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## INSIDE



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# Wellmark adopts new decline policy

*Hospice advocates approve of the less-restrictive language*

Wellmark Inc. has become the first fiscal intermediary to adopt changes within its own local medical review policies (LMRPs) for non-cancer diagnoses, and removed the controversial phrase "rapid decline" in order to make the policies less restrictive and provide better direction for hospice referral or recertification.

Instead of hospices having to prove rapid decline, hospices that submit claims to Des Moines, IA-based Wellmark will simply have to prove a "decline in health status." Under the original language, terminally ill patients who did not meet the strict criteria laid out for specific non-cancer diagnoses would have to document a precipitous drop in the patient's condition in order to admit the patient into hospice or be able to continue the benefit.

But experts pointed out that patients, especially those very close to death, often linger without showing a rapid decline in health. They argued that the language would require hospices to deny access or discharge patients who need the benefit the most.

**Brad Stuart**, MD, hospice physician with Visiting Nurse Association (VNA) and Home Hospice of Northern California and the author of the National Hospice Organization's (NHO) guidelines for non-cancer diagnoses, which became the basis of LMRPs, argued that the original language was too vague. Whether the language would be restrictive depended on how fiscal intermediaries would define "rapid decline." Without a true definition of what constitutes "rapid," interpretation was open to erring on the side that would prevent patients from accessing the hospice benefit or lead to discharge of current hospice patients, he said in the May 1999 issue of *Hospice Management Advisor* **(see cover story)**.

Stuart, along with the NHO, urged Wellmark and other fiscal intermediaries to revise their rapid decline policy to "clinical decline," believing that it would be less restrictive, but would still require adequate documentation on the part of hospices.

After reviewing Wellmark's revised policy for determining terminal status due to decline in health status, Stuart was pleased with the changes.

"All references to 'rate of decline' were dropped," Stuart said. "This is good news, because hospices are not required to drop patients who

are not declining fast enough according to some arbitrary standard."

**Karen Woods**, executive director of the Hospice Association of America, agrees while characterizing the revised policy as a helpful tool for hospices. "It really gives a good education on when a patient can be admitted into hospice," she says. "It's more concerned with looking at how to bring people into the program, rather than being exclusionary."

**Chris Cody**, director of NHO's National Council of Hospice Professionals, says Wellmark's policy represents a good template policy for other fiscal intermediaries (FI) to follow. "All of our concerns seems to be addressed, and this policy seems to be well received by providers as well," Cody says.

Cody was unaware of any other FI that has committed to adopting Wellmark's policy and remarked that others may go in a different direction.

Wellmark's policy establishes requirements to prove changes in a patient's health status based on clinical variables. The FI stresses that because determination of decline presumes assessment of the patient over time, it is essential that both baseline and follow-up determinations be reported, including changes functional assessment staging (FAST), Karnofsky Performance Status or Palliative Performance Score (PPS) / Adapted Karnofsky.

"These changes in clinical variables apply to patients whose decline is not considered to be reversible due to an intercurrent illness or condition," states the policy.

Policy lists these clinical variables, ranking them in order of importance and ability to predict poor survival. Wellmark does not require hospices to prove a specific number clinical variables, but says it would consider the absence of variables at the top of the list as being less predictive of the six months or less of life expectancy.

The clinical variables are listed below in hierarchical order:

- **Progression of disease as documented by symptoms, signs and test results.**
- **Decline in Karnofsky Performance Status or PPS/Adapted Karnofsky.**
- **Weight loss, decreasing anthropomorphic measurements — such as mid-arm circumference and abdominal girth — and decreasing serum albumin and cholesterol.** The weight loss, however, cannot be caused by reversible conditions, such as depression or diuretics use.
- **Dependence on assistance for two or more activities of daily living (ADLs), which include feeding, ambulation, continence, transfer, bathing, dressing.**
- **Progressive dysphagia, which includes documentation that would show difficulty swallowing, is leading to inadequate caloric intake.** Documentation must include a 72-hour calorie count. Criteria can be used to claim rapid decline if dysphagia leads to recurrent aspiration.
- **Low systolic blood pressure.** If patient has a systolic blood pressure less than 90 when prior readings showed systolic pressure greater than 90, this criteria could be used to claim rapid decline.
- **Emergency room visits.** Hospices could show rapid decline if the patient is increasingly visiting emergency rooms for conditions other than those considered minor or self-limited.
- **Functional Assessment Staging for Dementia.** Hospices would have to prove at least one stage of decline in three months with a baseline of no less than 5.
- **Pressure ulcers.** Persistence or progression of Stages 3 or 4 pressure ulcers in spite of optimal achievable care, such as nutrition and debridement.

