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Hospice managers think outside the box to address the rising costs of gasoline

Hybrid vehicles, fuel surcharges evaluated for effectiveness

A creative approach to getting travel costs under control will mean an annual savings of least $50,000 for Alegent Health at Home in Omaha, NE. Moving to a fleet of agency-owned hybrid vehicles, the hospice and home health agency expects to save money previously reimbursed for employees' business travel costs.

"Our organization has always reimbursed at the rate allowed by the Internal Revenue Service [IRS]," explains **Denise McNitt**, RN, MS, division executive for the agency. "Our employees travel more than 800,000

Market basket increases payments by 2.5% in 2009

Hospices serving Medicare beneficiaries will see a 2.5% increase in their payments for 2009, according to a final regulation published by the Centers for Medicare & Medicaid Services (CMS). The increase in the hospice wage index is the net result of a 3.6% increase in the "market basket" indicator of cost, offset by a 1.1% decrease in payments to hospices as CMS phases out a transitional payment to these providers.

As published in the *Federal Register* on July 31, CMS is phasing out an adjustment to the hospice wage index that was put into place more than 10 years ago to help hospices through a transition to the new wage index. CMS estimates that payments to hospices will decrease by about 1.1% for FY 2009, the first year of the three-year phase-out of the adjustment. **(For more information, see "Medicare proposal to reduce hospice wage index equals rate cut," *Hospice Management Advisor,* August 2008, p. 85.)**

To see a copy of the final regulation, go to the CMS Hospice web page at: www.cms.hhs.gov/center/hospice.asp and click on "CMS-1548-F" to link to the document. ■

miles each year, which meant $400,000 in mileage reimbursement for one year," she points out. The IRS' recent increase of the allowable mileage rate reimbursement to 58.5 cents would have meant an extra $10,000 to McNitt's agency if the vehicle lease program was not in place.

"We started evaluating leasing a fleet of vehicles to be owned by the agency for the use of our employees," McNitt explains. At first, the leasing company proposed an agreement for 50 cars to be leased with the same mileage allowance, she says. "The one-size-fits-all lease didn't work because we have some employees who travel 8,000 miles each year and others who travel over 20,000 miles," she says. By restructuring the lease to address different categories of mileage, the agency was able to see a cost advantage of agency-owned vehicles compared to reimbursement for use of a personal vehicle, she says. **(For specifics of Alegent's car program, see p. 99.)**

The agency fleet is comprised of 50 Toyota Priuses, hybrid vehicles that average 48 miles to the gallon, says McNitt. "We evaluated several vehicles and wondered if the Prius would be the best choice for our roads in the winter," she admits. After a Prius was brought to the agency on a snowy day for test drives by different employees, everyone agreed that the car had plenty of space in the trunk and handled well on the winter roads, she says.

Rural agencies face greatest challenges

The rising cost of gasoline is especially hard on hospices that serve rural areas, says **Lisa Genereux**, RN, director of Bear Paw Hospice in Havre, MT. "In fiscal year 2008, our employees averaged 20 miles per visit," she points out. Even with careful scheduling that groups employee visits as close together geographically as possible, staff members still spent a lot of time driving, Genereux says.

Although her agency continues to see patients throughout all parts of the service area, managers are carefully evaluating patients who live great distances away from the main office, says Genereux. For example, staff provided care last year to one hospice patient who wanted to die on his ranch, which meant a two-hour, one-way trip to see him, she says. "Luckily, he had a strong support system with family that lived within one mile of his home, so we were able to care for him in his last three weeks with less-than-daily visits," she recalls.

Telephone calls to the patient and family members supplemented visits and allowed the staff to

EXECUTIVE SUMMARY

With gasoline prices soaring and the Internal Revenue Service increasing the amount allowed for reimbursement of miles driven for business purposes, hospice managers are finding innovative ways to control costs.

- Leasing a fleet of 50 hybrid vehicles will save one hospice at least $50,000 annually.
- Using telephone contact for daily support of patients and family members when the patient lives a significant distance away from the hospice office supplements visits that cannot be made on a daily basis.
- Add a fuel surcharge for visits.

