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Form partnerships for better home care: Be part of a continuum

Relationships with other organizations expand referral base and services

(Editor's note: This is the first of a two-part series that looks at innovative approaches to patient care and expansion of services by home health agencies. This month's article describes partnerships with other organizations that are designed to both increase referral bases and enhance home health services. Next month's issue will examine the proactive approach of two agencies that have found a way to offer a more holistic approach to patient care.)

As the population ages and the needs of seniors change, home health managers are looking for ways to make their services more applicable to today's senior population. One way to expand services and increase the visibility of your home health agency is to form partnerships or relationships with other organizations in the community.

On one end of the spectrum of new ways to serve seniors is Elant, based in Goshen, NY, a senior health care and housing solution that combines a variety of housing options such as independent living units, assisted-living facilities, adult homes, and traditional skilled nursing facilities with community health services such as home care in several New York locations. Clients who join the system at the independent living stage receive services as needed and move into other housing settings as their health and needs dictate, says **Susan Schulmerich**, RN, MS, MBA, vice president of community health services for Elant, who is based in Newburgh.

"Home health is integrated throughout the system because it is appropriate for an organization that is managing the health needs of its clients to use home health to keep clients in the most independent setting appropriate for them," Schulmerich says.

"Home health can provide services that range from assistance with baths and hair washing to preparation of meals, to care for acute needs such as stroke recovery or wound care. The goal is to provide the level of support clients need to stay in their home," she adds.

Even when the home health agency and the assisted-living facility aren't part of the same corporation, there is a natural fit for the two

types of organizations to work together, explains Schulmerich.

It's much easier for private-duty agencies to establish partnerships with assisted-living facilities because rules related to anti-kickback statutes don't apply, says **Karon Austin,** MPA, RN, CHCE, a home care consultant and owner of Healthcare Concepts in Avon, CO.

"During my 21 years as an owner of a private duty home care company, I was able to establish several relationships with assisted-living facilities," she says. Her arrangements actually specified her agency as the preferred provider when the assisted-living facility needed to refer to a home care agency. While Medicare-certified agencies are unable to establish the same type of formal agreement, there are a number of ways that all home care agencies can establish relationships, she explains.

"One of the services we provided to our assisted-living facility partners was a monthly educational program in which we provided speakers on a variety of topics of interest to the facility's clients," Austin continues. "We would present topics on health issues such as osteoporosis and Medicare coverage topics, such as benefits for wheelchairs, canes, or other durable medical equipment," she says. "We also provided cholesterol screenings and coordinated annual health fairs," she adds.

Speakers for the educational programs and the health fairs can be a mix of agency nurses with expertise in certain areas, representatives from vendors such as durable medical equipment providers, and medical personnel such as podiatrists or dentists from the local area.

"We never charged the clients for the seminars, and we never paid fees to any of the speakers," Austin says. There was, however, never a lack of willing volunteers to speak, especially when local health care providers and physicians learned about the program and saw it as an excellent way to establish a connection with an audience that would most likely need their services at some point, she adds.

Before finalizing any agreement to provide health fairs or educational programs at an assisted-living facility, be sure to have an attorney review the agreement for violations of state and federal anti-kickback regulations, suggests **John Gilliland**, an Indianapolis-based attorney.

Basically, a home health agency cannot promise a free service such as an educational program in exchange for a promise of referrals, he explains. The laws differ from state to state, with some state regulations being even tougher than federal regulations, so each agency needs to have its agreements evaluated, Gilliland says.

It also is important to make sure the assisted-living facility has a policy that gives preference to patient choice when choosing a home care agency, and that the facility follows its policy. This gives a Medicare-certified home health agency an extra measure of protection against charges of kickback violations, he says.

The Visiting Nurse Association (VNA) of Central Connecticut in New Britain has relationships with assisted-living facilities through an entirely different arrangement.

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Editorial Questions

For questions or comments, call **Christopher Delporte** at (404) 262-5545.

