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Documentation issues can lead to long-term improvements

JCAHO's top five Type I's include clinical staff lapses

Most providers dread the microscopic inspection a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) review brings. Hospices are no different. They spend months preparing and breathe a sigh of relief after the reviewer has left.

Whether your hospice is preparing for review and is focused on meeting specific standards or whether you've recently gone through the process, it's easy to use the review as an exercise rather than a process that will lead to long-term quality improvements.

According to JCAHO data from surveys completed in 1998, the most common Type I recommendations were:

1. **Standard LD.7** — Defining hospice services in written contracts.
2. **Standard IM.9.20** — Documenting medication, and medication allergies and sensitivities.
3. **Standard TX.2** — Obtaining and updating physician orders.
4. **Standard HR.6** — Assessing, maintaining, and improving the competence of staff members.
5. **Standard IM.9.13** — Maintaining proper documentation of care planning activities in the patient record.

On the surface, lapses in these standards may not seem like much. Your hospice may do a good job of checking medications and communicating with physicians about changes in patients' care plans. But the culture of hospice has caused many to place less emphasis on making sure these items are documented.

"If you ask staff, they would probably say they could care less about Joint Commission accreditation," says **Karlene Conrad**, RN, director of hospice for the Hospice of Northern Virginia in Falls Church, VA. "Hospice nurses are more concerned with meeting the needs of the patient than with meeting regulations. As an organization, however, we believe Joint Commission accreditation is critical. We need it to get contracts."

Mary Labayak, MSW, president and chief executive officer of the Hospice of the Florida Suncoast in Largo, FL, says this attitude is partly based on understandable reasons. Hospice standards are more akin to

home health than to hospice care. Because of home health's formalized infrastructure, many home health nurses moved into hospice care to escape the growing focus on items not directly associated with patient care. But Labayak points out that hospices must now begin to break down this culture that shows contempt for paperwork.

"If paperwork is better, care is better," Labayak states. "Obviously in this environment, you have to do both care and paperwork."

Documentation reminder

Just because documentation-related standards are common Type I recommendations does not mean that hospices are not performing necessary duties, such as care planning. But from reviewers' perspectives, if there isn't a written record, the tasks never occurred. From the broader quality perspective, proper documentation allows for better interdisciplinary communication and helps avoid unnecessary mistakes.

The top documentation issue, according to the Joint Commission, is the keeping of medication information. Nearly 27% of hospice organizations surveyed last year scored 3, 4, or 5 on Standard IM.9.20.

The drill is common. Hospice nurses question patient and family about medication the patient is taking — both prescription and over-the-counter — and check the home for other drugs they may have inadvertently excluded. With changes in physician orders, nurses note the update in prescribed medication and dosage. Yet, the observations and changes communicated to the nurse fail to find their way to the patient record.

Peggy Pettit, RN, vice president of patient and family services for Vitas Healthcare Corp. in Miami, blames the volume of data that nurses must collect, which is made more difficult because they are working off a handwritten system.

According to Pettit, Joint Commission reviewers cited Vitas' approach to this problem as a good example of how to keep up documentation of medication use and changes over time. To begin, Vitas stresses diligent medication checks. After every visit, nurses are told to check medication and determine compliance with prescribed medicine and include results on a medication chart.

Next, each time a change is made to the medication record, the change is entered into a central computer. This allows other disciplines or shifts to have access to the patient's latest medication information.

"Human error is the reason why documentation doesn't occur," Pettit says. "Automation helps reduce human error."

While automation can help, nurses must still be accountable for making the updates and documenting changes, says Conrad. In order to ensure proper documentation, hospices must step up a process of checks and balances to promote proper behavior and modify poor documentation habits.

Conrad describes this process as a chain of accountability that begins with the nurse who must ask the patient and caregiver about medications and prescription compliance. The next link in accountability chain is a clinical manager who needs to diligently monitor nurse behavior and offer remedies for those who consistently fail to meet documentation standards.

At Hospice of Northern Virginia, a review of each patient's medication is done every 14 days during interdisciplinary team meetings. If there is a discrepancy between medications currently being taken and those noted in the patient record, the clinical manager is responsible for working with the staff member to bring him or her into compliance. But Conrad admits that bringing staff into compliance after years of relaxed documentation can be difficult.

