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INSIDE

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American Health Consultants® is A Medical Economics Company

Turn standard MCO contracts into hospice-specific agreements

Fight for per diem rate that includes all COP-required services

Managed care contracting can be an intimidating experience, pitting a David-like hospice against a Goliath-like health plan. Plans often require a platoon of representatives, lawyers, medical directors, and case managers. Paired against these formidable foes, a small hospice must negotiate a deal that will not only provide patients, but also pay enough to cover costs and perhaps make a small profit.

To do so, however, hospice leaders must have a basic understanding of managed care contracts and a keen eye for elements that could put their organizations in fiscal peril. According **Lisa Spoden**, chairwoman of the Arlington, VA-based National Hospice Organization's managed care task force, many hospices make the mistake of assuming managed care requirements are the same as those for Medicare. Even in Medicare-sponsored managed care plans, also called Medicare-risk, that type of assumption could cost hospices dearly.

> ***"End-of-life care just isn't on the radar of most managed care companies."***

"When hospices started getting exposure to managed care, it was totally foreign to them," says Spoden, a partner with the Columbus, OH-based consulting firm Strategic Health Care. "For example, they didn't understand that they had to verify authorizations."

Just as managed care is foreign to many hospices, hospice care is unknown to managed care companies. Health plans often assume incorrectly that hospice care is akin to home health and perceive integral hospice services, such as bereavement care, as unessential.

"End-of-life care just isn't on the radar of most managed care companies," says **Peter Benjamin**, partner with the Coconut Grove, FL-based Huntington Consulting Group. "Ideas like professional management of the patient remaining with hospice is an anathema to them; bereavement care and chaplain [counseling], it makes them crazy.

"We recently met with a managed care company and spent a majority

of the time going over basic definitions and levels of care," he adds. "When they think of routine hospice care, they think of a home visit where a nurse comes to the home for one home visit, not the hospice interdisciplinary approach where there could be several people waiting in the wings."

Hospice leaders should review a proposed contract by dividing it into these categories:

- preliminary review;
- defining key terms;
- provider and health plan obligations;
- compensation;
- termination.

When considering any prospective contractual relationship with a managed care organization (MCO), a hospice provider should review all available information from the MCO and other independent sources. In most cases, the MCO will provide a standard contract, one it uses for all its providers — physicians, hospitals, and post-acute settings. It's likely the document will have little to do with hospice care and will require a lengthy addendum to make it hospice-specific.

Hospices should use this opportunity to read over the language of the standard contract and have language removed that doesn't pertain to hospice care or is contradictory to its philosophy, says **Peter Moberg-Sarver**, MSW, president and chief executive officer of Upstate New York Hospice Alliance Inc. in Syracuse.

"Each entity appears to have their own boilerplate contract," he says. "Look for a lot of language written for physicians, like minimum office hours and maintaining credentials."

In addition to reviewing the proposed contract, it is important to determine how long the MCO has been in operation and whether it is a financially stable and solvent legal entity. It also may be wise for a hospice provider to talk with other hospices or providers in other segments of health care that have had relationships with the MCO to learn more about the organization's strengths and weaknesses.

Also, the provider should examine the MCO's member and provider disenrollment rates. If one or more of those rates are high, it may be a signal that those involved with the MCO, patients and providers alike, are dissatisfied.

One of the most important sections of the managed care contract is the definition section. Because standard MCO contracts may have been written originally for physician groups or hospitals, language specific to hospice will need to be added. Because MCOs are usually reluctant to make wholesale changes in the language of their contract, hospice specific language should be added in the form of an addendum. In this addendum, hospices must define key terms so both parties are clear on the scope of services and responsibilities.

For example, a hospice that makes the incorrect assumption that the MCO will interpret the term "routine hospice care" in the same manner that Medicare does could find itself providing services not covered by its per diem payment.

Such terms as "covered services," "covered persons," "emergency," and "medically necessary" should be adopted by the parties as part of the negotiating process and used consistently throughout the final contract and any related MCO policies and procedures. Key hospice terms, such as "routine hospice care," "palliative care," or "levels of care" should be defined clearly in the addendum. **(See story on basic hospice definitions and levels of service definitions, p. 68.)**

Provider and MCO obligations

At the very least, the contract should state that the provider is not obligated to provide any services under the contract that it does not customarily provide to its patients who are not members of the contracting MCO and its affiliate plans. In addition, the parties may want to consider adding an addendum to the contract that specifically lists all services, or types of services, that are covered by the MCO and the plans. Finally, the provider may want to add a paragraph providing that if the provider elects to limit or discontinue certain services in the future, the provider may do so without penalty, as long as appropriate notice is given to the MCO according to the contract's terms.

