HOSPICE Management ADVISOR™

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AHC Media LLC

IN THIS ISSUE

February 2007
VOL. 12, NO. 2 • (pages 13-24)

Prison hospices are thriving due to greater acceptance, older population

First U.S. prison hospice founded in 1987

It's been 20 years since Springfield, MO, Medical Centers Hospice Program became the first U.S. prison hospice program, and now there are more than 70 hospice programs within state and federal prisons.

Proponents for prison hospice programs say there is no downside. The programs are budget neutral at worst, and some claim they actually result in less violence among the general inmate population. These qualities, and the highly publicized success of the hospice program at the Louisiana State Penitentiary in Angola, LA, and in other correctional facilities across the country, have made prison wardens increasingly open to starting hospice programs.

But arguably one of the biggest reasons for the jump in prison hospice programs from about 25 at the turn of the century to more than 70 this year is due to demographics: American prisons have a rapidly aging population.

"In 2002, there were 121,000 prisoners 50 years and older, which is almost triple the number of older prisoners in 1992," says **Carol McAdoo**, coordinating consultant for end-of-life care in corrections for the National Hospice & Palliative Care Organization (NHPCO) in Overland Park, KS.

"In 2005, there were over 167,000 inmates over age 50 in state and federal prisons, which is 11.1 percent of all inmates," McAdoo says.

In 1992, the number of inmates age 50 or older was 41,586, she adds.

The aging population is due to several factors, including increasing numbers of middle-aged people being convicted, three-strikes-you're-out laws, and prison sentences that have long mandatory terms, she says.

"Lifers and long-term inmates, those who have 20-plus year sentences, make up 23 percent of the total state and federal prison population," McAdoo says. "Of all inmates sentenced between 1995 and 2003,

24.5 percent were between 40 and 54 years old, and that has accounted for 46 percent growth in the prison population in that time period."

Also, inmates tend to age more quickly than the general population, McAdoo notes.

"Because of the lifestyle of people who are often incarcerated, the pre-prison lifestyle, they are approximately 10 to 12 years older physically than someone of their own chronological age in the free world," McAdoo says.

There are half a million people arrested each year who are age 50 years or more, McAdoo says. Of these older people, 17 to 24 percent are arrested for serious felonies, she adds.

"There's a tremendous increase in the number of elderly males who are incarcerated for sexual offenses, and there is some question regarding the root of that — whether they just now are discovered, or rather the cause is dementia," McAdoo says.

Also, there are increasing numbers of women who receive life sentences and long sentences for their crimes, McAdoo says.

There are approximately 3,300 inmates who die from natural causes in prison each year, and the number of deaths is increasing at nearly 4 percent per year, McAdoo says.

"The trend has been such that there's a large increase in the number of aging people in prison, and prisons are trying desperately to get ready for it, but they're not funded adequately," McAdoo says. "There are many prisons that receive multiple new inmates each year, but they receive no increase in the number of dollars that are contributed to the prison to run the health care system."

Given these trends, hospice is a good fit for correctional facilities, says **Jamey Boudreaux**, MSW, MDiv, an executive director of the Louisiana Mississippi Hospice & Palliative Care Organization (LMHPCO) in New Orleans, LA.

"We want to spread the word that there are good things going on in prisons," Boudreaux says. "I've been holding monthly [hospice] meetings at Angola since 1999."

LMHPCO has accepted the Angola hospice as a member of the hospice organization, and the prison hospice receives the same assistance and technical support of other hospice programs, he says.

"My job is to make sure they realize they are part of a much larger, global care picture," Boudreaux says. "They're pioneers, and it's affecting corrections across the country."

Correctional systems typically include a hospice budget within the health care program.

Some of the correctional systems use inmates as volunteers, and others rely on the regular medical staff. The more successful programs provide training, and this might come from area hospices, as was the case at the Angola prison.

"What they're doing at Angola with inmate volunteers is part of a volunteer core of 380,000 hospice volunteers across the country," Boudreaux says.

"Hospice nursing is not the same as regular nursing, so we had training for nurses, doctors, and security officers so they would understand what we were doing," says **Carol Evans**, LCSW, a consultant to the Louisiana State Penitentiary Hospice Program. Evans spent about a year training inmates and staff at the Angola prison. Previously she had worked for a hospice in New Orleans, LA.

