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*Special Feature: Experts help hospices focus on bottom line*

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# With new COPs, visit tracking in 2008, could payment changes be on horizon?

*Hospice Medicare cap poses current problems*

Starting next month, hospices will have to report to Medicare all nursing, hospice aide, and social worker visits made for patients. Then a few months later, the new conditions of participation (COPs) will be finalized, which will require greater attention to documentation of services and quality.

If anything can be learned from the past, it's possible that some sort of Medicare payment changes will not be too far behind, experts predict.

"I think there's validity to the observation that Medicare might be thinking of doing something similar to the hospice environment that they've done already in home health," says **Jeneane Brian**, BSN, MBA, clinical executive of Misys Healthcare Systems of Raleigh, NC. Misys Healthcare markets Misys Homecare software, which provides financial and office management assistance to home care agencies and hospices.

"Look at what Medicare did with skilled nursing care," Brian says. "Even further back in the 1980s, Medicare put hospitals on the DRG reimbursement system, which has case rate payments."

### *Home care rates change — Is hospice next?*

Most recently, the Centers for Medicare & Medicaid Services (CMS) required home care agencies to use a new assessment tool, named OASIS, and then switched payment to a case rate, Brian adds. "It's not too much of a stretch to say Medicare is looking to do the same thing in hospice," she says. "Just look backward."

On the positive side, if CMS changes the way hospices are paid, it could

make transitions to and from hospice less complicated, she adds. "If everyone's payment is similar, then everyone's motives will be aligned, and then the decision will be clear without competing agendas," Brian says.

The Government Accountability Office (GAO) recommended in 2004 that there be a modification made to hospice payments, says **Annette Lee**, MS, RN, COS-C, clinical product development specialist for the Corridor Group of Overland Park, KS, which provides consulting services to the hospice and home care industry.

Although hospice reimbursement has not changed yet, the way hospices report data has changed. First, in 2007, CMS required hospices to start reporting where patients reside, and soon they'll have to report the visits made, she explains. **(See story on how hospices can become more efficient under current payment system, p. 136.)**

"We've never had to report this data because we're paid on a per diem basis," Lee says. "We're given a daily payment whether we saw the patient or not."

So while the reimbursement hasn't changed yet, the writing is on the wall, Lee says. "CMS is gearing up for quality in all areas right now, and that's their tag line: 'Getting the best care for the bills they're paying,'" Lee says. "But in other arenas, they're not tying that quality and measures of quality to payment."

While hospice directors and experts can only guess what the future will hold, it is clear that all hospices will need to maintain a steady and ongoing stream of referrals that give them the ability to manage their cost structure, says **Michael Ferris**, managing principal of Home Care and Hospice Marketing Solutions in Chapel Hill, NC. "One thing we can count on over the next five to 10 years is we have to be much better at running a hospice program or health care program, for that matter," Ferris says. "We have to be much better at generating those referrals with fewer resources, which means our sales people have to be better trained, more effective, and more efficient."

Staff who market hospices services will need to generate more business than they do now, and they need to look at some of the basic Business 101 strategies in doing so, Ferris recommends. **(See story about marketing hospice services, p. 138.)**

## Data quality is top priority

The hospice community faces several important changes, says **Jon Keyserling**, JD, vice president of public policy and counsel for the National Hospice & Palliative Care Organization (NHPCO) of Alexandria, VA.

"I think there's a trend in health care over the past 10 years or so to both document quality and to substantiate outcomes for your protocols," he says. "And the hospice community is not going to be immune to that."

NHPCO has sponsored several data gathering tools and benchmarking tools to help hospices with quality data collection, he notes. The tools are available online to NHPCO members only. NHPCO membership starts at $200 per year and goes up, depending on a hospice's total annual patient census.

"We're very active in suggesting to CMS that they include a quality improvement plan in the new COPs that will be released next year," Keyserling says. "This is an industry that is well known for its reputation of delivering quality improvement care, and the patient satisfaction

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scores are unequalled in any area of health care."

For that reason, Congress and other policy-makers have recognized that the Medicare hospice benefit is a wonderful success story within Medicare, he adds. "It's important to make sure that whatever changes policy-makers undertake does not threaten the high-quality and comprehensive interdisciplinary approach to end-of-life care that millions of patients and families have availed themselves of over the past 25 years," Keyserling says.

## Hospice Medicare cap changes discussed

One possible change that would be positive for hospices involves raising or eliminating the Medicare hospice cap, which is an aggregate per beneficiary limit on Medicare payments to hospices.

The Medicare Payment Advisory Commission (MedPAC) recently met to discuss issues surrounding Medicare spending and the limitations the cap places on the rapidly growing hospice industry. **(See comments from recent MedPAC meeting, p. 139.)**

In recent years, the cap has posed hardships for hospices that have seen dramatic changes in their patient population, including more non-cancer patients than cancer patients for the first time since the Medicare hospice benefit was introduced. As a result, it's become more difficult to predict the length of stay of a particular hospice patient, and some hospices are being forced to pay about 1 million dollars because they've unwittingly exceeded their Medicare cap.

The Medicare cap is $21,410 per hospice patient, so a hospice that has 250 patients in one year will have a total cap of about $5.4 million, according to CMS.

