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Hospital Home Health®

the monthly update for executives and health care professionals

AHC Media LLC

IN THIS ISSUE

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APRIL 2009
VOL. 26, NO. 4 • (pages 37-48)

Demonstration proves to reduce readmission rates; improve outcomes

Adult day services offer socialization for patients and respite for caregivers

Decreasing hospital readmission rates from 28% to 12% for the patients participating in the Centers for Medicare & Medicaid Services (CMS) Medical Adult Day Services Demonstration is only one indication that enabling home health patients to attend adult day center programs during their home health episode is beneficial.

In addition to reducing readmissions for the group of patients participating in the demonstration project through her agency, **Sue Meier**, RN, administrator of Landmark Home Health Care in Allison Park, PA, points to the 30% of project participants who continue adult day services after discharge from home health as another indication that patients and families believe there is a benefit to the program, even when they may pay for it themselves.

With only four months left in the demonstration project **(See pg. 41 for timeline and details of project)**, home health managers are watching the project carefully to see what lessons have been learned and if this will be a viable new service for home health to offer.

Although the data for the entire project has yet to be compiled and

EXECUTIVE SUMMARY

The final decision about reimbursement of home health services provided in an adult day services setting won't be known until 2010, but home health agencies participating in the Centers for Medicare & Medicaid Services (CMS) Medical Adult Day Services Demonstration have learned a lot during the project, which ends in July 2009.

- Significant education about the value of adult day services for home health patients is needed.
- Patient outcomes improve with lower hospital readmission rates as one indication.
- Reimbursement, transportation, and payment for adult day services after discharge from home health need to be evaluated.

analyzed, anecdotal stories of success can be found at all of the demonstration sites. "One of the first patients we enrolled into the demonstration project was depressed and had not talked in quite a while," says **Mercy Flores**, BSW, MA, social worker and demonstration manager at Doctor's Care Home Health in McAllen, TX. Being able to socialize and go to the adult day center several times a week, without missing his home health visits, the patient is now smiling and alert, she says. "His quality of life has improved, because he has a chance to be with other people," she adds.

Patients enrolled in the demonstration project are home health patients covered by Medicare. Previously, home health could not be reimbursed for seeing patients in a setting other than their own homes, but the demonstration project allows for care to continue for the home health patient even at the adult day center. Patients who choose to participate are able to go to the adult day center and be assessed, receive medications, have blood pressure monitored, see a social worker, or even receive physical therapy while at the center. Home health agencies in the demonstration are reimbursed for the visit, then the agency reimburses the adult day center a portion of the CMS payment for each day the patient is at the center. Reimbursement for home health visits to the day services center are reimbursed at 95% of normal reimbursement, because the initial assumption was that cost of care would decrease if the home health nurse could see several patients at one location.

The lower reimbursement rate is one issue that home health agencies in the project want to see studied further, says **Kim Delp**, RN, BSN, director of business development for Landmark. "The only thing we don't have to pay is travel expense between several homes if the nurse sees multiple patients," she says. "We still pay per visit, so seeing three patients at one adult day center counts as three visits. Then we have to pay the adult day center their fee out of our lower reimbursement," she adds. Even with the financial challenge, Delp says that her agency plans to continue the service if it is approved by CMS. "Our patients benefited from the service, and our staff enjoyed working at the adult day centers." **(For more about staffing, see pg. 40).**

Lack of knowledge creates obstacles

The need for education was the biggest challenge, as home health agencies began establishing partnerships with adult day centers and recruiting patients. "There was a lot of information for everyone at the beginning of the project," admits Flores. Patients and home health staff had to learn about adult day care, because the impression of adult day care was that it was little more than a babysitting service, she points out. "The adult day center could act as an extension of the home health agency by providing socialization opportunities for patients, transportation, and meals," she says.

Home health agencies in the demonstration had to partner with adult day centers that offered

Hospital Home Health® (ISSN# 0884-8998) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ***Hospital Home Health***®, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: customerservice@ahcmedia.com. World Wide Web: http://www.ahcmedia.com. Hours: 8:30-6 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

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Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

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on-site nurses and medical monitoring for high blood pressure, diabetes, and other chronic conditions. "Our challenge was that these adult day centers had never promoted the medical aspect of their services, so we had to educate medical staff, case managers, and social workers at our referral sources," says Delp.