## *Absence: A good thing*

The clinical variables set forth by Wellmark represent little change from the fiscal intermediary's previously proposed policy. The absence of change in the required clinical variables was seen as a positive thing by Stuart.

"The text is almost exactly what we agreed on during the last conference call with all the fiscal intermediary medical directors," says Stuart. "Wellmark made no additions after our call, and did not appear to want to tighten up policies."

Yet, while the policies were not tightened, hospice providers still must follow strict documentation standards. Failure to document clinical variables to prove declining health could result in the denial of a claim in extreme cases. But the purpose of Wellmark's policy is to monitor hospices whose patients' length of stay consistently last longer than six months. The policy provides direction regarding admission and recertification.

"It is understood that the condition of some patients entering hospice care either stabilizes or improves due to the care received," the policy states. "In such situations, if the patient's condition improves such that he or she no longer meets Medicare's requirement of six-months-or-less life expectancy, and that improvement can be expected to continue outside a hospice setting, then the patient should be discharged from hospice.

"On the other hand, patients in the terminal stage of their illness who originally qualify for the Medicare hospice benefit but stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care."

"Hospices are required to document decline according to the list of clinical variables under 'Indications & Limitations of Coverage,'" Stuart explains. "This is good news for two reasons: a) The list of variables is very broad. For instance, 'progression of disease' could be any sign or symptom of clinical worsening; b) This list can be used by hospice programs as 'prompts' for documentation. Staff no longer has to fish around for categories of evidence to document clinical decline. It would be wise for hospices to develop documentation forms using these categories for reporting decline in interdisciplinary group meetings, progress notes, replies to ADR letters, and other applications."

### *Eliminating vagueness*

The new policy was prompted by complaints since last December about vagueness of the decline language set forth in original LMRP policies. In an attempt to clear up the vague language, Wellmark, one of the largest of the five hospice FIs, set out to draft guidelines for determining terminal status due to rapid decline. **John Olds**, MD, FACP, regional home health intermediary contractor medical director for Wellmark, sent a draft policy of rapid decline criteria to the NHO in December for review.

While hospice advocates had little objection to the policy as a whole, it took issue with the possibility that rapid decline could be interpreted too strictly and that FIs would impose restrictive requirements to prove decline.

In a written response to Olds' draft of rapid decline guidelines, Stuart posed the following scenario plucked right out of a team meeting at VNA & Hospice of Northern California:

An 88-year-old woman whose physical condition has been declining as a result of Alzheimer's. She suffers from dementia, but not enough to qualify under the newly adopted Alzheimer's LMRP criteria. Her fluid and food intake has dwindled to a point where it barely sustains life and she has withered to 69 pounds; but in the last three months, her weight has changed very little. The woman is cared for at home by her husband who is barely able to cope, despite the assistance of a home health aide who visits seven times a week.

Because the woman does not meet the Alzheimer's LMRP requirement and the hospice would be hard pressed to prove rapid decline, she would have to be discharged from care, leaving the husband to provide the care he is incapable of providing.

"We elected to keep her on service because we expect her to die within a month or two," Stuart wrote. "We are able to document *clinical decline* in good faith, but under the draft criteria the patient does not come close to manifesting evidence of *rapid decline*. We would be compelled to discharge this patient, or risk denial of our claim — a claim that on clinical and prognostic grounds is entirely justifiable. The scenario would characterize the majority of end-stage debilitated patients for whom we provide hospice services."

In addition to having to discharge patients, Stuart believed that the rapid decline guidelines would lead to denial of claims in cases where patients who are obviously dying, but fail to exhibit enough decline during a benefit period.

Under Wellmark's new decline policy, the above-described woman can remain under hospice care. The hospice, however, must document each of the clinical variables that apply, but would not be subject to a specific number of clinical variables to qualify their assessment of the patient's decline in health status.

"No number of clinical variables is required to show a patient is declining," Stuart said. "Apparently, only one will be sufficient. For all these reasons, I think Wellmark's version is beneficial to hospice. It should not be difficult for hospice programs to document decline according to these standards." ■

# Successful fundraising requires a strategy

*Build donor base, focus on major contributors*

For hospices, the largess of their community can mean the difference between meeting its annual obligations or swallowing a loss at the end of the year. While hospices depend heavily on fundraising, not all of them are schooled in the art of raising money.

