AMERICAN HEALTH CONSULTANTS®

Private Duty Homecare™

COMMERCIAL INSURERS ◆ GOVERNMENT PROGRAMS ◆ MANAGED CARE CONTRACTS
PRIVATE PAY ◆ SERVICE CONTRACTS

INSIDE

JULY 1999

VOL. 4, NO. 7 (pages 77-88)

American Health Consultants® is A Medical Economics Company

Telehomecare: The revolution will be broadcast to your office

Declining cost, payment barriers speeding growth

Imagine a time when one home care nurse can visit 15 or even 20 patients a day. Picture having crystal clear, irrefutable documentation for the payer that just denied 25 of your 30 visits to a wound care patient. Dream of cutting your per-visit costs in half. Think about giving your patients further support and raising their satisfaction without expending more resources. Such visions may seem right out of the future, but they are here today and may be coming soon to your agency.

The home care industry has long embraced technology — some patients have virtual intensive care units in their homes; nurses document visits with various portable devices and have come to depend on beepers and wireless telephones. Connecting home care providers and patients, enabling them to exchange electronic data via plain old telephone service, however, is just now catching on. Big time.

Forward, into the past

The confluence of several major forces is propelling telehomecare technology toward widespread acceptance. Payers and providers are equally interested in cutting costs. Patients are demanding better access and communication. Innovators are doing all they can to capture some of a vast and virtually untapped market.

Soon, the constraints holding the telehomecare throttle, such as product cost, reimbursement, and medico-legal considerations, will break loose and the market will really take off, supporters say. **(See chart, p. 78.)**

"Telehomecare is where it's all going. Through the centuries, care was delivered in patients' homes, but when the [available] technologies couldn't fit in a physician's bag, patients went to the hospital. Now, technology will go back to patients' homes," predicts **Khalid Mahmud**, MD, FACP, founder, chief executive officer and chairman of Eden Prairie, MN-based American TeleCare Inc.

American TeleCare's Aviva SL product allows providers to make video visits, with nurses and patients communicating through

Reported Barriers to Program Sustainability

Barrier	Number giving top rank	Number reporting	Weighted ranking
Reimbursement	43	70	179
Physician participation/ interest	18	52	104
Telecommunications charges	17	31	71
Availability of grant funding	9	16	37
Lack of organizational support	6	11	24
State politics	5	7	18
Equipment costs	3	21	41
Technology obsolescence	3	19	33
Licensure issues	3	16	27
Revenue generation	3	7	14
Rural providers adoption attitude	2	5	12
Reliability of telecommunications services	2	5	9
Lack of standards/ interoperability	1	6	9
Liability concerns	1	5	9
Non-physician reimbursement	2	3	8
Community commitment	2	7	6
Organizational decision making	1	4	6

Total respondents: 121

Source: Association of Telemedicine Service Providers, Portland, OR.

telemedicine units placed in the provider's office and individual's home, respectively. **(See related article on telehomecare technology, p. 80.)**

"The field is ripe," agrees **Bill Grisby**, PhD, senior research associate at the Portland, OR-based Telemedicine Research Center, a non-profit organization devoted to providing telemedicine information. "The technological things are in place; it's becoming prevalent and costs are going down. Payment's the sticking point in home care. The programs are gravitating where they can find funding." **(See main sources of telemedicine program funding, p. 79.)**

Money. Oh that.

Telehomecare doesn't carry the mega-price of some other telemedicine technologies like teleradiology systems, but it still costs enough that many providers find it prohibitive given today's operating environment. Most payers, including Medicare, don't recognize telehomecare as a reimbursable expense. But that is changing.

Greenville, SC-based University Home Care has persuaded one payer to reimburse video visits at the same rate as traditional home care visits, reports **Bonnie Britton**, MSN, RN, C, supervisor of special programs.

"I don't expect that with everyone, but I am very optimistic. Medicaid pays for telehomecare in 15 states, so we're approaching ours," she says.

As more studies show that patients using telehomecare access higher-cost services less often, managed care companies will decide themselves that the technology pays, Mahmud predicts.

Even if payers won't reimburse for telehome-

COMING IN FUTURE MONTHS

- Where's the check? Steps to get paid . . . now!
- Dispelling the myths and fears about Y2K among clients
- Readers offer more recruitment and retention tips
- Should you check employees' vehicles?
- Looking for a niche market? Start a Doula service

care, the cost savings may more than offset the expense of the product for providers. Medicare-certified providers operating under low per-beneficiary limits face significant losses on some chronic patients who may require as many as 100 or more visits a year.

"If you spot those patients early and know that's where you lose all the money, you can do half the visits with a unit. You'll never get paid for those video visits, but you'll be cutting your Medicare losses," Mahmud says.