"I don't believe MedPAC or CMS are at the point of taking action around the cap, but they're in an information gathering and analytical mode," Keyserling says. "At some point, I anticipate MedPAC will make some recommendations based on further analysis of data and changes in the hospice patient population that we've seen over the years."

For example, hospice was once a service provided to cancer patients. Now, fewer than half of hospice patients are dying from cancer. Since other chronic conditions and diseases, such as Alzheimer's disease, have a less predictable life expectancy, it means hospices have a more difficult time predicting costs, experts say.

Another problem is that the cap is not adjusted for high-wage areas even though Medicare payments are adjusted. This means that hospices in high-wage areas will be able to provide fewer visits than hospices in low wage areas before they reach the cap.

Hospices sometimes are told two years after a hospice patient has died that they must pay back some of the Medicare payments they received, even though the patient was eligible and the payments were legitimate, Keyserling reports. The repayments are in response to the flaws and complexities associated with the aggregate financial cap, he adds.

Medicare spending for hospice care was $5.6 billion in fiscal year 2003, and CMS estimates the spending will exceed $10 billion in fiscal year 2008. Meantime, the hospice benefit has been unchanged for 25 years, Keyserling notes.

## Medicare cap is complicated

Since part of that Medicare hospice payment increase is due to more spending per beneficiary, it means that hospice providers increasingly are exceeding their allotted hospice cap. In fact, there was a 41% increase in hospice programs exceeding their cap in 2005 over 2004, Brian says.

Among the hospices that exceeded their cap, they were an average of $800,000 over the cap, per hospice, according to a major Medicare

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intermediary, she adds. "There are a lot more people in hospice who are staying longer, and it's very hard to manage under that cap," Brian says.

The cap is very complicated to compute even without the unknowns regarding patients, Keyserling says. For example, a hospice might admit a patient who has been served by another hospice. The hospice is required to apportion some part of that patient's Medicare cap to the other hospice, he explains.

"One of the suggested adjustments that may make real sense is to let hospice programs treat that patient as a whole patient rather than to share that patient's cap among other programs," Keyserling says.

One of our goals is to remove financial disincentive from the financial programs' sphere of issues and let it be a clinical decision, Keyserling says. "Nobody wants to game the system, but it's really an issue of making sure that eligible patients are able to be served without financial penalties being assessed well after the fact," he says.

Hospices should be able to serve eligible patients with quality services without being penalized because a group of patients had a longer than expected length of stay (LOS), he says. "There are different diseases, and different groups of patients have different trajectories, and it's those kinds of changes that the cap may not be keeping pace with," Keyserling says. "Ultimately, providers caring for eligible patients are being penalized for the services they are providing simply because the patient cap hasn't kept pace with the changing patient population." ■

# How to make the most of Medicare payments

*Prevent Medicare eligibility, cap problems*

While it's true that Medicare might change the way hospices are paid sometime in the future, it's still important to make the most of the current system, experts say.

**Special Feature: The Bottom Line**

For example, hospice directors and staffs need to learn everything they can about the Medicare payment gray areas and the aggregate per beneficiary limit on Medicare payments, or what is commonly called the Medicare cap.

Hospices also need to learn more about their own true costs so they can accurately portray the financial costs and health care savings benefits of hospice services. Without the best data available, Medicare likely will make mistakes when and if the hospice benefit is changed.

"Hospices save a lot of money, as opposed to having a patient spend the last six months of life in a hospital," says **Jeneane Brian**, BSN, MBA, clinical executive with Misys Healthcare Systems in Raleigh, NC. Misys Healthcare produces the Misys Homecare software that is used by hospices and home care agencies to manage financial and other business operations electronically. "Hospices need to portray expenditures in a true fashion so they can justify [the Medicare hospice payment] and keep getting more of this," Brian adds.

Hospice professionals also need to keep a positive attitude about data collection and the changes Medicare is imposing on hospices with regard to the new certificates of participation (COPs) and additional reporting requirements, says **Annette Lee**, MS, RN, COS-C, clinical product development specialist for the Corridor Group of Overland Park, KS. "Medicare is paying the bill, and we have to comply with what they are wanting," she says. "Don't be afraid of reporting data; take it seriously and be thorough and show whatever resources you're using."

### *Know eligibility criteria*

Lee and Brian offer these suggestions for how hospices can improve their knowledge and use of the Medicare hospice payment:

- **Understand eligibility.**

The Medicare hospice eligibility criteria are a prognosis that a patient has six months or less to live, Lee notes. "Each Medicare intermediary comes up with local eligibility determinations [LEDs], which are guidelines for noncancer diagnoses on what kind of patient fits this eligibility requirement," she says.

The key is to use these guidelines and admit the right patients as soon as a hospice can. Also, hospices need to spread the word to referral sources about which kind of patients they are looking for, Lee suggests.

- **Use technology to improve efficiency.**

Electronic technology can help hospices improve their financial tracking, including assisting them in staying under their Medicare cap, Brian says. "Personally, I've managed a hospice, and I don't know how I would do that without

robust financial reporting," she says.

