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SEPTEMBER 2007

VOL. 12, NO. 9 • (pages 85-96)

Hospices and NHPCO are preparing for anticipated COPs before the final rule

Experts offer advice on how to plan for the change

Time is running out for hospices to prepare for the new Medicare conditions of participation (COPs), and experts say the best strategy is to make quality improvement changes now and not wait until sometime in 2008 when it will become the law.

The major change hospice industry leaders expect to find in the final rule for Medicare COPs involves the quality assessment and performance improvement (QAPI) requirement.

The Centers for Medicare & Medicaid Services (CMS) will ask providers to put together a comprehensive assessment of where their organization is in business, as well as in clinical practice. Then they'll be asked to do some performance improvement projects, including analyzing data and making certain they're measuring improvement, says **Judi Lund Person**, MPH, vice president of quality for the National Hospice & Palliative Care Organization (NHPCO) of Alexandria, VA.

"The whole idea of collecting data is not new," Person says. "The whole idea that you will measure your performance against yourself and other hospices in the country is a new area."

These quality improvement (QI) measures will be more challenging for hospices than they are for other health care entities, Person notes.

"You have the challenge of having at least half of our patients who are not responsive enough to answer questions directly," Person says. "So hospices will need to get information and data from family members."

Another challenge is that patients won't be enrolled with hospices for very long. Many patients may be in the program for less than a week, and this makes it difficult to track QI, she adds.

NHPCO launched its Quality Partners program a year ago to help hospice providers incorporate QI into their process, Person says.

"Quality Partners is very tied to COPs, and it helps providers get ready for this process, and it's one of the reasons why we have over

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2,000 individual providers who have signed up for it and 250 hospice providers who have signed up," Person says.

CMS published the proposed COPs in the Federal Register on May 27, 2005, and the final rule is expected to be published in May, 2008. While the final COPs will be changed somewhat from what was proposed 2.5 years ago, hospice experts say they likely will include the major changes, such as the QI requirement.

The new COPs likely will focus on quality performance measures, as did the proposed COPs, says **Cordt Kassner**, PhD, executive director of the Colorado Hospice Organization of Colorado Springs, CO.

"Many hospices have their own internal quality /performance improvement process, but they aren't specifically required through the COPs, and in the new COPs, they'll be required," Kassner says. "So the hospices that don't have an FTE [full-time equivalent] dedicated to quality assurance are in for a change and need assistance on how to develop these programs and how to be in compliance with the new COPs."

It's important to put the changes in context.

Current hospice rules are 25 years old, and the proposed new COPs will update the existing rules, as well as provide more consistency and clarity, Kassner says.

"I believe this is a reasonable request to show the good work that hospices do," he adds.

When the Medicare agency changed the rules for home care organizations more than five years ago, it led to many organizations closing their doors. But this is unlikely to happen with hospices because the changes are not onerous, Kassner says.

"It doesn't seem like these new COPs are really out to significantly shrink the hospice industry, as other fields have experienced," he says. "I think there are some factors out there and some issues and concerns that we're monitoring that may have some impact on hospices, but it's nothing in the COPs."

Hospice leaders express some concerns about implementing the required changes, but none of them express fear that the changes may force them to go out of business, Kassner says.

"People aren't necessarily excited about it, but most hospice see how this is a good requirement in the new COPs," Kassner says. "Even for smaller hospices that don't have specific quality assessment programs in place do not think it will be an overwhelming burden."

On the positive side, smaller hospices may be able to implement the new COP changes more quickly and more smoothly than larger hospices because they won't have as much staff to train or as complex communication systems to adjust, Kassner notes.

Colorado Hospice Organization, like other state hospice organizations, has joined NHPHO's Quality Partners program and is offering services and resources to hospices that need help in preparing for the COP changes.

There have been two statewide telephone conferences on the proposed COPs, Kassner says.

And CHO's annual fall conference, held Oct. 11-12, 2007, in Vail, CO, will focus on the quality initiative, and four of the 10 quality components will be addressed in plenary sessions and workshops, Kassner notes.

"We selected the following components: patient and family-centered care, workforce excellence, clinical excellence and safety, and performance measurement," Kassner says.

For some hospices, quality performance has long been a focus.

