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Beyond the cookie jar: Hospice marketing requires a universal strategy

Hospice of the Valley boosts referrals with billboards, TV ads

Hospice of the Valley may not quite be a household name in central Ohio, but it's not from a lack of trying. From billboards to television commercials, residents in the three-county area of Youngstown, OH, are confronted with subject of death, whether they like it or not. Their morning commute into town includes passing by a towering billboard with a simple message absent of any bright colors and extravagant graphics: "We Wish There Was A Cure. Until Then, We're Here."

A television ad extols the benefits of hospice care: striving for the highest quality living possible during the final days and weeks, plus palliative care and an interdisciplinary team approach.

Public libraries serve as information sites where the public can pick up brochures on a host of hospice subjects, ranging from a detailed description of hospice and its interdisciplinary team approach to bereavement resources.

That represents only half of Hospice of the Valley's overall marketing strategy, which also includes programs that educate and promote its services to a broad range of potential referral sources, including nursing homes.

Hospice of the Valley is a typical hospice, experiencing the same challenges that face other hospices around the country, such as reduced lengths of service. Perhaps its greatest challenge was to increase admissions in each of the three counties it serves.

In the year since the hospice adopted its global marketing strategy, admissions have increased in all three of the surrounding counties it serves, including a 50% increase in Columbiana County and a 30% increase in its base, Mahoney County, a market mistakenly thought to have been long saturated.

Hospice of the Valley has also seen its average length of service

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increase, which it credits in large part to its increased marketing to referral sources. Its latest figures show average length of service between 40 and 45 days, compared to an average of 33 days a year ago.

Search for name recognition

Traditionally, hospices' marketing tack has been to use low-key approaches that didn't require the nonprofit organizations from having to reach too far into their coffers. Hospices focused mainly on physicians and hospitals by sending out volunteers to tout the value of hospice and preach the hospice philosophy. Community marketing for many hospices is an exercise in fundraising with some hospice education sprinkled on top.

The marketing strategy now employed by Hospice of the Valley assumes that marketing hospice services in a competitive health care marketplace requires more than a jar of cookies being delivered to physicians' offices and handing out black-and-white brochures at a local health fair.

"We needed to increase our name recognition," says **Karen Hill**, director of marketing for Hospice of the Valley. "We needed a professional marketing approach."

To begin, Hospice of the Valley officials discarded old notions of marketing hospice services. The focus of previous marketing to the community was heavily weighted toward persuading the public to donate money and attempts to educate the public about hospice care were inconsistent. Worse, it was indistinguishable from marketing efforts of competing hospices.

"Our brochures and ads all have a uniform look so that Hospice of the Valley will be easily identified and we made sure we were delivering a consistent message," says **Kimberly Stoffel**, RN, director of community education for Hospice of the Valley.

Yet the marketing approach isn't simply a collection of brochures and television ads. It's

a methodical approach to achieving goals given local market demands. While each market is unique, there are lessons to be learned from Hospice of the Valley's experience:

- **Identify your customers.**

The word "customer" carries a broad definition that includes physicians, as well as their patients. For Hospice of the Valley, "customer" meant potential referral sources, patients, and the community it serves.

Among the list of referral sources were:

- physicians;
- discharge planners at physicians' offices;
- hospital discharge planners;
- hospital-based social workers;
- nursing homes' directors of nursing;
- nursing home-based social workers;
- assisted living facilities' admissions coordinators;
- specialty hospitals' (long-term care programs) case managers.

Home health agencies are conspicuously absent from the list. While Stoffel says home health agencies are likely referral sources for many hospices, their market is unique. The agencies in the market were either too small or owned a hospice of their own.

Nursing homes have always been a tough sell for many hospices. Differences in care philosophy and lack of understanding between the two disciplines have limited cooperation between the two industries. In the Youngstown market, some nursing homes incorporate palliative care as part of in-house services. For those nursing homes struggling to compete, Hospice of the Valley markets its services as a value-added care that they too can market to the public and potential referral sources.

The community is filled with potential customers — from patients to donors to corporate partners. In particular, Hospice of the Valley focused on educating businesses about hospice care. Stoffel and Hill singled out the benefits coordinators of local businesses.

The logic behind the move was to impress upon businesses the need for a hospice benefit as part of their employees' health care plan. Union leaders were also approached. By doing so, union leaders might strive to include the hospice benefit during collective bargaining.

