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IN THIS ISSUE

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Demand for hospice climbs, but lengths of stay still low

Figures point to need for better marketing and education

Last February, a respected medical journal published a study that suggested non-cancer patients would be better served if they were admitted to hospice sooner. Days later, the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, released figures showing that a record number of people received hospice care in 2002, yet one-third of hospice patients died within one week of admission.

Hospice research published in the February issue of the *Annals of Internal Medicine* indicated savings of 7% to 17% could be realized for care of patients with aggressive forms of cancer. NHPCO data also revealed that length of service among cancer patients tends to be higher than among patients with other conditions, which improves cost-effectiveness.

"Hospice enrollment correlates with reduced Medicare expenditures among younger decedents with cancer but increased expenditures among decedents without cancer and those older than 84 years of age," researchers concluded. "Future studies should assess the effects of hospice on quality and on expenditures from all payment sources."

Earlier access to hospice care, both for people with cancer diagnoses and for those with non-cancer diagnoses, will bring superior end-of-life care to patients and their families and will improve the cost-effectiveness of hospice care, the NHPCO said in response to the study. Earlier access improves cost-effectiveness by reducing hospitalizations and utilization of expensive curative therapies that may offer little or no benefit to the patient, an NHPCO press release added.

"Hospice has always looked at each patient and family as a unique case requiring an individualized care plan," remarks **J. Donald Schumacher**, PsyD, president and CEO of the NHPCO. "Different illnesses require different services, and associated costs will vary, of course." Schumacher adds that his organization's research "has shown

that for a great many patients, hospice not only saves the health care system money but can also drastically reduce the financial impact for families while bringing them the care they want."

The other significant chunk of data comes from the NHPCO's National Dataset, an ongoing project to track provider and access data. According to the Dataset's latest figures, the nation's 3,200 hospice providers served 885,000 dying Americans in 2002. The record number of patients served represents an increase of almost 15% from the 775,000 people cared for in 2001. More than 80% of hospice patients were Medicare beneficiaries, the NHPCO says.

The Dataset, along with NHPCO's enhanced Family Evaluation of Hospice Care initiative, has been helpful in improving the industry's understanding of how hospices serve the dying and their families, says the NHPCO.

The Dataset also reveals that one-third of hospice patients die within seven days of entering hospice. That means hospices must have sufficient time to develop a sound care plan that addresses physical and psychosocial issues and to establish trust within complex family relationships.

Hospice experts say one- to two-month stays would help avoid costly hospitalizations. Increasing access and length of service are key focuses for the industry these days.

"It's essential that hospices serve patients and families as early as possible. Not only does this maximize the level of care and improve overall quality of life for patients, but it becomes more cost-effective for providers," says Schumacher. "Providing the best possible care is certainly the goal of all hospice care providers; however, an understanding of the cost-effectiveness of hospice is critical as our country faces a demographic shift of older Americans requiring care."

Data underscore need for education

The cost-effectiveness of hospice is not breaking news. In 1995, the landmark Lewin study commissioned by the NHPCO pointed out that for every dollar Medicare spent on hospice care, it saved $1.52. But at about the same time the hospice industry was touting the cost benefits of hospice, the industry also began to notice rapidly declining average and median lengths of stay. The percentage of hospice non-cancer admissions decreased dramatically in the 1990s. The drop in non-cancer admissions has been blamed on problems associated with determining a six-month prognosis for patients with non-cancer illnesses.

The study and NHPCO's Dataset point to the need for better physician and patient education, two areas that have proven to be tough nuts to crack for hospices in general. Specifically, it points to the need for physician education in the following areas:

- proper admission;
- communication with patients and family about end-of-life care options;
- basic hospice information.

Prospective patients need help understanding:

- the hospice benefit;
- advance directives;
- end-of-life care options.

A lack of understanding in any of the above areas amounts to a missed opportunity for hospices to increase patient access and length of stay.

"There is no short-term solution," says **Margaret Clausen**, executive director of the California Hospice and Palliative Care Association

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Target your marketing toward Baby Boomers

Try to convince the decision-makers

Educating physicians about the cost-effective, high-quality care provided by hospice is only half of the hospice marketing equation. Patients are the other half, and in many ways they're a tougher nut to crack.

