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IN THIS ISSUE

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No crystal ball needed; study to help predict pressure ulcers

OASIS data will help with early intervention, better outcomes

The cost of treating pressure ulcers is estimated at $9 billion per year and the cost for care for home health patients with pressure ulcers is 36% more than the cost of caring for home health patients without pressure ulcers.[1] One of the reasons for the increased cost is increased need for nursing visits: Patients with pressure ulcers require between one and two more nursing visits per week.[2]

"Add the cost of treating pressure ulcers in the home to the cost of re-hospitalization that many pressure ulcer patients receive, and this is definitely an issue to which home health agencies should pay attention," says **Sandra Bergquist-Beringer,** RN, PhD, CWCN, assistant professor, School of Nursing, University of Kansas who is a researcher on this topic. With re-hospitalization, a key component of Home Health Compare and a key factor in outcomes for pay for performance, it is important to address pressure ulcers before they develop or before they become too difficult to treat in the home, she says.

A collaborative study between Bergquist-Beringer and Cerner BeyondNow, a Kansas City, MO-based home care information technology company, is designed to help home health agencies predict which patients are most likely to develop pressure ulcers. "If we can more accurately identify patients at risk for pressure ulcers, we can initiate prevention strategies at the beginning of care," says Bergquist-Beringer.

A data extraction tool that relies on OASIS items commonly associated with pressure ulcer development has been developed and home health agencies are being recruited to participate in the study. "We begin data collection in the next year," says **Kim Wipf,** RN, BSN, CCRN, solution manager at Cerner BeyondNow. Two agencies participated in the pilot study and there are four agencies signed up for the more comprehensive study, she says. The only requirement for participation is the utilization of BeyondNow software, she adds. The goal is to collect information on 10,000 separate patients with unduplicated admissions.

Data collected in this part of the study will be used to develop more accurate prediction of pressure ulcer risks and identify effective inter-

ventions, says Bergquist-Beringer. "Pressure ulcers are not only extremely painful but they lead to other conditions such as depression, osteomyelitis, cellulitus, and frequently, re-hospitalization," she adds.

Previous research has shown that urine or stool incontinence, altered levels of activity, recent discharge from an institutional setting, and functional impairment are associated with pressure ulcer development, says Bergquist-Beringer. "Although the Braden Scale is often used to predict pressure ulcers in an institutional setting, very few studies have evaluated its effectiveness in home health," she adds. Her current study will see if use of OASIS data, along with tools such as the Braden Scale, is more effective. "We hope to identify other factors that contribute to increased pressure ulcer risk as well," she adds.

"The unique aspect of this study is that it focuses only on home health," points out Wipf. Home health nurses will use their point-of-care technology to input OASIS information and the system will alert them to the patient's increased risk for pressure ulcers, she explains. "The system will also suggest appropriate interventions," she adds.

Traditional interventions for pressure ulcers include:

- risk assessment upon admission;
- pressure redistribution, including the use of support systems and regular turning of patient;
- improvement of activity and mobility;
- nutritional support;
- reduce friction;
- improved education for patient and family.

Of these traditional interventions, nutritional support is key to prevention and treatment of pressure ulcers, says Bergquist-Beringer. While all of these interventions can be effective, home health agencies did not always apply them consistently, she admits. Another item that Bergquist-Beringer will be looking at during the study is identifying best practices that can be shared with other agencies. "If some agencies are successful at improving nutritional support or achieving patient and family compliance for repositioning, descriptions of how they accomplished these successes will help everyone," she says.

Data collection for this study is scheduled to last two years, with analysis of the data following, says Wipf. This is a good time to focus on pressure ulcer treatment, she says. "In previous research, many agencies did not have policies

SOURCES

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and procedures for thorough skin assessment, but with OBQI and pay-for-performance requirements, agencies are now developing these strategies to prevent complications such as pressure ulcers and re-hospitalizations."

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2. Huang L, Rosati R, Ptaszek A. Utilization of skilled nursing visits among home health care recipients with pressure ulcers. Abstr Acad Health Serv Res Health Policy Meet 2002; 19:7. ■

Offer wide scope of responsibility to attract NPs

Reimbursement covers costs of NPs

(Editor's note: This is the second of a two-part series that describes how two agencies use nurse practitioners in their program. Last month, we looked at services provided by the two programs, and this month, we evaluate reimbursement for nurse practitioner services as well as how to hire nurse practitioners.)