Hospice Management Advisor™ (ISSN# 1087-0288) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospice Management Advisor™**, P.O. Box 740059, Atlanta, GA 30374.

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Subscription rates: One year (12 issues), \$399. Add \$9.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues,** when available, are \$67 each. (GST registration number R128870672.)

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Editorial Questions

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"We have been preparing for this long before there were new COPs," says **Janet L. Jones**, RN, BSN, chief executive officer of Alive Hospice Inc. of Nashville, TN.

As a large hospice with more than 400 patient visits per day, Alive Hospice has been measuring quality performance organizationally for the past decade, Jones says.

"We attend to not just the clinical quality measures, but also the financial and other operational measures," Jones says. "So in preparing for the new COPs, it was a matter of pulling together things we were already doing and focusing on these a little differently."

The hospice was one of the first hospices to participate in the NHPKO Quality Partners program, says **Tamara Royse**, RN, BS[Ed], MSQA, director for quality improvement and training at Alive Hospice.

"That helped us learn new techniques for improvement, and it was a fantastic learning experience," Royse says.

Royse works with other hospices as a faculty coach, assisting them with their performance improvement projects.

Another major change hospice leaders made in preparing for the COPs was to assess the hospice's overall education and leadership training, notes **Karen York**, MA, CPHQ, executive vice president of organizational excellence and mission at Alive Hospice.

They started off with broad staff education, followed by updates on quality assurance plans, and incorporating changes suggested by the proposed COPs, York says.

At Family Hospice and Palliative Care in Pittsburgh, PA, part of the preparation for the new COPs involves having a detailed assessment done on all patients, says **Virginia Valentine**, RN, MS, CHPN, director of performance improvement.

"We evaluate right up front what their ability is to communicate," Valentine says. "We have tools for measuring pain in patients who are cognitively impaired or non-communicative, and we used guidelines in relation to non-cancer diagnoses."

Through using these tools, hospice leaders guide staff in making individual adjustments as needed, Valentine says.

Hospice leaders also hold discussions about the anticipated COPs and what these will mean to hospice professionals' daily work.

"We talk about current regulations related to the care planning and setting goals, and we looked at the proposed regulations out there because there are major changes in that whole area of care planning," Valentine says. "We've looked at doing care planning that would yield a focus on outcomes we could measure."

There are weekly team conferences in which staff review and individual patient's case and see how fast the patient's care is moving forward with regard to goals and outcomes, Valentine adds.

It takes time for staff to adjust to this change in how they think about patients and cases, she notes.

"I try to point out there will be a heavy focus on those outcomes," Valentine says. "If the goal is to achieve a certain level of comfort in terms of pain control, then you really need to monitor that and look at that."

Then at a two-week review, staff will have to see how the hospice is doing with regard to this outcome, Valentine says.

"We have to document that we have evaluated those outcomes and that we've moved on to developing new strategies for developing those outcomes," Valentine says.

It comes down to one word: documentation.

"When you talk to hospice professionals, you find that we all feel like we're doing a good job," Valentine says.

"But quality is a nebulous thing," she says. "We have to document with some measurable outcomes that we're in fact doing what we say we're doing."

So how do hospices do this?

The first step is conducting a comprehensive assessment for every patient at admission, Person says.

"It's not that different a process than what providers do now," Person explains. "It's goal setting and identifying each patient's needs."

The initial assessment is the beginning point for starting a quality assessment/performance improvement project, Person adds.

Basically, hospice organizations need to look within themselves to identify which areas need improving, and then they should start a clear and distinct process to make these improvements and measure their success, Jones says.

"Every organization will have to designate someone to be responsible for this process," Jones adds. "It doesn't have to be an additional person,

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but it has to be someone who has the key responsibility for helping with the process." ■

How to start a quality improvement project

Hospice directors discuss their strategies

Hospices beginning performance improvement projects for the first time, or those revising existing programs, could learn a few pointers from their peers' experiences.

Here are examples and advice from hospice leaders who have been working on quality assessment/performance improvement measures as anticipated under the new conditions of participation (COPs) proposed by the Centers for Medicare and Medicaid Services (CMS):

- **Improve medication delivery and medication safety:** "We looked at incidence reports for the previous two years, and like most organizations across the country know, medication is a high volume, high risk area," says **Tamara Royse**,

RN, BS[Ed], MSQA, director for performance improvement and training for Alive Hospice Inc. of Nashville, TN.