Because hospices routinely are paid on a per diem basis, it would be wise to have a provision in the contract that states all services provided by the hospice will be related to the terminal condition and necessary to implement patients' care plans.

With regard to regulatory compliance, it is not uncommon for managed care contracts to include a provision requiring the contracting health care provider to maintain all licenses, registrations, permits, and certifications required by law to perform the services set forth in the contract. One of those may be Medicare certification or compliance with federal conditions of participation (COPs). Hospices can use this to their advantage.

Federal law requires Medicare patients to receive the same care as non-Medicare patients. During negotiations, MCOs may try to carve out services in an attempt to bring down a hospice's per diem rate or insist on a per visit rate. Hospices should balk at an MCO's attempt to carve out any service required under Medicare's COPs or unbundle services provided by the interdisciplinary team into per-visit rates.

"I advise my clients that it is all or nothing," says Benjamin. "COPs are not optional. If they are not willing to give up professional management of the patient or pay for bereavement care, you have to be willing to walk away."

Just as the provider has obligations to the MCO, the MCO also has obligations to the provider that should be stated clearly. To properly anticipate future changes, language should be included in the contract that requires the MCO to inform the provider at least 30 to 60 days in advance of any proposed amendments to MCO bylaws, rules, regulations, or policies and procedures. The time should give a hospice provider an opportunity to review, comment, and adapt to the proposed changes. Hospices also should strive to have a "termination without cause" arrangement in the event proposed amendments are unacceptable.

Non-negotiable points

As Benjamin mentions, hospices should not provide hospice care that deviates from the Medicare standard. In addition, Spoden recommends hospices use the following points to ensure MCOs understand the importance of maintaining the Medicare standard for non-Medicare patients.

- COPs require hospices to be responsible for professionally managing the care and services of their patients for palliation and management of the terminal disease. Limiting care to a commercial plan enrollee could be construed as a violation of federal COPs and result in the hospice's loss of Medicare certification.
- Federal law requires hospices to make available the full continuum of prescribed services and to deliver the same level of services to all patients regardless of payment source.
- A nursing visit alone cannot be labeled hospice care. An insurer cannot label a benefit hospice unless the it meets the criteria defined by law.
- State and federal regulation require that the plan of care, interdisciplinary care team, case management, and use of ancillary services be under the direction of hospices.
- Hospice and home care services are separate licensed entities, and their services, functions, and contract language must be kept separate.

Compensation issues

A key element of any managed care contract is the provider's compensation for services. But before hospices can discuss how and when they should be paid, they first must get a handle on their own costs. Knowing the cost of average home hospice visit, for example, will help hospices determine whether a proposed per diem is enough to cover daily services.

After hospices have done their cost-accounting legwork, they should begin examining an MCO's compensation proposal. First, they should identify how and when they will be paid. They also should clearly understand the administrative requirements of submitting claims and the timing of receiving payment; for example, the time period within which a provider must submit claims must be clearly stated. Second, the particular forms used to submit claims must be identified by name. Third, all arrangements with regard to the coordination of benefits and late payments must be carefully spelled out in the contract.

Finally, because providers don't contract directly with the various payers and plans administered by the MCO, language must be added to the contract that requires the MCO to use its "best efforts" to ensure timely payments by these third-party payers and plans.

A managed care contract may offer different types of payment. Common types of payments include discounted fee-for-service, per diem, per visit, percentage of premiums, and capitated arrangements. Few hospices are paid in forms other than per diem. However, Spoden warns that some health plans are seeking per visit contracts, which should be refused, she says.

"The hospice benefit was designed to be reimbursed on a per diem basis," Spoden says. "If you break apart the hospice benefit into a nursing or social worker visit instead of a 24-hour, on-call service where members of an interdisciplinary team are waiting in the wings, you're losing the depth and breadth of the interdisciplinary team."

Compensation must include all services required under federal regulations. Hospices

(Continued on page 69)

Defining levels of care for managed care contracting

One of the keys to a successful managed care contract is a mutual understanding of what hospice care is and the services covered under the proposed per diem rates. Providers need to clearly define the basics of hospice care and levels of care they provide.