The challenges faced by home health managers when hiring nurse practitioners are many of the same challenges faced when hiring home health nurses. While it takes time and effort to find the right person, a nurse practitioner can add an extra level of service within your agency, according to experts interviewed by *Hospital Home Health*.

Physicians surveyed prior to the start-up of a palliative care consulting service offered by her home health agency indicated that while they wanted someone with a high level of assessment skills, they preferred not to work with a physician, says **Kim Kranz**, RN, MS, vice president of operations at Home Nursing Agency in Altoona, PA. The palliative care consultant works with physicians, hospital staff, and families to suggest symptom control methods, identify goals for the patient's future care, and help families make difficult decisions regarding their family member.

Although palliative care is common in a hospice setting, Kranz wanted a nurse practitioner who was not a hospice employee. "Not all of the patients seen by our consulting service are ready for hospice, so I did not want patients and their families thinking that we were suggesting hospice," she says.

Because the palliative care consultant is talking with patients and family members about sensitive, emotional issues, it is important that the person is compassionate, as well as knowledgeable, and able to talk to people in difficult situations, says Kranz. "The nurse practitioner also needs to be able to communicate with the physician at a different level as well," she adds.

Just as the shortage of experienced home health nurses makes it difficult to add staff, there also is a shortage of nurse practitioners, says **Joan Marren**, RN, MEd, CEO of the Visiting Nurse Service of New York. "I believe that there are a lot of nurse practitioners who would like to work with home health agencies, but we have not had a lot of openings for them, so they probably don't consider it a career option."

For Marren's service that has a nurse practitioner visit the patient in the hospital before discharge and at home before the first physician visit if needed, the requirements included community health experience and experience as a nurse practitioner. Just as she would not hire a new graduate to make home health visits without prior nursing experience, Marren wants nurse practitioners who are accustomed to working independently.

You also need to develop the job description to appeal to nurse practitioners, says Marren. "Nurse practitioners are interested in jobs with a wide scope of responsibilities for which they can make use of their nurse practitioner skills," she says. "They are interested in a collaborative practice and salary and benefits do play a part in their decisions."

SOURCES

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Nurse practitioners can be reimbursed under Medicare Part B, points out Marren. "As long as their activities are substitutes for physician services, you are reimbursed," she says. For example, visits to the patient to conduct medical assessment, manage a health condition, or provide intervention are all legitimate, she adds. "A telephone consultation or a conversation with a home health nurse to discuss a patient are not billable," she says.

Because the reimbursement falls under Medicare Part B guidelines, your billing department must have the correct forms to file and everyone needs to understand the documentation requirements, says Marren. "There are different requirements for nurse practitioner documentation and home health nurse documentation, so there is education involved," she adds.

While some activities or some costs may not be fully reimbursed, the nurse practitioner does offer other benefits to a home health agency, says Marren. "Our re-hospitalization rates have dropped since we implemented our nurse practitioner house calls program, and physicians have been very happy with the service," she says. "The physician satisfaction and the improved outcomes have resulted in more referrals to the agency." ■

Communication and falls top the list of challenges

Do not use abbreviations prove to be tough habit to kick

(Editor's note: This is the first of a two-part series that discusses the most challenging Joint Commission standards for home health agencies. This month, the top two challenges, standards for which agencies are cited 28% of the time, are discussed along with tips for compliance. Next month, five more challenging standards will be discussed.)

Compliance with Goal 2 of the National Patient Safety Goals, which calls for the improvement of effective communications among caregivers, dropped to 72% in 2006 from 76.8% in 2005.

Home health is not the only health care industry that struggles with this goal, says **Carol Mooney**, RN, MSN, senior association director of the standards interpretation group for The Joint Commission. "The most frequent reason for noncompliance with this goal is the use of do not use abbreviations," she says.

