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HOSPITAL HOME HEALTH

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IN THIS ISSUE

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Reimbursement changes to affect all home health services

HHAs have time to prepare for some significant reductions

[Note from editor: This is the first of a two-part series that looks at health care reform implications for home health. This month, we evaluate the issues that will affect home health and offer tips to prepare for changes. Next month, we will examine another issues more closely: outlier payment caps.]

There were no real surprises for the home health industry when the health care reform bill became the health care reform law, but home health experts recommend that agency managers pay close attention to a number of issues in the new law.

"We've known that Congress would want to rein in costs, and we've seen that MedPAC [Medicare Payment Advisory Commission] is skeptical of profit margins for home health," says **Andy Carter**, MPP, president

EXECUTIVE SUMMARY

After almost two years of debating health care reform and developing plans to change the model of health care delivery in the United States, the health care reform bill became law. Although there were no unexpected items in the final law for home health, experts say that it is now time to take proposed reimbursement cuts seriously and prepare for changes. Experts also point out that health care reform is not all bad for home health and there are opportunities for home health growth as provisions in the law take effect.

- Rebasing adjustments will not take effect until 2014 but home health managers need to make sure their costs reports are accurate and capture all costs of providing care to provide good data upon which adjustments will be made.
- A rural add-on of 3% will be included for 2010 through 2015.
- The Community Living Assistance Services and Supports (CLASS) Act will enable individuals to purchase long-term care insurance through payroll deductions. This will make it possible for more individuals to pay for home health services when Medicare is not an option or to pay for non-medical services that are received in addition to Medicare-reimbursed services.
- A study and, if needed, a demonstration project to evaluate the effect of payment system restructuring is a mandate of the law.

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and chief executive officer of Visiting Nurse Associations of America (VNAA). "We anticipated cuts in reimbursement and have been working with other home health organizations, such as the National Association of Home Care and Hospice, to educate lawmakers about the risks of making blind, across-the-board cuts," he says.

Although there are cuts planned for home health reimbursement, Carter points out that the numbers could have been higher. "We owe the Senate Finance Committee thanks for reducing the $60 billion of reimbursement cuts proposed by the House to under $40 billion," points out Carter. "Home health rebasing will also take place and will be based upon cost report data over the next two years," he says. The good news is that the payment adjustments will be phased in over a 4-year period of time, beginning in 2014. "This gives home health agencies time to make sure their cost reports are in order," he adds.

Because home health reimbursement has not been driven by cost reports, they are not always as accurate as they should be, points out Carter. "Now, it's important that the data that CMS will use to define reimbursement changes be accurate," he says. Home health managers should focus on capturing all costs the payment adjustments will be based present a true picture of home health costs, he suggests. (**For other tips on how to prepare for changes, see page 64.**)

Ensuring accuracy is important because if rebasing occurred today, the reimbursement reductions would total 16% based on current data, says Carter. The delay in implementation of rebasing adjustments not only gives the home health industry time to improve the accuracy of data, but it gives agencies time to prepare for significant cuts if they occur, he adds. In addition to implementing the adjustments over a 4-year period, the health care reform law also limits the amount of reduction per year to 3.5%.

In addition to rebasing, home health agencies will face other specific reductions, says Carter. "Case mix creep cuts will continue, but home health agencies will continue to get their market basket update, with cuts of 1% for 2011, 2012, and 2013," he says. The rural add-on was also reinstated so rural agencies will get an additional 3% for each year between 2010 and 2015, he adds. "Agencies also face caps of 10% on their outlier payments," he says, "which for a small minority of all agencies will entail significant reductions."

Home health agencies that serve populations that are high risk due to complex medical conditions or socioeconomic status are going to struggle if they rely upon CMS reimbursement, says Carter. "Non-profit agencies, such as VNAA members, can solicit philanthropic support to cover the gap between reimbursement and costs for these patients, but not all agencies have that option," he says. "Access to home health services may suffer in some areas if agencies cannot cover these gaps," he adds.

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Editorial Questions

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The good news is that a study to determine how home health payment restructuring will affect quality, outcomes, and access to care is one of the mandates in the reform law, says Carter. "The study will look at the clinical and socioeconomic factors that drive costs; and provide documentation of actual costs and provider losses on certain types of patients," he says. This study will also evaluate how reimbursement reductions may affect access, he points out.

