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IN THIS ISSUE

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HHAs prepare for cuts and changes with health care reform

Agency reps make sure legislators have all of the facts

Even before health care reform became a major topic of conversation, home health agencies have been facing a number of changes that affect reimbursement, documentation, staff education, and services. According to experts interviewed by *Hospital Home Health*, health care reform will only add to home health agency managers' already long list of challenges.

Although no one can predict what will be included in any health-care reform legislation, the reality is that it will probably include cuts in reimbursement, and these cuts will come on top of a number of cuts experienced in home health already, says **Mary Newberry**, RN, BSN, president of the Illinois Homecare Council and director of home health and outpatient infusion for Riverside HealthCare in Kankakee, IL. "When the case-mix adjustment was cut, MedPAC [Medicare Payment Advisory Commission] just used data from freestanding home health agencies to develop their recommendation," she says. Because MedPAC based their recommendation on the reported profit margins, which showed a higher profit margin than hospital-based

EXECUTIVE SUMMARY

There is no way to know what the final healthcare reform legislation will include, but home health agency representatives are not waiting to act. Advocacy efforts top the list of actions taken by managers at this point, but they also are looking at ways to improve their chance of surviving further cuts in reimbursement.

- Look for ways to diversify so that your agency is not reliant on one source of income.
- Use telemonitoring and staff cross-training to improve efficiency.
- Budget carefully for reimbursement cuts that are already planned.
- Make sure employees understand OASIS C, because it is one change that is definitely going to occur.

agencies tend to make, the cuts have a serious impact on most hospital-based agencies, she explains.

"I can't speak for the whole home health industry, but I believe, based on my agency's experience, that hospital-based agencies tend to have higher acuity rates," says **Greg Solecki**, vice president of Henry Ford Home Health Care in Detroit. Depending on circumstances, a hospital-based home care agency may have higher overhead costs, including salaries, which reduce profit margins, in addition to caring for sicker patients, he explains. "I've always questioned the accuracy of MedPAC data, but the reality is that Medicare Advantage programs will mirror Medicare payment policies recommended by MedPAC," he adds.

According to the National Association for Home Care and Hospice (NAHC), almost one-half of the $1.2 trillion that health care reform proposals would cost over a 10-year period would be paid with Medicare cuts. Some of the dollars would come from a freeze on market inflation, and some would come from a 1% reduction in payments every year for a "productivity adjustment." Home health care payment rates would be reset in 2011 after reassessing the amount of money earned by agencies for services and length of time associated with care.

"This will be the first time for this type of change since 1997, when the pay-per-visit payment system was changed to a payment based on type of care," says Tow. "We are asking that if payment cuts are made, to implement them over a period of time, not all at once," he adds. A slower implementation of reimbursement changes will give more agencies a chance to adjust to changing reimbursement, which will reduce the number of home health agencies that might go out of business, he points out. **(For other statistics from NAHC, see p. 111.)**

At the same time that agencies are trying to figure out how to deal with lower reimbursement levels, the general public believes that home health agencies are cheating the health care system. "We are fighting an image that home health is overly profitable," admits Newberry. "Not only do the number of fraud and abuse cases related to home health damage our industry's image, but the number of home health agencies sprouting up add to the impression that this is an extremely profitable business," she says.

Unfortunately for home health managers, the first step in advocating for the industry with legislators is to first address the image, says Newberry. "Although most people believe that home health is a valued and needed service, fraud and abuse is often the first issue we have to discuss," she says. In fact, Newberry was surprised when visiting a legislator's staff person, who was the lead health care person on staff. "The first thing she says is that 'You are going to have to do something about the fraud in your industry,'" she says. "Because she was referring to a case in Florida, we were able to counter her statement with the fact that home health agencies had reported the fraud two years before any action was taken," she adds.

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Keep staff up-to-date

Newberry and her key managers are not the only people in the agency who stay informed on legislative issues. "We use flyers, voice mail messages, e-mails, and staff meetings to educate all of our staff members on legislative and regulatory issues that affect the agency," she says. "We think it is important that they hear the information from us, not just from the general media." State and national-level associations offer tools and resources that can help with all educational and advocacy efforts, she suggests. **(See resource, right.)**

Showing legislators what you do is an additional step in advocacy that is effective, suggests **Brent Tow**, president and CEO of Community Health Professionals in Van Wert, OH. "We invite legislators to any community event that we have, and once each year, we invite them to make a home visit with us," he says. Conversations with legislators mean more after they've seen the impact of home health, he adds.