Eliminating all do not use abbreviations is difficult because it requires a behavior change for many staff members, Mooney admits. "We all learned to use certain abbreviations in our education and throughout our years in health care, so these are habits that are hard to break," she says. Staff education and ongoing reminders are the key to successfully meeting this goal. (For tips on educating staff, see "Sharpen your pencils: Nurses writing more as abbreviations disappear," *Hospital Home Health*, March 2004, p. 25.)

The second compliance challenge for home health agencies is Goal 9 of the National Patient Safety Goals, which requires agencies reduce the risk of patient harm resulting from falls. "This goal was cited in 28% of surveys," says Mooney.

SOURCES

For more information on Joint Commission standards, contact:

• Joint Commission Standards Interpretation Group, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181. Phone: (630) 792-5900. Web: www.jointcommission.org. To submit a question by e-mail, under "Standards," click on "Standards FAQs." Select "Click here to go to the Standards On-line Question Submission Form."

To view a full copy of the 2006 National Patient Safety Goal compliance data, go to www.jointcommission.org. Choose "Patient Safety" on the top navigational bar and then click on "National Patient Safety Goals." Scroll down the page to "Additional Resources" on the right and choose "NPSG 2006 Compliance Data." Also located on the National Patient Safety Goals page are FAQs related to specific goals, including falls reduction programs; a "do not use" abbreviation list; a list of look-alike, sound-alike medications; and implementation tips for standardizing abbreviations.

For advice and information about falls prevention among the elderly, go to: www.temple.edu/older_adult/fpp manual.html.

For copies of reports and presentations related to the Missouri Alliance of Home Care Falls Reduction project, go to www.homecaremissouri.org and click on "Bench mark Projects" on the right navigational bar, and then choose "Falls Reduction."

"Most home health agencies conduct a falls risk assessment and always look at the safety of the home environment, but this goal requires that agencies evaluate the number of falls, types of assessments, and interventions that occur to reduce falls," she explains. (For information on falls prevention, see "Help your elderly patients prevent falls," *Hospital Home Health*, May 2005, p. 56, and "How do you rate? Benchmark study identifies frequency, causes of falls," *Hospital Home Health*, August 2005, p. 85.)

Even though noncompliance with this goal was cited at a high rate, Mooney says that many agencies are addressing these issues informally. "Agencies must have policies in place to address assessment and intervention," she says. In addition to a home environment assessment, nurses should evaluate medications or impaired cognitive function that might increase risk of falls, she says.

In addition to policies that address the risk of falls, agencies should evaluate data on falls within their agencies at least once or twice each year, suggests Mooney. Unlike the patient goal related to falls in previous years, this goal requires agencies not only implement a falls reduction program, but also monitor the program's success, she says.

"Look at different populations and the different risks they may have," she says. For example, not all home health patients are elderly, she points out. "Some infusion patients are as young as 40 and your agency may also care for pediatric patients," she says. "Each of these populations has different types of risk." ■

States contracting with SNPs for Medicaid benefits

Under terms of the 2003 Medicare Prescription Drug, Improvement, and Modernization Act, Medicare Advantage plans can specialize in serving Medicare beneficiaries who are dually enrolled in state Medicaid programs, are residents of nursing facilities or similar institutions, or who have severe or disabling chronic conditions. Plans that take on these roles are known as special needs plans (SNP).

Several states have taken advantage of Medicare's SNP option to negotiate contracts with the plans to include Medicaid benefits for dually eligible individuals enrolled in such plans. In 2005, according to a Center for Health Care Strategies report, at least 42 SNPs in 13 states were providing Medicaid managed care to dual-eligible enrollees.

Report author **James Verdier,** of Mathematica Policy Research, says such arrangements are worth doing if a state is providing Medicaid long-term care in a managed care setting or plans to do so in the future. "The ability to coordinate long-term care in Medicare and Medicaid is the key," he says.

According to Verdier, when state officials look at the services and funding streams from both programs together, rather than in their separate silos, they are better able to identify opportunities for better integrating care. "Integrating care for dual-eligible beneficiaries can significantly improve beneficiary care and can also be a major asset for public purchasers like Medicaid and Medicare and for SNPs," he says. "Integration can be achieved by focusing on acute care benefits that both Medicare and Medicaid support, or more comprehensively by also including Medicaid's long-term care benefits. With a comprehensive integrated benefit package, purchasers and plans can focus on more effective ways to integrate care and on designing service delivery systems that help beneficiaries get the right care in the right setting, rather than worrying about who pays how much for which piece of care."