The agency's partnership began with the University of Connecticut as a way to both enhance community nursing training for student nurses and a way to continue care for patients once they no longer had a need for acute care home health, says **Karen Reid**, RN, BSN, director of public health services for the agency.

The home health agency and the nursing school developed CareLink, a program that uses student nurses to follow VNA patients with chronic, ongoing problems once they are discharged from VNA care for their acute episodes.

"There is no charge to the clients for the care," says Reid. The students make the home care visits, perform assessments and evaluations, and monitor the patients' condition under the supervision of both the nursing school and a VNA employee who serves as a liaison for the program, she says. **(Look for a more detailed description of this program in next month's issue of *Hospital Home Health*.)**

Students who work with the 200 patients in the CareLink program are excellent representatives for home health, Reid notes. "In addition to providing much appreciated monitoring of chronic conditions, the students are taught to assess changes in a patient's condition that might signal a need for more acute home health services."

A key to any successful partnership is to ensure that both organizations have the same goals and philosophies, Austin explains.

"I recommend that a home health agency tour the organization with which the partnership is being discussed," she says.

Austin looks for evidence of quality care, concerned staff members, and a clear definition of appropriate residents if she is looking at an assisted-living facility. "I want to make sure that the assisted-living facility makes referrals to nursing homes or other facilities when it is appropriate rather than keeping clients in inappropriate settings." This protects her staff as well, because they know what type of clients with whom they will be dealing and won't encounter surprise clients who require a much higher level of care than anticipated, she adds.

Working with assisted-living facilities may be a first step in establishing a relationship with another senior care organization, Austin points out.

The passage of the Medicare regulations in 2003 included a directive for a demonstration project that further evaluates the definition of homebound and its application to adult day care, she says. **(For more information about adult day care and home health partnerships, see *HHH*, September 2003, p. 101.)** "This type of change will open up entire new avenues for home health to explore," Austin explains.

[For more information on innovative approaches to home care, contact:

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Control supply costs through automation

On-line orders and direct shipping effective

Directors of supply management for home health agencies face a different set of challenges than do supply management directors for hospitals, but the rewards of an effective system to control supply costs can be significant, say experts interviewed by *Hospital Home Health.*

Supply management in a home health environment requires more advanced planning on the part of the nurse, points out **Billie H. Waldo**, RN, MS, vice president and general manager of the Extended Care Solutions Group of McKesson Information Solutions in Springfield, MO. "The field nurse can't just walk down the hall to a supply closet when she needs supplies, so she needs to know that the supplies are in the patient's home or in her car," she explains. Family and patient involvement in care also affects supply management because the nurse does not control the supply use between visits, she adds.

There are several ways to streamline supply

management in home health to increase efficiency and reduce costs, Waldo states.

Automation of supply management is the answer for many agencies, she says. Not only can automation decrease the amount of staff time needed in the ordering and inventory control process, but formularies created during the automation process also can keep costs down, Waldo explains.

The savings in staff time after the Visiting Nurse and Hospice Service of Southwest Michigan in Kalamazoo was the equivalent of 40 hours per month of clerical time, says **Lori L. Shifferd**, director of the agency's information systems.

Although no job positions were eliminated, the employees who previously spent this time on supply management now are available to support other areas, she adds.

Shifferd's agency chose McKesson to provide the supply management piece of their system because the agency already was using McKesson software for other areas.

"It was simple to add this piece of automation because we were already accustomed to automated documentation that fed into our billing system," she says. **(For information on software vendors, see box, at right.)** Even with the familiarity with computerized documentation, there was still of feeling of "will this really work?" she adds.

Standardize supplies for savings

The first step in automating a supply management system is to develop a formulary of products appropriate for the agency and its typical clients, Waldo notes. "By standardizing the supplies within a formulary, nurses can't order nonstandard supplies that don't correlate to billing codes and may not be readily available in the agency's geographic area." A formulary streamlines the ordering process and enables the agency to monitor costs, she adds.

