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the monthly update for executives and health care professionals

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IN THIS ISSUE

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Thorough documentation, accurate assessments add up to improvement

Raising dyspnea scores requires education for staff and patients

Increasing the percentage of patients who show improvement in dyspnea from the 2005 baseline score of 57.6% to 73% in November 2007 earned a certificate of achievement from the Oklahoma Foundation for Medical Quality (OFMQ) for Sequoyah Memorial Homecare-Home Health in Sallisaw, OK.

The higher score was the result of a performance improvement effort that focused on dyspnea, according to **Penny Martin,** RN, director of home health for the agency. "We developed a plan of action and used tools from OFMQ to help us improve our care of patients with dyspnea," she says. **(See resource box, pg. 38, for information on tools.)**

Assessing shortness of breath

One of the first steps taken at Sequoyah Memorial HHA was formal training on how to score the OASIS items related to shortness of breath, says Martin. "We realized that we were not always getting a good baseline during the initial assessment so we held training classes to make sure everyone assessed shortness of breath the same way," she says.

Consistency is also important when teaching patients, points out **Bonnie Dixon**, RN, BSN, director of Dunn Memorial Hospital Home Care in Bedford, IN. Dixon's agency improved its rates for improvement in dyspnea from a baseline of 49.44% to 63.07% in the first year the agency tackled dyspnea as a performance improvement project. The rates have fluctuated some since the first year of the program but remain around the national average of 61%, she adds.

"I've learned that just by starting a performance improvement project and talking about a specific issue, you raise awareness and see some improvement," admits Dixon. The real challenge is putting tools into place to keep staff members aware of the ongoing importance of activities such as teaching, she says. "We reviewed literature and tools that are available from different sources and selected best care behaviors to implement in our agency," she says.

"We developed a dyspnea teaching packet and we developed a care

pathway for dyspnea," says Dixon. By standardizing the teaching and the clinical decisions, all staff members were able to make sure that nothing was overlooked, she says.

Understanding the population

"We also saw a need for a smoking cessation program," says Dixon. Her patients live in rural areas in southern Indiana, and are farmers and foundry workers, she says. "There are a lot of smokers and ex-smokers so we have a lot of patients with lung cancer and chronic obstructive pulmonary diseases," she says.

A home health nurse who works in wellness programs for local companies put together a smoking cessation program and educational literature directed at patients and their families, says Dixon. "We did not have a lot of luck getting a large number of people to quit smoking, but we did educate people so that they do understand the link between smoking and their health problems," she adds.

The teaching packet contains information on dyspnea and tips on how to minimize shortness of breath, says Dixon. "We have tips such as elevate the head of the bed, avoid crunching the stomach, use a fan to blow air directly at the face to minimize hunger for air, use oxygen if necessary, and stop to rest before activities that increase shortness of breath," she says. **(For other tips, see pg. 39.)**

"We use occupational therapists to help patients learn how to pace their activities and use assistive tools to minimize shortness of breath," says Martin. The use of spirometers and pulse oximeters, as well as increasing the number of visits at the start of care have proved to be effec-

SOURCES/RESOURCES

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- **Penny Martin**, RN, director of home health, Sequoyah Memorial Hospital, 213 East Redwood, Sallisaw, OK 74955. Phone: (918) 774-1171. E-mail: pmartin@smhok.com.

For tools, literature, and action plans to address dyspnea improvement, contact:

- **Medicare Quality Improvement Community**. This on-line source of information is provided by the Centers for Medicare and Medicaid Services. Go to www.medqic.com. Under "What do you want to do?" select "browse by topic." Scroll down to "dyspnea" to be linked to tools, literature, and other resources.
- **Oklahoma Foundation for Medical Quality**. Go to http://www.ofmq.com/tools-and-resources and scroll down to "dyspnea tools" to find a list of assessment forms, care plans, strategies, and more resources.