"We had a meeting of inmate leaders and gave them an opportunity to ask questions," Evans recalls. "Then we went to the radio station run by

Hospice Management Advisor™ (ISSN# 1087-0288) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospice Management Advisor™**, P.O. Box 740059, Atlanta, GA 30374.

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Subscription rates: One year (12 issues), $399. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

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inmates, and the inmate leaders identified who they thought would be best as part of the first volunteer group."

A Louisiana public hospital system funded Evans and other hospice training at Angola, but a lot of the work also was done on a volunteer basis, Evans notes.

For instance, when Evans felt overwhelmed by the task, which included a 2.5-hour drive to Angola, she enlisted help from a friend, who would fly down at her own expense for a year to help with the training.

"Community hospice programs are generally very helpful to prisons in providing training to their inmates," McAdoo says. "There are multiple kinds of arrangements between hospice programs and prisons, but one of the major goals of NHPCO is to foster partnerships between community and state programs and state and federal correctional facilities."

This will increase dramatically the quality of end-of-life care, ease the mind of caregivers, and increase the level of training available for those who care for people who are dying, McAdoo adds.

"One of the multiple values of providing hospice care is the opportunity for the dying inmate to bring his or her life to closure to make amends, say 'I'm sorry,' reconnect with family members, and get ready for the end of his/her time," she says.

McAdoo and other prison hospice advocates say it's cheaper to let the inmates stay in the prison and receive hospice care, if that's what they choose.

"From a philosophical perspective, it might be interesting to people to know that it really doesn't cost any more to have a hospice program," McAdoo says. "The state is mandated to take care of their inmates and provide medical care to them, so to send them to a hospital and have them placed in the intensive care unit results in an ambulance trip, round-the-clock guards at the bed, and giving the inmate expensive treatment he or she might not want."

Convincing correctional officials of the cost-effectiveness of prison hospice programs is one obstacle. Another obstacle is the prison warden's attitude toward the idea.

"One of the things that is complex is that programs open and close and are not constant," McAdoo says. "They are very dependent on the will of the warden."

This issue could be resolved if hospice care was mandated by the Department of Corrections, which would mean states would find a way to accommodate the end-of-life needs of inmates, McAdoo says.

So far, this hasn't happened. The result is that programs thrive where there's a commitment at the top.

For example, Burl Cain, warden of the Louisiana State Penitentiary came up with the idea of starting a hospice at Angola in the mid-1990's after reading a Sunday newspaper article about hospice care.

"The article made me think about Angola and how we have people who are there for the rest of their lives," Cain says. "So hospice fits." (See story about Angola's hospice program, p. 16.)

"I didn't have any money to start a hospice program, so we restructured how we do medical care," Cain says. "I challenged the medical staff that we have to do this and in two years we want the best hospice program in the country, and we did it."

Violent acts of inmates on inmates decreased dramatically since the mid-1990s, and Cain gives the hospice program at least some of the credit for this.

The Angola prison and its hospice are somewhat unique. It won a Circle of Life Award by the National Hospital System in 2000 and 2001, and there has even been a video produced about the program, Boudreaux says.

However, there are a variety of models for hospices in prison, and these vary greatly, McAdoo says.

Here are a few examples of how they work:

- **Topeka, KS:** A women's facility in Topeka doesn't have many deaths, so a full-time hospice would be not be feasible, but it does have a set of policies and a plan of action that go into effect when an inmate is dying, McAdoo says.

"They have a death about once every three years," she explains. "So what they do is when a woman is identified as needing palliative care, or if she's diagnosed with a terminal illness, they put their program in place."

- **Vacaville, CA:** A men's facility in Vacaville has a 16- or 17-bed unit dedicated to hospice care.
- **Oakdale, IA:** The Iowa Medical and Classification Facility in Oakdale has two hospice and palliative care rooms that are in a special unit. Inmate volunteers live on that unit and are there around the clock to provide care for dying inmates, McAdoo says.

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Inmates come to the Oakdale facility at the beginning of their incarceration, and this is where they are classified as to which prison they'll be sent, she says.

The facility doesn't have an infirmary, but when inmates have medical problems, they're sent to the University of Iowa Medical Center for treatment, McAdoo says.

"The approach they use for end-of-life care is to have a large cadre of volunteers and a nursing staff around the clock, but it's just like living in a home," McAdoo adds. ■

Angola prison shows how TLC makes a difference

Inmates initiated rituals around death

In at least one way, the Louisiana State Penitentiary at Angola, LA, is an ideal setting for a hospice: It's an encapsulated village in which 90 percent of its residents will die within its walls and fences.

