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In-Depth Report: Open-Access Hospice On Rise

Open access can provide financial rewards for enterprising organizations

Experts in open access offer tips for success

(Editor's note: Hospice Management Advisor presents in this issue the second of a two-part series on how increasing numbers of hospices are adopting an open-access policy, in which all eligible hospice patients are welcomed, regardless of treatment status and ability to pay. The March issue of HMA featured an article on how the trend of open-access hospice has grown and what open access looks like in practice. This month, pioneers of open access tell how they've made open-access policies work financially.)

Skeptics may view the open-access hospice philosophy as certain death for hospices, but there are a number of examples across the country of not-for-profit hospices that have weathered the transitional days and turned open access into a resounding success.

And if that isn't enough to convince the doubters, there is one other example to consider: The for-profit hospice chain VistaCare of Scottsdale, AZ, has an open-access philosophy.

VistaCare initially embraced an open-access policy for philosophical reasons, says **Roseanne Berry**, MS, RN, co-founder of VistaCare and chief compliance officer.

"We knew there was a great need to provide hospice care to more patients for a longer period of time than what traditionally is done," Berry says. "So how do you do the economies of scale and negotiate the right contracts?"

Acknowledging that some open-access patients will cost considerably more than the typical hospice patient, Berry says the key was to attract enough patients to spread out the risk and cost.

"Being a for-profit company allowed us the ability to grow into it," she says. "A nonprofit might have to raise money to cover costs, but we were able to grow into it and go into new communities that didn't have hospice or open-access services and not rely on the community

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to raise the funds.”

Although having an open-access philosophy feels like a risk, it isn't a blind risk, says **David Rehm**, MSW, senior vice president for VistaCare.

“Hospice in some ways is funded on an insurance model,” Rehm explains. “We should lose money on care for some patients, and we should make it up on the care of other patients.”

While a longer length of stay (LOS) increases costs, the most expensive care is at the beginning of the stay, so longer stays actually help financially, Rehm notes.

Also, the broader the hospice's patient base, the better its chance to offset unusually expensive patients, he adds.

“It's a financial risk to do open access, certainly,” Rehm says. “Our experience over time is that even with relatively small programs, the profit-and-loss side will work.”

The Hospice of Michigan in Detroit has shown that it's possible to survive with an open-access

policy even in highly competitive areas where other hospices aggressively try to cherry-pick patients.

“For some areas without as much competition, when you do open access it awakens the health care community and public, so hospice utilization appears to be up,” says **Greg Grabowski**, senior vice president of external affairs and chief marketing and community relations officer of Hospice of Michigan.

“In areas where you have extensive competition, like we do here, it becomes more interesting,” Grabowski says. “For patients who don't have a caregiver but who would like to die at home, we're one of the few hospices that will handle that situation, so open access to a certain extent does create challenges, but it's part of our mission.”

Within Hospice of Michigan's greater metropolitan Detroit area, there are 53 hospices within seven counties, says **Dottie Deremo**, RN, MSN, MHSA, chief executive officer.

“So there's tremendous competition for less expensive patients, such as non-hospitalized, longer-LOS patients whom you would find primarily in nursing homes and assisted living arrangements,” Deremo says.

For instance, the least expensive patients might be those with Alzheimer's disease, congestive heart failure (CHF), failure-to-thrive patients, and end-stage emphysema patients, who tend to be in a hospice program longer and have less expensive treatments than cancer patients, Deremo explains.

The advantage an open-access hospice has is its ability to market a philosophy that is very attractive to the community and patients, she says.

“We pride ourselves as following through on our mission, and because of that, we've garnered a tremendous amount of trust within the community and with physicians within the community,” Deremo says.

Hospice of Michigan provides around-the-clock service and support with an admissions policy that would be challenging for a small hospice to follow, Grabowski says.

But a hospice that is able to quickly decide to take on a new referral and has the resources to get a nurse out to visit the new patient within an hour or two is likely to be the first choice for referrals by hospitals and physicians, Grabowski and Deremo say.

“If someone can get staff to a patient quicker, then that's who the referral source will go with

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because response time is significant in a competitive environment," Deremo says.

Hospice of Michigan has an overall LOS of 47 days and a median LOS in southeastern Michigan of seven days or less. This is because the southeastern area contains many academic medical health systems, Deremo notes.

"Thirty percent of our patients die within 36 hours of signing on to the program," Deremo says. "In Western Michigan, where there are fewer academic medical centers, we have a median LOS of 14 days, and in northern Michigan the median LOS is 20 days."

The hospice's overall case mix is about 40 percent cancer patients, Deremo says.