Here is a sample of how hospice care and levels of care should be defined, according to the National Hospice Organization's (NHO) managed care task force. **Lisa Spoden**, task force chairwoman and partner in the Columbus, OH-based consulting firm Strategic Health Care, says the task force is developing guidelines and educational material to help NHO members with managed care contracting.

Hospice defined

Hospice is an organized program that, upon informed choice, provides palliative care to terminally patients and supportive services to patients, their families, and significant others in home- and facility-based settings. A 24-hour on-call service is available to evaluate patients' changing needs.

The range and intensity of services will be consistent with those in the patients' care plans and those approved by the health plan. Hospice services to be provided by a hospice organization will be in accordance with each patient's individualized care plan and will include all equipment, medication, treatment, and care required to manage the terminal condition of each health plan patient admitted to the hospice provider.

• **Physician services.** Physician services provided by hospices are limited to:

— those associated with assisting in the coordination of the hospice program;

— those associated with quality assurance/utilization review functions for the hospice program. Direct physician medical care is billed separately from the hospice per diem.

• **Unrelated services**. These are the services, equipment, medication, treatment, and supplies that are not related to the terminal condition and, in the patient's care plan, are not covered under the hospice benefit but may be covered under other benefit categories as stipulated in the plan.

• **Professional management**. It is understood that hospice care is palliative rather than curative in treatment goals and methods and that the definition of accepted palliative goals and methods is exclusively the province of hospice for each patient and for all patients.

• **Patient residence**. The patient's residence is a private home, nursing facility, intermediate care facility, group home, assisted-living facility, hospice facility, or other alternative residence.

Levels of care

• **Routine hospice care.** This is intermittent scheduled care provided to hospice patients in their place of residence. A 24-hour on-call service is provided. As detailed in the patient's plan of care, the services may include:

— physician-directed interdisciplinary case management focused on patient symptom control;

— services by licensed nurses, social workers, chaplains, counselors, nursing assistants, and volunteers;

— family counseling services to family members during the time the patient is receiving hospice care;

— bereavement care and counseling for family members for at least one year following the patient's death;

— all interventions related to the terminal condition and necessary for the implementation of the patient's plan of care, including therapies, medications, routine medical supplies, and durable medical equipment, excluding ventilators.

• **Respite care**. A hospice may provide patient care in a facility it owns or contracts with to provide relief and rest for the patient's primary caregiver.

• **Continuous hospice care**. A hospice may provide hourly care in the patient's place of residence during periods of crisis, as necessary to enable the patient to remain at home. A period of crisis is a time in which the individual requires continuous intervention to achieve palliation or management of acute medical or psychosocial symptoms.

• **Alternative residential hospice care**. A hospice may provide routine hospice care and room and board in a residential facility (if available) it owns, leases, or contracts with. This level of care is commonly given to patients who have no a willing or able caregiver.

• **General hospice inpatient care**. A hospice may provide pain and symptom control not manageable in a home care setting in a health care facility it owns, leases, or contracts with. ■

must not allow MCOs to unbundle hospice services that would jeopardize the interdisciplinary team approach or weaken the team's ability to follow and manage the patient's plan of care.

That's why hospices must understand their costs. If they complete the cost-accounting exercise mentioned earlier, they will have a clear picture of per diem costs for their levels of care. Compared to the per diem proposed by an MCO, hospices will be able to discern readily between a fair offer and one that will lose them money. In addition, they can provide cost-report data to the MCO to help make a case for a higher per diem rate.

Terminating contracts

There are three primary ways to terminate a contract prior to its natural expiration at the end of its term. First, the contract may be terminated by a mutual agreement of the parties to the contract. Secondly, the contract may be terminated "without cause," which allows either party to walk away from the deal after the necessary notice required by the contract has been given to the other party. Although each of these methods allows the parties flexibility in terminating the contract before its completion, one or both of the parties may be reluctant to include such provisions, depending on how much the parties may depend on one another for patients or services.

The contract also should allow either party to terminate "with cause," in the event the other party fails to comply with its many promises and obligations as set forth in the contract. A 30-day "cure" period often is included to encourage the parties to resolve a breach or default before a termination with cause. An automatic termination provision also may be included in the event a party becomes insolvent, convicted of a health care crime, or loses insurance coverage or a regulatory license as required by law.