Its 5,108 inmates, who all are men, have been convicted of the most violent crimes, including murder, rape, armed robbery, and habitual offenders, says **Burl Cain**, warden of the prison.

Angola is unique in that it is a former plantation of 18,000 acres along the Mississippi River. Prisoners are paid pennies per hour to work on Angola's farms. Some prisoners have office jobs or other work, and those who volunteer and are accepted can become hospice volunteers in their spare time. The prison also has its own Bible College, chapel, radio station, and newspaper.

"These prisoners are selfish people; they take your money, your body, your life because they're selfish," Cain says. "So hospice is about giving back, and when these inmates become caregivers it works."

In the decade since Cain brought hospice into the prison, the violent acts between inmates have decreased from almost 400 acts in 1996 to about 90 acts in 2006, he says.

"We have 3,200 lifers, and the average sentence for others is 88 years, so this is a serious prison, and no prison in America has more maximum security inmates with more time than we do," Cain says.

Along with the hospice program, the prison also began a Bible college a decade ago, and that has also contributed to the reduction in violence, Cain notes.

"When the moral programs started having some effect, it started to have some success," Cain says. "The only true education is moral, and hospice is a part of that."

When Cain decided to start the program after reading about hospice care in a local newspaper, he encountered some resistance from his staff, which feared the inmates would take advantage of the program to smuggle drugs from the infirmary to the living quarters.

"I said to them, 'We'll keep them from doing that, but I believe we're going to do this anyway,'" Cain recalls. "Consequently, it didn't happen; the inmates didn't abuse it, and we never had a case where the drugs ended up back in the prison." In fact, the opposite transfer of good occurred.

Inmate hospice volunteers started using their own cash, earned at 4 cents to 20 cents per hour, to buy the supplies the hospice patients might like that are not provided by the prison, Cain notes.

"It's been an incredibly rehabilitative program, and it's also improved our morale," he adds.

Cain says he believes the key is that these predominantly selfish men suddenly find themselves on the giving end of life, often for the very first time.

He offers this example: "One of them said, 'I never believed I'd wash somebody's feet or wash their behind,'" Cain recalls. "He said it was the most humbling experience in the world and the most blessed experience to give that to someone else; the man said, 'I gave a fellow man a bath, and it didn't cost me anything.'"

This hospice volunteer was a man who had murdered someone without remorse, and now he was proud of the personal care he gave a dying man.

The hospice program also has removed the stigma the Angola infirmary had among inmates, says **Jamey Boudreaux**, MSW, MDiv, executive director of the Louisiana Mississippi Hospice & Palliative Care Organization in New Orleans, LA. Boudreaux visits Angola regularly to offer hospice support and assistance.

"Before the hospice program, inmates told stories about how you didn't want to go to the treatment center because you went into the treatment center and never came back," Boudreaux says. "With this new emphasis on hospice, the attitudes began changing in terms of the administration's commitment to patient care, and inmates began providing part of that care."

The hospice volunteers reported back to other inmates that the infirmary wasn't so bad, and people stopped fearing it, says **Carol Evans**, LCSW, a consultant to the Louisiana State Penitentiary Hospice Program.

"The inmates saw that the infirmary wasn't a horrible place, and the staff got to see a more human side of patients who were inmates and volunteers who were inmates," Evans says.

Another big change is that the hospice has reinforced a sense of community and family among inmates, she says.

"The hospice program lets inmates define their own family, and if they choose other inmates to be family, then those inmates have rights to visit them more liberally," Evans says. "They're treated as family members in the program, and they receive all the support that the program gives."

A lot of the men who have died in hospice care had families who had stopped visiting them years before, Boudreaux says.

"Now that they're dying, the families are coming back and trying to reignite family ties from years ago, and Angola is very accommodating to the families," Boudreaux says.

For example, the family members can stay with the dying man and attend the funeral service, Evans says.

The prison's inmates and staff became so transformed by the hospice experience of dying that they've added some additional traditions to the process.

"Prior to hospice, when an inmate died, he was wrapped in a sheet and dropped in a hole," Boudreaux says. "Now there are full-fledge funerals, and inmates built a horse-drawn carriage straight out of the 18th century, and there's a ritual around death."

Hospice volunteers transport the dead inmate's body to the morgue, where he is prepared for burial. Inmates build wooden coffins that the inmates are buried in, and there is a funeral service held in a hospice chapel on site, he says.