In addition to staying up to date, participating in advocacy efforts of national organizations, and educating staff members, what can home health managers do to prepare for whatever comes with health care reform? "Agencies must diversify their services," recommends Tow. Offering a variety of services and finding the most efficient way to deliver those services is essential for survival, no matter what happens with health care reform, he explains. **(See tips for survival, p. 112.)**

With all of the changes being discussed, there is one certainty, says Solecki. "OASIS C [Outcome Assessment Information Set] is effective January 2010," he says. Implementation of the new data collection and assessment tool will have a huge impact on home health agencies, because it does collect different information than the previous OASIS tool, he explains. **(See "Addition of process measures means more prep for OASIS C," *Hospital Home Health*, February 2009, p. 13)** "We are focusing on staff education for OASIS C to make sure our documentation is as accurate as possible," he says. **(See staff education, p. 113.)**

Because health care reform proposals recommend reimbursement cuts beginning immediately upon approval, the toughest challenge for home health managers is budgeting. "I'm working on my budget now," says Newberry. Between the wage index cut and the case-mix decreases that are already in place, she is already facing the need to increase volume or increase case mix to improve revenue, she explains. "Managers need to budget conservatively and expect all of the cuts in order to keep their agencies financially viable." ■

SOURCES & RESOURCES

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- **Greg Solecki**, Vice President, Henry Ford Home Health Care, One Ford Place, 4C, Detroit, MI 48202. Telephone: (313) 874-6500. DO NOT PRINT FAX E-mail: gsoleck1@hfhs.org.
- **Brent Tow**, President and Chief Executive Officer, Community Health Professionals, 1151 Westwood Drive, Van Wert, OH 45891. Telephone: (419) 238-0751. E-mail: brent_tow@comhealthpro.org.

- National Association for Home Care and Hospice offers a legislative action center that enables visitors to identify their legislators, send an email to them, and to view detailed information that can be used when talking with legislators. Go to www.nahc.com, select "Legislative Issues" on top navigational bar, then scroll down to "Home Care."

NAHC stats provide ammunition

Talking points focus on impact on home health

According to statistics published by the National Association for Home Care and Hospice (NAHC)[1], home health cuts in the House Tri-Committee health care reform proposal would take $56.8 billion over 10 years from the home health Medicare benefit. Medicare home health spending totals about $16.4 billion per year, which is $1 billion less than in 1997.

The legislative action center of NAHC's web site explains the details of health care reform proposals that affect home health and offers a number of

"talking points" that home health representatives can use when discussing health care reform with their legislators.

• The proposed home health cuts are disproportionate to the cuts affecting other providers. Home health is 4.5% of projected Medicare spending between 2010 and 2019, while current proposals recommend 11.4% of the cuts for home health reimbursement.

• The home health cuts in the Tri-Committee proposal are more than $22 billion more than those proposed by the Obama administration, and go well beyond the Medicare Payment Advisory Committee's (MedPAC) recommendations for cuts, while ignoring MedPAC's recommendations for true payment system reforms.

• Currently, about one-third of Medicare home health agencies have negative Medicare profit margins.

• MedPAC fails to evaluate the impact on care access that occurs with the current wide-ranging financial status of home health agencies. Regardless of average margins, there is a wide range in agency margins, which means a wide range in impact that the proposed across-the-board cuts would have.

• MedPAC's proposal to reduce home health payments is based on claims that home health agencies are making excessive profit margins on Medicare services. MedPAC's financial analysis of Medicare home health agencies, projecting a 12.2% margin for 2009 does not include the 1,626 agencies (21% of total home health agencies) that are part of a hospital or skilled nursing facility. In some states, hospital-based home health agencies make up the majority of the providers. Facility-based home health agencies have an average Medicare profit margin of negative 6.19%.

• Recent cost reports reveal that the average Medicare margin for rural agencies is negative 3.52%. The loss of the 5% rural add-on payment for home health services in rural areas has resulted in reductions in service areas, agency closures, and reports that some agencies had to turn away high-resource-use patients who are more expensive for agencies to serve.