It's an investment

Telehomecare may also help you get authorization for regular nursing visits. "If you allow a managed care case manager to come on-line with you and see the wound care process, she will see your predicament and participate with you and get you reimbursement," asserts **Jean Robertson**, president of Nashville, TN-based Rubicon. Rubicon's WoundBase technology allows providers to transmit digital images of wounds along with computerized computations of wound characteristics over the Internet.

A picture may also be worth thousands of dollars when it comes to successfully fighting payer denials. Telehomecare products are an expense, but in comparison to the value of denied claims, they are a drop in the bucket, says **Thomas Grier**, RN, director of Bibb Medical Center Home Health in Centreville, AL.

"Five hundred dollars a month [spent on telehomecare] is a lot of money, but it's not," he asserts. "If you submit $50,000 in claims and [a payer] is denying 10% of them, it outweighs the $500. You're not guaranteed payment, and having documentation to support your claim is invaluable. What better documentation do you have than an oozing ulcer in [the payer's] face?"

Telehomecare may even open marketing doors for providers. Rubicon's WoundBase program has caught the eye of larger hospitals that otherwise wouldn't be interested in Bibb, Grier reports.

As cost and reimbursement issues become resolved, other barriers to widescale use of telehomecare will also fall. Some providers are reticent to adopt telemedical technology because of liability concerns. What if the equipment fails? What if a provider misses a serious complication or gives erroneous advice?

"It's not a critical care thing. It's just another tool. If the equipment fails, or if the nurse isn't sure of anything, she can make a visit in person or advise the person to seek emergency care," argues Mahmud.

Telehomecare actually gives health care professionals better information, says **Jack Fisher**, MD, director of medical research for Rubicon and a practicing plastic surgeon. "We take care of patients kind of blindly now. We're put in an awkward position and we don't have adequate information. With telemedicine, we're given very timely information and the quality of the data is improved."

Mahmud agrees. "If you receive a patient complaint on the telephone, you make a blind assessment. But with telehomecare, you're more informed and can relay better information to the physician."

As telehomecare becomes more prevalent, not having it will eventually become a liability, Mahmud predicts.

Others have raised concerns about patient confidentiality and data security with the use of telehomecare, especially for products that relay information through the Internet. Rubicon protects data by using passwords and encryption or by scrambling technology when transmitting it over the Internet.

The American Telemedicine Association (ATA) has adopted a set of telehomecare clinical guidelines that it hopes will become the industry standard. One of the patient-related criteria stipulates the "patients cannot be viewed through the video without their knowledge or prior written consent. If other agency personnel or visitors come into the viewing site, the patient must be made aware of their presence, and the patient's approval must be obtained for such personnel to participate in the video visit. If a third remote site is participating in the video site, the patient must again be aware and

Main Sources of Telemedicine Program Funding

Source	Percentage
Internal/self/ parent organization	35%
Grants	34%
State	14%
Hospital	7%
Member fee	6%
Federal grants/contracts	4%

Source: Association of Telemedicine Service Providers, Portland, OR.

approve of such participation."

Another current limitation on telehomecare involves state medical licensure laws. According to the ATA, in the last four years at least 14 states have passed legislation that prohibits physicians in another state from practicing telemedicine on patients in their state unless the physician has a full and unrestricted licensure in their state. Nurses face similar issues. ATA and its members are fighting for changes, but in the meantime, there is much business to be had intrastate, Mahmud notes.

Nurses may also fear that telehomecare will take their jobs, but that's not the case, according to Mahmud. "A video visit takes only 15 to 18 minutes. Now you've saved the nurse's time for more revenue-generating activity."

With so many things that have restricted its growth now falling away, telehomecare will soon be bursting on the scene. Are you ready?

[Editor's Note: Copies of the ATA Telehomecare Clinical Guidelines are posted on the association's Web site: www.atmeda.org; telephone number is (202) *628-4700. For a copy of the* 1998 ATSP Report on Telemedicine*, which costs $295, contact the Association of Teleservice Providers at (503) 222-2406.]* ■

A tale of two technologies: Providers rave about them

Telehomecare saves money, averts denials

Telehomecare involves a broad range of technology and services delivered in the homes of patients. American TeleCare and Rubicon, two companies with different products, and their respective clients, University Home Care and Pitt County Memorial Hospital, both in Greenville, NC, illustrate the versatility and diversity of the telehomecare market.

American TeleCare's product allows providers to make "video visits." Nurses and patients communicate through telemedicine units placed in the provider's office and individual's home, respectively. The patient telemedicine unit is 10 inches high and weighs 16 pounds. It includes a video display, speakerphone, blood pressure and pulse meter, and stethoscope. Some units also have call buttons that allow patients to immediately access their home care provider at any time. Not all providers want this feature activated however, depending on their after-hours staffing arrangements and the type of central unit — portable or stationary — they have.

Create a video record

In addition to verbally interacting with and visually evaluating patients, those using the American TeleCare product can assess vital signs and take date and time-stamped photographs that can be stored for later review. The system also includes automated patient record software for use during video visits. It uses normal telephone lines and electrical outlets.