"There maybe singing, a funeral service, and everything is handled by the inmates," Boudreaux adds. "It's a very different prison than it was 10 years ago."

Before the hospice program began, none of the inmates wanted to die at Angola or be buried at Angola's Point Lookout cemetery, Cain says.

"Now they say, 'This is my family, this is where I live,'" and they are buried here," he says.

The dead man's coffin is carried to the cemetery in the carriage, which is pulled by two Clydesdale horses, and inmates, who also serve as pallbearers, sing songs along to the cemetery, where the man is buried in a grave dug by inmates' hands, Cain says. ■

Concerns allayed for hospice patients given opioids

Opioid use is not the bogey man feared by some

Opioid use for patients with advanced illness has been the focus of controversy and misconceptions, even among health care practitioners, an expert notes.

"There were concerns that opioid use and escalating doses of opioids may be contributing to hastening death," says **Russell K. Portenoy**, MD, chairman of the department of pain medicine and palliative care and chief medical officer of Continuum Hospice Care of Beth Israel Medical Center in New York, NY.

"This controversy has been going on for many years, including in the palliative care community,

where there are concerns that in some cases, opioid use is being used by physicians to hasten death without being overt about it," Portenoy says.

"In the context of controversy and profound ethical discussion around it, it's important to get some data," Portenoy says.

This is what led Portenoy and co-investigators to study data from end-of-life patients to see if opioid use had an impact on shortening patients' lives.

"Is opioid use associated with shorter life expectancy than those who don't get opioids?" Portenoy says. "This can only be determined during observational studies, and those studies in palliative care patients are difficult to do because they're ill, it's hard to get consent, and it's difficult to keep patients in the study and obtain reliable information."

Investigators examined two hypotheses: The first was whether merely being treated with opioids would be associated with shortened survival, and the second was whether larger doses or increases in opioid doses would be associated with a higher likelihood of dying, Portenoy says.

"If you accept the notion that respiratory depression is a potential complication of opioids, then it makes sense to suspect that opioids were associated with a shortened survival," Portenoy says.

The study's findings suggested that opioid use plays a weak and limited role in impacting survival, and that clinicians should not withhold appropriate doses from the hospice population out of concerns of its impact on longevity.

The answer was found in a large observational study by the National Hospice & Palliative Care Organization called the National Hospice Outcomes Project.

"That project collected data on over 1,300 patients admitted to hospices around the country," Portenoy says. "A large variety of data was collected, including data on use of opioids to treat pain in patients who were hospice patients."

Some of the patients included in the study died before the study concluded, and this allowed investigators to empirically evaluate their end of life, he notes.

"My colleagues and I took the opportunity to do a secondary analysis of the dataset, with the purpose to evaluate in multivariate analysis the relationship between survival and opioid treatments," Portenoy says. "We looked specifically at different aspects of opioid use and change in dose."

They found a statistical association with duration of survival and the dose of opioid the patient was on, but not with the percent change in dose.

In the multivariate analysis, the amount of variance in survival that could be explained by this factor was very small, between six and 10 percent, Portenoy says.

"So the bottom line is this finding resonates nicely with clinical experience," he adds. "People taking higher doses of opioids are people with more extensive disease or more complications of disease, so it's not surprising that higher doses of opioid is a marker of people who are sicker and whom might be likely to die sooner."

But the fact that investigators saw no relationship to survival when there was an increased dose, and that the overall dose impact was less than 10 percent of the difference in survival, suggest that opioids contribute very little — if at all — to the timing of death in a hospice population, Portenoy says.

"And so from the perspective of the relationship between this study and ongoing concerns and controversies out there for the past couple of decades, this study provides reassurance that using opioids to treat pain in advanced illness is medically appropriate and should not be restrained by concerns about shortening lives," Portenoy says.

"Moreover, those who make assumptions that opioid therapy is contributing to hastening death should be reassured that in real medical processes, this isn't going to hasten death," he adds.

"Among pain specialists, it's a given that opioids are stigmatized drugs," Portenoy says. "There's a varied degree of undertreatment, and it's a phenomenon with multiple generators."

Among the barriers to effective opioid use are physicians who conduct poor assessments and have inadequate knowledge of drug therapy, he says.

"Another set relates to patients and families," Portenoy says. "Studies have indicated that concerns about side effects and addiction causes patients to take fewer drugs than prescribed or to not describe their pain accurately."