Hospice nurses who have access to laptop computers for completing their documentation can save time, money, and staff energy, Brian says. This technology will help prevent staff burnout and unnecessary trips back to the office, she adds. "The hope is that hospice organizations will realize productivity gains and lifestyle gains that can be had from laptops in the field," Brian says. "When nurses bring a laptop and do documentation in the patient's home, they can synchronize it on the Internet and not have to return to the office to turn in paperwork."

This technology frees nursing time to spend with patients, and it enables nurses to readily see all nursing notes and reports from other disciplines on the electronic record, she adds. "There are many advantages that come from using mobile electronic health records," Brian notes.

For example, electronic records might improve communication between field staff and office staff. When Brian's own father died in hospice care, a nurse showed up for regular hospice duty the day after he died because of faulty communication between field staff and the office, she explains.

Also, the IV equipment remained in the home for five days because the paperwork filled out by the nurse who pronounced her father dead had not made its way to the office and to the medical equipment company as quickly as it should have, Brian adds. "These mistakes create an expense, family satisfaction issues, and they place an additional burden on nurses," Brian says.

Having a mobile electronic health record would prevent these types of problems, she adds. "It's not about having the hospice nurse make an extra visit, but it's about shortening her day," Brian explains. "Hospice nurses will work until 8 p.m., and that has downstream implications for turnover rates and burnout."

By using an electronic health record, the hospice enables nurses to shave precious minutes off their day and go home earlier, she adds.

• **Document fully and accurately.**

Incomplete documentation helps no one, and can cause a hospice to have Medicare denials. Hospice documentation should note the patients' improvements under hospice care but also outline the ways in which the patient is continuing to decline, Lee says.

"To avoid a denial, they need to show that the patient still meets the guidelines," she says. "First, admit the right folks and, second, make sure you're documenting correctly and thoroughly with objective data whenever you can."

It's not sufficient to simply say that the patient is continuing to decline; this has to be demonstrated. "In hospice care, you want to see progress in much smaller goals that can facilitate pain control," Lee says. "But on the other hand, the patient may still have a decrease in appetite and is still losing weight."

In the big picture, the patient continues to decline. "You can ensure the patient gets enough medication to be comfortable, but the patient still can't tolerate activity," she says.

## Work toward a mix of patients

The quality initiatives required under the new COPs will work out well with documenting eligibility because to track any outcomes as being positive, hospices will need to have objective data, Lee explains.

"The use of more objective data is going to help show the outcome and help show the eligibility, too," she adds. "So it can be a positive on both sides of that."

• **Use the right resources.**

"It's good to have a mix of short stay and long stay patients," Brian says. "You need a bell curve of utilization when looking at the resources of patients admitted to hospice."

Typically hospice patients require the most resources at the front end and back end, she notes. "A lot of the durable medical equipment and supplies you order in the beginning make the first few days of hospice care very expensive," Brian explains. "Then the interim period will have no new charges."

At the very end as the patient dies, there could be more intensive services as the patient requires more care, she says. "So you will spend more than a per diem amount in the beginning and end of hospice patients, and those three weeks of maintenance care in the middle will help subsidize losses in the beginning and end," Brian says.

If a hospice maintains a good mix of patients, then the shorter stay patients and longer stay patients will be offset, and it's less likely the hospice will run into problems with its Medicare cap. "If you get nothing but very short-stay patients, then you don't threaten your cap, but you're not going to be profitable," she says.

At the other extreme, having too many long-stay patients could cause a hospice to exceed the Medicare cap, which would cost hundreds of thousands of dollars in payment losses. "Don't

underserve or overserve," Lee says.

You may need to front load your visits to get that patient up and going, and a lot of education happens at the start, she explains. "But when you see your plan of care is effective, then you could decrease slightly so that the patient and caregiver could independently carry out the plan of care," Lee says.

Underserving patients will hurt patients and the hospice in the long run, she notes. "You won't have a good handle on their symptoms, and, secondly, they'll end up going to the emergency room, which hospices never want to see happen," Lee says. "So stay in close touch with that patient and try to send in a good mix of your interdisciplinary team."

When the nurses are not visiting, have home health aides visit, and try not to group visits all on one day, she suggests. "We have to meet as an interdisciplinary team so we can plot out those visits to try to get as many visits in throughout the week as we can," Lee adds.

• **Diversify the hospice's services.**

"One strategy of bigger hospice organizations is they diversify their organizations to include other service lines that are not under the cap, like palliative care," Brian says. "They embark on these other types of services that are out from under the cap, and these help subsidize their hospice when the hospice is getting into the position of bumping up against the cap."

Smaller hospices may not have the option of taking that step, however. "A number of home care agencies have hospices, as well, and that's good because they have an ability to diversify and balance and use one organization to balance the other one across the whole enterprise," Brian says. ■

# Maximize time, resources to improve marketing

*Strong relationship with partners is key*

Hospices traditionally devote too few resources to developing marketing staff, so they need to find ways to maximize the available time and resources, an expert advises.

**Special Feature: The Bottom Line**

"How do they maximize their time and resources, because hospices don't have enough sales people to go around?" says **Michael T. Ferris**, managing principal of Home Care and Hospice Marketing Solutions in Chapel Hill, NC.

One way to make the best of use of available marketing opportunities is to outline all of the ways in which a hospice organization can tell its story in the community, Ferris suggests. This would include having various managers and other staff give speeches to community organizations, including senior centers and civic clubs, he adds. "We have to make sure that what we're doing is done to the maximum advantage," Ferris says.