The large hospice has made open access work financially in a highly competitive environment through economies of scale with regard to indirect costs and corporate overhead, and through fundraising, Deremo says.

"I spend a lot of my time fundraising, because we have from four to five million dollars we need to raise every year to pay for open access and to cover patients without any kind of insurance and to cover robust grief support services and more in-depth spiritual care services," Deremo says. "We have a quality-of-life fund where we assist patients and families when, for example, a brother is too poor to fly up to be at a patient's bedside. We'd often be able to pay for that ticket."

The hospice even provides services to homeless patients, including having volunteers pick up the patient's friends from under the bridge where they'd lived for years and take them to the hospice home to visit him, Deremo says.

For hospices in less competitive areas, open access can be an easier strategy to employ.

Hope Hospice of Fort Myers, FL, has flourished under an open-access philosophy, growing from 50 patients a day to an average daily census of 800 since switching to an open-access mission, says **Samira K. Beckwith**, LCSW, CHE, president and chief executive officer.

The hospice owes part of its success to a strategy of developing a network of provider partnerships, including having contracts with a dialysis center, medical oncologists, IV therapy companies, and other providers, Beckwith says.

"We understand that everybody has to make money," she says. "So we try to strike a deal that will be fair to both parties."

For example, when a radiation oncologist wanted to charge Hope Hospice its top rate, managers asked the provider to lower the cost,

just as the oncologist already had done for managed care companies, Beckwith says.

When negotiating with hospitals, the hospice explains the benefits the hospice will provide as follows: "If we're partners in care, here's the benefit to you: less people coming through your emergency room and costing you money," Beckwith explains. "So let's find a rate we can agree to for inpatient and outpatient services."

Hospices need to stress the benefits of fewer emergency admissions and shorter LOS when discussing rates with hospital administrators, Beckwith adds.

Another strategy is to continually assess the hospice's case mix as a measure of how well the hospice is doing under open access, she says.

Educate referrals to adjust case mix

When the case mix is unbalanced, hospice administrators will consider educating referral sources to encourage admissions of lower-cost patients, Beckwith says.

For instance, the hospice began working with Alzheimer's disease associations early on so they would know how hospice could provide services to their dying members. The hospice even offered the association some office space in its building for several years, Beckwith notes.

The result is that the hospice now cares for more than 80 percent of the people who die from Alzheimer's disease within the community, Beckwith says.

The hospice also has contracts with nursing facilities and assisted living facilities, always marketing its services as benefits to the health care provider, she adds.

"We've continued to grow and take care of more people every year, and we've continued to increase our length of stay, which is really great because we take short-term patients who bring down our average LOS," Beckwith says.

The hospice routinely will take patients who may have only hours to live, but even with that short amount of time, the hospice can provide support to the patient and family, she says.

To mitigate financial risk under open access, hospices need to have a financial reserve to carry them through the months in which they have a concentration of high-cost patients who will hurt their profitability, Rehm explains.

"A nonprofit entity would have to resort to funding the balance through contributions over time before they can carry that risk," he says.

Open-access hospices typically will need a large risk pool with both expensive and inexpensive patients, says **Carolyn Cassin**, MPA, president and chief executive officer of Continuum Hospice Care of New York, NY.

"We take patients out of very aggressive acute care hospitals, and we have patients who have intact families and are at home and don't take an enormous amount of resources," Cassin says. "If you only have one kind of patient, a risk pool doesn't work."

Continuum Hospice Care's average LOS is 54 days, and the median LOS is 17 days. The organization has improved its referral base considerably in the few years since moving to an open-access philosophy, Cassin says.

"We've expanded into caring for many more patients in nursing facilities and taking care of patients with diseases other than cancer, such as Alzheimer's disease, chronic obstructive pulmonary disease, CHF, and end-stage renal disease," she says.

The hospice's daily census has grown from 100 patients to 450 patients because of the change to open access, Cassin adds.

For those who question how carefully a for-profit hospice might select patients, Rehm notes that VistaCare has a broad range of patient diagnoses.

"About 40 percent of our patient population are facility-based, including hospitals, assisted living, and nursing homes," Rehm says. "Just recently we discovered that as a company our patient diagnostic mix reflects the Medicare precedent diagnostic mix. We're serving the actual, eligible Medicare population, and I attribute that to open access."

It's also important to help patients make the transition from treatment to palliative care, even if they are continuing to receive chemotherapy or other treatments, Cassin says.

For instance, hospice nurses will say to patients, "You are undergoing chemotherapy. What has been the outcome? Has the tumor shrunk? Do you feel better because of the chemotherapy?"