The study, which must be completed no later than 2014, is the first of a two-part mandate, explains Carter. "If the study results justify a demonstration project to evaluate the effects of reimbursement adjustments on access, there is $500 million designated to fund the demonstration project," he says.

Need for home health to grow

Although the health care reform law does include reimbursement cuts, overall it will mean an increase in demand for home health, says **Marcia P. Reissig**, RN, MS, chief executive officer of Sutter VNA and Hospice in Emeryville, CA. "This is really more of a health insurance reform law than a health care reform law," she says. "Although there are a lot of ideas and programs that will change the way health care may be provided, the real change is that more people will have health insurance and be able to access services such as home health," she says.

"This is a tremendous opportunity for home health to increase its role in the health care system," says Reissig. The pressure to change the health care delivery model will come from the increased demand for health care services as more people have access to health insurance, she explains. Also, reimbursement reductions will force providers to find more efficient, effective ways to deliver care. "This pressure will mean more opportunities for home health to work with hospitals and other providers," she says.

One example of an opportunity is the law's provision that penalizes hospitals for readmissions, she says. "Readmissions have been an issue for home health for years, but hospitals were not as concerned because another admission meant more revenue," she explains. Now, hospitals will be open to work with home health agencies to prevent readmissions, she adds. "Because chronic conditions are often a reason for readmission, home health agencies that have chronic care management programs that keep people at home will be in a good position to partner with hospitals and other community providers," she adds.

Another provision that will provide opportunity for growth is the Community Living Assistance Services and Supports (CLASS) Act, says Reissig. The CLASS Act provides for a national, voluntary insurance program for purchasing community living assistance services and supports for adults with limitations of at least two or more activities of daily living, she explains. "It's not tied to Medicare benefits, and non-medical, or private duty services, can be provided in addition to Medicare home health services," she adds.

Beginning in 2011, all actively working employees of employers who decide to participate will have premiums automatically deducted from their paychecks to purchase the insurance, Reissig says. Employees who do not want to participate can opt out. A separate plan will be developed for self-employed individuals or people who work for an employer who has decided not to participate.

After a 5-year vesting period, individuals are eligible for $50 or more per day for non-medical services that enable them to remain in the community if they have functional limitations of at least two activities of daily living, explains Reissig. "Skilled nursing services will still be covered by traditional Medicare, but this policy will enable people to receive non-medical services in their homes," she says.

"I've always believed that private duty care is the future of home care, and the CLASS Act points out the need for agencies to offer affordable private pay or personal care services in addition to Medicare skilled care," says Reissig. "Most home health agencies would not be able to meet the demand for this type of care today, but we have time to develop programs to meet these needs because there is a 5-year window before benefits are paid," she adds.

No matter what the opportunities for growth might be, home health managers should be looking carefully at ways to improve efficiency and productivity, suggests Reissig. "We have to prepare to be paid less, so everyone should look at how nurses can care for more patients and how technology can improve back office and billing."

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Survival tips from experts

Health care reform presents opportunities and challenges

Reduction in reimbursement is the bottom line when it comes to home health and health care reform. Although no one wants to paid less, there is time to adjust and be prepared for cuts that will come, because they don't all come at one time, points out **Andy Carter**, MPP, president and chief executive officer of Visiting Nurse Associations of America (VNAA) in Washington, D.C.

Become more productive

One of the cuts that poses a real challenge to home health agencies is the productivity cut, says Carter. Because home health does not operate in the same manner as other health care providers, with staff and patients located in the same building, there are some productivity challenges that cannot be overcome, he says. "A nurse still has to drive to a patient's home to see one patient, and that won't change," he says. "However, there is room for productivity improvement in all areas of our economy, including home health," he says.

"How can we help nurses care for more patients is a key question," says **Marcia P. Reissig**, RN, MS, chief executive officer of Sutter VNA and Hospice in Emeryville, CA. Telemonitoring and telephone calls can supplement and possibly reduce the number of personal visits for some patients, she suggests. "Finding a way to keep home health care affordable, not only for Medicare patients, but also for private-pay patients is the key to success in the future," she says.