## *Develop strong relationships*

The primary key to improving a hospice's marketing efforts is to develop very strong relationships and partnerships with referral sources, Ferris says. "We've got to constantly look at ways to get referral sources to expand their use of hospice resources so that we're reaching and touching more individuals with our services," Ferris explains. "The more that we can work with our referral partners to keep a balanced flow of cases coming into the organization, the better we're going to be. This is not only to manage whatever payment rates are, but also, ultimately, to be able to best fulfill the mission of hospice globally."

For example, a hospice should start a marketing improvement project by stepping back and identifying who in the organization is conversing with the community about the hospice program, Ferris advises. Then ask these questions:

• Are they sufficiently trained to be able to maximize those interactions? If not, the hospice should provide the training or send the staff to hospice workshops of marketing training, including the marketing courses sponsored by the National Hospice & Palliative Care Organization (NHPCO) of Alexandria, VA.

• Do they have good account management skills, such as keeping an Excel spreadsheet of current referral sources and the number of referrals made by each in a given quarter?

• Are they constantly working to expand the referral partners' knowledge of hospice by leaving the hospice's brochure with doctors' office staff and mentioning specific pain management services to oncology physicians?

• Are they working to help the referral partners expand their thinking about which types of patients are suitable for hospice services? For example, do they check with clinical hospital and physician office staff to see whether

there are Alzheimer's disease patients, kidney transplant patients, and other patients with chronic diseases who are at the end stages of their diseases and could benefit from hospice and palliative services?

"I think one of the greatest opportunities for hospices today and one of our greatest obligations is to increase the number of people who would be appropriate for hospice," Ferris says.

But first these people and their health care providers need to know that hospice exists and what kind of services are provided under the hospice benefit, and they need to be referred to hospice within a timely fashion, Ferris adds. "So we have to look at who it is we have out there telling the story," he says. "And we need to make sure they're trained and supported, so they have effective interactions and are able to increase on a regular basis the yield of those marketing activities."

### *Competitors are increasing*

Accentuating a particular hospice's differences is especially important for hospices that are older and accustomed to a noncompetitive environment, he notes. "What we've seen in market after market is the number of competitors that come in are increasing, and they're chipping away at some of these relationships an older hospice had with the community," Ferris says.

This means that no hospice can be complacent and expect patients to continue to come to them without renewed marketing efforts. "Are we effectively reporting why we should be the logical choice for referrals in each of the markets, including skilled nursing facilities and other referral partners?" Ferris says.

For example, hospices could show how the hospice Medicare benefit in a nursing facility could complement the skilled nursing facility benefit by providing hospice nursing visits, volunteer, and chaplain visits. All of these hospice services will raise a patient's satisfaction level, which has an indirect benefit to the nursing home as well.

Hospices who closely evaluate their marketing efforts and staff education/preparation for marketing hospice will be in a much better position to compete for hospice referrals in coming years. This process is ongoing, Ferris says. "Develop a plan in the coming year or two that will improve any of those elements once you've determined what your strengths are," Ferris says. "Maximize the benefits of your strengths." ■

# MedPAC discusses hospice Medicare payment cap

*Here are a few comments from meeting*

Members of the Medicare Payment Advisory Commission (MedPAC) met in October and discussed the hospice payment benefit's aggregate, average, per beneficiary limit, which providers call the Medicare cap.

MedPAC staff expert **Jim Mathews** and MedPAC commissioners, including chair **Glenn M. Hackbarth**, JD, vice chair **Robert D. Reischauer**, PhD, **Thomas M. Dean**, MD, **Mitra Behroozi**, JD, and **William J. Scanlon**, PhD, discussed possible changes that might be recommended for the cap at the recent meeting. Here are some excerpts from the panel's 50 pages of comments at the meeting:

**Special Feature: The bottom line**

**Mathews:** "Last year, the fiscal intermediaries that process Medicare hospice claims reported that about 5% of hospices reached the cap in 2004. Hospices reaching the cap tended to be smaller in terms of their average patient count, 190 patients on average in 2002, compared to 308 for noncap providers. They also had lengths of stay that were about 54% greater than noncap hospices in 2002 and 107% greater in 2005.

Some diagnoses as you see here, such as Alzheimer's disease and chronic ischemic heart disease, have relatively long lengths of stay. Further prognosticating the likely remaining life span of patients with terminal stages of these diseases is something of an inexact science.

Because of the association between diagnosis and length of stay, we hypothesized that cap hospices may be treating a disproportionate number of patients with conditions that typically have longer lengths of stay. If so, the caps maybe unduly impeding access to hospice for these patients and adversely financially affecting the hospices that treat them."

**Reischauer:** ". . . If we relax the requirements so that people get in earlier, do you end up saving Medicare money or costing Medicare money?"

**Mathews:** "There is a reasonable body of literature on this specific question, and it runs the gamut. There are three or four studies that say hospice saves the program money relative to traditional Medicare, and other studies that say it costs money.