If there appears to be no productive reason to continue the chemotherapy, the hospice staff might ask the physician what he or she hopes to accomplish. If the doctor believes the tumor can be shrunk, then the hospice staff will advocate for the patient to continue the chemotherapy, Cassin says.

"If not, then I go back to the patient and say, 'I'm not sure this is having the value you think

it is, and we should re-evaluate the cost-benefit of this treatment,'" she says.

"Open-access hospice is the best service that anyone at the end of life can be offered," Cassin says. "I believe in open access because I believe everyone facing the end of life can and should have hospice, and they shouldn't have to give up treatment to get it." ■

Hospice patient education handbook wins award

Patients, staff use book with each visit

A Florida hospice has created an education program that helps it handle its rapid growth while improving patient and family satisfaction.

Each year, Covenant Hospice of Pensacola, FL, gives away more than 1,000 patient education handbooks that serve as a comprehensive guide to hospice for both families and hospice staff.

The hospice has given away about 5,000 handbooks since the education tool was created several years ago, says **Julie Patton**, LCSW, curriculum development manager for the hospice, which has more than 700 employees.

Covenant Hospice won an award of excellence in education last year for its patient and family education program. The award was sponsored by the National Council of Hospice and Palliative Professionals and presented by the National Hospice and Palliative Care Organization of Alexandria, VA.

Also, Covenant Hospice's family satisfaction with education increased from around the 40th percentile in July 2001 to the 70th percentile in December 2003 as a result of using the education handbook. The measure for family satisfaction in receiving adequate help in combating stress and anxiety increased from the 50th percentile in 2001 to about the 80th percentile in 2003, Patton says.

"And we had 97 percent of caregivers [in a recent survey] say that hospice had increased their confidence in caring for their loved one as death approached," she adds.

In 2001, when Covenant Hospice's staff were preparing for re-accreditation by the Joint Commission on Accreditation of Healthcare Organizations of Oakbrook Terrace, IL, they decided their patient education program wasn't

working as well as they wanted it to, Patton says.

"There were a lot of different teaching sheets, and to make it successful, a nurse needed to have the right sheets in the home at the right time," she says.

Boosting education, improving care plans

The idea for an education handbook was a melding of the patient and family education goals with the hospice's latest project of improving the care plan process, Patton explains.

"In talking about it, we felt the two would complement one another," she says.

When hospice managers began to examine the current care planning process, they realized it involved too much writing and too little interaction with patients, so they decided to reverse those trends, says **Dee Leslie**, RN, CHPN, director of the Partners in Care Program. Leslie was the one who spearheaded the changes to the care planning process.

"Now when nurses select teaching sheets from the patient education handbook, they also are selecting teaching interventions," Leslie says. "After finishing the teaching sheet, they review the interventions at the bottom to make sure they have covered those teaching interventions."

The handbook is nearly 300 pages long and is fairly inexpensive to produce since the hospice uses its own copying machines, but it does require about 20 volunteers to put it together, Patton says.

While the hospice could have the book published for sale to other hospices, the idea of making a profit from the book doesn't fit in well with the hospice's philosophy.

"Our philosophy up to this point is that we are all, as hospice providers, contributing to a relatively new body of knowledge," says **Liz Stewart**, RN, BSN, CHPN, director of internal education.

Patton, Leslie, and Stewart describe how the award-winning handbook was created:

1. A needs assessment was conducted.

"What we found out was we had care plans that had been carried over from a number of different settings and were not terribly hospice-appropriate," Patton says. "So we did an extensive needs assessment."

Hospice staff decided they would need to improve both the care planning process and patient education materials. A committee that included clinicians was formed to develop hospice interventions for problems like pain and

nausea or working with the patient and family to comply with around-the-clock dosing, Patton explains.

The result was the development of a care planning process that is simpler than what staff used previously, Patton notes.

"In doing care planning, the staff doesn't have to do a great deal of writing," she says. "They can use a drop-down menu on the computer and select interventions that correspond with teaching sheets."

"What's unique about the care planning process is it came from the staff up to the management," Leslie says. "It's a method that makes it easier for hospice staff to do care planning and to do it effectively, without spending a lot of time writing out things."

Also, the care planning process is completely independent of hospice reimbursement and financial concerns, Leslie adds.

2. A separate committee developed the education handbook.

Initially, the hospice's committee was formed to improve the family education program, but it progressed into a committee to create the patient and family handbook, Patton says.

"We were using a file box for teaching sheets, so it became a patient and family handbook," Patton says.

Committee collaborated via e-mail

Committee members gathered new information while reviewing existing teaching sheets, and they e-mailed one another with suggestions for changes, Patton says.

"I'd write something and send it to someone else to see if they would change anything or if there were things I'd left out or if there was anything that might be offensive," Patton explains. "They'd make comments and e-mail it back to me."

