

HOSPICE Management ADVISOR

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In-Depth Report: Open-Access Hospice On Rise

Pioneers in open-access trend cite benefits, as do relative newcomers

One hospice has 75-day length of stay

(Editor's note: Hospice Management Advisor presents in this issue the first of a two-part series about how increasing numbers of hospices are adopting an open-access policy that welcomes all eligible hospice patients, regardless of treatment status and ability to pay. We spoke with pioneers of this trend, who discuss in the story below why they feel open-access hospice is the industry's best hope for the future. The April issue of HMA will feature additional reporting about strategies for succeeding with an open-access policy and how hospices have made open access work financially.)

With hospitals and other health care providers beginning to horn in on hospice's palliative care business, it's time for the hospice industry to evolve in response to these developments. One effective way to do this is to adopt an open-access philosophy, in which a hospice seeks out and admits all eligible patients, experts say.

Open-access hospices start with the basic notion that all patients eligible for the benefits of a hospice program should be admitted with no barriers to their care, says **Carolyn Cassin**, MPA, president and chief executive officer of Continuum Hospice Care in New York.

"It goes back to the fundamental criteria in law in 1982, which said first that in order to be a hospice patient, a patient had to be certified by a physician as having a life expectancy of six months or less given the normal course of a disease, and second that the patient had to want the benefit and provide informed consent," Cassin says.

Unfortunately, much of the hospice industry has introduced barriers that were not meant to exist, she notes.

"In my experience, hospices have decided who they would and wouldn't serve, as opposed to running a hospice more like an emergency room where anyone needing services can walk in," Cassin says.

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"Hospice in my opinion is no different than that."

It's partly because of these barriers that common hospice referral sources now are looking into offering their own palliative care and end-of-life care services, thus eliminating the hassle of trying to find a hospice who will take care of all of the referrer's eligible patients, hospice experts say.

"Long term care centers and nursing homes are saying, 'Maybe I want to provide this service, and why can't I do palliative care and hospice?'" says **Greg Grabowski**, senior vice president of external relations and chief of the marketing and community relations office for Hospice of Michigan in Detroit.

"One way for the hospice industry to stay out in front is with open access, managing their case mix and managing finances to cover this," Grabowski says. "Folks must band together."

Hospice of Michigan always has had an open-access philosophy, even though the hospice was

part of a 10-hospice merger in 1994, says **Dottie Deremo**, RN, MSN, MHSA, chief executive officer of the hospice. Hospice of Michigan has about 800 employees and 1,000 volunteers, and had 7,500 admissions last year.

Hospice of Michigan's 24 sites in 45 counties of lower Michigan provide 25% of all end-of-life care in the state, despite operating in a very competitive market where there are 53 competing hospices within seven counties in the greater metropolitan Detroit area, Deremo notes.

"We accept everyone regardless of age, ability to pay, diagnosis, or expense of treatment," Deremo says. "We've gotten referrals from other hospices that wouldn't accept a patient who's getting palliative radiation or palliative chemotherapy. Their admission criteria would be so narrow that they'd have a number of barriers and say, 'We can't accept you, but Hospice of Michigan will.'"

Many could provide open access, but don't

The National Hospice Workgroup was formed seven years ago in San Diego as a think tank devoted to increasing access to palliative competencies of hospice care, says **True Ryndes**, ANP, MPH, president and chief executive officer.

The Workgroup's 26 members include some of the North American pioneers in the hospice industry, and all believe in moving toward open access, although some are further along than others on the open-access continuum, Ryndes says.

"Our intent is to help people who are suffering and in pain in the last phase of their lives, and that may mean by helping to get them admitted to hospice," Ryndes says. "We look at the internal and external barriers to hospice care."

Barriers may include patients and families who are not ready emotionally for hospice care, so many of the Workgroup's members have created palliative care services, consulting services, and palliative home health to meet the needs of those patients, he says.

However, one of the chief barriers patients face at the end of life is erected by hospices themselves, experts say.