Each patient unit costs around $5,000. Most providers lease the product at a cost of around $5 per day per unit, according to **Khalid Mahmud**, MD, FACP, founder, chief executive officer and chairman of the Eden Prairie, MN-based company. American TeleCare provides the central station as part of any lease or purchase arrangement.

University Home Care uses its 26 American TeleCare patient units on a variety of patients, including those with pregnancy-induced hypertension (PIH), chronic diseases like congestive heart failure and chronic obstructive pulmonary disease, and asthmatic children and infants at high risk for apnea.

It combines video and in-home visits to reinforce teaching, monitor compliance, and evaluate the status of the most vulnerable among these patient groups.

The results so far are impressive. Among the first five PIH patients, for example, the combination of video and traditional home visits averted 53 hospital days and saved about $23,000, according to **Bonnie Britton**, MSN, RN, C, supervisor of special programs. The agency only recently implemented the service on other patient populations and does not yet have documented outcomes.

Patients also seem to like the service. University Home Care conducted a qualitative study to gauge patients' adaptation to technology. It found that patients and their families felt a sense of pride in being more responsible for their own care than they might otherwise be. Some also said they preferred video over traditional visits because they didn't have to worry about making themselves or their homes presentable. Others liked having the additional connection with the agency, even though it does not use the 24-hour call button.

Although it covers the same territory as a traditional in-home visit, a typical video visit takes

less than half the time. They last about 12.5 minutes compared with around 30 for those in-home, according to Britton. "I'm not sure why they're shorter. It may be that [the nurse and patient] are more focused on the task at hand, and they don't have the paperwork and setup time of a traditional visit," she says.

University Home Care spent approximately $145,000 on its system. Its parent, Pitt County Memorial Hospital, purchased five patient telemedicine units. It acquired the remainder through several grants ranging from the Children's Miracle Network to a state foundation to the nursing society Sigma Theta Tau. Britton plans to apply for more grants in the future and is optimistic about receiving funding.

One commercial payer has recognized the technology and reimburses University Home Care's video visits at the same rate as a traditional visit. The agency successfully argued that there is no difference between the two except that during video visits, nurses can't touch patients or perform interventions like dressing changes that require hands-on care.

"I don't expect that [level of reimbursement] with everyone," Britton reports.

Still, she is very optimistic about future reimbursement prospects. Although video visits are less expensive than traditional ones, they don't excessively emphasize the cost savings when pitching the service to payers. Doing so may open the door for them to reimburse at cost, Britton cautions.

Even if other payers won't recognize the service, it still pays financially, according to Britton. "I'm not concerned with Medicare. When the [prospective payment system] happens, it won't matter that it's not reimbursed. It will be a cost savings survival tactic," she explains.

Taking the patients no one wants

Through no fault of their own, patients with wounds such as decubitus ulcers are the pariahs of the home care world. Their care can cost an agency as much as $40,000 per case. It can cripple any provider, especially Medicare-certified agencies struggling under low per-beneficiary limits.

Even under the best of circumstances, wounds are among the most intractable chronic conditions. But their treatment among primary and specialist physicians, enterostomal therapists (ET), home care providers, and payers is rarely timely and well-coordinated.

"It's the most mismanaged condition. The wounds are neglected, not because people aren't trying, but because they occur in debilitated elderly patients. They're not life-threatening, and they're chronic," says **Jack Fisher**, MD, director of medical research for Nashville, TN-based Rubicon. Fisher is also a practicing plastic surgeon. His frustration at seeing so many poorly managed wound cases lead him, in collaboration with Rubicon president Jean Robertson and Jeff Bauer, vice president of information systems, to develop the company's WoundBase product.

WoundBase uses "store-forward" technology. During a normal home visit, a nurse photographs her patient's wound using a digital camera outfitted with a floppy disk. Later, back at the office, she inserts the floppy disk into a personal computer (PC) while running WoundBase software. The software measures a variety of wound characteristics such as its width, granulation, and epithelialization down to the millimeter and stores the image in its database. The nurse can view the image on the screen and also make a hard copy using a standard laser jet or laser printer.

Still later, using the PC in his office, the patient's physician connects to the Internet, uses his pass code to access the WoundBase system, and pulls up his patient's wound images. He can view the image side by side with an analysis of changes in the characteristics of the wound over the course of its treatment. He too can make a hard copy of the wound image to place in the patient's chart.

Later, the case manager from the patient's insurance company can also access the image and make a hard copy of it if she chooses.

The digital camera creates images that are a far cry from the grainy ones typically seen on Web sites, according to Fisher. "I call them Rembrandts. I can see more things, such as fine hairs, than if I was looking at the wound in person."

The images are "crystal clear," agrees **Thomas Grier**, RN, director of Bibb Medical Center Home Health in Centreville, AL. Bibb Home Health now uses the WoundBase product on every wound care patient that it follows, as well as those with implanted catheters and other invasive technologies.