Many different people collaborated on the changes, including Stewart, Leslie, the director of operations, the director of special programs, a social worker, a health and safety officer, and a chaplain, Patton says.

"Forty to 50 people contributed to it altogether, including an administrative assistant who prepared dividers and helped with formatting some of the sheets," Patton says.

Hospice staff also came up with ideas to reduce costs in reproducing the handbook. For example, it was begun as a loose-leaf notebook

and now is a bound notebook that is printed entirely at the hospice, Patton says.

The volume of printing was wearing out the hospice's copying machines, so the hospice invested in a larger copying machine that also inserts tab dividers, and volunteers assist with the printing and assembling, she adds.

3. Patient education materials were developed with psychosocial issues in mind.

One of the unique features of the handbook is that it reflects the holistic and psychosocial aspects of hospice care, rather than focusing primarily on nursing and medical interventions, Patton says.

Many other care plans didn't reflect the breadth of hospice care, so Patton and others worked to develop many psychosocial teaching sheets.

"We feel our program is very broad and reflects the work of everyone on the interdisciplinary team," Patton says. "The teaching sheets identify opportunities for growth at the end of life, and they facilitate growth in a variety of areas, including the spiritual."

4. The patient handbook contains alphabetized sections and teaching sheets.

Stewart recalls that when she was a case manager using the handbook, it was a wonderful tool for hospice families.

"When a patient was approaching death and I wanted the family to be aware of the signs and symptoms, or when we had a conversation about hydration, the teaching sheets were there and readily accessible," Stewart says. "The family receives the entire handbook with teaching sheets, and the nurse will identify the sheets to which she refers the family."

Care plans prompt use of teaching sheets

Care planning works closely with the handbook, Leslie notes.

"Care planning was integral to the patient and family handbook," Leslie says. "In the electronic care plans, nurses can use a drop-down menu that says 'Review teaching sheet,' and there's a blank space to type in the teaching sheet that's reviewed."

Also, nurses do not have to repeat the interventions in the documentation because all of these are written in the handbook, Leslie says.

"I found it a very useful tool because, while I might remember some of the interventions, like how to request a volunteer, I may forget to go over what a volunteer can and can't do," Stewart

says. "So I'd open the book to the page on volunteers, and it gave me a prompt of what I needed to say."

Previously, nurses would document teaching with a check-off in the nursing notes of "Teaching accomplished," and they would write on a small line what was taught, Stewart recalls.

"Now, because of this tool and electronic care plan, we can better document what teaching has been done and whether it's a true intervention," Stewart adds.

The teaching sheets are listed alphabetically, and items are cross-referenced in the index, Patton says.

The handbook begins with a mission statement and covers such items as services, on-call system, safety issues, and nursing services before beginning the sections with education and teaching sheets. Also, there are sections devoted to medication, medical equipment, financial and insurance information, and discharge/transfer of hospice patients.

"It has an initial section that describes the organization and team," Patton explains. "Then a second section has the teaching sheets, alphabetically arranged, from advance directives to volunteers."

The handbook also covers hurricane preparedness, fire safety in the home, diarrhea and constipation, placement in a nursing facility, and unconventional teaching items, such as opportunities for growth, anxiety, anger and depression, end-of-life care, and a comprehensive description of what a patient might experience, Patton says.

The book is written at an eighth-grade education level and is in a clear font so it's easy to read, she says.

Patients who are admitted to hospice when they are very close to death are referred to a small section in the book for terminal patients, so they don't have to worry about reading the entire book if they choose not to, Patton says.

While the handbook has been a time-consuming and costly project, it has helped improve satisfaction among hospice staff and families of hospice patients, Stewart says.

"When the handbooks are put into facilities with hospice families, they're often left at the facilities, and we're actually spreading our mission in education by teaching families," Stewart says. "Research shows that even when one person receives hospice care in a facility, all persons tend to benefit from the education that's provided." ■

Medicare program reduces amputations and spending

Face-to-face sessions cornerstone of success

An intensive face-to-face care management program for severely ill Medicare patients with advanced congestive heart failure and/or complex diabetes has paid off for XLHealth, a Baltimore-based disease management firm. The company reduced spending by as much as 26% after 24 months of intervention for private HMO patients and has reduced lower-limb amputations by more than 60%.

The program provides face-to-face care management sessions with patients and person-to-person pharmaceutical consultations when needed. In addition, the nurse care managers meet with physicians and their clinical staffs to discuss the patient's care plan. The patients picked for the program are those who are at risk for consuming the greatest amount of health care resources.