"So, we wanted to reduce our medication error rate, and while we were doing this, we were implementing new medication lockers and a computerized medication administration system," Royse says.

The hospice put together teams who reviewed the medication administration process, specifically identifying factors that caused medication errors, she notes.

"We held brainstorming sessions with staff about what they thought were the causes of the mistakes," Royse says. "And we implemented a do-not-disturb zone in the medication room to prevent interruptions."

The goal was to reduce the medication error rate by 50 percent, and that goal has been achieved, she says.

"We've had two months this year where there were no medication errors," Royse says.

The focus was on inpatient beds, and the next step will be to use the same performance improvement process when more beds are added to the inpatient unit, Royse notes.

"We didn't tackle the medication error rate at home because it's a whole different setting, and you have less control over the medication there," she says.

- **Measure outcomes during audits:** "One thing, we've begun to do in performance improvement is measuring outcomes in our audit," says **Virginia Valentine**, MS, RN, CHPN, director of performance improvement for Family Hospice and Palliative Care in Pittsburgh, PA.

"We've done a lot of process auditing in the past," Valentine says. "Now, we are shifting our focus and looking at outcomes auditing versus process auditing."

Valentine defines the two this way:

- Process auditing is when you make certain certifications are signed, pain assessments are conducted, advanced directives are reviewed, etc.

- Outcomes auditing is when you focus on whether or not the outcome identified has been achieved, such as pain being kept under control, caregivers expressing confidence, safety achieved, etc.

"We look at the results we get from the family survey we send out, and we use that to say, 'I think we're doing a good job in these areas,'" Valentine says.

The hospice's performance improvement committee documents outcomes and conducts ongoing audits, including audits of discharged patients, she says.

"We collect data, collate it, and look at it for analysis," Valentine explains. "We use the family survey data that the National Hospice & Palliative Care Organization (NHPCO) has developed."

Also, the hospice's clinical managers conduct ongoing audits in terms of actual documentation and tabulation of data, she adds.

• **More effectively audit pain control outcomes:** "We used to audit the pain assessment at every visit, but not now," Valentine says.

Now, the hospice audits whether a patient's pain is contained within zero to 3 on a zero to 10 scale at 48 hours, 72 hours, and one week after admission, she says.

The pain assessments still are obtained regularly, and so there also is an audit of what the patient's pain was like within six hours of his or her death if the patient is an inpatient, and perhaps within less than 24 hours if the patient is not, Valentine explains.

"We want to make sure patients are comfortable," Valentine says. "We want to see whether the patient was having a lot of pain."

For part of this audit, hospice professionals look at the pain medications the patient has been taking, and how they're delivered, she says.

"We want to know what percentage of patients are on IV, oral, or a combination in administering pain medication," Valentine says.

"We also look at how many after-hours calls for pain problems occur, and this also helps us look at how well we're doing."

Other audit questions are as follows:

- Are after-hours calls handled by a triage nurse or do they require an on-call nursing visit?

- What type of complementary therapies are used to help the patient feel comfortable (i.e., music therapy, art therapy, massage, therapeutic touch)?

"Complementary therapies release a lot of anxiety, and sometimes anxiety can lead to greater pain or more difficulty in controlling it," Valentine says.

• **Measure caregiver confidence, safety, and advanced directives:** "In terms of caregivers, we look at confidence data from the hospice survey," Valentine says. "We're involved with several research projects that deal with comfort and care-

giver confidence, but we've just begun this."

The overall outcome would be to have the patient and family understand what their own expectations are about death and about the patient's care during the end of life, she notes.

"We look at some of the things we do like increasing phone monitoring during visits and whether the patient has used volunteer services," Valentine says. "When we look at the patient's chart, does the documentation reflect that the family understands how to care for the patient who is dying?"

With safety quality issues, the main goal is to look at the risk of falling, Valentine says.

"We conduct fall risk assessments and home safety assessments on patients living in their homes," she says. "We look at interventions that are appropriate for their level of risk, and the outcome is how many falls they are having, and we track that."

For advanced directives, the hospice has looked closely at the discussions employees have with families about advanced directives and living wills. Here are some questions reviewed:

- Has the patient identified actual end-of-life wishes?

