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CMS programs tackle the chronic care costs of Medicare patients

Home health agencies use case management experience to get involved

(Editor's note: This is the first of a two-part article that looks at care of chronically ill patients. This month we discuss the programs implemented by the Centers for Medicare & Medicaid Services to address high-cost and chronically ill patients. Next month, we examine strategies used by some agencies to provide more efficient, improved care to patients with chronic illnesses.)

With 15% of Medicare patients representing 75% to 80% of Medicare costs, it is no surprise that Section 721 of the Medicare Modernization Act calls for the development of chronic care improvement organizations that address the management of patients with chronic illnesses.

A strategy to address needs of patients with chronic illnesses is a logical way to decrease costs, says **Jim Pyles**, JD, a partner with Powers Pyles Sutter & Verville, a Washington, DC, law firm that specializes in health care law, and founder of the Farragut West Group, a policy development group that provided the CMS data and suggestions on how to address care for chronically ill patients. "If we can identify the sickest patients and help them manage their disease more effectively, we can cut down on hospitalizations and emergency care," he points out. This type of change does require a shift in the health delivery system from facility-focused care to patient-focused care, he admits.

CMS announced the nine voluntary Chronic Care Improvement Programs (CCIPs) that are designed to improve the care of chronically ill patients and decrease costs, but Pyles has reservations about the effectiveness of the programs. **(For a list of all nine companies, see box, p. 15.)**

"When researching potential strategies to address the costs of chronically ill patients, we found a number of existing programs that were designed to help patients better manage their conditions. There were two major reasons that they didn't significantly affect costs," he says. Many of the programs, most of which were disease management companies, failed to target the sickest, most costly patients, and they did not involve physicians, Pyles notes.

"The CMS initiative started to get off the track we suggested in the

bidding process that required providers to serve a minimum of 10,000 beneficiaries," Pyles says.

"This means that only large providers were eligible to submit proposals, and we found that smaller programs that were able to tailor care plans to individuals were more successful," he explains. "It is not effective to use a cookie-cutter approach that applies the same services a healthy diabetic patient would need to a sick diabetic patient."

Physician involvement also is minimal, and that means the sickest patients are less likely to volunteer to change management of their care, Pyles says. "Although we want the sickest patients in this type of program to ensure a significant effect on costs, they are the least likely to volunteer."

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In these cases, it will be important for physicians who believe the CCIP may be able to better manage the patient's condition to be involved so they can help the patient understand that the switch to someone else to manage the condition won't affect care or benefits, he adds.

Home visits still critical

Even if the CCIPs are successful in recruiting some of the sickest patients, home health managers are concerned that the reliance on case management protocols and telemedicine or telephone contact alone may not be enough to effectively manage a patient's condition.

"We provide care to over 4,000 home care patients, and many of them have one or more chronic conditions," says **Michael T. Caracci**, chief executive officer of Sta-home Health Agency in Jackson, MS. "Although telephone contact with someone who is having no problem managing a chronic illness will work, the best way to educate patients who are having problems is to see them in their home.

"A nurse who is providing diabetes education needs to see what foods are in the pantry so that when the patient states that he or she never eats sugar, the nurse can point to the can of baked beans and show how much sugar is in the food," he adds.

CCIPs will be responsible for coordinating care of the Medicare beneficiaries who volunteer to enroll, and this will require coordination with existing providers, Pyles explains. "This does present an opportunity for home care agencies to work with CCIPs to provide on-site patient visits when needed."

Although the CMS' request for proposals from companies requesting designation as a CCIP did not specify home care as a qualifying applicant unless partnered with another organization, Caracci says his agency is working with the CCIP for his region to provide the face-to-face visits the CCIP may need for some patients.

"It makes sense for home care to work with CCIPs because we have the case management experience with chronically ill patients," he notes. Because home care nurses are accustomed to tailoring education programs to a patient's lifestyle, age, educational level, and capabilities, home care visits only can enhance a CCIPs ability to manage patients, Caracci adds.

Although Sentara Home Care in Chesapeake, VA, successfully uses telemedicine to reduce the

number of home visits per week to congestive heart failure patients, nurses still see the patients in person, says **Ray Darcey**, vice president of Sentara Home Care.

"Even though our telemedicine program has helped us cut costs, reduce hospitalizations, and improve our patients' care, there is no replacement for a nurse sitting with a patient who needs extra support," he notes.