Adult day centers also had to be educated, says Flores. "Adult day centers had the expectation that the patients would come to the center every day and receive all home health services at the center," she explains. In reality, the number of days at the center was determined as part of the overall plan of care and differed for each patient according to the patient's needs, she says.

Although her agency is not part of the demonstration project, **Judith Bellome**, RN, BSN Ed, MS Ed, CEO of Douglas County Visiting Nurses in Lawrence, KS, is watching carefully, because her agency is evaluating the feasibility of this service for her community. "I do think education has been the biggest challenge for agencies," she says. "This is a new way to provide home care, and it is hard to explain," she admits. A home health aide might help the patient dress in the morning, then the adult day center's van transports the patient to the center, she says. "At the center, a nurse or a therapist might conduct the patient assessment, provide care needed that day, then the patient joins other people in various social activities," she explains. Continuity of care even when the patient is not at home is the goal of the program, she adds.

Another issue that participating agencies see now is the need to address funding of adult day services once the patient is discharged from home health. They learned that many patients wanted to continue adult day services after the home health episode ended. Delp says that her staff began looking for financial resources at admission. State funding such as Medicaid, or private pay for families and patients with the ability to pay, was identified early, so that there was no interruption in adult day participation, she says. **(For other lessons learned during the project, see pg. 40).**

Regardless of the demonstration project's outcome, it is still good practice for home health agencies to establish relationships with adult day service providers in their communities, suggests Bellome. "It is smart marketing to make friends with all potential referral sources, and adult day centers can offer beneficial services to your patients and their caregivers," she says. A home health agency can conduct a health fair, along with an adult day center, and both organizations can distribute each other's brochures. She adds, "Adult day services can also be a good resource to provide respite care for family caregivers." ■

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Data analysis to begin in August

CMS demonstration project ends in July

The Centers for Medicare & Medicaid Services (CMS) Medical Adult Day Services Demonstration began in August 2006 and will end July 2009. There is no set date for the final report, but CMS is required to submit the report and recommendations to Congress within eight months of the end of the project, according to a CMS representative. If approved, implementation will begin March 2010.

The demonstration project began with five home health agencies in different geographic locations. Over the first two years of the project, two agencies dropped out of the demonstration. "The data from these sites will be incorporated into the analysis and will provide positive information," according to CMS. Input from all agencies, including those that left the project, will

enable accurate identification of areas that need to be addressed to improve the service. Although reasons for leaving the demonstration project varied, the geographic differences, as well as other factors, will add to lessons learned during the demonstration.

Although the design of the overall demonstration project has not changed since inception, individual sites were able to make approved changes to reflect specific issues faced in their communities. A CMS representative adds, "Overall, CMS feels good about what has been learned during the demonstration." ■

Staffing models differ from site to site

Biggest challenge is turnover at adult day centers

The home health agencies participating in the Centers for Medicare & Medicaid Services (CMS) Medical Adult Day Services Demonstration had rules to follow regarding patient selection, partnership with adult day centers, and data collection, but they each were given the freedom to staff the program in the manner that worked best for their agency.

Because all adult day services centers with which the home health agencies partnered had medical staff, such as a registered or licensed vocational nurses in place, Doctor's Care Home Health in McAllen, TX, opted to designate case managers to oversee the adult day center staff's monitoring of the home health patients, says **Mercy Flores**, BSW, MA, social worker and demonstration manager at the agency.

"The case manager also sees home health patients and educates the adult day nurse about documentation," says Flores. The adult day nurses document their care for the home health patients in the demonstration project on paper forms that are picked up once each week by a home health employee. These nursing notes are added to the patient's home health chart, she says. Although the documentation is not as complex as the documentation required by the home health nurse, such as OASIS, the adult day center nurses do complain about the extra paperwork, she admits. "They are not experienced with this level of documentation, so there is a learning curve," she explains.