"It's fantastic," Grier says of the product. In addition to documenting wounds in graphic detail, it knocks days or even weeks off the home visit-wound intervention cycle, he reports.

Under traditional wound care, "if the physi-

SOURCES

- **Jeff Bauer**, Vice President of Information Systems, **Jack Fisher**, MD, Director of Medical Research, and **Jean Robertson**, President, Rubicon, 8303 21st Ave. S., Suite 300, Nashville, TN 37212. Telephone: (615) 297-3511.
- **Bonnie Britton**, MSN, RN, C, Supervisor of Special Programs, University Home Care, 6 Doctor's Park, Greenville, NC 27835. Telephone: (800) 227-3894.
- **Thomas Grier**, RN, Director, Bibb Medical Center Home Health, 164 Pierson Ave., Centreville, AL 35042. Telephone: (205) 926-3211.
- **Bill Grisby**, PhD, Senior Research Associate, Telemedicine Research Center, 2121 S.W. Broadway, Suite 130, Portland, OR 97201. Telephone: (503) 223-6191.
- **Khalid Mahmud**, MD, FACP, Founder, Chief Executive Officer and Chairman, American TeleCare Inc., 7640 Golden Triangle Drive, Eden Prairie, MN 55344. Telephone: (612) 897-0000.

cian who is only a family practitioner gets a call from a nurse who says the wound's not healing and wants to consult with an ET, he needs an image of it," he explains. "The nurse takes a Polaroid shot. No two Polaroids are the same and they're blurry, but he sends the image to the doctor in snail mail. By the time the doctor looks at the image, you've lost another week. By the time he contacts the ET or plastic surgeon, you're now two weeks removed, and the wound's significantly worse, and the staff member out in the field is saying, 'Help me!'"

Rubicon charges a $500 per month software licensing and service fee. It includes software upgrades, a WoundBase work station installed in the provider's offices and initial system training. There is no added user fee; providers can take as many images of as many patients as they want. The digital cameras Rubicon recommends for use with WoundBase cost around $800; the floppy disks for the camera are about 25 cents each.

Grier hasn't yet had to use WoundBase images as documentation to fight denied claims, but that's one of the main reasons he believes the system is worth using even though no payer provides funding for it.

"This is a defensive mechanism," he says. "The road to reimbursement is getting more crooked and tighter, and this is extra ammunition in your pocket." ■

Can't get the time of day from your scheduler?

Tips for higher productivity, less stress

A private duty operation with an ineffective scheduler is like a car with a bad starter. It's not worth having. Not being able to count on filled shifts, loyal staff, and happy clients can make you want to ditch the tin lizzie and take up walking.

Wringing more productivity from a scheduler is only part of the equation. The scheduling function in a private duty agency is "one of the most difficult jobs that ever was," says **Darien Zimmerman**, RN, director of Bayada Willow Grove Pediatrics in Willow Grove, PA.

Walking the fine line of balancing an admittedly tough workload without unduly stressing the scheduler can have far-reaching consequences for the organization.

"Schedulers are the lifeline to the office. They can make or break your operation," says **Lauri Snow**, RN, LPN, patient care coordinator for the Daytona Beach, FL, office of Pediatric Services of America.

Making scheduling easier

You can create a smooth-running scheduling function, however, by using these tips:

• **Find the right person.**

Not every one is cut out to be a private duty scheduler. The person must be a self-motivated, organized, critical-thinking-cheerleader-mother superior-diplomat all rolled into one.

"You've got to have someone who's outgoing with an upbeat personality who can switch gears at the moment's notice and doesn't get upset. And if she needs to discuss a problem with a nurse, she's got to use finesse to get the point across and not cause the nurse to cancel her next five shifts," Snow explains.

"It's not a job for everyone," Zimmerman agrees. "The person has to be tenacious, totally comfortable on the phone, and not afraid to ask someone to drive 25 miles further than they usually go. The pressure is intense, but they have to be nice no matter what."

Although computerized scheduling programs can match client needs with nursing availability and skill levels, effective schedulers also envision a complicated puzzle beyond the system, according

to **Tina Shivar**, RN, location director for the Greenville, SC, and Augusta, GA, offices of Pediatric Services of America.

"They've got to maneuver people around and sometimes do three-way swaps to fill shifts. They must have critical thinking and organizational skills," she says.

Finding a person with such a variety of talents is not easy. While Shivar wouldn't consider someone without prior scheduling experience, both Zimmerman and Snow would.

Former field staff can also make great schedulers. That's the case at Fayetteville, NC-based Home Health Services of Cumberland County Inc., according to **Elizabeth Hudspeth**, RN, MSN, executive director. The company's private duty scheduler is a former home health aide who previously worked in its health and hospice divisions.

