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IN THIS ISSUE

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It's a good idea, but will it work? How to evaluate a new service

Look closely at market, staff, and management to predict success

As home health agencies prepare for success within a pay-for-performance environment, ideas for new services or redesigned existing services are popping up everywhere. Seminars, audio-conferences, and newsletters articles describe successful new services implemented by agencies throughout the country. Although these successes are thought-provoking and inspiring, experts interviewed by *Hospital Home Health* remind managers to evaluate a new service's potential for success from the perspective of their own agency, their marketplace, and their patient population.

Start your evaluation of a new idea by looking first at your ownership and your organization's financial goals, suggests **Jill Rumberger,** PhD, assistant professor of health administration at Pennsylvania State University at Harrisburg in Middletown. "A home health agency that is owned by a hospital may develop a service that is focused upon meeting the hospital's need to discharge certain patients as opposed to create a new source of revenue," she explains. "The most important focus for another agency might be a positive financial return in a specified amount of time," she adds.

Whatever objective you have for the new service, there are specific steps to take to evaluate the program's chance of success, says Rumberger. Although you want to evaluate the potential financial success of the program, the first three steps are not strictly financial, she points out.

1. Evaluate your market

"Is there a market for this service?" asks Rumberger. "This is the first question you should ask yourself," she says. Based on your current patient population, your community, and your referral services, look at who would use the service, she suggests. Is there enough demand for the service to guarantee a continuing patient base?

Don't forget to look at your competition in the marketplace, says Rumberger. "If another agency is offering the same or a similar service in the community find out how they are doing," she says. While the other agency may not share specific numbers and data on their pro-

gram, talking to mutual referral sources, peers in the agency, or other people in the community will give you an idea of what the other agency is doing and how well it is received. Even if another agency offers the same program, it doesn't mean that you should not proceed with yours, points out Rumberger. "

Competition can be a good thing because it means that there is a market for the service and one agency may not meet all needs," she says. "If there is a competitor in the marketplace, you have to determine if there is enough demand to justify two agencies offering the service, or you have to differentiate your service from the other service,".

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When management at the Home Nursing Agency in Altoona, PA, developed a chronic disease management program for cardiac and congestive heart failure CHF patients, cardiologists and surgeons in the area were consulted to find out what services would improve home care for their patients, says **Kim Kranz**, RN, MS, vice president of operations for the agency. "We were already caring for many of their patients but we knew we had to change the way we provided that care in order to reduce re-hospitalizations and visits to the emergency department," she explains. **(For more information about the agency's disease management program, see p. 76)**

Cardiac and CHF patients were chosen as the focus of the disease management program after reviewing OASIS data, points out Kranz. "We knew we had a large patient population with these diagnoses and we also knew that this group represented a large percentage of re-hospitalizations," she says. Talking to physicians gave Kranz a chance to find out what other agencies might be doing for cardiac patients and to find out what physicians thought about services that home care could add, she says. "It also made physicians aware that we were looking for ways to be proactive and produce better outcomes for their patients," she says.

Another part of your market analysis should include how you can leverage existing services and patients to promote the new service, says Rumberger. "How many current patients or their family members would be eligible for the new program? she asks. "We struggle to market ourselves in-home health agencies," she admits. "Word-of mouth advertising is so important, but we hesitate to tell our patients and families about new services," she says. Even if the patient or family member doesn't want to become a telehealth patient, they might tell someone else that your agency offers the program, she points out.

2. Scrutinize management

"Many times home health agencies will try to add a service for which no one on the management staff has experience," says Rumberger. Even if you have staff members who can provide the care, it is important to have someone managing the program who understands all of the business and clinical components, she explains.

Components of Kranz's disease management program include telehealth, improved patient education, focused staff education, and access to a pharmacist for consultation. All of these compo-

nents were in place at the agency so managers and staff members were familiar with them but the services had not been pulled together to address a specific patient population, says Kranz. "We had already invested in some telehealth equipment but we expanded the program to include all cardiac and CHF patients," she says. "We had also had a pharmacist available for consultation but that service was rarely used by home health nurses,". Because the agency had all of the individual services in place, in addition to management staff with cardiac care experience, there was no need to look for someone with experience for this program, she adds.