While most hospice patients are older Medicare beneficiaries, they can be a diverse lot, especially if you account for the fact that their middle-age children may be the decision-makers for medical care.

As the nation's population grows older, Baby Boomers — the proverbial cow making its way down the python's gullet of U.S. health care — will be faced not only with their parents' mortality, but their own, as well.

Boomers have been characterized as a group that is accustomed to being in control. It was the Boomer-aged women who prompted hospitals to rethink their approach to labor and delivery. They demanded more choices and greater power in the process, and changed an industry as a result.

Baby Boomers are poised to change the hospice industry in much the same way. They will watch their parents go through the dying process, and that experience will provide the basis for their own choices regarding end-of-life care. Hospices have every reason to make that experience as good as possible.

According to **Kristen Wolf**, president of Spitfire Strategies, a Washington, DC-based communications consulting firm that helps organizations effect social change, targeting marketing efforts toward health care decision-makers within a family and those who have influence on family decisions can go a long way.

The traditional hospice marketing approach can be summed up simply: "Get the word out." That usually entails producing brochures and videos explaining the hospice philosophy and debunking old myths. At its best, this approach is a rational way of increasing awareness and is perhaps better-suited for people who are not faced with the prospect of death. But it's less effective as a way to reach a middle-aged daughter confronted with the declining health of a parent.

"These are emotional times," says Wolf. "Your marketing cannot be rational."

In other words, brochures or nurses explaining hospice care may not be enough. In a time of crisis, the hospice message will be lost if it is not delivered by a figure of trust. You have to target marketing to those who have an emotional connection to the patient or family. For example, clergy can have a tremendous influence on families in times of crisis.

A targeted marketing approach begins with understanding exactly who you are trying to reach. Look for the gatekeepers, Wolf says. These are the people who are advisors to patients and their families.

Once you determine who your target is — women in their forties, for example, because they are the primary medical decision-makers for elderly parents — ask yourself this question: What motivates this population to seek hospice for a family member? There may be a number of answers, such as guilt, fear of watching loved ones suffer, or dissatisfaction with current medical care.

Targeted marketing is nothing new. It's omnipresent. Just look at the wide variety of television ads. Fast-food companies aim their messages at a variety of different audiences. Cereal boxes are designed to appeal to children because producers know children can affect the buying habits of their parents.

"If you want to grow your customer base, you'll have to target your marketing," Wolf says. ■

in Sacramento. "We're talking about changing culture."

An obstacle to changing physician behavior is that physician memory isn't short enough to forget the days when Medicare questioned a hospice admission if the patient survived longer than six months. A barrier to patient access is the fact that most people would rather not discuss death or dying, even after they have been diagnosed with a potentially terminal illness.

Hospices are aware of the barriers that have inhibited patient access to hospice, and the industry has made attempts to address these problems. Clausen points to her own state,

where hospice-friendly laws have been passed. Lobbying by industry leaders has persuaded Medicare officials to make public statements regarding terminal illness certification, and physician groups are trying to change the culture of their profession.

For instance, Education for Physicians on End-of-life Care (EPEC) has provided train-the-trainer programs to thousands of physicians in the hope that they will encourage better end-of-life care among their peers. EPEC was developed by the American Medical Association and originally funded by a grant from The Robert Wood Johnson Foundation. Northwestern University Medical School now sponsors the project. It is designed to educate physicians on the essential clinical competencies required to provide quality end-of-life care.

EPEC consists of a core curriculum that gives physicians the basic knowledge and skills needed to provide appropriate care for dying patients. The EPEC curriculum consists of four 30-minute plenary modules and 12 45-minute workshop modules that are transportable and self-contained. EPEC teaches fundamental skills in communication, ethical decision-making, palliative care, psychosocial considerations, and pain and symptom management.

"Our experience with EPEC has been that physicians who come get a lot out of it, but change is slow," says Clausen.