"Every agency manager should be reviewing all processes within the agency," recommends Reissig. "Look at all of the back-office activities and see if you need as many staff members as you have," she says. Cross-training and technology can be two solutions to improve efficiency and productivity in your billing and claims departments, she adds.

Technology is an important part of preparing for the next years, says Reissig. "From point-of-care documentation to back-office systems, every agency needs a system that ties all agency activities together," she says. "Another critical component of a good computer system is ease of use," she points out. No agency should invest in a system that requires lengthy training sessions for employees, she says. "One or two days should be the maximum for clinical personnel," she suggests.

Although technology can be expensive, it doesn't have to be prohibitive, says Reissig. "We just implemented a new system that we pay for on per-visit basis," she points out. "We had no capital investment, but it integrates everything we need."

Develop programs for chronic care

Chronic care management is an area that all home health agencies should evaluate, says Reissig. "It's not enough to provide care for heart failure, when the same patient may also have diabetes, chronic obstructive pulmonary disease, and renal failure," she points out. "A good chronic care management program will require a high level of clinical competence," she points out. Nurses will need to be able to think critically when caring for a patient with multiple chronic conditions," she says. As more home health agencies develop chronic care programs to meet the increasing need, there will be more competition for highly qualified staff, she adds.

The Independence at Home Act sets up a 3-year demonstration project that promotes multidisciplinary care, including primary care physicians, nurses, social workers and therapists, for Medicare patients with complex, chronic care needs in their homes, says Carter. "The project will begin no later than January 2012," he says. "Sophisticated home health agencies that are capable of assuming a wider range of responsibilities should evaluate this as a service to develop," he recommends.

Diversify to survive

Expanding the number of payer sources and patient audiences that your agency relies upon is another way to survive, but you need to develop programs that meet the needs of these different audiences.

Diversification may include development of a private duty program, says Reissig. "As more

people purchase long-term care insurance, we'll see a greater demand for home care," she says. Although long-term care insurance usually provides reimbursement for both home care and nursing home care, the affordability of home care and the desire to stay in the home will create more opportunities for home care agencies, she says. "We need to make sure our services are affordable for patients who are not Medicare patients," she points out.

Affordability and easy access are important aspects of home care, points out Reissig. "Throughout the health care reform debate, we saw more people realize that home care plays an important part in cost-effective patient care. Now, we have to make sure we can provide the services that patients need at a rate they can afford." ■

Medical home: Focus on better communications

Focus is on care coordination

When Blue Cross Blue Shield of Michigan measured the rate of hospital admissions for patients with diabetes, chronic heart conditions, and asthma, the Detroit-based health plan found that hospitalizations for patients being cared for in a patient-centered medical home (PCMH) were 23% lower than for patients treated in other practices.

"If patients have access to a primary care physician, receive better care coordination and better support for self-management, they can be expected to have fewer admissions because they are getting timely, competent care. That's why we think that the patient-centered medical home model is an important component of improving the care for our members and saving costs at the same time," says **David Share**, MD, MPH, senior associate medical director for health care quality for the health plan.

The program involves 80 physician organizations and more than 8,000 physicians. Of these, 1,200 physicians in 300 practices have achieved the patient-centered medical home designation, based on implementing changes in their practice to meet PCMH criteria and having good results on quality and cost-performance measures, Share says.

The health plan has developed two transaction codes (T-codes) that physician practices can use to bill for care coordination, care management, or self-management training and support.

In the patient-centered medical home model, a primary care physician leads a team of clinicians who work with the physician to make sure that the patient understands and follows the treatment plan and has everything he or she needs to stay healthy and/or manage a chronic disease.

The team varies from practice to practice but may include case managers, social workers, nutritionists, and diabetes educators who make sure that the patient is getting the care he or she needs on a timely basis, so the physician can focus on treating the patients, Share says.

"In a patient-centered medical home model, the physician and his or her staff partner with patients to identify patient needs, set patient-specific goals, and act on the goals and patient needs in a proactive way, as well as reaching out to patients who don't come in for care but who need preventive care or tests and procedures," he adds.