While termination language may seem innocuous, it is perhaps the most pragmatic portion of the contract. It stipulates a way out if a hospice is not satisfied with the business arrangement or prompts the MCO to adopt changes that would remedy a bad situation. "I take a pragmatic approach to contracts," says Moberg-Sarver. "My concern is the backup provisions and the escape clause. You can scrutinize a contract based on the amount of risk it presents. If they are only going to provide a few patients, just sign it and file it, but know if you can get out if it's not working." ■

Internet is a valuable resource for hospice info

Web sites educating public on end-of-life care

The Internet is teeming with life. You can shop, invest, meet friends, and plan vacations, all with a click of a mouse. A person can practically live on line. So it should come as no surprise that dying — the final stage of life — has its place in cyberspace.

For one Florida hospice, the Internet is the main messenger spreading the word about hospice and end-of-life care. What started as a pet project of a nurse/computer enthusiast has grown to become one of the most comprehensive hospice resources on the Internet.

In many respects, the Hospice of North Central Florida (HNCF) in Gainesville is much like any other hospice around the country. HNCF, which provides home hospice care and residential facility care to about 250 patients, also struggles with census and patient-stay issues. A large part of the problem, as most hospices can attest, has been the public's lack of knowledge about end-of-life care. This includes physicians who largely are responsible for sending patients to them.

Filling a need

In 1997, HNCF's Webmaster, **Jim Nash**, RN, and a nurse at the hospice tinkered with a personal Web site that offered links to other hospice sites on the Internet. In his cyberspace travels, Nash began to realize there was need for a hospice resource on the Net, one that brought together the fragmented pieces of information that already existed.

"I originally started it as a personal project," he says. "Initially, my goal was to disseminate information. Our purpose has changed since then. Now we are trying to promote hospice on a large scale as well as promote our organization."

HNCF's Web site is divided into two sections. One promotes its hospice, including an interactive tour of the residential facility, and provides information about its services. The other, called Hospice Hands, is a gathering place for people to become familiar with hospice care through original articles, a chat room, and an index to other sites.

Nash has built a tool that takes one of the most basic events of life and connects it with one of the century's biggest technological phenomena. Judging from comments e-mailed to Nash, the HNCF Web site is educating and comforting people in its own community and around the world.

Voices from the Internet

Here is a sample of visitors' feedback:

• "My sister is in the dying stage. I am flying to Calgary to be with her and the family. Your Web site has helped me understand the process of dying. She is going to be in the most peaceful place, free from pain. Before I fly home to say goodbye, I just wanted to take this opportunity to share with you how much support I received through your Web site. I can say goodbye to my sister with a peace in my heart."

• "I read a number of articles here at your Web site. I wish this information had been available to me when I was going through my parents' deaths. My mother passed away 8-1-94, and my father passed away 11-19-96. I didn't understand the process of death and dying — didn't understand everything my mother was going through. I read one of your articles, which explained the process, and I cried as I read it. Even though it is after the fact for me, it was still helpful — although I wish I had done some things differently. I'm sure it is a great comfort to people experiencing death processes now."

• "I am a faculty member in the Department of Pharmacy Practice at the School of Pharmacy at Texas Tech University Health Sciences Center. My practice interest is hospice care / palliative medicine, and because of this interest, I will be preparing material for a lecture series for our students on death and dying. Your article on your Web page is excellent. I would like to quote this article in my lectures."

As evidenced by the above comments, HNCF's Web site has, at least in small part, helped educate the public and physicians who are uniformed about palliative care. Its early success has opened the eyes of HNCF's administrator, **Patrice Moore,** MSN, who now is a strong advocate of using the Internet to promote hospice care.

"This is an effort to get the word out in any way we can," she says. "We thought we could use the Internet to promote our services within the community and create something that could be used as a resource outside our community."

While its Web site has generated some referrals from local physicians, it may be getting more than it expected from the global community. A chance meeting of hospice professionals based in Oklahoma and Germany in the chat room resulted in the organization of an American-German hospice conference last June in Germany, where U.S. hospice professionals shared experiences with their German colleagues.

The chat room also was the site of hospice care via the Internet. According to Moore, an Australian woman living in a remote area with her dying mother solicited the advice of the hospice professionals who regularly visited the Hospice Hands chat room. The clinicians were able to advise the woman on how to care for her mother and make her as comfortable as possible until her death.

"The usual things that we do in hospice, we did on line," said Moore.