The supply order form is on the nurse's laptop and pops up as the nurse completes documentation on each visit, Shifferd states. "As we become more virtual, we become more accustomed to doing things on-line, but initially the use of the order form required a behavior change for all of our nurses," she admits.

The greatest change of behavior was submission of orders no later than 3 p.m. to ensure timely shipments of supplies to patients, Shifferd says. Because the supply management system enables direct on-line order of supplies by the agency and shipment directly to the patient's home, timely submission is important, she adds.

"One thing we learned early in the process was that we needed to think ahead about holiday weekends," she points out. "If we have a holiday approaching, we send a message to all of our field staff reminding them to place supply orders early enough for delivery before the holiday if the patient will need supplies," she explains. "We also allow nurses to telephone the person responsible for placing the on-line orders if there is an emergency need for supplies," Shifferd adds.

In general, supplies are shipped from the warehouse twice each week, she points out. Supplies that are not critical to patient care, or that nurses don't immediately need, such as educational forms and other paper supplies, are shipped in bulk to the agency office where they are placed into the nurses' cubbyholes. "Nurses come into our office for mandatory meetings twice each month. They know to check their cubbyholes for notices, supplies, forms, and other materials," Shifferd continues. This cuts down on some shipping costs for the agency.

By having the supplies shipped directly to the patient's home, nurses don't have to go to the office outside of the mandatory meetings, she notes.

"We even ship supplies that the nurses need to carry directly to their homes if they have run out," Shifferd explains. This cuts the cost of travel reimbursement for the field staff, she adds.

Another advantage to shipping directly to

Supply Management Software

These companies offer software for supply management. Prices vary according to services purchased and size of organizations:

- **McKesson Information Solutions**, 1550 E. Republic Road, Springfield, MO 65804. Phone: (800) 800-5403. Fax: (417) 874-4015. Web: www.McKesson.com. Click on Information Solutions, then choose products and services, and click on homecare.
- **Byram Healthcare**. Phone: (877) 902-9726. Web: www.byramhealthcare.com.
- **Medline Industries**, One Medline Place, Mundelein, IL 60060. Phone: (800) 633-5463. Fax: (800) 351-1512. Web: www.medline.com.
- **Sterling Medical Services**, 2 Twosome Drive, Moorestown, NJ 08057. Phone: (800) 291-8500. Web: www.sterlingmedical.com.

homes as the supplies are needed, is that it makes it unnecessary for agencies to keep a large stock of supplies that take up space or to throw out supplies on which expiration dates have passed, Waldo points out.

"In fact, one agency with which we work reports an annual savings of $20,000 in both clerical time and cost of supplies," she says.

"We keep one-half of the amount of stock we previously kept in house," Shifferd explains. "We do keep three cases of normal saline, along with lab vials, gloves, catheters, and general supplies."

Automating a supply management process does not add any costs for most agencies, points out Waldo. "You do need an Internet access line for the ordering process, but no special hardware is needed," she says.

At Shifferd's agency, the clinicians complete the order form on their laptops and then send it over a phone line to the clerk responsible for online ordering. The clerk then sends the order to the supply house with which McKesson contracts, she says.

Shifferd likes having the supply house account manager available to offer advice on cost trends of the agency, new products that the agency might want to evaluate, and formulary changes that might improve efficiency as well as patient care. "Not only does the account manager evaluate prices but she also makes sure our formulary meets national standards of care for different types of patients, such as wound care patients," she adds.

When evaluating systems, be sure to look for reporting features that enable you to look at supply costs per patient as well as per diagnosis, Waldo suggests. An automated system collects a tremendous amount of data, and you should be able to manipulate it to produce reports that are truly useful to your specific needs, she adds.

Even though the training required prior to the implementation of the system was about half a day of time, make sure that your nurses are well-prepared to utilize the system, Shifferd says. "It took some time to change the way everyone behaved, but it was worth the effort when we look at our improved efficiency and our cost savings."