And with the shrinking availability of

government funds, hospices face increased competition from other nonprofit organizations in their communities, raising the need for a well-thought-out fundraising strategy that not only addresses a hospice's current obligations, but positions it for continued community support.

"Any nonprofit wants to be able to control their fate," says **Dee Vandeventer**, MA, president and partner of Mathis, Earnest & Vandeventer, a Cedar Falls, IA-based public relations firm that consults with hospices on fundraising. "Whenever you have just one source of revenue — namely Medicare — that can be cause for some sleepless nights."

Aside from the need to raise additional money to decrease an organization's dependence on Medicare, the need for charitable donations is heightened when you look at the laundry list of things that Medicare doesn't pay for — bereavement care, volunteer and community outreach programs, to name a few.

At Cedar Valley Hospice, the development team faces similar challenges each year and recently committed to building a $1.5 million residential facility, adding to its need for community-raised money.

"What I've noticed over the years has been more and more competition for charitable money," says **Terri Walker**, co-director of development for Cedar Valley Hospice in Waterloo, IA. "Our need for charitable dollars are increasing, but at the same time dollars available are falling."

## *The fundraising pyramid*

Like any successful project, hospice fundraising needs to start with a plan and a core of people — volunteers and staff — who will put the plan in motion. Then set a goal. For hospice, that goal might include the cost of all non-reimbursed services, including community programs that help spread the hospice message. Vandeventer advises that hospices follow these steps:

• **Build a fundraising pyramid.**

The base of the pyramid represents the core of donations, the smaller contributions made by individuals. The tip of the pyramid accounts for the smaller number of higher contributions. Those who do not have an established base of contributors will have to focus on the base of pyramid and increase the number of entry-level donors who will hopefully become higher-level contributors in the future.

Hospices who have a strong base of donors can focus on moving those donors closer to the top of the pyramid by building on their past support and asking for a higher amount.

The trick to meeting your fundraising goal is to decide what amount constitutes major, medium, and small gifts and how many gifts you need at each level of the pyramid. For example, if you need to raise $300,000 and decide that $5,000 or more is a major gift, $1,000 is a medium gift, and $50 is a small gift, you need:

— At least $100,000 from major gifts or 20 people or organizations donating $5,000 each;

— $100,000 in medium gifts, or 100 people or organizations giving $1,000 each;

— $10,000 in small gifts, or 2,000 people or organizations donating $50 each.

Hospices should strive to build a donor base so that it can focus on developing the top half of the pyramid where they can get the greatest return for their effort. "Too often, organizations are spending more time on their low givers," Vandeventer says.

• **Build a fundraising team.**

You want to create a network of people — volunteers and staff — who will join you in asking or money, each of whom can build their own network of givers. The more people and institutions that you get involved in asking for money, the easier it will be to reach your goal.

• **Build a prospective list of potential donors.**

Fundraising is a grass-roots effort. The easiest place to start is the family, friends, and business contacts of each fundraising team member. Each member should think about where their personal contacts fit into the fundraising pyramid — major, medium, or small contributors. They should also look at their contacts' abilities to not only make a contribution, but the contacts' abilities to raise money from their own relationships.

When Cedar Valley Hospice committed to building residential facility, its fundraising team built a list of potential donors that included current donors, past donors, civic groups, and businesses.

Once a list is put together, a hospice is ready to ask for money. There are five basic ways for groups to raise money:

**1. Personal solicitations.**

**2. Fundraising events.**

**3. Sales of goods and services.**

**4. Requests for donations from corporations or foundations.**

**5. Planned gifts.**

Because fundraising can be an overwhelming task, some experts suggest starting out simple. Instead of launching fundraising efforts with an

event, use the simple approach of personal solicitation.

But many hospices have already established events and perhaps rely more on their events to raise money than on personal solicitations. While simple, personal solicitations can be a powerful form of fundraising for hospices.

Cedar Valley Hospice relied mostly on its two events — a bike ride and Christmas tree campaign — to raise money to meet its annual obligations. But when it needed to raise $1.5 million for its residential facility last year, it found it had no choice but go directly to potential donors.

"The experts have always said face-to-face fundraising is the way to go," says Walker. "We were surprised by the response we received."

With Vandeventer consulting Cedar Valley Hospice, the organization raised $1.5 million in seven months, with 90% of its donations being $2,000 or more.