"It can be a real struggle because it is a culture problem," she says.

Keep updated physician orders

Another common documentation problem is failing to keep updated physician orders. Physician orders change regularly, as doctors react to the changing condition of the dying patient. Often, these changes are made verbally with a written order expected to follow.

However, in the course of treating the patient, nurses often forget to follow up with the physician and get a written order. Or perhaps the written order is received but not placed in the patient record.

"The biggest mistake is that because we work with standing orders, [nurses] forget to put new orders in the chart," says Conrad.

Both accuracy and timeliness are issues providers must be concerned with when it comes to physician orders, says Pettit. Across the hospice industry, providers are having difficulty getting their nurses to not only keep a complete collection of physician orders, but also update the orders in a timely fashion.

The same problems are also seen in clinical

staff's documentation of care planning activities, which include communication with physicians and interdisciplinary meetings or discussions regarding patient care planning.

According to both Pettit and Conrad, the best way to ensure compliance is routine audits of the patient charts and routine inservice training to stress the importance of this task.

At Vitas, hospice managers conducted inservice training that included clinical staff input. Management stressed the importance of keeping an accurate and updated patient record. But rather than impose solutions that originated from management, staff are asked to help solve the problem by coming up with suggestions to improve the documentation process. "This way you get immediate buy-in from the medical staff," Pettit says.

The most successful way to achieve organizationwide compliance is audits. "The things you check on is what people will follow up on," Conrad observes.

The audit process introduces both team and individual accountability, adds Pettit.

Document staff competency

Nurses at the Hospice of Northern Virginia are subject to several levels of audits. The first is a self-review of their own documentation. The second level involves the clinical manager who conducts spot reviews of selected charts looking at each provider's performance. The third level is performed by the organization's quality improvement team, which calls for a review of 10% of each region's charts.

In order to facilitate behavior change, clinical staff must receive individual feedback from audit results. At Vitas, clinical staff who exhibit tendencies to update physician orders and perform other documentation tasks, are given one-on-one direction from their clinical manager. If the problem persists, the employee is placed in a counseling mode where the clinical manager is more directly involved promoting compliance.

"Most get turned around by this point," Pettit says. "Occasionally someone is told to seek another profession."

Type I recommendations are not always the fault of clinical staff. A frequently overlooked standard deals with assessing, maintaining, and improving competence of staff members or at least proving that there is a process to do so. This is a responsibility that falls squarely on management.

"This is so important, because you're getting

more and more critical patients," says Conrad. "You need to show that you have the skills to handle them."

"It's important to ensure competence, especially when you're dealing with staff that are going into the home," says Pettit. "Because no one is in the home to look over their shoulder, you have to trust that they are competent."

Hospice of Northern Virginia holds "skills days" for each of the disciplines involved in patient care. This inservice training has a similar feel to a health fair, with different stations dedicated to specific tasks. Staff members go from station to station to receive training in various competencies, with management documenting each session and noting the worker's ability to demonstrate competency in each task.

In addition, each staff member is required to submit a self-reported skill assessment, where the staff member indicates his or her confidence in performing the tasks he or she has received training. If the staff member indicates that they would like additional training, remedial training is scheduled.

At Vitas, inservice training is also part of maintaining staff competency. In addition to inservice training, there is also a testing component, the results of which are used to document staff competency. The testing begins at the time of hire. After a three-week orientation, new clinical staff are tested for basic skills and asked to fill out a needs assessment, indicating their level of comfort in performing specific skills and whether additional training is needed.

For the rest of the organization, all disciplines are subject to pain and symptom management tests on an annual basis.

All these recommendations have a common theme: Missing documentation does not translate into missing or poor care. Often, clinical staff take on the attitude of "what does it matter if the patient is being treated well." That is the challenge managers will have to overcome if they are going to resolve the documentation problems described above.

To get there, Pettit recommends stressing the importance documentation has in the success of your organization. For example, illustrate the role documentation plays in reimbursement or winning contracts.

"The chart is a picture of what they do and how their peers are going to view their care," Pettit says. "You want it to be as accurate and up-to-date as possible." ■

Home health partnership smooths hospice transition

Hospice Care Inc. places its nurses in home care

The trials and tribulations of your home care counterparts are well-documented. Changes in their payment structure place them in a position to improve continuity of care as they begin moving toward per-episode care.