[For more information about automating supply management systems, contact:

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Cash & Counseling program leads to more home care

Program participants direct own services

An evaluation of Arkansas' Medicaid Cash & Counseling program, in which enrollees direct their own personal care services, indicates that individuals are much more likely to receive such services than are those who were eligible for services but had to get them in the usual way.

Because Cash & Counseling enrollees were less likely to have used nursing homes, health care costs ultimately were lowered even though better access to care led to higher overall costs for personal care under the consumer-directed program.

Cash & Counseling programs in Arkansas, Florida, and New Jersey have been funded by the Robert Wood Johnson Foundation in Princeton, NJ, as demonstrations of the concept of giving Medicaid enrollees who qualify for personal care an allowance and a high degree of freedom in choosing personal care assistants and managing their personal care needs.

Cash & Counseling national demonstration director **Kevin Mahoney**, who leads the program from the Boston College Graduate School of Social Work, says those who organized the demonstrations knew that consumers would benefit if they could make their own choices about how their personal care needs are met.

"But we weren't so sure what would happen to Medicaid costs," he adds. "We're thrilled to discover that under Cash & Counseling, consumers can get more personal care services at no more cost to Medicaid."

The latest of the demonstrations to be evaluated compared the level and cost of personal care services provided through consumer- and agency-directed approaches.

An earlier look at the Arkansas program found that it greatly improved quality of life, reduced unmet needs for care, and did not compromise patients' health or safety.

The current study found that partly because of a shortage of personal care workers, home care agencies in Arkansas delivered only two-thirds of the personal care services to which consumers were entitled, with some consumers receiving no services at all.

More consumers who hired their own personal care assistants were able to receive services in the evenings and on weekends.

The differential in the amount of services resulted in the consumer-directed care approach costing more than $2,000 more than the agency model in both the first and second years after enrollment. By the second year after enrollment, however, these higher personal care expenditures were offset by reductions in expenditures on nursing home and other Medicaid services.

The evaluation team was led by **Randall Brown**, a Mathematica Policy Research senior fellow in Princeton, NJ, and professor at Rutgers University.

His report notes that states are increasingly interested in improving the well-being of beneficiaries who are eligible for personal care services by allowing them to plan and direct their own care. Advocates for consumer-directed care contend that individuals, rather than agencies, are best suited to make decisions about the care they receive and the workers they hire.

"However," the report cautions, "critics are concerned that consumers might misuse the funds intended for their care, receive inadequate care, or use a cash benefit to pay family members to provide care once provided by them for free. States are wary that the program might raise total Medicaid costs."

The IndependentChoices program in Arkansas was open to adults at least 18 years old who were otherwise eligible for personal care services under the state's Medicaid plan.

About 11% of personal care services users (2,008 beneficiaries) enrolled in the demonstration between December 1998 and April 2001. Control group members continued relying on agency services or, if newly eligible for Medicaid personal care, received a list of home care agencies to contact for first-time services.

Helping patients develop plans

Treatment group members were contacted by a counselor to help them develop written plans for spending their allowance. Such plans could include hiring workers (excluding spouses or representatives) and purchasing other services or goods related to their needs, such as supplies, assistive devices, and home modifications. Counselors also monitored satisfaction, safety, and use of funds.

Brown says the evaluation team found the program greatly increased the likelihood that beneficiaries received paid assistance. Elderly community residents in IndependentChoices were much more likely than those in the control group to receive paid assistance during their two most recent weeks at home before an evaluation interview nine months into the program. The difference for nonelderly beneficiaries was even larger.

"The lack of any paid assistance among control group members was striking," Brown writes in his *Health Affairs* web exclusive evaluation report, "particularly among new applicants — those who were not receiving publicly funded home care services when they enrolled in the demonstration [about a quarter of the sample]. Fifty-one percent of new applicants in the control group, compared with only 8.1% of new applicants in the treatment group, did not have a paid caregiver nine months after enrollment, despite being eligible for personal care services. Among those receiving publicly funded home care at enrollment, the treatment-control difference in the percentage of consumers without paid assistance at nine months was statistically significant but much smaller [5.1% for treatments vs. 13.7% for controls].

