knowledge that HHHC workers altered documents.

The judge also questioned agents' interpretation of standard records practices. The judge said agents made the standard practice of revising documents look suspect and intentionally deceitful.

The judge also found the federal investigators omitted facts to their benefit. Specifically, federal officials pointed to an earlier investigation of HHHC's fraud and abuse. They did not clarify their reference by including the fact that the investigation led to no criminal prosecutions, leaving the impression that evidence of fraud was uncovered.

In April 1996, the federal court threw out the search warrant and ruled that the false information and omission of facts rendered the search warrant unable to support a finding of probable cause to search HHHC's offices.

The federal government was ordered to return the seized documents, but it took a 1997 U.S. District Court order to force the investigators to return HHHC's documents.

Looking back at the experience, Withrow points to two areas that led to their persecution by federal investigators:

1. Investigators' refusal to see that errors in billing were the result of honest mistakes made by human beings.

2. Investigators' lack of knowledge about Medicare and Medicaid regulations.

"They were confusing Medicaid rules with Medicare rules," Withrow said. "The agents needed to be educated on Medicare and Medicaid regulations."

While the OIG investigates the majority of health fraud cases, it did not handle the HHHC case. And its officials deny that it represents the conduct of its investigators, nor do they take an innocent-until-proven-guilty approach to investigating fraud and abuse.

"A vast majority of providers are honest and do the right thing," says **Judy Holtz**, a spokeswoman for OIG. "We're not interested in honest billing mistakes. We're interested in intentional fraud and abuse. The numbers just don't bear out what providers are saying."

In the past year, Holtz says 12 hospices have been audited by OIG, focusing on whether patients were eligible for the hospice benefit at admission. She disputes claims that recent reductions in overpayment are the result of investigators bullying providers to either pay back claims, and credits the decrease on provider-government cooperation.

"The anti-fraud efforts have had a deterrent affect," Holtz says. "But there has also been input from the provider community on how to make the system better. It's both the industry and government working toward a clean system."

Prevention methods

Looking back, Withrow believes there was little that her agency could have done to prevent the events that began in January 1995. She admits mistakes may have been made in billing, but that they were honest. However, she says HHHC tried to convince investigators that the information they were basing their accusations on were false and essentially the testimony of a disgruntled employee.

But there have been changes at HHHC, including the implementation of a compliance program — which Queen recommends — to show investigators and prosecutors that a provider has policies in place to ensure federal and state regulations are being followed.

Withrow says there were informal policies within HHHC that addressed claims development and submission prior to the 1995 investigation. Since then, HHHC has developed a lengthy compliance program that outlines specific policies and procedures workers, physicians, and vendors must follow to avoid fraud and abuse issues.

Washington, DC-based National Hospice Association also believes that a compliance program will help hospices limit the number of

errors and avoid the perception that errors are incidences of abuse.

In addition to a compliance program, hospices should consider creating a hospice compliance officer position or assigning compliance program oversight to an existing management employee, says Queen. **(See related story on developing a compliance program, below.)**

"Since this happened, I've gotten several calls from other agencies who are were in similar situations and felt they were being treated unfairly," Withrow says. "I told them that we knew we were honest and were willing to stand up and prove it. I would tell others to get a good legal team together. Look for an attorney with criminal experience because your corporate attorney may not have the experience.

"It's unfortunate that some agencies can't fight because that's what causes the government to continue this practice." ■

Compliance program could placate authorities

Good plan requires compliance chief

If a hospice finds itself the target of an investigation, one administrative element investigators look for is a compliance program, a set of written policies that spell out the company's system for spotting incorrect claims and corrective procedures.

"One of the first things the U.S. Attorney's office will ask is whether there is a compliance program in place," says **David Queen**, JD, a Baltimore-based attorney who handles fraud cases for home health and hospice providers. "If there is, the provider is in a position to argue that they were following regulations in good faith."

This is not to say that a compliance program will prevent investigators from conducting an aggressive examination of a hospice's Medicare billing practices. It does show, however, that the hospice has policies that are intended to eliminate false claims.

In the eyes of the federal government, a compliance program has numerous benefits — not the least being the ability to identify weaknesses in internal systems and management.