• The "case mix creep" adjustment ignores increases in patient acuity, particularly a significant increase in orthopedic and neurologically impaired patients requiring restorative therapy.

Reference

1. National Association for Home Care and Hospice. Ensure adequate and appropriate payment for Medicare home health services. (2009) Retrieved August 2009. http://www.congressweb.com/nahc/docfiles/march_on_wash_09/Ensure%20Adequate%20and%20Appropriate%20Payment%20for%20Medicare%20Home%20Health%20Services.pdf. ■

Diversification, efficiency are keys to success

When costs can't be cut, improve productivity

Surviving current reimbursement cuts and preparing for potentially more cuts with health care reform can be accomplished with careful planning and a willingness to make tough decisions.

"Diversification is the key to success," says **Brent Tow**, president and CEO of Community Health Professionals in Van Wert, OH. "We offer Medicare home health, private duty nursing, home hospice care, and inpatient hospice care," he says. The range of services enables his agency to continue caring for patients as they move through the continuum of care, he points out. "We don't have to discharge them to another provider," he adds.

Management of chronic care conditions is another way that home health agencies can expand services, suggests **Mary Newberry**, RN, BSN, president of the Illinois Homecare Council and director of home health and outpatient infusion for Riverside HealthCare in Kankakee, IL. "There are many opportunities for home health agencies to provide care for the chronically ill using the same staff and expertise in outpatient areas," she suggests. "Chronic care programs can also help agencies meet their goals of keeping patients out of the hospital," she adds. **(See "Improve outcomes with chronic care disease management programs," *Hospital Home Health*, August 2009, p. 85.)**

"It will also be important for agencies to become as efficient as possible," says Tow. His agency uses telemonitoring to increase efficiency and patient care, as well as cross-training of all nurses. "Because we are a rural agency, it makes sense that a home health nurse be able to visit a hospice patient that lives close to the home health patient that she has driven 40 miles to see," he says. Although some home health and hospice

managers say that it is difficult to find staff members who want to care for both types of patients, Tow says he has no problem finding staff members. "In fact, the opportunity to see a variety of patients reduces staff burnout," he says. "If we do have someone that wants to only work with hospice patients, they have the opportunity to work in our inpatient hospice facilities," he adds.

Newberry's managers and supervisors will be evaluating staff productivity on a daily basis, she says. "We have to keep tighter reigns on productivity without making the workplace a disagreeable place to be," she admits. "We know that patients cancel visits, so we're telling staff members to pick up an extra visit the next day if it is not possible to add a visit when the patient cancels," she explains.

Keeping productivity high is important, because there is not a lot of room for cost cutting at most agencies, says Tow. With salaries and benefits making up the majority of expense for all agencies, it is frustrating to see potential reimbursement cuts that might affect an agency's ability to offer raises, he says. "In order to get good people, we have to pay competitive salaries, but if Medicare doesn't allow for cost of living increases, then we may not be able to offer them to our staff." ■

OASIS education ensures accurate reimbursement

Teach staff reasons for new items as well as technique

A different approach to teaching staff members how to use OASIS C [Outcome Assessment Information Set] may be the key to successful implementation and assurance of accurate reimbursement, says **Greg Solecki**, vice president of Henry Ford Home Health Care in Detroit.

Because people learn differently, Henry Ford staff are not going to rely only on mass inservice education classes to teach the new OASIS, says Solecki. "We have identified a group of experts who will be educated, then these experts will educate our front-end people, who will be responsible for educating new staff members," he explains. In addition to the small group sessions, the agency will remind staff members of OASIS tips of the day with e-mails, voice mail messages, and flyers, he adds. "We want to tell everyone multiple times in multiple ways," he explains.

The small groups will have no more than six employees with each expert, points out Solecki. "This will enable the expert to teach the ins and outs of OASIS in detail, and it will enable the expert to zero in on the staff members who need extra help," he says.

Not only is the setting for education different from typical inservices, but the approach is different, says Solecki. "We start by explaining the philosophy of OASIS," he says. Because most staff members don't look forward to learning a new way to complete OASIS and because it can be confusing, Henry Ford's educators will start the class by explaining that OASIS is the agency's opportunity to tell the patient's story, he says. "Even if we don't like it, this is the tool we must use to document every aspect of the patient's care, and it is our only option to tell an accurate story," he says. By making sure that staff members understand the importance of an accurate OASIS to reimbursement, it is easier to move on to the specific tasks needed to complete the OASIS, he adds.