While the idea of identifying one's customers seems elementary, Stoffel says it's easy for hospices to focus on one or two without realizing there are others that need attention. "Up until the time we started looking at who are customers are,

Clarification

In "Can home health nurses provide hospice care?" (April 2000, pp. 37-40), the Rev. Anne Huey is the director of hospice with Family Home Hospice in Philadelphia, a division of the Visiting Nurses Association of Greater Philadelphia. ■

everything was spotty.”

- **Refine your message.**

Traditionally, hospices have used volunteers to call on referral sources. As a result, the message can be inconsistent from one volunteer to the next. Volunteers' lack of clinical knowledge may discourage physicians and nurses from accepting the message, no matter well delivered.

Hospice of the Valley relies on one person, Stoffel, who has a nursing background, to call upon potential referral sources rather than risk the pitfalls of volunteers.

Along with a consistent voice there is a consistent message. “We realized that universally there is a lack of understanding of what hospice is all about,” says Stoffel. “We assumed people knew nothing about hospice, even physicians.”

From physicians to the general public, the message of hospice care is basic, stressing the value of palliative, spiritual, and emotional care. For physicians with advanced knowledge of hospice care, Stoffel states the message as an explanation of hospice care that physicians can convey to their patients.

The message to the public, Hill says, should stress what hospices do best, not why people should donate money. “We’re not in the business of raising money. We give hospice care.”

- **Effective advertising.**

While the message of hospice care is delivered by one person to potential referral sources and specific segments of the community, a more effective way to reach the community was needed. Like many hospices, Hospice of the Valley relied on print advertising and a small amount of television and radio. In addition, hospice representatives attended health fairs to help educate the public.

As hospice officials began formulating their marketing strategy, they re-evaluated their advertising approach. They found print advertising and public appearances at health fairs were not generating a buzz.

Billboards that once were home to Joe Camel and the Marlboro Man became the domain of Hospice of the Valley. Billboards are an effective way to reach a lot of people, says Stoffel. The cost, however, can be prohibitive to cost-conscious hospices.

In order to keep costs down, Hospice of the Valley has pre-emptive agreements with its outdoor advertising company, allowing the advertising company to remove the hospice ad if another customer wants the space. Unlike other hospices that use television to promote their services,

Hospice of the Valley chose to pay for its advertisement time rather than rely on free public service time. “We paid for it because we didn’t want our ads just running at 3 a.m.,” says Stoffel. “We were able to get time during the morning and noon news, and during shows like ‘Touched by an Angel.’ We’ve gotten very good response from this.”

Spend money, make money

“You can get a lot more accomplished in 30 seconds than you can in a print or radio ad,” Stoffel says. “We know these things are working, unlike newspapers ads, where we got zero recognition.”

- **Be willing to spend money.**

Of course, all of this requires more money than hospices have traditionally spent. Hospice of the Valley spent about \$65,000 on marketing and public relations last year.

Another example the hospice’s willingness to spend money is the series of brochures it developed to educate the public and referral sources. Written material in the past was black and white, cheaply produced. Recognizing that its brochures played an important role in projecting an image, hospice set out to create a set of brochures that not only tell its story, but one that easily identifies it.

This is important because those same brochures, available in Youngstown area public libraries, are also given to referral sources. The brochures are expected to influence not only the public, but also referral sources.

“Don’t be afraid to spend a little money,” says Stoffel. “But make sure you’ve pinpointed those area you want to reach.” ■

Florida considers dropping certificate of need

Hospices object to opening markets to competition

Since the 1970s, health care providers in some states have been allowed operate and flourish relatively free from competition. Florida is the latest state to consider lifting barriers to competition by eliminating the certificate-of-need (CON) program. For now, however, intense lobbying by Florida’s hospice industry has led lawmakers to exempt hospices from the proposal to eliminate CONs.

For three decades, some health care providers had to obtain a CON from state authorities before setting up shop or expanding their programs into other areas. In Florida, one of the few states that still require CONs, lawmakers are considering doing away with the regulation in hopes of sparking competition. Competition, proponents argue, will give patients greater choice and force hospices to become more efficient and improve quality.

Not just hospices

The proposal to remove CONs was initiated in January by Florida's Agency for Health Care Administration (AHCA), which oversees state health care policies. The proposed legislative changes not only affected hospices but hospitals, home health agencies, and nursing homes, as well.

But the Florida hospice industry opposed the measure, arguing that if isn't broken, don't fix it. "There's no rationale for the proposal," says **Lynne Mulder**, MS, executive director of the Florida Hospices & Palliative Care Inc., a Tallahassee-based state hospice trade organization. "There is no analysis to show that by removing CONs it will increase access. It may actually limit access."

Through negotiations with state lawmakers, the industry was able have hospices removed from the measure, allowing them to continue operating under the CON requirement.