"Among treatment group members, about two-thirds hired family members, and most others hired friends or acquaintances. A minority of those hired lived with the treatment group member," he explains.

IndependentChoices was found to expand the provision of care during hours that agencies didn't operate and also affected the way that nonelderly people met their personal assistance needs.

Control group received less

Medicaid expenditures were larger for the treatment group because the control group received a smaller-than-expected share of the services authorized for them.

Control group members received much less care than was authorized, resulting in annual Medicaid personal care services spending per sample member that was almost twice as high for the treatment group as for the control group

during the first year after enrollment.

Brown says that lower long-term care costs for treatment group members suggest that Cash & Counseling enables consumers to substitute personal care services at home for other, most costly services, particularly nursing facilities.

While it is not clear how much the Arkansas results can be generalized because other programs have varying features that could affect the outcome, Mr. Brown says that the findings for IndependentChoices are clear: "The program greatly increased consumers' access to care and ability to purchase needed equipment and supplies. However, the results raise two issues that could concern policy-makers:

1. Paid care could substitute for previously unpaid care.
2. Consumer direction could raise Medicaid spending."

According to Brown, some people question why enrollees should be allowed to pay family members for care they should be expected to provide without compensation.

"It's a reasonable concern," he says, "but the truth is that families are providing 80% of care, even if a patient gets agency care. These are benefits that patients are entitled to, and I think it is shortsighted to worry too much about whether patients are paying family members for care they should [receive]."

System has failed

The reason Medicaid expenditures for personal care services went up in the demonstration, he adds, was that the traditional system has failed, and patients were unable to get the services they needed and were entitled to — perhaps, because agencies are stretched too thin and there are no workers available. Even if they are hiring relatives, he says, they are receiving the services they need under IndependentChoices. And increases in personal care services costs pay off in lower costs elsewhere in the health care system, Brown says.

"Not only can you provide much better care and relieve a burden on families, even though costs are up," he continues, "that is offset by savings in nursing home costs. In 27 years of evaluating public programs, I have almost never seen one this successful. This is a program that seems to benefit everyone. There are no losers. We can't find a downside, and we looked very hard because we have no ax to grind and are not trying to promote this or any other particular program."

Brown and his colleagues conclude that Arkansas' experience demonstrates that states can design a Cash & Counseling program that meets recipients' needs better at no greater cost per month of service than historically incurred under the traditional agency approach.

"Even if total costs for personal care services are higher than they would have been as a result of the improved access to care or induced demand, they appear to be offset by reduced need for long-term care services," the report says. "The better the traditional agency model is at meeting authorized needs, the greater the likelihood of immediate savings from a Cash & Counseling alternative. The worse the agency model performs, the greater the likelihood that spending will increase initially under the Cash & Counseling model, but the greater the need for this option to ensure adequate access to home care as an alternative to higher-cost Medicaid services, especially nursing home care."

Program wins award

The Arkansas program won the Council of State Governments 2003 Innovations Award granted in recognition of innovations in state government.

The U.S. Department of Health and Human Services has taken action to assist more states to develop consumer-directed services along the lines of a Cash & Counseling program. The department's Independence Plus waiver program, introduced in 2002, established a process for states to obtain authorization to operate such programs.

In the fall of 2003, the Centers for Medicare & Medicaid Services awarded $5.4 million in Independence Plus grants to 12 states to support such efforts.

In addition, President Bush has proposed changes to the Medicaid program that the administration says would gives states more flexibility to implement programs such as this without obtaining permission from the department.

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For information on the Cash & Counseling demonstration, go to: www.umd.edu/aging. To see the evaluation report, go to: www.healthaffairs.org.] ■

HIPAA Q & A

[Editor's note: This column addresses specific questions related to Health Insurance Portability and Accountability Act (HIPAA) implementation, if you have questions, please send them to Sheryl Jackson, Hospital Home Health, *Thomson American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsmjackson@cs.com.]*

Question: Does the security rule prohibit transmission of protected health information (PHI) by e-mail?