"Most are socially isolated and clinically depressed with little social support," says **Paul Serini**, executive vice president for XLHealth. "They don't want to bother the doctor. They can't drive to the podiatrist, and they don't want to call a taxi because it costs too much."

Patients often unaware of ulcerated wounds

Serini credits the face-to-face interventions for the dramatic reduction in amputations and health care costs. For instance, many of these patients in Medicare programs have foot ulcers that they treat with over-the-counter medication, waiting until it becomes so severe that sepsis has set in or the patient is facing an amputation.

"We have found that when we call the patients before a home visit, about half of those who have ulcerated wounds say their feet are fine. If they have neuropathy, they can't feel their feet. Many are obese and can't see their feet. They may live alone and not know they have problems, or they may not know it's serious," he says.

Home assessment helps identify any problems the patient has before they worsen into a costly health care episode, Serini notes. "Our medical experts tell us that almost 95% of amputations are avoidable from a clinical perspective if we intervene with the patient early enough," he says.

The nurse care managers call each patient and conduct a 15- to 20-minute telephone assessment. Depending on the patient's level of severity, the nurse care manager asks the patient if he or she would be willing to participate in a 45-minute face-to-face assessment.

The assessment may be conducted at the patient's home, at a special area set aside for XLHealth at a local pharmacy, at a physician's office, a senior citizens center, or another location that is comfortable for the patient.

During the assessment, the nurse care manager collects clinical data, checks diabetic patients for neuropathy and hot spots, conducts a depression screening, reviews all the patient's medications, and in some cases collects blood samples. "Based on 500 or more data points that we collect, the patient is restratified and the information is used to create a patient care plan that supports the physician's plan," Serini says.

When the initial care plan is developed, the nurse care manager goes to the physician's office and meets with the physician and clinical staff to walk them through the report, ensuring that the plan supports the physician's efforts and telling them about frequency and content of follow-up reports.

Program designed to be physician-friendly

"The packages that are given to the physicians were developed over a period of four years by asking physician groups what information they want and what they want the reports to look like. They are very physician-friendly and helpful," Serini says, adding that the disease management company gets a 96% approval rating among physicians.

The patient also gets a copy of the care plan and a follow-up telephone call from the care manager.

Recommendations in the care plan are flagged in the company's computer system until they are followed. For instance, if a patient has a history of hypertension and is not taking an ACE inhibitor, the physician receives a report suggesting an ACE inhibitor might be recommended for the patient, and the nurse care manager follows up with the patient, reminding him or her to speak to the physician about the drug. "These two tasks are scheduled by the system, and they remain on the schedule until they are completed," he says.

Patients in the highest risk categories receive the most interventions. There is no set number of

interventions per patient. Instead, they are event-driven. For example, the nurse care manager may advise a patient with foot problems to go to a podiatrist and may arrange for transportation if needed. Two weeks after the podiatrist visit, the nurse care manager visits the patient to review what happened during the visit and to make sure the patient truly understands home foot care and foot issues.

"We are happy to pay for the follow-up because amputation can affect a patient negatively, and it is expensive; and it is always effective to have the care manager reinforce what the doctor told the patient," Serini says. ■

Chronic care success requires innovation

Agencies provide special training for clinicians

While the Centers for Medicare & Medicaid Services (CMS) introduces new programs designed to address the care of chronically ill patients, home health agencies continue to find innovative ways to provide care to diabetic and congestive heart failure (CHF) patients — two of the most common diagnoses identified as chronic illnesses.

"We provide care to 4,000 patients, and half of them are considered chronically ill," says **Ray Darcey**, vice president of Sentara Home Care in Chesapeake, VA. "The most common diagnoses are diabetes, CHF, and chronic obstructive pulmonary disease [COPD]," he says.

After identifying CHF patients as the group for which costs were increasing and reimbursements were decreasing, Darcey's agency evaluated different ways to continue providing quality care at a lower cost. "We do have standard protocols that we follow for all of our chronically ill patients, and those do streamline our care. But we wanted to see if telemedicine would help us reduce our labor costs," he notes.

The telemedicine program for CHF patients was introduced four years ago. "The program involves a combination of telemedicine and nursing visits," Darcey explains. "The telemedicine visits are designed to supplement — not completely replace — nursing visits. Our program is a live, interactive video that requires a computer

screen and a telephone line. The patient's unit has a blood pressure cuff, a scale, and a stethoscope that are used during the telemedicine visit, with the results appearing on the nurse's screen."

Although the program has reduced staff costs because nursing visits to the home can be reduced, it also has produced some other significant results, he says. "We've seen a 70% reduction in hospital readmissions, a 78% decrease in emergency department visits, and a 50% improvement in activities of daily living for our CHF patients on the telemedicine service," Darcey notes.