- Have the end-of-life wishes changed from the time the patient was admitted to the time the patient is discharged?

- Does the patient wish to have hydration and nutrition?

- Does the patient want a do not resuscitate order or not, and what are the outcomes?

- If a patient has a living will that says he or she doesn't want to have feeding tubes, is the staff honoring this request?

"We want to have the discussion about advanced directives with the patient and family, and we want people to feel they are able to identify the patient's wishes," Valentine says. "We want to make sure when those wishes are identified that we are honoring those wishes, and the best way to honor them is to know what they are and have it documented."

• **Even emotional states of mind can be measured:** "Quality is even more important at the end of life than it may be at other times," says **Janet L. Jones**, RN, BSN, chief executive officer of Alive Hospice.

"Quality is not about a cure; it's about whether their pain is being managed," Jones says.

It's also about these existential issues:

- Is the patient living in the kind of setting he or she wishes to live in?

- Are there issues regarding the patient's human existence that he or she is struggling with, such as issues involving meaning and purpose in life?

"Those are things we measure, and they're extremely important so people can finish their lives in a manner that's meaningful to them," Jones says.

"We're very fortunate to have resources and a board of directors who understand our mission of supporting quality," Jones says. "For hospice organizations that may not have as much support as we do, I think there still are very simple and easy and clear ways they can target and measure their organization to evaluate their quality and how they're performing." ■

Trends in Hospice: Palliative Care Growth

[Editor's note: In this issue of Hospice Management Advisor, we've included the second part of a series about the recent growth of palliative care programs in the hospice industry. Featured in this issue is a story about how one hospice organization has made palliative care a big part of its mission and business. In the August issue, there were articles about the palliative care continuum of care provided by a Midwest-based home care and hospice organization and the palliative care hospital services offered by a smaller East Coast hospice.]

The Hospice and Palliative Care of Charlotte Region in Charlotte, NC, is one of the largest hospices in North Carolina and a national leader among hospices that have incorporated palliative care into their mission.

The organization even changed its name from Hospice of Charlotte to a name that includes palliative care several years after shifting its focus to include palliative care.

"We cover all medical services for hospice and palliative care, and we have seven physicians who are dedicated toward the palliative care side," says **Judith Kinsella**, RN, MSN, CHPN, assistant vice president of medical services. The hospice has a daily census of 450 patients.

"We hand-picked and carefully selected physicians to work in our practice," Kinsella says.

Among the physicians who work in palliative

care are a pulmonary specialist and a neurosurgeon, she notes.

By employing physicians and nurse practitioners to work in palliative care, the hospice has reaped some benefits. About 35 percent of the patients in the palliative program, which began in 2003, eventually transition to hospice care, and the hospice's census have increased from about 250 in 2002 to about 450 in 2006, Kinsella says.

"In 2006, we saw 1,982 new consults," she notes. "It's pretty significant."

Also, the palliative care patients who are transitioned to hospice care tend to be less expensive to the hospice than typical hospice patient because these patients have already received assistants with establishing goals of therapy, Kinsella says.

Here is how the comprehensive palliative care program works:

- **Employ a productivity model:** "We built a productivity model," Kinsella says. "We have a budget and billable visits that we want to achieve every month to cover our costs."

Each palliative care practitioner is given a budgeted number of visits to reach each month, and their actual visits are tracked electronically, Kinsella says.

"We have a ratio of what we want to see of how many patients per FTE [full-time equivalent] each month," Kinsella explains. "We look at this to see if we're on target."

It's a detailed process that includes sending practitioners quarterly reports telling them how many visits they've made for the quarter and year-to-date, she adds.

The organization also has hired a medical billing specialist who makes sure providers are in compliance with Medicare Part B billing requirements, Kinsella says.

"We submit bills to her, and she makes sure they're the right code," Kinsella says. "She reads the notes to make sure we're maximizing our utilization of the code appropriately."

All of these measures have helped keep productivity high.

"We've been constantly amazed," Kinsella says. "They all have salary positions, but they're highly motivated to see patients, and they've been consistently meeting their productivity goals."

Palliative care services include patient visits at home and in long-term care facilities, and in March, the organization opened outpatient clinics, Kinsella says.