The certificate-of-need program has determined whether a health care provider can enter a market or expand into other markets. For years, states have limited competition to ensure quality care and financial stability of the providers. But the majority of states have done away with the requirement for a variety of reasons. According to the Hospice Association of America in Washington, DC, only 11 states had certificate of need requirements in 1998.

"It's really a mixed bag as to why states do it," says **Karen Woods**, executive director of the Hospice Association of America. "It allows states the opportunity to screen programs and make sure the market doesn't get flooded. This creates a burden for some states."

The proposed legislation is an example of changing attitudes about health care. Health care providers have long seen themselves as a community service, not a collection of business vying for customers. In some regions of Florida, hospices have been allowed to operate free from competition. Florida officials now want to see

competition in one-hospice regions.

"You should have a choice between at least two," Scott Hopes, director of the Office of Health Policy for Florida's Agency for Health Care Administration, told the *Wall Street Journal*. "I believe in more of an open-market system."

While the original proposal would affect all providers in Florida, hospices would be most affected. Florida has a small number of hospice programs in comparison to the number of patients it treats. In 1995, Florida had about 55,000 hospice patients, which was about 10% of the nation's total. There are 2.66 hospice programs per 1 million in population, significantly less than the national average of 8.62 hospices per 1 million in population.

Given the number of patients and the small number of hospices available, state officials believe patients should be given more providers to choose from, particularly in areas where there is only one hospice program.

And not all hospices agree with Florida Hospices & Palliative Care. Catholic Hospice in Miami has aspirations to expand into neighboring Broward County, which already has four hospice providers. Despite the number of providers in Broward, leaders at Catholic Hospice believe the Catholic community is underserved.

"Competition is not embraced by the hospice industry," Anthony Palumbo, president of Catholic Hospice, told the *Wall Street Journal*.

Florida Hospices & Palliative Care was able to persuade lawmakers to amend the proposal by using the following arguments:

- **Fixed price and fixed customer base are not characteristics of a free market.**

Because payment rates are set by Medicare and Medicaid, and because hospices are limited to serving specific regions, two important components of competition would be impeded. Without the ability to set its own price or expand its customer base, the only alternative would be to reduce cost by eliminating noncore services.

- **Competition would limit offered services.**

Using the certificate-of-need process to determine the entrance of a hospice into a market allows existing hospices to develop their programs beyond the core services mandated by the federal government.

"Hospices have been allowed to grow larger and flourish," Mulder says. "Larger hospices are able to offer additional services that smaller hospices cannot, such as residential care, community grief counseling, and children's grief counseling even in cases

when the deceased was not a hospice patient. Smaller hospices can't do these things because they don't have the efficiencies of larger hospices."

Because hospices must care for a fixed population for a fixed payment rate, hospices would be forced to eliminate additional services and focus only on required core services in order to remain economically viable.

- **Hospice patients are not customers in the traditional sense.**

While competition is based on customer choice, it is wrong to consider dying persons as consumers in the traditional sense because they cannot afford the luxury of a bad choice, the trade group wrote in its eight-page position paper.

"People who are dying are not as prone to shopping around and other health care customers," says Mulder. "Hospice is a community service, not a traditional business."

Rather than assuring quality care through competition, Mulder argues that legislative oversight is needed to protect terminally ill patients.

- **Competition doesn't guarantee increased access.**

By limiting hospices' ability to grow and add additional services, patients' access to services beyond required core services would be adversely affected.

"Unlike other products and services, the number of persons who may choose hospice is determined by God, not by marketing," Mulder says. "Profit incentives should never be allowed or encouraged to top the list in this area of health care."

In addition to having to reduce programs in the face of competition, innovations and program improvements that were once openly shared among hospices statewide would become proprietary secrets of individual hospices.

- **Evidence doesn't support need for change in CON.** Mulder argued that the AHCA would be using hospices and home health agencies as guinea pigs in an experiment with competition. She says the AHCA has not studied the impact the elimination of CON would have. Comparing Florida to other states without CONs is an unfair comparison, she says, because officials from those states likely don't have first-hand knowledge of how hospices are allowed to grow and enhance their services.

"No other state with prior history of hospice regulation, a high demand for hospice services, and established significant programs that provide quality care and access for anyone who desires services, has eliminated CON review for hospice,"

the trade group wrote in its position paper. "Thus, there is no way to make a comparison of what could be the impact in Florida by making a comparison with other states."

A neutral stance

National hospice groups have little comment about Florida's proposed CON changes. The Hospice Association of America, for example, remains neutral on the subject of competition and CON.