The patient-centered medical home has a focus on care coordination and improved communication between patients and providers, making it a good fit for case managers, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president of Mullahy & Associates LLC, a Huntington, NY, case management consulting firm.

"The principles of the patient-centered medical home underscore many of the core elements in case management and are strongly aligned with advocacy and empowerment of patients," Mullahy points out.

Since case managers are dedicated to improving outcomes while improving costs, the patient-centered medical home model offers opportunities for them to work in another practice setting and for case managers to once again be the catalyst for change, she adds.

A patient-centered medical home provides more comprehensive care for patients by freeing up physicians to focus on complex decision making and building relationships with patients, Share says.

"When a physician sees a patient who has three chronic illnesses, he or she has time to focus on the patient's big issues because the nurse, care manager, or social worker has already educated the patient about his or her condition. The physician can spend more time dealing with the patient's complications because someone else has taught the patient how to use a glucometer or explained how to take his medication. When everybody works as a team, the result is always better patient care," he says.

Electronic records are a vital part of a patient-centered medical home, because they allow the physician to identify at a glance gaps in care and other patient needs, adds **Carol Cordy**, MD, medical director at Community Health Medical Home at Swedish/Ballard, part of the Seattle-based Swedish Medical Center.

"When I go in to see a patient, I shouldn't have to research whether the patient is due for a Pap smear or when she had a tetanus shot. I'm working to have this automatically generated by the electronic record, so I can focus on diagnostics and patient education," she says.

Physicians at the Swedish/Ballard medical home pilot project spend an hour with patients on the first visit and 30 minutes on subsequent visits.

"One of the headaches of medicine is that you constantly need to see more and more patients and spend less time with them. It's a recipe for burnout and for physicians retiring early, because their jobs are too stressful. As we move toward working more efficiently and our healthy patients are automatically taken care of, we can focus on patients who need more time," she adds.

The patient-centered medical home model will help save primary care by ending some of the frustrations physicians feel and preserve the doctor-patient relationship, adds **Nicholas Bonvicino**, MD, medical director at Horizon Blue Cross Blue Shield of New Jersey.

The health plan has partnered with the New Jersey Academy of Family Physicians on a patient-centered medical home pilot project and pays participating practices a care coordination fee.

"One of the big issues leading to the demise of primary care has to do with trends in reimbursement, which make it more difficult for physicians to practice medicine in the way they may have originally envisioned. This leads to burnout and early retirement," Bonvicino says.

Member surveys sent out by health plans often come back with criticism that the doctor spent too little time with the patient, wasn't receptive to answering questions, and that the patient doesn't know where to go for services, says Bonvicino. Patient-centered medical homes can reduce or eliminate these issues by improving the members' experience and helping them get the services they need and avoid services they don't need, he adds.

"The old concept of having a primary care physician who shepherds patients through the health care system, helps them get the services they need, and avoid services they don't need has been lost," Bonvicino says.

The result is a fragmented health care system with little coordination between providers and frequent duplication of services, he adds.

"People get lost in the system when their providers don't have complete information. As a result, we're paying too much for the care of some patients and too little for the care of others," Bonvicino says.

"The medical home is another strategic tool that case managers can implement to address spiraling health care costs while broadening and expanding the range of services available to a larger population of people," Mullahy adds.

"We have long recognized that episodic intervention doesn't work and that our opportunities to truly make a difference extend beyond discharge planning and need to occur in a coordinated, community-based manner," she says.

Four professional organizations, representing more than 330,000 physicians, define a patient-centered medical home as "a health care setting that facilitates partnerships between individual patients and their personal physician, and when appropriate, the patient's family."

The American Academy of Pediatrics, the American College of Physicians, the American Academy of Family Physicians, and the American Osteopathic Association collaborated on principles that describe the components of the patient-centered medical home.

The principles include: a personal physician who leads a team of individuals at the practice level who take responsibility for the ongoing care of patients; whole-person orientation; coordinated and/or integrated care across all elements of the complex health care system and the patient's community; quality and safety initiatives; enhanced access to care; and a payment structure that represents the value provided to patients. ■

Patient-centered care in primary care settings

Emphasis is on care management at the provider level

Blue Cross Blue Shield of Michigan is partnering with more than 8,000 physicians in about 80 physician organizations to develop better ways

to manage the care of patients, with an emphasis on care coordination at the primary care level.