States wanting to contract with SNPs to cover Medicaid services have a number of options, he says. A threshold question is whether there are SNPs in the state that are interested in contracting with Medicaid and are qualified to provide the services for which the Medicaid program wants to contract. SNPs that cover exclusively dual-eligibles are most likely to be interested, he says, while institutional and chronic condition SNPs, which also cover those who are not dually eligible, may be less interested because of the potential extra complexity of having different benefit packages for dual and nondual enrollees.

Assuming there are interested plans, Verdier says, states can contract with SNPs and other Medicare Advantage plans to cover a variety of Medicaid services. He lists options in order of contracting complexity apt to be involved, with the least complex and comprehensive Medicaid coverage listed first:

1. Medicare premiums and beneficiary cost-sharing that Medicaid is required or chooses to pay for dual-eligibles and others enrolled in Medicare Savings Programs;

2. Prescription drugs excluded by the Medicaid

Modernization Act from Part D but still covered by Medicaid;

3. Acute care services not covered or only partially covered by Medicare, such as vision, dental, hearing, durable medical equipment, transportation, and care coordination;

4. Behavioral health services not covered or partially covered by Medicare;

5. Comprehensive case management and personal care services;

6. Medicaid long-term care services not covered by Medicare such as nursing facility, home health, and home- and community-based services.

Apart from the issue of which services to include, Verdier says, there are issues relating to the different types of Medicare and Medicaid contracting that are feasible and the Medicare and Medicaid rules that apply.

As states enter into more detailed discussions with SNPs on potential contracting for Medicaid services, several specific payment rate and contracting issues that relate to areas of overlap between Medicare and Medicaid may be relevant to consider, Verdier says. Those areas include:

1. **Medicare cost-sharing.** Medicaid is not required to make Medicare cost-sharing payments directly to plans, and the cost-sharing payments Medicaid makes either to plans or providers may be limited by the amounts Medicaid would pay for the service, even if Medicare payments are higher. Thus, many states may be able to offer significant benefits to SNPs by agreeing to pay these cost-sharing amounts directly to the plan in the form of upfront capitated payments, which could lead to administrative efficiencies for states, plans, and providers.

2. **Drugs excluded by statute from Part D coverage.** The excluded drugs that Medicaid still covers are usually lower-cost generics and are most valuable to beneficiaries as part of a broader care package. Verdier says Medicaid programs could achieve administrative efficiencies and improve beneficiary care if they contracted with SNPs to cover these drugs as an additional no-cost benefit, or with an appropriate upfront capitated payment to cover any additional cost.

3. **Sharing data on prescription drug utilization.** States have an interest in obtaining information on prescription drug utilization by dual-eligibles for care coordination and quality monitoring, especially when Medicaid remains responsible for most of the cost of care for dual-eligibles, such as home- and community-based services and long-term nursing facility care. SNPs have an interest in obtaining information on prior drug use by new dual-eligible enrollees, which states are likely to have for disabled Medicaid beneficiaries younger than age 65 who are emerging from the two-year waiting period for Medicare coverage or Medicaid beneficiaries approaching age 65. Arrangements for sharing these kinds of data could be a topic for contracting discussions between states and SNPs, Verdier says.

4. **Acute care services not covered by Medicare.** Medicaid covers some acute care services that Medicare does not cover or covers less extensively, such as vision, dental, hearing, durable medical equipment, transportation, and care coordination. Verdier says these Medicaid benefits are generally not very costly and probably could be handled more efficiently for dual-eligibles if Medicaid contracted with Medicare SNPs for the services. They could be funded either as an additional no-cost benefit offered by the SNP, if there are savings under the Medicare Advantage capitation payment, or through additional capitation payments provided by Medicaid.