The one home health agency partnering with another company to serve as a CCIP is the Visiting Nurse Service of New York (VNSNY). "We are partnered with United Healthcare Services to provide case management services for high-risk patients," says **Holly Michaels Fisher**, vice president of program planning for VNSNY.

"We already offer a long-term managed care program, and we see this move as a natural progression for our agency," she notes. Not only will VNSNY's familiarity with the clinical care plans for chronic illnesses be beneficial, but the agency's track record of working with other providers to coordinate care is important to the success of the project, Fisher adds.

Another CMS effort to address high-cost beneficiaries is the Care Management for High-Cost Beneficiaries (CMHCB) that is geared toward smaller companies, Pyles explains. This demonstration project differs from the CCIP initiative in that it specifically targets the high-cost patient, he adds. The deadline for applications for this demonstration project was early January 2005, and CMS expects to name participants in the project 30 to 60 days following that deadline, he says.

Both the CCIP initiative and the CMHCB demonstration place responsibility for meeting performance standards for clinical quality of care, beneficiary and provider satisfaction, and Medicare savings, but Pyles is concerned about the way those standards are enforced. CCIPs will be given the names of beneficiaries in their geographic area who have a chronic illness.

It is the CCIPs responsibility to contact the beneficiaries and enroll them in the program. Because the program is voluntary, a CCIP may not get all of, or even a majority of, the beneficiaries in the intervention group identified by CMS, Pyles says. "The CCIP, however, is still responsible for costs and outcomes of the entire group."

While this responsibility does create an incentive for CCIPs to enroll as many beneficiaries as possible, there is the chance that many may not enroll, making it difficult for the CCIP to manage care in a way that does control cost and improve outcomes, Pyles explains.

"The risk to patients who enroll is that a CCIP that is suffering financial losses may decide to discontinue participation in the program, leaving vulnerable patients with no one in place to manage their care," he says.

Because CMS has set up each CCIP as a regional monopoly, it will also be difficult to renegotiate agreements that are favorable to CMS. This gives the CCIPs more negotiating strength once beneficiaries are enrolled, he adds.

Pyles does admit that targeting chronically ill Medicare patients who typically are high-cost

Nine programs will test chronic care intervention

The Medicare Modernization Act of 2003 authorized development and testing of voluntary Chronic Care Improvement Programs (CCIPs) to improve the quality of care and quality of life for people living with multiple chronic illnesses. The programs will help participants adhere to their physicians' plans of care and obtain the medical care they need to reduce their health risks.

Each of the local CCIPs will offer self-care guidance and support to chronically ill Medicare beneficiaries to help them manage their health, adhere to their physicians' plans of care, and ensure that they seek and obtain the medical care and Medicare-covered benefits they need. The programs will include collaboration with participants' health care providers to enhance communication of relevant clinical information.

The programs are intended to increase adherence to evidence-based care, reduce unnecessary hospital stays and emergency department visits, and help participants avoid costly, debilitating complications. The organizations operating the programs are required to assist participants in managing their health holistically, including all comorbidities, relevant health care services, and pharmaceutical needs, as well as unique individual needs and cognitive impairments.

Phase I pilot programs will be operated by Aetna Health Management in Chicago; American Healthways Inc. in Washington, DC, and Maryland; CIGNA HealthCare in Georgia; Health Dialog Services Corp. in Pennsylvania; Humana Inc. in Central Florida; LifeMasters Supported SelfCare Inc. in Oklahoma; McKesson Health Solutions in Mississippi; Visiting Nurse Service of New York in partnership with United HealthCare Services Inc.-Evercare in Queens and Brooklyn in New York City; and XLHealth in Tennessee. ■

Medicare patients, is the most positive strategy for addressing rising Medicare costs. Other options such as decreasing benefits or increasing the financial burden to other taxpayers are not attractive to politicians, he says.

As CMS proceeds with plans to target high-cost patients, Pyles sees opportunity for home health agencies to work with CCIPs and CMHCBs to demonstrate how effectively their approach manages chronically ill patients' conditions.

"Even though home health agencies have been providing care to this population and finding ways to cut hospitalizations, CMS has cut home health reimbursement. This is a golden opportunity to use data from your own agency to demonstrate home health's value to the health delivery system."