• **Don't mix private duty and visit scheduling.**

Combining the scheduling function for shifts and visits is like mixing oil and water. Although it's possible for one person to do both, especially on a small scale, it's better to keep the two areas separate. Visit scheduling necessarily involves lots of paperwork tracking, and extensive communication with physicians, insurance case managers, patients, and professional field staff. Integrating those activities with the often-urgent nature of private duty scheduling may set a person up for failure.

"It's really two different mindsets," says **Kathleen Bailey**, president of Lancaster, PA-based Private Duty Solutions, a private duty consulting firm.

• **Set realistic productivity and staffing standards.**

It's better to establish private duty scheduling standards based on the number of hours rather than cases, according to Shivar. "I'm responsible for two offices; one with 21 patients, and one with eight, but they both have the same hours," she explains.

Although it depends on the relative stability of your cases, number of available field staff, and average shift length per case, most schedulers should be able to handle about 1,000 hours per week. Bailey recommends a 1,200-hours-per-week standard as a starting point.

"It really varies for each agency. If you have three 24-hour cases that run themselves, the scheduler can probably do more. But if you have a lot of cases with two or four hours, it might be less. You also have to consider what else the scheduler does, such as interviewing and orientation," she explains.

The scheduler at Home Health Services of Cumberland County arranges between 8,000 and 9,000 hours per month, according to Hudspeth. The caseload has several 24-hour cases, as well as many three and four hours and involves mostly CNAs and companions. The scheduler is also responsible for filing the daily case records.

• **Schedule as far in advance as possible.**

The longer out your schedules go, the better, according to Zimmerman. She prefers two-month cycles. "If you're really good at it, you can get the nurses to commit that far in advance. Two weeks ahead is really last minute," she says.

• **Require daily updates.**

Shivar requires schedulers to maintain a Microsoft Excel spreadsheet that shows the daily openings for all cases. She reviews those with the schedulers, along with records of field staff called and the overall staff roster.

When reviewing a call list with the scheduler, look closely to see that she is efficiently making phone calls, Bailey advises. "It's not just making the phone calls. Does she narrow the possibilities before calling? It saves a lot of time and frustration on the part of the staff."

In addition to the number of phone calls that she makes, other productivity and performance measures include the amount of overtime paid to field staff, the percentage of shifts filled for each case, and the level of staff and patient satisfaction. "If you have too much overtime it's because the same people are doing all the work and the scheduler is not finding other people," Snow advises.

Good schedulers manage to keep patient complaints to a minimum, and not only have shifts covered, but have the best of the staff working. They also intimately know each case and remember which staff aren't acceptable to which patients, as well as a good sense about ones who shouldn't be tried on certain cases, she adds.

• **Emphasize teamwork.**

If your operation is large enough to support two schedulers, put systems in place to ensure that they work together.

"Have them in the same room so they can see each other and talk back and forth. Put a board on a wall and post all the unfilled shifts so each one can offer anything available to a staff member who wants to work," Bailey advises.

With more than one scheduler, "don't divide the caseload. It can fail if you separate the cases by territory. Have masterbooks and have one put out calls on open shifts and the other do the monthly maintenance work," Snow recommends.

Zimmerman disagrees. "If you don't assign cases, you don't have accountability. It may work to have one do openings and the other maintenance, but I wouldn't want to be the one to have to fill the openings."

Another benefit of assigning cases is that instead of having two people who each know a little about 40 cases, for example, each will instead know everything about 20, she adds.

When assigning cases, evenly divide both the hours and the proportion of easy and difficult-to-staff cases, Bailey recommends. "Give both a percent of ongoing, easy-running cases. Don't have one with all the problems."

Whether you have one or five schedulers, it is important to have other staff members cross-trained and ready to pinch hit in their absence. At Home Health Services of Cumberland County, the private duty biller, nurse manager, and the person who handles orientation can all substitute for the scheduler.

It's important that those filling in are well-trained. "The director must instill teamwork. No one wants to return from a vacation and find their cases trashed," Zimmerman says.

Teamwork that helps keep the scheduler on board also extends to the field staff. "Our staff are really educated in orientation about the importance of showing up or calling in when they can't. They know it's really an offense if they don't show up," says Hudspeth.

• **Consider an on-call scheduler.**

In some agencies, any after-hours phone calls go to the nurse on call. She handles everything from referrals to patient complaints to staff call-outs. With so much on her plate, and perhaps not that familiar with all the cases and staff members, she may not be able to do justice to unfilled shifts or next-day call-outs.

To combat this problem, Home Health Services of Cumberland County now has a private duty scheduler on call with the on-call nurse providing backup. "It's an added expense, but it works really well and the scheduler likes it because she gets extra pay," says Hudspeth.

• **Don't accept cases you can't fill.**

It's impossible to fill every shift every day on every case. But how many shifts need to be filled at the start of a case when you expect to continue recruiting and ultimately fill more shifts?