"Unfortunately, there are too many programs who have the capacity to practice open access. They have the money, but they just don't do it," says **Samira K. Beckwith**, LCSW, CHE, president and chief executive officer of Hope Hospice in Fort Myers, FL. Hope Hospice received the Circle of Life Award in 2004 and the Circle of Life Citation of Honor in 2003 for its innovative program to

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Editorial Questions

For questions or comments, call **Leslie Hamlin** at (404) 262-5416.

improve the care of patients near the end of life. The awards are supported by the Robert Wood Johnson Foundation in Princeton, NJ, and are sponsored by the National Hospice and Palliative Care Organization (NHPCO), the American Medical Association, and the American Association of Homes and Services for the Aging.

"They hang on to what they think the old hospice model is, and they don't want to change," Beckwith says. "I think those programs are wrong because hospice never started out to have barriers, but they feel comfortable in their own little box."

Beckwith experienced this barrier first-hand when her own mother was dying with Parkinson's disease in another area of the country. Since it's difficult to make a terminal prognosis with Parkinson's, Beckwith had difficulty convincing hospices in her mother's area to understand that the woman could benefit from hospice services.

An open-access hospice such as Hope Hospice would have accepted her mother as a patient with open arms, looking beyond her disease diagnosis to see how the woman was indeed dying and needed help, Beckwith says.

Hope Hospice is a good example of how a small hospice can succeed with an open-access philosophy. When Hope Hospice began operating under open access 10 years ago, the hospice had about 50 patients per day, Beckwith says. "Now our average daily census is about 800," Beckwith says. "So people who think that only large hospices can provide open access are wrong."

Through open access, Hope Hospice has increased its average length of stay (LOS) to about 75 days. Its case mix is about 40% cancer patients and 60% other diagnoses, Beckwith says.

By comparison, the average LOS in hospice care is 55 days, according to statistics collected by the NHPCO.

Hope Hospice cares for 60% of the dying patients within its service area, which is one of the highest percentages in the country, Beckwith says.

Nonetheless, many hospices have been reluctant to make the transition to open access, she says.

"The open-access philosophy does have a long ways to go, and that's why it's exciting to have more and more recognition of open access in formalized programs," Beckwith notes.

For instance, open access has been a featured subject at conferences held by the NHPCO.

"I think a lot of hospices are recognizing that palliative care services are integral to meeting the needs within their communities, so we're seeing a lot of hospice providers reaching out and offering either more palliative care or open access to bring patients to care earlier," says **Jon Radulovic**, vice president of communications for the Alexandria, VA-based NHPCO.

"The face of dying America is changing, and more people are suffering from long-term ailments like ALS and Parkinson's disease," Radulovic says. "Hospices are learning to respond to these patients and their families and are learning to reach out earlier in the disease trajectory."

NHPCO's strategic business plan for 2005-2007 lists "access" as one of its two chief themes (the other one is "quality"). The plan

states that the goal is to increase the "use of palliative and hospice care and integration of end-of-life care into the health care continuum."

Another sign that open access might be the trend of tomorrow is that one of the nation's largest for-profit hospice chains provides a version of open access. VistaCare of Scottsdale, AZ, was founded with a modified open-access philosophy, says **Roseanne Berry**, MS, RN, co-founder and chief compliance officer.

"We knew we wanted to admit all eligible patients, but we weren't sure how to put that together with a business sense," Berry says. "We worked at it, but we weren't as open as we are now, and the open-access philosophy started taking hold in 1998 within our company."

In 1998, VistaCare grew from six hospice locations to 46 sites within 30 days, says **David Rehm**, MSW, senior vice president.

"We did a review of our mission criteria and decided to go ahead and do open access," Rehm says. "One of the issues is that size gives you a level of comfort in taking on that kind of risk."