About 1,200 of the physicians have achieved the designation of a patient-centered medical home practice.

"We recognize that when the health plan provides care coordination, it's at a distance from the doctor-patient relationship. According to the patient-centered medical home model, care coordination that happens within the context of the patient-doctor relationship in a medical home is more likely to be effective, because the patients and doctors are more motivated," says **David Share**, MD, MPH, senior associate medical director for health care quality for the health plan.

The Detroit-based health care plan began structuring its patient-centered medical home initiative in 2004, when the health plan provided incentives for physicians to create shared processes of care and information systems and to use them to work with specialists to collectively take responsibility for a population of patients.

"We are always looking at ways to partner with the physician community to improve patient care. We recognize that physician organizations can't provide comprehensive care management without a system in place. We decided to offer the resources for doctors and patients to work together to manage patient care more effectively. Initially, we used our incentive money to support physician organizations in creating the infrastructure and information systems they need for new processes of care," he says.

Many of the features of the patient-centered medical home involve care coordination and care management, Share says.

Nurses in Blue Health Connections, the health plan's case management program, already coordinate care and follow up with patients at risk for chronic illness, those who have chronic illness, or those who have complex health care needs, Share points out.

The new initiative aims to move care management closer to the point of patient care with a goal of improving communication among patients and providers.

"We recognize that when the health plan provides care coordination, it's at a distance from the doctor-patient relationship. According to the patient-centered medical home model, care coordination that happens within the context of the patient-doctor relationship in a medical home is more likely to be effective because the patients and doctors are more motivated," he says.

The health plan has created specific transition codes (T-codes) that offer fee-for-service payment for specific procedures that involve care coordination, care management, or self-management training and support. One T-code for care management and self-management support is for telephone contact; the other is for in-person support.

The procedures may be provided by a variety of disciplines, including nurse case managers, social workers, nutritionists, diabetes educators, and respiratory therapists.

"If these professionals engage with patients about patient-specific chronic illness education, either in person or by telephone, the health plan will pay for it separately. This provides the medical offices with the resources they need to provide the services and expand their ability to provide care management," he says.

In the early phases of the initiative, the health plan provided funds to practices to help them get started. Ultimately, the majority of the extra services provided by the medical home will be paid for by reimbursement using the T-codes.

"Our plan is to support physician practices as they take responsibility for care coordination and self-management, which leads to better outcomes. To get from where we are to a truly patient-centered medical home model requires the physicians to do a lot of work that involves building new systems and hiring new people. It's part of the health plan's responsibility to support that creation of infrastructure. Once it's created and we start to pay for results and care coordination, we won't be paying as much for medical services," he says.

When patients have access to a primary care physician practice, which provides better care coordination and support for self-management, they can be expected to have a lower cost of care, fewer admissions, and fewer emergency department visits because they are getting timely, competent care, Share says.

"In the patient-centered medical home model, the case managers reach out and help the patients set goals based on their doctors' treatment plans. When patients forget to schedule regular visits, the case manager calls and reminds them. It all leads to better control and fewer complications," he says.

The health plan is beginning a new pilot project to develop a provider-delivered care management program, which shifts all care management services from the health plan to the physician office.

"This is taking the concept to the next level. If

physicians have a comprehensive care management program embedded in their offices, they can effectively engage with at-risk patients to comprehensively manage their conditions," he says.

In the provider-delivered care management program, physician practices and the health plan will share data.

"We know from claims data which patients are at higher risk than average and can provide the practices with a list of people they can reach out to for care management. The doctor's office can send data back to the health plan and let us know who engaged and how. We will be able to reach out to our customers, the employer groups, and let them know if their employees are taking advantage of the case management services they contracted for," he says.

Having the physician office engage in care management will make the patients feel that physicians care about their conditions, he points out.

"When someone from a physician office calls a patient to follow up, it becomes a different conversation in terms of the human dimension than when someone from the health plan makes the call," he says.

"We know that being a patient makes you feel vulnerable. It matters if someone who is treating you cares about your health and doesn't just look at you as a number," he adds.

