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Hospice chains put pressure on nonprofits to boost services

Hospice industry, like the rest of health care, is growing

In 1975, when the Hospice of Marin in Corte Madera, CA, became the second hospice to open in the United States, no one envisioned a time when hospices would become the standard for end-of-life care—even in profitable chains.

"Our founding ideals were about service and serving people who were dying in a manner that was appropriate, being responsive to their needs, bringing them comfort and dignity, and helping their family stay together as a unit," says **Mary Taverna**, president of the Hospice of Marin Foundation in Corte Madera and chairwoman-elect of the National Hospice & Palliative Care Organization (NHPCO) in Alexandria, VA.

Taverna, who has been with the Marin hospice since it was founded, says she was surprised, shocked, and disappointed the first time she heard that a for-profit hospice chain had set up shop.

"This reaction was short-lived because I learned that this particular national provider was really very invested in the same principles that everyone else who was not-for-profit was interested in," Taverna recalls.

Hospice providers and industry experts say the growth of for-profit chains might be more of a sign that the industry's tide has risen high enough to float all boats than it is a warning of a storm for the nonprofit sector of the industry.

The growth of for-profit and chain hospices is a sign that the hospice industry is now fully developed as part of the health care continuum, says **Jonathan Keyserling**, JD, vice president of public policy for the NHPCO.

"Even though it's a relatively young program compared to other health care delivery systems, it's reaching its late teens to early maturity. There is increasing attention paid to economies of scale and how to grow programs," Keyserling says. "I think that points to consolidation and/or growth in the provider base."

In recent years, the number of for-profit hospices has grown significantly, while the growth in the number of nonprofit hospices has been fairly flat, according to a June 2004 report by the Medicare Payment Advisory Commission (MedPAC) of Washington, DC.

The number of for-profit hospices increased from 706 to 883 between 2001 and 2003, a 25% increase, according to *A Data Book, Healthcare Spending and the Medicare Program*, published by MedPAC in June.

MedPAC also found that the number of not-for-profit hospices increased from 1,340 to 1,384 in that same time period, a 3% rise.

Likewise, the number of freestanding hospices increased by 29% between 2001 and 2003, while the number of hospices based in skilled nursing facilities decreased by 20%, and the number of hospices owned by home health agencies declined by 12%, the report said.

Because of the growth among for-profit hospices, the overall hospice industry grew in size by 8% between 2001 and 2003, rising from 2,266 hospices to 2,454 hospices, the report says.

The report also notes that Medicare spending for hospice care has increased from $3.5 billion in 2001 to $5.9 billion in 2003, a 30% average annual increase.

Expect more growth

"I think what we see today is a lot more growth, and I think the growth in the hospice industry really is no different than what it is in other areas of health care," Taverna says.

"As a long-term veteran in the field and chair of the national organization, what I'm always interested in is what happens to that person at the bedside," she says. "If that person receives quality care and is satisfied with the care received, then whether the care came from a chain or an independent hospice is not the issue."

However, the question many administrators with nonprofit hospices might ask is whether a for-profit chain's entrance into their market could spell problems for their program.

For instance, the Largo, FL-based Hospice of the Florida Suncoast provides $8 million a year in uncompensated service to its community, and its ability to do so is based on the fact that it's the only hospice in the area, says **Mary Labyak**, president, chief executive officer, and executive director of the large nonprofit hospice, which serves 1,800 patients per day.

"We have a unique provider status, and donors support us because we're their hospice," Labyak says.

In Florida, where state law prohibits hospices from having a for-profit status, all hospices provide a wide range of services for their communities, she says.

"We have everything from our own hurricane shelters to food pantries to neonatal programs, and we have hundreds of volunteers, AIDS programs, palliative care, and various other programs," Labyak says.

Fears of 'cherry-picking'

Such independent hospices based on the comprehensive care model quite naturally fear that if hospice chains focusing on the Medicare model were to become dominant players in their area, the existing hospices might suffer from competition that cherry-picks its clients, Labyak says.

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Editor: **Melinda Young**, (864) 241-4449.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@thomson.com).
Production Editor: **Brent Winter**.

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

If many of the patients who have better reimbursement were picked up by chain hospices, non-chain hospices would be left with a smaller proportion of adequately reimbursed clients, making it difficult for them to provide charity care and still meet their bottom lines, she explains.

This trend has occurred in other areas of health care, leading to the closing of hospitals, home health agencies, and other providers, Labyak notes.