"We believe that [CON] is a matter for individual states to decide," says Woods.

David Abrams, senior vice president of the Miami-based Hospice Foundation of America, can see both sides of the debate. The hospice advocacy group does not have a position on the matter.

"On one hand, competition is good," Abrams says. "It's capitalism, the American way. How can that be bad? On the other hand, the problem is the economic environment that hospices are in isn't so good."

There is logic to the assumption that competition makes hospices more efficient and leads to improved quality, he says. But at what cost? Competition could pit small hospices against larger ones, jeopardizing the financial viability of smaller hospices. Consolidation is also a by-product of competition. "Then you're back to where you started," Abrams says.

For Florida hospices, it's now a wait-and-see situation. The Senate proposal is still waiting to be released from committee for a vote and the House has a similar bill awaiting a vote. There is still no guarantee that hospices will be added back to the proposal, Mulder says.

"For some reason, the Agency for Health Care Administration really wants hospice included," Mulder says. ■

Home funerals take root in California

Should hospices add this to their resource list?

In the early 1990s, **Jerri Lyons** got an unusual request from a friend: When she dies, she didn't want her body to be cared for in a mortuary. Instead, she wanted Lyons and her other friends to take her home, bathe her, dress her,

hold the memorial service at home, and have her body cremated.

“Is it legal?” Lyons wondered.

The friend had done some checking and it was indeed legal in California. Her friends agreed and said they would do their best.

In 1994, the friend died suddenly and her friends sought to fulfill her wishes. They were surprised to learn how much paperwork was required to care for the dead at home — everything from obtaining the death certificate to getting a permit to transfer the body from the hospital to the dead woman’s home.

“We took her body home bathed her, dressed her, and took her to the crematorium,” Lyons said. “It was a very moving experience and was life-changing for me.”

Eighteen months later, operating out of Lyons’ Sebastopol, CA, home, Home Funeral Ministry was born, an alternative to traditional funeral arrangements that whisks patients back to the days when family members prepared their loved ones’ funerals at home.

In 1996, Lyons’ first clients were a hospice patient and her husband. Lyons helped the man maneuver through the paperwork needed to bring his wife home for a funeral service and the hospice helped by bathing and dressing the woman after she died. Lyons also provided transportation to the crematorium and the required cardboard casket.

Hospices have long been supporters of alternative treatments for their terminally ill patients — everything from pet therapy to music therapy to art therapy. Lyons, owner and director of Home Funeral Ministry, has found another niche in the business of death and dying.

She has helped spawn a small movement called “home funeral guidance” that advocates — as the name suggests — caring for and memorializing the deceased at home. For an average of \$700 — a bargain compared to traditional funeral home costs — Lyons helps family members plan funeral arrangements, instruct them in how to fill out a death certificate, provide the items needed to keep the deceased at home, and handle the required paperwork.

Family members feel more involved

Beyond providing a lower-cost alternative to traditional funeral arrangements, Lyon’s service helps family members feel more involved in the planning of their loved one’s funeral, it brings about a greater sense of closure for family

members; and empowers dying patients to plan their own funerals.

Since her first case in 1996, Lyons has helped 130 families plan home funerals. “It’s like planning a wedding or anything else,” Lyons says.

Two of those clients were patients of **Phyllis Cimino**, RN, BSN, PhN, hospice clinical supervisor at the VNA & Home Hospice of Northern California in Santa Rosa. “The families just wanted it to be as personal as possible,” Cimino says.

Cimino, formerly a case manager at her hospice, speaks about the service in glowing terms. She recalls the husband who was able to hold his wife’s funeral at the home of a relative who was a park ranger that overlooked the picturesque northern California mountains.

“The family chose [Home Funeral Ministry] over traditional funeral homes because the family wanted to be more involved after the patient’s death,” Cimino says.

Lyons delivered the cardboard casket and family members penned their farewells directly on the casket and decorated it with long, flowing ribbons. The family dressed the dead woman in her favorite clothes. They surrounded her casket with candles and played music for the three days her body lay in state.

“It was tremendous closure for the family,” Cimino says. “I went to the funeral with a social worker and I can’t tell you how moving it was. It was incredible.”

The service had a distinct impact on the husband’s ability to cope with his grief, she adds. “I was invited to the same spot a year later for a memorial service. The husband spoke of the service a year ago and how it helped him feel connected to his wife. For him, it was very healthy.”