But change allows for opportunity. Hospices have traditionally suffered from short lengths of stay and struggled to come up with ways to bring patients into its care sooner. Because hospices encounter higher costs in the first few days following admission and in a patient's final days, per-diem payments are often not enough to cover the cost of program introduction at admission and intensive care at the end of a patient's life.

With the move from per-visit payment, home care's incentive is to look at episodes of care with some agencies needing to have shorter stays.

Hospice Care Inc. in Stoneham, MA, may have come up with a solution that helps achieve shorter home health stays and increase hospice stays — using hospice nurses in the home care setting to help facilitate a quicker transition into hospice care.

"For the first time, home care has an incentive to control the patient stay," says **Kate Colburn**, MA, executive director of Hospice Care, a home hospice provider. "[Home care agencies] need to have shorter stays. This complements hospice, which wants its stays to increase."

Reducing money problems

With its median length of stay at 14 days and its average length of stay 41 days, Hospice Care's dwindling length of stay is typical of the hospice industry. The two most intensive periods of care — program introduction and patients' final days — were overlapping, eating up more money than their Medicare per-diem payment provided.

According to Colburn, if the new program is successful, it will increase their median length of stay to 20 days and may reduce the hospice's dependence on donated funds.

To reach its goal, Hospice Care fashioned an arrangement with a local home care provider that calls for the home care agency to subcontract a hospice nurse to provide home health care to the

agency's patients on a per-visit basis. The hospice/home care nurse — aside from delivering visits on behalf of the home care agency — can help educate patients and their families on the benefits of hospice.

The process begins at the assessment stage, held during home care admission. Patients admitted with potentially terminal illnesses are cared for by Hospice Care nurses, who are paid on a per-visit basis.

By using a hospice nurse in a home care setting, the patient is given the opportunity to forge a relationship with a nurse that could potentially carry into the hospice setting, says Colburn.

One of the struggles hospices face in order to increase length of stays is an unwillingness to move into another health care segment out of fear of losing the special relationship the patient has forged with members of the home care team, Colburn says. The prospect of a new care discipline and a new set of caregivers, no matter how comprehensive or compassionate, can be unsettling to those who have come to rely upon the care and kindness of the home health providers.

"Patients don't want to lose the two people that they have developed a close relationship with," Colburn says. "Once they move into hospice, they continue their relationship with their home care team and gain new members through the interdisciplinary team, each of which sees the patient for assessment."

Putting the model to work

To further promote the continuity of health care providers, Hospice Care will also subcontract the home health aide from the home care agency to provide services after the patient is referred to hospice.

"This way, they don't lose the two people that they have developed a close relationship with. When they are readmitted to hospice, they gain the additional members of the hospice [interdisciplinary] team," says Colburn.

Although the model encourages earlier home health care discharge into appropriate hospice care, one home health provider sees this arrangement as an improvement in patient care more than an arrangement that enhances efficiency.

"This is about improving continuity of care, enhancing care, and sharing skill sets," says **Patricia Demers**, RN, MS, MPH, executive director of Winchester Home Care in Winchester, MA.

Winchester Home Care is the first home care

agency to sign an agreement with Hospice Care to share nurses and home health aides.

While Colburn sees her model as being one that can be adopted by most hospice and home care agencies across the country, she admits that it isn't as simple as it sounds.

To begin, Colburn says the transition model should be implemented by a hospice and a home care agency that already have a solid working relationship. Aside from the obvious reason of trust and collegiality, those that already have a track record can use past experiences to determine which home care admissions call for the use of a hospice nurse.

"What hospices ought to do is focus on one or two [home care] organizations that they are comfortable with," Colburn says, "and start with specific types of diagnoses, such as cancer."

How to make the partnership work

Although both hospice and home care agencies have worked well in the past, the Hospice Care model requires both sides to enter the realm of their colleagues and understand the demands and constraints of their partners.

In order for the partnership to work, clinical workers on both sides must be trained in home care and hospice requirements. Although clinical care will not vary too widely, documentation and required forms for reimbursement will.

For that reason, hospices nurses must undergo training and orientation in home care documentation and become familiar with the home care agencies' required forms for reimbursement.