Now VistaCare has 49 hospice programs operating in 14 states. The company's average LOS is

"The face of dying America is changing, and more people are suffering from long-term ailments like ALS and Parkinson's disease. Hospices are learning to respond to these patients and their families and are learning to reach out earlier in the disease trajectory."

about 90 days, and its median LOS is about 31 days, Rehm says.

According to NHPACO data, the national median LOS is 22 days.

“Nationally, hospice services 35% of the eligible population,” Rehm says. “We have some markets where we take care of almost everybody who dies in the market — above 90%.”

This proves that if a hospice implements an open-access philosophy and does it effectively, then over time the hospice can assist just about everyone who is eligible, Rehm says.

Making the switch to an open-access philosophy is a process, not a task with a set end point, he notes.

“It’s a transition that involves training, and it involves a culture change, an attitudinal change,” Rehm adds. “It requires a different set of clinical skills in order to implement it, and it’s not a transition that every [employee] is able to make.” ■

Interdisciplinary pathway improves teamwork, care

Pathways increase staff satisfaction

Hospice Care Plus of Berea, KY, switched to a pathway model for patient care in the mid-1990s as way to improve care for patients and their families. What they’ve found in the decade since beginning the process of changing their care model is that it also has improved teamwork, communication, and staff satisfaction.

“We wanted a stronger interdisciplinary approach,” says **Gail McGillis**, RN, MSN, chief executive officer of Hospice Care Plus.

After talking with staff and outlining what each discipline did with patients, they found that with rare exceptions, all of the disciplines had overlaps in the specific care they provided, so it made more sense to strengthen the interdisciplinary approach, McGillis says.

“We decided the old system didn’t match the hospice philosophy, and we needed a different type of documentation system and other changes,” McGillis says.

After a lengthy search for a good fit, hospice administrators decided to create a pathway model, which didn’t completely evolve to its present form until a few years ago, McGillis says.

“We wanted to change it from handwritten to computerized, so when we were looking for a computer system, we wanted something that was the way we needed the pathways to be,” McGillis says.

The result is a detailed pathway that divides patient care into five phases, from preadmission to bereavement.

Staff satisfaction improved from 70% to 90% after the pathway was implemented, McGillis says.

While the time spent doing documentation is about the same, it is easier and more efficient now, she says.

For instance, when a new nurse or staff member enters a patient’s home for the first time, they used to have to read seven or eight notes to learn what was going on with that patient, and now they can read one note for a complete update on the patient, McGillis explains.

Although the pathway is extensive, the staff quickly memorized it, says **Peggy Patrick**, MRE, chaplain discipline leader. (See **sample pathway**, p. 30.)

“You go through the categories to make sure you don’t miss anything,” Patrick says. “We carry the philosophy with us in our heads and hearts.”

The expectations, listed as bullet points for each phase, were developed with the staff’s expertise and knowledge, McGillis says.

“We use their expertise to say what is normal with what’s happening to patients at any point in time,” McGillis explains. “The pathway describes what the outcome is that the patient and family typically need at that point in time, and it’s driven by the expertise of people who had done hospice work for 10 years or more.”

The documentation system also fits the patients’ and families’ needs, McGillis says.

From a nursing perspective, it is a more intuitive documentation system, says **Nancy Isaacs**, RN, primary nurse for the hospice.

“I’ve been a nurse for 36 years and have worked in hospital long-term care settings and used several different models of documentation,” Isaacs says. “And this is by far the most sensible and logical way to look at patient care, and I’d never choose to go back to any other model after using this one.”

The biggest difference between the care plans used in hospice and plans used in the hospital is that hospital plans were based on diagnosis, Isaacs says.

"For this pathway, all we look at is the terminally ill patient, and it doesn't matter what the diagnosis is," she adds.

By the time patients have been diagnosed as having less than six months to live, they all have the same kinds of basic needs, Isaacs says.

"So we plan their care according to whatever their needs are," she says.

For example, in the first two phases, hospice staff expect patients to be alert and oriented, while in the later phases, the staff work toward keeping the patient as comfortable as possible and minimizing the patient's confusion, Isaacs says.