At Landmark Home Health Care in Allison Park, PA, home health nurses normally assigned to the geographic area in which the adult day center is located see patients at the center, says **Kim Delp**, RN, BSN, director of business development for the agency. "Usually, it is the same one or two nurses that go to the adult day center on a regular basis, so they get to know the day center staff and the program," she says. When the demonstration project started, the home health nurses visited the center to introduce themselves and become familiar with the day center's services, she says. Having the same people work with the day services center improves communication between the two organizations, she adds.

The adult day service centers and the home health agency rely on the Internet and voice mail to document services and maintain constant communication, says **Sue Meier**, RN, administrator of Landmark Home Health Care. "We use an electronic, web-based documentation system, so we are able to give adult day nursing staff access to specific patients' charts to enable them to make notes as they see the patients on days that our nurse does not see the patient," she explains.

The communications process also requires the adult day nurses to leave a voice mail for the home health nurse to alert him or her when a change has been noted, or a concern expressed by the adult day nurse, explains Meier. "This alerts us that the patient may require a home visit to follow up on the concern," she says.

There has been no problem finding staff to see patients at adult day centers, says Meier. "Our staff members enjoy seeing patients in the adult day center," she says. "They like the environment and like being able to see several patients in a shorter period of time than required when they drive from home to home."

The staffing challenge that has been faced during the demonstration project is the turnover of nursing staff at the adult day centers, says Flores. There is a learning curve for proper documentation and assessment of home health patients that are now at the day services center, she says. "Turnover requires additional education by the case manager, or even the case manager's presence at the adult day center, to see patients in the demonstration project while the day services center tries to fill the open spot," she explains.

The adult day services center's nursing staff does have additional responsibilities during the demonstration project, because nurses may see 19 patients during the day rather than five or six,

points out Flores. "Eighty percent of the adult day centers in our demonstration project area gave nurses a bump in pay to compensate them for the extra responsibilities," she says. This incentive is important to keep in mind if the project is approved for all home health patients, because adult day centers will see more patients that require daily monitoring, she adds. ■

Some surprises uncovered during demonstration

Reluctant patients, transportation issues addressed

No one was surprised at the amount of public and referral source education needed to get the Centers for Medicare & Medicaid Services (CMS) Medical Adult Day Services Demonstration off the ground, but there were a few unanticipated challenges faced as home health agencies have recruited patients for the project during the past 2 years.

• **Patients reluctant to leave home**

"Homebound patients are socially isolated, and the unknown is a challenge for them," explains **Judith Bellome**, RN, BSN Ed, MS Ed, CEO of Douglas County Visiting Nurses in Lawrence, KS. If the patient is not familiar with an adult day service center, the idea of traveling to another location for a day is frightening, she says.

"Traveling to an adult day center is also physically taxing for many patients," points out **Mercy Flores**, BSW, MA, social worker and demonstration manager at Doctor's Care Home Health in McAllen, TX. If a patient believes that he or she will be exhausted from the travel, the idea of going to an adult day center is unappealing, she says.

Because the physical demands of travel are an issue for older home health patients, be sure you select adult day center partners that are located in areas that don't require long rides in a van from their homes, suggests Bellome.

• **Transportation can be an issue**

Although adult day services centers in many areas offer transportation, be aware of limitations, suggests **Kim Delp**, RN, BSN, director of business development for Landmark Home Health Care in Allison Park, PA. "Our challenge was a transportation system operated by our state department of aging services that did not have an easy set-up process," she says. Once the home health agency enrolled the patient in the CMS demonstration project, transportation services needed to be available within 24 to 48 hours, she explains. This is several weeks sooner than the existing system could handle unless the patient's need was deemed medically necessary, she says. By working with the department of aging's staff, Delp was able to get these patients' need for transportation deemed medically necessary, similar to the needs of dialysis patients, she says.