In California, where nonprofit hospices like Hospice of Marin have already been forced to deal with competition from chain hospices, this fear has not been realized, Taverna says.

"Competition, while none of us like it, does a number of positive things," Taverna says. "If you're good, it says you need to get better because you're no longer the only kid on the block, and you have to convey to your constituents that you are of the highest quality and have to respond to their needs."

Plus, since the industry relies heavily on Medicare and third-party payers, the pricing is fairly standard, and there's unlikely to be a Wal-Mart effect.

"Maybe a chain has a little more room to do some things where they're absorbing the costs because they're national and have more resources to spread around, but there's not an opportunity to underprice their services," Taverna says.

VistaCare — 14 states and growing

At least one for-profit chain has focused its marketing strategy on increasing hospice's presence overall through gaining clients who otherwise might never have been referred to hospice care.

VistaCare Inc. of Scottsdale, AZ, one of the nation's largest hospice chains, has a presence in 14 states and serves more than 5,300 patients daily, says **David Rehm**, MSW, senior vice president of VistaCare.

The 9-year-old chain initially expanded through acquisitions but now opens new freestanding sites, including three new hospice sites in Georgia and three sites under development in New Mexico, Arizona, and Texas, Rehm says.

The chain will have more than 50 sites when these are all on line, he adds.

"We're the largest provider of what we call 'open access' hospice in the country," Rehm says. "We have a commitment to serving all eligible patients under Medicare criteria, and that's the principal mission driver of the company."

VistaCare hospices admit any patient who meets the basic Medicare criteria of having a life expectancy of six months or less, Rehm explains.

VistaCare bases this practice on the fact that only about one-third of the eligible hospice population receives hospice care, he says.

"As you can tell, on a national basis there's room for continued substantial growth in hospice care," Rehm says.

The hospice company's sites offer consistent services under the Medicare benefit, including nursing care, physician services, social workers, chaplains, home health aides, nutritionists, volunteer services, physical or occupational therapy, hospitalization, respite care, continuous 24-hour care, and bereavement counseling for the family for 13 months after the patient has died, Rehm says.

"We also serve patients anywhere they reside, including nursing homes and retirement communities," he adds. "And one thing we've been doing over the last year to two years is to develop strategic partnerships with other health care provider organizations so we can develop an effective and highly coordinated approach to those settings."

New focus is start-ups

Although the organization began to expand through acquisitions, the strategy now is opening start-ups, where VistaCare more easily can create its own operating model, Rehm says.

Another market penetration strategy is for the company to increase its penetration in a particular area, he says.

For example, VistaCare has developed 10 sites in Georgia that extend the hospice company's reach into areas where there is not a great deal of hospice competition.

"We're not really looking to open sites in markets where we'll go in and attempt to take business away from existing providers," Rehm says. "We really look for areas that are underserved."

Nonprofit hospices that feel market pressure from for-profit chains also need to find ways to increase their community stature and expand, Taverna notes. **(See story on strategies for improving hospice marketing and expansion, p. 136.)**

"It's an interesting challenge we're facing nationwide, but it's not a bad challenge," Taverna says.

The hospice industry, like the health care industry in general, is ripe for substantial change, Keyserling says.

"The difficulty is that it's such a huge ocean liner that small deviations in that course take enormous pressure and have massive impacts on the patient populations," Keyserling says. "We should never lose the core values, but there's always room for extensions of services to meet the needs of the patients and families." ■

For-profit hospice growth due to marketing, quality

There's room for more growth for all

As for-profit hospices grow and gain market share in the hospice industry, their nonprofit counterparts might learn a few new tricks from them about marketing hospice services to the public.

VistaCare Inc. of Scottsdale, AZ, has plans to grow by reaching more of the people who are eligible for hospice services, says **David Rehm**, MSW, senior vice president.

"Our first focus is professional referral sources, because when family or patients are making a decision about needing hospice care, they are almost always in the active care of a physician," Rehm says.

Quality measured internally

"We have a real commitment to quality in our company and have high standards for internal quality measures," Rehm says. "And we have an internal survey process where all sites are surveyed annually, and we indicate that to our referral sources, as well."

While a hospice can grow initially through aggressive marketing and sales efforts, the only way growth can be sustained is if referral sources and health care professionals believe that a hospice consistently provides high-quality care, Rehm notes.

"That's a key driver for any kind of sustained growth," he says. "That's the first focus, and the second focus is on the community itself and the patients themselves."