"Don't accept a case if you can't fill at least 80% of the hours," Bailey advises.

"You should have the first week fully staffed. That's a critical time. If you have more open than filled shifts, communicate with the family and referral source and discuss what they'd like to do," Snow says.

It helps to have a long lead time to staff a new case, such as four weeks for complicated cases involving hi-tech care, according to Zimmerman. And avoid opening a case on weekends and holidays at all costs, she recommends.

To determine the number of staff ultimately needed for a case, Snow doubles the number required with no overtime. For example, a 24 hour case involves 168 hours per week. Assuming a 40-hour week, the case would require 4.5 people. To staff it on a day-in, day-out basis, you'd need at least 10 nurses available and trained.

• **Recognize and respond to signs of burnout.**

If call-outs that normally wouldn't cause your scheduler to bat an eye send her over the edge, or she seems less willing to make just one more call to fill an open shift, she may be on the verge of becoming a casualty to the scheduling grind. Other indicators include taking longer to complete scheduling-related functions, such as time reports for payroll, and increasing overtime and open shifts.

Intervene immediately when you notice signs of scheduler burnout, and take steps now to prevent it from happening. If your operation is experiencing a temporary crunch — taking on a complex new case, for example — do your part to help ease tensions. Zimmerman buys lunch for the entire

SOURCES

- **Kathleen Bailey**, President, Private Duty Solutions, 313 W. Liberty St., Suite 126, Lancaster, PA 17603. Telephone: (717) 509-4452.
- **Elizabeth Hudspeth**, RN, MSN, Executive Director, Home Health Services of Cumberland County Inc. 235 N. McPherson Church Road, Fayetteville, NC 28303. Telephone: (910) 860-4764.
- **Tina Shivar**, RN, Location Director for Greenville, SC, and Augusta, GA, offices, Pediatric Services of America, 500 E. North St., Suite C, Greenville, SC 29601. Telephone: (800) 725-6950.
- **Lauri Snow**, RN, LPN, Patient Care Coordinator, Pediatric Services of America, 1182 Pelican Bay Drive, Daytona Beach, FL 32119. Telephone: (800) 937-1692.
- **Darien Zimmerman**, RN, Director, Bayada Willow Grove Pediatrics, 607 Easton Road, Suite B1, Willow Grove, PA 19090. Telephone: (215) 657-3900.

office at such times; Snow recommends that managers roll up their sleeves and work side-by-side with employees.

It also helps to require the scheduler to take vacations and holidays and send her home early on occasion.

• **Give flexibility and freedom.**

Of course, certain things need to be done a certain way, but when possible, give the scheduler the freedom to do things her way. "Don't be stuck on rules. You have to be creative in doing what works and give staff the ability to do the job in their own way as long as it works," Zimmerman advises.

It also helps to make clear your expectations about how the job is to be done. Along with that, set high, but realistic performance goals. Doing so will give the scheduler a sense of empowerment and ultimately more job satisfaction when she achieves them, Zimmerman says. ■

Put your agency ahead of the pack with PACE

Unique program offers great benefits

C'mon. Several home care providers are considering it, but no one's done it yet. Why not put your company on the vanguard by becoming the first home care sponsor of a Programs of All-Inclusive Care for the Elderly (PACE) program?

PACE received full Medicare program recognition with passage of the Balanced Budget Act of 1997 (BBA). The Medicare and Medicaid-capitated program for frail, nursing home-eligible elderly had previously been in demonstration status with the Health Care Financing Administration (HCFA).

PACE is modeled on the system of acute and long term care services developed in the early 1970s by On Lok Senior Services in San Francisco. On Lok slowly developed the PACE model in response to community concern for the frail elderly of San Francisco's Chinatown, North Beach, and Polk Gulch neighborhoods.

Poor and vulnerable seniors from those communities were being "placed in nursing homes far away; they had no further contact with people they knew before, they were given food they'd never eaten before, and they basically went off and died," says On Lok director **Kate O'Malley**.

On Lok was granted Medicare demonstration status in 1979, and has been fully Medicare and MediCal-capitated since 1983. It now has six centers throughout San Francisco and about 750 enrollees.

With the help of more than $5 million in grant support from the Robert Wood Johnson Foundation, five other program sites replicated the On Lok model in the mid-1980s. The fully capitated sites now operate under Medicare and Medicaid waivers while awaiting HCFA's release of the final PACE regulations as required in the BBA. Originally due out in August 1998, HCFA now says they'll be issued by August 1999.

More information about PACE programs is available from the National PACE Association at (415) 749-2680. Its Web site is www.natlpace-assn.org. HCFA also has information about PACE on its Web site, www.hcfa.gov.

Today, 25 sites in 13 states are fully capitated; another eight operate PACE-like programs with only Medicaid capitation. At the end of 1997, there were only about 5,000 enrollees nationwide.