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provide the support needed by the patient and family, she points out. "If he had required daily visits because there was no family support, we couldn't have provided the care because of the distance," she adds.

Her hospice doesn't reimburse mileage at the full IRS rate, so Genereux reminds employees that they can claim the difference as a deduction on their tax returns. Even with this tip, she is concerned that employees have to spend so much of their own money at the gas pump. "Our reimbursement checks come after employees after already spent their money, and this can be a hardship, especially for home health aides who are our lowest-paid employees," she admits. While an increase in reimbursement is being considered, Genereux also plans to provide tips on how to increase gas mileage to help employees save a little more money. **(See gas-saving tips, p. 100.)**

Another approach to reducing the effect of travel costs on a hospice's bottom line is to add a fuel surcharge to the visit charges, suggests **Lezlie Snoozy-Kaitfors**, owner of Comfort Keepers, a private duty home health and hospice in Rapid City, SD. While Medicare doesn't reimburse a fuel surcharge, her agency has found the surcharge paid by private duty clients to be helpful in offsetting travel costs of employees. The fuel surcharge for each visit is $3, she says. The total amount of money collected by the agency is given to employees on a monthly basis, with the reimbursement based on the number of visits made by the employee during the month.

Because her employees are going from their homes to the patient's home, the agency doesn't reimburse mileage charges, so the fuel surcharge does help, Snoozy-Kaitfors explains. Aides do not travel between patients' houses or to and from the hospice office, so there is usually no mileage reimbursed, she says. "We do reimburse employees the IRS allowance if they take clients to the physician office during the day," she adds.

Rural agencies that serve a large geographic area may have to make tough decisions that may reduce service areas, says Genereux. She says, "We are not reducing our service area at this time, but we will re-evaluate everything next year to see if steps we've taken are effective and if gasoline costs have continued to rise." ■

Divide lease fleet into mileage groups to save

Using car for personal use keeps program simple

The idea of an agency-leased fleet of cars for use by employees might seem overwhelming to some home care managers, but careful planning, thorough evaluation, and choosing the right vendor are essential for a successful program, says **Denise McNitt**, RN, MS, division executive for Alegent Health at Home in Omaha, NE.

The year-long process of developing a lease program for the fleet of cars is expected to save the agency at least $50,000 each year in travel costs. "The first proposal from the leasing company used the same parameters to set the lease for all 50 cars," says McNitt. Rather than walking away from the idea as too expensive, the agency asked the vendor to split the cars into four groups with prices based on different mileages for each group. "Our employees drive different distances, so we were able to identify ranges, such as 8,000 to 12,000 miles, that we could use for each group," she says. Because vehicle lease prices are based on anticipated mileage, the overall cost of the contract was cut when the leases for all 50 vehicles weren't priced on the highest levels of anticipated mileage, she explains.

The cars are assigned to full-time employees who make home visits. This group includes nurses, aides, and a chaplain, points out McNitt. "Our employees login by computer and go to their first visit of the day from their homes, so they keep the cars at home with them," she says. Because McNitt did not want agency managers to

Tips on Saving Gas for Hospice Employees

There is little chance that most hospice managers will be able to completely compensate employees for all costs associated with their business travel, but offering tips on how they can improve the mileage they get with each tank of gas might help them stretch their dollar a little further. The following tips might help:

- **Change your attitude.**
  Slow down, and you'll burn less fuel.
  Avoid quick starts and sudden stops.
  Don't haul extra weight in the passenger compartment, trunk, or cargo area of your vehicle because a heavier car burns more fuel.
  Look for low fuel prices, but don't waste gas by driving to a distant filling station to save a few cents.
- **Change your driving style.**
  Know the correct starting procedure for your car.
  Don't race a cold engine to warm it up or allow it to idle for an extended time.
  Maintain steady speeds, because a car uses extra fuel when it accelerates.
  High speeds require more fuel, so travel at moderate speeds on the open road.
  Use your air conditioner's "economy" or "recirculation" setting to reduce the amount of hot outside air that must be chilled.
- **Maintain your car for fuel efficiency.**
  Make sure your spark plugs are in good condition.
  Check the air and fuel filters at least twice a year.
  Inflate tires according to manufacturer recommendations. Underinflated tires are a safety hazard and can cut fuel economy as much as 2% per pound of pressure below the recommended level.
  Have your vehicle serviced regularly.
- **Pay attention at the pump.**
  Don't top off your gas tank, because overflow can occur in warm weather.
  Make sure the gas cap is right for your car if you must replace it. The wrong cap can cause engine problems and reduce fuel economy.
  Track your gas mileage so that you can see any decrease in fuel economy, and take steps to address it.