Those who have effective compliance programs in place will have, in the opinion of federal officials, safeguards that will identify and prevent illegal or unethical behavior; a view of expected employee and contractor behavior relating to fraud and abuse; and a document that demonstrates to the government and public that the hospice is committed to honest provider and corporate conduct.

No compliance guides

To date, the Department of Health and Human Services' Office of Inspector General (OIG) does not have a compliance program guideline for hospices. It is currently developing a guideline that will help hospices implement compliance programs of their own.

In March, OIG completed the comment period, which will be used to help develop the compliance program guideline. In the Jan. 13 *Federal Register,* OIG identified seven elements that have been discussed in the development of past compliance programs for other segments of health care, such as home health:

1. **Written policies and procedures.**
2. **Designation of a compliance officer.**
3. **Development and implementation of effective training and education programs.**
4. **Development and maintenance of effective lines of communication.**
5. **Enforcement of standards through well-publicized disciplinary guidelines.**
6. **The use of audits and other evaluation techniques to monitor compliance.**
7. **The development of procedures to respond to detected offenses and initiate corrective action.**

With those elements in mind, hospices can begin roughing out a compliance plan of their own. They can also look at already-established guidelines for their closely related colleagues in home health. In fact, the elements above are listed as the minimum elements of a compliance program for home health and other provider types.

Written policies and procedures should be developed under the direction and supervision of a compliance officer and compliance committee. At a minimum, these policies and procedures should be provided to all individuals who are affected by the particular policy at issue, including contractors and vendors.

Elements within policies and procedures should include, but are not limited to, standards of conduct; risk areas; claim development submission process; and physician certification.

The Arlington, VA-based National Hospice Organization (NHO) has asked the OIG to provide

specific language and reference to statutory requirements in its guidelines to aid hospice providers develop written eligibility policies.

"While we expect that you would include the issue of eligibility, we would urge OIG to describe the requirements with specific reference to statutory and regulatory standard regarding terminal illness certification," NHO president **Karen A. Davie** wrote in response to OIG's request for comments.

The compliance officer serves as the focal point for compliance activities. This may be an employee's sole responsibility or it may be added to the job description of an existing position. According to the OIG, designating a compliance officer with the appropriate authority is critical to the success of the compliance program.

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Compliance officer background

The compliance officer should be a high-level official in the organization with direct access to the president and chief executive officer, its governing body, senior management, and legal counsel. The compliance officer should have the authority to review all documents and other information that relate to compliance activities, such as billing records, patient charts, and arrangements with contractors.

Queen says providers often make the mistake of placing people with accounting backgrounds as the head of compliance programs. While accounting skills are valuable, they represent a small portion of overall job responsibilities. Instead, Queen says compliance chiefs should have a human relations background with management skills.

"You need someone who is able to interact with both employees and upper management," Queen says.

Because many hospices are small operations, the prospect of creating one full-time equivalent position dedicated solely to monitoring its compliance program is dim. But the OIG will allow part-time compliance chiefs, Queen says.

Whether full-time or part-time, the primary responsibilities of the compliance officer should:

- **Monitor the implementation of the compliance program.**
- **Certify that employees have received, read, and understand the standards of conduct.**
- **Develop the education and training programs to ensure staff is knowledgeable of not only organizational policies, but state and federal standards as well.**

Investigate and act on matters related to compliance, such as suspected violations.

A compliance committee should be established to advise the compliance officer and assist in the implementation of the compliance program. The committee should be made up of employees in various positions within the hospice.

Training sessions spearheaded by the compliance officer must highlight the hospice's compliance program, summarizing fraud and abuse laws, federal health care program requirements, claim development and submission processes, and patient rights. Training should not be limited to just hospice employees, but should include physicians contractors and other agents.

Based on the home health compliance program guidelines, the OIG is likely to recommend that hospices require a minimum number of educational hours per year as a condition of employment. It may also recommend that an employee's failure to attend training should lead to disciplinary action, including termination.

Keep communication open

There should be an open line of communication between employees and the compliance officer. The OIG may suggest that written confidentiality and non-retaliation policies be developed to encourage employees to report potential fraud. The process of communication needs to be clear among employees to prevent confusion when reporting potential fraud. These lines of communication can take several forms, such as a hotline, e-mail, a written memo, and a suggestion box, to name a few.