The third set of barriers to effective opioid use are system issues, although in hospice care these are largely managed by the hospice and are not the main problem, he adds.

Portenoy hopes that his study, and others with similar findings that may follow, will contribute to a lessening of the stigma associated with opioids and result in a greater willingness by

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patients to use the drugs when needed, he says.

"We're doing further analyses of this dataset to understand the nature of pain and how it might be better managed," Portenoy says. ■

Complexity of coding requires coding staff

Education for entire staff essential for accuracy

With an average of 300 new codes, and the development of guidelines that change the way old codes are applied each year, it is critical that your agency keep staff members up to date on coding requirements to ensure that you receive the highest appropriate reimbursement, say experts interviewed.

While codes and guidelines are published in October and November of each year, for implementation in January, coding inservices should not be limited to once a year, especially since updates can occur throughout the year, points out **Judy Adams**, RN, BSN, HCS-D, COS-C, a home care clinical consultant with Larson, Allen, Weishair and Co. in Charlotte, NC.

Home health agencies approach coding in different ways, says Adams. "Some agencies have the initial clinician assign codes at the time of the assessment, along with the diagnosis," she says. "Other agencies have the clinician assign the diagnoses in order; then a coding staff member assigns the codes.

"Studies have shown that 96% of every assessment requires some change in the code assignment," states Adams. "These changes can include use of a code not supported by the diagnosis, use of a code that makes an incorrect assumption about the cause of the condition, or inaccurate sequencing of codes," she says.

Because coding has become so complex, Adams says she sees more agencies moving toward using a specialized coding staff, or coding experts, as backups. Many agencies designate one or more staff members as coding experts who not only serve as the "go to" person or people when clinicians have questions, but they also stay on top of changes in coding requirements and audit their own agency's performance, she says.

"The expert does not have to be certified as a coder, but he or she does have to be passionate about coding and interested in staying current," she says. **(For more information on how to choose a coding expert, see p. 20.)** "Attendance at coding seminars, and having current guidelines and manuals, is essential for this person."

"We have the nurses who are completing the OASIS do the bulk of the coding," says **Stacey Benner**, RN, HCS-D, staff development coordinator for Family Home Health Care in Columbia, KY. While clinical managers and Benner review claims before submission to verify codes, the agency took steps to reduce the number of coding errors made in the field two years ago by redesigning the new clinician orientation to include a basic coding course, she says. The basic course covers issues such as how to determine primary and secondary diagnoses and codes and highlights codes that are most often used incorrectly, she explains.

The eight-hour course was not only presented at orientation for new nurses, but initially all nursing staff members had to take it. "We presented the course at all of our offices until every staff member had attended," she says. It was important that everyone take the course because everyone needed to hear the same information, she points out. "Now we offer the course only once each month for new nurses, or for nurses who need a refresher."

Attendance is mandatory

Attendance at the basic coding course is mandatory, but the agency does pay staff members for attending, says Benner. "Our clinicians are paid on a per-visit basis, so I was not sure how we would handle paying for their time, but the benefits to the agency outweigh the cost of paying them to attend," she says. Not only do clinical managers spend less time correcting errors but also the agency is reimbursed at the

highest appropriate level, she explains. Benner tried to make the daylong course interesting with interactive activities and games.

Coding accuracy improved after the basic coding course was offered, but Benner noticed that nurses were having trouble with V-codes. "I developed a more advanced course that addressed V-codes, and all staff members attended that course," she says. Now, the advanced course is offered every other month.

Just offering a coding course isn't enough to guarantee an improvement in coding accuracy though, Benner points out. "We do a pre-test and a post-test for the course to determine how effective the class is and how well the nurse understood the material," she says. "We also have several pairs of eyes looking at all of our coding before we submit claims, and I conduct audits on different offices to see how clinicians are coding."

While the clinical managers are finding significantly fewer errors, their review serves two purposes, says Benner. "Not only do the reviews give us a chance to correct errors before claims are submitted, but the reviews give us a chance to identify trends in errors that indicate a need for more education," she explains.

If there is an individual that seems to struggle, then the nurse is sent to the basic coding class again, says Benner. If the problem seems to be more widespread, then Benner will go to the office and offer an inservice to the full staff, she says.

There are some codes that routinely cause problems, says Adams. "Wounds are very difficult to code because there are so many different types of wounds, and often the nurse has minimal information," she says. The key is not to make an assumption that just because the wound appears to be a trauma wound, it was not caused by something else such as surgery, she says.