Although efforts have been slow to bear fruit, that doesn't mean hospices should wait until change occurs. Clausen says local hospices need to work with physicians in their own communities. She recommends the following:

- Use hospice medical directors to communicate with physicians, because physicians are more likely to accept direction from other physicians.
- Work with local medical schools to bring medical students into your hospice as part of their rotation.
- Conduct routine education sessions on proper hospice admission.
- Work with state and local physician groups to educate physicians about the components of high-quality end-of-life care. ■

Hospice Trends

Donors invest in you; treat them like investors

Show how your program pays dividends

By **Eric Resultan**
Editor, *Hospice Management Advisor*

It may not have been all that long since you launched your 2004 annual campaign. As always, your loyal contributors came through, and you were pleased with the contributions of some new donors. Going forward, the same folks will eventually get a letter asking for money to help fund a capital campaign for a new inpatient facility, or maybe you'll send them an invitation to a special event where you'll try to reach into their pockets again.

As you prepare your next fundraiser, you can't help but think: "How often can we go to the same people year after year, sometimes more than once a year, before they say 'no more'?"

Let's look at why people donate:

- **Gratitude.**

Your hospice helped a donor's loved one. The impact on the life of the patient and his or her loved ones was so great that the donor is compelled to support your mission.

- **Prestige.**

Many donors use their donations to gain prestige and honor in their communities. Contributions to worthy causes are feathers in their caps. Your positive image reflects favorably upon them.

- **Sense of community.**

The donor may not have ever had a loved one in the care of hospice, but he or she may understand hospice's importance to the community. By implication, donors are adopting the hospice mission as their own in the belief that the community cannot do without your hospice.

No matter why donors give to your hospice, a donation is more than a gift. By definition, a gift is something given without any expectation of getting something back in return. Donors, however, do want something in return, whether it's improved hospice care, prestige, or some other commodity. That makes a donation more than a gift; it's an investment.

An investment is the act of acquiring something — property or some other possession — for future gain. This means hospice donors are in

some sense assuming ownership of your program via their donation/investment. And they expect you to make good on their investment by working on behalf of their reason for donating. Those who give out of gratitude expect you to help more people in the same way you helped them and their loved ones through a difficult time; those who donate for prestige want to see the hospice rise in prominence; and those whose charity comes from a sense of community expect measurable benefit to the community.

Failure to make good on your donors' investment will result in divestment from your hospice. Almost as bad as not honoring donors' investment is a failure to communicate the returns your hospice has achieved by means of their donation.

It's been said that saying "thank you" is a small price to pay to each and every donor. But even a heartfelt expression of gratitude may not be enough. Hospices need to do more than acknowledge donors; you need to treat them like shareholders who have invested in the company. This includes being accountable to them and showing them how you've spent their money.

Successful fundraising is all about building relationships with donors, whether they are individuals or major corporations. It has nothing to do with begging for money. Donors want to know what was achieved with their donated money. The most effective way to say "thank you" is a progress report. Donors are less interested in your activities than in the results of your activities.

Proving to donors that you have been good stewards of their money begins long before you accept that first dollar. Your success must be measurable and plainly obvious to your donors/investors, and that takes some planning on your part. When marketing to potential donors, be sure to take the following steps:

- **Establish goals to be achieved by using donor money.**
- **Communicate those goals to prospective donors.**
- **Communicate past successes to them also.**

If you tell donors when you have reached or partially reached the objectives you stated when you asked for the donation, the chances of repeated giving are more likely, even in the same fiscal year.

If we are to view donors as investors, then they should be entitled to the same considerations extended to shareholders of publicly held companies. Each year, for example, donors should receive an annual report that shows the hospice's financial situation: revenue from Medicare reimbursement, fundraising, and other forms of revenue, compared with the hospice's various cost categories.

An annual report, however, isn't just about numbers and figures. It's an opportunity to describe your successes of the previous year, such as new community programs that are not reimbursed but paid for using donated funds. Your annual report should be treated with the same care for appearance and professionalism as any other marketing document. Remember, this report is your opportunity to tell your story and leave a positive impression with your loyal donors, as well as prospective ones.

Another way to communicate donation dividends is through quarterly newsletters. Much like the annual report, the newsletter should provide quarterly financial updates and comparisons to previous years. Use this publication to update donors on goals set for the year. While you want to put a positive spin on things, be honest. If a goal has been difficult to achieve or cannot be attained, say so and explain why.