Because of the positive experience of the small number of hospice patients’ families that have used Lyon’s service, Home Funeral Ministry is on the hospice’s list of resources it makes available to patients. When patients are prompted by a hospice social worker to discuss their funeral plans, Home Funeral Ministry is offered as an alternative to traditional funeral homes.

“We tell them that there is something new,” says Cimino. “Most people react by saying, ‘Ooh,’ and some ask, ‘Can we do that?’ And then there are those who say right away, ‘That’s what I want.’”

Cimino sees a growing trend of patients opting for at-home funerals and believes this will become a popular alternative, if not for the emotional benefits but because of its cost benefits. “The cost factor is a big reason,” Cimino says. “Because of the state

people are in during this difficult time, many willingly accept the cost of a traditional funeral, but months or years later they question what they got from it.”

But a glaring shortcoming of the service is its lack of industry standards, certifications, and licensure. Unlike their funeral home counterparts, there aren't standards and licenses to help protect the consumer.

Lyons, along with Janelle Va Melvin, a former hospice nurse's aide, formed a nonprofit organization called the Natural Death Project, which is charged with promoting home funeral guidance and developing a certification process for future providers of home funerals. Lyons, who shares co-director title with Melvin, says the certification process will include training programs and a minimum number of hours doing filed work.

In the absence of certification, hospices are left to determine the legitimacy of similar programs based on instinct. Lyons warns that hospices should be wary of providers who are preoccupied with profit. Other than trying to gauge one's motivations for providing home funeral guidance, she is apologetic for the absence of better advice is spotting charlatans in this new industry.

The National Hospice & Palliative Care Organization (NHPCO) neither recommends nor condemns home funeral guidance. But it does recognize that hospices serve as a resource, linking patients and their families to services that meet their needs.

“One of many services that hospice programs provide to patients and their families is serving as a resource,” says **Angela Thimis**, spokeswoman for the NHPCO. “Therefore, it is important that the hospice team keeps on top of the latest offerings of resources in their communities. They would evaluate businesses like the Home Funeral Ministry as they would any other potential resource to make sure that it's reputable, serves the needs of their patients and families.”

Because funeral arrangements are not a typical hospice service, hospices should feel compelled to offer a variety of services available within their community, including services that meets the financial needs of their patients.

“Whether a hospice would get involved in the actual planning of funeral arrangements, it really would depend on the wishes of the patient and family,” Thimis says. “Usually the role of the hospice team is to assist in initiating the discussion, if asked, or assist in identifying resources for the patient and family.”

Cimino was lucky. She had the luxury of knowing Melvin as a hospice worker before Melvin suggested she consider Lyons' service. “We knew their intentions were in the right place,” Cimino says.

Given opposite circumstances, Cimino says she would have to rely on the provider's good faith that they will attend to the needs of patients and their families. VNA and Home Hospice also stresses — as it does with all community services it refers it patients to — that the service is no part of the hospice program and that they cannot be responsible for poor service.

She, too, believes that hints of motivations based on profit are a clear sign to steer clear. “Maybe it's my naiveté, but I hope people won't [use] death and dying as a way to make money,” Cimino says. “For some funeral homes, it seems that way.” ■

News From the End of Life

Study: Physicians who listen can make a difference

People who care for terminally ill patients say that they feel less depressed and better able to cope with their lives when they can talk to a doctor who simply listens to their problems and their concerns about their loved ones, according to a new study.

The study, published in the March 21 issue of the *Annals of Internal Medicine*, is the first study to show that empathetic doctors can help reduce the enormous emotional and psychological burdens shouldered by millions of caregivers — the wives, daughters, sisters, etc. — who provide an array of services for people dying of illnesses, such as emphysema, cancer, Alzheimer's disease, liver disease, and kidney failure.

The study documents the high economic toll that caring for terminally ill patients can take on caregivers — adding to their emotional, as well as their physical stress. And, for the first time, it suggests an effective method for alleviating some of these burdens.

Compassion is a must

Physicians of terminally ill patients who show compassion and empathy to caregivers can make an important difference in their mental health, the

study asserts. Researchers interviewed 893 caregivers of 988 patients. Among the caregivers, 35% said the patients they cared for had high levels of need, including transportation, nursing care, homemaking, and personal care. The data suggested that caregivers for dying patients with high care needs whose doctors listened to them were less likely than other caregivers to be depressed (28%), compared to those whose doctors did not listen (42%). They were also less likely to report that their caregiving responsibilities interfered with their personal lives (32%, compared to 48%).