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Energy conservation strategies for dyspnea

Ambulation
• Walk at a slow, comfortable pace
• Have chairs placed throughout home to allow rest stops
•Use a rolling cart to transport items, instead of carrying
• Consider using a walking aid (i.e., wheeled walker)
Bathing
• Use a bath stool or bench during bathing
• Use a handheld shower head and adaptive equipment such as long-handled sponges or brushes
• Consider sponge bathing
• Use a terrycloth robe to help dry off after bathing
Dressing
• Use slip-on shoes, shoes with elastic laces
• Use dressing aids (sock aid, shoe horn, dressing stick, reacher, etc.)
• Put underwear inside pants or skirt, and pull them on together
• Dress seated instead of standing
• Avoid clothes that are tight, or have many buttons, etc.
Grooming
• Consider performing grooming tasks seated
• Select low-maintenance hair styles
• Let hair air dry, or use hair dryer cap instead of a blow dryer
Toileting
• Avoid waiting to toilet, which might cause rushing and anxiety
• Consider use of bedside commode
General
• Plan ahead and get organized
— So you can function in at a slow and comfortable pace
— Organize your daily routines, alternating easy and more demanding activities
— Organize "work centers" so all necessary equipment is readily available
• Simplify tasks as much as possible (i.e., prepare light meals)
• Consider eliminating unnecessary tasks (especially those that stress you out!)
• Prepare for activities by resting and performing breathing exercises
• When possible:
— Complete tasks using larger muscle groups (i.e., legs vs. arms)
— Use both hands to complete tasks (i.e., lifting or pushing)
• Keep room temperature comfortable
• Recognize when you need help, and ask

Source: Krulish, L. Oklahoma Foundation for Medical Quality, Oklahoma City.

tive ways to help the patient improve dyspnea, she says.

"We also have patients monitor their oxygen levels at night so we can see when they are having the most difficulty," says Martin. Patients use a pulse oximeter with a printout that is read by the nurse because at this time the agency does not have telehealth services, she says. "Telehealth is a service we are looking at for the future," she adds.

A team approach is the best way to improve dyspnea scores, says Dixon. Although she has no full-time therapists on staff, physical therapy and occupational therapy are called in to help with patients as needed. "We meet as a team to discuss patients and evaluate our performance in all quality measures, including dyspnea," she says.

In addition to keeping the importance of treating dyspnea in front of staff members, Dixon also found threats effective. She laughs as she explains, "When we were talking about the necessity for an accurate assessment and complete documentation at the start of care, I told everyone that they needed to fill out the OASIS completely. Then I threatened to create a respiratory evaluation sheet that would give them another document to complete if the OASIS wasn't filled out completely. The threat worked; I didn't need to develop another form!" ■

Meet baby boomers' needs; offer non-traditional services

Take steps now to integrate services

It is not easy to create significant change in health care but 78 million baby boomers may be the impetus for home health agencies to change their approach to service, according to experts interviewed by *Hospital Home Health*.

"Members of the Greatest Generation were very respectful of health care workers and were willing to defer to our advice and recommendations," says **Ellen Bolch**, president and CEO of THA Group, a Savannah, GA-based home health agency that provides traditional and non-traditional services. "Baby boomers are very differ-

ent," she says. Boomers demand information, value, and independence, she points out. "They don't want to watch their health deteriorate and they don't want to feel dependent on others, so they ask a lot of questions and want to know what services will help them stay independent," she says. "Baby boomers are going to make it necessary for home health agencies to change the way they've always done business in order to survive."

Because the first baby boomers have just turned 65, they are more likely to be your customer rather than your patient now, says Bolch. "They are at the point in their life where they are looking for care for their parents," she says. "The Internet is ideal for boomers because they are voracious information gatherers," she points out. Visiting agency web sites and using Home Health Compare are two ways that baby boomers narrow their search for the best home health agency for their parents, she says.

Although baby boomers may be searching for care for their parents now, it is important to realize that this is your first opportunity to create an impression that could result in them choosing your agency for their own needs, points out Bolch. "These folks are busy people so they want an agency that can help them with all of their needs in one call," she says.

An integrated approach that encompasses traditional home health services with other needs identified by the customer is the home health model that will succeed in the future, says Bolch. The concept of the geriatric caseworker is the answer to most baby boomer needs but be careful how you title the position, she warns. "Boomers do not want to be told that they are old so avoid words like geriatric or silver," she says.

Because people are looking for service, the staff members at New Dimensions Home Health in Pasedena, TX, who identify services and resources that are needed by customers are called customer service representatives, says **Josie Lightfoot,** president and CEO of the agency.