5. **Mental health services.** Medicaid coverage of mental health services is much broader than Medicare's. The report says about half of disabled dual-eligibles younger than age 65 have significant mental health problems and are heavy users of costly antipsychotic and antidepressant medications. They also are likely to be heavy users of Medicare-funded inpatient hospital and emergency department services. Including Medicaid mental health services in an SNP benefit package would provide a more integrated and comprehensive benefit package that could help reduce overall costs for dual-eligibles with mental health problems by providing a broader range of less costly services such as targeted case management, rehabilitation services and community mental health center services, that could reduce use of costly inpatient hospital and emergency department services and improve care for beneficiaries over the longer term.

6. **Comprehensive case management, personal care services, care coordination, and Medicare Advantage supplemental benefits.** Medicaid coverage of care management and personal care services is substantially broader than Medicare's, so including all or some of these Medicaid benefits in the SNP benefit package would make more resources available to improve care coordination between Medicare and Medicaid, Verdier says.

7. **Prescription drug use in nursing facilities.** Because many SNPs and Medicare Advantage

plans have little experience in managing prescription drug use in nursing facilities, Verdier suggests they could benefit by partnering with Medicaid to help manage the Part D benefit in nursing facilities, especially since Medicaid is responsible for non-drug nursing facility services for dual-eligibles after the short-term Medicare skilled nursing facility benefit ends. He says such data-sharing and partnership could help lay the groundwork for inclusion of Medicaid-funded nursing facility services in the SNP benefit package.

8. **Medicaid nursing facility, home health, and home- and community-based services.** The broadest integration of Medicare and Medicaid benefits within SNPs, Verdier says, would be to include Medicaid nursing facility, home health, and home- and community-based services in the SNP benefit package. Doing that, he says, would achieve the ultimate goal of fully integrating Medicare and Medicaid acute and long-term care services in a single managed care benefit package. Because Medicare coverage of long-term care benefits is limited, adding Medicaid benefits would be a major enhancement. And because Medicare does not cover any nonmedical community services beyond a limited home health benefit, including Medicaid nursing facility, home health, and home- and community-based services in the SNP benefit package could open more opportunities for less costly community placements that could reduce Medicare nursing facility and inpatient hospital costs, and provide greater satisfaction for plan enrollees.

9. **Use of Medicare savings resulting from inclusion of Medicaid services in the SNP benefit package.** Verdier says there are likely to be savings to Medicare if Medicaid services are included in the SNP benefit package, especially from reducing inpatient hospital, emergency department, and skilled nursing facility utilization, and from more appropriate use of prescription drugs. Such potential savings and their uses should be an explicit topic of discussion between states and SNPs, he says. Some of the savings could be used to further enhance care coordination and other high-value services for dual-eligibles, and some could be used to reduce the capitated payments that Medicaid agencies might otherwise pay to SNPs for coverage of Medicaid services.

Verdier says that five states — Florida, New Mexico, Minnesota, New York, and Washington — are in a Robert Wood Johnson Foundation-funded Integrated Care Program to help states develop an infrastructure for integrating health care services and contracting with SNPs. He says officials from these states are participating in a variety of opportunities to share their experiences and learn from each other. The Center for Health Care Strategies is helping the states facilitate exchange of information. The center also has put out a checklist for states dealing with integrated care program design, rate setting, and risk adjustment.

[More information is available from the Center for Health Care Strategies on-line at www.chcs.org. Contact Mr. Verdier at (202) 484-4520.] ■

Multi-pronged plan helps members with chronic illness

Interventions depend on the severity of disease

Health Plan of Nevada Inc. takes a multi-pronged approach to managing the care and services of its chronically ill members throughout the continuum of care.

Depending on the severity of their condition, members' care and services may be coordinated by an RN health coach or a case manager. A home health nurse at one of Health Plan of Nevada's sister companies, Family Health Care Services, may become involved when the member requires regular monitoring of his or her condition using an in-home telemonitoring device.

Health Plan of Nevada is a wholly owned subsidiary of Sierra Health Services, a Las Vegas-based diversified health services company. Other Sierra Health subsidiaries include Southwest Medical Associates, the largest multi-specialty medical group in Nevada with a staff of 250 staff doctors who work in 14 clinical locations.

Health Plan of Nevada's health management program focuses on four chronic conditions — chronic obstructive pulmonary disease, congestive heart failure, diabetes, and pediatric asthma.