If you are looking at a new program for which you don't have management experience, look for someone to bring into your agency to manage the program, suggests Rumberger. While the expense of a new manager or a consultant will add to the initial cost of the program, it might be the key to ensuring long-term financial success for the program, she adds.

Experience with managing a nurse practitioner program also was helpful at Visiting Nurse Service of New York, admits **Joan Marren**, RN, MEd, operating officer of the agency. "Our agency has had a nurse practitioner [NP] program since 1998 but the NPs worked only with long-term care patients in our managed Medicaid program," she explains. In 2005, an NP was added to the home health staff as part of a program to improve assessment and care provided during the transition from the hospital to the home, she says. Because nurse practitioners were not new to the agency, managers understood the role of NPs, billing rules related to NPs, and the advantage of having access to an NPs' experience and training for all home health staff members who provided care to patients, she says. **(For more information about HHA's use of nurse practitioners, see p. 76)**

3. Review operations' requirements

The next step in reviewing a potential new program is to determine if your staff already have the key skill sets to provide the service, says Rumberger. "Is it a complex program that requires new skills your staff doesn't possess?" she asks. If the answer is yes, how easily can you find or train staff to provide the service? she asks.

"Most of our nurses already have medical/surgical or intensive care experience, so it was just a matter of additional staff education to improve their knowledge of cardiac or CHF patients," admits Kranz. Key points in staff education included facts that showed that visits alone didn't reduce re-hospitalizations for cardiac patients, but more frequent follow-up through phone calls and telehealth monitoring were effective, she says. Nurses learned what to ask and how to evaluate a patient in a phone conversation, so that nurses and patients were comfortable with this type of follow-up, she adds.

In addition to reviewing staff requirements for the program, look at equipment or supply needs as well, suggests Rumberger. Remember that supply or equipment maintenance costs must be built into the financial projections as ongoing expenses, she adds.

4. Project financial return

"The financial step is fun," says Rumberger. "Throughout all of the previous steps, you've identified what you need and what it will cost to get the specific equipment, staff, or training for the new program, so this final step is just compiling everything you've already collected" she says. At this step, you answer questions about what it will cost to equip and staff the program, as well as what it will cost to market and manage the program, she explains. "This is the step in which your operating budget is developed".

Also at this step you determine how long you think you will require to need a profit on the program, Rumberger points out. "Have a specific timeframe to present to your board so that they know to expect a one or three year period before profits are seen," she says. "If you negotiate those expectations upfront, you won't find yourself being told to shut the program down after only six months because administration or the board expected immediate profit"

If your new program is capital intensive and requires purchase of new equipment or extensive staff training, it will require a longer period of time to recoup investment costs, so be sure to give the program time to succeed, suggests Rumberger. At the same time, it is not a bad idea to build in a timeframe for review, she says.

"You can also plan to review the program's performance in six or 12 months to determine if it is performing as expected," says Rumberger. "If you find that outcomes have not changed, or expected reimbursement is lower than projected, you have an opportunity to identify problems and make changes," she says.

If your primary goal was something other than financial profit, quantify how you'll measure that outcome as well, she suggests. Specify

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how frequently you will report decreases in re-hospitalization, or visits to the emergency department, if that is your goal, she says.

Although your evaluation of a new program's potential for success should be orderly, thorough, and as accurate as possible, Rumberger has one warning; "We tend to stumble when we over think any new program". "

Once you've planned the specifics of the program and negotiated the financial issues with your board, go and implement it," she says.

Kranz agrees and admits, "I'm a risk-taker. Once I have the basic information I need, I trust my instincts and take a leap of faith." ■

NPs bridge gap between discharge and first visit

Transition and palliative care benefit from experience

(Editor's note: This is the first of a two-part series that describe how two different agencies use nurse practitioners in their program. This month, we look at the two programs and next month, we will evaluate reimbursement for nurse practitioner services as well as how to hire nurse practitioners.)

Making sure that patients are properly assessed by referral sources before they are discharged from a hospital is a continuing challenge for home health agencies. There are many times a home health nurse arrives at the home for the initial assessment visit to find that the patient's condition and needs were not accurately described or that the patient is not appropriate for home care.