Be familiar with your area's state or local regulations, Delp suggests. "Every organization has different requirements, so knowing up front will help you better prepare," she adds. For example, initially her state required birth certificates or drivers' licenses to access transportation services, she says. "Many of our older patients don't have birth certificates or any way to obtain them, and they are not driving," she says. Exceptions to the requirement were obtained due to the medical necessity of the transportation, she adds. ■

'Senior Sensitivity' training helps staff understand

Participants simulate vision and hearing loss

Before they start their job managing the care of senior members, case managers at Senior Care Action Network (SCAN) Health Plan try to sort pills while wearing heavy gloves, strain to understand a speaker whose voice is muffled, and fill out a medical information form while wearing special glasses that simulate vision loss.

It's all a part of the Long Beach, CA-based Medicare Advantage Plan's Senior Sensitivity program to help employees feel, see, and hear what common physical and cognitive changes that occur with aging actually feel like and understand how much loss seniors experience as they age.

The health plan requires the Senior Sensitivity training for all of its employees, including board members, says **Sherry Stanislaw**, senior vice president at the health plan.

"The training is a good complement to the clinical training of the nurses and social workers, because they literally get to be in the shoes of the seniors. It helps our staff understand the challenges that their clients face in their everyday life and in adhering to their treatment plan," says

Lisa Roth, MS, gerontology, director of independent living power and geriatric health management and monitoring.

For instance, during the training, Roth had to walk around with popcorn in her shoes to experience the pain of neuropathy or arthritis in a senior's feet.

"This class helps our case managers understand the problems that members face so they can work with them on strategies that keep them safe at home and out of the hospital. If the senior's eyesight or hearing is limited, the case managers know how to overcome the barriers," Roth says.

The health plan started its Senior Sensitivity training about five years ago.

"The program is based on experiential learning. We use tools to accelerate aging and help the participants understand how seniors may struggle with everyday activities as well as the challenges they face as they maneuver through the health care system," Stanislaw says.

Tools include vision loss glasses that simulate glaucoma, cataracts, and other eye diseases.

In one exercise, the participants are asked to put on the glasses and a pair of bulky gloves and try to open a pill bottle filled with small candies, and then sort the candies according to color.

"This exercise helps the participants understand how seniors struggle when they have arthritis or have lost dexterity in their hands and at the same time have impaired vision," Stanislaw says.

It's a real "ah-ha" moment for many case managers, who often suggest that members who are on multiple medications fill the compartments in a pill box with their medications for each day of the week, says **Kelly Giardina**, MS, gerontology, manager of geriatric health management and monitoring.

"It was hard to fill the box while we had gloves on. Another challenge was trying to separate pills by color while wearing glasses to simulate vision loss. It helps the case managers consider if they are being realistic to expect seniors to fill their pill box. From our perspective, it's easy to think they could use a pill box, but if they have a deficit, it could prevent them from implementing the plan. Typically, they need to have someone set up the pill box for them," she adds.

The participants have to fill out a standard medical information form, similar to the kind used in physician offices, and fill it out with their left hands (to simulate impairments caused by a stroke) and while wearing the vision-altering glasses.

They must write down what they hear on a tape when the speaker's voice is muffled.

"During the classes, we talk about common hearing loss problems, which are common in the senior population. Many seniors can hear vowels but lose their ability to hear consonants, particularly on the end of words. When we play the tape, the participants are straining to hear and understand, and most of them get most of the words wrong," she says.

The program also deals with psychological losses that occur as people age. The participants have to write down the three most treasured things they have — family members, jobs, etc. The facilitator walks through the room and starts snatching things away from the participants.

"It's amazing how people react when the facilitator takes away the things that are important to them," she says.

A memory loss exercise gives participants a list of items that they have to remember.

"At the same time we are doing these exercises, we also remind participants that you can never stereotype seniors. Not every older adult experiences all these losses. A lot of it is individual," she says.

The trainers give the class tips on how to compensate for the disabilities during their interaction with members.

The case managers at SCAN range in age from the very young to those who are almost seniors themselves. Some have experience working with patients face to face, but others have only telephonic case management experience, Roth says.

"Without the experience of a deficit yourself, it's hard to understand what seniors face in the real world and to come up with unique ways to help members be adherent. The classes give them the feel of having a deficit and serve as a good reminder to put ourselves in the situation of the seniors," she adds.