An effective compliance program will include clear disciplinary guidelines for officers, managers, and employees who violate policies and standards of conduct. The OIG says compliance programs for all health care settings need to set forth the degrees of disciplinary action and ensure that workers are aware of the consequences of illegal or unethical behavior.

There should be an ongoing evaluation process to ensure compliance. OIG suggests performing regular audits by internal or external examiners who have an expertise in state and federal health care program requirements. According to past guidelines, OIG has recommended that the minimum scope of audits include laws governing kickback arrangements, physician self-referral, claim development and submission, reimbursement, cost reporting, and marketing.

There may be more

Procedures for investigating suspected abuse should take into account the possibility that a single incident may be indicative of a systematic problem. Procedures may include bringing in outside counsel, auditors, or other health care experts to assist in the investigation. The compliance officer is also responsible for reporting misconduct to the proper authorities along with evidence uncovered during the internal investigation. The reporting of misconduct will be considered a mitigating factor in OIG's determination of administrative sanctions.

The OIG in past guidelines has recommended that providers report the existence of misconduct within 60 days. The NHO is concerned the requirement is "too prescriptive for a voluntary program."

Davie also expressed concern that the stressful atmosphere created by impending death might cause patients and families to make unwarranted accusations and that investigators would interpret the emotional response as credible evidence of wrongdoing. The NHO is asking OIG to take into account the unique atmosphere in hospices when directing providers to report suspicions of abuse. ■

Public awareness in the hands of hospice

Target clinicians, public for palliative care message

The idea that death is simply a stage of life is a difficult concept to grasp for most people. Even more difficult to understand is ending curative efforts in favor of comfort care. It is the perception of giving up that has denied dying patients the palliative care they deserve. So, it becomes incumbent on health care providers to educate the public and teach an acceptance for care that is aimed at addressing physical and emotional pain in the last few weeks of life.

As health care providers begin looking at ways to promote end-of-life care, one thing that has become plainly evident is that hospices are in the best position to promote palliative care to both the public and to other segments of the health care industry.

In 1997, the Robert Wood Johnson Foundation (RWJF) asked providers around the country to examine end-of-life issues through its $12 million initiative, Excellence in End-of-Life Care.

As providers begin looking at how end-of-life care is being delivered and formulate how to better deliver the palliative care message, hospices are in the forefront, says **Lisa Spoden**, MS, executive director of the Kentucky Association of Hospices in Pikeville, KY. But hospices will face competition in the future as innovative ways to provide palliative care outside hospice begin to emerge, such as palliative care units in hospitals.

"If we can influence politicians, clinicians, and the public, the result will be better care during the dying process with unique opportunities in various settings. Hospices are the premier way to deal with the dying," Spoden says.

Although hospices are in a position to promote palliative care because that is what they do, their collective voice is muted by the fact that most hospices are small organizations with few resources for public campaigns.

But the efforts by RWJF-funded health care providers, which include hospice providers, to educate both the public and other segments of the health care industry, provide a glimpse at what can be done to promote palliative care and improve end-of-life care.

Kentucky United to Improve End-of-Life Care is one of 15 statewide coalitions being funded by the RWJF initiative. Its approach offers examples of how hospices can inform and educate in order to increase public awareness and ensure that hospice not only grow in use, but also continue to be the premier setting for end-of-life care.

"There is a general lack of knowledge about treating chronic pain," says **Cynthia Keeney**, RN, executive director of the Center for Nursing and Allied Health Professionals at the Kentucky Hospital Association, which is overseeing the Kentucky project. "Unless you have an informed public, you are not going to change anything."

Its three-year strategy includes identifying problems in end-of-life care and formulating solutions:

• **Public forums.** The public will be asked to share its experiences, both good and bad. The public testimony will be videotaped so that the coalition can show it to health care providers and raise awareness of problems within end-of life care.

• **Pain management guidelines.** A task force appointed by the coalition will develop pain management guidelines and develop pain management curriculum to be used in two state medical schools and four nursing programs. The curriculum is designed to help educate a new crop of health care professionals in the value of palliative care.

• **Continuing education.** The coalition will develop a continuing education program on palliative care and interdisciplinary pain management. This is designed to address working clinicians that were trained in an era when greater emphasis was placed on curative techniques.