Diabetes poses the same type of problem because there are so many different manifestations of the disease, says Adams. "We treat a lot of diabetic patients in home care, but before you list diabetes as the primary diagnosis, be sure that the plan of care supports that as the diagnosis," she says. If the plan of care describes treatment that is not related to diabetes, then the primary diagnosis cannot be diabetes, she explains.

While it makes good sense to have your coding expert or clinical manager review coding to ensure accuracy, be sure that your process to change codes meets standards set by the Centers for Medicare & Medicaid Services, says Adams. "An area that most agencies have problems with is actually a condition of participation requirement that says agencies must have a written procedure to correct codes," she points out.

Not only should your policy identify the review or audit process, but it should also explain the steps to take to change the code, suggests Adams. "The best practice is to identify the original clinician as the only one who can change a code; but you need to address situations in which the original clinician is not available," she says. The person who notices an error during review should contact the original clinician to discuss the code and get more information if needed.

If the clinician agrees that the original code is incorrect and agrees to the code suggested by the reviewer, then the clinician can give consent to the change by phone, e-mail or in person, says Adams. "Be sure to document what the change is, why the change was made, and who was involved in making the change," she says. "It is very important to document these details so that you don't appear to be making changes simply to increase reimbursement," she adds.

Although hospital-affiliated agencies may have access to more coding experts than freestanding agencies, it is important that a home health agency have its own experts on staff, Adams stresses. "There is no one that knows the home health business like your own staff so you will get the best coding from a home health expert." ■

Coding expert must be a master at solving puzzles

Designating a staff member as the "coding expert" for your agency is one way to ensure accurate reimbursement; but the person does not have to be a certified coder to help your agency understand the myriad codes and guidelines.

"A certified coder is wonderful, but is not required," says **Judy Adams**, RN, BSN, HCS-D, COS-C, a home care clinical consultant with Larson, Allen, Weishair and Co. in Charlotte, NC. "What you want is a person who is very detail oriented and likes puzzles or mysteries because coding is like a puzzle. You are looking for the right pieces to fit together," she explains.

Don't assume that the expert must be a clinician, either, adds Adams. "I've seen very good coding

experts who come from the billing department because they do have experience with codes."

Be sure that you offer your expert opportunities to attend seminars and courses so that he or she can develop the expertise needed for the job, says Benner. "I'm a staff development educator but when I became responsible for teaching coding to the rest of the staff, I chose to pursue certification," she says. While certification is not necessary, an agency manager must be willing to support the coding expert's need for information, she adds.

Current guidelines and access to on-line updates are essential, says Benner. It's also helpful to watch national and state home care associations' news and seminar offerings to see what is current and what might be hot topics, she adds.

Although smaller agencies may find it necessary to have their coding experts handle the coding responsibility in addition to other responsibilities, be sure that the employee does have time to stay up to date on coding and to share the information with staff members, says Adams. "This is a responsibility that directly affects the agency's bottom line, and it must be an ongoing process to ensure success." ■

Don't forget hospitalists in your marketing plan

Make good impression with research

(Editor's note: This is the first of a two-part series that looks at marketing in home health. This month we look at the importance of marketing to hospitalists. Next month we'll discuss how to choose and manage an effective sales staff.)

All home health agency managers understand the need to market their agencies to ensure success. The use of web sites, brochures, sales staff, and communication with referral sources will produce success, but be sure that you are addressing all of your referral sources in your efforts.

"Many hospitals are using hospitalists as one way to handle increasing patient loads," says **Lucy Andrews**, RN, MN, CEO of At Your Service Home Care in Santa Rosa, CA. "Not only are hospitalists not accustomed to thinking about home care choices that are available, but hospitalists are usually pretty insulated and not very accessible to home care marketing staff."

Usually, the hospitalist just passes the patient to the discharge planning staff when it is time for discharge, she adds. While your agency may be communicating with the discharge planners at the hospital, it is worth the effort to talk with the hospitalists, she says.

"If you do have a relationship with the discharge planner, be sure to let him or her know that you do plan to meet with the hospitalists to educate them," suggests Andrews. "You don't want the discharge planners to think you are trying to go over their heads, so you need to let them know that by giving the physicians more information, it might make the discharge planners' job easier because the physician will give more information upon discharge." One way to keep the discharge planner in the loop is to ask his or her advice about whom to contact, she recommends.