To reach the community and potential patients, VistaCare has developed a variety of educational materials, including brochures and advertisements, Rehm says.

"Our staff will speak to groups, and we're always trying to educate people about hospice in general and the options people have at the end of life," he says. "We have them think about what course of care they will need to pursue, and we have a sophisticated array of support tools that can be employed."

In addition, VistaCare was the first in the hospice industry to develop national media programs through a partnership with the consumer health care web site WebMD Health, Rehm says.

WebMD Health has more than 20 million visitors each month. With VistaCare's support, WebMD Health began in October 2004 to offer Caregiver University, a four-week course offered on-line for people who need to learn more about the realities of caregiving, Rehm says.

"The other thing we've done is provide a professional course that offers [continuing education] credits for physicians and nurses in the area of end-of-life care and palliative medicine," Rehm says. "This course certainly benefits VistaCare, and of the 5,000 people who took it, 30% might be in the communities we serve."

VistaCare has a 60-second advertising spot about hospice on NBC's private television network that provides programming in patient rooms in more than 1,000 hospitals around the country, Rehm says.

"We sponsored it around end-of-life issues and talk about a whole range of needs and questions," Rehm says. "We have an advertising spot about hospice and finish with VistaCare's name and phone number."

Nonprofit expansion strategies

While VistaCare is working on increasing its and the industry's market for hospice services, some nonprofit hospices are coming up with their own expansion strategies.

For example, the Hospice of Marin in Corte Madera, CA, also has a strategy of expanding geographic boundaries, says **Mary Taverna**, president of the Hospice of Marin Foundation and chairwoman-elect of the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA.

"While hospices in the past were, maybe, a community or county provider, now we have to

look differently at this and wonder whether that will ensure long-term survival," Taverna says.

The hospice has expanded to three counties and split into two separate entities as part of its long-term strategy. Another major change was the recent decision to hire a new chief executive officer to handle the hospice side of the business, while Taverna stepped down from that role and became the foundation's leader, she says.

"I invested so many years into this organization and cared deeply about it, and I wasn't going to be a passive leader as I saw this industry changing," she says.

The hospice's flexibility in changing with the times seems to have worked. Despite the increased competition, the hospice's census has never been higher, and the growth has all come from an increase in non-charity-care patients, Taverna says.

The combination of marketing strategies being deployed in the hospice industry might be contributing to the industry's overall growth.

According to *A Data Book, Healthcare Spending and the Medicare Program*, published in June 2004 by the Medicare Payment Advisory Commission (MedPAC) in Washington, DC, growth in hospice use has been fastest among Medicare beneficiaries with noncancer diagnoses, which now account for half of the hospice population, and among those who are older. The MedPAC report also notes that hospice use has increased considerably among nursing facility residents. The report notes that the three most common noncancer diagnoses for hospice patients are congestive heart failure, dementia, and lung disease.

As growth continues, it's important for all hospice organizations to stay focused on their core mission, says **Jonathan Keyserling**, JD, vice president of public policy for NHPCO.

"As general health care evolves and changes its treatment and interventions with patients, hospice has also evolved, so there's a good fit between the two and a continuum of care — a seamless transition between life-prolonging therapy and hospice care," Keyserling says. ■

Special Report:
Expanding Hospice to Alternative Sites

Ties with assisted living require unique approach

A little bit of home, a little bit of an institution

(Editor's note: In this issue, Hospice Management Advisor *presents the second article in a two-part special report on how hospices nationwide are beginning to expand their services to treat people residing in long-term-care facilities and assisted living communities. This article features information about making the most of a partnership with an assisted living community.)*

Hospice organizations that wish to expand their reach might consider forging ties with assisted living facilities, which are expected to grow in size as the Baby Boom generation ages and retires.

"So much is in synch between hospice care and assisted living facilities, and I think sometimes they're just overlooked," says **Karen Carney**, director of community and provider relations at the Hospice of the North Shore in Danvers, MA.

Hospice of the North Shore has a preferred provider relationship with Sunrise Senior Living Inc. of McLean, VA, and also serves patients in about 10 other assisted living communities in the service area, Carney says.

In a little more than a year of working with Sunrise, the hospice's business with assisted living clients had grown substantially, Carney says.

"We've seen steady growth every year in working with Sunrise," she says.

"Sunrise's efforts to develop preferred provider relationships was a catalyst that caused us to focus on how well we are working with assisted living and how we can do a better job," Carney says.