Most recently there was a study, I think it just came out last month, by some folks at Duke University who looked at cost of hospice use for patients relative to a cohort of patients both in their last week of life, in the period between their death and the election of hospice, and in their last year of life, and they kind of had some interesting observations about the cost effects of hospice use relative to nonhospice users.[1] I think they found that for decedents with cancer, hospice use was more cost-effective up to 233 days of care. And for noncancer patients, hospice use was cost-effective up to 154 days of hospice care, above which the cost for hospice patients was greater than nonhospice."

**Behroozi:** "On the issue that you identified, Jim, about the cap not being adjusted by the wage index but the payments counted against the cap and presumably the costs to the provider are adjusted by the wage index — being from New York, you know I have to say, 'No fair.' And as the cost and wage index continues to go up so the payments continue to go up and the caps don't get adjusted that way, are providers in New York in particular — or any other high-wage index MSA [Metropolitan Statistical Area] — going to start dropping out? And then when it's my turn I won't have one to go to, but Tom and his buddies will have plenty of options."

**Dean:** ". . . And so I just wonder is [hospice] truly just a substitute for nursing home care, which it sort of looks like it is in some cases."

**Scanlon:** ". . . Having seen, as probably everybody has, personally how well a hospice can do in terms of providing benefits, and it's something that you want to really protect and preserve. But from a Medicare payment perspective, I — at the same time — felt so ignorant about what's exactly happening with respect to Medicare hospices, the trends over time, etc., that it's kind of hard to come to conclusions as to what the appropriate Medicare payment policies should be.

Another part of this is that it's not just payment policy that we should be focused on. There's this whole issue of — we've had 600 new hospices, according to your chart, between 2002 and 2005 — what are the entry requirements? What are we asking a hospice to demonstrate before we're admitting them to the program? And then once admitted, what are we asking in terms of continually showing capacity to provide the services that we expect?"

**Hackbarth:** "I've heard from people in the industry, Jim, that the entry requirements are pretty low, that the ease of entry is pretty high. And that often hospices are very small entities with only a few staff — maybe often is not the right characterization. But there are many that are very small.

". . . I've heard the same accounts, but I have not verified those independently. I mean, there are conditions of participation for hospice that have been in existence since — I want to say very early on in the benefit — '83, I think."

**Scanlon:** "I just wanted to put one more thing on the table, and we can maybe talk about it in some of the future presentations, and that's another area of my ignorance, which is the issue of what's happening with respect to hospice and nursing home residents. Because it's not that hospice is precluded. In fact, I heard that it's increasing in terms of the proportion of long-stay nursing home residents that are getting hospice care. And how it relates to the care that the resident or the Medicaid program is paying for in the nursing home is something that I think we should be looking at as well."

### Reference

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# Link with respite care agency expands marketing

*Choose organizations with similar focus, philosophy*

Family caregiver burnout is a real concern for nurses who also check on the well-being of the caregiver during patient visits. Studies have shown that a large majority of family caregivers experience fatigue, frustration, and stress; that two-thirds of caregivers believe that caregiving has strained their marriages; and that one-quarter have felt despair as a result of caregiving.[1]

Partnering with a respite care agency or referring caregivers to churches or other community organizations that offer respite care are effective ways to help patients' families deal with the stress of providing care.

In Port Byron, IL, a nonprofit respite care organization and a home health agency have found that the partnership also can be used to increase visibility and expand marketing opportunities for both organizations.

"It's the best of both worlds," says **Elizabeth**

### Need More Information?

For more information on partnering with a community organization, contact:

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**Saelens**, executive director of the Faith in Action (FIA) program in Port Byron and senior program director for Lighthouse Homecare. The faith-based volunteer respite program offers free companion visits, respite care, light housework, and transportation services for clients. "If the client reaches the point where more in-home care or nursing care is needed, the nonprofit organization refers them to Lighthouse," she says.

The Faith in Action program relies on volunteers so community awareness is a critical part of the program's success, says Saelens. At the same time, marketing services also is important for the agency, she adds. "When I started working at the home health agency, I saw how the two organizations could work together to improve service to clients as well as to improve visibility in the community."

When a client starts service with FIA, medication needs are assessed as well as the client's overall situation such as mobility and physical needs, says Saelens. "Our volunteers are with clients two to four hours per week, and they have an opportunity to see if the client's situation has changed to the point that nursing or personal care is needed," she says. When this occurs, the volunteer reports the changes to a supervisor who can contact the family with information about the agency.

On the agency side, the affiliation with FIA makes it easy for staff to refer family caregivers to FIA if the staff believe there is a need for some respite care other than the nursing care, says Saelens. Staff members have been used for caregiver seminars for FIA clients, which are open to FIA volunteers as well, she says.

The affiliation between FIA and the agency is not a formal business relationship, but is an informal arrangement, says Saelens. "My involvement in both organizations has made the arrangement work smoothly, but other agencies can work together to define the affiliation," she says.

The first step in determining if your agency and a community organization can work together successfully is to look at your mission statements, suggests Saelens. The focus on client satisfaction and a concern for client safety and health were common to FIA and the agency, she points out.

Look at the services offered by each organization, recommends Saelens. "You want to make sure that your services will complement each other's services." For instance, FIA volunteers don't perform personal services, but Lighthouse staff members do, she explains.