Source: Based on information from "Gas Watcher's Guide. Tips for conserving fuel, saving money, and protecting the environment." AAA Auto Club South, Tampa, FL. 2008. Accessed at www.aaasouth.com/acs_news/8556.asp.

have to "police" employees' use of car for business vs. personal reasons, employees can pay $200 per month to the agency to use the car for personal business. Some employees have sold their personal cars and rely upon the agency car for their personal use, she says. "Employees can only use the car for personal use within a 200 mile radius of our office but our vendor, Enterprise, offers our employees discounted rental rates for cars they can take on longer trips," she says.

One surprise that McNitt learned about in the "eleventh hour" is the Internal Revenue Service rule that using a company car for personal use is considered a benefit and employees must pay income tax on the value of the benefit. "We calculated the number of miles that $200 represents and told employees that if they drove more than that number of miles on personal business, we would withhold income tax," she says.

Employees submit a report each month detailing business and personal miles for which the car is used, so keeping track for accounting purposes is easy, she adds. **[The report is available with the online version of *Hospice Management Advisor* at www.ahcmedia.com. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]** The agency pays for insurance on all cars in the fleet and also buys the gas, points out McNitt. The agency is paying about $70 per month per car for insurance coverage, she says. Each employee has a gas card that is used only for the agency car, she says. The gas card also can be used at approved automobile repair shops that were chosen by the leasing vendor for maintenance and repairs, she adds. *(Editor's note: AAA's web site, www.aaa.com, also has a list of approved repair shops if a leasing vendor does not offer one. On the homepage, go to "automotive" on the top navigational bar and select "approved repair facilities.")*

"One key to success of this program is that I did not have to add a staff person to manage the

fleet," says McNitt. "Our vendor has a staff person assigned to manage our account." Not only does the leasing company manager notify each employee when it is time for an oil change or tire rotation, but the manager also monitors gas card usage to identify trends that might indicate misuse of the cards, she adds.

"Be sure to get employee buy-in as you develop the program," says McNitt. While most employees were thrilled with the idea of the agency providing a car, some employees thought of their monthly mileage reimbursement checks as "extra money," she points out. Agency managers spent a lot of time showing the real costs of using a personal car for business as compared to what is actually reimbursed so employees would understand the benefit, she adds. *(Editor's note: To calculate the costs of driving, including gas, oil, maintenance, and tires, go to www.piercetransit.org and click on "See how much the old jalopy really costs you.")*

McNitt offers one last tip to ensure a smooth introduction of agency cars, "Don't let employees choose the color of their car." The agency wanted a consistent look in the community, she says. "We told everyone up front that the cars would be either white or silver, and management would make the decision." ■

New NPSG addresses central line infection risks

Requirements on anticoagulation therapy cut

The importance of reducing deadly drug-resistant, health care-acquired infections is the basis for the requirement in The Joint Commission's (TJC's) 2009 National Patient Safety Goals (NPSGs) to reduce the risk of infection associated with central lines.

"The issue of health care-acquired infections continues to get bigger," says **Peter B. Angood**, MD, vice president and chief safety officer for TJC. There are many different types of infections that require different approaches by each entity, he adds.

The element that requires hospices and home health agencies to "implement best practices or evidence-based guidelines to prevent central line-associated bloodstream infections" has a one-year phase-in period, but there are specific deadlines to meet within the year, Angood points out. **(See p. 102 for deadlines.)** Appropriate guidelines include guidelines from the Centers for Disease Control and Prevention or other professional organizations. **(See resources, above.)**

"This will be a complicated process for many entities, which is the reason we designed a phase-in period," admits Angood. "Although most home health personnel don't insert central lines, they are often responsible for maintaining them." Staff members should receive proper education on prevention of possible infections and should be able to educate patients and their families, he says.