Although this approach to staff education is not typical, it does fit within Henry Ford's culture, points out Solecki. "This will work for us, because we have an open, transparent relationship with our staff. We share clinical and financial information with them, and we promote an environment of respect for each other," he says. "Although the ultimate goal of effective OASIS education is financial well-being for the agency, it is important not to forget the people involved and to develop a program that respects their experience and abilities." ■

For the best outcomes, consider patients' culture

Knowledge, understanding help ensure adherence

In an increasingly diverse society, case managers must be aware of the cultural beliefs and practices of the people they serve in order to effectively coordinate their care and help patients or clients adhere to their treatment plan, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy & Associates, a case management training and consulting company.

"Cultural competency is essential to close the widening gaps of disparities in health care. When

providers are knowledgeable, respectful, and responsive to the issues surrounding cultural diversity, positive outcomes are much more likely to occur," Mullahy says.

Refugees and immigrants cannot be expected to give up their cultural and religious beliefs when they come to this country, points out **Lucy Ricketts**, director of public affairs and cultural and linguistic services for Passport Health Plan, a member of the AmeriHealth Mercy family of companies.

"It's all about negotiation. We can't force our members to shift their attitudes about health care, but we can negotiate and educate them so they receive quality care," she adds.

For instance, the Louisville, KY, area, where Passport Health Plan has its headquarters, also is home to a number of agencies that resettle refugees and immigrants, according to Estes.

In fact, students in the public school system of Louisville speak more than 100 languages.

"We have great relationships with the resettlement agencies and work closely with them, so when they tell us which new group of people [is] coming into the area, we start doing research on the practices and beliefs of that culture," Estes says.

The Louisville area has had a huge influx of Somali families in the past two years, Estes adds.

"We found out that the local obstetricians were having difficulty understanding Somali women and their feelings about labor and delivery and prenatal care. We did a lot of research on our own and sought the assistance of experts in the area to help the obstetricians come up with strategies for caring for these women," Estes says.

The health plan partnered with a local Somali-Bantu women's empowerment group to gain the trust of the women, learn about their religious and cultural beliefs related to labor and delivery, and share information about the American approach to pre- and post-natal care.

For instance, the Somali women were upset because when they were admitted to the hospital for delivery, they didn't receive a meal.

"They told us that in Africa, it was very important to eat a large meal during labor so you'd have the strength to deliver," Estes says.

The health plan shared the information with the obstetricians in person during the health plan's annual cultural competency conference and in the plan's provider newsletter.

Passport Health produced audio and hard-copy versions of its booklet "Mommy & Me Basics" in the Somali-Bantu language and instituted a pilot project to educate the Somali-Bantu women on Western medicine standards of care. The women and a facilitator from the health plan read sections of the book and had an open discussion on the cultural differences in prenatal care, labor, and delivery.

Being aware of a member's cultural background helps case managers, disease management nurses, and health coaches come up with effective strategies to keep the member healthy, says **Trish Nguyen**, MD, senior medical director of medical operations.

For instance, while Vietnamese eat a lot of vegetables, they also enjoy salty soups and fatty foods such as pork legs, says Nguyen, who is Vietnamese.

"When the health coaches work with our Vietnamese members to help them manage their chronic illness, they are aware that although Vietnamese and others in the Asian culture tend to eat a diet high in fruits and vegetables, those fatty, salty soups could be interfering with their treatment plan," she says.

"This is very important, because they can use key words and messages that will resonate with that member. Telling them just to eat more fruits and vegetables is a very 'vanilla' message, and it may not be effective," she says.

Although Vietnamese tend to be thin, many also have abdominal fat that makes them more likely to become diabetic or die at an early age from heart disease, she points out.

"If our health coaches were not aware of this, they might take it for granted that since the clients are thin, they don't need to modify their diet," she says.

One of the keys to coordinating care with people of different cultures is to understand their beliefs and practices so you can determine what will resonate with them, Nguyen says.