"The pathway is more about what we need to do for the patient and family to make them comfortable," McGillis says. "Our care plan has been modified so it changes as a patient gets closer to death, and that's why it's in five phases, which all patients go through, and there are different outcomes for the patient for each phase."

The pathway reinforces a concept of teamwork, and this strengthens interdisciplinary care within hospice care, Patrick notes.

"Now everyone is working off the same sheet of music and talking about the same issues rather than everybody having their own issues," Patrick says. "Spirituality blends into social work, but the chaplain at the same time might be talking about comfort and how that impacts the patient."

The pathway model uses the term "expected patient outcomes" (EPOs), which are the ideal of what staff hope to have the patient and family achieve for a particular phase, McGillis says.

For example, in phase II, the EPO for nutrition is to make certain the patient is comfortable with food choices and that the family knows what to expect, McGillis says.

By phase IV, which is when the patient is expected to live for less than two weeks, the patient's nutritional EPO is to be comfortable but probably not eating anymore, and the family's EPO is to be comfortable and accepting of the situation, McGillis adds.

"Most families still are very concerned with having patients eat because they're used to feeding people when they're sick and trying to make them well again," Patrick explains. "So we do a lot of teaching about what's normal in this area as people get closer to death."

Training staff is one of the more difficult aspects of using the pathway, because nurses and others who come from a hospital setting are accustomed to focusing on treatment goals rather than on a hospice care pathway EPO, Isaacs says.

"The first thing I usually do with a new employee is start off with the five phases and tell them what they are and say, 'When we see people, here's which phase they're in,'" Isaacs says. "Then we look at the EPOs and the patient and see how we're doing with them."

When the hospice first switched to care pathways, it was a battle to obtain buy-in from the staff, many of whom had worked for the organization for years, McGillis recalls.

"But once they did switch to the pathways, they would never go back," McGillis says. "The pathways make people think more critically about what they're doing and why they're doing it for their patients and families."

The pathways also have taught the staff how each team member brings his or her own values to each of those outcomes and how the pathway creates a holistic model, McGillis says.

Pathways summarized for physicians

Although the staff now are fully on board with using the pathways, which typically are five pages long, physicians are not, so they're given one sheet of paper that summarizes care for a patient at one point in time, McGillis notes.

"We add a narrative summary to the report for physicians," McGillis says. "That's what they want to look at, since the care plan is too long and arduous for them to go through and the pathway is too long."

Twice each month, the hospice staff meet with the medical director to go over all the EPOs that have been covered in the past two weeks, Patrick says.

For staff purposes, the notes they write electronically will update the pathway, making the pathway part of daily documentation, McGillis says.

"Every note has a pathway incorporated into it, and they say whether a patient is meeting that outcome or not and why not," McGillis explains.

"If a patient is not meeting those outcomes, then the team plans different approaches to help them meet those outcomes, and that's called a variance," Patrick says.

From a nursing perspective, communication has improved since the pathways were incorporated, Isaacs says.

"The team has to agree and all decide together to move patients from one phase to the next phase," Isaacs says. "We have a team meeting every week where we talk about that." ■

Hospice interdisciplinary pathway chart in nutshell

Here's how a pathway works

Hospice Care Plus of Berea, KY, uses an interdisciplinary pathway chart that outlines steps and outcomes for each of five phases of care for hospice patients.

With permission from Hospice Care Plus, *Hospice Management Advisor* reprints a portion of the copyrighted pathway chart below.