To address this issue Visiting Nurse Service of New York is piloting a program that has a nurse practitioner visit the patient at the hospital to perform a pre-discharge assessment to determine level of care needed following discharge and proper placement, says **Joan**

Agency reduced re-hospitalization rate by 7%

Disease management program improves follow-up

The Centers for Medicare & Medicaid Services' (CMS) pay-for-performance initiative is making home health managers look closely at their outcomes to determine the best ways to improve performance in many areas.

When the management staff at Home Nursing Agency in Altoona, PA, noticed a 24% rate of re-hospitalization for cardiac and congestive heart failure (CHF) patients, they also recognized an opportunity to reduce the re-hospitalization rate by developing a cardiac disease management program. Less than two years later, the re-hospitalization rate dropped to 17%.

"We noticed that there was no difference in re-hospitalization for patients who received two visits per week compared to patients who received three visits per week, so we knew we had to look at issues other than number of visits," says **Kim Kranz**, RN, MS, vice president of operations for the agency. In order to improve the continuity of follow-up with the patient, a combination of telehealth and telephone calls from nurses was added to the protocol for patients with cardiac problems or CHF.

"We also improved our patient education materials to more clearly describe symptoms and their causes," says Kranz. By improving the patient education and reviewing it frequently, patients were able to better understand how things such as diet or fluid intake affected their condition.

Staff education sessions explored cardiac disease and CHF in more detail and focused on day-to-day activities that can improve a patient's outcome and avoid re-hospitalization, says Kranz. "Medication management is a critical issue for these patients so our nurses can call a doctor of pharmacy with whom we have an agreement for consultation," she says. Nurses generally call the pharmacist service when patients are on more than eight medications to determine what risks they may have and to ensure that the medications are not duplicates, she explains.

Pillboxes were purchased with funds from the agency's foundation to help patients better organize and manage their medications, says Kranz. "This is a simple tool we can provide to help patients," she adds.

Marren, RN, MEd. chief operating officer of the agency.

Nurse practitioners are not new to the agency. "We have nurse practitioners who work with our long-term, managed Medicaid patients but we saw a role for nurse practitioners in home care," says Marren. Not only were discharge assessments not always accurate, but also because hospitalists or clinic physicians see many of Marren's patients, there can be a significant gap between discharge from the hospital and the first follow-up visit in the clinic, she explains. To make sure that the patient is discharged to the proper community care and to bridge the gap before the first visit to the physician, nurse practitioners will visit the patient in the hospital. "The nurse practitioner evaluates the patient for risk factors that might result in re-hospitalization or a visit to the emergency department and identifies information that can be given to the family and the home care nurse to help avoid any decline in the patient's condition," she explains.

Although there is no guaranteed method to predict which patients might decline or be at risk for re-hospitalization, reviews of OASIS data have shown that patients who have been re-hospitalized previously, are taking a large number of medications, and have some type of altered functional status are at greatest risk, says Marren.

To address the risk that improper medication management poses, the nurse practitioner will review medications with the patient to make sure that the medication list is accurate, says Marren. "In our pilot program, we are seeing only patients who we have previously had in our care," she explains. "This enables us to take the last medication list we have to the hospital to compare the information collected by the hospital as well as add the new medications," she says. Because patients may not see a physician for as long as two weeks following discharge, the nurse practitioner can ensure that the medications are properly managed and that medication interactions or mistakes won't cause a decline or a re-hospitalization, she says.

While the nurse practitioner will "follow" the patient's care, he or she does not make the initial home care visit, points out Marren. The nurse practitioner's notes are more detailed and more complete than the typical discharge notes, so the home care nurse has more information with which to begin the assessment, she says. "The home care nurse makes the initial visit and completes the OASIS," she says. "If there are any questions, or the home care nurse notices a decline or change in the patient's condition, the nurse practitioner can be consulted by phone".

Because the nurse practitioner has seen the patient previously, he can help the home care nurse evaluate any changes, says Marren. "Home care nurses appreciate the extra set of eyes and ears as well as other ideas from someone who has a clinical perspective on the patient," she says. If necessary, the nurse practitioner will visit the patient at home, she explains.

During the pilot program the nurse practitioner is working with two teams that have an average daily census of 600 patients, says Marren. Of these patients, the nurse practitioner has seen about 120, or 20%, of these patients, she adds. "On average, the nurse practitioner makes one to two visits per day, then spends time communicating with physicians and home care nurses," she explains.