Five physician offices of various sizes and with different practice models are testing the provider-delivered care management program.

"We want to be able to examine the processes, how information is exchanged, and how the service varies and which staff are providing the services in different settings," he says. ■

Primary care clinic takes a team approach

Goal is to improve communication

When **Carol Cordy**, MD, has a concern about a patient, she often asks a nurse to follow up with a phone call to make sure the patient is doing well and to answer any questions or concerns.

"We have a team approach to caring for patients, and our nurses spend time in the care management role. Whenever I feel a patient needs a little extra care, I alert the nurse to make sure the patient understands his or her treatment plans, has gotten his prescriptions filled, and has what he or she needs to stay healthy," says Cordy, medical director at Swedish Community Health Medical Home in Swedish/Ballard.

With headquarters in Seattle, Swedish is a comprehensive, nonprofit health provider with three hospitals and more than 40 primary care and specialty clinics. The Swedish/Ballard primary care clinic is the first Swedish pilot using the patient-centered medical home model of care.

The clinic focuses on expanded access to care, close communication between the patient and the health care team, and providing continuous, comprehensive, and evidence-based care, Cordy says.

Physicians spend an hour with patients during the first visit and half an hour on subsequent visits. Patients always talk to staff when they call the clinic during business hours and, in most cases, can get an appointment within 24 hours.

The clinic opened in the spring of 2009 with no patients and now is providing care for 1,300 patients.

"We want to cap the patient panel at 2,500 so each provider cares for a smaller number of patients than the typical primary care physician. Our bottom line is the health of the patient. The goal is to keep patients in our panel healthy by proactively managing their care. If patients get the care they need when they need it, it will cost less in the long run," Cordy says.

The practice is located in a hospital wing that was remodeled to accommodate a primary care practice.

The clinic opened with four part-time family medicine residents, a front-desk person, a nurse, a part-time faculty physician, and Cordy. Now there are two front-desk staff, six residents, two nurses, a nurse practitioner, two half-time faculty physicians, and a part-time clinic manager.

The nurses and nurse practitioners serve as care managers for the patients. The front-desk staff call patients to remind them of appointments and notify the physician if patients fail to make their appointments.

"One of the goals of a medical home is to utilize a team approach to taking care of patients. Patients shouldn't identify only with their doctor or nurse practitioner; they should know all the people on their health care team, starting with the front-desk staff," she says.

When the practice gets a notice that a patient is in the hospital, a nurse or sometimes a resident

or physician calls the day after discharge and goes over medication and makes sure the patient has a follow-up appointment.

The nurses follow up with pregnant patients and mothers of newborns to make sure they aren't experiencing any difficulties.

They make regular follow-up calls with patients on antidepressants to encourage adherence to the medication regimen.

"In the case of patients with depression, studies have shown that if the nurse calls them a week after they begin treatment and checks back in a few weeks, the patients are more compliant," she says.

The practice is just beginning to identify high-utilizing patients and formulate care plans for them, looking to the community to help meet their health care needs.

"We need to go beyond the medical home to the medical neighborhood. It's not just what we do in the clinic, but what is going on outside the clinic that helps patients lead healthy lives," she says.

For example, the staff have researched local community services, so patients can get into low-cost exercise or diet programs. They work with nearby pharmacies to make sure that patients can get their medications at a low cost.

Technology makes it easier to manage patients and ensure that they are getting the tests and procedures they need, Cordy points out.

Already, the clinic has set up a secure e-mail system, so patients can e-mail their health care providers with questions or concerns. It is also using its electronic medical record to identify patients who need extra care management and to communicate with providers at other levels of care.

"With electronic records, if we send patients to a specialist or they go to the emergency department or are hospitalized within our system, it's all automatically on the electronic record. If a patient is seen in the emergency department or is in a hospital in our health system, I'll be automatically notified," she says.

Goals for this year include managing care for high-risk patients with chronic diseases and ensuring that all patients receive evidence-based recommended screening tests and immunizations, she says.

"If we can identify patients with polypharmacy issues, chronic pain, diabetes, and other chronic diseases, we can focus on how to better help them manage their care and keep them healthier and out of the emergency room," she says.