Statistics provoke stronger interest in hospice

Sunrise, the largest assisted living company in the United States, has always focused on quality-of-life issues, but the company now has extended this philosophy to hospice care after taking a close look at company statistics, says **Bobbie Pontzer**, MSIM, RN, BSN, national director of hospice services for Sunrise Senior Living.

Two years ago, Sunrise managers discovered that of the company's more than 200 sites and roughly 20,000 residents, only 2% utilized hospice, Pontzer says.

"The other thing is we're not a continuum-of-care model where we have nursing care," she

says. "Our goal is to keep residents here as long as possible."

If a resident moves in and needs a higher skill level than Sunrise can provide, the facility will work with families to identify all options for keeping the patient in the Sunrise community, including hiring home health aides or providing hospice care, Pontzer says.

Sunrise now has more than 400 sites with almost 45,000 residents, an expansion fueled in part by its acquisition of Marriott Senior Living Services, she says.

Nationwide, the company has a hospice utilization rate of about 8%, while 45 to 50% of Sunrise residents die while residing in the Sunrise community, Pontzer says.

There are pockets of the company where 20% of Sunrise residents receive hospice care, but the lack of faster growth in providing hospice services partly is due to the inconsistent nature of hospice service within an assisted living facility, Pontzer explains.

"We have had a lot of problems with hospices coming into our community," she says. "What we have found was there was a lot of inconsistency in quality of care from hospices and inconsistency in services offered and in collaboration and coordination of that care."

This is why Sunrise has decided to form partnerships with hospices within the communities served by both organizations, Pontzer says.

"Our cofounders are behind what we're doing in our hospice approach," she says. "So what we did was say, 'Let's partner with the best of the best and establish preferred provider relationships with the intent of raising the awareness and quality of services and to educate the hospices about assisted living and senior living.'"

Changing practice assumptions

Through the Hospice of the North Shore's experience with assisted living centers, hospice staff have learned that some of their practices and assumptions needed to change, Carney says.

"One of the things we stress is the words you use," she says. "Assisted living has its own language, and they would shiver if you call them a 'facility.'"

Instead, assisted living companies prefer to call their residential sites "communities," Carney says.

"They operate differently than both homes and facilities," she explains. "So one thing we give our staff is a glossary of key words and how you talk their language."

Carney and Pontzer offer these additional tips for how hospices can adapt to working with assisted living organizations:

1. Think in terms of care managers — not aides or caregivers.

Sunrise calls staff who provide aide services "care managers," Carney says.

Who's responsible for taking temperatures?

"Care managers are the people who attend to personal care needs and follow residents throughout the day," she says. "And if they call us at 11 p.m. and say, 'This resident who is a hospice patient seems to have a temperature,' we can't ask them to take the temperature."

Unlike when a patient is at home or in a nursing home, the hospice nurse must send someone to take the patient's temperature, Carney says.

"That's something hospices need to be prepared for," she says.

2. One goal is to keep residents in the assisted living community.

"The goal is to help assisted living residents age in place," Carney explains. "That's their family members' goals when they go in there, and that's the residents' goals and assisted living staff's goals, so they live out their days and eventually die there as they would at home."

When patients become ill and are moved to a hospital or skilled nursing facility, the goal remains to return them to the assisted living facility, Pontzer says.

Hospices can assist with this goal by providing additional client support, Carney says.

3. Emphasize how partnering with a hospice can benefit the assisted living community.

Hospices should emphasize the services they have to offer to assisted living residents, including bereavement support for family members, assisted living staff, and other residents, Pontzer says.

"Our team members suffer when they lose a resident because they're an extended family," she says.

The other benefits hospices offer are the services of hospice volunteers and assistance with medical ethics, advance directives, and funeral home planning.

"We try to be really creative in how we use home health aides, nursing visits, and volunteers," Carney says. "So if we space them out

during the day and week, you get a broader spectrum of oversight that might work in concert with what the family can manage."

Another benefit hospices may offer is the provision of durable medical equipment reimbursed through Medicare, she says.

"Sometimes having those costs taken care of can free up money for the family to buy some additional care beyond what the assisted living community can provide," Carney says.

Also, hospices can provide on-call services for staff and residents, and hospice nurses will respond quickly, while it might take a while to reach a family member or doctor, she says.

4. Focus on staff training.

Hospices need to teach staff about the specific needs of assisted living communities in order to achieve the necessary collaboration and coordination, Pontzer says.

"The biggest issue to residents and families is the quality of care," she says. "But we're also talking about potential license issues."