The first step to take when contacting a hospitalist is to find out what specific issues the hospital faces, says Andrews. "You definitely don't want to meet with a physician and say that you can help them address their shortage of beds when the hospital always has empty beds available," she points out. "Knowing what type of patients the hospital sees, what services they offer, and what problems they face will help you focus your presentation on their needs."

Once you know what your focus will be, find out how to set up a meeting, says Andrews. "Try to meet with the chief of the hospitalist department, or if the hospitalist department is new, go through the CEO of the hospital to identify the best contact," she says. It is important that you meet with a hospitalist, not the chief of the medical staff because the medical staff chief's focus and way of working with patients is very different from the hospitalist, she explains.

"You will probably only get one shot to sell your agency's services, so be sure you make a good first impression," says Andrews. Approach the physician with the question, "What can we do to help you?" she suggests. "Tell about specialized programs you offer related to diabetes, cardiac care or telemonitoring, but also talk about how you can help get the patient discharged more easily."

Be sure the hospitalist knows that you work frequently with certain physicians in the area and you are familiar with their patients so you can facilitate their admission to home health, says Andrews. "Position yourself as a resource for both the hospitalist and the discharge planner," she adds.

While your agency may have a number of very nice brochures about home care, be selective about what you take to leave with the hospitalist, suggests Andrews. "First, ask yourself what your chances of meeting with them again might be," she says. If it was an ordeal getting the first meeting scheduled, take a few key items that directly relate to their patients or their specific challenges, she suggests. "Even if you take a few things, if your conversation uncovers another area of interest for which you have a publication, offer to bring it back to the physician another time," she says. The opportunity to go back, even if to deliver a publication, helps establish a relationship, she adds.

Whatever you take to the meeting, don't take a supply of patient brochures and expect the hospitalist to distribute them, warns Andrews. "The hospitalist does not have a long-term relationship with the patient and won't be seeing them in an office setting so they are less likely to hand out information for your agency," she says. "You want your meeting to focus on what you can do for the hospitalist, not what he or she can do for you." ■

Attorney: 'Rotation' referrals may compromise care

DPs also cautioned about legal risks

Patients' right to freedom of choice of providers has been a source of continuing conflict, especially between hospitals and post-acute providers not owned by or affiliated with hospitals — so-called freestanding providers, notes **Elizabeth Hogue,** Esq., a Burtonsville, MD-based attorney specializing in health care issues.

Hospitals may be tempted to ease that tension, she adds, through a rotation system of referrals, whereby they assign patients who cannot or will not choose a provider to one on a list to receive referrals. Under such a system, Hogue says, each listed provider receives one referral before any provider receives another.

But while the rotation system is an appealing solution, she continues, it actually may compromise quality of care.

"First, many post-acute services are provided under the supervision of physicians based on their specific orders," Hogue explains. "Because physicians supervise these services, they are at risk for legal liability, along with providers and their staff members, if the providers and staff members do not meet applicable standards of care."

As a result, physicians have a clear interest in assuring the quality of care provided by post-acute providers to their patients, and so may choose to designate in their orders which provider will render those services, she says. "This helps to assure quality of care and manage their liability risks."

When physicians order services from a particular provider, Hogue points out, other providers — including discharge planners and case managers — may not ignore, alter, or delete any orders from patients' medical records. If these discharge planners and case managers are licensed nurses or social workers, she adds, they may be subject to discipline by state licensure boards if they modify orders from patients' physicians.

Some post-acute providers have developed specialty programs in orthopedics, respiratory services or palliative care, for example, Hogue notes. Quality of care received by patients who need services in these areas may be compromised, she suggests, if they are referred to providers that don't offer them when those who do provide these specialty programs are available in the area in which the patients live.

Hospitals' risk of liability may be significantly increased, she says, when specialty physicians order care from a provider that has a specialty program and those orders are ignored in favor of a system of referral rotation.

Whatever the situation, Hogue says, all providers are required to abide by patients' right to freedom of choice of providers, as she explains below.

1. All patients have a common law right based on court decisions to control the care provided to them including who renders it. When patients, regardless of payer source or type of care, voluntarily express preferences for providers, their choices must be honored.

2. Federal statutes of the Medicare and Medicaid programs guarantee beneficiaries and recipients of these programs the right to freedom of choice of providers, although Medicaid recipients who participate in a waiver program may have waived this right.