After determining the amount a potential donor was able to give, Cedar Valley Hospice fundraisers asked for that amount, rather than starting at a lower figure then trying to work their way up. Contrary to what many inexperienced fundraisers think, seeking a lower amount you ask for will not significantly increase the number of people who give. It will simply reduce the average contribution and total funds raised.

Because of the personal solicitation success, Cedar Valley Hospice is now considering integrating into its annual fundraising efforts, along with its events and mail campaign, says **Jodi Deery**, co-director of development at Cedar Valley Hospice.

## *Special events*

While personal solicitation is perhaps the most effective means of raising money, so can special events or benefits. But special events can be very time-consuming to plan and execute, says Vandeventer. In addition, the cost could far outweigh the financial benefit.

"It's a great way to the hospice message out," says Vandeventer. "You can get valuable public exposure. There is a downside, however. The amount of time spent vs. the amount raised [is] often inverted."

Also, because most events call for small donations to bring more participants, it is another example of how a hospice can spend more time catering to small donors when it should be concentrating its efforts on medium and major contributors.

Aside from successfully generating money for its annual obligations, Cedar Valley Hospice's events are aimed at re-educating the public about hospice. Events such as its bike ride help remind the public of the programs it offers to both patients and the community.

"In the beginning it was education, education, education," says Deery. "Twenty years later, there are those who don't understand what we are all about and the depth of care we provide."

## *Create ownership*

Events such as those helped by Cedar Valley Hospice also have the ability to bring in new donors — people who otherwise would not have contributed. If the new donor learns about a hospice's programs, they may feel compelled to donate again.

But more goes into cultivating repeat donors than a quick school about the hospice philosophy. Vandeventer urges hospices to stimulate a sense of ownership among their donors.

"People give to people," says Vandeventer. "Sure, they are giving to an organization, but they are giving their money to help others. You need to show them how their money is helping others."

For Cedar Valley Hospice, that task was made simple by the facility's location, which is on one of the city's busiest streets. Donors have watched the facility evolve and will be invited to tour the campus when it is completed.

Cedar Valley Hospice also has programs that must be funded annually. In addition to its patient services, it provides community outreach services, including a youth program that helps children deal with grief.

In order to show the fruits of donors' generosity, Cedar Valley Hospice tries to keep its programs in the public eye, through media exposure and ongoing stewardship. In order to stay in the public eye, the hospice tries to send out at least one press release a month. In addition, volunteers and staff continually keep up with past donors and network with community leaders to cultivate more.

Vandeventer says hospices should offer larger donors a seat on the board to further nurture a sense of ownership. Major donors are often solicited by other charities; by placing these donors on the board, there will likely be a greater attachment to the hospice than other charities that are competing for the donor's money.

Perhaps often overlooked is the need to thank donors. All donors should receive a thank-you

letter, with major donors receiving a personal thank-you from a volunteer or the administrator of a hospice.

Give thanks in a timely manner, advises Vandeventer. "You should plan to give the appropriate thank-you based on the gift."

### *Planned giving*

Aside from recruiting annual donors, hospices should also solicit estates for planned gifts, assets set aside for the hospice upon the benefactor's death.

A planned gift must be evaluated not only on the basis of the impact that it will have upon the hospice, but also how it will be of benefit to the donor. A full-service planned giving program that offers a full range of options to the potential donor is very technical in nature and requires a significant amount of legal expertise on the part of the parties.

Planned gifts fall into these three basic categories: a) Bequests or outright gifts; b) invested funds with the principal going to the charity and the investment income going to the donor or the donor's family; c) Invested funds with the principal reverting to the donor and the investment income going to the charity.

Charitable trusts are generally more complicated forms of planned giving. Depending upon the type of trust involved, the hospice recipient may receive income payments for a pre-determined number of years from a trust. After that period, the assets are returned to the donor. In this case, the income from the trust benefits the nonprofit, and the principal is retained by the donor.

For the smaller nonprofit hospice, some of those more complicated arrangements may be too ambitious. Your organization isn't too small to get started with the simpler options, however. At the very least, consider adding a line to your newsletter stating that you accept bequests. Contact attorneys in your area to let them know of your interest. Start with the simplest options and add others, as you are able. ■

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# Start your paperwork; get ready to file in 2000

Now that the Health Care Financing Administration (HCFA) has made the hospice cost report requirement official, hospices must now prepare for their first filing, which for some will be as early as August 2000.