[For more information about Centers for Medicare & Medicaid Services' programs to address high-cost Medicare patients and the role of home health, contact:

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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: sherylsjackson@bellsouth.net.]*

Question: What are the deadlines for compliance with the HIPAA security rule?

Answer: For all covered entities, other than small health plans, the compliance deadline is April 20, 2005, says **Robert W. Markette Jr.**, an Indianapolis attorney. "If you are a small health plan, you have until April 20, 2006," he adds.

"Contrary to a popular rumor, there is not an exception for small health care providers. All covered health care providers must comply with the security rule by April 20, 2005," he warns.

Question: What happens to noncompliant providers on April 20, 2005?

Answer: If you are just beginning your HIPAA security rule compliance efforts, your first question is most likely what will the Centers for Medicare & Medicaid Services (CMS) do if you are not in compliance by the deadline, admits Markette.

"At least for the near future, CMS is sticking to its stated policy of assisting noncompliant providers to become compliant, rather than imposing large fines," he says.

"However, the possibility of leniency from CMS should not lead you to feel complacent about Security rule compliance," suggests Markette.

"You should make every effort to be in compliance or be well on your way to compliance because CMS is far more likely to be lenient if it can see documentation of the efforts you are making to comply, how far along you are, and how far you have left to go," he explains.

"In the event of a complaint, a CMS investigator will not be interested to hear that you have read the rule, but have done little else," Markette warns.

"In addition to the potential penalties from the government, there are other potential consequences of a HIPAA violation that fall entirely outside of the federal government's jurisdiction," he points out.

For example, it is possible that HIPAA violations will become the basis for civil lawsuits, Markette says. "Providers who are subject to state licensure surveys may also encounter a state surveyor who erroneously cites a covered entity for a HIPAA violation. This could affect a provider's license even without a violation."

Finally, a HIPAA violation presents the potential for negative publicity, Markette says. "With the current focus in America on individual privacy, a provider who is found to have violated the HIPAA security rule may be perceived as insensitive the concerns of patient privacy," he explains.

This perception could have a negative effect on patient confidence and, therefore, business, adds Markette.

HIPAA guidance available on security for covered entities

The first in a new series of Health Insurance Portability and Accountability Act (HIPAA) white papers designed to address issues related to the security rule is available from the Centers for Medicare & Medicaid Services.

The paper provides background on the rule and its relationship to the HIPAA medical privacy rule.

Topics of future papers will include administrative, physical, and technical safeguards; organizational policies and documentation requirements; the basics of risk analysis and risk management; and implementation for small providers.

To access the paper, go to www.cms.hhs.gov/hipaa/hipaa2/education/Security%20101_Cleared.pdf. ■

Question: Where should I start when putting together my compliance plan?

Answer: First, appoint a security officer, says Markette. The HIPAA security rule, like the privacy rule requires the covered entity to designate someone as responsible for the entity's compliance with the HIPAA security regulation, he explains. "This person is known as the security officer. The security officer does not need to be an information security expert or hold any special certifications but the person should be familiar with the HIPAA privacy and security rules and be able to manage a project and complete it in a timely fashion," he says.

"Larger organizations should consider a security compliance team to assist the security officer," recommends Markette. The security rule allows this kind of assistance, but the security officer retains responsibility for your organization's compliance efforts, he says. "The team should include managers from each department or persons designated by the managers," he suggests. It is important the team remember the security officer retains final control, and the security officer should be able to put pressure on the team to meet deadlines, he adds.

"Next, the security officer must familiarize himself or herself with the security rule," says Markette. "A good place to start is the rule itself and the CMS web site [www.cms.hhs.gov] provides a number of resources including CMS' recently published overview of the security rule — *Security 101 for Covered Entities,"* he suggests. **(For more information, see box, at left.)**

"Reading the rule serves two purposes," says Markette. "You will learn the more specific requirements of the rule as set forth in the 19 standards and 36 implementation specifications, and you will also see that you have already implemented a number of the rule's requirements as you implemented programs to comply with the privacy rule," he adds.

[For more information on the HIPAA security rule, contact:

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LegalEase

Understanding Laws, Rules, Regulations

Know how to avoid gaming the system

By Elizabeth E. Hogue, Esq.
Burtonsville, MD

Home health managers have responded admirably to an increasing emphasis on compliance in recent years. Routine compliance activities in home health agencies now include verification of data, pre-billing reviews, reviews to identify inconsistencies, etc. These activities certainly should be continued and enhanced.