Hospice managers received good news with the release of the 2009 goals, because several requirements for compliance with the goal to reduce harm from anticoagulation therapy were removed from home care's manual, says Angood. Elements 3 through 7 of the requirement were too specific and did not apply to home care, he explains. "Removing these elements for home care did make life easier for home health managers," he admits.

The anticoagulation safety goal was published last year with a one-year implementation period and specific checkpoints throughout the year. Hospice and other home health agencies already should have their implementation plan to meet this goal in place and should have conducted a pilot test of the plan by Oct. 1, says Angood. The plan to reduce the risk of anticoagulation therapy in the hospice agency should be fully implemented by Jan. 1, 2009.

Overall, home health agencies are complying with the National Patient Safety Goals well, says Angood. "Medication reconciliation is still difficult for home health, but there are many tools, including electronic health records, that can help," he suggests. "Because the elements of the

Resources

To see a copy of the 2009 National Patient Safety Goals for home care, go to www.jointcommission.org. Select "Patient safety" from top navigational bar, then select "National patient safety goals." Scroll down to "home care."

For a copy of the Centers for Disease Control and Prevention's "Guidelines for the Prevention of Intravascular Catheter-Related Infections," go to www.cdc.gov/ncidod/dhqp/gl_intravascular.html.

goal related to medication reconciliation were revised this year, home health managers should review them to make sure their programs still meet requirements."

Two other requirements were added to the goal to reduce health care-associated infections, but the multidrug-resistant organism and surgical site infection requirements do not apply to hospice and other home health services. ■

Interim deadlines keep you on track to compliance

Milestones must be met for infection control goal

The newest requirement for compliance with Goal 7 of the 2009 National Patient Safety Goals from The Joint Commission is "implement best practices or evidence-based guidelines to prevent central line-associated bloodstream infections." The requirement applies to short- and long-term central venous catheters and peripherally inserted central catheter lines.

The requirement has a one-year phase-in period that includes specific milestones with defined expectations for planning, development, and testing. Full implementation of a process that meets the requirements of the patient safety goal is expected no later than Jan. 1, 2010. Deadlines throughout the year are:

• **April 1, 2009:** The organization's leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of the goal to reduce health care-associated infections related to central lines.

• **July 1, 2009:** An implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a timeline for full implementation by Jan. 1, 2010.

• **Oct. 1, 2009:** Pilot testing is under way for the requirements.

• **Jan. 1, 2010:**

— The elements of performance are fully implemented across the organization.

— The organization educates health care workers who are involved in these procedures about health care-associated infections, central line-associated bloodstream infections, and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in these procedures is added to an individual's job responsibilities.

— Prior to insertion of a central venous catheter, the organization educates patients and their families as needed about central line-associated bloodstream infection prevention.

— The organization implements policies and practices aimed at reducing the risk of central line-associated bloodstream infections that meet regulatory requirements and are aligned with evidence-based standards.

— The organization conducts periodic risk assessments for surgical-site infections, measures central line-associated bloodstream infection rates, monitors compliance with best practices or evidence-based guidelines, and evaluates the effectiveness of prevention efforts.

— The organization provides central line-associated bloodstream infections rate data and prevention outcome measures to key stakeholders including leaders, licensed independent practitioners, nursing staff, and other clinicians.

— Use a catheter checklist and a standardized protocol for central venous catheter insertion.

— Perform hand hygiene prior to catheter insertion.

— Use a standardized supply cart or kit that is all-inclusive for the insertion of central venous catheters.

— Use a standardized protocol for maximum sterile barrier precautions during central venous catheter insertion. ■

Should you upload info to a personal health record?

Use of online PHRs raises questions, concerns

Hospice nurses are accustomed to point-of-care technology for completing charts and assessments. But, is your agency prepared for access to, or uploads to, your patient's personal health record (PHR)?