Despite the illusion of time, hospice leaders need to begin collecting the required data in a way that allows the filing process to go smoothly and efficiently. HCFA has said that hospices should expect to spend more than 170 hours preparing their cost report for filing. Whether a hospice can complete its cost report in less than that, without errors, will depend largely on the organizational changes it makes today.

"The problem I see right now is that hospices don't understand costs," says **William Cuppett**, CPA, partner in the Clarksburg, WV-based Doak, Cuppett & Poling, a home health and hospice consulting firm. "Our concern is that they don't know what HCFA wants."

The need for accurate reporting is important on both macro and micro levels. The importance for individual hospices is that accurate cost reports will enable them to make better business decisions. For the hospice community as a whole, accurate cost reports will enable HCFA to better understand the costs that hospices incur and adjust rates.

"Hospice organizations need to recognize the importance of the cost report," Cuppett says. "The report will provide HCFA with substantial information. This information could be used to modify payment rates, establish provider-specific payment rates, set base years for determining future rates, stimulate future legislation, indicate specific provider problems to HCFA, and much more. We strongly encourage the hospice to take this report very seriously. We have seen how HCFA interprets and uses other cost reports."

Cuppett recommends that hospices do the following to begin preparing:

- **Educate board and management.** This should be the first step in hospice preparation. Management and a hospices board of directors should know about the new requirement, when the first cost report deadline is and the need to begin collecting data, which will affect information systems.
- **Identify management personnel to further promote education.** A hospice should identify individuals who need more detailed education about cost reporting. Determine who will be responsible for the preparation and completion of the cost report, and make those employees

## Collect Data for Cost Centers

***The hospice cost report requires providers to collect costs figures for these categories:***

- **General Services**
  - Capital related — buildings and fixtures
  - Capital related — moveable equipment
  - Plant operations and maintenance
  - Transportation — staff
  - Volunteer services coordination
  - Administrative and general
- **Inpatient Care Services**
  - Inpatient — general care
  - Inpatient — physician services
  - Inpatient — respite care
  - Inpatient — physicians, respite care
  - Inpatient — medical social services
- **Visiting Services**
  - Physician services
  - Nursing care
  - Speech therapy
  - Medical social services
  - Occupational therapy
  - Spiritual counseling
  - Dietary counseling
  - Other counseling
  - Home health aide
  - Homemakers
  - Other visiting services
- **Other Hospice Service Costs**
  - Drugs and biological
  - Durable medical equipment/oxygen
  - Patient transportation
  - Imaging services
  - Lab and diagnostic
  - Medical supplies
  - Outpatient services, including emergency room services
  - Infusion therapy
  - Radiation therapy
  - Other
- **Non-reimbursable Services**
  - Bereavement program costs
  - Volunteer program costs
  - Fundraising
  - Other program costs

responsible securing educational material about cost reporting.

• **Determine changes in financial accounting.** The way a hospice keeps its financial records will likely have to change. These changes should be determined based on not only cost centers identified in the cost report, but also by a hospice's own internal reporting needs.

"You can't design an accounting system just for the cost report," Cuppett says. "Hospices need to be able to use the data for their own purposes to help them make business decisions."

• **Determine data that needs to be collected and the process for doing so.** The cost report is the first place you should look. The report and worksheets are specific cost centers, providing direction in the kinds of data HCFA will expect you to collect. The process a hospice will use to collect the data will largely be determined by its current data collection processes and information system. **(See list of cost centers, above.)**

In addition to the cost centers specified in the cost report, hospices should be prepared to collect additional data for their fiscal intermediary or attach additional information to the provider questionnaire (Form 339). Cuppett advises that hospices create medicare cost report permanent files. The files represent information that requires updating from time to time, rather than the constant accumulation of data required for cost center data. They should include:

— organizational documents;
— chart of organization;
— job descriptions for all key personnel;
— square footage for each facility utilized, reflecting the dimensions of each room, each room's use, and cost center classification of each room;
— identification of all related parties;
— copies of all long-term debt agreements;
— copies of all non-cancelable lease obligations;
— capitalization policy;
— copies of all patient service contracts, such as nursing, physicians, hospitals, and nursing homes.
— standard charge structure and prices.

• **Prepare interim cost reports.** Because preparing cost reports will be new to some administrators — aside from those who may have experience from other segments — a hospice should consider preparing quarterly cost reports for the first year. This will allow hospices to identify data collection problems and allow time to correct them before the year-end cost

report is filed with their fiscal intermediaries.