The 60 patients on Sentara's telemedicine program are between 65 and 80, and none of them were apprehensive about the use of the telemedicine equipment, he says. "There was no hesitation, and we've discovered an unexpected bonus to the telemedicine program," Darcey says. While the patients are not nervous about the equipment's digital camera sending their image to the telemedicine nurse, they are especially careful about their appearance during the telemedicine visits, he points out.

"When nurses go to the home to see these patients, many of them will still be wearing their pajamas. But for the telemedicine visit, the patients dress up, put on makeup, and fix their hair," Darcey laughs. Their attitude also is different, he adds. "They take their responsibility for their care between visits very seriously, and they are diligent about recording the information the nurse will request during the telemedicine visit."

The telemedicine patients see this program as a way for them to participate in their care, and their attitude and approach to self-care has improved greatly, he adds.

Patient satisfaction scores have increased

Although Sentara did experiment with the use of the same nurse for both the telemedicine and in-home visits, Darcey notes it was not an efficient use of staff time. "Some of our patients live over 100 miles from the office with the telemedicine equipment." Scheduling the nurses who cover these distant areas to come to the office to make telemedicine visits wasn't effective, he explains. "Patients don't mind two different nurses overseeing their care, and patient satisfaction scores for this group of patients has increased."

In addition to having their own CHF program that includes comprehensive protocols and patient education, Sta-Home Health Agency in

Jackson, MS, has targeted diabetic patients as one group to receive special attention to reduce complications and the need for hospitalization.

"We have a team approach to caring for diabetic patients that includes nurses, diabetes educators, and dietitians to make sure our patients receive the best education and care," explains **Michael T. Caracci**, chief executive officer. "All of our nurses are familiar with the potential complications and the neuropathy of diabetes, and we have seven certified diabetic educators on staff to serve as resources for the nurses and to visit patients," he says.

Agency offers foot-care clinics

In addition to comprehensive patient education for his agency's own home care patients, Caracci's staff offer foot-care clinics through physician offices. The clinics are held in the physician's office for patients of that practice.

"One of our nurses, along with the physician, will talk to the group of patients about foot care in general for diabetics. Then our staff will work with each patient on an individual basis to trim toenails and check feet," Caracci explains.

To avoid any Stark violations, the physician pays the agency on an hourly basis to provide the education and the foot care, he adds.

Because Caracci's agency covers a wide geographic area with 40 offices and more than 4,000 patients, it is not possible for diabetic educators to see every diabetic patient on a regular basis. That doesn't mean that nurses don't have access to the diabetes educators as a resource, he points out. "Although our nurses are well-trained in the care of diabetic patients, there are times when they may need advice," Caracci says.

Nurses can reach the diabetic educators by phone or e-mail. Also, if nurses are concerned about a patient's skin breakdown, they can use digital cameras to give accurate information about the patient's skin condition. "We don't use telemedicine at this time, but we do have digital cameras in each of our offices that nurses can use to photograph a patient's wound and transmit the picture to the diabetic educator," Caracci says. "This makes it possible for the educators to determine if the patient should be seen by another clinician or themselves for other treatment."

While technology such as digital cameras is affordable for most agencies, Darcey admits that telemedicine requires a significant investment. "The cost of training nurses to use and set up the

equipment in the patient's home is not much, but the equipment and software can add up," he admits. "We are fortunate that we are part of a larger health system with several hospitals. The reduction in readmissions and emergency department visits and a shorter length of stay when hospitalization is needed for CHF patients combined to make a strong argument in favor of the investment in telemedicine," he adds. "We are planning to expand our telemedicine program to include COPD this year, and we expect to see positive results for those patients as well," he says.

As CMS proceeds with chronic care improvement organizations and demonstration projects, some agencies such as Sta-Home will work with the chronic care organizations to provide the face-to-face visits required for some patients. "I think it is important to make sure that technology and emphasis on efficient care and education don't completely replace actual visits," says Caracci. "There are things you learn about the patient when you are in the patient's environment that won't always be communicated because the patient doesn't consider them pertinent," he explains.

Daylong visit reveals blood-sugar culprit

Caracci's favorite example of the importance of being in the home is his agency's experience with a diabetic patient whose blood sugar levels could not be controlled. Repeated visits to the patient and reinforcement of education were not working, so a nurse spent the entire day at the home to see if she could determine what the patient was doing, or not doing, to prevent control of her blood sugar level without sending her back to the hospital, he continues. "Everything was fine from 8 a.m. until 3 p.m., with the patient eating correctly, checking her blood sugar, and doing nothing that explained her out-of-control blood sugar. At 3 p.m., the woman's granddaughter stopped at the house on her way home from school carrying the special treat she brought her grandmother every day — a Slush Puppie," Caracci says.