"We're entering uncharted territory with online personal health records," says **Karen Golden Russell**, MBA, senior marketing manager for Philips Home Healthcare Solutions in Andover, MA. The difference between PHRs and electronic health records used by home health agencies and other health care providers is that the patient has complete control of his or her record and determines who else has access to it, she explains.

EXECUTIVE SUMMARY

The increasing availability of online personal health records (PHR) raises questions about the responsibility and liability for hospice agencies when accessing a PHR.

- Is a hospice nurse responsible for identifying potential health risks based on patient-entered information?
- Will the knowledge that clinical notes may be uploaded to a patient's PHR affect how a physician or nurse documents?
- Do the benefits of accessing a patient's PHR outweigh the liabilities?

Because the interest in personal health records is just beginning, now is the time to develop a plan to handle a request by a patient for information to upload into the record or a grant of access to a PHR, says Golden Russell. **(For tips on preparation, see p. 104.)**

While electronic records now used by hospice agencies can be used to enhance the medical information contained in a personal health record created by the patient or a patient's family member, there are several questions about liability, security, and appropriateness of uploading information to a patient's health record, points out Golden Russell.

"Currently, electronic health records are closed systems that are only accessed by the provider who creates the record," she says. "There may be information in notes regarding diagnoses, treatments, or the patient's condition that a clinician does not want the patient or a patient's family member to see." If a clinician knows that the entire record might appear on a personal health record that can be accessed by several individuals, he or she might not include the same details or the same information, she says. There are too many issues related to privacy, security, and liability that might restrict the clinician's willingness to make detailed notes, she adds.

Although there are challenges, the benefits to patients and providers will be significant with a growing use of personal health records, says **Holly Miller**, MD, MBA, medical information officer for University Hospitals in Shaker Heights, OH. A personal health record can be used to improve communication between providers as the patient offers access to the record to hospice providers or to a new physician to review, and it also can be used to improve communication with family members who don't live near the patient, she points out.

Even though a large number of hospice patients are older, don't assume that age determines a patient's willingness to use the Internet, points out Miller. "I've seen studies that show that age does not predict a willingness to use an online PHR. Instead, the number of health issues, or diagnoses, a person has is a better predictor than age," she says.

Having one record into which the patient collects information from all providers will improve coordination of care, points out Miller. "Medication reconciliation will also be improved," she says. In fact, Miller foresees the day when technology will enable a physician not only to prescribe medication, but also to monitor whether or not the patient takes the medication. "I will prescribe medication and two weeks later change the medication because the patient's condition has not improved," she says. "In reality, the patient never filled the first prescription." E-prescribing will not only make sure the patient's record reflects accurate prescriptions, but also will send a message to confirm that the prescription was filled, she says.

While no one can predict how prevalent personal health records will become or how they can be safely uploaded with provider information, Miller does anticipate increased interest as baby boomers age. "By 2030, one-fifth of our population will be over the age of 65, and this is a generation that is accustomed to having information and using the Internet, so PHRs will appeal to them." ■

Source and Resource

For more information on personal health records, contact:

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The Healthcare Information and Management Systems Society (HIMSS) offers free resources related to personal health records. For access to guidelines, studies, and tools related to the use of personal health records, go to www.himss.org. On the left side of the page, select "view all topics." Under "Interested in ambulatory IS?" choose "personal health records."

Tips to keep in mind for personal health records

Not many hospice nurses have had patients offer them access to their online personal health records (PHR). However, but now is the time to prepare for that offer, suggests **Karen Golden Russell**, MBA, senior marketing manager for Philips Home Healthcare Solutions in Andover. Although the benefit of having access to a thorough medical history is obvious, there are issues that online personal health records raise that go beyond just reviewing information, she points out. Consider these questions:

• What type of record does the patient have?

Is the patient using a system into which he or she enters all of the information? If so, how reliable is the information? Patients might be transcribing some information from physicians or pharmacies, but others might use their online record as a diary of how they feel or what their blood pressure, weight, or other vital signs were each day, points out Golden Russell. Clinical information or medication should be verified with the physician or by looking at medication containers in the home, but diaries might give a nurse extra information about the patient's condition on a day-to-day basis.