"Understanding a member's cultural beliefs and practices is important, because it impacts health outcomes. If a care manager doesn't understand the person's cultural background, they will have difficulty engaging with that person, whether it's on the telephone or face to face, and they may not be able to help the person modify his or her behavior," she says.

For instance, health care professionals who are trying to communicate something of importance to patients may infer that patients are resistant to the information, embarrassed, or even depressed if they don't make eye contact. However, in some cultures, direct eye contact is perceived as threatening and case managers should be aware of this,

Mullahy points out.

"In some cultures, Asian and Christian African-American populations among them, pain and suffering are believed to redeem and purify. Understandably, therefore, a patient may be unable or unwilling to provide a truly accurate assessment of his pain," Mullahy says.

Native Americans consider wellness as harmony and balance among mind, body, and spirit, Mullahy adds.

"That kind of belief may present a challenge for a diabetic patient facing amputation of a limb. How can he be whole in his afterlife if he is buried without his leg?" Mullahy says.

Mullahy relates that in the case of the diabetic man who was reluctant to lose his leg, practitioners made arrangements to ensure that the limb would be buried in the same place as the patient after his death.

Latino patients tend to resist home health services because of a tradition that all of the elders' needs should be taken care of by family members, adds **Janice Crist**, RN, PhD, associate professor at the University of Arizona College of Nursing.

Case managers shouldn't think that their Latino clients are non-compliant if they refuse home health services or it doesn't work out, Crist says.

Crist has received a grant from the National Institutes of Health to produce a short film that can be used to educate Latino families about the benefits of home health care.

Crist advises case managers and home health nurses to spend part of each visit or conversation getting to know their Latino clients before starting care.

"One of the most important things that health care providers can do when working with the Latino population is to talk things over in a personal way, instead of being official and impersonal like they would be with patients in the Anglo culture," she says.

Achieving cultural competency is not easy, and while your organization may provide information, individual case managers should assume some of the responsibility for learning about and understanding the populations they serve, Mullahy says.

"Fortunately, much of this information is a mouse-click away," she adds. Care managers should ask open-ended questions, rather than just telling the member what he or she should be doing, Nguyen adds.

"Care managers need to be able to engage and have rapport with the members. When they ask open-ended questions, the member's cultural beliefs and perceptions come out and can be addressed," she says.

For instance, the case manager may ask members to name their favorite foods, then they ask about what is in their diet to isolate and understand where to begin working with the member on healthy eating habits.

"People in certain cultures have menus in their diet that are high in fat and calories. The health coaches and care managers can help them find healthy alternatives to some ingredients, so the food tastes the same but is healthier," she says.

For instance, if a member with hypertension eats a lot of chicken noodle soup out of a can, the health coach knows that it is high in sodium and can work to find alternative foods, she says.

"These open-ended questions can help the care coordinator or health coach discover the member's beliefs and understand why he or she isn't compliant," she says. ■

Diversity training helps CMs understand patients

Being aware of beliefs, values is important

Increasingly, health plans and provider organizations are taking steps to understand the beliefs and values in the populations they serve and help gear their treatment plan to accommodate them.

For instance, BlueCross and BlueShield of Florida encourages all employees to go through diversity training.

"Our case managers coordinate care for a diverse membership and are required to participate in formal diversity training. After that, they are required to present an overview to their peers as [to] how to identify a member's cultural beliefs and to incorporate them in their role as case managers," says **Trish Nguyen**, MD, senior medical director of medical operations.

The company has a diverse employee group and attempts to hire staff who mirror its membership and who are fluent in the languages that their members speak.

"We require cultural competency as a skill for all our care managers, so we don't necessarily pair them with someone from their own culture. We don't want to label people and make assumptions about their beliefs. After the case manager

conducts an assessment and determines the member's needs, we can align them with someone from their own culture if appropriate," Nguyen says.

BlueCross and BlueShield of Florida also offers computer-based on-site training and e-learning programs for employees who want to hone their cultural competency skills. Nearly 70 workshops are available on topics that include cross-cultural communication, bridging the generation gap, culturally competent hiring practices, dealing with prejudice and racism, and workshops that speak to specific populations.

"With all of these requirements, it becomes innate to the case managers to become sensitive and to remain cognizant of the needs of the whole person," Nguyen says.