"We're fortunate that we have an integrated documentation system in the hospital that serves the area in which we're running this pilot program," says Marren. The integration means that the nurse practitioner's notes about the patient will be seen not only by the home care nurse, but also by the clinic physician who sees the patient for the follow-up visit.

NPs act as consultants for palliative care

Palliative care specialists often are found in hospice settings but the staff at Home Nursing Agency in Altoona, PA, discovered the need for palliative care consulting for physicians with chronically ill patients in the hospital.

"Hospitalists can call our palliative care consultants to work with families to help them make some of the difficult decisions or prepare to make them in the near future," says **Kim Kranz**, RN, MS, vice president of operations for the agency. Although the patients are chronically ill, they may not be at the point where they need hospice care, so Kranz does not use hospice employees for this position.

"We asked physicians who would be most likely to use the service what type of person they would be most likely to consult," explains Kranz. "They all agreed that they did not want a physician," she says. Because of the complexities of assessing a chronically ill patient and determining the best place for care as well as understanding the wide range of options for palliative care, Kranz decided to hire nurse practitioners or physician's assistants for the service.

The palliative care consultants visit with the patients and their families before discharge to assess their situation and help the family identify goals for moving their family member to the right agency for care, explains Kranz. Community resources that are available to help families are also discussed, she adds.

In addition to working with the family, the palliative care consultant advises the physician, says Kranz. Because the consultant focuses on palliative care, he or she is aware of different symptom control options of which a physician may not be aware, she adds.

In addition to strengthening the relationship between hospitalists and her agency, Kranz points out that this service is a real benefit to patients and their families. "We make sure that the patient receives the right care at the right time and we offer options that help the patient and family manage their quality of life." ■

SOURCE

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Get creative in dealing with long-stay patients

Tertiary care hospital frees beds for other acute cases

Through the efforts on an interdisciplinary team, the University of Wisconsin Hospitals and Clinics has been able to shrink the number of patients who remain in the hospital for 30 days or longer from an average of 60 or 70 in-house each day to an average of 20 or fewer.

As a tertiary care hospital, the University of Wisconsin Hospital receives patients that need specialized care from other hospitals all over the state. Many of the long-stay patients are trauma patients with complex head injuries or patients who have undergone transplants.

In the past, many of the patients have stayed at the University of Wisconsin Hospital for 30 days or longer even though they no longer needed specialty care, says **Barbara Liegel**, RN, MSN, director of coordinated care for University of Wisconsin Hospitals and Clinics in Madison.

Now, following a series of initiatives aimed at improving throughput, the hospital transfers many of the patients back to the referring facility after treatment or finds creative discharge solutions in the community.

"The level of acuity of the patients we treat is what turns many patients into a long-term stay patient; but keeping them for long lengths of stay impacts our capacity. It's not that we don't want these patients, but we have to open up beds so we can continue to serve patients with specialized needs," Liegel says.

A multidisciplinary team meets weekly to discuss patients with the potential for a long stay and looks for solutions. The team is chaired by case management and social work and includes representatives from admissions, the therapy staff, the legal department, physicians, palliative care, and the access center team, the hospital department that is accountable for admitting patients from referring hospitals.

"By participating on the committee, the access center staff learn what happens if a patient is not appropriate. Having them on the team makes them aware of the challenges with patients who are difficult to place," she says.

The team began by identifying the types of patients whose stays exceeded 30 days so that everyone in the organization would recognize the type of patients whose care needs to be managed, Liegel says.

At the recommendation of the team, the hospital updated all of the hospital transfer agreements with referring hospitals so that when the patient's tertiary care needs are completed, he or she is transferred back to the receiving hospital.

"Even on admission we talk to the transferring hospital and let them know that when we finish meeting the specialized needs of that patient, we are going to transfer them back," she says.

Holding referring hospitals accountable

In the past, many of the patients transferred for specialized care ended up staying at University of Wisconsin Hospital, Liegel says.

"We've done a fair amount of push-back. Some

of the facilities don't want these patients back because they are hard to place. With the support of our senior management and the contracting team, we're holding our partners accountable for their patients. We tell the referring hospitals that we need to free up beds so that we will be here for them when they have a complex case," she says.