One of the areas that hospices will spend a great deal of time in collecting data and preparing the cost report is in the administrative / general cost area. According to Cuppett, the cost report will allow for the election of multiple administrative general cost centers.

Hospice will be allowed to choose from three separate alternatives for handling administrative costs:

**1. Allocation of administrative general costs on the basis of accumulated costs of all managed activities.**

**2. Segregation of administrative general costs into hospice administrative costs, non-hospice administrative costs, and organizational administrative costs.**

**3. Segregation of administrative general costs into multiple categories.**

The first method requires no advance approval, but the remaining two must be approved by a hospice's fiscal intermediary. "It is imperative that the hospice determine the allocation impact of any alternative selected," Cuppett says. "This clearly indicates that the hospice should begin to look at the options available at the earliest possible date." ■

# Choosing best info systems

*Choose one that works with manual processes*

As hospices and their colleagues in the post-acute segment of the health care continuum begin searching for information systems to handle the wealth of data they are required to collect, they will find that the technology has been slow to catch up to industry demands.

Specifically, current systems' reporting capabilities fall short of providers' needs, says **William J. Gardner**, information systems consultant with Lorenz & Associates in Baltimore. Sound reporting capabilities allow providers to determine internal benchmarks from which to base utilization and outcome goals. Those needs are highlighted by pending ORYX outcomes measurement and the implementation of cost reports.

"Capture the appropriate information up front so that you can report benchmarks," Gardner says. "Benchmarking will measure [the] internal progress — or lack of — you are making."

According to Gardner, information systems in this data-intensive era need to be able to link clinical and financial in order to generate reports about:

- **Referrals.** Providers should have a snapshot of where their referrals are coming from — by physician or discharge planner, for example. The more sophisticated the system, the greater the opportunity to drill into the data to report referrals from specific geographic areas, for instance.
- **Admissions.** Information systems should be able to generate reports based on admissions by payer, diagnosis, and ZIP code.
- **Visits.** Providers need to be able to track visits according discipline or cost center as required by the new cost report.
- **Demographics.** The ability to break down patient characteristics by age, sex, geography, and activities of daily living (ADL) can provide added insight into how these factors affect costs and utilization.
- **Discharges.** Tracking discharges and length of stay can enlighten providers about utilization and track cost trends by diagnosis, payer, referring physician, and geography.

### *An efficiency tool*

But an information system that can do all of the above can cost organizations well above $100,000, not to mention the time required to train personnel on its use. Providers also should ask themselves whether the large cash outlay is the worth it; whether the system they are considering can perform up to expectations; and whether the proposed system fits in with the provider's short-term and long-term goals.

For now, providers should focus on systems that will help streamline their organization as well as provide a slew of reports, Gardner says. Before taking the plunge and purchasing an expensive information system, providers need to evaluate their operation. These evaluation steps include:

- **Examining the process involved in moving information through the organization.** If you are a young organization, it's likely that a majority of your information is manually moved through the company. Nurses, billing clerks, and administration all have a hand in putting various pieces of data on forms and patient records and moving them from one department to the next.

Providers need to have confidence that their existing process is solid or understand where weaknesses exist. The term "information system" doesn't necessarily imply automation, either. An information system in smaller facilities might be

made up of a number of manual processes and low-level automation. It is more important to look at how efficient those processes are, than measure by technology, says Gardner. Automation should serve as an aid to enhance efficiency.

"There are probably a lot of manual pieces to this process that will very possibly remain manual," Gardner says. "There is information and work flow that isn't wrong just because it isn't automated. You have to do a work flow analysis to understand what your process is. Fix what's not right."

• **Fix redundancies and inefficiencies.** Among the things that are wrong with many providers' information processes are the existence of redundant tasks that bog its ability to run efficiently. It's very common to find at least two groups doing the same review of the same information, but for different purposes.

For example, a hospice nurse may review orders for frequency and duration of visits to ensure that clinical tasks are being done as planned. At the end of the month, the billing department reviews copies of physician orders to determine what should have been done and match them up to the visits made.

"It's an example of the redundancies that are created," Gardner says. "There are two different groups looking at the same information and asking the same questions, except one is using it for billing purposes and the other is using it for clinical purposes. The answers are the same, but they don't share."

Providers need to also look for information that isn't moving or going where it is supposed to go. Identify the point in the process where information is slowed or fails to reach its destination. The problem can be solved by changing the manual process or implementing automation.

• **Create efficiencies where the opportunities exist.** As mentioned earlier, look first at process improvement as a means of creating efficiency. Then look at automation.