"We started our customer service center about a year ago when we realized that people wanted information on a wide range of topics," she says. Not only were callers asking for information about Medicare and Medicaid coverage, but seniors were also asking for help finding people to prepare their tax returns and even how to obtain food stamps, she says. "There is no other service in our area that provides a centralized source of information for seniors so we saw this as a real need in the community," she says.

Central service for seniors

The first step to offering the information service was to gather descriptions and contact information for resources that are available and to find out how applications are made and who qualifies for the services, says Lightfoot. Once that information was collected, agency staff members were ready to assess callers' needs, she says. "We visit each caller to evaluate their needs," she says. The visits are made by the client development staff members who used to spend time knocking on physician doors, says Lightfoot. "Now they go directly to the customer and find out what they need," she says.

While some customers may only need help finding a pharmacy that delivers, or someone to take care of their lawn at first, everyone at the agency recognizes them as a potential home health care patient, Lightfoot explains. "There is no reimbursement for this service but some customers have become patients," she says. "Because we've worked with them to address other needs, they know us and trust us, so it makes sense to them to call us for home health services," she says.

Thorough documentation on all clients is kept so that the agency can track trends as well as clients' individual needs, says Lightfoot. "We noticed a need for transportation for some clients but our area has no public transportation," she says. After researching the issue, her staff discovered that the city had grant money to make taxi vouchers available for clients who were unable to drive themselves to doctor appointments, she says. "We also negotiate discounts with local small businesses to provide lawn services, tax preparation, and other services that our clients need," she adds.

Moving from traditional services

Although her agency still stays in touch with traditional referral sources, her client development staff also go directly to the community to talk about senior services and home health care, points out Lightfoot. "We speak at health fairs and we've participated in some programs offered by the local police department that highlighted scams directed at seniors," she says. In all situations, the staff members present the agency as a central location of information that can help people live independently, she adds.

Talking directly to consumers is the way to position your agency for success, says Bolch. People

are not aware of all of the different services that can be provided by a home health agency and they don't know how different services can be combined to meet their specific needs, she says. In addition to making sure all parts of your agency, home health, hospice, and private duty stop working in isolation from each other, be sure to develop a service that ties community services into the mix as well, she suggests. "If a patient needs help finding a grocer that will deliver, help find one," she says. "We need to start listening to what patients need in addition to health care in order to integrate all of the services and enable patients to age at home," she adds.

Integration may require a different approach, admits Bolch. "The leadership of each division needs to be integrated so that all patients become 'our' patients as opposed to 'their' patients and 'my' patients," she points out. Case managers who oversee total care of the patient can also identify resources to offer respite care for family members, suggest private duty care to supplement Medicare home health, or find community services that address financial needs, she explains.

Hilton Head, SC, is in the service area of Bolch's agency and represents a wealthy population, she says. "These are people with high expectations for service and value and if they don't believe they are getting what they need, they hire their own geriatric case manager to manage their care," she says. The growth in the number of privately hired case managers will continue and poses a great threat to home health agencies, she says.

"We need to offer clients the one-stop shop that they want so that we can control our destiny," says Bolch. "If we don't think outside the box and offer non-traditional services, someone else will become the integrator and we'll be dependent on them for referrals." ■

SOURCES

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OIG offers guidance on 'pre-operative' activities

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

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services, the primary enforcer of fraud and abuse prohibitions, has issued another Advisory Opinion about so-called "pre-operative" activities of home health agencies.

The home health agency that requested the Advisory Opinion provides post-operative total knee and joint replacement to patients. The services provided by the agency to these types of patients are often paid for by Medicare, Medicaid or other federal or state health care programs.

Orthopedic surgeons usually refer patients to the agency for post-surgical care at the same time that surgeons' offices schedule patients' operations. Surgeons or their staff members complete written referrals and forward them to the agency. No payment of money or allotments of goods or services are provided by the agency to surgeons or their staff members in connection with the referrals for post-surgical care. Likewise, the surgeons who make referrals do not own and are not employed by the agency.

After receipt of referrals, agency staff members call each patient referred on the telephone. During these calls, patients are reminded that surgeons referred patients to the agency. Also during the call, agency staff members confirm the information they have about each patient and reminds them of their right to choose a different home health provider. Preparations are also made to send patients an educational video at some point prior to surgery.