And now, back to the "thank you." A letter of thanks, preferably from the CEO or president of the hospice, is crucial as a follow-up to a donation. A thank-you letter following the achievement of major goals or milestones also is important because it tells the donor he or she is part of the team, an invaluable partner.

Remember, you are competing for a limited amount of charitable dollars. If you cannot prove donor money is yielding dividends, you will not be able to persuade people to continue investing in your mission. ■

Shrpn yr pncls; abbrev. disapp.'ng

Sharpen your pencils; abbreviations are disappearing

Old habits are hard to break. But the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, is asking home health nurses to break some habits they've had since nursing school.

National Patient Safety Goal No. 2 requires health care organizations to standardize abbreviations, acronyms, and symbols and develop a list

Joint Commission's List of 'Do Not Use' Abbreviations

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, has issued the following list of five abbreviations that should not be used in patient-specific documentation, including discharge or medication instructions.

Abbreviation	Potential Problem	Preferred Term
U (for unit)	Mistaken as zero, four or cc.	Write "unit"
IU (for international unit)	Mistaken as IV (intravenous) or 10 (ten).	Write "international unit"
Q.D., Q.O.D. (Latin abbreviation for once daily and every other day)	Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for "I".	Write "daily" and "every other day"
Trailing zero (X.0 mg), Lack of leading zero (.X mg)	Decimal point is missed.	Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)
MS MSO_4 $MgSO_4$	Confused for one another. Can mean morphine sulfate or magnesium sulfate. Write "unit"	Write "morphine sulfate" or "magnesium sulfate"

Source: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

of "do-not-use" abbreviations. The list includes abbreviations that are commonly misinterpreted and are thus likely to cause an adverse outcome. All Joint Commission-accredited organizations were required to have a minimum list of "do not use" abbreviations in place by Jan. 1 of this year, and they have until April 1 to add at least three other abbreviations pertinent to the organization to the list. **(See lists of required and suggested "do not use" abbreviations, above and p. 43.)**

"Home health agencies are struggling with this requirement more than other areas of health care for several reasons," says **Patricia W. Tulloch**, RN, BSN, MSN, senior consultant with RBC Limited, a health care management consulting firm in Staatsburg, NY. "This requirement significantly affects organizations that have not automated their documentation methods. Our studies have shown that between 40% and 60% of home health agencies still have staff members handwriting patient-specific information such as assessments, chart entries, and patient instructions," she says.

"We also have nurses with an average age of 48, which means they have been using these abbreviations for [more than] 20 years," Tulloch adds. "Use of some of the abbreviations, such as d/c for discharge, is an ingrained behavior for many of these nurses," she explains. "Add the extra amount of writing required when abbreviations can no longer be used, and you've got a real challenge to change the behavior," she says.

The Joint Commission's minimum required list contains five items, and there are seven items on the list of additional abbreviations to consider when expanding the "do not use" list.

"When we reviewed the additional list, we realized that they were all abbreviations we regularly use, so we included all of them, to come up with 12 items on our 'do not use' list," says **Sue Gibson**, RN, director of Midwest Home Health Services in Del City, OK.

The shortness of the list was a positive point that Gibson emphasized when introducing the new requirement to nurses. "Previously, we had a huge list of approved abbreviations that nurses had to flip through, so we promoted the new list as only 12 abbreviations that you have to remember not to use," she said.

Be sure to explain why the change is necessary, recommends Tulloch. "If nurses hear that we have 100,000 deaths each year in this country due to medication errors as a result of illegible writing, they will immediately understand the importance of this change," she says.

Joint Commission's List of Suggested Organization-Specific 'Do Not Use' Abbreviations

In addition to the five abbreviations that the Joint Commission has required accredited organizations to place on a "do not use" list, organizations must add at least three organization-specific abbreviations to the list no later than April 1, 2004. The following list includes seven abbreviations that should be considered.