On the other hand, home care personnel must be trained to spot cases that have the likelihood to lead to hospice care. To facilitate the learning process, Colburn recommends sharing local medical review policies (LMRP) with their home care partners so they have a clear understanding of what Medicare and their fiscal intermediaries require before a patient can be referred to hospice.

The hospice and home care agency will likely rely on experience to show which patients have the potential to be moved into hospice care. A review of charts will often reveal a pattern. Certain diagnoses will more often lead to hospice referral than others. Sharing LMRPs with the home care agency will help them better prepare for admission and trigger the use of a hospice nurse to facilitate an earlier referral to hospice care.

Hospice nurses and home health aides are

required to participate in 16 to 21 hours of orientation training, where they learn the clinical policies and procedures of the organization they will be working for on a contractual basis. As part of the training, each is familiarized with the required paper work of each organization and schooled in proper documentation.

The element of cross-education and sharing skills is what attracted Demers to the Hospice Care model.

"If you have someone who works in hospice and can teach it, it will be easier to sell. Hospice is hard to sell, especially to physicians," she says. "Hopefully, we can help people understand. When I think of programs like this, I think of the Peace Corps, where you teach people how to be successful."

The elements of cross-education and sharing skills are what attracted Winchester Home Care to the Hospice Care model. Still, Demers warns that the model is not for every patient that is identified as a potential hospice referral.

"But for specific patients," she says, "the transition in hospice care will come earlier and provide additional resources and counseling."

Offering options

Although both sides are providing services to the other, there is no exclusive arrangement, especially in the area of referrals. It is important to note that hospice nurses educate patients and families about hospice care prior to hospice admission; education includes providing a list of all hospices in the area, allowing patients to choose from a number of providers that include Hospice Care Inc.

For now, the Hospice Care model is an experiment. Colburn says she hopes to collect a year's worth of data to track the length of patient stays and measure improvement in continuity of care.

Beyond the numbers, however, Hospice Care and Winchester Home Care hope to prove that despite the challenges facing both their industries, partnerships like theirs can address the needs of all their customers, including the patient, Medicare, and each other.

The patients benefit because they are given information and choice about hospice when their condition makes hospice care appropriate. They are transferred in a manner that does not interrupt the care team they have grown to trust. Medicare is served by moving the patient

along the health care continuum appropriately.

Ultimately, hospice and home care learn more about each other as they strive to create a seamless transition for their patients. ■

Alzheimer's volunteers help supply respite care

In-home care provided despite absence of admission

Providing hospice care to Alzheimer's patients has always been a challenge to hospices. The problem in clearly identifying the terminal phase of "six months to live or less" has kept many deserving patients from hospice care.

Hospice Atlanta, a division of the Visiting Nurse Health System that serves 26 counties in metropolitan Atlanta, is no different. In addition, the demand for Alzheimer's care is so great, patients are placed on a waiting list and often die before even being admitted into its Alzheimer's care program, which includes both home health and hospice components. It is a problem that can only be solved by changes in federal requirements that would allow more patients and money to flow into the program, which allows for sliding fees to accommodate impoverished families. As it stands, the program's respite care services are paid for through donations.

"We are totally dependent on benefactor money to run the program," says **Talya Bloom**, RNC, director of the Alzheimer's Care Program at Hospice Atlanta. "As it stands, we can only handle 20 to 25 families at a time."

Rather than shrug its shoulders and accept the realities of Medicare regulations, Hospice Atlanta found a way to meet a portion of Alzheimer's patients' needs through a network of volunteers.

With as many 95 patients and their families waiting to get into Hospice Atlanta's Alzheimer's program, officials there believed they could at least provide respite care, resource referral, and track patient progress by using volunteers.

"Every month, the most-often-asked question was whether we provided respite care. Caregivers would say, 'I just need time to get away,'" says **Jolita Wainwright**, volunteer coordinator of Hospice Atlanta's Alzheimer's volunteer program. "The obvious was staring us in the face. The problem was what to do about it."