Finally, evaluate your service areas, says Saelens. "You must both serve the same areas or a portion of the same areas," she says. "FIA does not have volunteers in all areas that Lighthouse serves, but our contacts with Lighthouse clients give us a chance to reach out to churches in those areas." As more churches become involved, FIA will extend the geographic area that it serves, she adds.

Overall, the partnership has been well received by FIA clients and Lighthouse clients, says Saelens. Staff and FIA volunteers appreciate the increased exposure for both programs and, as she points out, "We are both able to serve more clients."

### *Reference*

1. Kasuya RT, Polgar-Bailey P, Takeuchi R. Caregiver burden and burnout: A guide for primary care physicians. *Postgrad Med* 2000; 108:119-123. ■

# Are your employees ready for an emergency?

*Personal emergency plans essential part of planning*

Effectively preparing for an emergency requires plans that address those emergencies you are likely to experience. In New Hampshire, agencies have always been prepared for winter storms that cause treacherous road conditions and loss of power. What caught many New Hampshire agencies off guard in 2005 and 2006 was heavy flooding in many areas that created different situations than those previously experienced.

"Blizzards and other winter weather rarely cause a problem for our agency because most staff members can make it to work," says **Claudette Boutin**, RN, CEO of The Homemakers Health Services in Rochester, NH. "Weather reports let us know that storms are coming, so we have a chance to double

up on patients before the storm, and we are accustomed to driving in snow, so we can usually get to all of our patients following the storm."

The heavy floods occurred on a Sunday in 2006, so most staff members were visiting family, and some were well away from the agency's home county. "I was visiting my mother four hours south of Rochester, so I didn't even realize what was happening," she recalls. Boutin's agency's emergency preparedness plan worked well, even though it didn't specifically address floods, she points out. "We do have an adult day care service with several buses, so the city asked us to help transport seniors to shelters," she says.

In addition to transportation, staff members were called upon to check on the patients who were classified "high priority" in an emergency.

"When we admit a patient, we classify them as high priority for emergencies if they live alone, if the home has two elderly adults caring for each other, or if they are disabled," says Boutin. "Our staff members helped those patients who needed to evacuate pack their belongings that they needed for the shelter and ensured that they had their medications," she explains. Staff members who transported seniors to the shelters often stayed to volunteer their time, she adds.

The floods washed out roads, caused the evacuation of entire neighborhoods, and affected employees more than winter storms, Boutin says. Employees who found themselves evacuated were unable to come to work until they found safe places for their families, she says. Sometimes, employees had to leave the area to stay with family or friends.

## Prepare at home to report to work

Because it is important that employees take care of their own families before they can report to work, Boutin's challenge to her employees in 2007 was to create their own emergency plans. A staff survey asked each employee if they would be willing and able to work after different types of emergencies such as snowstorms or power outages. Employees could answer yes, after personal needs are handled, or no.

"The majority of employees answer that after their own personal needs and family needs are handled, they would be willing to work during any type of emergency," says Boutin.

Because home health employees are an important part of a patient's ability to handle an emergency, it is important that employees be able to report to work so they are asked to prepare themselves and their families for an emergency. "This means having an emergency kit in their home that contains three gallons of water for every person, nonperishable food, a manual can opener, flashlights, extra batteries, and other supplies that might be needed for different situations," says Boutin. **[An emergency preparedness checklist is available with the online version of *Hospice Management Advisor*. If you're accessing your online account for the first time, go to www.ahcpub.com. Click on the "Activate Your Subscription" tab in the left-hand column. Then follow the easy steps under "Account Activation." If you already have an online subscription, to go www.ahcpub.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." Choose *"Hospice Management Advisor,"* and then click "Sign on" from the left-hand column to log in. Once you're signed in, select "2007" and then select the December 2007 issue. For assistance, call Customer Service at (800) 688-2421.]**

## A checklist for employees

Another aspect of preparing for an emergency is the development of a personal emergency plan. Boutin gave all employees a checklist that guides them through development of their own emergency plan. The checklist is a series of questions that asks employees questions about their children's school's emergency plan, child care, or elder care in the event of an emergency, and locations of emergency meeting places for family members, she says. Completing the checklist provides employees with a good sense of what needs to be done and what resources are to be used in the event of an emergency, she says. **(The checklist is available with the online version of *HMA*.)**

"We also gave every employee an 'Emergency Readiness and National Security Wheel' that contains tips on how to prepare yourself for a variety of emergencies," says Boutin. "The wheel describes specific preparations for emergencies such as terrorist threat, weather-related emergency, or power outage." **(For information on ordering the wheel, see resource box, p. 143.)**

Preparation of their families and their homes for an emergency was the first step in Boutin's emergency preparedness seminars in 2007. The next step for Boutin's employees is preparing themselves for an emergency. "When they arrive at the

next series of inservice classes, they will be asked if they prepared their own emergency plans," she explains.

Employees who have done so receive a "Good to Go" bag that contains items such as a flashlight, a first-aid kit, a Mylar blanket, a bottle of water, a few energy bars, and a list of other items they need to add. Other items include one change of clothes, copies of important documents, and a copy of their emergency plan with phone numbers they will need, she says. "This bag is for the employee's car so that even if the emergency occurs while they are away from home, they have what they need."