Answer: No. The security rule requires covered entities to address the security of electronic transmission of PHI," says **Robert W. Markette, Jr**., an Indianapolis-based attorney.

Depending upon a covered entity's perception of the threat, the home care agency may decide to implement encryption or some other security feature, he says. However, encryption is not a required standard, he adds.

"In the comments to the security rule, the Department of Health and Human Services [HHS] stated that one of the reasons they were not requiring encryption was due to the prevalent use of e-mail by rural providers to communicate with patients," Markette says.

These comments from HHS recognize that PHI will be transmitted by e-mail, he adds.

Question: Are health organizations responsible for the protection of unsolicited e-mails sent by patients?

Answer: Once a home care agency comes into possession of electronic PHI (EPHI), such as e-mail from a patient, the organization must protect it, Markette explains. "However, the agency is not responsible for the security of the information as it is transmitted from patient to the entity," he adds.

Question: If an employee, other than field staff, works out of his or her home, either full time or part time, (e.g., during maternity leave, on weekends or evenings, as part of telecommuting job description) do the HIPAA security regulations apply? If so, how do we ensure compliance?

Answer: If the employee is working at home with EPHI, yes, the security regulations apply, according to Markette. Compliance will depend upon a number of factors:

- Does the employee access EPHI remotely?
- Does the employee maintain EPHI on his or her home PC?
- Who in the home can access the PC?

"If the employee is accessing EPHI remotely, I would recommend at least evaluating the security of EPHI in transit," says Markette.

"If you have concerns about the security of that transmission, you might consider steps to increase the security," he suggests.

There are numerous technologies that could work in this environment, and each entity will need to assess the risks and determine an appropriate operating procedure, he adds. You also may want to establish password protected access if other people have access to the employee's computer. **(For information about setting up passwords, see HIPAA Q&A, *HHH*, February 2004, p. 16.)**

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Understanding Laws, Rules, Regulations

Protecting the patient's right to select care

By **Elizabeth E. Hogue**, Esq.
Burtonsville, MD

At present, the right of patients to choose providers who will render them home care is based upon three key sources:

1. Court decisions that establish the right of all patients, regardless of payer source and the setting in which services are rendered, to control treatment, including who provides it.
2. Federal statutes for both the Medicare and Medicaid Programs that establish the right of patients whose care is paid for by these programs to choose providers who render care in the absence of a waiver.
3. The Balanced Budget Act of 1997 (BBA) that

currently requires hospitals only to provide a list of home health agencies to patients. According to the BBA, the list must meet these criteria:

- Agencies that provide services in the geographic area where patients reside, are Medicare-certified, and request to be included must appear on the list given to patients.
- If hospitals have a financial interest in any agency that appears on the list, this interest must be disclosed on the list.

Despite these requirements intended to protect the right of patients to choose providers, there is a lingering perception, however unfair it may be, that hospitals give lip service to patients' right to freedom of choice but still operate based upon a culture that emphasizes ownership of patients and the need, and perhaps even the right, to go to great lengths to keep patients within the system.

Further developments in 2004 with regard to the right of patients to choose providers will make it even more clear that this lingering perception, whether true or not, is outdated.

Specifically, a proposed Condition of Participation (COP) for hospitals published in the *Federal Register* Nov. 22, 2002, likely will be published in final form this year.

This COP requires hospitals to keep statistics about referrals to home health agencies and other entities and to report them to the Centers for Medicare & Medicaid Services (CMS). In turn, CMS will publish these statistics to help ensure patient choice. This year also is likely to see more enforcement actions by state survey agencies with regard to the rights of patients to choose their providers. Recent action taken by a provider in Indiana is instructive.

Specifically, the provider documented instances of alleged violations and reported them to the state survey agency. Surveyors treated the reports like a complaint and conducted a complaint survey of the hospital's practices.

Surveyors concluded that the hospital violated its own policies and procedures and BBA provisions in the process of making referrals for home health services. The hospital received a statement of deficiencies and was required to submit and follow a plan of correction.