The little-known programs offer huge benefits for all involved. "It's the best thing since sliced bread!" declares **Judy Baskins**, RN, vice president of geriatric services at Columbia, SC-based Palmetto-Richland Memorial Hospital. She oversees Palmetto Senior Care, one of six original PACE demonstration sites. It now serves 400 patients and has been fully Medicare and Medicaid-capitated since 1994. Baskins is also president of the National PACE Association in San Francisco.

"It allows providers the flexibility to provide care based on patient needs while maximizing Medicare and Medicaid reimbursement. It improves the quality of life of participants. It brings value and trust back into the health care system, and it allows patients and families to be more participatory and proactive rather than reactive about their health care choices," Baskins says.

Medicare and Medicaid also both gain from PACE. It is conservatively estimated to save at least 5% for Medicare; Medicaid savings varies between states, but ranges from around 5% to 15%.

PACE is an innovative program and it's a win for patients, providers, and payers alike. But there's one glitch that probably explains why no home care provider has yet opened one: It takes lots of money. Between $1 million and $1.5 million is needed at a minimum for program development expenses and to cover losses until there are a sufficient number of enrollees, Baskins estimates. That doesn't include the cost of either constructing or renovating an adult day care center, which is the mainstay of PACE.

SOURCES

- **Karen Armacost**, RN, C, MSA, Clinical Director and Acting Program Director, Hopkins Elder Plus, 4940 Eastern Ave., Baltimore, MD 21224. Telephone: (410) 550-7124.
- **Judy Baskins**, RN, Vice President, Geriatric Services, Palmetto-Richland Memorial Hospital, 15 Medical Park Drive, Suite 203, Columbia, SC 29203. Telephone: (803) 434-4418.
- **Anita Langford**, Senior Director of Long Term Care, Johns Hopkins Bayview Medical Center, 5501 Hopkins Bayview Circle, Baltimore, MD 21224. Telephone: (410) 550 0756.
- **Kate O'Malley**, Director, On Lok Senior Health Services, 1333 Bush St., San Francisco, CA 94109-5611. Telephone: (415) 292-8888.

Wow! That's a small fortune, especially for independent private duty companies. But every existing PACE program is not wealthy. To be sure, some have more resources than others. Hospitals and health systems run 49% of them. Community-based agencies, health centers, and long-term care providers operate the remainder.

One way to afford a PACE program is by obtaining grant funding. Money is already available for programs that involve the health and well-being of seniors and it's only increasing. **(See article on finding grant funding, *Private Duty Homecare,* December 1998, p. 165.)**

Local foundations in particular may be interested in supporting such a beneficial program in their own backyard, Baskins advises.

If the upfront investment doesn't frighten you, then assuming the full downstream financial risk for very sick and potentially very costly enrollees will. It shouldn't, however. With an effective interdisciplinary team and aggressive case management, it is not only possible, but probable that you can provide the care that enrollees need without going bankrupt.

The current operating experience of all PACE programs bears that out. All are financially viable under capitation, according to O'Malley. Utilization data of PACE enrollees nationwide supports that position.

Despite the fact that they are all eligible for nursing home care, only about 7% are residents at any given time. PACE enrollees also have only a slightly higher hospitalization rate than then general Medicare population that includes healthy seniors: 2,180 days per 1,000 enrollees per year in 1997 vs. 2,014. Medicare does not separately report utilization data on the frail elderly receiving standard Part A benefits. When they are hospitalized, PACE enrollees have shorter lengths of stay than other Medicare patients; 4.1 vs. 6.6 days in 1996.

Stop-loss insurance is available to shift risk in the event of catastrophic care that enrollees need, Langford says.

The amount of money available to care for each PACE enrollee varies depending on the provider's location. Like other Medicare risk programs, the PACE Medicare capitation is based on regional adjusted area per capita cost (AAPCCs), with a 2.39 adjuster to account for the frailty of PACE enrollees.

In 1997, the rates averaged $1,200 per member per month (PMPM). Medicaid payments averaged $2,100 PMPM during the same period. Most states take some discount from their overall long term care costs. The state of Maryland, for instance, uses a blended rate derived 70% from adult day care and 30% from nursing home expenses, according to Langford.

In one sense, the PACE capitation is a limitation. You only get a certain amount of money each month to care for some very old people that may require significant levels of care. On the other hand, though, it is liberating. It frees providers to give the service needed without being subjected to the normal and often restrictive rules that go with fee-for-service care.

For example, Medicare requires three days' acute hospitalization for transitional care eligibility. A PACE enrollee who needed transitional level care would be directly admitted there, bypassing a more costly and unnecessary inpatient stay.

"Instead of looking at whether a person has this benefit, you can look at what they need," explains **Anita Langford**, senior director of long-term care at Baltimore-based Johns Hopkins Bayview Medical Center. Langford is responsible for Hopkins Elder Plus, the Johns Hopkins Health System's PACE program located near the Bayview Medical Center campus.