Abbreviation	Potential Problem	Preferred Term
µg (for microgram)	Mistaken for mg (milligrams), resulting in one thousand-fold dosing overdose.	Write "mcg"
H.S. (for half-strength or Latin abbreviation for bedtime)	Mistaken for either half-strength or hour of sleep (at bedtime). q.H.S. mistaken for every hour. All can result in a dosing error.	Write out "half-strength" or "at bedtime"
T.I.W. (for three times a week)	Mistaken for three times a day or twice weekly, resulting in an overdose.	Write "3 times weekly" or "three times weekly"
D/C (for discharge)	Interpreted as discontinue whatever medications follow (typically discharge meds).	Write "discharge"
c.c. (for cubic centimeter)	Mistaken for U (units) when poorly written.	Write "ml" for milliliters
A.S., A.D., A.U. (Latin abbreviation for left, right, or both ears)	Mistaken for OS, OD, OU, etc.	Write: "left ear," "right ear," or "both ears;" "left eye," "right eye," or "both eyes"

Source: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

Mandatory inservices to explain the list and the patient safety factors involved were presented before implementing the "do not use" list in January, but Gibson's nurses also received a laminated card with all 12 abbreviations that they could place in their clipboard so it would always be available.

Tools like laminated cards are essential to making sure nurses will comply with the requirement, points out Tulloch. "There must be a visual reminder such as the card, signs on the bulletin board, and a flyer to hang above the desk if we are to help nurses remember not to use these abbreviations," she says.

Don't rely on one inservice to get the message across, either, suggests Tulloch. "You must plan to reinforce this lesson in staff meetings, patient conferences, chart reviews, and other inservices," she says.

Monitoring adherence to this policy also is important, especially in these first few months, says Tulloch. "Setting a goal of 100% compliance is unrealistic, so I recommend that an agency start with a goal of 80% compliance and then improve from that point," she says. "Unfortunately, the agencies of which I'm aware have not reached 80% yet," she adds.

"We always review 100% of our records every month during our billing audits," points out Gibson. "We added the 'do not use' abbreviations as another item on the audit tool used by our staff. As our staff members begin to audit the first month's records, they will note who is and isn't using the correction terminology, and we will schedule one-on-one retraining," she adds.

Gibson also has asked the nurses reviewing the records to look for any other commonly used abbreviations that might be misinterpreted. "We are going to use our findings from the first several months of audits to identify any other abbreviations that should be included on the list," she explains.

"It is important not to make the chart-review process result in any punitive actions against nurses," points out Tulloch. "The ideal review would involve a nurse reviewing a chart, noticing an abbreviation that should not be used, then directly contacting the nurse to remind her of the

new requirement," she says. "If the audit and follow-up is peer-to-peer rather than peer-to-supervisor-to-nurse, the process is less threatening," she says. The contact between peers to report an error also should occur immediately so the nurse who made the error can correct her records and stop making the error as he or she goes forward, she adds.

Organizations accredited by the Community Health Accreditation Program (CHAP) in New York City do have to ensure patient records and instructions are legible, accurate, and easily understood, but they don't have to develop a specific list of abbreviations to avoid, says **Harriett Olson**, RN, MNEd, vice president of CHAP.

CHAP standards address these issues in several sections of their core standards that apply to all organizations and in sections that are applicable to home health, she says. "Our surveyors will look for a policy that designates acceptable medical terminology and abbreviations, but we do not issue a list that we require to be used," she says. "We describe the outcome, such as a process to ensure accurate, legible records, and we let the home health agency staff determine the best way to reach the outcome for their agency," she adds.

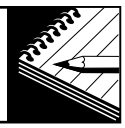
Coordinate list with hospital partners

When evaluating the abbreviations you plan to add to your "do not use" list, or even your list of acceptable abbreviations, be sure to coordinate your list with the hospital with which you're affiliated or the hospitals from which you get many of your patients, suggests Gibson. She explains, "It's common for many home health patients to go from home care into the hospital and back to home. If you make sure you are all documenting in the same manner, the communication between different providers improves, and we ensure safe, high-quality patient care."

(Editor's note: For more information about the Joint Commission requirements, go to www.jcaho.org and click on National Patient Safety Goals in the "Top Spots" section. The web site contains a list of frequently asked questions about the "do not use" abbreviation list and other issues related to patient safety goals.