Nearly half of terminally ill patients with high care needs reported that medical care costs created economic hardships for their families, said Ezekiel J. Emanuel, MD, chair of the National Institutes of Health's Department of Clinical Bioethics at the Warren G. Magnuson Clinical Center and lead author of the study. It is not unusual, Emanuel said, for family members to have to sell some of their assets, take out a loan or mortgage, or obtain another job to pay for a dying relative's medical care.

For the study, terminally ill adults and their primary caregivers were interviewed between March 1996 and March 1997. Patients and caregivers in the study came from six randomly selected cities — Birmingham, AL; Brooklyn, NY; Mesa County, CO; St. Louis; Tucson, AZ, and Worcester, MA. Patients were located by referral from their physicians. The most common illnesses among them were cancer, heart disease, and chronic lung disease. Patients with HIV/AIDS were ineligible for this study. More than 90% of patients were living at home. However, patients who were hospitalized or living in a nursing home or a residential hospice were included in the study.

"These families need help — and doctors can do a lot to provide it," Emanuel said, "This study indicates that doctors have a pivotal role to play by listening better to caregivers and providing them with support at a stressful time in their lives."

The study is one of a series of eight papers in the Commonwealth-Cummings Project on the End of Life, an effort to expand the nation's understanding of the dying experience and finding ways to improve it.

Karen Davis, president of the Commonwealth Fund, said the study also carries important implications for insurance coverage of terminal illness. "The findings of high out-of-pocket costs for medical bills and medications to care for dying patients point to serious gaps in health plan policies," she said. "We need to look at the adequacy

of current insurance coverage in the event of serious illness."

Listening is a challenging role for many doctors, but it has a direct bearing on how patients feel about the quality of their care, the authors wrote. Although doctors are starting to become more aware of end-of-life needs for patients, they might not be as cognizant of the needs of their caregivers, said co-author Linda L. Emanuel, MD, PhD, vice president of the Institute of Ethics at the American Medical Association.

"Caregivers are critical supports for terminally ill patients," she said. "But they are also subject to great stress. Heavy caregiving responsibilities often result in less time with families and friends, conflicts at work, and financial insecurity. Many physicians are not aware of how much they can accomplish by giving family members and other caregivers the opportunity to air their thoughts and feelings about the challenges they face. It can be a huge relief for them, allowing them to pursue their responsibilities with renewed energy. And, in the end, patients benefit when their caregivers feel less stressed."

The researchers said that physicians need more training and education in end-of-life-care, including listening. One effort to provide physicians with the basic knowledge and skills to care for dying patients is an initiative at the AMA's Institute for Ethics called Education for Physicians on End-of-Life Care (EPEC). Linda Emanuel heads the EPEC Project.

"Family caregivers of terminally ill patients are shouldering huge emotional and financial burdens," said Charles Halpern, president of the Nathan Cummings Foundation. "This study provides needed direction for supporting these people. We have a responsibility to care for those who care." ▼

VOA to explore improved prison hospice

Volunteers of America has received a two-year \$251,696 grant from The Robert Wood Johnson Foundation to help establish model end-of-life care programs for inmates confined in the nation's jails and prisons.

"Each year, about 3,000 incarcerated individuals die," **Charles Gould**, president of Volunteers of America, says. "Crowded jails and prisons pose difficult challenges to caregivers who want to

provide end-of-life care to dying inmates. This grant makes it possible for Volunteers of America to partner with other organizations in four demonstration sites to create comprehensive programs that will provide quality care in a prison setting.”

The program, Guiding Responsive Action for Corrections at End-of-Life (GRACE), will incorporate the use of community standards in end-of-life care for prison inmates. GRACE will promote state-of-the-art pain management, education for health and correctional staffs, as well as training to involve inmates as hospice volunteers. The project sites are McCain Correctional Hospital in McCain, NC; Cossackie Regional Medical Unit in Cossackie, NY; Oregon State Penitentiary in Salem, OR; and Federal Medical Center in Carswell, TX.

Volunteers of America is a national, nonprofit, spiritually based organization providing local human service programs and opportunities for individual and community involvement. Volunteers of America serves more than 1.5 million people each year, and provides services to about 50,000 prisoners, parolees, and their families. ▼

Boards urged to take action against poor pain care

The Compassion in Dying Federation has launched a national effort to enlist medical licensing boards in their battle to improve pain care.

According to the organization, which strives to improve end-of-life care, too many people suffer unnecessary pain, and that medical treatment of pain is often deplorable. Medical licensing authorities are key to achieving necessary changes.

Compassion in Dying Federation, which is based in Portland, OR, wrote a letter to Federal State Medical Boards (FSMB) and each state medical board. The letter follows a 1998 letter to the same recipients detailing significant inadequacies in pain care throughout the nation, and concrete steps FSMB and state boards should take to improve pain management.