Part of the initial case management assessment is to gather information that helps the case manager understand any challenges the member may face, Roth says.

"We ask about their vision, their hearing, and other functional aspects to assess some of the potential challenges the member has, so we don't assume that the member can do things or understand things when they can't," she adds.

The case managers learn to adjust their pace and their volume as they interact with members, Giardina says.

"They stop and confirm that the member

understands what they are saying and can repeat it back. It is a matter of adjusting interactions to compensate for whatever deficits the member may have," she says.

The case managers are trained to look for signs of deficits and vary the services they provide based on the different needs of their clients, Roth says.

For instance, if someone is visually impaired, the case managers may send them information in large print or provide an audio resource for the information.

"As a result of the program, the case managers work with the physicians to get the members a large-print copy of the medical questionnaire and send it to the members ahead of time.

"The case managers in our geriatric health management program always work on preparing the members for their doctors visits, helping them gather the information the doctor needs, and empowering them to make their doctor visits successful," she says.

As a backup to help overcome hearing and memory deficits, after the case managers talk to members, they send out a letter recapping what they have gone over during the telephone call, Giardina says.

"We do this because many of our members have trouble hearing, and it gives them the information in writing that they can take to their doctors," she adds.

The health plan uses risk stratification software to identify high-risk members based on their diagnoses and prior medical encounters.

When a member is determined to be at risk for hospitalization, the health plan's outreach staff contact them to find out if they are interested in enrolling in the case management program.

The case management program also receives referrals from physicians and from members who learn about the program and want to participate.

The case managers work with the members to help them manage their health care and adhere to the treatment plan. In addition to their extensive assessment, the case managers have information generated from encounter data with the physician medical group and hospitals.

"They have a picture of the patient before they call them. This puts us in a good position to come up with a plan to help the members manage their chronic conditions and live as independently as possible," Roth says.

The case managers use motivational interviewing techniques to determine the members' willingness to make changes and help them set short and long-term goals.

In addition to requiring Senior Sensitivity classes for its staff, the health plan has offered customized training to contracted providers to help them understand the challenges that the senior members face. For instance, during the training, the staff at physician offices spend a lot of time trying to fill out the patient registration form while using equipment that simulates deficits.

In Arizona, the health plan recently partnered with Dependable Medical Transportation Services to train more than seasoned van drivers about the challenges that seniors face.

SCAN has given classes to elementary school children to help them learn to better understand their grandparents.

"We talk to the kids about communicating with their grandparents and teach them techniques, like being face to face when they talk, so the seniors can hear them and pick up on both visual and audio cues. It's all a matter of understanding the other person's challenges," Stanislaw says.

*(For more information, contact **Lisa Roth**, MS, gerontology, director of independent living power and geriatric health management and monitoring, e-mail: lroth@scanhealthplan.com.)* ■

Hospices start down road of quality improvement

QAPI requirements go into effect as hospices

A group of 15 Indiana hospices has a two-year head start on all other hospices to meet the Quality Assessment and Performance Improvement (QAPI) requirements of the new Conditions of Participation (COP). The COPs, which were introduced in June 2008, require the collection and use of data to conduct studies designed to evaluate quality

"We anticipated implementation of the COPs in 2007, so, in 2006, we developed a benchmarking project that would help our member agencies meet the requirements," says **Todd Stallings**, executive director of the Indiana Association for Home and Hospice Care (IAHHC) in Indianapolis. Because the implementation of the quality assessment requirement was delayed until February 2009, the participating hospices began 2009 with a lot more experience at collecting, analyzing, and using data, he says. "The problem

with being proactive in this instance is that we went through a lot of effort, then nothing happened with the COPs," he laughs. "The good news is that the project is working well, and the participating hospices have learned a lot prior to implementation."

Each participating hospice enters data through an online system, then submits them to the vendor with whom IAHHC contracts, Outcome Concept Systems in Seattle. "The hospices receive a report that compares their results within their own peer group, as well as with national data," Stallings says. The four categories of information collected are quality outcomes, quality practices, patient volume and mix, and quality operations.