At the weekly meeting, the case management team gives a brief summary of each patient's status, including whether he or she still is meeting acute care criteria, and discusses the problems with discharge planning.

The entire team brainstorms to find solutions to the challenges the hospital faces in placing the patients. The team typically discusses patients who have been in the hospital 20 days or longer.

However, sometimes staff members may bring up patients with shorter stays who have the potential to become long-stay patients.

"Being in the hospital for days and days isn't the only solution. There are several kinds of alternative managed care home care situations in our city for young disabled patients and one for the elderly. They provide assistance with our creative care planning," Liegel says.

LTAC provides more discharge options

The opening of a new long-term acute care facility (LTAC) in Madison has given the hospital another option for discharge, she says.

"This has made it easier to discharge patients to an acute care facility that provides care and support for patients requiring prolonged hospitalization," she adds.

Before the facility opened earlier this year, the closest LTAC was more than an hour away, which put a burden on families whose loved ones were discharged there, she adds.

"We struggle with placement. The long-stay patients are quite complex. We have established a good relationship with the local nursing homes so we can help support patients who are appropriate at the nursing home level of care," she says.

The hospital often continues its support for complex patients after they have been discharged to a skilled nursing facility. "Once a patient goes to a skilled facility, we help problem solve and support the patient at that level of care. We are working with the skilled nursing facilities to elevate the level of care they can provide," she says.

The case managers often look for creative referrals for placement of some of the long-stay patients who no longer need an acute level of care.

"If the patient meets community care criteria, we have a case manager who works with the physician and nursing team to put a creative plan into place. A creative approach to discharge allows us to bring in a paying patient to fill the bed," she says.

For instance, a young woman from Illinois was transferred to the hospital after an automobile accident and needed to be on bed rest for six to seven weeks. She couldn't return home because she lived alone. She had no insurance. The hospital was able to place her in a group home and send out a home care agency to take care of her needs.

"She doesn't need an inpatient level of care and doesn't need a nursing home. Our choices were to leave her at the hospital for six weeks until she's ready to go to rehab or home or to look for a place in a less intensive setting," Liegel says.

The patient's workers' compensation company agreed to pay for her stay in the group home.

"Even if we don't get reimbursed for home care or durable medical equipment, it's more economical to pay for these patients to be in a less costly setting and open up the bed for paying patients who have acute care needs," she says.

The hospital's home care program has a home ventilator program that is an option for many patients on ventilators.

"If a patient has any chance of going home on a vent, we pull them into the program. We still need to set up home nursing and sometimes 24-hour nursing care is hard to find," she says.

Discharging to home

The team came up with a creative discharge plan for a long-term ventilator patient who was terminally ill. The woman wasn't competent to make health care decisions anymore, and her guardian didn't want to remove the vent in the hospital because she had promised the patient that she would make it possible for the woman to die at home.

"We sat around as a team and made the recommendation that we would arrange for transport home, support her at home, and disconnect the ventilator at home," Liegel says. Planning her discharge to home extended the patient's stay to well more than 30 days.

The committee arranged a family meeting and found a primary care physician in the community who was willing to go into the home. They arranged a home respiratory therapist and hospice care.

"It was a very creative solution to a unique situation," Liegel says.

The long-stay committee was developed as part of a far-reaching initiative aimed at improving throughput and increasing inpatient capacity. The average length of stay has dropped by more than a day since the initiative began in 2002.

Even with the more acute patients, the University of Wisconsin Hospital's average length of stay of 5.4 days compares favorably with a local community hospital with a length of stay just above four days.

"They have obstetrics, which typically means short-stay patients, and we do not," Liegel says. ■

Home visits help members avoid preterm births

Program saves $2.80 for every $1 spent

A combination of telephonic case management and home visits has helped Optima Health decrease preterm births and low-birth-weight infants.

Optima Health estimates that it has saved $2.80 for every dollar spent on its award-winning Partners in Pregnancy program and has avoided nearly 3,000 days in the neonatal intensive care unit since the program began in 2002.

Optima Health, the health plan division of Norfolk, VA-based Sentara Healthcare, established the program to promote healthy pregnancies and reduce premature births for both its Medicaid and commercially insured populations.