The Joint Commission also recommends that organizations review a list of dangerous abbreviations relating to medication use that the Institute for Safe Medication Practices has published. That list is available at www.ismp.org.) ■

GUEST COLUMN



Gifts for referrals? Know the law

By **Elizabeth E. Hogue**, Esq.
Burtonsville, MD

Discharge planners and case managers certainly cannot accept cash payments from providers in exchange for referrals of patients. But what about non-cash items that have a relatively low value and that providers are not obligated to provide to case managers? Can case managers accept such items?

The key area that must be considered when answering these questions involves a federal statute that prohibits illegal remuneration, kickbacks, or rebates in Medicare, Medicaid, and other federal and state health care programs. This federal statute makes it a crime for providers to offer to give or actually give anything to anyone in order to induce referrals.

Case managers and providers who violate this federal statute may be guilty of criminal conduct and may go to jail or be forced to pay large amounts of money in the form of fines or civil monetary penalties. They also may be excluded from participation in government health care programs. If case managers are licensed, they also face loss of licensure.

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, the primary enforcer of fraud and abuse prohibitions, has said regulations will be published that will help to define what items of nonmonetary value may be accepted from providers who receive referrals.

Until specific guidance on these issues is provided by the OIG, providers and case managers may be wise to apply final regulations under the Stark laws, even though these laws technically apply only to physicians.

Specifically, the Stark laws indicate that free items of relatively low monetary value are unlikely to cause overuse, if provided within reasonable limits. The regulations further state that as long as all of the following criteria are met, such nonmonetary compensation will not violate the Stark laws:

• The annual aggregate value of nonmonetary gifts does not exceed $300.

• Providers that give nonmonetary compensation must make the same compensation available to those similarly situated, regardless of whether they refer patients to the provider for services.

• The compensation is not determined in any way that takes into account the volume or value of referrals to the provider.

Providers and case managers also should be aware of the following limitations under the Stark laws:

• Protection from violations of the Stark laws is not available for gifts that are solicited.

• The exception for nonmonetary compensation up to $300 only protects gifts to individuals.

At this point, it seems unlikely that the OIG will conclude that case managers received kickbacks and rebates if the requirements of the Stark regulations described above are met. Providers and case managers should, of course, monitor developments in this area, especially because the OIG has stated that specific regulations applying to all practitioners will be published in the near future. ■

Overcoming education hurdles takes innovation

Don't rely solely on books or videotapes

Employees spread over a large geographic area, people who don't like sitting in one place for any length of time, patient visits that don't always follow a "normal" schedule, and a lengthy list of educational classes that staff members must take — these are just a few of the challenges faced by home health managers as they address staff education.

"Home health agencies also use a lot of per diem nurses, so managers find themselves trying to figure out how to pay nurses for required inservices," says **Glenda A. Burke**, RN, owner of Alternatives . . . An Education & Consulting Service in Panama City, FL. "Not only are home health nurses and aides required to obtain a certain number of educational credits to maintain licensure and certification, but the agency also has to ensure that certain topics are presented to meet requirements of accreditation and government regulatory organizations," she says. "This means that managers have to be creative as they plan and schedule inservices."

The switch from cost-based reimbursement to the prospective payment system also has meant a reduction in the number of staff members available to conduct educational programs, says Burke. "Not all agencies can afford an educational coordinator, performance improvement coordinator, or infection control nurse on staff to be able to develop and present courses," she says. Because accreditation and regulatory requirements have focused more on performance improvement in recent years, agencies are beginning to add performance improvement coordinators, and those people can be responsible for coordinating education efforts, she adds.

"Don't expect one person, however, to be able to develop and present courses that meet all staff members' needs," warns Burke. "It takes a lot of time to create a course, and you can't present the same class more than once to any group of employees," she says. For this reason, agency educators should look outside for help from experts on different topics, she suggests.

In addition to education consultants such as herself, Burke recommends that home health agencies tap into resources offered by specialists such as wound care nurses, diabetes educators, and respiratory therapists. "To find experts in your area, talk with other home health managers, check with your local home health association, and look at who is presenting topics at national or regional conferences," she suggests.

"Don't forget to check with your vendors, either," Burke points out. "Many suppliers of wound care or diabetes products offer free educational programs that can address specific needs in your agency," she says. "Some also may include continuing education credits, which is a bonus for your staff members who need the credits to maintain licensure," she adds.