She says her hospice's Web site has become an integral part of the organization's overall strategy to educate the public and referral sources. HNCF's routine campaigns to educate physicians through letters and brochures, for example, also includes invitations for prospective referral sources to visit the Web site. The same is true for donors and others on its mailing list.

More info is needed

Moore would like to see the Web site expanded to include telemedicine capabilities, in which patients in remote areas with computer literacy can communicate with interdisciplinary team members.

As the Internet becomes an even greater source of health care information, other hospice providers will turn more and more to the growing medium to educate referral sources and the public, either through Web sites of their own or by referring people to other sites.

While HNCF represents a responsible information source, one of the biggest challenges will be keeping consumers away from dubious information. The Internet is a vast, unregulated medium. Information about hospice or end-of-life care can range from personal experience to local hospice promotion. According to Nash, most hospice information available on the Internet is good but unorganized.

"Most of what is out there are on-line pamphlets," Nash says "But there is some good information out there."

Web search: The end of life

Here's where to start

Type the phrase "end-of-life" or the word "hospice" into your favorite search engine, and you're likely to come up with thousands of Web pages. Here is a short list of sites that will get you started in your search for information you can pass along to referral sources and the public.

• Growth House.
A nonprofit organization, Growth House is dedicated to providing end-of-life information to the public and promoting global professional collaboration. The site features original articles, a public forum, and an on-line bookstore. The address is www.growthhouse.org.

• Hospice Association of America.
An arm of the National Association of Home Care, the nonprofit trade association of home health providers, the hospice association provides general consumer hospice information. For professionals, the site includes listings for educational opportunities and industry news. The address is www.hospice-america.org.

• Hospice Foundation of America.
This nonprofit organization's site provides general information about hospice as well as guidance in choosing a hospice. The site also features a story page where people can share their hospice experiences with other visitors to the site. The address is www.hospicefoundation.org.

• Hospice Net.
A nonprofit organization that operates exclusively on the Internet, Hospice Net provides information and support for patients and their families facing life-threatening illnesses. The site features articles for patients on a wide range of topics, including pain management and the dying process. For caregivers, there are articles regarding support, legal matters, and bereavement. The address is www.hospicenet.org.

• National Hospice Organization.
The largest trade association of hospice providers offers professional information to its members and general hospice information for the public, including access to a database of hospice providers, both NHO members and nonmembers, to aid in a person's search for hospice care. The address is www.nho.org. ■

What separates the good sites from the mediocre ones is the organizations' commitment level — the addition of new articles, attention to the length of time between updates, and the services they offer to visitors, such as chat rooms or hospice searches.

Become a better judge

So how can hospice care professionals discern the good Web sites from the not-so-good ones? Moore and Nash suggest using the following checklist:

❑ **Look for established hospices and organizations.** Start with the "About Us" section. Find out how long the hospice has been in business and make a judgment in context with the information they are providing. You can't go wrong with established organizations such as the National Hospice Organization.

❑ **Look for sites that update information regularly.** Web sites normally show the date they were last updated. There is no specific rule as to how often, Moore says, but the articles should reflect the latest available information. "There's a lot of information on end-of-life issues, and things are ever-changing," she says. "They should keep up with them."

❑ **The site should be monitored by someone with a clinical background.** For example, Nash is a nurse by profession whose responsibility as Webmaster includes making sure the information presented is accurate.

❑ **Look for links to other sites.** This shows a willingness to share information and not operate in a vacuum, Moore says.

❑ **Look for the hospice philosophy.** Sites should promote hospice and clearly establish its philosophy and goals. Sites that do so not only educate people on what hospice is, they also dispel what it isn't, including false notions that hospice speeds up the dying process.

Still, to many hospice administrators, the Internet is a low priority compared with the everyday demands they face.

"Someone might ask, 'Why do you bother to dedicate so much time to your Hospice Hands Web site? Does anything concrete ever come out of it?'" Nash says. "The answer from Berlin, Germany, is a resounding, 'Yes.'"

(Editor's note: Hospice of North Central Florida's Hospice Hands World Wide Web site can be found at www.hospice-cares.com.) ■

Creative grieving goes a long way with adults, too

Try a remembrance quilt, storytelling circle

Hospice grief work with children often involves play: drawing pictures, cutting out magazine photos, molding clay, and in other creative ways describing, shaping, and displaying sadness over the loss of a parent or relative.