The agency produced two very similar videos:

One for patients who are scheduled for knee surgery and one for patients scheduled for hip surgery. The videos educate patients about restrictions and physical limitations that post-surgical total joint replacement patients typically encounter during their convalescence at home following surgery. The videos advise patients on issues such as optimal furniture placement, sleeping and bathing, strategies for negotiating stairs, as well as what clothing, durable medical equipment, and special items or tools best suit patients' special needs. Patients are also invited to consider the possibility that they may desire or need primary caregivers during convalescence.

The content of the videos consists primarily of scenes in which individuals and families demonstrate simple advance preparations for convalescence at home after surgery. They act out certain physical challenges of recovery after surgery. Individuals identified as former patients also speak on camera about their own process of recovery from surgery.

Voiceover and visual "placards" identify the agency as the producer of the videos at the beginning and end of the videos. Otherwise, there is no mention of the agency or its services. No substantive promotional claims are made on their behalf.

The videos provide neither medical advice or diagnoses. Instead, they advise patients to consult their own physicians and physical therapists about various issues. The OIG concluded that similar information is available on the Internet and from other public sources without charge.

Patients typically keep the videos. The agency does not charge for the videos and, according to the agency, they have no resale value. Patients are not required to view the videos in order to receive home health services.

In view of these facts, the OIG first pointed out that these activities may violate the federal statute governing illegal remuneration. The so-called "kickback" statute generally prohibits providers from offering to give or actually giving anything to anyone, including potential patients, to induce referrals.

The OIG then considered the question of whether the free educational videos are remuneration to patients who receive them and whether their value is more than nominal since providers generally cannot give patients items worth more than $10 at a time or $50 per year.

Specifically, the OIG said that the value of the videos to beneficiaries is the key issue. The OIG emphasized that the videos contain no medical advice or diagnoses by surgeons, physical therapists or other health professionals related to individual patient's conditions. Rather, the videos make only general suggestions and recommendations that patients obtain the personal advice of their health professionals about various issues.

The OIG, therefore, concluded that prospective patients who receive the videos are unlikely to believe that they have received items worth more than $10 or be willing to pay such an amount if the videos were not provided for free.

The second issued addressed by the OIG was whether the videos are likely to influence patients to select the agency as their provider of post-operative care.

The OIG concluded that the videos were unlikely to influence patients to choose the agency for the following reasons:

- Patients do not receive videos until after their surgeons have referred them to the agency.
- Implicit endorsement of the agency by surgeons determines patients' ultimate choices of agencies.
- The content of the videos is applicable to patients regardless of which agency they ultimately choose.
- Similar content is widely available without charge on the Internet and from other sources.

No personalized safety or health care recommendations accompany the videos.

Although the Advisory Opinion described above technically applies only to the agency that requested it, the Advisory Opinion may also provide useful information to other agencies. The Advisory Opinion seems to support agencies' programs to engage in certain pre-operative activities consistent with policies and procedures that appropriately address applicable requirements. ■

Approach helps members avoid asthma attack

Plan contracts with agency for home-based services

An asthma management program that includes telephonic case management, home visits, and physician incentives has saved money and earned accolades for Priority Health, a health plan company based in Grand Rapids, MI.

In six years, participants in the Healthy Encounters asthma program reduced the number

of emergency department visits for asthma by 26% and increased the use of proper medication from 69% to 98%, according to **Mary Cooley**, RN, BSN, MS, CCM, senior manager of case and disease management at Priority Health. During the same time, hospital admissions for asthma dropped dramatically for both the health plan's commercially insured and Medicaid members.

In 2005, the health plan saved an estimated $1.5 million when actual costs were compared with expected costs, Cooley says.

The health plan's model received the National Leadership Award from the U.S. Environmental Protection Agency (EPA) as well as the Region 5 National Exemplary EPA award and the Michigan Association of Health Plans' Pinnacle Award for chronic illness.

About 8,000 people insured by Priority Health have persistent asthma. The health plan's goal is to help them understand their disease and learn to manage it by using medication properly and avoiding situations that can trigger an asthma attack, Cooley says.

Understanding asthma

"Asthma is quite misunderstood. Persistent asthma is a chronic disease but many people treat it acutely. They go to the emergency department and receive nebulizer treatment, which makes them feel better so they don't follow up. They don't understand that they need to take daily controller medication," she says.