Whether you use in-house staff members or outside instructors to present educational programs, there are a few points to keep in mind to guarantee an effective inservice, says Burke.

• **Make the class interactive.**

"No one looks forward to sitting still for a one-hour lecture," says Burke. The nature of home health means people in the industry are energetic and want to be in control of their schedule, she points out. "You have to find a way to make them enjoy the class, and that means you have to find a way for them to participate," she says.

"In one of my classes on Occupational Safety and Health Administration [OSHA] regulations, I start the class with a demonstration and explanation of some of the safety items OSHA requires for employee safety," says Burke. "After the discussion, I divide the class in two groups and we have a relay race," she says. Each team is given instructions to find items used for certain purposes. Then they have to go one by one to the table and pick up the item. "The first team to successfully find all of their items wins," she says.

Because the interactive component is essential to a staff member learning the material, Burke cautions home health managers not to rely solely upon audio- or videotapes. "If you choose to incorporate a videotape into a class, that's fine, as long as there is a moderator who can comment upon the content of the video and ask questions to make sure the class understands the material," she explains.

• Use real-life demonstrations.

Show students how your lecture applies to their everyday jobs by demonstrating the points you are making in the context of a situation they regularly encounter, says Burke.

In a class on assessments, Burke discusses the need to observe the patient and the patient's environment closely to make an accurate assessment. To demonstrate how nurses and aides can miss an obvious sign of a problem by relying only on answers from the patient or family member or simply following a checklist, Burke has the students assess a "patient" she brings into the class with her. "I watch nurses ask questions about medications, symptoms, and general health, but almost every nurse forgets to ask about or indicate incontinence on the assessment form," she says. "Although the patient doesn't volunteer the information that he or she is incontinent, the patient is sitting on a blue incontinence pad during the assessment demonstration," she adds.

• Choose instructors with the appropriate professional experience.

Don't ask a business manager to talk about clinical issues, says Burke. "A nurse wants to learn from a nurse," she points out. An instructor with a background similar to that of his or her audience can use examples and tell stories from real experiences to make the class more interesting and more applicable to the audience, she explains.

"Home health aides love continuing education, but they want to learn from other, more experienced aides or other home health-experienced staff who understand what the aides do on a daily basis," Burke explains.

Look for instructors who are experienced home health nurses, diabetes educators, wound care nurses, or physical therapists, she adds. "If your staff is attending a class on OASIS, make sure the instructor has completed OASIS forms in the home," she says. If the instructor can't relate to the challenges of working independently and working in a patient's home, the audience can quickly dismiss the information as irrelevant to them, she adds.

• Take advantage of conferences and seminars.

"Too many home health agencies send managers or supervisors to conferences, then never use the information gathered at the conference," says Burke. She recommends that agencies send a number of different employees to conferences rather than the same few managers over and over, and that the agency require the conference attendee to present information from the conference to other staff members as an inservice. She adds, "This approach rewards a variety of employees by sending them to a meeting, and it ensures that the agency gets the most out of its investment by sharing the information with all staff members." ■

News From the End of Life

NHPCO to offer manager program

The National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, has launched a new training program designed for hospice professionals. The Hospice Manager Development Program (Hospice MDP) will not only expand current knowledge but will also provide an intensive training program rooted in hospice values, NHPCO officials said in a press release.

State-of-the-art, hospice-specific tools will be used to develop additional skills for managers to meet today's challenges. The program, the first of its kind, combines the latest innovations in audio

and web-based learning with the benefits of classroom training.

"The presence of learner-focused hospice and palliative care training reflects NHPCO's commitment to meet the demands of hospice professionals," commented **J. Donald Schumacher**, PsyD, NHPCO president and CEO. "With this exciting new program we are responding not only to the current needs of hospice and palliative care managers but better preparing them to assist patients and families. The Hospice MDP is an investment in the future of hospice and palliative care."

Highlights of the program include personal access to national hospice experts, opportunities to achieve three levels of designation, centralized training locations, and the opportunity for past participants to become involved as a trainer.