There's no reason for hospices to limit this type of creative grief work to children, because adults also need creative outlets for expressing grief, says **Sherry E. Showalter**, MSW-LCSW, a bereavement coordinator with the Hospice of Northern Virginia in Arlington. Showalter spoke about creative grief at the Arlington-based National Hospice Organization's annual symposium in Dallas last November.

"With hospice work, we try real heard to reach the children by giving them permission to play, and I thought, 'I wonder if we as adults have become too civilized for such things?'" she says.

Learning to grieve

She decided to see if adults in her weekly grieving group would be open to creative activities. So Showalter, who is an Eastern Band Cherokee, asked them what they thought of this quote from Ohiyesa, a Lakota tribe Native American from the 1800s: "As a child I understood how to give, how to be open. I have forgotten this grace since I became civilized."

The group's members, who ranged in age from 20s to 80s, started to laugh slightly. Encouraged, Showalter began to suggest they use creativity in their grief. "I told them how as adults we have been taught to treat people, grieve, and get into new relationships," she says. "And what's wrong with our society is we don't know how to play because grief is a solemn occasion."

She provided crayons and construction paper and asked the adults to draw their grief, showing what it looks like and what was troubling them. To help create the mood, she put on some Native American flute music.

"One woman will always stand out in my mind because she picked black construction paper and drew with a red crayon a heart with a break in it," Showalter recalls. "This is really profound, because these are people who have not picked up crayons since they were children."

Since that initial experience, Showalter's hospice group has engaged in a variety of creative grief activities. Here are a few of her suggestions:

- **Make a book of loved ones.**

Showalter's group meets each week, and participants often talk about their loved ones who have died. But while other group members can share their grief, they didn't know the person who died. So Showalter decided to have the group make a photo album with photos of the group's loved ones.

Each member brought in 20 photographs and passed them around to each other, sharing anecdotes as they looked at the pictures. The exchange increased the group's intimacy, Showalter says. "They felt like they had gotten to know the person instead of just hearing stories."

After that meeting, the group put the photographs in an album so the pictures could be shared with new members.

- **Create a remembrance quilt.**

Remembrance quilts consist of large fabric squares that people can design in any way they choose to show something about the life of the person they love and miss. Showalter worked on a remembrance quilt that was started four years ago with 13- by 13-inch squares. Each square was hung on a separate dowel, and the center square had a rose in it with the words, "We continue to care." Each section had nine squares, which could be hung on a hospice's conference room wall.

Creating a quilt

A remembrance quilt is a terrific creative activity for adults, even those who don't know how to sew, she adds. They can use glue and a variety of materials to create the scene they want to show. And while the quilters worked on their pieces at a group session, they told marvelous stories, Showalter says.

Not everyone wants to make a quilt section in a grief group, so Showalter gave members the option of working on them at home and bringing them in. Some people even mailed their quilt sections anonymously.

There was one square Showalter will never forget. A woman created it in memory of her husband, who had loved the beach, which they visited regularly. First, the woman made an angel of cotton, with a wooden head and a halo. On the

square, she depicted the beach by gluing sand onto the fabric and fashioning a tiny chaise lounge from bits of fabric and toothpicks. She hung a little cane, representing her husband's walking stick, on the back of the chair and put some doll-size glasses on the seat. Since they had always brought the cat to the beach, she took a little hair from the pet, made it into a ball, and glued it on the beach scene so the cat also would be represented there.

Then she placed the angel — representing her husband — a little above the square, as though he were looking down at the ocean and beach scene. She topped off the square with some little wooden disks on which she wrote her husband's name, her name, and how many years they had been married, then she framed the square with colorful beads. "Then she handed me a tube of the beads and said, 'Sherry, you are now the steward of this quilt square, and here's the beads in case any of these fall off,'" Showalter says.

• Use a crumpled facial tissue to spur grief discussions.

One universal thread when you lose someone you love is that at some point you find their crumpled tissue. It's fascinating how that tissue takes on the deceased person's memories, Showalter says. When her own grandmother died, Showalter received her grandmother's jacket, and inside its pockets were several crumpled tissues.

Showalter's grief groups often discuss the tissue symbol, and perhaps while teary-eyed and using a tissue themselves, members discuss different memories they have of their loved ones. Just holding up a tissue can serve as a catalyst for members to talk about something they miss about their spouse, parent, sibling, or grandparent. And it adds a bit of humor to the storytelling.