The program takes a three-pronged approach to asthma management combining case management and disease management, community partnerships, and provider initiatives.

Case managers and disease managers work telephonically with members who are at risk for an exacerbation and refer those who are at highest risk for face-to-face case management provided by the Asthma Network of West Michigan, a grassroots, nonprofit agency.

Priority Health was the first health plan in the country to provide reimbursement for home-based services to members with asthma, Cooley points out.

"This partnership underscores Priority Health's commitment to its members as well as to the community," Cooley says.

The Asthma Network sends certified asthma educators, who are nurses or respiratory therapists and act as case managers, into homes to assess the home for environmental issues that could trigger an asthma attack, provide education and support, says **Karen Meyerson**, MSN, RN, FNP-C, AE-C, manager of the organization.

After the referral, the Asthma Network case managers take over care coordination for Priority Health members who agree to participate in the voluntary program.

"We contact them if necessary and provide a discharge summary when the member completes the process. It's a seamless process," Meyerson says.

The community case managers work with the members' physicians to create an asthma action plan, visit schools and daycare centers that members attend and provide asthma education to the staff, and work with the members to ensure that they are following their treatment plan.

'Eyes and ears in the home'

"We realized that our case management program is excellent but we did not have the ability to assess the members' environment. We needed eyes and ears in the home," Cooley says.

The health plan pays for up to 18 home visits a year for members with high-risk or difficult-to-control asthma, Myerson says. "Some members don't require 18 visits to learn how to manage their asthma. Others need long-term support," she adds.

Initially, the asthma educators visit the families every two weeks for three months, presenting a series of six asthma education sessions. After that, they visit the family once a month if they feel the family needs more support, or more often if appropriate.

"We follow the members for a year and help them learn how to manage their disease through the seasonal changes and to deal with environmental and psycho-social concerns," Myerson says.

They educate the members about their disease; make sure they are using the right tools, such as peak flow meters and inhalers, and teach them to use them correctly; work with the family on trigger management; and help them understand what factors in their home could be contributing to asthma exacerbations.

"The most important part of the visit is to assess the home environment for triggers. The personal assessment helps them identify problems that we may not find out about over the phone. If we ask a member if anyone in the family smokes, they may or may not say yes but the case manager visiting the home can smell it if someone is smoking," Cooley says.

The on-site case managers look for pets or evidence of cockroaches, dust mold, and water stains on the ceiling that indicate proliferating mold. They zero in on the bedroom and may recommend removing the carpeting or encasing pillows and mattresses in a plastic cover.

Making home modifications

The organization has a social worker who can help the family get assistance for home modification issues, such as removing carpeting or getting an exterminator to deal with a cockroach problem.

The case managers who visit the homes can also identify physical and psycho-social problems the members may be facing and call in a social worker for assistance, Myerson says.

"Many of the families we visit are living from crisis to crisis. Life gets in the way of complying with their asthma treatment plan. They're worried about not having enough food or being evicted and have to deal with whatever bubbles to the top of their list. They have so many issues, that a chronic disease is at the bottom of the list until they have an attack," Myerson says.

The social worker can help the family find assistance with issues such as housing and transportation so the asthma case managers can help patients learn to treat the disease as a chronic condition, rather than wait until they have an asthma attack.

Having someone go into the home and assess a member's living condition and home life helps the health plan's case managers understand the obstacles to following their treatment plan that the member may be facing, Cooley says.

"We know that we need to deal with the psycho-social issues that people confront in their everyday lives before we can tackle the asthma issue. Our community-based model helps us see what the barriers are and help the members overcome them," Cooley says.

Once the Asthma Network case managers have completed their work, the Priority Health case managers pick up the cases.

"We pick up the case to make sure they understand their asthma action plan and that they comply with their treatment plan so that the outcomes are sustainable over time," Cooley says.

Priority Health began its asthma disease management initiative in 1995 with a population-based health management initiative. The health plan created an asthma registry that contained the names of all members with asthma, stratified by risk level.

The members in the HealthyEncounters program receive targeted interventions based on their risk level.

High-risk members include those who have been hospitalized for asthma, who have multiple emergency department visits for asthma, and those who are overusing their rescue medicine or under-using their control medication.