"I enjoy technology for the sake of technology," Gardner admits. "But that's the wrong thing for providers to be doing. It does not make sense to automate everything. It makes very good sense to develop an information system plan and then a technology plan. While most things will eventually be automated, that doesn't necessarily make sense to automate them right now."

• **Create an information system plan that supports your business plan.** With all the challenges facing providers these days, it's likely that most have developed a business plan outlining short- and long-term goals. Information systems technology should help provide solutions to issues raised in the business plan, such as emerging managed care business.

For example, Medicare may represent 80% of a hospice's revenue, with fundraising making up a majority of the difference. If the provider is planning an expansion of its managed care business or moving into other product lines, the new information system needs to address this aspects of the business as well.

"Its goal is to provide information systems solutions to business issues, Gardner says. "The business plan says where you're going. The information system plan says how you are going to get there."

## *Cost-benefit analysis*

After an analysis of information processes, providers should have a clear idea of their information system needs. Now comes the task of weighing cost against the benefits of various information system options. What providers should be willing to pay for, according to Gardner, is good reporting capabilities.

Through accurate reports, providers can gain valuable insight into their utilization and costs and make adjustments to improve patient care and efficiency. "Vendors will tell you that they have custom report writers," Gardner says. "Some do and some don't. It's a matter of how well they work and what their capabilities are. The way I approach this issue is that there are two extremes. On one end, there are information system vendors that have integrated good report writing and querying into their system. On the other end, you have less expensive systems that require you to export the data from your existing information system to a desktop database system such as Microsoft Access."

Purchasing an information system is like any other investment. Providers should weigh the short- and long-term benefits. For example, there are some entry-level systems for $20,000. Based on a provider's long-term plan, spending the least amount can be an expensive proposition three years later when increased patient volume renders the system obsolete. Perhaps spending less serves more immediate short-term goals and the less expensive system provides something to build on over the next few years.

"If you're a small [hospice], you can get into

some automation pretty reasonably," Gardner says. "But also, you're still not so big that you can't handle many of the processes manually on a stand-alone PC using a spreadsheet. That agency needs to look at where it intends to go. Is it going to be a bigger [hospice] in one or two years? If so, now is the time to act; you'd better automate." ■

# Y2K concerns remain despite assurances

Although year 2000 (Y2K) readiness status information on biomedical equipment is available through the Food & Drug Administration's (FDA) clearinghouse, it has not been able to review the claims of manufacturers who say their products are compliant.

Because the FDA has not been able to review test results supporting manufacturers' certifications, there is still a concern that biomedical equipment with date-dependent chips may not work as intended.

In testimony before a House subcommittee, **Joel C. Willemssen**, director of civil agencies' information systems, accounting, and information management division of the General Accounting Office (GAO), told committee members that the FDA and Veterans Health Administration (VHA) have made progress in obtaining compliance information from more than 4,000 biomedical equipment manufacturers.

But there is still some concern, because the FDA has relied only on manufacturers to validate compliance; the agency did not require the same equipment makers to submit their test results. But the FDA and VHA have balked at such requirements, citing that neither agency has the resources to verify manufacturers' test results.

"We continue to believe that [an] organization such as the FDA can provide medical device users with a greater level of confidence that their equipment is Y2K-compliant through independent reviews of manufacturers' compliance test results," Willemssen said. "The question of whether to independently verify and validate biomedical equipment that manufacturers have certified as compliant is one that must be addressed jointly by medical facilities' clinical staff, biomedical engineers, and corporate management. The overriding criterion should be ensuring patient health and safety."

### *Information from users incomplete*

Despite the growing availability of Y2K-compliance information through FDA's clearinghouse, it's not clear how extensively health care providers are using the information, Willemssen said.

The GAO reviewed readiness surveys sent to providers by several federal agencies and found that only a small percentage were aware of the FDA clearinghouse. Only 26% of home health providers responded to the Y2K readiness survey and only 4.7% said their organizations' were compliant. Forty-one percent of nursing homes responded. Of those only 4.2% reported being compliant.

"Because a significant number of health care providers are not responding to Y2K surveys sent by federal agencies and professional associations, the public lacks information on the readiness of providers," Willemssen said. "Such information would help alleviate public concerns about the Y2K readiness of health care providers and the biomedical equipment they use in patient care." ■

# AHA advises against stockpiling of medicine

The latest fear among health care industry experts is that providers who depend on pharmaceuticals and other medical supplies plan on stockpiling their supplies in anticipation of the new millennium.