But without a model, Wainwright had to start

from scratch. From the beginning, she faced three immediate challenges:

1. **Identify the needs of the caregiver.**
2. **Identify volunteers within a close proximity to visit with the patient and caregiver.**
3. **Keep caregivers connected to the community.**

Once a patient is placed on the waiting list, which has an average two-year wait, Wainwright contacts the family to perform an assessment. The family is told of the possibility of volunteer help and asked if they are interested. About one out of three families indicate that they are interested in having volunteers come to their homes, she says.

Although families waiting to have their loved one placed in the Alzheimer's program have indicated that respite care was needed, the types of relief care were not known. For instance, some caregivers simply wanted time to themselves, where they could sit in another room and read a book or sleep, while others needed volunteers to care for a family member while the caregiver ran essential errands.

"I found out that a lot of families didn't want to leave the house," Wainwright says. "Some just wanted time to focus on tasks like cleaning and doing the laundry."

In order to get to the specific needs of each patient, each caregiver is asked to fill out a needs survey. (See survey on p. 83.)

The survey asks about transportation the caregiver needs to places such as church, shopping, and social activities. The caregiver is asked to list the normal dates and times those trips occur during the week.

The survey also queries caregivers about common errands, such as trips to the grocery or post office, and whether they need a volunteer to prepare meals or perform household chores. The survey asks whether patient companionship is needed to give the caregiver a two- to four-hour break. There is a section that asks whether the caregiver needs telephone assistance in the form of assurance or in trying to secure community services and programs.

The survey allows Wainwright to match the needs of the family with the best-suited volunteer. The Atlanta Hospice Alzheimer's volunteer program has about 40 volunteers, all with a variety of skills, availabilities, and restrictions. For instance, some volunteers are clear about the types of patients they are willing to work with,

(Continued on page 84)

Caregiver Survey of Need

Date _____

CAREGIVER'S NAME _____

CAREGIVER'S PHONE NUMBER _____

PATIENT'S NAME _____

PATIENT'S ADDRESS _____

Directions to home _____

Does caregiver want to continue to be on waiting list _____ If no, why _____

TRANSPORTATION

To scheduled/unscheduled appointments _____ To church service _____

_____ Days/times

_____ Address

Shopping _____ Pleasure _____

ERRANDS

(Pick up groceries, post office, pay bills, cleaners, other)

TELEPHONE ASSISTANT

Assurance (how often and best time to call) _____ Help obtaining information (services, programs) _____

COMPANIONSHIP

Staying with Alzheimer's patients while caregiver takes a break (2-4 hours)

Day and time preference

MEAL PREPARATION OR DELIVERY

Once a week _____ When possible _____ Special diet _____ Diabetic _____

HOUSEKEEPING _____ (laundry, vacuuming, general cleaning, spring cleaning)

Volunteer Assigned _____ Date _____

Source: Alzheimer's Care Program, Hospice Atlanta.

while others have work and family obligations that limit their availability.

“From this, I fashion the lengths of time volunteers give respite care, [which is] usually one to four hours,” Wainwright says.

Finding volunteers is No. 1 challenge

The next challenge is finding volunteers to fill the specific needs of families. As Wainwright discovered, the abilities and availability of volunteers varied more than the families themselves. Adding to the challenge was recruiting volunteers in outlying areas of metro Atlanta to meet the needs of families in suburban and rural counties.

“It’s still a challenge,” Wainwright admits. “When a new family is added to the list and I ask if they want a volunteer, right off the bat they ask for one.”

Often a volunteer isn’t available right away, leaving Wainwright to search for other resources, such as churches, for initial help. “If there is one thing I’m disappointed with, it’s the response of churches,” Wainwright says.

But where churches have failed, Wainwright has found success in recruiting volunteers in other areas. Most notably, she is pleased with the response she has received from nursing schools in nearby colleges and universities. She has also found volunteers from the Visiting Nurses’ Association.

Training program

Once volunteers have been brought into the program, they are not simply sent into the homes of families to fulfill whatever request they have. Rather, recruitment is just the beginning. Volunteers are subjected to an intense training program that covers a wide range of focus, including a quick education about the disease and rules about their role as a volunteer in the patient’s home.

Volunteer training consists of four distinct parts:

1. Program overview.

Volunteers are introduced to the Alzheimer’s care program and given its history and a brief introduction to the volunteer program. The first part of the training outlines other venues in which patients are cared for, such as day care and home health. By informing volunteers of alternative care sites — such as day care centers — they are armed with knowledge they can pass along to families

looking for additional respite care.