The nurse looked at the sweet frozen drink and knew why the woman's blood sugar levels couldn't be stabilized. "The woman and her granddaughter never mentioned the daily treat because it never occurred to them that this one drink could cause so many problems," he adds. "The nurse suggested other treats that the granddaughter could bring that wouldn't make hospitalization necessary." ■

Hospice teaches nursing students about end of life

Program wins national award

The Hospices of Henry Ford, Saint Clair Shores in St. Clair Shores, MI, have developed an extensive nursing education program for area colleges, ensuring many nursing students will have a greater appreciation for hospice and palliative care.

Seeds for the education program were sown in 1996 when a nursing school clinical instructor at an area college met with **Ken Grunow**, RN, BSN, CHPN, MEd, hospice education coordinator at Henry Ford, to discuss an end-of-life nursing educational course for nursing students.

The program won an award for Excellence in a Program Designed to Increase Access to Hospice and Palliative Care, presented by the Alexandria, VA-based National Hospice and Palliative Care Organization in October 2004.

"They could see this would be a valuable service for nursing students, so we put together a one-day conference for nursing students at a community college," Grunow says. "We put it on with great fanfare, and it was videotaped, with several hundred students attending."

Several hospice professionals served as faculty for the program, and they created a syllabus of more than 100 pages of materials for the students, Grunow recalls.

"But it was like launching a battleship or a cruiser — it was overwhelming for the students and for us," he says.

After spending time assessing the one-day conference and its success, hospice officials decided it was a good program that would need some adjustments. They also decided to offer it as a one-day course in nursing schools, Grunow says.

The program includes lectures on the philosophy and history of hospice care, pain management, children's hospice programs, nuts and bolts of hospice care, characteristics of hospice services, role of the hospice nurse, hospice team approach, communication with dying patients, physiological changes during dying, medication, and spiritual and psychosocial services, Grunow says.

"We have a social worker talk about communication at the end of life and what patients tell us about when they're going to die and how they're dying," he explains.

Grunow provides a summary at the session's end with an overview of ethics and financial accountability, as well as a list of web sites, books, and other additional resources.

When possible, the hospice class is taught by Grunow, a physician who discusses pain management, a nurse, a social worker, and a chaplain.

Although the class initially was designed to fill one day's schedule, some colleges have requested a half-day version for their nursing students, Grunow notes.

"I can cram everything in there in half a day, but I prefer the longer version," he says.

During the one-day class, Grunow shows students a 1996 HBO documentary about the hospice journey and letting go.

"It's an incredible film that follows the lives of three patients, a little boy and two adults, and it shows the services that the hospice team provides, as well as family dynamics," Grunow says. "I think it's a masterpiece and haven't found anything better."

The movie is very intense, and Grunow initially showed it to students later in the day. "But it took people's breath away, and the people I coordinate with would show it in the morning," he says.

After the one-day or half-day class, nursing students are invited to spend some time at the hospice with nurses and other staff, preferably to attend patient visits, Grunow adds.

So far, the hospice has provided the educational program about 15 times a year to six Michigan colleges serving nursing students, he says.

"We do this as a free service," Grunow says. "We think it's important to help these young nurses get a little more comfortable working with patients at the end of life."

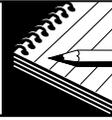
Hospice managers also hope the nursing students they help train may one day become willing and knowledgeable referral sources when they come across dying patients in hospitals or other locations, Grunow says.

Some of the students have expressed enthusiasm for working for a hospice some day, he notes.

"We recommend they get a couple of years of clinical and hospital experience before they come to us, because there's a fair amount of autonomy needed in home care," Grunow adds.

The feedback has been very positive, he says.

"Clinical instructors have told me that they found their students [after the course] were more comfortable with talking with people about end-of-life questions," he says. ■



Feds receive thousands of HIPAA privacy complaints

108 cases referred to Department of Justice

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

The deadline for compliance with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule — April 14, 2003 — came and went with little fanfare. What has happened since that date in terms of enforcement?

There has been one reported conviction for violation of the privacy rule. Richard W. Gibson of Washington entered a guilty plea in *U.S. v. Gibson*, W.D. Wash. No. CR04-0374FM.

Employee used info to get four credit cards

Gibson pled guilty in a Seattle federal court to wrongful disclosure of individually identifiable health information for economic gain. In the plea agreement, Gibson admitted that he obtained a cancer patient's name, date of birth, and Social Security number while he was employed at the Seattle Cancer Care Alliance.