• **Toll-free help line for clinicians.** A help line will be established to encourage telephone consultation for clinicians who are experiencing difficulty managing their patient's symptoms, such as nausea and pain. A clinician will have access to a palliative care specialist to answer pain management questions.

• **Long-term care facility workshops.** The coalition will develop educational workshops for residents and staff at long-term care facilities. One workshop will be designed specifically for residents and their families. The resident/family workshop will include an educational program, but more importantly, it will include an open discussion of end-of-life issues. Residents will discuss advance care planning issues and be given assistance in developing a directive for the kind of care they want to receive during the final stage of their life. Participants and their families will be instructed to follow up with their area hospice for additional information.

• **Community workshops.** In addition to the nursing home workshops, there will also be community workshops targeting a variety of groups. Like the long-term care workshops, the community workshops will also facilitate an open discussion about end-of-life issues and advance care planning.

The above strategies represent elaborate, well-planned efforts to effect public opinion and behavior. If the programs are successful, it will be in large part to the concerted effort of the community of providers that contributed to its implementation.

Yet, for hospices whose resources are limited, the efforts of Kentucky providers and other coalitions in the RWJF initiative provide at least an outline for hospices who want to improve palliative care awareness in their own communities.

To begin, look at the underlying themes in the above strategies — education and dialogue. Then look at the targeted audiences. On the clinical side, there is the next generation of doctors and nurses and the experienced doctors and nurses. In the community, there are the legions of elderly who may be beginning to contemplate their own mortality and their families who want to make sure their loved ones receive the best care possible.

The challenges to raising awareness that the Kentucky coalition faces are not much different from communities around the country. Palliative care suffers from near anonymity among clinicians whose training has focused more on curing disease than treating symptoms and among the public that embraces heroic attempts to overcome illness and disease.

"We need to convince people that palliative care is not giving up," says Keeney. "We need to teach clinicians and the general public that we can treat patients with the same intensity they were given during the curative stage."

Hospices looking to raise awareness about palliative care on a smaller scale should keep in mind these underlying themes and target similar audiences. Approach key targets in their own community in the following ways:

• **Physicians**. One of the hurdles hospices face in getting physicians to refer patients earlier is the perception that they would be letting go. Hospices need to get across the message that hospice care is still physician directed. Perhaps physicians in a hospice provider's community are unaware of hospice's physician-directed interdisciplinary team approach. Hospices need to explain to physicians who have referral potential that the hospice team approach calls for the patient's physician to take a lead role and work with the hospice medical director, nurses, social workers, counselors or chaplains, and other needed health care professionals.

Unlike those involved in the RWJF initiative, programs designed to reach physicians will be small, even informal. No matter how it is done, Keeney says the program should be structured so that it can be repeated without variation. She suggests hospices start with hospital medical staff meetings to educate physicians about hospice and palliative care. Another educational devise is

a newsletter aimed at physicians that explains the principles of hospice care, including the value of palliative care.

The Kentucky project stresses dialogue between physicians and end-of-life care promoters, either through educational efforts such as pain management guidelines or a toll-free hotline. While a single hospice cannot influence the curriculum of a medical school or nursing school, it can influence the habits of the clinicians it works with.

• **Community.** If the idea behind educating physicians is to improve the number of referrals, then hospices would want to educate the public so it will consider hospice care when it becomes appropriate.

Hospices can accomplish this by visiting various groups within their community, much the same way the Kentucky coalition plans to reach the public. Hospice leaders should identify groups in their community that would benefit from a presentation about hospice, such as nursing homes, community centers for the elderly, or local chapters of the American Association of Retired Persons.

Keeney also suggests talking to a population that has had little exposure to death and dying — teenagers. Religion classes in churches and schools are ideal platforms for end-of-life discussions, she says.

"Teenagers love end-of-life discussions," Keeney says. "Because teenagers think they are immortal, they aren't afraid to talk about death, while elderly people living in a nursing home don't like to talk about it because it can be depressing. Talking with teenagers are some of the most spirited discussions I've ever had."

The end result is that teenagers share the discussion with their parents and get them thinking about end-of-life issues and how they want their parents to be treated.