Phase I: Preadmission

- Begins with referral, ends with admit to hospice or referral to other agencies
- Usually completed by admission nurse
- Plan of care is initiated (Medicare Std.)
- Admit criteria validate appropriateness
- DME, meds and supply needs are identified
- Can be several contacts/notes

Phase II: Admission

- Explain hospice philosophy
- Admission process
- Assessing initial patient/family needs (all disciplines visit)
 - Meeting basic patient needs
 - Determining priority expected patient outcomes (EPOs); pain, nausea/vomiting
 - Two weeks or less
 - Primary team obtain baseline
 - Storytelling
 - Overlaps with Phase I
 - Initial assessment:
 - Nurse: diagnosis, presenting symptoms, medical history, and physical needs
 - Social work: family systems, available resources, patient/family coping, and grief and loss history
 - Chaplain: spiritual needs & resources and grief issues
 - Paint a picture of patient/family

Phase III: Transition

- Begins with admission completed
- Decline, with peaks/valleys
- Ends with rapid decline & death imminent
- Team focus: symptom management, end-of-life planning, teaching
 - Assess appropriateness and re-evaluate admit criteria throughout this phase

Phase IV: Dying

- Ends with death
- Patient may be admitted in this phase
- Team focus: preparing patient/family for death, comfortable with decline
 - EPOs shift drastically: ex., nutrition
 - Increase in visits and resources
 - Short-stay admissions:
 - When prognosis is two weeks or less
 - Admitted in phase IV
 - Discipline initial assessments are more focused on imminent needs
 - One integrated form for all disciplines
 - Hospice Carepath Notes:
 - Flow of note: EPO, assessment, comments, managed care & teaching (comments)
 - Discipline-specific questions
 - Pain assessed with each contact
 - Common areas of managed care & teaching
 - Prompts thorough, evaluative notes
 - Notes: EPOs across phases:
 - Patient/family express grief through storytelling (Phase I)
 - Patient/family acknowledge their grief (Phase II)
 - Patient/family begin to process their grief (Phase III)
 - Patient/family feel grief is validated (Phase IV)
 - Notes: Variances:
 - EPOs are not being met
 - Variances are expected secondary to changes in patient/family condition and continued decline
 - Way to focus where the team needs to re-evaluate the care/approach
 - Pain increases: meds changed, frequency changes, increased follow-up
 - Anxiety increases: meds changed, social worker/chaplain increase visits and support
 - Notes: Assessment:
 - Comprehensive
 - What is most important to the patient/family at that time
 - Discipline-specific and common areas
 - Comments individualize the assessment
 - Paint a picture
 - Notes: Managed care and teaching:
 - Interventions and actions
 - Integrates algorithm and standing orders
 - Choices are same on all notes and across all disciplines
 - Prompts you for additional care needed and also recognizes care provided

- Closure Visits:
 - Same note used for all disciplines
 - Team identified who is appropriate to make closure visit after death
 - EPOs focus on families' ability to process grief
 - EPO discipline-specific and common
 - Educate on bereavement services

Phase V: Bereavement

- Begins at death of patient, ends at 13 months
- Bereavement risk assessment created with input from the team
 - EPOs guide for level of risk and care
 - Three levels of risk: low, medium, or high
 - If unable to discharge, refer to appropriate resources ■

'Medicine-On-Time' finds following among hospices

Patients, families find it easier

A new type of medication service is beginning to capture the interest of hospices and families of hospice patients. The system, called Medicine-On-Time, provides patients with medication that is divided into doses corresponding to a calendar-formatted card.

Hospices who have used the Medicine-On-Time distribution method find that it eliminates emergency room visits because there are no lapses in medications. The system also reduces some of the time a hospice nurse might have otherwise spent in assisting patients and families with complex medication regimens, says **Stacy Fortier**, CPE, director of pharmacy education at The Medicine Shoppe of New Bedford, MA.

"It's a much more effective way to give medications," Fortier says.

For example, if a hospice physician wants to prescribe a patient a medication that will be used only on an as-needed basis, the Medicine-On-Time distribution method makes it easy for the hospice to provide the patient with a special packet that will be taken only if needed in the dosage amount already enclosed in the packet, Fortier explains.

So if the patient needs that particular medication, the patient's family won't have to make a

special trip to the pharmacy to fill it, she adds.