At AmeriHealth Mercy, all employees who interface with members receive training in cultural and language awareness.

"We serve a large Latino population and an increasing Asian population. We try to be culturally sensitive and language oriented," says **Jay Feldstein**, DO, corporate chief medical officer for the AmeriHealth Mercy family of companies.

Passport Health Plan offers free cultural competency training to its providers and advocates.

The health plan has assembled a cultural and linguistic services council, a cross-functional group of associates that meets regularly to come up with strategies for providing care for an increasingly diverse population.

Passport Health Plan sponsors an annual professional conference on culturally and linguistically appropriate care that is free to providers and offers providers free continuing education units. The conference focuses on different cultures each year.

For instance, the 2008 conference focused on the Somali and Hispanic/Latin cultures along with a presentation on cultural competency and treating individuals with disabilities. A video presentation entitled "They Bring the World" was produced by Passport Health Plan and is available free to interested organizations.

"We provide a lot of diversity and cultural competency training for our associates and our providers. We offer classes for providers about Title 6 and CLAST standards, diversity, and stereotypes," says **Loretta Estes**, cultural and linguistic services coordinator for Passport Health Plan.

Passport Health Plan has enlisted the help of Spanish-speaking individuals and advocates to provide feedback on diabetes materials so they can be appropriately written and designed for Latino members, according to **Lucy Ricketts,** the plan's director of public affairs and cultural and linguistic services.

Passport Health Plan's disease managers and case managers use the AT&T Language Line, which offers interpreters in 150 languages to facilitate conversations with members.

"We have member services representatives who are bilingual and are assessed annually in Spanish and English. If they don't meet the highest levels of proficiency, they are not assigned to speak with members in Spanish until they do," Estes says.

When working with members from Somalia, the health plan often will provide translated printed material, along with a professionally recorded CD, so the person can hear and read the text at the same time.

Non-English-speaking members receive "I Speak" cards that are about the size of business cards and printed in English and their native language. They receive the cards at outreach events and are encouraged to give the cards to their providers to request an appropriate interpreter and request that the information is documented in their medical record.

The cards are available in Arabic, French, German, Maay, Russian, Somali, Spanish, Swahili, and Vietnamese.

"We also work with our members who aren't fluent in English to make sure they ask for an interpreter, to write down all the questions they have for their physician, and to make sure they understand everything they hear," Estes says.

If case managers feel that language or cultural beliefs are interfering with a member's care and they can't make any inroads telephonically, they can arrange a home health visit with a qualified interpreter to help bridge the gap, she says. ■

Health care reform puts CM in the spotlight

Lawmakers affirm the value of care coordination

All that hard work educating lawmakers, providers, and the public about the value of case management is paying off.

This year, the Case Management Society of America (CMSA) has been invited to give input into the health care reform bills under consideration by Congress, the new president of CMSA,

Margaret Leonard, MS, RN-BC, says.

"We have been offered several opportunities to move case management into an arena we've never been in before. We have been invited to the table to talk with lawmakers and representatives from the Centers for Medicare & Medicaid Services [CMS] about some of the health care bills being presented to the president," adds Leonard, who is senior vice president for clinical services at Hudson Health Plan in Tarrytown, NY.

All of the bills that have been introduced include the concept of care coordination as a quality standard for health care, Leonard adds.

"Case management is in a very special place. This is our year, our big shot. Everybody who is putting together these bills wants our opinion. The stars are aligned for a terrific year for case management," she says.

Much of the success has been due to the work of CMSA's public policy committee, which has sought to make lawmakers on the local, state, and national level aware of the benefits of case management, Leonard says.

"We've gotten into the legislative game. We are working with partners who have political action arms, and they have been very generous in letting us take advantage of their knowledge and their connections at the Centers for Medicare & Medicaid Services and the Office of Budget and Management," she says.

In addition, CMSA's leadership in convening the National Transition of Care Coalition brought recognition to the organization for bringing together 30 of the biggest players in the health care arena to develop ways to transition patients safely, she adds.

All of the health care reform proposals being discussed in Washington offer opportunities for case managers because they all recognize the importance of care coordination, Leonard points out.

"Care coordination can only help save health care funds. When case managers in the hospital setting coordinate care, they help prevent falls, decubitus ulcers, or other problems that should not occur. Good discharge planning and follow-up helps keep patients healthy after discharge and prevents readmissions," she says.