He disclosed this information to obtain four credit cards in the patient's name. Gibson then used the credit cards to incur more than \$9,000 in debt in the patient's name. Gibson used the cards to purchase various items, including video games, home improvement supplies, apparel, jewelry, porcelain figurines, groceries, and gasoline for his personal use.

Gibson was fired shortly after the theft was discovered. The government and Gibson agreed that he should be sentenced to a term of 10 to 16 months.

In terms of civil enforcement, the Office of Civil Rights (OCR) of the Department of Health and Human Services, the primary enforcer of HIPAA privacy requirements, said in a "Compliance Activity Summary" issued July 31, 2004, that it has received more than 7,577 complaints. Fifty-seven percent of these complaints already have been closed.

The cases were closed because OCR lacked

jurisdiction to enforce them under HIPAA for one reason or another. Examples of cases closed on this basis include complaints alleging a violation prior to the compliance date or claiming a violation by an entity not covered by the privacy rule.

OCR also has closed a number of complaints in which the alleged HIPAA violation does not actually violate the rule, such as when covered entities have declined to permit disclosures when they are not mandatory or when the claim has been satisfactorily resolved through voluntary compliance.

The types of claims most frequently received by OCR are:

- impermissible use or disclosure of identifiable health information;
- lack of adequate safeguards to protect identifiable health information;
- refusal or failure to provide individuals with access to or copies of their records;
- disclosure of more information than is minimally necessary to satisfy a particular request for information;
- failure to have the individual's valid authorization for a disclosure that requires one.

Complaints have been filed most often against the following:

- private health care practices;
- general hospitals;
- pharmacies;
- outpatient facilities;
- group health plans.

OCR still in early stages of enforcement

OCR refers appropriate cases that involve knowing disclosure or obtaining protected health information in violation of the rule for criminal investigation and possible prosecution to the U.S. Department of Justice. OCR has made 108 such referrals thus far.

Based upon that information, it is tempting to conclude that providers, especially long-term care facilities, home health agencies, home medical equipment companies, and hospices are doing an excellent job of compliance with the privacy rule and should simply keep up the good work. Providers should bear in mind, however, that OCR still is in the early stages of enforcement efforts. Enforcement may become more stringent in the future, and providers should remain vigilant with regard to compliance with the HIPAA privacy rule. ■

NEWS BRIEFS

Fixed performance areas for random JCAHO surveys

The fixed performance areas for random, unannounced surveys of home care organizations by the Joint Commission on Accreditation of Healthcare Organizations in 2005 are: assessment and care/service, patient safety, information management, and the 2005 National Patient Safety Goals that are applicable to home care. The Joint Commission has conducted one-day surveys at a randomly selected 5% of accredited organizations since 1993. The Joint Commission also posted a clarification to the national patient safety goal related to infusion pumps. It is acceptable to have “pre-assembled” free-flow protective mechanisms, rather than “intrinsic” free-flow protection, on intravenous administration sets used with infusion pumps. ▼

CMS codes, coverage for wheelchairs and scooters

In its continuing effort to improve Medicare coverage and payment for power wheelchairs and scooters while protecting the Medicare program and taxpayers from abuse, the Centers for Medicare & Medicaid Services (CMS) recently released draft coverage criteria, the National Coverage Decision (NCD) for these devices, as well as new codes to ensure proper payment.

Medicare’s proposed coverage criteria would rely on clinical guidance for evaluating whether a beneficiary needs a device to assist with mobility, and if so, what type of device is needed. This new approach would replace an older, more rigid standard that relied on whether a patient was “nonambulatory” or “bed- or chair-confined.” The analysis begins with whether the beneficiary has a mobility limitation that prevents him or her from performing one or more mobility-related

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activities of daily living in the home.

The evaluation includes the consideration of whether an assistive device — a simple cane, a sophisticated power wheelchair, or anything in between — would improve the beneficiary’s ability to function within the home. The criteria also take into account any conditions, such as visual or mental impairment, that would affect the beneficiary’s ability to use the mobility equipment effectively.

CMS plans to publish the final NCD in March and to provide guidance on how to use and document the new criteria. It also is establishing new billing codes for power wheelchairs and scooters to assure that Medicare pays appropriately for these devices. To better reflect the range of power mobility products now available on the market, Medicare will expand the number of codes used for billing from five to 49. The more detailed coding will help get the right products to patients and improve Medicare’s ability to pay suppliers appropriately. The codes go into effect Jan. 1, 2006.

The proposed NCD will be posted at www.cms.hhs.gov/coverage. A description of the new billing codes for wheelchairs will be posted at www.cms.hhs.gov/suppliers/dmepos. ■