• What is the responsibility of the home health nurse with access to a PHR?

Home health managers should be talking with an attorney to answer this question, recommends Golden Russell. "If an agency is offered access to a PHR, is the nurse responsible for recommending care based on notes the patient made in the record?" she asks. For example, a patient who keeps a diary-type record might make a few statements that indicate depression, but is the nurse responsible for identifying depression and recommending a consult? Obviously, if a nurse suspects depression during an assessment or a follow-up visit, he or she will talk with the patient to determine the need for further assessment by a physician or other clinician, but what happens if the nurse doesn't see something in a lengthy online record?

"There is also concern about relying on patient-entered information, because we don't know if the patient included everything," Golden Russell points out.

• How much time can a nurse spend with a PHR?

"Time spent reviewing a PHR is not reimbursable, so agency management needs to determine who reviews the PHR and how much time can be allowed," Golden Russell says.

There are situations in which nonreimbursable activities are good business, such as telehealth, she admits. The investment in telehealth and the staff time needed to monitor telehealth patients has proven to be effective in increasing productivity and improving outcomes, so even though telehealth activities are not reimbursed, overall they can help an agency's bottom line, she says. There are unanswered questions about the effect of PHRs on outcomes, so an agency manager needs to consider how much staff time is spent with PHRs.

• What type of access should an agency have to a patient's PHR?

"There are two types of access to a PHR, read-only and write," says Golden Russell.

One of the first things an agency must decide is whether nurses are going to enter information into a patient's PHR, either through notes at the home or by uploading information, she says. Issues related to entering information include HIPAA [Health Insurance Portability and Accountability Act] privacy and security requirements that health care providers must meet but that private companies that offer PHRs don't have to follow, she points out.

If you opt to accept read-only access, be sure to set parameters, recommends Golden Russell. "You might agree to review the PHR at start-of-care only," she says. This initial review of the PHR might be helpful as the nurse assesses the patient and could lead to follow-up questions that enhance the assessment. A policy that specifies start-of-care review won't commit the nurse to spending time at each visit reviewing a PHR, and that policy can address nonreimbursable time concerns, Golden Russell adds. ■

Difficult decisions faced during financial crises

Closing, changing services may be best move

It's a tough time to be a hospice manager. For years, you've implemented new processes designed to strengthen your agency, but it's hard to fight an economic environment that is forcing all industries to re-evaluate how they conduct business.

Even when management has taken steps throughout the years to position the agency for financial health, changes in the marketplace, in reimbursement levels, and in the cost of doing business are forcing managers and boards of directors to make tough decisions.

Sometimes the decisions affecting the home health services come from another entity, says **Terry Cichon**, CPA, director of homecare operations for FR&R Healthcare Consulting in Deerfield, IL. "We have hospitals in the Chicago area that are selling their home health businesses," she says. "Unfortunately, a home health agency is a small piece of the hospital's business, so even if the home health agency is not making money, the rest of the facility's business can underwrite the home health agency." If, however, financial pressures are affecting the hospital overall, home health becomes a logical choice for a service that can be discontinued, she adds.

Closing an office

Another tough decision is the closing of a branch office. **Linda Leone**, RN, president of Prairieland Home Care in Fargo, ND, says, "It was not an easy decision, and it was not made over a six-month time period. The branch office had not been making money for years." Increasing economic and staffing pressures initiated the process to evaluate the closing, she adds.

"The office was in a sparsely populated area of North Dakota and served a 50-mile radius," explains Leone. This meant that driving from one side of the area served to the other side meant a 100-mile trip, and patients were spread throughout the area, she says. "Unfortunately, the office was also located in North Dakota, which receives the lowest level of Medicare reimbursement, a case mix of 0.76," she explains.

Staffing costs were a drain

Staffing also was an issue. "It was hard to find nurses who were willing to drive the distance required to the office and pay for their gasoline if they did not see a patient on the way into the office," says Leone. "If they did see a patient on the way to the office, we paid for the commute, which increased our costs."