This action opens the door for clear enforcement action against hospitals that violate patients' right to freedom of choice. If violations are at the condition level of deficiencies, hospitals could, at least in theory, lose their right to participate in Medicare and Medicaid programs.

In addition, the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services issued a special advisory bulletin on contractual joint ventures on April 30, 2003. The bulletin addressed contractual arrangements for the provision of items and services that the OIG previously identified as suspect in a special fraud alert on joint venture arrangements in 1989.

In 2004, the OIG almost certainly will undertake enforcement action against the types of joint ventures described in the special advisory bulletin.

The bulletin focuses on joint ventures in the form of contractual arrangements in which a provider in one line of business expands into a related health care business by contracting with an existing provider of a related item or service to provide a new item or service to existing patients. In other words, a referring provider with an existing base of patients contracts out substantially the entire operation of the related line of business to a managing party that is otherwise a potential competitor and receives profits of the business in return. Arrangements between some hospitals and home health agencies may be included in these types of arrangements.

The OIG further explains in the bulletin that the protection of safe harbors or exceptions to the kickback and rebate statute are unlikely to apply in these types of situations.

The right of patients to choose providers has generated considerable conflict within the provider community. This right is likely to be tested and reinforced throughout the year. Providers will require a thorough understanding of the issues in order to stay out of the fray.

[A complete list of Elizabeth Hogue's publications is available by contacting: Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Phone: (301) 421-0143. Fax: (301) 421-1699. E-mail: ehogue5 @comcast.net.] ■

Leadership centers aim to boost palliative care

Six centers will provide hands-on training

The Center to Advance Palliative Care (CAPC) in New York City has launched a Palliative Care Leadership Center (PCLC) initiative to help health care organizations create programs to more

effectively manage advanced chronic illness.

Under the initiative, health care teams are invited to visit one of six palliative care programs to receive hands-on training and technical assistance to fast track their own palliative care programs. In an early sign that the three-year initiative is addressing the growing demand for this type of training, more than 100 health care institutions already have registered to make visits, CAPC says.

Focus on relieving suffering

Palliative care is medical care focused on relief of suffering and support for the best possible quality of life for the growing number of patients facing advanced chronic illness.

That kind of care is offered at any stage of illness, simultaneous with all other appropriate medical treatment.

Palliative techniques have been shown to improve pain and symptom management, improve patient outcomes, and increase patient and family satisfaction, as well as facilitate compliance with pain management and quality accreditation standards.

Palliative care programs also improve continuity of care and reduce fragmentation of care delivery, contributing to efficient and effective use of health care resources.

The number of hospital-based palliative care programs has doubled in recent years to more than 950 in response to the critical need to provide high-quality care to seriously ill patients living with advanced chronic illness.

The PCLCs — located at academic medical centers, cancer centers, health systems, and community-based organizations — will provide visiting health care teams with expertise on the financial and operational dimensions of establishing a palliative care program.

That expertise includes:

- hospital needs assessment;
- financing and business planning;
- how to choose organizational and service models;
- staffing;
- measuring clinical and financial impact;
- strategies for ensuring and managing growth;
- hospice-hospital collaborations;
- marketing palliative care to clinicians and patients.

"The large number of health care organizations already participating in this initiative signals the increasing recognition that palliative care effectively addresses top health care concerns: quality improvement, the aging boom, and the need to manage patients with advanced chronic illness well," explains **Diane E. Meier**, MD, director of CAPC.

The six PCLCs are:

- Fairview Health Services, Minneapolis;
- Massey Cancer Center of Virginia Commonwealth University Medical Center, Richmond;
- Medical College of Wisconsin, Milwaukee;
- Mount Carmel Health System, Columbus, OH;
- Palliative Care Center of the Bluegrass, Lexington, KY;
- University of California, San Francisco.

Funding provided by Robert Wood Johnson

The nationwide initiative is funded by a $4.5 million grant from the Princeton, NJ-based Robert Wood Johnson Foundation, the largest U.S. philanthropic organization devoted exclusively to health and health care.