Participating hospices do pay an annual fee to the contractor, but IAHHC negotiated a reduced rate specifically for its members, says Stallings. "It was important to make the cost as reasonable as possible to encourage participation," he explains. "Hospices now realize that the fee is a good investment and is helpful."

Not only are participating hospices using the data to identify areas in which they are below the national or local peer group median, but also IAHHC has used the results to develop educational programs for hospices, says Stallings. "When we began collecting data, we realized that our hospices had almost no nurses who were certified for hospice and palliative care," he says. "We began sponsoring certification exam programs twice a year, and we've seen the number steadily grow. In fact, one hospice sent the entire nursing staff to the program."

Some hospices starting from scratch

Most hospices don't have the history of quality improvement programs such as the one in Indiana, and the new QAPI requirements are a shock, says **Lynda Laff**, BSN, principal with Laff Associates, a home health and hospice consulting firm in Hilton Head, SC. "Everyone is capable of more sophisticated data collection and reporting, but it has not been a priority until now," she explains.

The reality is that the QAPI requirements are not onerous, says Laff. "They are standard performance improvement activities, but CMS [Centers for Medicare & Medicaid] does require that the studies and the program be ongoing, not just periodic," she says. "Most hospices have pieces in place; they just don't know where to start." Hospices that are affiliated with a home health agency, which already has been meeting this requirement, are 70% ready for QAPI, Laff says. "Hospices that are community-based and self-contained have more work to do," she adds.

The first step in developing a performance improvement program is to evaluate the data you are collecting, suggests Laff. "Look at your current weekly, monthly, or quarterly reports," she says. You should have information on days on service, length of stay, diagnosis, and age groups by length of stay, "then look at symptom management and adverse events that you want to monitor," Laff adds.

This point is where it becomes overwhelming for some hospices, says Laff. "Don't try to eat the elephant in one bite," she says. "Pick one symptom or event to monitor, then decide what information you need to collect." Falls will be a common first study for many hospices, because it is possible to collect the information, and reducing the number of falls is important to improvement of quality of life for patients, Laff points out.

Pain also is a key symptom to monitor for hospices, says Laff. Whichever symptom you select for your study, be sure your nurses are collecting information in the same manner, she warns. Develop a data collection tool that is very specific about how questions are asked, what is documented, and where the information should be kept in the chart, Laff suggests. Don't just ask if pain was controlled, she says; instead, ask about pain in 24- or 48-hour segments. "We don't just want to know about symptoms at the moment the nurse sees the patient; instead we want to know what happened before the visit," she says.

Although tracking your own trends and results is important, look for ways to compare yourself to other hospices, suggests Stallings. His benchmarking project is limited to his membership, but he recommends that hospice managers approach their associations about a similar project. Even if you can't find an overall QAPI benchmark project, look for symptom-related projects as well, Stallings suggests.

"In addition to the QAPI project for hospice, our association is participating in a pressure ulcer reduction project as part of a comprehensive program coordinated by the State Health Department," he says. Also, look for existing tools, studies, and research that can give you a reference point for your own data, Stallings recommends.

One of the hospices that Laff advises is Tidewater Hospice in Bluffton, SC. "We are a small hospice, but I have a home health background, so I am familiar with performance improvement," says

Susan E. Saxon, RN, administrator and principal of the hospice. "We have been conducting patient care and clerical audits to identify adverse events such as falls or issues such as timeliness of documentation or physician orders," she says.

Even with a small staff, Saxon's agency is able to use multiple performance improvement teams to address issues such as falls or documentation. "You should use as many staff members as possible in the quality improvement process to improve understanding of the process and to make the program successful," she says.

With QAPI in place, Saxon has expanded her studies to address constipation, shortness of breath, and pain. "We have some information on these symptoms, but we've developed a tool to standardize the information that we capture and to give us data that we can use to identify areas of improvement," she explains. All three of these affect quality of life, and all three can be affected by staff members' actions, she adds.

Hospice managers shouldn't panic, Laff says. "Just read the COPs carefully, and pay close attention to QAPI," she adds. As you select outcomes to measure and studies to conduct, choose items that prove quality care, Laff suggests.