Steps taken to reduce the driving time of the nurses included placing a fax machine in the nurses' homes so schedules and patient information could be faxed to the home. "We also had some nurses with computers, so they could access the office computer for schedules and to scan their forms," she says.

Even with these cost-saving measures, the board of directors agreed that the fiscally sound decision for the agency was to close the office. The 11 employees at the office served 300 patients annually, and part of the difficulty of the decision was the knowledge that these patients didn't have another option, Leone says. Agency management focused on quick, honest communication with patients, referral sources, and staff members to notify everyone of the closing and explain what would happen in the three months between the decision to close the branch and the date of the closing, she says.

Patients were discharged on schedule during the three months, and the agency offered assistance to find other providers for patients who required service after the closing date, says Leone. It was not possible for employees to be offered positions at other branch offices, because they were several hours from other offices, but agency management made sure that employees got information they needed to prepare for their personal financial situation as soon as the decision to close was made, she adds. ■

Agency discontinues private duty home care

When the decision was made to close the private duty home care division of Riverside Home Health in Kankakee, IL, the good news for employees was the opportunity to accept other positions in the Medicare-certified home health agency.

After 23 years of offering private duty service, the administrators decided that it was not possible to continue, explains **Mary Newberry**, RN, BSN, director of home health and outpatient services at the agency. Private duty home health relies upon the presence of a few long-term care patients who require a lot of hours each week to provide the stability you need to maintain staff and income, Newberry points out. "We began losing two long-term care patients at one time and only adding one to replace the two patients," she says. The agency reached the point that there were not enough long-term patients to sustain staff to provide services to

all patients, Newberry says. "You cannot keep your caregivers on staff if you can't keep them busy," she adds.

Simultaneously, they found that they were pricing themselves out of the market, because they insisted on paying our private duty employees the same pay rates and benefits that employees in the Medicare-certified agency and the rest of the hospital received, says Newberry. "We knew that this would make our rates higher, but we did not think it was right to pay some employees less than other employees who were doing the same jobs, just in a different department," she says.

Telling patients

Communicating the closing to patients was difficult for everyone, admits Newberry. Nurses and managers spent time with the patients, explaining options, identifying other community resources, and listening to their concerns, she says.

While established agencies might have to evaluate closing a branch office or a service when financial pressures arise, some agencies are having difficulty getting off the ground, says **Terry Cichon**, CPA, director of homecare operations, FR&R Healthcare Consulting, Deerfield, IL. "The ability for new agencies to generate referrals is especially difficult in Illinois, Florida, California, and Texas, where there are a large number of established agencies," she says. "I've had some clients take months to get enough referrals to apply for Medicare certification."

Because competition for referrals is increasing, Cichon suggests that agencies make sure they have a good marketing staff. "There is more emphasis on marketing for all agencies, but especially for agencies that offer hospice and private duty service," she says.

Data are the key

Successful agencies that can survive tough financial times are agencies that are data-driven, points out Cichon. "Their staff members understand how OASIS [Outcome and Assessment Information Set] affects reimbursements, and they make sure that OASIS is accurate," she says. Agency managers also need to make sure they are constantly monitoring income, expenses, productivity, and all other agency activities on a regular basis so that they have an opportunity to make tough decisions to ensure the future of the agency, rather than close the doors, Cichon adds. ■

Medicare addresses how to report charges

The Centers for Medicare & Medicaid Services (CMS) has posted a question and answer that is of interest to hospice providers.

• **Question:** Change Request (CR) No. 5567 provided instructions for the expanded claims data reporting requirements for Medicare hospice claims. As part of those instructions, in Section 30.3 "Data Required on Claim to FI" of Chapter 11 "Processing Hospice Claims" of the *Medicare Claims Processing Manual*, CMS states that as part of the reporting of visit information on the hospice claim, hospices are required to report "charges" for the services described on each revenue code line. Can CMS provide further guidance as of how to report "charges" on the hospice claim?