The high-risk population includes both Medicaid and commercial members, often for different reasons, says **Karen Bray**, PhD, RN, CDE, vice president, clinical care services.

"The Medicaid members often have financial and social issues. In our area, we have a renowned in vitro fertilization program and we are managing the care of a number of older women in the commercial population who are carrying multiple babies," she adds.

The health plan partners with Virginia's Comprehensive Health Investment Project (CHIP) to conduct home visits to assess the needs of hard-to-reach members and to follow them through the pregnancy if needed.

'We rarely miss a pregnancy'

The majority of members in the program are identified when their physicians send in authorization forms for obstetrical services. Members can self refer or physicians can directly refer them. In addition, the health plan scans its claims database regularly to identify members who have had positive pregnancy tests.

"We rarely miss a pregnancy," Bray says.

As soon as the plan identifies a member who is pregnant, the information is automatically transmitted to the Partners in Pregnancy team.

Women who are likely to be at risk for problems during the pregnancy, such as very young women, older women, and women with a history of problems in pregnancy automatically are assigned to a case manager who calls them and conducts a detailed risk assessment over the telephone.

Low-risk pregnant members are assigned to patient service coordinators, who contact the member, conduct the risk assessment, and determine whether the woman should be referred to a case manager.

The patient service coordinators and case managers make monthly telephone calls to the women throughout the pregnancy, talking to them about how things are going, and conduct serial risk assessments to screen the members for problems with the pregnancy.

"The patient service coordinators and case managers can increase the frequency of the telephone calls if the members request it or if they feel the member would benefit," Bray says.

When the case managers or patient service coordinator can't get in touch with a pregnant woman who lives in an area with a high incidence of low-birth-weight babies, Optima calls on its community partner, CHIP, to locate the members and conduct a risk assessment.

If the member is at high risk for complications of pregnancy, CHIP continues to provide home visits by nurses and other outreach workers, if appropriate.

Contracting with home health

In areas where there are no CHIP programs, Optima contracts with home health agencies to provide specific services.

The case managers can also call on CHIP if they have concerns about the situation in a pregnant member's home.

"In these cases, the case manager feels that a more thorough evaluation of the home situation may help to determine the risk level," she says.

CHIP lay workers and nurses who visit the

home evaluate the home condition, family's financial and social issues, and the stress level of the mother-to-be.

"We know that stress seems to be a factor in low-birth-weight infants. Some of these members are at risk of losing their home or have terrible family problems. We get them in touch with community social services and have gone so far as to intercede with landlords who were trying to evict a family," Bray says.

CHIP services include transporting women to medical appointments, connecting them with substance abuse programs, teaching them how to care for their infants, and connecting them to social services agencies that can provide assistance. The case managers follow the members throughout their pregnancy, making sure they receive the standards of care, such as regularly seeing the physician. They help the women manage any complications or comorbidities, such as gestational diabetes or hypertension, and educate them about community services that are available if appropriate.

For instance, poor dental health can adversely affect a pregnancy.

"Many women don't realize that the condition of their teeth can affect their baby. We send them toothbrushes and toothpaste and refer them to a dental provider if needed," she says.

The health plan sends out regular packets to the mothers with information about pregnancy and a small gift. For instance, the stress management packet includes information about how to deal with stress and a bottle of lotion.

T-shirts, water bottles, diaper bags, and a book about baby's milestones are other gifts that the members receive as long as they are in the program and talk regularly to the case manager or patient service coordinators.

The Partners in Pregnancy program has won numerous awards including a national award from the Disease Management Association of America. ■

CM program keeps preterm delivery rate low

Doulas pitch in when moms-to-be need extra help

A program that targets women at risk for premature deliveries for case management has paid off for ConnectiCare, a regional HMO based in Farmington, CT.

ConnectiCare's preterm delivery rate (babies born before 37 weeks) ranges from 7.8% to 6.5% compared to national rates of 11.3% to 12.7%.

In 2006, ConnectiCare's low-birth-weight rate (less than 5.5 pounds) was 6.8% compared to a national average of 8.2%.

"It's hard to compare our statistics year by year because every nine months, there's a whole new set of people with a whole new set of risk factors. One year, we may have a preponderance of women with preterm deliveries and the next year, a large number of multiple births," **Maggie Perracchio**, RN, program manager and nurse case manager for the ConnectiCare's Birth Expectations program.