Providers must, however, also recognize that there are limits on appropriate activities in this regard. It may be fair to say that there is sometimes a very fine line between a legitimate compliance activity and what constitutes "gaming" the system which is clearly unacceptable.

Below are some activities that are likely to be considered appropriate:

1. **Data verifications within an assessment in the form of basic Haven edits**

Most agencies have access to these edits in their MIS system or in their OASIS data entry software. These systems usually include about

400 edits and help to identify significant errors in assessments.

2. **Data verifications within an assessment that go beyond Haven edits**

These systems have additional edits beyond Haven to help identify logical inconsistencies and data errors within an OASIS assessment prior to submission to state agencies.

3. **Patient-specific assessment trending**

These systems allow for desktop analysis so agencies can track patient progress across assessments and identify and address declines in patients' clinical conditions. This analysis usually is performed after submission of data to state agencies as a part of ongoing quality improvement activities.

But some agencies want to move beyond the above types of analyses to data checks that, if used improperly, may cross the line from compliance into outright fraud and/or abuse.

Specifically, some agencies have expressed a desire to perform assessment-to-assessment data checks prior to submission of data to state agencies using software that flags declines in patients' clinical conditions and/or opportunities for increased reimbursement.

Buyer beware! Use of such data should be handled very sensitively to avoid fraud and/or abuse.

When agencies generate these types of data, managers must ask and answer a very crucial question: How is the agency using these data?

It would be appropriate, for example, to use the data as a teaching tool to improve outcomes. It also would be appropriate to use these data to clinically manage declines in patients' conditions. But it would be inappropriate, for example, for agencies to use these data to decide "if" they want to submit them as a decline in patients' conditions.

From a practical standpoint, there are two significant issues that managers must address regarding use of these types of data:

- If the data are to be used appropriately as described, why is it important to have the data prior to submission to the state (i.e., a question of timing)?
- If agencies generate the data, what controls will be established and implemented to help ensure they are not used inappropriately?

These two crucial questions should be asked and answered with the understanding that there is an extremely fine line between flagging declines prior to transmission to state agencies and verifications designed to maximize reimbursement and appropriate compliance activities. Agency staff members easily can cross the line into the realm of fraud and/or abuse.

In view of the issues described, it is understandable, and perhaps prudent, that companies that develop and market software to home health agencies are reluctant to provide software that includes capabilities to produce data that may be used inappropriately.

Fraud and abuse has been such a hot and extremely sensitive area that possession and use of such software may raise suspicions on the part of regulators and enforcers, however unfair they may be.

Reimbursement on a perspective basis, periodic completion of OASIS assessments, and Outcome Based Quality Improvement activities present new challenges for home health providers to achieve compliance without crossing the line into questionable activities. The key is undoubtedly vigilance with regard to what data are generated and how they are used.

[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.

To obtain more information about gaming issues in a book — Medicare/Medicaid Fraud and Abuse: A Practical Guide for Providers, *send a check for $30, including shipping and handling, to Elizabeth E. Hogue, Esq. at the above address.]* ■

Work environment may hasten nurse retirement

Flexibility and accommodations would help

Work stress and dissatisfaction with the work environment may hasten the retirement of aging nurses, according to a study by the Center for American Nurses, an Austin, TX-based affiliate of the American Nurses Association.

Almost half (47%) of 4,000 nurses surveyed said the relationship with nursing management or administration caused them to think about leaving.

Nurses also cited staffing concerns and "the effect of organizational shift from patient to

finance or other [issues]" as reasons they might leave.

Yet nurses said they would consider postponing retirement if they could have flexible schedules or a phased retirement with shorter hours or fewer days worked. More than one-third (37%) of the nurses surveyed said they plan to retire between 2015 and 2020.

"Most nurses retire from the bedside at 52 and from the profession at 62," says **Claire Jordan**, RN, MSN, president of the Center for American Nurses, noting that the average age of nurses now is 46. "We are barely six years away from looking at 50% of the nurse work force leaving the bedside."

To retain nurses, facilities need to alter the work environment to make it more suitable for older workers, she says. "Nurses have jokingly said to me, 'I guess we'll keep working if it'll pay for our total hips and our total knees,'" she adds. "The lifting issue is a big issue for nurses."