No matter the group, hospice supporters should try to facilitate end-of-life discussions. For instance, the audience should be encouraged to talk about their experiences with the death of friends and relatives and their impression of how clinicians treated them. This not only gets the audience to think about issues they haven't considered, but it also give providers a glimpse of the public's impression of end-of-life care.

As people begin to contemplate end-of-life care, hospices should encourage the audience to begin thinking about advanced care planning and offer further assistance in establishing a statement for how they want to be treated in the last few weeks of their lives.

• **Managed care organizations (MCOs).** As managed care becomes more prevalent in some markets, contracting with MCOs becomes more important. Like physicians, nurses, and the general public, MCOs need a dose of education as well.

However, the message to MCOs will be slightly different than the two previous audiences. Hospices will want to stress their place and value in the health care continuum, says Spoden.

"Managed care is beginning to embrace hospice," Spoden says. "And MCOs are in position to make sure physicians are keeping palliative care in mind."

Like the Kentucky initiative, the goal of hospices should be to raise awareness in their own communities about palliative care and hospice care in general.

"We need to influence politics, clinicians, and the public, says Spoden. "The result will be the improvement of the dying process." ■

Guard against misuse of chaplain by workers

Avoid using chaplains as primary counselor

When you think of your hospice chaplain, what comes to mind? For most hospice workers, a number of descriptions seem apt — spiritual caregiver, counselor, sage, and friend. However, for some, these words have a far more personal application, rather than being a patient-oriented description of their chaplain.

As part of the interdisciplinary team, it's easy and appropriate for chaplains and other members of the team to develop close collegial relationships. After all, co-workers in other walks of life develop friendships that blossom outside the context of work.

The relationship between chaplains and their team members is unique, however. In times of personal or professional crisis, the hospice chaplain is often the first person other hospice workers turn to for emotional or spiritual guidance.

Because chaplains have a predisposition to reach out to help, it's easy for workers to seek their counsel. In most cases, the loss of a patient

triggers strong feelings of grief; ministering to employees, for example, is acceptable to a point.

One expert warns that hospices should evaluate chaplain-employee relationships to ensure the chaplain is not overburdened and that workers don't cross ethical boundaries that could impede the team approach to hospice care.

"When you get the job, it's natural to see yourself as a chaplain to the staff as well as to the patients, and before long you're worn out trying to be all things to all people, says," the Rev. **Jeanne Brenneis**, MDiv, STM, director of the Bioethics Center and Chaplain at the Hospice of Northern Virginia, both in Falls Church, VA. "And then there are all the boundary issues."

It's the blurring of boundaries that can cause problems between chaplains and their co-workers. **Jay Stark-Dykema**, MA, pastoral counselor with CareMed Chicago, offers these warning signs:

- **A chaplain finds himself or herself counseling a worker on an ongoing basis.**
- **Workers without a support system continually seek the chaplain's counsel.**
- **A chaplain notices that he or she is spending more time with one team member than others, perhaps diminishing his or her availability to other staff.**

If a chaplain is playing the role of counselor too often with a worker, the chaplain runs the risk of diluting his or her effectiveness with the very people he or she is trying to help. "[A chaplain] would be in a dual role as counselor and co-worker and that doesn't work," says Brenneis. "You can't do a good enough job because there is not enough distance and objectivity."

This is not to say that chaplains should not minister to their co-workers or that hospice administrators should measure the amount of time their chaplains spend helping co-workers. Chaplains play a key role in ensuring that their co-workers' as well as their patients,' spiritual and emotional needs are met.

Provide encouragement

It is common for hospice workers to feel a sense of loss or grief when a patient dies. Sometimes that grief is heightened when a patient or a patient's situation reminds workers of their own personal experiences. Caring for an Alzheimer's patient in the final weeks of life may trigger memories of the death of a worker's own parent from the same disease.

Often these feelings of grief, while strong, are not enough to prompt the worker to seek counseling through the hospice employee assistance program. An observant chaplain will likely notice the signs of grief the worker is experiencing or the worker will seek out the chaplain's help.

Employee ministry allows for discussion between the worker and chaplain, enough for the chaplain to assess the worker's problem. It's at this point where ethical lines are at risk of being crossed.