Some of the billable visits involve nurse practitioners in the long term care setting, Kinsella says.

"It's never going to be 100 percent covered, but the benefit burden is significant," she says.

Nurse practitioners are paid through the Medicare Part B billable visit. When palliative care patients are transitioned to hospice care, they'll receive the Medicare A benefit and the nurse practitioners will no longer see them, Kinsella notes.

"We see patients in 25 nursing homes, and we have about 60 home patients," Kinsella says.

"We've had up to 120 home patients, and once we opened the outpatient clinic, many palliative care patients transitioned there."

There are detailed reports that are used to look at average monthly expenses, and administrators continually analyze the palliative care budget, Kinsella says.

• **Expand physically and organizationally to accommodate new services:**

Hospice and Palliative Care of Charlotte Region has contracted with the flagship health care system in the region to provide palliative care services, and this arrangement helps to cover some salary costs, Kinsella says.

The hospice organization expanded its office space to accommodate palliative services.

"We have a whole floor for medical services, and each doctor and nurse practitioner has his or her own desk and space," Kinsella says.

Palliative care nurses, doctors, administrative staff, and a social worker meet each Friday to discuss case studies, Kinsella says.

Administrative assistants manage the organization's database and keep track of the staff's CMEs, disability administrative work, and scheduling.

"The scheduler helps physicians and nurses schedule their palliative care visits," Kinsella says.

Whether a site has one palliative care patient or 10 patients, the clinicians will go to see them, but the organization works to create greater density in the hospitals and nursing homes visited by staff, Kinsella says.

"Having a large number of patients in a nursing home is wonderful," she says. "Having one or two is difficult."

• **Educate, market, assist other health care professionals:** When the hospice first began the palliative care program and began the contract with the major health care system, hospice lead-

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ers held many inservices and discussions with the health care system's hospital and nursing home staff, Kinsella recalls.

"Nursing homes like having us there," Kinsella says. "They love having a physician come in and see patients and help them establish goals of therapy and refocus the care of patients."

The organization has a journal club that meets monthly for PowerPoint presentations about palliative care and end-of-life issues, Kinsella says.

Physicians and nurse practitioners read current literature and create the two-hour presentation which is presented to peers and other professionals, including nursing and medical students, she says.

"They're highly motivated to make sure the literature review has been complete," Kinsella notes.

Sometimes the topics selected are part of a theme chosen for the year.

"This year we decided we wanted to spend journal club time on a dementia series, so each topic is related to dementia," Kinsella says.

Among hospice and palliative care populations, the diagnosis of dementia is increasing, she notes.

The presentations are saved in a medical service library so they can be accessed later by anyone who missed the original presentation.

Also, the staff can receive CMEs for listening to the PowerPoint presentations, and the person who develops the program receives CME, as well, Kinsella says.

The program's reputation initially was enhanced by the advocacy of the hospice's medical director, who is well known in the community. But it has also grown by virtue of its own success.

"We love to look back at where we've been,"

Kinsella says. "It speaks loudly about our senior leadership who are strong advocates of what we've been doing, and that's key."

Also, the partner hospitals believe palliative care is an important service to add, so it helps the program thrive and grow, she says.

"We continue to look at maintaining our growth by adding new hospitals, new nursing homes, and new service areas," Kinsella says. "We have to do that to maintain as a palliative medicine program." ■

A new tool to help predict pressure ulcers

OASIS data will help with early intervention

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, as well as identify effective interventions, says Bergquist-Beringer. "Pressure ulcers are not only extremely painful but they lead to other conditions such as depression, osteomyelitis, cellulitis, 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; and
- 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 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." ■

References

1. American Medical Directors Association. Pressure ulcer prevalence and cost in the U.S. Population. *JAMDA* 2007; 8:B20.
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 duties to attract nurse practitioners

Reimbursement covers costs of NPs

The challenges faced by hospice managers when hiring nurse practitioners are many of the same challenges faced when hiring hospice 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.

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."

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

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 non-compliance 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.

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. "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.

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

Several states have taken advantage of SNPs

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.

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.

2. Drugs excluded by statute from Part D coverage. 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. 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. 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

COMING IN FUTURE MONTHS

■ Improve practitioner home visits

■ Optimize opioid management

■ Develop evidence-based comfort care order sets

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.

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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. ■