The need for accommodations came out in focus groups conducted by the Center for American Nurses. But most nurses said administration had not made any changes in scheduling or work environment to take into account the aging work force. "Twelve-hour shifts in nurses over 52 just becomes almost impossible," Jordan notes.

Meanwhile, health care facilities won't be able to fill their nursing needs just with new recruits, she cautions. "Obviously, one of the best ways to prepare for this shortage is to prolong the working life, to change the plans for retirement. We are trying to work up an agenda for all the acute-care employers [to retain nurses]."

The aging work force also has a major impact on nursing injuries and workers' compensation. ■

Communication is key to client satisfaction

Tips for communicating about pain management

Everyone who works in health care has a list of ideas for what needs to be done to improve client satisfaction, but one theme appears to be a common thread throughout: communication.

"Communication is always a challenge," says **Jan Jones**, RN, BSN, FAAMA, president and chief executive officer of Alive Hospice in Nashville, TN.

"We're looking at how we communicate with the families and how to improve tools we use to communicate," she says.

"Pain management is an area where we certainly perform well, but we also feel there are ways we can improve in terms of communicating with families about pain management efforts being made," Jones explains.

Honing employees' listening skills is a goal of Bayada Nurses in Moorestown, NJ, says **Mark Baiada**, president of the company.

Bayada has more than 115 home care offices nationwide that work with hospices and care for patients with terminal illnesses.

Nurses are trained to listen actively and observe clients' facial expressions to look for nonverbal communication, he says.

"We teach them to look at the person's face to see if the person is communicating fear, discomfort, or worry. The patient may be fearful and cannot express how he's really doing," Baiada adds.

Communication skills constitute an important aspect of coordinating patient care among a multidisciplinary team, says **Christie Franklin**, RN, CHCE, vice president of professional services, acquisitions, and start-up for AseraCare of Fort Smith, AR.

When facilities coordinate care, it's important for the patient and caregiver to understand which services will be provided, she notes. "The case manager will review that with the patient and family, and with the facility staff if the patient is in a facility."

There are other important aspects of improving client satisfaction that health care facilities need to implement. Jones, Baiada, and Franklin offer these additional suggestions for improving client satisfaction:

- **Focus on pain management, even if patients do not have complaints.**

"Typically, we find that families perceive pain to be at a higher level than patients do," Franklin says. "This is something that we're working on, an area where we might be able to do something differently."

AseraCare has held a series of inservice training sessions on pain management this year, offering a focused approach to palliative care, she notes.

After AseraCare began to use the family satisfaction survey promoted by the National Hospice & Palliative Care Organization of Alexandria, VA, pain management was one of the top three priorities identified in survey results, she says.

"We always focus on pain management, and one of the indicators we are focused on is the amount of pain medication received," Franklin says. "We really look at pain management, how often the patient was treated with respect, and the overall rating of care."

Pharmacists join some training sessions

Pain management education has included instruction by pharmacists, who join in conference calls with health care staff, she says.

"We have some drug formularies that we review for educational purposes, and we give an overview of all the medications utilized for a facility," Franklin explains. "We had courses in Pain Management I and II, plus the overview of medications and how to use them."

- **Improve staffing and access after hours.**

"One thing that's always a challenge for us is how after-office care is delivered," Jones says. "As a result of information gathered on patient and family satisfaction surveys, we've made changes in our after-hours staffing."

For example, several people surveyed said the facility didn't have someone to respond in a timely fashion after hours, she recalls.

"So that's our trigger to look more in depth at what's happening with our triage system and our after-hours staff and how we need to build it into our budget for more staff," Jones says.

This is how a quality improvement project should work once a problem is identified, she notes.

"When we see a trend like that, we delve more deeply, and we certainly go to patient records and talk to family members and get specifics about what their issue was," Jones adds.

"We talk to staff, including triage staff, to find out what it was they experienced; and from that, we begin to gather data and look at what needs to be changed, where the gaps are, and what our expectations are for what was delivered," she continues.

- **Put the client first.**

One speaker who trained Bayada's staff on pain management said to the nurses: "Remember one thing when you come to the door of a [patient]: Just remember to show love," Baiada recalls.