Showalter also has found that it takes a special type of hospice professional to listen to grieving adults talk about their sorrow. Sometimes, whether in a support group or at home with the hospice worker, a person will need time to speak about mundane issues before moving to the painful subject of grief. While a symbol, such as a tissue, can help, it might not be enough.

• Write a letter to loved one.

Showalter's groups write in journals, but they also engage in a ritual of penning a letter to their loved ones. They can say anything that remained unsaid when the person died, and they can express their grief and how much they miss their loved one.

Then Showalter added another twist to the ritual. She had group members write a letter from their loved ones back to them. "Your only role is to hold the pen and write what you hear them say," she says.

• Give grieving adults crayons.

Writing might be difficult for some adults, so Showalter also hands them crayons and asks them to color. She also uses crayons as part of a grief circle in which people draw on a big poster board with a wheel on it. The exercise demonstrates that grief is not a straight line uphill, starting at a low point and ending at the top, when the grieving person is "cured" from the pain.

"People lose control over death issues, and the pain of loss is a vulnerable place to be in."

Instead, participants learn as they draw that grief may rise and fall. Showalter asks them to draw their own experience of grief using the wheel, connecting different points with jagged lines. For instance, a person might write some of the grief buzz words, such as denial, acceptance, and anger, and put them at different points, connected by lines that rise and fall like mountain peaks.

"They might draw a triangle with a series of breaks and jags in it, and the lines would intersect," Showalter says. "So you'd ask them how they're feeling, and they'd say, 'I go from here to here and missed all these other places,' or they could go from the top to the bottom, drawing a symbol of their body at the top and their heart at the bottom."

• Create places to keep memories.

Grieving adults can create a memory box to hold their favorite items of memory. They can create them out of old shoe boxes, cans, or other items, or they can use a cedar chest or jewelry box they already possess. "Special things go into it, like a hope chest, only the hope has just changed," Showalter says. "The person you loved died, but the relationship with them didn't die, so it becomes a real journey on how you can continue the relationship in a healthy way."

• Wrap a blanket around for comfort.

Showalter tells grieving adults to use a blanket as a sort of comforter when they're feeling particularly blue. Just like when they were children, and their one favorite blanket or stuffed animal gave them solace when they were sad, a blanket now can provide them with some security.

"We talk about how people when they feel bad want to get under the covers, but you don't have time," Showalter says. "But maybe you just need to give in to the blanket, wrap it up around you and give in to it."

• **Listen to guided imagery.**

Showalter has found that people are very receptive to guided imagery. Guided imagery exercises help put them into a more relaxed and peaceful mood. "Guided imagery is amazing to me because people who say they can't do those types of things are still receptive to it," she says. "I think guided imagery is a ritualistic way to help people."

All that's needed for guided imagery is peaceful music, perhaps light classical, flute, harp, or albums with sounds from the ocean, whales, or birds. Some people have found the repeated sounds of thunderstorms to put them in a peaceful frame of mind. Then a facilitator can read a guided imagery passage or create one in which the listeners are taken down a path to a place of special importance to them. People often visualize the beach, a forest, a favorite spot in their backyard, or some other peaceful image.

Creating opportunities for expression

Showalter says such creative activities give people a chance to express their grief in ways that don't fit in the neat little box society has created for them. Especially for adults who have lost a parent, American society dictates that they must fly home, attend the funeral, grieve briefly, and then get over it and return to their workplace — all within three days time.

Unfortunately, it's never that easy. "People lose control over death issues, and the pain of loss is a vulnerable place to be in," Showalter says. "The more we can allow for expressive interventions in grief work, the more we can say that inside all of us is a kid who may say, 'I'll go outside and play.'"

[Editor's note: For more information about creative grieving, Sherry Showalter has a series of booklets, called Circle of Hope, each selling for $5.50, including shipping. The booklets are "Stepping into Spring and Remembering," "Forgotten Mourners," and "How to Weather the Holidays During the Winter of Your Grief." Contact Showalter at P.O. Box 50451, Arlington, VA 22205, or call (703) 486-0463.] ■

News from Home Care

HCFA rescinds sequential billing, payment policies

The practice of withholding a patient's claim until Medicare has paid the previous month's claim has ended. The Health Care Financing Administration (HCFA) has instructed its fiscal intermediaries to discontinue sequential billing and payment policies for home health claims effective July 1.