The program was developed in partnership with Southwest Medical Associates, which many members choose for primary care providers.

The health management program has resulted in an increased number of members who receive the recommended tests and procedures for their chronic diseases, reports **Deborah Wheeler**, MSPH, director of quality improvement.

For instance, the percentage of members with

diabetes who had hemoglobin A1c tests increased from 72.8% in 2003 to 83.5% in 2006. During the same time period, the proportion of individuals with diabetes who received LDL cholesterol tests rose from 75.2% to 91.5% and those who received screenings for kidney disease increased from 49% to 62%.

When members are identified for the program, they are stratified into low, moderate, and high-risk groups, based on their history of inpatient hospitalizations, emergency department and outpatient visits, and/or laboratory test results, according to Wheeler.

Depending on their level of risk, the members receive interventions designed to help them get their condition under control and avoid developing complications or being hospitalized.

All members receive disease-specific materials when they are identified for the program and receive follow-up postcards reminding them of recommended tests or procedures such as eye examinations for members with diabetes and flu shots for all members in the program.

Members at high and moderate risk work with health coaches who educate the members on their disease, make sure they receive recommended tests and procedures, and work with them to help them follow their physician's treatment plan.

The RN health coaches are supported by non-clinical staff who make initial contact with the members and schedule them for a phone call from the health coach, helping maximize the time of the health coaches, Wheeler says.

When the health coaches make their first telephone calls to the members, they conduct a health assessment and review the member's health issues. They encourage the members to see their primary care physician if they have not had the recommended disease-specific tests and examinations, she adds.

The role of the health coaches is to support the treatment plan of the providers, to make sure the members remain compliant with their medication regimen, and to schedule appointments for recommended care. The frequency of the telephone calls depends on the member's risk level. The health coaches work to develop a relationship on an ongoing basis and typically work with the same member as long as he or she is in the program.

"The health coaches work with the primary care physician to encourage the member to self-manage his or her condition. They help the physician identify other issues with the members and contact the physician if they feel a member may be experiencing an acute problem," Wheeler adds.

The health plan's electronic case management software application allows the health coaches to communicate instantly with the home health agency, Southwest Medical Associates, Health Plan of Nevada's case management department, and other services, and to transfer members seamlessly between various components of the program.

"This helps coordinate care between the services and the departments. Our system allows for referrals to go back and forth. Members who are in case management may be referred back to a health coach when they become stable or refer them to the home health program if they need to be closely managed," says **Dana Zuckerman**, RN, BSN, MA, CCM, assistant vice president for utilization management and case management.

For instance, if the health coaches determine that members have complex issues, acute issues, and/or needs beyond monitoring their condition, they are referred electronically to case management. This includes members who need durable medical equipment or help getting access to social services.

Once the acute issues are stabilized and the member has been set up with equipment or linked to community social services, the case manager transfers him or her back to the health coach.

The case managers coordinate the care for members with major trauma after an accident — from acute care through rehabilitation and outpatient rehabilitation. They manage the care of premature infants, high-risk obstetric patients, members with cancers, and those who are receiving care outside the service area.

"The case managers coordinate care for people who need a lot of services including those with complex conditions who see multiple physicians. Members in case management represent about

1% of the population and they are the ones at highest risk," Wheeler says.

When a member is referred to case management, the case manager conducts a complete assessment.

"We are not just looking at diabetes or heart failure. We take a holistic approach and look at the entire person and everything that is happening with them," Zuckerman says.

The case managers develop a plan of care and take care of what the member needs right then.

If their plan of care is related to a specific disease and the member requires no other interventions, he or she is referred to health management and a health coach.

If the member has comorbidities or other issues or is going outside the service area for care, the case manager coordinates the care.

Most members of Health Plan of Nevada who need organ transplants must go out of state for the service.

For instance, if a member with diabetes needs a kidney transplant, the health plan case manager coordinates the appointments for laboratory procedures, X-rays, and treatment at the hospital where the transplant will take place and follows the members after the surgery to make sure they get everything they need.

Some members with congestive heart failure are eligible for a telemonitoring program offered by the health plan's affiliated home health company.

When a member is eligible, a home health nurse makes a home visit, evaluates the home environment for safety, and determines if the member would be a good candidate for telemonitoring.