2. Patient and family information.

Volunteers are trained in assessing caregiver needs and getting to know the patient. This helps the volunteer establish a relationship with the patient and captures information that will help clinical staff when the patient is admitted into hospice.

They are introduced to the program’s participant highlight sheet, which prompts them to ask a series of questions about the patient, including where the patient grew up, hobbies, and favorite foods.

“It teaches them to be observant,” Wainwright explains. “We ask them to look around the house for things like pictures. Do they see pictures of family around the house or not? This can tell us a lot.”

Volunteers are trained to look for items that could lead to falls or injuries by using a prevention checklist. The checklist requires volunteers to investigate the bathroom for non-slip surfaces and safety rails.

They also perform nutrition screening, using a form that helps the volunteer to assess functional status. For example, the form asks a volunteer to circle whether the patient is able to cook and feed him or herself; requires some assistance; relies on the caregiver to prepare food; or relies on caregiver to both prepare and feed.

3. Role of the volunteer.

This section of training deals with procedures the volunteer must follow. At Hospice Atlanta, the role of volunteer is described as:

- **Purpose.** To ensure that Alzheimer’s caregivers on waiting lists have access to volunteer support in conjunction with an interdisciplinary team and the plan of care.

- **Policy.** Volunteer coordinator will assess each patient/family for needs that could be met by a trained volunteer. The volunteer, once assigned to a patient, becomes part of the interdisciplinary team, communicating observations made during each visit.

The volunteer respite provider is trained in establishing an initial relationship with the client, establishing trust and learning about the impact they can have on the family. They are taught that trust is gained through positive body language, a war approach, assuring their support of the family, and letting them know that they enjoy the client’s company.

4. Overview of Alzheimer’s disease.

One of the ways to establish a trusting relationship with the client, volunteer trainees are told, is show knowledge of the disease. Part of the training

includes a comprehensive education of the disease's symptoms, diagnosis, and treatment. Volunteers are schooled in the progression of the disease, problem behavior, and bereavement.

The disease education begins with a brief description of the disease along with statistics, including the cost of caring for an Alzheimer's patient.

They learn that Alzheimer's is a long process with three distinct stages of dementia that can last a dozen years. As volunteers learn more about the disease, they will come to understand

basic principles involved in caring for patients with the disease, treating each patient with respect and dignity, and that creativity is necessary in caring for an Alzheimer's patient.

The creation of a volunteer program to complement the Alzheimer's care program has been critical to Hospice Atlanta's efforts to serve patients and their families, even if they have not been admitted into the program.

"It's a way to keep in touch with them and provide them with the resources they need," says Bloom. ■



Surviving the new hospice cost report takes diligence

Reports could lead to payment changes in the future

The Health Care Financing Administration (HCFA) recently released the final version of the hospice cost report. That means hospices whose fiscal year begins in the next few months will have to begin gathering cost data.

According to HCFA officials, it will take 176 hours to fill out the year-end report is. Hospices who begin preparing now and adopt changes in the data collection to mirror the cost report will save time filling out the forms and go a long way toward eliminating costly errors.

Over the next few months, Hospice Management Advisor will provide helpful advice from experts in the field on how to cope with this new requirement.

By **Teresa R. Craig, CPA**
The Hospice of the Florida Suncoast
Largo, FL

Future reimbursement for hospices may be seriously affected by the new hospice cost report, but it will not affect current reimbursement.

However, Tom Hoyer, director of the Office of Chronic Care and Insurance Administration for the Health Care Financing Administration (HCFA), stated that he hopes the new reports can be used in setting pricing for hospice care in the future. On Feb. 18, 1998, Hoyer said he wants the report to

"validate and perhaps establish new rates."

HCFA officials have also said the agency is trying to get an idea of how much it costs to provide care to evaluate whether hospice rates are appropriate, questioning whether the nature of care has changed so much that current reimbursement is no longer appropriate reimbursement.

Most of us agree the current rate structure is no longer adequate. We must work to provide the data to support a more equitable reimbursement formula in the future. The Balanced Budget Act of 1997 provided for hospice rates to increase by the hospital market basket less 1% through the year 2002. Because reimbursement after 2002 may be related to current cost reports, hospices must provide accurate data.