• **Answer:** With regard to guidance to hospices on how to report charges on the hospice claim, we refer hospices to these areas of CMS' manuals:

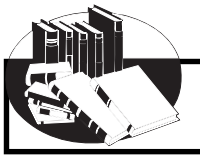
1. At Pub 100-04, CMS' *Medicare Claims Processing Manual*, Chapter 25, "Completing and Processing the Form CMS-1450 Data Set," we provide the following guidance/ instructions:

- Under Section 75.5 — Form Locators 43-81, for "FL 47 — Total Charges," we say the following: This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is "0001," which represents the grand total of all charges billed. The amount for this code, as for all others, is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

2. Furthermore, in CMS' *Provider Reimbursement Manual*, Part 1, Chapter 22, "Determination of

Costs of Services," we say at:

- Section 2203, "Provider Charge Structure as Basis for Apportionment," that to ensure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure that is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program.
- Section 2204, "Medicare Charges," we further say that the Medicare charge for a specific service must be the same as the charge made to non-Medicare patients (including Medicaid, CHAMPUS, private, etc.), must be recorded in the respective income accounts of the facility, and must be related to the cost of the service. (See §2202.4.)
- Section 2202, "Definitions," at 2202.4 "Charges," we say that charges refer to the regular rates established by the provider for services rendered to beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions. (See §2206.l for information on accrual of charges and §2204.l for hospital-based physician charges.) ■



JOURNAL REVIEW

Bereaved family members rate care from hospices

How to achieve an 'excellent' rating

A survey of bereaved family members shows that good communication, emotional support, accurate information, and a single caregiver are more likely to rate their satisfaction as "excellent."

In an article that appeared in the *Journal of Pain and Symptom Management*, researchers described the specific issues that contribute to high satisfaction by family members of a hospice patient.[1] "Understanding the determinants of family members' overall satisfaction with hospice service may provide information that can help the hospice industry improve both the quality of care patients and families receive at the end of life as well as the family member's overall satisfaction with this care," according to the authors.

A total of 116,974 surveys from 819 hospices in the United States were used to evaluate satisfaction levels. When asked to evaluate their satisfaction with the hospice staff's attendance to family needs for support, respondents were more likely to rate the service as excellent if they felt they had sufficient contact with the hospice team about their religious or spiritual beliefs and if they believed that the hospice team provided them with the right amount of emotional support, report the authors.

Higher overall satisfaction levels also were reported by family members who believed they had adequate information about what they could expect while the patient was dying, medications used to manage pain, and information about treatment for dyspnea. Family members were three times more likely to have higher satisfaction levels

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if they were kept regularly informed of their family member's condition, add the authors.

Satisfaction levels were higher when family members believed that there was strong coordination of care. Knowing that one nurse was in charge of the patient's care is important, as is feeling confident that members of the hospice team are knowledgeable about the patient's medical history and are giving accurate information to the family.

Preparing the family for the patient's death requires honest communications and accurate information. This preparation may reduce complications of the grieving process, such as depression and anxiety, for family members, the authors add.

Reference

1. Rhodes RL, Mitchell SL, Miller SC, et al. Bereaved family members' evaluation of hospice care: What factors influence overall satisfaction with services? *J Pain Symptom Manage* 2008; 35:365-371. ■

CMS issues report on RAC demonstration

According to the recently released report on the Medicare Recovery Audit Contractor (RAC) three-year demonstration program, RACs recouped $992.7 million in overpayments to providers, while $37.8 million in underpayments were repaid to providers.

Of the overpayments, 85% were collected from inpatient hospital providers, 6% from inpatient rehabilitation facilities, and 4% from outpatient hospital providers. After expenses, appeals, and underpayments repaid to providers, the program returned $693.6 million to the Medicare Trust Fund. The report also outlines lessons learned during the demonstration and improvements the Centers for Medicaid & Medicare Services (CMS) will make to the permanent program that, at press time, was scheduled to roll out summer 2008. While hospice and home health providers were not included in the demonstration project, they are expected to be included eventually in the permanent program. **(For more information about RACs and their potential effect on hospice care, see "Prepare now to reduce risk and consequences of RAC audit," *Hospice Management* Advisor, May 2008, p. 54.)** To download a copy of the report, go to: www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf. ■

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