ConnectiCare's Birth Expectations program was developed in 1995 to help women identify signs and symptoms of preterm labor, the primary cause of pre-term births.

Women identified in risk assessment

Women are identified through a risk assessment form that asks for medical history, including chronic conditions, such as hypertension and diabetes that may put them at risk for a preterm delivery. Other risk factors include an incompetent cervix, a history of preterm births, or multiple births.

When physician offices precertify pregnant women with ConnectiCare, the health plan mails the members a risk assessment to fill out and return.

"Many of the physicians fill out the risk assessment and they alert us when there are risk factors so we don't have to wait for the member to return the assessment," Maggie Perracchio says.

If a woman hasn't returned the survey by the time she's 23 weeks pregnant, ConnectiCare sends another survey. And the health plans sends another survey to pregnant members at 23 weeks to find out if anything has changed.

"Sometimes someone might find out later in the pregnancy they are carrying twins or that they are having issues with their cervix that could put them at risk for a preterm delivery," she says.

In 2006, the health pan completed a risk assessment on 91% of all women precertified for maternity benefits.

Once a member is identified as having a risk factor for a preterm delivery, Perracchio makes an outreach call.

"My goal is to educate them regarding what to

expect, what to watch for, and what to report to their physician. I can't prevent anyone from going into preterm labor but I can educate women with potential risks about the early signs and encourage them to seek medical care," she says.

When a physician determines that a woman needs to be on complete bed rest in order to have a full-term delivery, the health plan may offer the services of a doula if the woman has small children at home or otherwise needs extra help.

Doulas are women who provide physical and emotional support to women before and after childbirth. ConnectiCare contracts with a doula service to provide doulas for a certain number of hours a day, depending on the needs of the mother.

"If a woman is the primary caregiver of a toddler, there's no way she can stay in bed. We live such fragmented lives that we don't have support from mothers or sisters who live nearby like we used to. That's where the doulas come into play," Perracchio says.

"We want to make sure our pregnant members have the physical and emotional support they need to have a healthy pregnancy with a good outcome," Perracchio adds.

The frequency with which Perracchio calls the members depends on what the women need. Some members in the program don't need much reinforcement. Others need to be called frequently, she adds.

She advises them on the importance of nutrition and healthful habits and encourages the diabetic members to follow their diet and take their medications in order to avoid being hospitalized for complications of pregnancy.

"My job is to make sure they know what symptoms to look for that may be a sign of problems and when they should call their physician. Women are sometimes reluctant to bother their doctor but I tell them it's better to find out they're OK than to wait until they have to be hospitalized," she says.

At 22 weeks

When the women in the program are 22 weeks along in their pregnancy, Perracchio may increase the frequency of contact, depending on what is happening with the member and the pregnancy.

"Sometimes I follow up to talk about the results of their last appointment. Sometimes when we are talking they'll bring up something that happened and I may tell them to ask the doctor or at the next visit or to call right away," she says.

The plan also covers post-partum doulas as part of its early-discharge program. If members opt to stay in the hospital for a shorter period of time than their coverage will pay for, ConnectiCare will provide a doula to help out with the children, prepare meals, do grocery shopping, or take care of other household tasks so that the mom can rest and take care of the baby.

"Some women like to leave the hospital early when they can have additional support at home," she says.

The post-partum doula program is available to all pregnant members, not just those at risk for complications of pregnancy. Members call ConnectiCare to sign up for the benefit.

"We don't do outreach for this program. All pregnant members get mailings during the course of the pregnancy with information about all the services available to them. This program is not limited to members in case management," Perracchio says. ■

NEWS BRIEFS

CMS awards grants for nursing home alternatives

Thirteen states and the District of Columbia will get more than $547 million in grants over

COMING IN FUTURE MONTHS

- Accreditation issues that present greatest challenges
- Tips to retain high quality rehab staff
- HIPAA update
- How do PPS changes affect your agency?

five years to build Medicaid long-term care programs that will help keep people at home and out of institutions, says **Leslie V. Norwalk**, acting administrator of the Centers for Medicare & Medicaid Services (CMS).