3. The Balanced Budget Act of 1997 (BBA) requires hospitals to develop a list of home health agencies that meet these criteria:

a. Medicare certified;

b. provide services in the geographic areas where patients reside;

c. asked to be on the list.

If hospitals place on the list the names of agencies in which they have a financial interest that should be disclosed, the relationship between the hospital and the agency must be specified on the list, she adds. "This list must be presented to patients so they can choose the home health agency they wish to provide services to them."

If physicians have written orders for services from specific agencies, Hogue continues, case managers and discharge planners must tell patients about the orders when the list is presented to them and must tell patients they have the right to choose a different agency, if they wish.

4. Hospital Conditions of Participation (COPs) include the basic requirements of the BBA, described above. They also require discharge planners/case managers to develop an appropriate discharge plan for each patient.

The risk of legal liability for both hospitals and discharge planners/case managers may be increased, Hogue notes, when discharge planners/case managers fail to develop a plan that best meets patients' needs in favor of a system of rotation.

Patients are likely to accept the agencies ordered by their physicians, she adds. If, however, patients voluntarily express their preferences or choose an agency other than the one ordered by their attending physicians, Hogue says, patient choices "trump" physician orders and must be honored.

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IOM report: Medicare should switch to P4P

A recent Institute of Medicine (IOM) report recommends that Medicare gradually replace its current fee-for-service payment system with a new pay-for-performance system for its 42 million beneficiaries.

However, since pay for performance doesn't yet have an established track record, the committee recommended that it be phased in to avoid unintended consequences.

Here are other recommendations from the IOM report:

- For an initial period of three to five years, Congress should reduce base Medicare payments across the board and use the money to fund rewards for strong performance.
- Large organizations that already have the capacity to begin participating in the pay-for-performance system should be required to do so as soon as it is launched.
- A reduction in base payments should be used to fund bonuses initially, while exploring long-term solutions such as savings generated by improved efficiency and cost-reducing reforms.
- To increase the likelihood of participation by as many health care providers as possible, give significant rewards to those who improve their performance, as well as those who meet or exceed designated thresholds of excellence.
- Offer incentives to encourage providers to submit data, since obtaining technology and skills needed to collect and submit performance data could impose a burden.
- Make data publicly available to patients and stakeholders.

The IOM report represents a significant development for the future of pay-for-performance, says **Steven A. Schroeder**, MD, chair of the IOM committee and distinguished professor of health and health care at the University of California, San Francisco. "The report presents a snapshot of where we are at the present time," he says. "The fact that it was commissioned by Congress indicates how serious Congress is about pay for performance."

Very little hard data on the effects of pay-for-performance systems are available — more than 100 incentive programs have been launched in the private sector in the past few years, but few studies have assessed the impact on quality of care, say the researchers.

However, pay for performance has demonstrated enough promise based on early experi-

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ence to justify being pursued in a way that allows for adjustment as needed, says Schroeder. "Pay for performance is just one part of the solution. Other interventions will be needed to achieve the level of quality that Medicare patients deserve," he adds.

Medicare will likely go forward with a pay-for-performance program, possibly along the lines suggested by the IOM report, says Schroeder. "How quickly it will proceed will depend on the new CMS director, the seriousness with which Secretary Leavitt views this issue, the pressure it receives from Congress, and the pace of parallel developments in the private sector," he adds.

The report is one more piece of evidence of growing interest among federal officials about ways to improve quality, says Schroeder. Hospital-based professionals should read the report carefully, understand what will be measured currently and what is likely to come online in the near future, he recommends.

Quality professionals should get a sense of the implementation issues they will face, share these with senior leaders at their institutions, assess how well positioned they are to implement pay for performance, and be ready to discuss its merits and challenges with clinician colleagues, says Schroeder. "They should also monitor the performance of their institution, because public reporting will become increasingly important," says Schroeder. ■

CMS expands preventive service coverage

The Centers for Medicare & Medicaid Services (CMS) has expanded coverage for preventive services such as diabetes screening. Beginning Jan. 1, 2007, CMS is increasing payments for services that affect people with diabetes. Payments to physicians for some of the most frequently billed face-to-face doctor/patient services has increased and access for rural and underserved areas also has been enhanced. Preventive services, such as abdominal aortic aneurysm screening, have been added to the initial Medicare exam and colorectal screening procedures have been excluded from the Part B deductible. For more information on preventive tests covered by CMS, go to http://www.cms.hhs.gov/partnerships/downloads/diabetesupdate.pdf ■