The Good to Go program is part of the Home Care Association of New Hampshire's (HCANH) program that emphasizes the concept that emergency preparedness begins at home, says **Susan Youn**g, executive director of HCANH in Concord, NH. "We have been offering programs to home health agencies over the past two years to assess their level of readiness and to help them improve their agency's preparations," she explains. "The Good to Go program was developed when it became obvious that no matter how good your plans are, they will only work if staff are available.

"The program is very low tech, but it is essential," admits Young. "For example, one of the items on the checklist is, 'How do your family members reach each other in an emergency?'" When local phone service isn't available or when areas are evacuated, it is important that there be a contact person located outside the employee's home area so that all family members can check in to let others know they are safe, she explains.

HCANH provides the personal readiness bags for the employees to all agencies along with a sample kit and a list of items that should be placed in the bag. Boutin says, "Some agencies are filling the bags for their employees while others only place a few items in the bag, but everyone includes the list so that employees can fill the bag with what they need."

"We have seen that home health agencies are very conscious of their role in an emergency, and most agencies have good plans in place," says Boutin. "We never expected to have our own version of Katrina in the past two years, but the experience has helped everyone better plan for emergency situations we might never have considered."

One tip that Boutin offers managers who are evaluating their emergency preparedness plans is to look carefully at the priority given to emergency planning. "Agencies are struggling to provide good quality services in a time of declining reimbursement, so multiple tasks are assigned to managers or supervisors," she says. "This often means that emergency planning becomes part of a to-do list for a person who is already very busy. It's important that emergency planning not fall to the bottom of the to-do list, because it is an issue that should be continually reviewed, updated, and communicated to employees."

Emphasizing the personal emergency readiness plan also is important, says Boutin. "It's easy to prepare yourself for an emergency, and it doesn't cost anything," she says. ■

## Need More Information?

For information on emergency preparedness, contact:

- ☎ **Claudette Boutin**, RN, CEO, The Homemakers Health Services, 215 Rochester Hill Road, Rochester, NH 03867-1701. Phone: (800) 660-1770 or (603) 335-1770. E-mail: cboutin@thehomemakers.org.
- ☎ **Susan Young**, Executive Director, Home Care Association of New Hampshire, Eight Green Street, Suite Two, Concord, NH 03301-4012. Phone: (800) 639-1949 or (603) 225-5597. Fax: (603) 225-5817. E-mail: syoung@homecarenh.org.

**The "Emergency Readiness and National Security Wheel"** can be purchased from EHS Publishing in Durham, NH. The price starts at $10 each plus shipping and handling, and the price declines with larger quantity orders. For more information, go to www.ehspublishing.com/cart/product.php?productid=16134. Phone: (800) 558-3464 or (603) 868-1496. Fax: (603) 868-1547. Web: www.ehspublishing.com.

## *COMING IN FUTURE MONTHS*

- ■ Apply family systems theory to hospice work
- ■ Develop patient-centered hospice model in long-term care
- ■ How to improve relationship with nursing homes
- ■ Optimize hospice staff following these tips

# OIG gives guidance on free services

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

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services issued another *Advisory Opinion* recently that provides additional guidance to providers about giving free items to potential patients. Specifically, the OIG responded to a request from home medical equipment (HME) suppliers for guidance on whether it is appropriate to provide an in-home congestive heart failure (CHF) assessment with oximetry testing to patients in their homes.

The suppliers proposed to provide patients diagnosed with CHF with an in-home assessment with oximetry testing at no charge to determine whether patients qualify for oxygen paid for by the Medicare program. The patient also would receive education regarding his/her condition, including tips about how to recognize and self-manage symptoms. In addition, the patient would undergo pulse oximetries in their own homes conducted at rest, with activity, and overnight. The value of this testing is approximately $22. The HME suppliers further pledged that they would not seek reimbursement for any of the above services.

In addition, the services would be publicized through communications by sales and marketing staff directed exclusively to physicians and their staff members. Information about these services would not be communicated to patients directly or included in marketing materials.

Finally, the suppliers said that recipients of these services were free to choose any HME company of their choice. In fact, the suppliers promised to provide each participant with a written freedom of choice disclosure.

The OIG stated that there were several issues:

- whether the free assessment with oximetry testing constitutes remuneration paid to beneficiaries who receive them;
- whether the remuneration provided is likely to influence beneficiaries to select the HME dealers as the source of their oxygen or other goods and services reimbursable by the Medicare program;
- whether the suppliers know or should know that the provision of free services would be likely to influence beneficiaries' selection of the suppliers for oxygen or other supplies paid for by the Medicare program.

The OIG concluded that HME suppliers that provide the above services free of charge may violate the federal anti-kickback statute.