After discharge, patients need someone to help them understand and navigate the health care system, she adds.

"Even on a good day, it's hard to understand everything about your treatment plan or newly diagnosed disease, whether you're in the hospital or a physician's office. When people feel bad on top of that or are anxious about an uncomfortable test or procedure, all that stress prevents them from taking in the information they need to know about taking care of themselves at home," she says.

Leonard says that often when telephonic case managers call patients after discharge, the patients say they don't remember getting discharge instructions; when prompted they do remember getting a pink or yellow sheet of paper but say they've never looked at it.

"The nurse in the hospital may have spent half an hour telling them about their discharge plan, but they weren't ready to hear it. After discharge, when they don't have a call button handy and the questions start to arise, someone needs to make sure they understand what they're supposed to do and how to take their medicine. They need to have someone to call with questions and concerns, and that's where case managers come in," she says.

In addition to providing input on health care reform proposals, CMSA has been asked to provide language for a model case management law. The case management model law includes the proposed new case management standards of practice, which includes a list of criteria that must be met before someone can call him or herself a case manager.

The new standards of practice were introduced at the CMSA national conference in June and went out for public comment this summer, Leonard adds.

"However, case management is not going to be included in health care reform just because we've written a model unless we're all out there lobbying for it," she adds.

Teri Trieger, RN-C, MA, CCM, CCP, CMSA president elect, and **Carol Gleason**, MM, RN, CRRN, CCM, LRC, former board member, are developing a strategic plan for a grassroots initiative to make case management a vital part of whatever health care reform legislation is passed.

"We think this is an opportunity we won't see again for many years. We hope that if any of the proposed bills get passed as part of health care reform, some of the language in our model case management law and our definition of case management will be included," Leonard says.

Leonard urges case managers to visit their senators and representatives to educate them about case management and the National Transitions of Care Coalition. If they can't visit in person, Leonard urges them to make a phone call and talk to their legislators about the benefits of case

management.

The CMSA web site contains talking points and information sheets as well as a grassroots handbook that case managers can read to familiarize themselves with the legislative process, how to contact and talk to their lawmaker representatives, and issues that affect case management.

In addition to promoting case management in health care reform, Leonard's agenda for her year as president includes continuing the effort to get CMS to develop a mechanism to reimburse for case management services.

"We've been working for the past 18 months to get CMS to approve CPT codes for certain case management services. After meeting with high-ranking government officials, it's become apparent that CPT coding may not be the right route to take," she says.

All of the health care reform bills being proposed say that case management services are reimbursable, Leonard adds.

"We want the language to incorporate the standards of care and list what services are considered case management services and what the criteria must be for a person to be a case manager," she says.

Leonard says the organization will continue its grassroots effort to push for multi-state licensure for nurses.

Currently, when nurses provide case management services telephonically to patients in another state, they are violating the law unless they also hold a license in that state. Some companies purchase licenses for case managers in all of the states in which they have members, but others choose to ignore the law, Leonard says.

Not being licensed in states where they talk to members may put case managers at risk for financial penalties, loss of licensure or up to a year in jail, depending on the laws in that state.

"This issue is of major importance to case managers, since many of us work with clients in other states. We are trying to get multi-state licensure enacted in all 50 states. The 24th state passed the measure in July, which was a big milestone for us," she says. ■

CMS issues proposed home health cuts

The Centers for Medicare & Medicaid Services (CMS) proposes a net decrease of 0.86% in Medicare payments for home health agencies in calendar year 2010. This includes a 2.2% market basket update, which would be decreased by 2.75% as part of a 4-year series of cuts that adjust for coding changes between 1999 and 2005.