State regs can affect coordination of care

The assisted living business is responsible for all that happens with residents, so assisted living staff need to have clear communication with hospice staff. If there is a problem that a hospice employee discovers, the assisted living staff will need to know about this immediately, Pontzer says.

"They need to understand our regulations, know the community's protocols, understand how communication works with the resident's family, have a grasp on case conferencing," she says.

It's important to educate hospice employees to understand the differences between the assisted living environment and the home environment, Pontzer adds.

"Who can give the resident medication and how orders should be written depends on state regulations, so hospice staff will need to know how it's licensed in that state," Pontzer says.

Training is the cornerstone of forging a solid relationship with assisted living businesses, Carney says. "We did a broader, overview training," she says.

Then the hospice managers realized that higher numbers of staff would be required to provide services in an assisted living environment and that more details of this type of work would need to be covered in the training sessions, Carney explains.

For example, hospice nurses need to know the route of communication in an assisted living center. When working with patients at home, the nurse simply will speak with the patient and then the patient's family. In a skilled nursing facility, the nurse will speak with the resident, family, staff, and physician, most of whom will be found at the nursing home, Carney says.

However, in an assisted living community, the nurse will need to talk with the patient, the family, and certain members of the community's staff, depending on that site's preference. For instance, a certain community could want hospice workers to speak to the wellness coordinator or the care manager, Carney says. In assisted living units devoted to Alzheimer's and other dementia patients, the staff person to contact might be a reminiscence coordinator, she adds.

Other training details that need to be addressed include the nurse's role at the assisted living site, such as when and how to complete documentation, Pontzer says.

"We have hospices that say, 'We bring documentation back once a month, and we say, 'That's not sufficient,'" Pontzer says. "We need documentation every time they walk into the door."

Perhaps the simplest way to look at it is to understand that the assisted living program is a social model, Pontzer says.

"Most hospices are more of a medical model with a continuum of care, and that's where we have a disconnect," she says. "It's like the nurse at the edge of the bed, saying to our resident, 'You don't belong here, you belong in a nursing home.'"

Keeping patients at 'home'

This causes problems and shows a lack of respect for the resident, who feels as though the assisted living community is his or her home, Pontzer says.

"So there needs to be a recognition of this philosophy and this approach in how you communicate," Pontzer says. "If the patient has a higher-skill need, then the hospice nurse can give that freedom of choice back to the resident and family to make a decision about what's best for them."

And with training, hospice staff will learn how to be sensitive to the assisted living environment when they speak with residents and make recommendations, Pontzer adds. ■

Services continue despite losing building in hurricane

Staff overcome communications and travel problems

(Editor's note: The devastation that Florida has experienced this hurricane season is unlike any the state has seen before. Following are the lessons learned from one agency caught in the middle of Ivan, one of the more powerful storms.)

Charley, Frances, Ivan, and Jeanne might be the names of friends you invite to your house for dinner. But for people living in Florida, these names represent a trying, traumatic series of hurricanes that kept Floridians and the home health agencies that serve them in a constant state of evacuation, preparation for storm damage, and clean-up.

Many houses and offices are still standing in Florida, albeit with damage. Some others, such as the facilities of Sacred Heart Home Care in Pensacola, must be rebuilt because the original structure was destroyed.

Rolodex file lost in storm

Ivan's wind, rain, and storm surge collapsed the part of the building that housed Sacred Heart's administration, nursing, clinical, and pharmacy departments, says **Connie Hetterich**, RN, administrator of the agency. "Luckily, a fire wall in the building protected our durable medical equipment offices," she adds.

Records for all active patients were packed up and moved to a safe space at the hospital before the hurricane arrived. Records for inactive patients were left in the office and were moved to higher locations in case of flooding and covered with plastic. "The actual medical records are computerized, but we kept paper records of consent forms and supporting documentation," Hetterich explains. "Unfortunately, we no longer have those records, or many of the items we had in our desks," she says.

Little things like Hetterich's Rolodex file of important phone numbers and names are missing because no one imagined that the entire office would disappear, she adds.

"We focused on active patient information and employee contact information so that we could resume care as soon as possible and so we could check on patients and employees," Hetterich points out.

The announcement that Ivan would make landfall at Pensacola came over a weekend, so Sacred Heart employees started emergency preparations on Monday, says **Nona Wainwright**, RN, director of nurses for the agency. Nurses spent the day contacting patients to see which patients were leaving the area with family members, which ones were going to a shelter, and which ones were planning to stay, she explains.