What should providers do in response to the latest OIG *Advisory Opinion* on the subject of giving services at no charge to beneficiaries? It is absolutely crucial for providers of all types to put policies and procedures in place or to review and, if necessary, revise existing policies and procedures that govern all free services provided to beneficiaries, including the conduct of so-called health screenings. These policies and procedures must be established and implemented to take into account all of the OIG's guidance on this topic. ■

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# 2007 Index

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# EMERGENCY PREPAREDNESS CHECKLIST

**Your Home**

- ☐ Water:  At least one gallon, per person, per day
- ☐ Can Opener (non electric)
- ☐ Battery-powered radio
- ☐ ABC-type fire extinguisher
- ☐ Smoke detector and carbon monoxide detectors
- ☐ Prescription medications
- ☐ Wired telephone —- not cordless
- ☐ First aid kit
- ☐ Flashlight and battery powered lantern
- ☐ 3 days worth of canned or dried foods
- ☐ 3 days worth of baby food and formula

**Your Car**

- ☐ Bottled water
- ☐ Food (granola/energy bars)
- ☐ First aid kit
- ☐ White distress flag
- ☐ Flashlight and extra batteries
- ☐ Flares/light stick
- ☐ Blanket or sleeping bag
- ☐ Emergency reflective blanket
- ☐ Jumper cables
- ☐ Tire jack and spare tire
- ☐ Fix-a-flat
- ☐ Shovel
- ☐ Maps

**Good to Go Bag**

- ☐ One day's clothing and shoes for each family member
- ☐ Personal care products (toothbrush, toothbrush, diapers, etc.
- ☐ Towel and wash cloth
- ☐ Blanket or sleeping bag
- ☐ Flashlight and extra batteries
- ☐ Granola bars/trail mix
- ☐ Extra set of car keys
- ☐ Cash
- ☐ Prepaid phone card
- ☐ Copies of important documents, such as drivers license, insurance papers, medical and prescription information, bank account information, etc.

If you must leave your home, don't forget your prescriptions, eyeglasses, hearing aid.

*Source:* The Homemakers Health Services, Rochester, NH.

# THE HOMEMAKERS HEALTH SERVICES
# EMPLOYEE EMERGENCY PREPAREDNESS SURVEY
# SEPTEMBER 2007

Our agency provides many different kinds of services to over 600 people who live in the Strafford County area. We'd like you to think about the individual clients who receive your particular care or services, and how well they would manage without them. In an emergency or disaster, probably not too well.

Now think about your own needs and family situation. In case of a disaster, how ready, willing, and able would you be to continue your work responsibilities to your clients as well as meet your financial obligations to your family?

Your responses to this questionnaire will help us to plan for our level of employee availability during different types of disasters, and will also start you on your way to being **GOOD TO GO !**

*********PLEASE ANSWER THE SURVEY AND RETURN TO YOUR SUPERVISOR BY SEPTEMBER 28TH TO BE ELIGIBLE FOR THE SPECIAL PRIZE DRAWING AT OUR ANNUAL TRAINING DAY.*********

1. Would you be able and willing to work during the following disasters?

| | **Definitely** | **Yes, after taking care of personal needs** | **No** |
|---|---|---|---|
| a) Hurricane | _____ | _____ | _____ |
| b) Flood | _____ | _____ | _____ |
| c) Snow storm | _____ | _____ | _____ |
| d) Power outage | _____ | _____ | _____ |
| e) Terrorist attack | _____ | _____ | _____ |
| f) Epidemic | _____ | _____ | _____ |

2. Would you need help arranging for any of the following before you would be able to come to work in time of an extended disaster or emergency?

| | **Definitely** | **Maybe** | **No** |
|---|---|---|---|
| a) Child care | _____ | _____ | _____ |
| b) Elder care | _____ | _____ | _____ |
| c) Pet care | _____ | _____ | _____ |
| d) Transportation | _____ | _____ | _____ |
| e) Money | _____ | _____ | _____ |
| f) Safe place to stay overnight | _____ | _____ | _____ |

3. If schools were closed for an extended time is there someone else to care for your child(ren) while you work?
   Yes_____ No_____ Don't need_____

4. If schools were closed for an extended time would you be available or offer to care for a co-worker's child(ren)?
   Yes_____ No_____

5. If schools were closed for an extended time would you feel comfortable with a co-worker caring for your child(ren) so you could work? Yes_____ No_____

6. Do you have an elderly family member that would rely on you for supervision, meals, shopping, or medication in a disaster? Yes_____ No_____

7. Would you be available to assist another co-worker's elderly family member so they could go to work?
   Yes_____ No_____

8. Would you be willing to carpool or pick up a co-worker who did not have transportation in an emergency?
   Yes_____ No_____

9. Would you be willing to help a co-worker who needed a temporary place to sleep in an extended emergency so he/she could come to work? Yes____ No_____

10. Have you discussed emergency planning with your family? Yes____ No_____

11. Do you have these items at home?

a) 1 gallon of water for each family member for three days Yes____No____
b) Emergency phone numbers of relatives? Yes____ No_____
c) Manual can opener? Yes_____ No_____
d) Storage of canned food that does not need to be heated, or dried food, for family for three days?
   Yes_____ No_____
e) Candles, matches in a plastic bag, flashlight, batteries? Yes____ No___
f) Three-day supply of any medications your family needs in an emergency medication box?
   Yes____ No_____ N/A_____
g) Battery-powered radio? Yes_____ No_____
h) Extra set of clothes and toiletries packed in a travel bag for each family member?
   Yes____ No_____
i) Spare cash available on hand? Yes____No_____
j) Blanket? Yes____No____

NAME _____

Must be completed to be included in prize drawing

*Source:* The Homemakers Health Services, Rochester, NH.