The clinic has set up a model in which many patients pay a monthly fee, rather than fee-for-service. The goal is to have 100% of patients on the monthly payment plan.

The monthly fees include a long list of procedures, tests, immunizations, and annual exams, including disease management for patients with chronic diseases such as diabetes and hypertension.

"We can manage 95% of what patients need in the clinic," she adds.

Patients at the community health medical home have a variety of payment plans.

"We want to be able to take all comers. Many of our patients have no insurance but don't qualify for Medicaid. They can't afford $400 or more a month for an insurance premium, but they can pay the monthly fee," she says.

At present, about 26% of the patients are self-pay and pay $45 for the first family member, $40 for the second family member, and $35 for children.

"The number of self-employed and self-pay patients who have signed up indicates that there is a big need for this kind of practice and that there is a great need for low-cost basic primary care," Cordy says.

Some patients are employed by small companies that can't afford high-cost, comprehensive insurance for their employees but can afford to pay $45 a month for their employees.

A managed Medicaid program has contracted with the practice and is paying the clinic on a monthly basis for its patients. The practice also is working with a private insurance company that has contracted to pay the clinic on a per-member per-month basis. ■

Hispanics more likely to develop Alzheimer's

Study also shows higher risk for African-Americans

According to the Alzheimer's Association's 2010 Alzheimer's Disease Facts and Figures, Hispanics are about one and

one-half times more likely than whites to have Alzheimer's and other dementias. The report also indicates African-Americans are about two times more likely than their white counterparts to have Alzheimer's disease and other dementias.

Although Hispanics and African-Americans are more likely than whites to have Alzheimer's and other dementias, the report reveals that Hispanics and African-Americans are less likely than whites to have a formal diagnosis of their condition. National data show that Hispanics and African-Americans with Alzheimer's and dementias are less likely than whites to report that a doctor has told them they have a "memory-related disease." Forty-five percent of whites with Alzheimer's and dementias report a diagnosis compared with 34% of Hispanics and 33% of African-Americans with these conditions.

Family members and others may notice early symptoms of possible Alzheimer's disease or other dementias, but there are often long delays between this first recognition of symptoms and the scheduling of a medical evaluation. The resulting delays in diagnosis mean that Hispanics and African-Americans are not getting treatment in the earlier stages of the disease, when the available treatments are more likely to be effective and do not have an opportunity to make legal, financial, and care plans while they are still capable.

There are no known genetic factors that can explain the greater prevalence of Alzheimer's and other dementias in Hispanics and African-Americans than in whites. On the other hand, high blood pressure and diabetes, which are known risk factors for Alzheimer's and other dementias in all groups, are more common in Hispanics and African-Americans than in whites. Socioeconomic factors, such as having a low level of education and low income, are also associated with greater risk for Alzheimer's and other dementias in all groups. ■

FDA to give guidance on home medical devices

The U.S. Food and Drug Administration (FDA) wants to ensure that caregivers and patients safely use complex medical devices in the home.

Hemodialysis equipment to treat kidney failure, wound therapy care, intravenous therapy devices, and ventilators are among the medical products that have migrated to the home in recent years. And more hospital patients of all ages are being discharged to continue their medical treatment at home.

"Using complex medical devices at home carries unique challenges," said **Jeffrey Shuren**, MD, JD, director of the Center for Devices and Radiological Health. "Caregivers may lack sufficient training, product instructions may be inadequate or overly technical, and the home environment itself may pose environmental or safety hazards that can affect the product's functioning.

Currently, the FDA does not have a clear regulatory pathway for devices intended for home use. The new home use guidance document that FDA intends to develop will:

- make recommendations for actions manufacturers should take to support premarket approval or clearance of these devices, including device testing with at-home caregivers and patients in a non-clinical setting;
- define circumstances under which the FDA may exercise its authority to require that certain devices cleared for marketing carry a statement in the labeling that the device has not been cleared for use in the home;
- recommend postmarket surveillance to identify and address adverse events that may occur in the home.