"When you show love, you're helping patients with all of the needs they have, including the physical and emotional. So you have to prepare yourself to be of service in a loving and caring way, and to be reliable and have the skills in place so you can do a good job," he adds.

- **Families must be able to trust staff.**

Also, the client's satisfaction is more important than scheduling concerns, Baiada says. "If the family is dissatisfied with a nurse, then bring in someone new. Staff support is so important because it's a time of crisis for most families, and if one thing goes wrong, they lose trust."

- **Educate staff about client satisfaction surveys and quality improvement.**

AseraCare hospices provide short educational sessions through the "lunch-and-learn" training program, Franklin reports.

These hour-long sessions are conducted by teleconference and are attended by executive directors and directors of clinical services first, she says.

AseraCare held these training sessions to show staff how the company planned to use a new client satisfaction survey, including details about the scoring guide, frequently asked questions, and some sample information on the reports generated from the survey information, Franklin explains.

A second teleconference session teaches staff how to complete the survey's spreadsheet and provides them with data to enter during the call, she adds.

"We go through the steps of entering data and have the information technologies department on conference call to answer any follow-up questions," Franklin says. "Then we go over the reports and how those are to be reviewed and utilized, and we continue with the training." ■

AHRQ tool measures patient safety skills

Encourage professionals to support change

Patient safety is on everyone's minds these days, but how do you know how well your organization already is doing on this topic?

One way is a tool offered by the Agency for Healthcare Research and Quality (AHRQ), an arm of the Department of Health and Human Services in Washington, DC.

The AHRQ is offering a new tool to help hospitals and health systems evaluate employee attitudes about patient safety in their facilities or within specific units.

The Hospital Survey on Patient Safety Culture, being released in partnership with Premier Inc., the Department of Defense, and the American Hospital Association, addresses a critical aspect of patient safety improvement — measuring organizational conditions that can lead to adverse events and patient harm, says AHRQ director **Carolyn M. Clancy**, MD.

"Improving patient safety is not just a function of having the best research findings available," she says.

"There has to be an environment or culture that encourages health professionals to share information about patient safety problems and actions that can be taken to make care safer, and that also supports making any changes needed in how care is delivered," Clancy explains.

Patient safety culture assessments

Gina Pugliese, RN, MS, vice president of Premier's Safety Institute, says assessments of patient safety culture typically include an evaluation of a variety of organizational factors that have an impact on patient safety, including:

- awareness about safety issues;
- evaluating specific patient safety interventions,
- tracking changes in patient safety over time;
- setting internal and external benchmarks;
- fulfilling regulatory requirements or other directives.

"Premier considers health care organizations' ongoing evaluation of the safety culture in their facilities as a basic yet crucial step in improving safety and overall quality," Pugliese says. "This tool will be valuable in targeting interventions and then measuring their success over time."

The Hospital Survey on Patient Safety Culture includes the survey guide, the survey, as well as a feedback report template in which facilities can enter their data to produce customized feedback reports for management and staff.

These items provide health care facilities with the basic knowledge and tools needed to conduct a safety culture assessment and suggestions about how to use the data.

The survey was pilot tested with more than 1,400 employees from 21 facilities in the United States to ensure the items were easily understood and relevant to patient safety.

To see the survey, go to www.ahrq.gov/qual/hospculture/. Printed copies may be ordered by calling (800) 358-9295 or by sending an e-mail to ahrqpubs@ahrq.gov. ■

Public reports on quality measures to increase

Improve processes with team approach

Public reporting of quality measures is likely to increase in the near future, and hospitals should get ready, asserts **Carolyn Scott**, director of collaborative services and CEO work groups for clinical excellence with VHA Inc., an Irving, TX-based health care cooperative.

In 2005, the Centers for Medicare & Medicaid Services (CMS) plans to expand the 10 quality indicator measures in its public reporting sector to between 17 and 22 measures, she points out.

"The burden is not going to lessen. It's going to be greater. The quicker we can get a handle on improving quality indicators now, the more prepared we'll be for additional measures," Scott adds.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) already provides a financial incentive for prospective payment system hospitals to voluntarily report quality of care information.

Those who submit data will be eligible to receive full Medicare payment for health care services under MMA. Those who do not submit data will receive a 0.4% reduction in annual Medicare payments.