“Too often, medical boards close their eyes and fail to make physicians accountable for woe-filled undertreatment of their patients’ pain,” says **Kathryn Tucker**, director of legal affairs for Compassion in Dying Federation.

In 1998, medical licensing boards responded by saying they never hear of cases where patients are inadequately treated for pain in their jurisdictions.

In response, Compassion In Dying officials have assisted patients and families prepare formal complaints of inadequate pain care and present them, along with expert opinions, to state medical boards.

In March, the organization announced its second complaint presented to the Medical Board of California (MBC). The complaint involves treatment of a 14-year-old boy hospitalized with excruciating headache pain and treated with placebos instead of real pain medication. The family recently filed complaints with the MBC and the California Board of Registered Nursing.

Compassion For Dying Federation’s first complaint to the MBC — involving 85-year-old cancer patient William Bergman, whose terminal cancer pain went untreated — failed to draw a response from the MBC. But the case received national attention when it featured on NBC’s news magazine, “Dateline.”

Bergman’s family filed suit in California State Court asserting that the lack of pain treatment constituted elder abuse. On a 10-point scale Bergman was complaining of pain ranging from 7 to 10 while in the hospital. Another physician later prescribed pain medication and the patient was discharged to die at home. He died the next day.

The trial was expected begin in March, but has been delayed until November.

“These cases are typical of many we review through our pain management and advocacy efforts,” the letter states. “We know there are thousands we never see. We are working hard to increase the tempo of response to the problems reflected in the stories above.” ■

News From Home Care

Self-disclosure overtaking integrity agreements

Corporate integrity agreements are falling out of fashion in favor of self-disclosure requirements contained in corporate compliance guidelines. The Department of Health and Human Services’ Office of the Inspector General (OIG) announced in March that the size and scope of CIAs would be scaled back in lieu of existing compliance programs.

The shift in focus was revealed in a March 9

letter to HHS Inspector General June Gibbs Brown. To date, more than 4,000 health care providers have entered into CIAs, but their expanding requirements were beginning to annoy providers. Since the OIG has begun issuing voluntary compliance guidelines in various segments of the health care industry, more than 70 health care professionals have disclosed potentially abusive conduct. While a small number, it represents an increase since Brown expanded the program.

Hospices recently were issued compliance guidelines that emphasized the creation of an effective compliance plan, which included a process in which a designated compliance officer oversees the organization compliance program and reports potential billing problems.

The shift from CIAs to compliance guidelines shows the extent to which OIG wants providers to develop effective compliance programs.

“If the self-disclosing provider has demonstrated that its compliance program is effective and agrees to maintain the compliance program as part of the False Claims Act settlement, the OIG said it may not even require a CIA,” said Brown. “In those cases, where in our judgment, it is necessary to require the self-disclosing provider to enter into a CIA, the provider may need to make only limited changes to its existing policies and procedures to meet most of the requirements of the CIA.” ▼

Congress may eliminate 15% reduction in PPS

It seems that home health agencies will be spared the 15% reimbursement reduction that had been a cornerstone of the Health Care Financing Administration’s (HCFA) impending prospective payment system.

In March, the U.S. House of Representatives passed its version of the 2001 budget that included a call to both House members and the Senate to work together to avoid implementation of the 15% reduction in Medicare home health outlays still

scheduled to be implemented in 2001.

Home care advocates seem to believe the tide in Congress has turned after the Congressional Budget Office (CBO) estimated sharp decreases in reimbursement since the implementation of HCFA’s interim payment system. The CBO estimated that outlays plunged almost 45% between fiscal years 1997 and 1999.

“We are getting positive feedback from Congress about eliminating the additional 15% reduction,” said a home health lobbyist.

One of the more promising signs includes House Budget Committee Chairman Rep. John Kasich (R-OH) and House Ways Means Health Subcommittee Chairman Rep. Bill Thomas (R-CA) apparently backing away from their joint effort to include the 15% reduction.

The issue is far from being a foregone conclusion. Rep. Bob Weygand’s (D-RI) amendment to add \$72 billion to the 2001 budget that would have essentially erased the 15% reduction was defeated along party lines. The move did, however, prompt Kasich to promise to discuss the issue further with Thomas. ▼

NAHC details a crowded agenda

The Washington, DC-based National Association for Home Care (NAHC) on April 2 outlined a busy legislative and regulatory agenda as home health agencies enter the final turn leading to the transition to a prospective payment system (PPS) for home health. The update came on the opening day of NAHC’s National Policy Conference in Washington, DC.