The FDA already has collected information on safety concerns related to home hemodialysis and is now collecting similar information on the use of some wound therapy devices. ■

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Case study: how discharge follow-up calls work

Patient case was challenging

A hospital discharge program that has social workers make follow-up calls to patients is designed to address patients' psychosocial needs and issues, as well as their medical ones.

"Historically we've looked at patients from a medical perspective and have minimized these psychosocial and compartmental parts of their lives," says **Madeleine Rooney**, MSW, medical center liaison for older adult programs at the Rush Medical Center.

"So, our work has been focused on providing additional support and assistance with the transition from hospital to home," Rooney says. "Also, we've been tracking over the last three-plus years the psychosocial environmental factors that impact outcomes, including where there are gaps in services and how these impact people's lives."

Here's a case study of how it works:

"We had a case of a senior, who is in her 80s, who had been in the hospital several times," Rooney says. "She lives alone, is very anxious, and has experienced over time some increased physical problems that have made it more risky for her to live alone."

However, the woman was reluctant to receive help from community services and agencies.

While she was in the hospital, she was recommended to be placed in a skilled nursing facility or to receive department of aging services if she returned home, Rooney says.

"She wasn't willing to accept those services and insisted on going home," she adds. "But when she went home, she became very anxious about not being able to manage as she had before."

The woman sometimes calls the hospital after her discharge and eventually is readmitted.

"We had intervened with her at some point in the past, and then she was referred back to us by the inpatient case management team," Rooney says. "We spent a great deal of time talking with her to try to assess exactly what it was she wanted and to find out if there was some way that she would allow us to help her."

Also, because of her age and health issues, it was imperative that the woman receive some immediate home support.

"We were trying to prevent a crisis that would result in her returning to the emergency depart-

CNE QUESTIONS

9. What can home health managers do to ensure that future payment adjustments are based on data that produces a true picture of home health costs, according to Andy Carter, president and chief executive officer of Visiting Nurse Associations of America (VNAA)?
   A. File claims in a timely manner
   B. Make sure costs reports are accurate and comprehensive
   C. Increase productivity
   D. Use quality improvement studies to show value of home health

10. What does Marcia P. Reissig, chief executive officer of Sutter VNA and Hospice in Emeryville, CA, believe is a necessary step to take to prepare for changes home health will see in the next few years?
   A. Invest in technology that increases productivity and efficiency
   B. Develop chronic care management programs
   C. Evaluate feasibility of a private duty service for the agency
   D. All of the above

11. What is the most significant healthcare reform issue for home health agencies with durable medical equipment (DME) divisions, according to Michael Reinemer, vice president of communications and policy for the American Association of Homecare in Arlington, VA?
   A. The Independence at Home demonstration project
   B. Expansion and acceleration of the competitive bidding program
   C. Increase in number of individuals with long-term care policies
   D. There are no programs that will negatively impact DME

12. According to the Alzheimer's Association's 2010 Alzheimer's Disease Facts and Figures, what populations are at a higher risk of developing Alzheimer's Disease?
   A. White and Hispanic
   B. African-American and White
   C. Hispanic and African-American
   D. None of the above

Answer Key: 9. B; 10. D; 11. B; 12. C

ment unnecessarily," Rooney says.

The social worker also called the woman's primary care physician and orthopedic physician, who treated her following hip surgery.

"We asked them to agree to our recommendation, which basically was to convince her to accept some home health services," Rooney says.

The woman had been resistant to this type of help all along, but after telephone conversations with the social worker, she changed her mind.

"We got some orders in place for her to receive nursing care in her home," Rooney says.

The woman was at risk for falling, so she would also be eligible for physical therapy. And the discharge program social worker put the patient in touch with a home health care social worker to further address her psychosocial issues.

"This is where our connections come in," Rooney explains. "We recognize the limitations of our services, because they're telephonic; and we're obviously not able to be there in the home with her."

With the physicians' input, they formulated the most cohesive and best possible plan to prevent the patient from having a crisis, to stabilize her situation, and to get her to agree to home care services, she adds. ■

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CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify the clinical, ethical, legal, or social issues particular to home health care.
2. Describe how the clinical, ethical, legal, or social issues particular to home health care affect nurses, patients, and the home care industry in general.
3. Integrate practical solutions to the problems faced by home health professionals into daily practices. ■

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