"We had a good idea of patients' plans before we made these calls because, during admission of new patients, we always ask what they will do if there is an evacuation or a threat of a hurricane," Wainwright says.

"All of our supervisors also made sure they talked with each of their employees to find out what their plans were as well," she adds. **(For other tips on preparing employees and patients for emergency situations, see box, p. 141.)**

Extra meds and oxygen delivered early

"Our pharmacy compounded enough drugs to carry our patients through 72 hours or a week, depending on the medication," Hetterich notes. Employees then spent Monday and Tuesday making extra deliveries, she adds. "[We] also spent time delivering extra oxygen tanks to patients.

"We were very glad to see that our patients had no problems with oxygen in the aftermath of the storm and that we had correctly planned for their needs," Hetterich continues. "What we didn't anticipate were the number of calls from clients of other vendors who needed oxygen tanks but could not reach their vendors."

While Hetterich's agency helped other vendors' clients as they could, the unexpected calls point out a need for agencies in the area to work together to develop a plan to address patients' needs before, during, and after an emergency, she stresses.

Ivan hit Pensacola at 1:50 a.m. Wednesday. "We were unable to see patients until Saturday because entire areas were flooded, roads were closed, and it was dangerous for anyone to travel," Wainwright says. "On Saturday, nurses started seeing priority patients as they could, such as wound-care patients," she explains.

Although access to many areas was restricted to prevent looting, home health workers with an identification badge could go into any area to check

Don't neglect regulatory issues in an emergency

Industry works with CMS to lighten penalties

Although the safety of employees and patients as well as the resumption of care to patients is a priority for a home health agency following an emergency, don't forget to address financial and regulatory issues that affect your agency's operation, says **Connie Hetterich**, RN, administrator of Sacred Heart Home Care in Pensacola, FL.

"We notified our CMS intermediary that we would be submitting paper claims immediately after the emergency due to lack of electricity and damage to our server," explains Hetterich. Fortunately, CMS [the Centers for Medicare & Medicaid Services] had approved paper claims for agencies affected by the hurricane. We also notified the state licensure agency and our accreditation agency that we had experienced a significant loss of documentation due to the destruction of our building," she says.

This notification is important so that Sacred Heart is not penalized for missing documentation for this time period, she says.

Home health agencies in Florida are experiencing challenges that CMS has not addressed because many of the issues have only recently developed as a result of multiple massive storms, says **Gene Tischer**, executive director of the Associated Home Health Industries of Florida, the state association for home health agencies in Florida.

His state association, along with the National Association of Home Care and Hospice in Washington, DC, has been working with CMS to address issues such as the financial penalties agencies suffer when patients are evacuated to other areas, which affects claims processing and OASIS (Organization for the Advancement of Structured Information Standards) time frames.

"We have agencies that have missed OASIS collection points and reporting deadlines, so we have asked CMS to provide relief, but until that is given in writing, Florida agencies must do the best they can to meet OASIS mandates," Tischer notes.

Another policy revision that will help home health agencies that experience major disasters and disruption of service is the development of some type of "holding pattern" for patients who are forced to evacuate the service area, he says. "A time frame of up to 30 days could be established during which another home health agency can provide service to the agency and get paid for services performed during the patient's evacuation, while the initial home health agency can pick up care where it left off before the evacuation," he suggests.

That type of rule would help home health agencies avoid losing revenue when patients leave their service before the completion of episodes of service or before enough therapy visits have been made to meet prospective payment system requirements, Tischer adds.

Another issue the state association is addressing is the development of a process that enables home health agencies to use out-of-state home care nurses to supplement their staff, especially if agency staff are unavailable due to their own personal situation or due to evacuation, he says.

"Out-of-state health workers were allowed to assist Florida agencies, but they had to volunteer their time and work through the Red Cross," Tischer explains. "We need to find a way to allow them to work for pay under the auspices of a Florida provider in the future."

Until emergency rules are put into place, it is important to stay in touch with CMS intermediaries and other regulatory agencies to alert them to problems that your agency may experience in meeting deadlines, he advises. ■

on patients, Wainwright notes. "Our employee badge became a very important accessory in the aftermath of Ivan," she says.

While the agency requires employees to wear identification when seeing patients, all employees were reminded to keep their badges with them starting on Monday, rather than leaving them in their desks, she points out. This was a good idea because, after Ivan came through, many of those desk items were missing, Wainwright explains.