The five-year demonstration project is designed to evaluate the effectiveness of programs that shift Medicaid's traditional emphasis on institutional care to a system offering greater choices that include home and community-based services.

Grants were awarded to: Delaware, District of Columbia, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, New Jersey, North Carolina, North Dakota, Oregon, Pennsylvania, and Virginia. These states expect to be able to move more than 14,000 people into community settings using these grant awards.

States receiving grants will design programs with four major objectives:

- Increase the use of home and community-based, rather than institutional, long-term care services;
- Eliminate barriers or mechanisms that prevent Medicaid-eligible individuals from receiving support for appropriate and necessary long-term services in the settings of their choice;
- Increase the ability of the state Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to move from an institutional to a community setting; and
- Ensure that procedures are in place to provide quality assurance for individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

All states were eligible to participate in the five-year demonstration program and had to commit to provide demonstration services for at least two years.

For more details about the New Freedom Initiative, of which this demonstration is part, visit the CMS web site at: www.cms.hhs.gov/newfreedom/. ■

HHS provides web site on HIPAA privacy rule

The Department of Health and Human Services (HHS) has developed a new web site

CNE *questions*

13. When marketing a new service, to what group do home health agencies typically forget to promote the service, according to **Jill Rumberger** PhD, assistant professor of health administration at Pennsylvania State University?
    A. Payers
    B. Referral Sources
    C.Current patients
    D.Staff members

14. By how many percentage points did Home Nursing Agency in Altoona, PA, reduce the re-hospitalization rate in the first year of its cardiac disease management program, according to **Kim Kranz**, RN, MS, vice president of operations?
    A. 3
    B. 7
    C. 9
    D.12

15. How do nurse practitioners improve care and reduce re-hospitalizations at the Visiting Nurse Service of New York, according to **Joan Marren**, RN, MEd?
    A. By completing OASIS before hospital discharge
    B. By communicating with payers
    C. By reviewing physician notes before admission to home health
    D. By bridging the gap between discharge and first physician visit.

16. In 2006, ConnectiCare's preterm delivery problem completed a risk assessment on 81% of all women precertified for maternity benefits.
    A. True
    B. False

Questions in February issue should have been numbered 17-20, March 21-24, April 1-4, and May 5-8.

Answer Key: 13. C; 14. B; 15. D; 16. B.

that provides information on enforcement of the Health Insurance Portability and Accountability Act (HIPAA) privacy rule.

The site gives consumers and healthcare providers information on HHS activities, results, and guidelines for enforcing the rule.

Additionally, the site provides information on consumers' rights to access their health information and their control of how their personal information is used or disclosed.

The site offers access to case studies by issue, such as lack of safeguards, and by covered entity. To view HHS' new web site, go to www.hhs.gov/ocr/privacy/enforcement/. ■

CNE objectives

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

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

CNE instructions

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

Dear *Hospital Home Health* Subscriber:

This issue of your newsletter marks the start of a new continuing nursing education (CNE) semester and provides us with an opportunity to review the procedures.

Hospital Home Health, sponsored by AHC Media LLC, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options and physician office practices. Our intent is the same as yours - the best possible patient care.

The objectives of *Hospital Home Health* are to:
• identify particular clinical, ethical, legal, or social issues pertinent to home health care;
• describe how those issues affect nurses, patients, and the home care industry in general; and
• describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices.

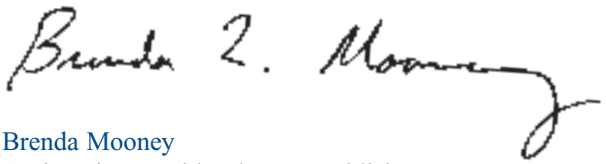
Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You can then compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form we will mail you a letter of credit. This activity is valid 24 months from the date of publication. The target audience for this activity is nurses, managers, directors, and management involved in hospital-owned home care agencies, including health care professionals involved with home care issues such as end-of-life care, pain management, multicultural issues, elder care, and similar issues.

If you have any questions about the process, please call us at (800) 688-2421, or outside the U.S. at (404) 262-5476. You can also fax us at (800) 284-3291, or outside the U.S. at (404) 262-5560. You can also email us at: customerservice@ahcmedia.com.

On behalf of AHC Media, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,



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