NAHC is actively pursuing co-signers for separate bills in the House and Senate that would put the final nail in the coffin for the additional 15% reduction in Medicare home health spending still technically slated for next year. Sentiment has swung decisively against the additional cut but NAHC is not taking any chances.

In the Senate, the Home Health Payment Fairness Act, which would strike the additional reduction, has already gathered 18 original

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co-signers. That bill is being spearheaded by the offices of Sen. Kit Bond (R-MO), Sen. Susan Collins (R-ME), and Sen. Jim Jeffords (R-VT), each of whom chair an important committee. A similar bill is also expected in the House.

NAHC's Theresa Forester also noted several work force issues likely to surface this year. She said NAHC expects a \$1 increase in the minimum wage over a 2-year period. But she added that the average wage for a home care aide ranges between \$7 and \$9 an hour, which is already ahead of the \$6.15 that would be established under the increase. ▼

HCFA names third DMEPOS bidding demonstration site

And the next competitive bidding site for durable medical equipment is . . . San Antonio.

The Health Care Financing Administration (HCFA) announced in March that the Texas City would be the second competitive bidding demonstration for durable medical equipment prosthetics orthotics and supplies (DMEPOS).

The demonstration is set to begin Jan. 1, 2001. HCFA expects to save between 17% and 30% for DMEPOS, based on savings seen from the first demonstration that was launched in October 1999 in Polk County, FL. The two demonstration sites represent two of the three intended demonstration projects. HCFA hasn't announced the site of its third demonstration.

The announcement of the second demonstration site comes despite the objections from the National Association for Homecare (NAH) that objected to another competitive bidding demonstration without first looking at the impact of the Polk County experiment.

According to the NAH, the Polk County demonstration has created numerous problems. In addition, one of the winning bidders has since filed for bankruptcy, causing confusion among Medicare beneficiaries.

The San Antonio demonstration will operate in three area counties and will include oxygen supplies, hospital beds, manual wheelchairs, noncustomized orthotic devices and albuterol sulfate and other nebulizer inhalers.

HCFA says that Medicare allowances for some of those items, such as albuterol sulfate, were found by the Department of Health and Human Services' Office of Inspector General (OIG) to be

three times the supplier's acquisition costs. In addition, OIG says the same drugs can be purchased by mail order and through retail pharmacies for substantially less than what Medicare pays. ▼

OIG questions DMERCs' anti-fraud efforts

Durable medical equipment regional carriers (DMERC) are apparently meeting the objectives established by the Health Care Financing Administration (HCFA) to reduce fraud, but the Department of Health and Human Services' Office of Inspector General (OIG) still questions the effectiveness of DMERC's fraud units.

While the four DMERCs have successfully targeted fraud in many specific cases, a lack of complete information made an assessment of their overall effectiveness impossible, the OIG said. The DMERCs workload data quantified their

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Editorial Questions

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anti-fraud efforts to the OIG; it could not provide data that documented the quality and result of their efforts.

The OIG urged HCFA to require DMERCs to maintain information in their automated information systems that includes complete and accurate documentation on the sources of opened cases and detailed financial information on fraud cases in overpayment status. The data, OIG said, would help facilitate an analysis of both the quantity and quality of the work performed by the DMERC fraud unit.

HCFA administrator Nancy Ann DeParle agreed with the OIG's recommendation, and reported that the agency is currently developing a reporting system that will require Medicare contractors to report on fraud and abuse overpayments. ▼

Medicare error rate in 1999 remains steady

Medicare's fee-for-service error rate held steady in 1999 compared to the previous year, reported Department of Health and Human Services Inspector General June Gibbs Brown.

The 1999 error rate was 7.97%, less than a percentage point higher than the 7.13% error rate reported in 1998, Brown told a Senate Appropriations Subcommittee in March.

According to Brown, HHS' detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 5,223 fee-for-service claims processed for payment during 1999, found that 1,304 claims did not comply with Medicare laws and regulations. Based on the errors, Brown estimated that \$13.5 billion was overpaid nationally, about 7.97% of the total payments made that year.

Unsupported services represented the largest error category, Brown said. Unsupported services totaled \$5.5 billion — \$4.5 billion from insufficient documentation and \$1 billion from claims in which no documentation was provided.

Brown pointed her finger specifically at home health agencies. She said much of the errors were attributable home health providers. She estimated that \$1.7 billion in overpayments was attributable to errors in home health claims. She also pointed out that durable medical equipment providers (\$1.6 billion) and physicians (\$1.1 billion) were also to blame. ■

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