Home health employees were able to continue working during and after the storm at Sacred Heart Hospital, where they helped move patients to safer locations within the building, deliver meals, supervise children in the "Hurricane Kid Camp" set up for 200 children of hospital and

home care employees during and after the storm, and sit with patients to calm them.

"I was surprised to see the number of pregnant women who were at least 36 weeks pregnant, some due in one or two days, who came to the hospital as their shelter," Hetterich says. "We provided mattresses that the home care agency keeps so the women would not have to sleep on the hard hospital cots," she adds.

Following the storm, many physicians in the area were unable to provide intravenous therapy in their offices, so their patients came to the hospital for their IV therapy. "Our home health nurses with IV training were able to supplement the hospital staff so these patients [could receive] their therapy," Hetterich notes.

"Our staff really pitched in to help during the storm; then the hospital employees helped us after the storm," she says.

Gasoline becomes precious commodity

Hospital support for the home care agency included space, help from information systems, maintenance, and administrative departments, as well as supplies such as water, ice, and gasoline.

"We did not have to stand in line for water and ice; the hospital provided it," Wainwright explains. "Our sister hospitals in Mobile and Jacksonville brought cans full of gasoline so our field staff could make visits, and they also provided employees to help us get back into business."

The gasoline was critical because there was no electricity in the area, and gasoline pumps at service stations don't work without electricity, she points out. "We did tell employees to make sure their gas tanks were full Tuesday evening, but power wasn't restored for many days in some areas."

In the two days prior to the storm, all field staff made sure records from OASIS (Organization for the Advancement of Structured Information Standards) forms and any information on their laptops were dumped to the server, Hetterich says. "We made sure we had backups of the information, and we also exported information to our state CMS [Centers for Medicare & Medicaid Services] intermediary before we took the server off-line," she says. Even with those precautions, the server did suffer some damage, requiring the agency to work with paper records for three days. For some time, they were unable to submit claims electronically, she adds.

Hetterich says she is working with her CMS intermediary to make sure claims are processed properly, and she also is notifying other organizations that OASIS records, medical records, and claims information may appear out of sync due to storm damage and losses.

Wainwright plans to incorporate before-and-after pictures of the agency's office into her employee education on emergency preparation. "When you live in Florida, you develop a tendency to become complacent when a hurricane is predicted, because we often prepare for a storm that doesn't come. I want to make sure that we don't forget what happens when it does hit, to make sure we all take emergency preparations seriously," she adds.

"I just never imagined that we would literally lose our building," Hetterich adds. If she had anticipated the loss, she would have taken items such as her Rolodex file with her.

"My staff have always said that if anything happened to me, they would be fine, because they would have my Rolodex file," Hetterich points out. When asked if her staff are more protective of her now that the Rolodex file is gone, she laughs and says, "Actually, the thing that concerns me is that they are still looking for the Rolodex file." ■

What to do before and after an emergency

Communication is critical

The most critical issue before, during, and after any emergency is communications, say the Florida home health managers who faced multiple hurricanes during the 2004 hurricane season.

"We had no electricity after the hurricane, so we had no phone system for the home health agency," says **Sheila Carlson**, director of Lee Memorial Home Health in Fort Myers, FL.

"Cell phones were not always effective because the cell phone system was so stressed with the volume of calls people were making," she adds. "Our field staff have wireless laptops, so they were able to communicate with each other, but our managers don't have them, so it was a challenge to keep in touch with all of our staff."

Her agency also discovered that the hospital's

telephone system continued working, thanks to backup generators and a more sophisticated system. "We will use the hospital's voice mail system next time," Carlson explains. "We can leave messages for staff members who can call in for updates and information."

"We are considering two-way radios for our emergency communications," says **Bobbie D'Angola**, administrator of United Home Care Services in Miami. "Our employees see patients in their own geographical area, so they can check on patients once travel is possible, but with no telephone or sporadic cell phone service, we can't always communicate with them," she notes.

Prior to all of the hurricanes' arrivals, home health staff members throughout the state got on the telephone with all clients and staff members to verify their plans for evacuation. Although this season has been unusually active, Floridians are very aware of the possibility of evacuation in case of weather emergencies, says **Karen Rutledge**, RN, director of nursing for Omni Home Health in Homosassa Springs, FL. Evacuation is a reality for many of her patients because they live in mobile homes near the Gulf of Mexico, she adds.

"All new patient admissions include the completion of an emergency medical service contact form that includes a description of the patient's needs and the patient's plans or needs in case of evacuation," Rutledge says.