"Our case managers reach out to every member who is at high risk. One of our current innovations is to move upstream and touch members with moderate risk as well. We always have taken a reactive approach and worked with the members who are having difficulties but we also want to take a proactive approach and target people upstream who haven't yet had a crisis. We want to keep them from reaching that point," she says.

Referring members in real-time

As part of its vision to provide assistance to people "just in time" the health plan has implemented an on-line stratification tool that refers members who are newly categorized as moderate or high risk to the case management department on an ongoing basis.

"My nurses are apprised of new cases on a weekly or bi-weekly basis," Cooley says.

In addition, the case managers receive e-mail alerts as soon as a member they are managing hits a risk factor, such as refilling his or her rescue medication too frequently or having an emergency department visit for asthma.

"Our interactive tools not only notify the case managers when new members are at risk but it gives them real-time information that helps them manage the care of their patients," she says.

The health plan is in the process of implementing between 15 to 20 different alerts into its software system to automatically notify case managers when members are newly diagnosed or hit certain thresholds.

"Our case managers will be able to click onto a dashboard when they receive an alert that a member has hit a risk level. Then they can pick up the phone and call the member to find out how they are doing. This gives the case manager an opportunity to help the member avert a potential crisis and avoid an emergency room visit or a hospitalization," she says.

The health plan offers provider tools that include a patient profile that identifies all patients with asthma who are covered by Priority Health.

The physicians can use the tool to identify patients who are not refilling controller medication or refilling rescue medication too frequently.

In addition, physicians who meet quality benchmarks for asthma care receive additional reimbursement from the health plan.

"We give the physicians the tools to make them successful in treating their patients with asthma and we incentivize them to meet quality benchmarks," she says. ■

CM helps high-risk members avoid hospitalizations

Initiative reduces cost, improves members' health

Face-to-face case management for members at high risk for health care exacerbations has paid off for Great-West Healthcare, a Greenwood Village, CO, health plan that serves as a third-party administrator for about 6,000 self-insured employer groups.

In about 50% of Great West's markets, eligible patients in the health plan's end-stage renal disease program and the neonatal intensive care program meet face to face with case managers who go on-site to the hospital or to members' homes.

Case managers in the health plan's end-stage renal disease program work with members at home or in the dialysis center, helping them stick to their diet and plan of care. The neonatal ICU program places case managers in the NICU where they collaborate with the physicians and nurses on the plan of care and ensure that the parents have the skills they need to care for their newborn after discharge.

Since the case management program began, hospitalization rates for end-stage renal disease patients have decreased by 10% to 14%.

The neonatal ICU program has shown a 32% reduction in readmissions for premature infants and generated a three to 5.5 return on investment for the program.

Great-West contracts for the NICU case management program through an outside vendor. The high-risk pregnancy program is provided by another vendor but they are linked together through the data feeds and through the health plan's care management system.

"The programs provided by our vendor partners are completely branded for Great-West Healthcare. The vendors all feed information into our system or use our software system so we can ensure that our members receive continuity of care and no one falls through the cracks," Norris says.

When the health plan is notified that a member has delivered a baby prematurely, it triggers a referral to the on-site case manager who goes to the hospital's neonatal intensive care unit and goes over the chart with the physician who is managing the infant's care.

The health plan has arrangements with the hospitals to have the nurse case managers come to the unit and review the cases.

"They work very closely with the NICU nurses and physicians. Having another pair of eyes looking at the chart and the child's condition is very beneficial to the baby," Norris says.

If the mother is still in the hospital, the case manager meets with her at the same time.

"The case managers make it a point to meet with the family to discuss what is taking place and go to the family's house if necessary. We want to help the family understand the child's condition, and the discharge plan," Norris says.

The neonatal case manager visits the NICU and reviews the chart weekly, working with the doctors and nurses to make sure that the infant gets the appropriate level of care that meets their needs.

"Some of these infants have very intensive needs and requirements for care and others are in the NICU only a few days before discharge and could receive a lower level of care. We work with the doctors and nurses to make sure that the level of care the baby receives is based on the severity of his or her condition," Norris says.

They stay in touch with the family, keeping them apprised of what is going on and when they can expect the infant to be discharged to home.

"The biggest piece of our on-site neonatal case management program is to make sure that the parents receive the education they need to be able to take care of the baby at home," he says.

When a premature infant is scheduled for discharge, the case manager verifies that the baby meets the required outcomes for going home.