The single most important variable in successfully operating a PACE program is very strong primary care. The idea is to aggressively manage enrollees, continually adjusting their care plans and reacting to even the slightest change in their condition to keep them as healthy as possible and out of high-end care for as long as possible.

PACE also requires a shift in care philosophy that emphasizes preventing functional declines rather than restoring functional impairments. For example, a traditional model would focus on

preventing a 90-year-old with degenerative hip disease from falling. But under PACE capitation, it would be equally important to teach the individual how to fall.

"You have to have strong primary care. These strategies are not rocket science, but they are the hardest lesson to learn [in running a PACE program]. Fee-for-service has so shaped our standards of care that when you take that away, it takes a while to get used to the new system," says Baskins.

An interdisciplinary care team provides that necessary care management and shift in care philosophy. It should be egalitarian, advises **Karen Armacost**, RN, C, MSA, clinical director and acting program director of Hopkins Elder Plus.

"The physician's not more important than the driver, because the driver's the first person to note that the [enrollee] had a problem getting in the van today and not yesterday," she explains.

In addition to the drivers, the Hopkins team includes board-certified geriatricians, a nurse practitioner, two RNs, an LPN, part-time physical and occupational therapists, and several home health aides.

PACE care teams primarily interact with enrollees at each program's adult day care center. There, enrollees receive everything from music therapy to exercise and hot meals.

PACE team members also staff primary care clinics, where enrollees receive most of their day-in, day-out medical care. If enrollees require facility-based care, the team oversees their treatment. Although most PACE programs either have their own or contract with a home care agency, some members of the care team also follow patients in their homes. At Hopkins ElderCare, an RN is always on call, and geriatricians make house calls if necessary.

Adult day care is the center of PACE. Across all PACE programs, the center accounts for about 36% of operating expenses. On average, enrollees go there nine days a month.

Private Duty Homecare™ (ISSN 1091-1839) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Application to mail at periodical rates is pending at Atlanta, GA 30304. POSTMASTER: Send address changes to **Private Duty Homecare™**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). 8:30 a.m.-6 p.m. M-Th, 8:30 a.m.-4:30 p.m. F, EST.

Subscription rates: One year (12 issues), $279. Approximately 18 nursing contact hours annually, $289; outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $167 per year; 10 or more additional copies, $112 per year. Call for more details. 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 $47 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Gina Rollins**, (301) 589-1974, (vngrrolli@aol.com).
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@medec.com).
Production Editor: **Nancy McCreary**.

Editorial Questions

For questions or comments, call **Lee Landenberger** at (404) 262-5483.

The second-largest PACE component is home care. Nationwide, it's about 22% of operating costs. If you're not able to consider operating your own PACE program and your business is located near an existing one, consider approaching that program about subcontracting for home care services, Baskins suggests.

With PACE participants coming in and out of day care, visiting clinics, and receiving care at home, communication and coordination are critical. Add to that the oversight of those in facilities and the sometimes challenging home and family situations of enrollees, and you have a resource-intensive service.

"The management is complex. It's amazing. We can't believe 68 people keep us this busy! But it's a great model. It makes great sense instead of all this fragmented care," says Armacost.

If you're willing to break the ice and become the first home care organization that develops a PACE program, your efforts will be rewarded, says Langford. "It's a wonderful quality-of-life program, and it's the wave of the future. But it's also very challenging. Don't do it unless you like challenges." ■

About PACE enrollees . . .

At the end of 1997, around 5,000 frail, elderly people were enrolled in Programs of All-Inclusive Care for the Elderly (PACE). By law, they are all at least 55 years old, live in the catchment area of the PACE program, and are certified as eligible for nursing home care by an appropriate state agency.

More than 70% of PACE enrollees are age 75 or older. Most have close to eight diseases; nearly half suffer from dementia. The 10 most prevalent conditions include:

- hypertension;
- diseases of the eye;
- arthritis;
- dementia;
- anxiety or depression;
- cerebrovascular disease;
- diabetes;
- coronary artery disease;
- diseases of the ear;
- peripheral vascular disease.

PACE enrollees need help with both activities of daily living (ADLs), and instrumental ADLs like taking medications, preparing meals, and doing laundry. On average, they are dependent in 3.5 of the five ADLs and most need assistance with all eight instrumental ADLs.

In 1998, the average number of prescription medications taken by the enrollees of 12 PACE programs ranged from three to five and a half. Those same programs reported that from 20% to 94% of their enrollees received in-home personal care. The average number of monthly personal care-home chore hours per user ranged from 19.8 to 124.1. ■

CE objectives

After reading this issue of *Private Duty Homecare*, CE participants will be able to:

1. Identify ways that telehomecare benefits providers.
2. Identify how telehomecare can improve wound care treatment.
3. List three tips for maximizing the productivity of a private duty scheduler.
4. Describe a PACE program. ■