Why should hospice managers take QAPI seriously? Not only are they a COP that affects your reimbursement, but Laff believes this is a first step to further changes. "I foresee a standardization of information collected by all hospices, much like the OASIS [Outcome and Assessment Information Set] data collection tool that is required of all home health agencies," she says. ■

Telephone may be effective in weight loss maintenance

Face-to-face and telephone follow-up sessions appear to be more effective in the maintenance of weight loss for women from rural communities compared with weight loss education alone, according to a report in the Nov. 24 *Archives of Internal Medicine*. In addition, telephone counseling appears to be just as effective as face-to-to face counseling for weight loss management.

"Rural counties in the United States have higher rates of obesity, sedentary lifestyle, and associated chronic diseases than nonrural areas, yet treatment of obesity in the rural population has received little research attention," according to the authors. Studies have shown that diet, exercise, and behavior changes can produce significant weight loss and that extended care programs such as clinic-based follow-up sessions can improve weight loss maintenance. "However, in rural communities, distance to health care centers represents a significant barrier to ongoing care," the authors write.

Michael G. Perri, PhD, of the University of Florida, Gainesville, and colleagues conducted a randomized trial involving 234 obese women (ages 50 to 75) who completed a six-month weight loss program in six medically underserved rural communities. The women were randomly assigned to three extended-care programs consisting of 26 biweekly sessions for one year. There were 72 participants who received telephone counseling, 83 who received face-to-face counseling, and 79 who received biweekly newsletters containing weight loss maintenance tips. Estimated program costs were also assessed.

Average weight at the beginning of the study was 96.4 kilograms (212.5 pounds). The average weight lost during the six-month intervention was 10 kilograms (22 pounds). One year after the beginning of the study, "participants in the telephone and face-to-face extended-care programs regained less weight [an average of 1.2 kilograms (2.6 pounds) for each group] than those in the education control group [an average 3.7 kilograms (8.2 pounds)]," the authors write.

"The beneficial effects of extended-care counseling were mediated by greater adherence to behavioral weight management strategies, and cost analyses indicated that telephone counseling was less expensive than face-to-face intervention," the authors note. "Our findings highlight the benefits of extended-care interventions and indicate that telephone counseling represents an effective and cost-efficient approach to the management of obesity in underserved rural settings." ■

Are sleepy workers a threat to safety, productivity?

About one-third of 1,000 workers said they had fallen asleep or become very sleepy at work in the previous month, according to a recent National Sleep Foundation survey.[1] Also, about 10% of adults reported not getting enough

sleep every day for the previous month, says a recently published study from the Centers for Disease Control & Prevention (CDC).[2] The study also indicated that the percentage of adults who report sleeping six hours or less has increased from 1985 to 2006, across all age groups.

What can occupational health professionals do about this dangerous problem? According to **Lela R. McKnight-Eily**, PhD, the study's lead author and a behavioral scientist in CDC's Division of Adult and Community Health, you can begin by assessing whether workers are sleep-deprived. McKnight-Eily recommends using measures such as the Epworth Sleepiness Scale and Stanford Sleepiness Scale, which are used to measure daytime sleepiness.

"There are numerous health benefits that can be linked to employees improving sleep habits," says McKnight-Eily. Sleep disorders and sleep loss are significantly associated with mental distress, depression, anxiety, obesity, hypertension, diabetes, high cholesterol, and adverse health behaviors such as cigarette smoking, physical inactivity, and heavy drinking, she says.

"Sleep can be incorporated into employee wellness programs," she says. McKnight-Eily recommends:

- Encourage workers to take short naps; avoid caffeine, alcohol, or stimulants several hours before going to sleep; and relax before going to bed.
- Warn employees to be cautious about drowsy driving, as it is a cause of motor-vehicle morbidity and mortality.
- Encourage shift workers to obtain adequate sleep during the time that they are not working.

"Employees who have persistent issues with obtaining adequate sleep, may require an assessment by a health care employee for the presence of a sleep disorder," says McKnight-Eily.