Technical assistance for the initiative is provided by the CAPC, located at the Mount Sinai School of Medicine in New York City.

The CAPC is a national initiative of the foundation, providing hospitals and other health care organizations with tools and technical assistance to develop hospital-based palliative care programs.

[For more information about palliative care and the Palliative Care Leadership Centers, go to: www.capc.org or call (212) 201-2670.

To register for a CAPC site visit, visit the web site or e-mail pclc@mssm.edu.] ■

Web site provide tools for medication use

Free tools and techniques to help home care nurses identify and avoid potential adverse drug events are described on a web site sponsored by the American Association of Health

Plans-Health Insurance Association of America in Washington, DC.

The approaches to patient and medication safety included in the web site are applicable to a variety of health care settings, including home care.

Conditions such as asthma, diabetes, hypertension, and depression are covered.

To visit the web site, go to: www.aahp.org/redirect/ImprovedMedicationUse.htm. ▼

CDC journal focuses upon chronic disease

The Atlanta-based Centers for Disease Control and Prevention (CDC) has launched a free, peer-reviewed on-line journal on chronic disease.

The inaugural issue contains articles on the these topics:

- nutrition programs for the elderly;
- diabetes prevention programs;
- osteoporosis screenings;
- surveillance of dementias.

For more information, go to the organization's web site at www.cdc.gov. To view the journal, click on "Preventing Chronic Disease Journal" under the publications and products heading on the left navigational bar. ▼

Free guide educates Hispanic diabetics

La Opinión, a Spanish-language newspaper, and the California Healthcare Foundation (CHCF), have produced a newspaper supplement that serves as a guide for diabetics and their families.

The supplement addresses topics such as:

- how to detect and treat diabetes;
- how to work with healthcare providers to manage diabetes;
- how to use resources to obtain more information or assistance in California.

According to the CHCF, nearly 1.5 million California adults have diabetes, and at least 1.8 million are at risk for the disease.

As the rate of diabetes grows nationally, Latinos have the highest risk for developing diabetes, with Hispanics born in 2000 having about a 50% risk of developing the disease sometime in their life.

The supplement is free and can be obtained by calling (888) 430-2423 or by going on-line to www. laopinion.com/supp28/. ■

COMING IN FUTURE MONTHS

- Check for patient needs beyond reason for admission
- Partnership provides potential new employees
- How to dispose of old computers and still be HIPAA-compliant
- New Medicare law means new fraud and abuse concerns
- How do you rate your manager's retention savvy?

CE *questions*

1. While partnerships with assisted-living facilities may be a good move for many agencies, what is one pitfall that a manager of a Medicare-certified agency be sure to avoid, according to John Gilliland, an Indianapolis-based attorney?
   A. spreading your staff too thin
   B. not marketing in different areas
   C. not choosing according to payer plans
   D. violation of state and federal anti-kickback laws

2. How did an automated supply management system help the Visiting Nurse and Hospice Service of Southwest Michigan in Kalamazoo cut costs and increase efficiency, according to Lori Shifferd, director of the agency's information systems department?
   A. standardized supplies and cut clerical time needed
   B. forced nurses to complete documents in a timely manner
   C. enabled agency to order supplies only once each month
   D. opened up patient choice of products

3. Any employee can handle electronic protected health information at home during as part of a telecommuting arrangement or if on leave such as maternity leave if the home care agency takes proper precautions to protect the security of transmission of data and access to the home PC.
   A. true
   B. false

4. According to Elizabeth Hogue, the right of patients to choose home care providers currently is based upon three sources, including:
   A. court decisions that establish the right of all patients, regardless of payer source and the setting in which services are rendered, to control treatment
   B. federal statutes for both the Medicare and Medicaid programs that establish the right of patients whose care is paid for by these programs to choose providers who render care in the absence of a waiver.
   C. individual state laws governing home care referrals
   D. A and B
   E. none of the above

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

CE objectives

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

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