If so, they receive a device in their home that they use to input their weight, vital signs, and health status. The home health nurses monitor the results and call in the member's physicians if they see a decline in health status.

Sierra Health Services' computer system is set up so that components that receive a referral can instantly tell if a member's care is already being managed by another component.

For instance, if a health coach receives a referral of a member who is at high risk for hospitalization for congestive heart failure, he or she can immediately determine if the member is already enrolled in another program, such as the home health remote telemonitoring program or South west Medical Associates' congestive heart failure clinic.

"If members are already being managed by other services, the health coaches don't duplicate the services," Wheeler says.

The health plan sends a quarterly profile to the members' primary care physicians showing which of their patients have or have not had disease-specific examinations, along with information on the frequency of hospital, outpatient, and emergency room visits for the condition.

The pediatric asthma program works much the same as the health coaching programs for other chronic diseases. The RN health coaches work with the parents of children less than 18 who have asthma and help them learn to manage their children's disease.

The parents receive educational materials and information about how to participate in Sierra's health education and wellness classes on childhood asthma. ■

Collaboration key in new discharge notice rule

Expands patients' rights to appeal discharge

Beginning July 2, hospitals must begin a new process of notifying Medicare beneficiaries of their discharge appeal rights.

The final rule, Notification of Hospital Discharge Appeal Rights issued by the Centers for Medicare & Medicaid Services (CMS), requires hospitals to give patients a revised "Important Message from Medicare" (IM) stating their right to appeal their discharge and to issue a "Detailed Notice of Discharge" as necessary.

The final rule requires patients receive an initial "Important Message" within two calendar days of admission and a signed copy of the notice within 48 hours of their discharge, if their length of stay is longer than two days.

Medicare beneficiaries' right to appeal

The rule, which applies to both original Medicare beneficiaries and those who are enrolled in Medicare health plans, establishes how hospitals must notify Medicare beneficiaries of their right to appeal, their financial responsibility, and how to appeal a hospital discharge.

If patients request a review by the quality improvement organization (QIO) following the hospital's determination that inpatient care is no longer necessary, the hospital must give the

patient a "Detailed Notice of Discharge" no later than noon on the day the QIO notifies the hospital of the beneficiary's request for a QIO review.

"This process is an expansion of previous dictates regarding a Medicare patient's right to appeal his or her discharge. For some time, CMS has required hospitals provide Medicare beneficiaries with the Important Message from Medicare" at the time of admission. Now CMS is requiring that patients who have an inpatient length of stay of longer than two days also receive a copy of the IM within two days of discharge as a reminder of their rights to appeal the discharge decision," says **Lorraine Larrance**, BSN, MHSA**,** CPHQ, CCM, manager with Pershing Yoakley & Associates, a health care consulting firm with offices in Knoxville, TN; Atlanta; Tampa, FL; and Charlotte, NC.

Interdisciplinary collaboration is going to be key in assuring compliance with the new rule, points out **Cassandra Barnes**, RN, MS, CCM, senior consultant for case management at Pershing Yoakley & Associates' Atlanta office.

How to comply

"Hospitals must formalize how they identify potential discharges in order to be compliant with the rule. Case managers are good at anticipating the discharge date. What hospitals need to do is to determine who will deliver a copy of the discharge appeal notice within the 48-hour window," she says.

Barnes suggests developing a tickler system to remind staff that patients must receive another copy of the IM form two days before discharge and a way of documenting in the medical record that the patients received the additional notice.

"This form is like any other hospital form that stays part of the medical records. If Medicare comes in and audits the charts, the documentation should be there," Barnes says.

Hospitals should already have procedures in place for giving Medicare beneficiaries a copy of their right to appeal notice on admission, Larrance adds.

Look at which disciplines could be involved in making sure that the patient receives a copy of the notice before discharge, she suggests. "This is likely to be an interdisciplinary effort that may involve the patient access staff, nursing, and physicians as well as case managers," Larrance says.

For some time, hospitals have had to give patients the notification that they can appeal their discharge and that notice will be sufficient for patients whose length of stay is two days or less, Barnes points out.