The report must be filed for hospices with fiscal years beginning on or after April 1, 1999. Most hospices will be affected later this year when their next fiscal year begins. The report is due five months after the fiscal year ends. The first reports will be due Aug. 31, 2000. Few reports will be due before November 2000 because most hospices will begin fiscal years in July or later. It will be important that hospices complete and file their reports on time. Medicare will withhold payments if the report is incomplete or late.

As with most cost reports, there are three basic elements:

- 1. Trial balance with adjustments for Medicare allowable expenses.**
- 2. Allocation of overhead costs.**
- 3. Apportionment of costs by payer source and reimbursable vs. non-reimbursable costs.**

This breakdown of hospice costs is somewhat different from current hospice practices. Included in patient care costs are nursing, social work, counseling, home health aide, homemaker, spiritual counseling, and other. Education costs will be reported as part of Line 39, "Other hospice

service costs, other.”

Volunteer service coordination is reported in the general service cost centers. Non-reimbursable services include bereavement programs, volunteer service coordinations, fundraising, and non-hospice programs. We believe the non-reimbursable portion of volunteer service is any payment to volunteers for their services. It will be important that hospices can show their costs clearly in their trial balance and report any adjustments necessary to provide correct reporting.

Hospice programs that are part of an agency that already prepares a cost report, such as a home health agency or skilled nursing facility, will begin preparing schedules related to their hospice program in the home health or skilled nursing facility cost report. For example, if a home health cost report is prepared, detailed hospice schedules will be included in the home health cost report. Regardless of size of the hospice program, the hospice will always become part of other cost reports already being completed. Hospice schedules should mirror those in the hospice cost report.

The report provides these worksheets and attachments:

- **WORKSHEET S-1.** Hospices will provide data on days of care by reimbursement source, average length of stay, and days by level of care.
- **WORKSHEET D.** Here, hospices will have these summarized costs:
 1. **Total cost for all levels of care.**
 2. **Unduplicated days of care provided to all hospice patients.**
 3. **Average cost per day — 1 divided by 2.**
 4. **Unduplicated Medicare days and average Medicare cost.**
 5. **Unduplicated Medicaid days and average Medicaid cost.**
 6. **Unduplicated days of care for Medicare hospice patients residing in an SNF and average SNF cost.**
 7. **Unduplicated days of care for Medicaid hospice, patients residing in a nursing facility and average cost.**
 8. **Other unduplicated days and average cost**

for those days.

9. Total days of care.

Other forms include the balance sheet, which will be reported on **Worksheet G**; the statement of changes in fund balances, which will be found on **Worksheet G-1**; and the adjusted statement of patient revenues and net income, which will be found on **Worksheet G-2**.

“Medicare” within the cost report refers only to Medicare patients and the days of care provided while those patients had a valid Medicare Hospice Election. Statistics for those patients not under the election who are cared for should be included with statistics for days of care paid for by other payers. “Other” includes patients not making the hospice election under Medicare or Medicaid.

Reporting by metropolitan statistical area (MSA) is not included in the cost report. Because of questions and concerns raised by providers, HCFA eliminated separate cost reporting by MSA. This is probably helpful for hospices providing care in multiple MSAs as the detail needed would have been difficult to accomplish. In **Worksheet S-1**, where HCFA asks which county service was provided, the county where the administrative offices are located should be used.

- **ENROLLMENT DAYS — Schedule S-1, Part II.** Programs will have to report days by level of care provided. Although continuous home care is reimbursed by the hour, it will be necessary to report the actual number of days the patient received continuously if at least eight hours of continuous care were provided each day. Unduplicated Medicare days, Medicaid days, and other payer days will be reported by number of days by level of care. In addition, the Medicare and Medicaid hospice benefit days will also be reported separately for patients residing in a skilled nursing facility. Other payer sources are not reported by location of care, only level of care.

- **CENSUS DATA — Schedule S-1, Part III.**

The total number of patients receiving hospice care in the reporting period will be reported based on payer source.

If a patient’s stay overlapped two reporting periods, the stay should be counted once in each

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reporting period. The patient who initially elects the hospice benefit, is discharged or revokes the benefit, and elects the benefit again within a reporting period, is considered to be a new admission with a new election and should be counted twice.