"The trend in public reporting is well on its way with JCAHO [the Joint Commission on Accreditation of Healthcare Organizations] publicly reporting some quality indicators for hospitals. We're only going to see more of that happening as we go along," adds **Earl Kurashige**, RN, project manager for Qualis Health, a nonprofit health care quality improvement company based in Seattle.

Beginning in 2005, quality data will be available on a consumer web page, Hospital Compare, which can be found on www.medicare.gov.

Quality improvement means involving all the people in the health care delivery system, Kurashige points out. "It's not just doctors and not just hospitals. We can't just point the finger at one group and say, 'You need to do better.' It's a team effort," he says.

The team approach to improving quality is a paradigm shift for health care providers, notes Kurashige.

"Everyone working together to improve health

care of the individual can have a big influence on the care and quality," he says.

Scott and Kurashige work with health care facilities on quality improvement projects, particularly those relating to the CMS and JCAHO quality indicators, where most facilities focus because they are the center of attention in health care. They agreed to share strategies, pointing out the techniques will work for any quality improvement project.

The first step in driving improvement is starting at the top, Scott asserts. "If you really want to drive improvement or change in the organization, senior management must be involved and actively engaged. The senior leadership needs to be engaged and make others realize that this is a priority," she says.

Involve people on the quality improvement task force who work directly with the patients whose care you want to improve. "It must be a collaborative effort. Members of the task force learn from each other as well as from the materials you provide," Scott says.

Along with the administration's backing, staff need to have one of their peers championing the cause, she adds. Don't choose a champion who is new to the team or someone who wants to work his or her way to the top, Scott suggests. Find someone whom everyone on the team looks up to and respects.

Case managers should play a very large part in assuring that the quality of care continues to improve, Kurashige notes.

"In many cases, we want to be sure that those patients who are in the hospital have sufficient information on how to take care of themselves when they are discharged, especially if they go home and have home health agencies provide care for them. Case managers certainly do the brunt of that work in handling discharge management," he says.

Case managers can be invaluable when it comes to making sure that the quality indicators are met, Scott adds.

"By reviewing the charts and reminding staff about the requirements of some measures, they can help drive improvement. Sometimes the staff are just too busy to remember everything they need to do," she says.

Scott works with the CEO work groups for clinical excellence, bringing the CEOs of its member facilities together and working with them on areas where they want to drive improvement. After receiving input from the CEOs, she convenes the task forces from participating organizations to address the identified areas of need.

"Because of public reporting, coupled with pay for performance, many of them select to work on AMI, heart failure, community-acquired pneumonia, and surgical infection prevention," she says.

VHA sets goals for compliance on each performance measure. Facilities that perform at 90% or more on every single measure are called green-light hospitals. Those performing at 80% to 90% are yellow-light hospitals. Any performance less than 80% is considered to be red light.

"That is how we set goals and develop at thresholds," Scott notes. The facilities that participate in VHA's quality initiatives enter their data every quarter using a web-based tool.

"Within our work groups, the data are not blind. It's no secret who is performing well and who is struggling. Those who need improvement on a certain measure can ask their counterparts in other areas who are doing well on the measure for extra help," she says.

Qualis compiles data from JCAHO, CMS, and other organizations and distributes them to participating facilities, showing them how they compare to state, regional, and national data.

The company has just finished its first round of meetings for each of the five regions in the state of Washington. The topics covered at regional meetings are suggested by participants and are specific to the needs of that region.

In some cases, the facilities are asked to present programs on quality as well. "We ask the hosting health care facility to showcase their quality program and share what they are doing to help raise the bar for everyone else. The goal is not to create

COMING IN FUTURE MONTHS

- How to perform a risk analysis that complies with HIPAA security rule
- Are your employees safe? Tips for a safe work environment
- Three reasons you need a nurse preceptor program
- Benchmarks from other home health agencies; best practices in action
- How one agency went from 'failing' to 'succeeding' in one year

an atmosphere of competition. The intent is to raise the bar for quality, and we're emphasizing a cooperative endeavor to achieve that," Kurashige says.

If a facility discovers their rates are low in one of the quality indicators, Qualis suggests simple methods they can use to help improve their rates, especially for national reporting of data, he says. "We do this so others can gather the information that is presented and start one of their own programs or enhance a program they already have," Kurashige explains.