On the other hand, in cases when the delivery of the initial "Important Message" occurs more than two days before discharge, hospitals will need to deliver a follow-up copy of the signed notice to the beneficiary as soon as possible prior to discharge but no more than two days before, she adds.

Notifying observation patients

One challenge will be to ensure that patients who are initially placed in observation status receive the form when they are admitted as an inpatient.

"One way of meeting the criteria for observation patients who are later converted to inpatient status might be to give the IM notice to all Medicare patients whether they are in observation or inpatient status. This assures that they will receive the IM within two calendar days of the actual admission to the inpatient level of care," Larrance says.

An interdisciplinary approach to the process will be necessary in order for a hospital to comply with the rule, she adds.

"Since the entry point for most hospital patients, such as the emergency department or patient registration area, is staffed by clerks who are not medically trained professionals, system-wide education should be provided to everyone involved in the process. All staff should be trained to educate patients on the intent of the IM notification document," Larrance says.

When patients are admitted, the original copy of the notice should go into the medical record. When the decision is made to discharge a patient, a nurse or case manager should deliver a copy of

the notice within two days of the discharge date, to the patient to remind them of their right to appeal their discharge, Larrance says.

"Case managers are in the best position to anticipate the discharge date, based on the patient's diagnosis and other factors and are crucial in assuring that the requirements of the final rule are met. Open communication between the case manager, the nursing staff, and the physician will be required to make this a seamless process," Larrance says.

Medicare has stated that the intent of the "Important Message" is to make sure that patients understand they have a right to appeal their discharge and to understand the appeals process.

"Patients often are very sick when they come in or they may not understand everything they sign. Because of these and other circumstances, CMS wants to make sure that the patients understand that they can appeal their discharge and the second notice should serve as a reminder of this. Just having them sign the paper doesn't meet the intent of the Important Message notification," Larrance adds.

*(For more information, contact **Lorraine Larrance,** BSN, MHSA, CPHQ, CCM, manager with Pershing Yoakley & Associates, e-mail Llarrance@pyapc.com. **Cassandra Barnes**, RN, MS, CCM, senior consultant for case management with Pershing Yoakley & Associates, e-mail: cbarnes@pyapc.com.)* ■

CHAPS offers on-line service

Home health agencies accredited by the Community Health Accreditation Program in Washington, DC, can now move away from paper forms for accreditation information to an online system.

The organization launched the beta test of its computer-based accreditation review System (CARES), a software application consisting of a

CNE *questions*

17. What are factors identified with an increased risk to develop pressure ulcers, according to **Sandra Bergquist-Beringer,** RN, PhD, CWCN, assistant professor, School of Nursing, University of Kansas in Kansas City, KS?
    A. Incontinence
    B. Altered level of activity
    C. Functional impairment
    D. All of the above

18. Because reimbursement for nurse practitioners falls under Medicare Part B, what does **Joan Marren**, RN, MEd, CEO of the Visiting Nurse Service of New York say that home health agencies need to make sure they have?
    A. An updated contract with managed care organizations
    B. Different liability insurance
    C. Proper forms to file the claims
    D. Additional signatures on the admissions' referrals

19. What is one part of National Patient Safety Goal 9 that addresses patient falls upon which agencies need to focus more clearly, according to **Carol Mooney**, RN, MSN, senior association director of the standards interpretation group for The Joint Commission?
    A. Home environmental assessment
    B. Monitor effectiveness of falls reduction program
    C. Re-hospitalizations that result from falls
    D. Staff education

20. The excluded drugs that Medicaid still covers are usually lower-cost generics and are most valuable to beneficiaries as part of a broader care package.
    A. True
    B. False

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

web-based portal and synchronized stand-alone application, recently and plans full implementation and deployment of the system by the end of the third-quarter in 2007.

"CHAP has made a significant long-term commitment to bring this new technology on-line to better serve its customers and staff," states Terry A. Duncombe, CHAP president and CEO. "CHAP CARES enhances our ability to more efficiently benchmark quality and develop more robust reporting tools for our customers and the national community-based health care market."

CHAP customers will benefit as they transition from a paper to an electronic process, as most functions will be completed on-line and communications between CHAP and its customers will be more fluid and timely. ■

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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. ■