Also, if there's a snowstorm or other weather that prevents a hospice nurse from visiting the patient or explaining any change in a patient's medication, the Medicine-On-Time system will enable the family to call for a refill that will be delivered in whatever dosages the hospice physician most recently had prescribed. The patient will simply take what is included in the calendar packet for that date and time, Fortier says.

"We also provide prescription relief kits that are kept on hand at all times," she says.

The Medicine-On-Time service originally was designed for independent, ambulatory patients who wanted to stay out of a nursing home but who needed some help in remembering their medications, says **Ian Salditch**, chief executive officer of Medicine-On-Time in Owings Mills, MD.

"This is a common experience that people have of going over to an elderly patient's house and setting up the person's medications for the next week because the person is not able to manage the variety of medications and conflicting dose schedules themselves," Salditch says.

So the system was designed to be easy enough for the average person to self-administer, Salditch notes.

"While that is still what we essentially would term our primary market, other secondary markets, which in the past had been considered a part of the long-term care infrastructure, introduced themselves to us," Salditch says. "We found there were many settings where lay people were responsible for distributing prescription medications."

The company's primary mission is to simplify drug administration. It has found a wide audience, with about 400 pharmacies in 43 states using the system, Salditch says.

The Medicine Shoppe, which is one of those pharmacies, found that the distribution system may meet resistance at first, but once it's been tried, it's a quick sell, Fortier says.

"When we started with one hospice, they said, 'We won't need the prescription system because the family takes care of it,'" she says. "Then when hospices realized the system alleviated pill problems with patients, I've found that more hospices are adopting the system because it's much more cost-effective this way — and it's safer."

The Medicine Shoppe will deliver the medication calendar packets on a monthly, weekly, or biweekly basis, depending on the patient's needs and the hospice's directions, Fortier says.

Also, if patients are transferred or travel outside of the delivery service area, the packets, which come in a hard plastic shell, can be mailed, she says.

For patients who have difficulty seeing or reading, the medication packets are color-coded so that one color always means to take the enclosed pills at a certain time of day, Fortier says.

"It's delivered days before the rotation of new medication starts, and it's personalized for each particular patient as he or she needs it," Fortier adds. ■

CMS tackles chronic care costs of Medicare patients

Use case management experience to get involved

(Editor's note: This is the first of a two-part series that looks at care of chronically ill patients. This month we discuss the programs implemented by the Centers for Medicare & Medicaid Services [CMS] 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 the 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 requires 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.

"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 to both a healthy diabetic patient and 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."

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.

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 can only enhance a CCIP’s ability to manage patients, Caracci adds.

No replacement for a bedside nurse

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 Care Management for High-Cost Beneficiaries (CMHCB), which 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 CCIP’s responsibility to contact the beneficiaries and enroll them in the program. Because the program is voluntary, a CCIP may not get all, 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 controls cost and improves 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 notes that targeting chronically ill Medicare patients who typically are high-cost 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 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." ■

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 health care organizations should get ready for it, says **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, Scott 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," she observes.

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 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.

CMS is now making quality data available on a consumer web page, Hospital Compare, which can be found at www.medicare.gov.

Quality improvement entails 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 quality of care," he says.

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

Choose a respected peer to champion effort

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 choose to work on AMI, heart failure, community-acquired pneumonia, and surgical infection prevention," she says.

VHA sets goals for compliance with 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. Performance of 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 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. ■



Know how to avoid gaming the system

Stay on the right side of a very fine line

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, and reviews to identify inconsistencies, for example. These activities certainly should be continued and extended.

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 an unacceptable "gaming" of the system.

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 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 or opportunities for increased reimbursement.

It's all in how you use the data

Buyer beware! Use of such data should be handled very sensitively to avoid fraud 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 agencies to use these data to decide whether 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 are small but crucial differences among flagging declines prior to transmission to state agencies, verifications designed to maximize reimbursement, and appropriate compliance activities. Agency staff members easily can cross the line into the realm of fraud or abuse.

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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 prospective 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. ■

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