The rule also warns that CMS is considering additional coding reductions that are based on further analysis of case mix change. These reductions could lower 2010 payments by 4.9%. The proposed rule would also cap outlier payments at 10% per agency and limit total outlier payments to 2.5% of total HH PPS payments. The rule was published in the Aug. 6 Federal Register and comments will be accepted through September 28. ■

ACIP targets high-risk groups for H1N1 vaccine

The Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) recommends that five groups be targeted for initial vaccination against H1N1 flu. The groups, which total an estimated 159 million people, are: pregnant women; people who live with or care for children under 6 months old; health care and emergency services personnel; children and young adults aged 6 months through 24; and adults aged 25-64 with chronic health disorders or compromised immune systems. If the initial supply of H1N1

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vaccine is very limited, the committee recommends that the following groups receive the vaccine first: pregnant women; people who live with or care for children under 6 months old; health care and emergency services personnel with direct patient contact; children aged 6 months through 4; and children aged 5-18 who have chronic medical conditions. Adults aged 65 and over currently face the least risk from the H1N1 virus, but should receive the seasonal flu vaccine as soon as it's available, the panel recommends. ■

Don't hide your head in the sand, ID depression early

Your involvement is 'crucial'

Depression is not as visible as a back injury — but it is without question a significant drain on workforce productivity — both absenteeism and presenteeism. According to **Garson M. Caruso**, MD, MPH, FACOEM, co-director of the American College of Occupational and Environmental Medicine (ACOEM) Depression in the Workplace project, "The occupational health nurse is crucial to improvement of management of depression in the working population."

A new position statement from the ACOEM says that only half of depressed workers are receiving any treatment at all. Of these, less than half receive care that is consistent with current treatment guidelines from organizations such as the American Psychiatric Association.

ACOEM estimates the cost of depression at $36 billion in lost productivity per year. The position statement, *Depression in the Working Population*, notes that unlike conditions such as cardiovascular disease or hypertension, depression often strikes very early in a worker's career, creating a disease burden that may last for decades in the workplace. The statement calls for a new approach of screening programs and early treatment.

Caruso stresses that businesses can achieve a positive return on investment by creating programs to intervene and treat depression at its early stages. "There is a general under-recognition and under-acceptance of the existence and effects of depressive illness by third party payers and others," says Caruso.

Many employers still fail to realize the actual costs of depression in their workplace, or the return

CNE *questions*

1. What is a significant challenge when discussing health care reform and home health with legislators and their staff members, according to Mary Newberry, RN, BSN, president of the Illinois Homecare Council and director of home health and outpatient infusion for Riverside HealthCare in Kankakee, IL.
   A. The belief that home health care is not necessary
   B. The perception that home health agencies have high profit margins
   C. The image of home health as an industry filled with fraud
   D. B and C

2. The National Association for Home Care and Hospice (NAHC) reports that home health comprises 4.5% of projected Medicare spending between 2010 and 2019. What percentage of reimbursement cuts recommended by current healthcare reform proposals would affect home health, according to NAHC?
   A. 9.8%
   B. 10.3%
   C. 11.4%
   D.12.2%

3. What is one way that a diversified rural home health agency can improve efficiency and productivity, according to Brent Tow, president and CEO of Community Health Professionals in Van Wert, OH?
   A. Cross train staff
   B. Be selective about which patients to accept
   C. Improve staff understanding of OASIS
   D. Set limits on number of miles staff will drive

4. What changes in staff education is Henry Ford Health Care making to ensure successful OASIS C implementation, according to Greg Solecki, vice president of Henry Ford Home Health Care in Detroit?
   A. National experts will speak to staff
   B. Education sessions will be centralized to teach as many at one time as possible
   C. Staff will be educated in small group sessions, with reinforcement from emails, voice mails and flyers

Answer Key: 1. D; 2. C; 3. A; 4. C.

on investment of enhanced depression care for workers, says Caruso. "This was one of the reasons that ACOEM decided to take a lead role in exploring and addressing this issue," says Caruso.

Depression in the working population is an under-recognized source of both direct and indirect costs to business, notes Carson. "We are still in the early stages of defining the full benefits of increased corporate investment in enhanced depression care," says Caruso. "However, evidence is beginning to demonstrate significant effects."

One analysis suggested that approximately $100 to $400 in additional outreach and care management costs could result in an annual increase in $1800 of work value.[1]

"In addition to lack of recognition, other factors such as the stigma associated with mental illness continue to impede the recognition of and effective intervention in depressive illness," adds Carson.

Reference

1. Wang PS, Simon GE, Kessler RC. Making the business case for enhanced depression care: The National Institute of Mental Health-Harvard work outcomes research and cost-effectiveness study. *J Occup Environ Med* 2008; 50(4):468-475. ■

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 **March** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■