"Support a staff member as you would any other staff," Brenneis says. "I would not put myself in the position of counseling that worker,"

What does that mean? Should hospices not allow workers to discuss their problems with a chaplain? The answer is "no," but chaplains shouldn't be the primary counselor. Instead, experts say chaplains should feel free to help the worker identify the underlying issues that are at the root of their problems, but they should also encourage that staff member to seek counseling outside the hospice.

This is especially true in situations where the problem lies outside work, but is affecting work performance, such as marital problems, caring for a chronically ill relative, or parenting issues. While this may seem like straightforward advice, Brenneis says chaplains are often trapped by their most valued assets — their compassion and their desire to help others.

Stark-Dykema provides a real-life example of how chaplains should provide for individual needs of workers, while still preserving the boundaries of the worker-chaplain relationship:

An employee who had been discouraged by a recent reprimand approached Stark-Dykema with his problem. He complained to the chaplain that he had been unfairly treated and was misunderstood. The obvious danger is that the chaplain would be put in the position of having to take sides or, at least, leave an impression that he favors one co-worker over the other.

"I listened to his problems," he says. "I affirmed his good qualities."

The worker also reflected on his response to the situation that led to the reprimand and admitted that he could have handled the situation better. The discussion then turned to areas in which he could improve. Yet, rather than acting as the primary counselor for the employee's journey toward self-improvement, Stark-Dykema left it to the employee to seek further counseling outside the hospice. He suggested that the employee

participate in a program that focused on personal growth.

Acting as a resource for workers in need is an excellent way to minister employees. In cases where co-workers have questions about their own spirituality, for example, chaplains should encourage the worker to seek the guidance of their own minister, priest, or rabbi.

Use team approach

While individual cases need to be handled delicately to preserve professional relationships between chaplains and the interdisciplinary team members, ministering to employees is still a part of a chaplain's responsibilities.

For example, chaplains should recognize their responsibility to bolster the team atmosphere through his or her ministry and act as an advocate for the team to help ensure that the interdisciplinary team needs are met.

Stark-Dykema recommends that chaplains play leadership roles in developing team-building activities. More importantly, the team atmosphere that a chaplain has been helping to foster can also aid in employee ministry.

Chaplains can use team meetings to openly discuss feelings of grief or distress that arise from a patient loss or other situations that may effect morale. For instance, the death of a patient that has had a significant impact on staff could be addressed during a team meeting where staff are allowed to light a candle in memory of the patient and openly reflect on personal memories each has about the deceased patient.

"You need to ask how you can love and support your fellow team members," Stark-Dykema says. "You need to promote the sense that everyone is in it together."

Chaplains can also proactively minister to their co-workers spiritual needs by holding educational inservice training on religious issues, such as different types of faiths. Chaplains can use the opportunity to get workers to reflect on their own spirituality by talking about how their own spiritual beliefs interact with those of a patient or patient's family, Stark-Dykema says.

The bottom line for chaplains is that the misuse of their services by co-workers can have the net effect of diminishing their effectiveness with patients and their families because of overwork or burnout. Chaplains must be able to exercise professional judgement when it comes to employee ministering, yet still encourage co-workers to seek their assistance when needed.

"It's about maintaining a balance," Stark-Dykema says, "and the bottom line is that they know I'm available." ■

Salaries for hospice directors rise in 1998

The average salary for hospice directors in 1998 was $56,035 — up 4.32%, compared to the previous year's average of $53,713, according to the *1998-99 Hospice Salary and Benefits Report*.

The report, which is published by the Hospital and Healthcare Compensation Service and the Hospice Association of America, shows that director's salaries have been increasing steadily for the past four years. Since 1995, directors' average salaries have increased 13.8% from $48,309.

For the first time, researchers noticed that hospice director salaries increased at a higher rate than their home care counterparts. Home care provider salaries increased 4%, according to the survey.

"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 **Rosanne Cioffe**, director of reports for Hospital Healthcare Compensation Service. "Owners are leaving home care and going to hospice and taking the salaries with them."

COMING IN FUTURE MONTHS

- Elements of a good managed care contract
- Improve cash flow despite sequential billing
- Get ready for hospice cost reports
- End-of-life information on the Internet
- The future of the hospice nursing home benefit

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 87 cents more per hour. On the other hand, aides in hospices earned an average of 18 cents less per hour.