The regional meetings have been very popular, he says. "We ask them what quality issues they are interested in hearing about and what kind of speakers, data, and tools they would like to have to help improve quality. When we follow up, they express appreciation to have the opportunity to share information that can help them improve quality," he adds. ■

U.S. flu activity is on the increase, CDC says

Flu activity has risen steadily in the United States since mid-December and does not appear to have peaked, the Centers for Disease Control and Prevention (CDC) reported.

The agency strongly encouraged people in flu vaccine priority groups to seek vaccination, noting that flu viruses may continue to circulate for several more months.

It said both inactivated flu vaccine and nasal spray vaccine generally are available, though supplies vary by area, and encouraged people to contact their doctor or local health department to learn where vaccine is available.

In addition, CDC said, an inactivated flu vaccine produced by GlaxoSmithKline for use in Europe will become available later this month at clinics in areas of the country where the need for vaccine persists. Once the clinics are identified, information on their location will be available through local and state public health authorities by calling the CDC flu hotline, (800) 232-4636. ▼

CMS announces project to pay for flu medicines

Seniors who get the flu can get assistance to help pay for antiviral medicines under a demonstration project announced by the Centers for Medicare & Medicaid Services (CMS).

"There are prescription drugs that have been proven to prevent the flu and its serious complications, and Medicare is taking steps to make these drugs more affordable," said CMS Administrator **Mark McClellan**, MD, PhD. "This demonstration program will provide useful evidence on how prescription drug coverage affects the health and costs for Medicare beneficiaries ahead of the drug benefit in 2006."

The demonstration is intended to last through May 31, 2005. Each beneficiary can get up to a total of two prescriptions filled during the demonstration period. The project is designed to help determine if coverage for these medicines can reduce the impact of flu on Medicare beneficiaries, especially those currently without drug coverage.

McClellan said the flu vaccine remains the best protection for Medicare beneficiaries and urged seniors who have yet to be vaccinated to do so. Adults who are 65 and older and other Americans with chronic illnesses are in the high-priority group to obtain vaccines, and there is an adequate supply for these groups. Four antiviral medications (amantadine, rimantadine, oseltamivir, and zanamivir) are approved for treatment of flu.

For detailed information about each medication, including dosage and approved people for use, go to www.cdc.gov/flu/professionals/treatment. ▼

California web site offers free resources

California families and caregivers now have even greater resources available to them for making difficult long-term care decisions. An expanded CalNHS.org features detailed information on 834 home health agencies and 172 licensed hospice programs in addition to extensive quality information on the state's 1,400 nursing homes.

The site features new tools and resources to help consumers evaluate the level of long-term care that is needed, find providers, compare quality, and manage important financial, legal, and end-of-life

issues. It also includes valuable information on alternative long-term care options. Although the agency-specific information is related to California, the general tools can be used by any consumer. The web site is www.calnhs.org. ■

CE *questions*

In the January 2005 issue, the CE questions and answers were numbered incorrectly. They should have been numbered 13-16. The correct answers should have been: **13. C; 14. D; 15. D; 16. A.** We apologize for any confusion.

17. Why does Jim Pyles, JD, a partner with Powers Pyles Sutter & Verville, believe CMS' CCIPs that address management of chronically ill patients provide a golden opportunity for home health agencies?
    A. Companies participating in the programs are required to contract with home health agencies.
    B. Home health agencies' experience and outcome data can help CCIPs better manage patient care.
    C. Patients in the program are required to utilize home care.
    D. CCIPs will be managing the sickest patients.
18. By what date should all home care agencies be in compliance with the HIPAA security rule, according to Robert W. Markette Jr., an Indianapolis attorney?
    A. March 1, 2005
    B. March 23, 2005
    C. April 10, 2005
    D. April 20, 2005
19. Which of the following communication strategies can be used to improve patient satisfaction in regard to pain management?
    A. Focus on pain management, even if the patients do not have complaints.
    B. Families must be able to trust staff.
    C. Educate staff about client satisfaction surveys and quality improvement.
    D. all of the above
20. In a survey conducted by Center for American Nurses, which of the following did the nurses NOT cite as an incentive to postpone retirement?
    A. flexible schedules
    B. higher pay
    C. phased retirement with shorter hours
    D. phased retirement with fewer days worked

Answer Key: 17. B; 18. D 19. D; 20. B

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. ■

CE instructions

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