At the beginning of each hurricane season (June 1 through Nov. 30), staff members contact each patient to update the forms, she explains.

Copies of the forms are forwarded to the county emergency medical service (EMS) so EMS personnel know which patients need assistance for evacuation. As weather worsens, or the threat of severe weather increases, home health nurses contact patients to check on them and see if they need further help, Rutledge adds.

Following the hurricane, staff members contact patients who planned to stay alone in their homes during the storm, she says. "If we can't reach them by telephone, we go to them if we are able to travel to the area, or we ask EMS personnel to check on them."

Prepare patients for evacuation

Admission information for Homosassa Springs' patients also includes a checklist for items to include in an evacuation kit. "We make sure patients have all of their medications, a copy of their medical history with names and phone numbers of physicians or health care providers, a list of allergies, a copy of their living will (if they have one), and any other information that will help them continue receiving care in the area to which they evacuate," Rutledge says.

Because United Home Care also provides community-based services to patients other than Medicare-certified patients, staff help prepare their patients for the hurricane by stocking pantries with water and three to five days of meals that don't require electricity to store or prepare, D'Angola adds.

"We've been lucky this season because our personal care attendants have been able to continue seeing patients with no more than a one-day delay," she says.

Traumatized patients need reassurance

Because many Miami residents still have horrible memories of the devastation wrought by Hurricane Andrew in 1992, the aides and nurses often are responsible for reassuring patients and reducing their anxiety, D'Angola notes.

"We make sure our employees know to stay upbeat and calm during threats of hurricanes so that we are able to prepare our patients for the weather and possible evacuation without scaring them," she says.

"If we do have a patient who is extremely anxious, and the aide cannot reassure [that person], our licensed clinical social worker will visit the patient to counsel him or her," D'Angola adds.

Most home health agencies are providing counseling services to patients and employees, and it is a needed service, Rutledge explains. The emotional toll on staff and patients from this year's busy hurricane season concerns her.

"I noticed that, with each hurricane watch or warning, people were more laid back, less alert," she says. "I know that continuous warnings of a storm that doesn't always arrive create a 'wait and see' attitude that can be dangerous," Rutledge admits. She plans to continue teaching staff and patients to take each warning seriously.

One of the more depressing aspects of a hurricane is that even when the threat is taken seriously, plans can backfire. Rutledge explains, "One of our nurses decided that she would leave our area when Jeanne was approaching. She left the night before to head to Jacksonville, only to discover the next day that the storm changed direction and Jacksonville was right in the middle of its path." ■

NEWS BRIEFS

Joint Commission's 2005 survey fees to increase

Survey fees charged by the Joint Commission on Accreditation of Healthcare Organizations will increase for 2005.

The fee increase, only the second in the last decade, will vary by program and, within programs, will vary by the types and volumes of services provided. The Joint Commission also announced plans to institute a subscription billing model in 2006 that will allow accredited organizations to begin to spread their survey fees over the three-year accreditation cycle.

The final fee schedule had not been set at press time, but the estimated average increase for home care is $880. For specific pricing, contact the Joint Commission Pricing Unit at (630) 792-5115 or pricingunit@jcaho.org. ▼

Prepare your hospital for a very unusual flu season

With the unprecedented shortage of influenza vaccine this flu season, hospitals are scrambling to prepare for what may be a record number of flu patients presenting to their already overcrowded EDs and for staff shortages due to record absenteeism. After almost half of the planned U.S. vaccine supply was contaminated, high-risk candidates — mainly the very young, the elderly, the immunocompromised, and health care workers — have been identified as those to receive the vaccine.

In response to the national shortage of vaccine, Thomson American Health Consultants has developed an influenza sourcebook to ensure that you and your hospital are prepared for what you may face this flu season. *Hospital Influenza Crisis Management* will provide you with the information you need to deal with ED overcrowding, potential liability risks, staff shortages, and infection control implications for staff and patients.

This sourcebook will address the real threat of a potential pandemic, and the proposed response and preparedness efforts that should be taken in response to such an event. Major guidelines and recommendations for influenza immunization and treatment are included, along with recommendations for healthcare worker vaccination and the efficacy of, and criteria for, usage of the live attenuated influenza vaccine.

Hospital Influenza Crisis Management will also offer readers continuing education credits. For more information, or to reserve your copy at the pre-publication price of $149 (a $50 discount off the regular price), call our customer service department at (800) 688-2421. ■

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