Concern over suppliers' and distributors' ability to provide uninterrupted flow of medicine

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and medical supplies have led some providers to make larger-than-normal purchases. The American Hospital Association (AHA) is urging providers to resist the temptation to hoard supplies, and is assuring that supply requirements will be met as long as all purchasers stay with their normal buying patterns.

"The prudent, responsible approach to year 2000 (Y2K) materials management is not to hoard or stockpile," says **Jonathan T. Lord**, MD, chief operating officer of the Washington, DC-based agency.

In preparation, however, the AHA recommends providers:

- **Identify pharmaceuticals and medical/surgical supplies are mission-critical for patient care delivery, and the normal purchasing requirements for those supplies.**
- **Develop contingency plans with your suppliers and distributors to support your normal inventory needs for these mission critical supplies; identify any substitute items that can be used; and plan for managing potential supply interruptions.**
- **Expand existing emergency agreements between hospitals to include Y2K.** ■



## News From the End of Life

# Nursing texts short on end-of-life, palliative care

Current nursing textbooks pay little attention to the care of the dying, including pain and symptom management, according to a new study published in the June 1999 issue of the *Oncology Nursing Forum.*

Only 2% of the content contained in the 50 widely used nursing texts in the United States address end-of-life care, yet nurses provide most of the hands-on care for people near death, said the study's author **Betty R. Ferrell**, PhD, RN, a grantee of the Robert Wood Johnson Foundation in Princeton, NJ.

"It's true that care of the dying receives a lot of media attention — partly as a result of the 1997 Supreme Court ruling and the antics of Jack


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Kevorkian — but if we really want to improve the situation, we have to get back to fundamentals," Ferrell said. "We have to be sure we are teaching our health care professionals what they really need to know about state-of-the-art care. Sadly, we are not, as this study shows."

The study reviewed 50 textbooks frequently used in nursing undergraduate schools, including 45,683 pages within 1,750 chapters. The texts were analyzed in depth using an analysis framework with consultation from end-of-life care experts. The findings revealed that only 2% of content and 1.4% of chapters were related to any end-of-life care topic.

The nine critical areas of end-of-life issues examined in the textbook process were: Palliative Care Defined; Quality of Life; Pain; Other Symptom Management; Communication with Patients and Family Members; Role / Needs of Family Caregivers; Death and Dying Process; Issues of Policy, Ethics, and Law; and Bereavement.

Other key findings reported in the Oncology Nursing Forum include:

- **Compared to content regarding non-drug interventions for pain (44 pages), there was far less (25 pages) for pharmacologic interventions for pain.**
- **Quality-of-life issues and role/needs of family caregivers received the smallest amount of coverage.**
- **The pharmacology books reviewed were weak and often had outdated or incorrect information regarding pain and symptom management.**
- **Information about sharing bad news or communicating among interdisciplinary health professionals was lacking.**
- **The issues of assisted suicide and euthanasia were discussed in only 17 texts, with 4 texts devoting only one paragraph to this topic.**
- **Only one text mentioned regulatory barriers to effective pain management.**
- **Overall, 74% of critical end-of-life content was found to be absent from the texts.**

"Our team is hard at work to address the deficiencies noted in the textbook review. We've teamed up with Stephen McPhee, MD, a professor of medicine at the University of California, San Francisco, and held a very successful conference that brought together publishers, authors, and editors to discuss our results. We were heartened by their interest," Ferrell said. McPhee is also conducting a review of medical textbooks with similar results. ▼



# Investigators criticized by end-of life advocates

In the May 1999 issue of *Hospice Management Advisor*, the cover story examined whether overzealous investigators were unfairly characterizing innocent billing errors as fraud and abuse. Hospice experts complained that the federal government's effort has left honest agencies with the burden of defending themselves from investigators bent on finding questionable billing practices.

On its Web site, Last Acts, a Robert Wood Johnson Foundation-funded, nonprofit organization dedicated to promoting awareness about palliative care and other end-of-life issues, made a similar observation.

"Some observers now argue that access to hospice care is being limited by excessive government oversight, namely a three-year investigation conducted by the Office of Inspector General (OIG) of the Department of Health and Human Services into alleged fraud and abuse in the Medicare hospice reimbursement program," said the article.

Critics of Operation Restore Trust said federal investigators' focus on hospice lengths of stay may be part of a larger pattern of punitive oversight of the entire Medicare program. ■