References

1. National Sleep Foundation. 2008 Sleep in America Poll. 2008: Washington, DC.
2. McKnight-Eily LR, Presley-Cantrell LR, Strine TW, et al. Perceived insufficient rest or sleep — Four states, 2006. *MMWR* 2008; 57:200-203. ■

NEWS BRIEF

Family health history tool released by HHS

Internet-based tool expected to improve care

The U.S. Department of Health and Human Services (HHS) has released an updated and improved version of the Surgeon General's Internet-based family health history tool. The new tool makes it easier for consumers to assemble and share family health history information and helps practitioners make better use of health history information.

"This valuable tool can put family histories to work to improve patient well-being and the quality of care," former HHS Secretary **Mike Leavitt** said. "The tool is built on health information technology standards that make it more convenient for consumers and more useful for practitioners. It is ready for use in electronic health records. And its software code will be openly available to other health organizations, so they can customize and build on its standards base."

Key features of the new version of the Surgeon General's My Family Health Portrait include:

Convenience – Consumers can access the tool easily on the Web. Completing the family health history profile typically takes 15-20 minutes.

Consumer control and privacy – The family health history tool gives consumers access to software that builds a family health tree. But the personal information entered during the use of the tool is not kept by a government or other site.

Sharing – Because the information is in elec-

COMING IN FUTURE MONTHS

- Effective use of clinical pathways
- Music therapy's effect on outcomes
- Housing market's effect on seniors and home health
- Cultural diversity programs that increase referrals

tronic form, it can be easily shared with relatives or with practitioners.

EHR-ready, decision support-ready — Because the new tool is based on commonly used standards, the information it generates is ready for use in electronic health records and personal health records. It can be used in developing clinical decision software, which helps the practitioner understand and make the most use of family health information.

Personalization of care – Family history information can help alert practitioners and patients to patient-specific susceptibilities.

Downloadable, customizable — The code for the new tool is openly available for others to adopt. Health organizations are invited to download and customize, using the tool under their own brand and adding features that serve their needs. Developers may also use the code to create new risk assessment software tools. A ready process for organizations to download the family health history code is at https://gforge.nci.nih.gov/projects/fhh.

The Surgeon General's new My Family Health Portrait tool is located at https://familyhistory.hhs.gov. A presentation of sample risk assessment tools under development can be viewed at http://videocast.nih.gov/summary.asp?live=7297. ■

MedPAC does not recommend HH update

Home health agencies will not receive a payment update in fiscal year 2010, according to payment recommendations submitted to Congress by MedPAC.

Under the recommendations, hospital inpatient and outpatient services will receive a payment update equal to the increase in the market basket index, concurrent with implementing a pay-for-performance program that would be funded in part by a 1-percentage point cut in the indirect medical education adjustment for teaching hospitals.

Long-term care hospitals will receive a full market basket update minus an adjustment for productivity growth, for an estimated 1.6% update. Skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies would not receive a payment update. ■

CNE *questions*

13. At what level are home health agencies reimbursed for visits to patients while they were at an adult day services center during the Centers for Medicare & Medicaid Services (CMS) Medical Adult Day Services Demonstration?
    A. 90%
    B. 95%
    C. 100%
    D. 105%

14. What was the biggest challenge at the start of the adult day demonstration project, according to Mercy Flores BSW, MA, social worker and demonstration manager at Doctor's Care Home Health in McAllen, TX?
    A. finding home health nurses to see patients
    B. developing relationships with adult day centers
    C. educating referral sources, patients, and home health staff
    D. documenting care in the adult day center

15. Home health agencies participating in the Centers for Medicare & Medicaid Services (CMS) Medical Adult Day Services Demonstration had to follow specific staffing protocols and models during the project.
    A. True
    B. False

16. Why are home health patients reluctant to attend adult day service centers, according to Judith Bellome, RN, BSN Ed, MS Ed, CEO of Douglas County Visiting Nurses in Lawrence, KS?
    A. Social isolation
    B. Fear of the unknown
    C. Physical demands of travel
    D. All of the above

Answer Key: 13. B; 14. C; 15. B; 16. D.

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Readers of *Hospital Health Management* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2008 Healthcare Salary Survey & Career Guide*.

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CNE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **September** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■