For more information, call the NHPCO Professional Education Office at (703) 837-1500. ▼

Hospital to pay $9.5M for Medicare billing issues

A hospital in Greenville, SC, will pay nearly $9.5 million to resolve Medicare billing improprieties from 1997 through 1999 in its home health, hospice, and durable medical equipment programs, the Office of Inspector General (OIG) announced recently. The settlement is the largest reached in such cases. Acting principal deputy inspector general **Dara Corrigan** announced the settlement with St. Francis Hospital, which self-disclosed the improper billing.

When purchasing St. Francis in 2000, Bon Secours Health System discovered billing and documentation problems at St. Francis. Bon Secours then launched an internal investigation that revealed "significant error rates and systematic documentation lapses" in St. Francis' Medicare billings, Corrigan says. The hospital brought its findings to OIG under the Self-Disclosure Protocol, which encourages providers to approach the government voluntarily when they uncover evidence of potential fraud and compliance problems in their organizations.

Under the Self-Disclosure Protocol, OIG outlines how providers should investigate and audit compliance problems and how OIG will work with disclosing providers to resolve the situation. Corrigan says St. Francis was subject to much higher penalties than the settlement amount, but because the organization self-disclosed and quickly took corrective steps to remedy the problems, the OIG took a cooperative approach to remediation. ▼

Two-page advance beneficiary notice gone

Throw away the two-page advance beneficiary notice that you've had the option of using since 2002.

The Centers for Medicare and Medicaid Services has said the only advance beneficiary notice it will accept is the single-page notice (CMS-R-296). The form, used to tell beneficiaries they are refusing or reducing physician-ordered care, can be accessed at www.cms.gov/medicare/bni/. Scroll down to Home Health Advanced Beneficiary Notice. You can access the form and instructions for it in English and Spanish. This requirement applies to services ordered on or after Jan 1. ▼

CMS describes HIPAA authorization form

The Centers for Medicare & Medicaid Services (CMS) is offering a preview of a privacy authorization form that includes the core elements and necessary statements required in the privacy rule of the Health Insurance Portability and Accountability Act (HIPAA).

CMS is in the process of developing a standard authorization form for Medicare beneficiaries to use. Although the form will not be available for several months, the program memorandum offers a guide to the elements necessary for a valid privacy authorization.

The core elements of a valid authorization must contain at least the following elements:

- a description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
- the name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
- the name or other specific identification of the person(s), or class of persons, to whom the

covered entity may make the requested use or disclosure;

• a description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when the beneficiary initiates the authorization and does not, or elects not to, provide a statement of the purpose;

• an expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;

• the signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual also must be provided. Although the HIPAA Privacy Rule only requires a description of the representative's authority to act for the individual, CMS requires that documentation showing the representative's authority, such as a Power of Attorney, be attached to the authorization.

The memorandum also includes examples of wording that may be used to place an individual on notice that he or she can revoke the authorization and to inform the individual of the process that must be followed to revoke authorization.

The program memorandum can be accessed on the CMS web site at: www.cms.gov/manuals/pm_trans/AB03147.pdf. ▼

Prescriptions blamed for dependencies

The Waismann Institute in Beverly Hills, CA, has released findings of its 2004 Opiate Dependency Report, which shows that 56% of patients' opiate dependencies began with medication prescribed by their doctors, *NewsRX.com* reported in March.

The findings are based on a survey of patients receiving treatment for dependency on opiates such as prescription painkillers Lortab, Vicodin, and OxyContin, and the illegal narcotic heroin.

"The results of our 2004 Opiate Dependency Report indicate that there is a challenge faced by doctors treating patients in the evolving field of pain management," says **Clare Waismann**, executive director of The Waismann Institute.

"The survey shows how painkiller dependencies often begin with a legal prescription to treat pain, and then the brain unsuspectingly develops a chemical reliance on the drug. These are not people who indulged in recreational drug use to achieve a high."

The Waismann Institute's 2004 Opiate Dependency Report also reveals that 53% of patients who were dependent on a prescribed medication did not ask for assistance from the prescribing doctor to get off the drug after the patient realized he or she was dependent.

The study also found that 14% of dependent patients visited multiple doctors to obtain their drugs. Also, for the majority of dependent patients, the survey results indicated that dependency on prescription pain medication was their only experience with a drug dependency. Fifty-three percent of drug-dependent survey respondents reported they had never experienced dependency issues with any type of illegal drug. ■