This is different than the reporting we do for our cap computation in which each patient is only counted once as electing hospice care. However, average length of stay by patient includes all time periods under which the election was in place for that patient. All days are combined for the patient within each payer source to determine total length of stay for that patient by payer source. See instructions, page 38-8.

• **WORKSHEET A — Reclassification of trial balance expenses.** Careful review of the definitions and line items for the A worksheets will be important in determining your chart of accounts and changes you may need to make. The instructions on pages 38-9 through 38-16 are details of reporting you will provide. You should review your current chart of accounts and approach to cost allocation with these governmental definitions and requirements in mind. You may wish to share these line item definitions with all accounting staff involved

in cost allocation and expense analysis.

• **Line 10 — Inpatient — General Care, page 38-11.** Costs incurred by a hospice furnishing direct patient care services to patients receiving general inpatient care either directly from the hospice or under contractual arrangement in an inpatient facility is to be included in the visiting service costs section. This means only the direct costs of furnishing routine ancillary services for inpatient general care or the contractual amount paid to another facility will be recorded here. If the hospice maintains its own inpatient beds, these costs include costs of furnishing 24-hour nursing, meals, laundry and linen services, and housekeeping.

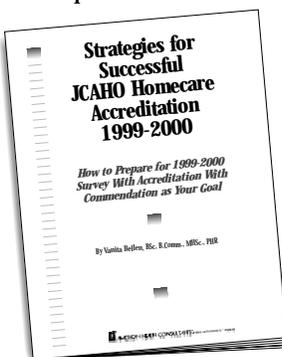
The direct patient care costs for programs contracting with an inpatient facility will be included in the hospices visiting services section.

Some concerns about the cost report include:

1. Hospices have learned to raise enough money to survive on the reimbursement, even though it is inadequate for the full services provided.

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Editorial Questions

For questions or comments, call **Lee Landenberger** at (404) 262-5483.

2. Some programs do not offer all options to their patients. For example, chemotherapy, blood transfusions, and some medications are used to provide pain control and symptom management in many programs. Others have elected not to admit patients using those therapies because their policy states these are not palliative care. This may lead to reporting a wide variety of costs and create confusion when HCFA begins reviewing the reports.

3. Hospices use inconsistent definitions and cost allocations. It will be important that consistent reporting occurs throughout the country.

4. The cost report does not break down costs by level of care. The separation of cost per patient day is only for location of care — whether in the patient's own home or in a nursing home. This appears to support the idea that reimbursement should vary based on patient location.

5. It is unclear how to count patients who move from their own home to a nursing facility or vice versa.

6. The cost per day on Worksheet D will blend costs for all patients. This will result in an inaccurate per diem for Medicare or Medicaid Hospice patients because many insurers do not have hospices provide all of the care related to the terminal illness.

Maybe next time

Hospices should begin making changes to their payroll, income, and expense tracking systems immediately to provide the needed reporting. Tracking will include staff time and other expenses separated by patient residence. Staff will need to report time by patient and program if non-hospice programs are provided. Bereavement and other non-reimbursed services will be separated. Time sheets will need to be detailed for staff that provide both direct patient care and other non-reimbursed services so costs can be allocated appropriately.

Although the hospice community was hopeful the cost report would provide detailed reporting to support the high level of cost incurred by programs, it appears this will be incomplete.

On the bright side, the cost report follows typical cost report formats and will provide an average aggregate cost per day for most program costs. This will give a starting point for more thorough cost analysis in the future. ■

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News From Home Care

Home care trade groups flirt with unifying proposal

Five national home care associations are advancing a unified proposal that would bring legislative relief to the industry. One of the principles contained in the proposal calls for the elimination of the 15% across-the-board reduction, and members of the coalition are confident it has a strong chance of being enacted by Congress.

The five groups that support the proposal include the National Association for Home Care, the American Federation of Home Care Providers, the Home Care Association of America, Home Health Staffing and Services Association, and the Visiting Nurses Association of America. Their confidence, however, comes despite the group not having a congressional sponsor to forward their principles. The group is counting on growing support within Congress that the Balanced Budget Act of 1997 exceeded intended cuts in program costs. ■