The median home care nurse's hourly rate was 49 cents per hour more than hospice a nurse, and home care nursing aides had an average hourly rate that was 30 cents higher than hospice nursing aides. Hospice nurses earned and 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. Last year, hospice nurses earned an average of 55 cents per hour less than home care nurses. In 1997-98, the average hospice nurse's hourly rate was $17.30 while the average home care 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 positions with the highest turnover in hospices were 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%. ■

News From Home Care

HHS: Overpayments at all-time low

It seems the Health Care Financing Administration's (HCFA) efforts to crack down of overpayments are paying off. The Department of Health and Human Services ' (HHS) Office of the Inspector General reports that improper Medicare payments declined significantly in 1998.

The error rate for fiscal year 1998, was estimated at $12.5 billion, the lowest since the agency initiated audits three years ago. The previous year's erroneous payments totaled $20.3 billion and $23.2 billion in 1996.

According to the Inspector General, home health agencies accounted for 13% of erroneous claims. Hospitals accounted for the largest portion, 39%, of erroneous claims.

HHS credited HCFA for the steep reduction, in part citing the agency's stepped up anti-fraud and abuse initiatives. HHS also acknowledged improved provider compliance with Medicare reimbursement rules and improved documentation. ■

GAO releases surety bond report

The long-awaited General Accounting Office (GAO) report on proposed surety bond requirements was released in March and was mostly good news for home care providers. The non-partisan investigative arm of Congress recommended that bond requirements be capped at $50,000; exemptions be granted to agencies that have a proven financial track record; and separate bonds be required for agencies who participate in both Medicare and Medicaid.

Now, providers are waiting for the Health Care Financing Administration (HCFA) to publish its final rules. Upon publication in the *Federal Register,* providers will have 60 days to comply.

The original deadline for home health agencies to secure surety bonds dates back to January 1998. But pressure from Congress and provider difficulty in securing bonds under the proposed rules has led to a series of postponements. Industry protest prompted Congress to request GAO to study the proposal.

So far, HCFA is unable to give a definitive answer as to whether the regulation will be reinstated or what changes it might face.

The current surety bond requirement calls for home health providers to secure the larger of a $50,000 surety bond or one equal to 15% of annual Medicare reimbursement. Many home health providers, especially small or rural agencies, have been unsuccessful in meeting the Health Care Financing Administration's requirement and complained that it was an unfair financial burden.

The provision was originally designed to fight the existence of fly-by-night home health operators seeking to defraud Medicare, but grew into

an indemnity policy against overpayment. The net effect, its critics claimed, was that instead of weeding out fraudulent home care providers, the new rule seems to be so restrictive that surety bond companies are reluctant to provide bonding.

These conditions have the potential of wiping out small agencies that are finding it difficult to find companies to underwrite the bonds, critics say. According to HCFA, 60% of home health agencies have yet to purchase bonds. ■

Health care Y2K reference resource available

With the year 2000 deadline fast approaching, health care providers and the medical device industry are scrambling to complete a process that in many cases was started too late.

What may have once been a logistical issue is burgeoning into an overwhelming problem, compounded by the scarcity of time, rising costs, and a lack of programming resources and expertise.

As the Y2K issue moves far beyond a mere "technological" issue, American Health Consultants, publisher of *Hospice Management Advisor*, has published the *Hospital Manager's Y2K Crisis Manual*, a compilation of resources for nontechnical hospital managers.

This 150-page reference manual includes information, in nontechnical language, on the problems your facility will face, the potential fixes, and the possible consequences, including:

- Will your computers and software work in 2000?
- What does Y2K mean for patient care?
- What will happen to your medical devices?
- How can you make sure your vendors are Y2K-compliant?
- Are you at legal risk due to Y2K?
- Are you prepared if Y2K delays Health Care Financing Administration's payments?

Jan. 1, 2000 is not a moving target. Either your computer systems, medical devices, and suppliers can handle the date change and maintain business as usual, or they can't — in which case your entire organization may face serious problems.

The Hospital Manager's Y2K Crisis Manual is available now for $149. To order, contact American Health Consultants' customer service at (800) 688-2421. ■

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