The memorandum released by HCFA in April instructed fiscal intermediaries to remove all edits from their claims processing system and to process all claims, despite the absence of a previous month's claim.

"We're glad the industry was able to make Congress realize that sequential billing was putting the squeeze on the industry, said **Scott Lara**, a spokesman for the Jacksonville, FL-based Home Care Association of America.

However, Lara points out that the revocation of sequential billing takes place on the same day 15-minute incremental billing begins. Under the Balanced Budget Act, home care agencies will be required to include a code that will identify the length of each visit in 15-minute increments. ▼

Home oxygen suppliers unfazed by GAO report

Despite a General Accounting Office report submitted recently to Congress that is critical of home oxygen providers, the industry says it has little to fear if the Health Care Financing Administration (HCFA) issues new standards to ensure patient access to home oxygen.

"It's about time that HCFA got around to issuing standards for home oxygen suppliers," says **Erin Bush**, associate director of government relations for the Health Industry Distributors Association in Alexandria, VA. "We have been working toward more realistic standards ever since we held a consensus conference on this issue in 1996."

The GAO study concluded that HCFA has failed to take steps to ensure access to home oxygen, and it recommended that HCFA monitor trends in beneficiary access to various types of home oxygen equipment, restructure the modality-neutral payment, and educate physicians on their right to specify the home oxygen systems.

The GAO also called upon HCFA to establish service standards for Medicare's home oxygen benefit and chastised the agency for not having met this requirement. HCFA has been unable to come up with standards for the home oxygen industry because it has spent much of its resources dealing with other pressing matters, such as year 2000 computer problems.

HCFA, however, has promised to issue standards that would apply to all durable medical equipment within the next few months. ▼

NHO offers grief counseling

In the wake of April's shootings at Columbine High School in Littleton, CO, the National Hospice Organization (NHO) is offering to provide grief counselors to schools and communities struggling to make sense of the shootings that left 15 people dead, including the two teenage assailants.

"As school administrators and civic leaders grapple with how to talk about this tragedy and help people who may be frightened, confused and in pain, hospices offer grief and counseling support at no cost," says **Karen Davie**, NHO president. "We simply want to make local hospice grief experts available wherever they are needed."

The NHO stressed the expertise that hospices have in grief counseling and pointed out that they are also trained to provide grief counseling following community tragedies.

"Whenever there is a situation where people need our help, we want to be there to lend a hand," Davie says. "Whether it is in Colorado or elsewhere, hospices are committed to making sure that its bereavement services are available for all who need them." ▼

HFA brochures offer help for dealing with grief

The Hospice Foundation of America (HFA) has released a series of educational brochures to help people deal with grief better in the workplace, at school, and in worship communities.

COMING IN FUTURE MONTHS

- Aiding the transition from home care to hospice care
- Get ready for hospice cost reports
- Volunteer programs: A look at some shining examples
- Meet your fund-raising challenges

The *Living with Grief* series, which includes *Living with Grief: At Work; Living with Grief: At School* and *Living with Grief: At Worship* was developed in conjunction with HFA's annual national bereavement teleconference, Living with Grief: At Work, At School, At Worship, which was broadcast to more than 2,300 communities in April.

The brochure series offers straightforward advice and basic guidelines for dealing with grief. For example, the *At Work* brochures addresses situations involving a co-worker who has been diagnosed with a terminal illness and how employees can cope with the news. It illustrates grief from the different perspectives of the diagnosed employee, his co-worker and his supervisor.

The brochures were written by Kenneth Doka, PhD, senior consultant to the HFA. They were written for the layperson but are targeted to hospices conducting community outreach programs and community education.

To order the brochures, which cost 50 cents per copy, call HFA at (202) 638-5419 or order via HFA's Web site at www.hospicefoundation.org. ▼

Faxed CMNs can initiate payment

The Health Care Financing Administration now says durable medical equipment suppliers can use faxed certificates of medical necessity (CMNs) to initiate billing to the Medicare program as long as the original documentation is maintained.

In addition, HCFA has instructed durable medical equipment regional carriers (DMERCs) to lift any restrictions that prohibit suppliers from communicating with physicians using cover letters. Cover letters had been the source of confusion when one DMERC restricted their use last year.

According to HCFA, a written order must be sufficiently detailed and must include the patient's name, a description of the item, a physician's signature, and all options and additional features. Also, the date on the written order of the CMN should be the date on which the physician signed the written order. ■

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