They educate the family on the plan of care, teach them how to use the equipment and monitors that will accompany the baby home, and reassure them that they will receive the support they need when the baby is home.

"We want to make sure the family knows how to take care of the baby. If the infant is on a nebulizer or a ventilator, we make sure that they understand how it works and what they need to do," he says.

Once the baby is discharged, the case manager follows up with the family to make sure they are following the plan of care and educates them about when they should call the doctor or take the baby to the emergency room.

For instance, infants often get a stomach ache or vomit when they are being transitioned to oral feedings. If the family takes a baby who has been in the NICU to the emergency department, the baby almost always will be readmitted to the NICU as a cautionary measure.

"We want to educate the family about what is normal and what is not so they can avoid unnecessary trips to the emergency room and hospitalizations," he says.

The family also has around-the-clock access to the health plan's nurse line in case they have questions or concerns.

Many of the members in the NICU program are identified through Great-West's high-risk maternity program, a telephonic program in which case managers follow members at risk for complications of pregnancy or premature births through the pregnancy and work with the members' physicians to ensure that they receive the care they need.

When claims data or referrals identify a member as being pregnant, she receives an outreach call from a case manager who conducts multiple assessments to determine the risk.

The high-risk maternity case managers follow up with women who are at risk for complications of pregnancy on a regular basis and work with the members' physicians to make sure their needs are being met.

Members are referred to the end-stage renal disease program when they are in active dialysis.

When a case manager receives a referral, she contacts the members' physician for information about the patient's condition, meets with the patient in their home, at the dialysis center or the nephrologist office and conducts an extensive assessment to find out where the case management focus should be.

The assessment includes questions about the members' home life, living conditions, and personal life.

"We make sure that the patient's home environment and family support would facilitate them being able to complete the dialysis process. We make sure the family can handle getting the patient to the dialysis center and assist the family in communicating with the physician," he says.

The case managers help the members stick with their physician's dietary recommendations and teach them how to keep their dialysis access point clean.

"The majority of hospitalizations for these patients are due to infection of the access point for dialysis. By educating the members and working with them on the correct type of access, we have been able to reduce hospitalizations quite dramatically," he says.The case managers reinforce the physician's recommendations for a diet and exercise regimen.

"We fill the space in between the doctor visits, following up to make sure they are following the treatment plan," he says.

The case manager contacts the member every other week on average, depending on the member's needs and availability. If the members have comorbidities, such as diabetes or congestive heart failure, the renal disease case manager coordinates the care for those conditions.

"All our programs follow a primary nurse model. One case manager works with the member as much as is possible," Norris says. ■

CMS posts follow-up info for HHAs

The Centers for Medicare and Medicaid Services (CMS) has posted follow-up information for an issue raised in a Feb. 20 open door forum for home health, hospice, and durable medical equipment

COMING IN FUTURE MONTHS

- How to use the Internet to generate referrals
- Are you looking at the right data?
- P4P update
- Tips to build the value of your HHA

organizations.

Question: When completing a ROC, do the clinicians mark the number of PT visits in M0826 that was originally on the SOC or do they mark how many PT visits they feel are left?

CMS Response: M0826 is an OASIS item with a single use of facilitating payment under the Home Health Prospective Payment System. Typically, at the SOC (RFA 1) and Recertification (RFA 4) data from M0826 (along with other relevant OASIS items) are used to determine the payment under PPS for the current or upcoming episodes respectively. In addition to SOC and Recert, M0826 is also collected at the ROC (RFA3) time point. Typically, data from this ROC is not used for PPS payment determination and in cases where the data is not need for payment, response NA - Not Applicable: No case mix group defined by this assessment could be reported on M0826. Alternatively, providers may choose to report the total of therapy visits that have been provided during the episode to date, added to the number of therapy visits planned to be provided during the remainder of the current episode. If the ROC assessment will not be used to determine payment, then it does not matter which of the above approaches an agency chooses. While data from the ROC time point does not usually affect PPS payment, there is a specific situation in which it does; that is when a patient under an active home health plan of care is discharged from an inpatient facility back to the care of the home health agency in the last five days of the certification period. In that situation, CMS allows the agency to complete a single ROC assessment to meet the requirements of both the resumption of care and of the pending recertification. When a ROC assessment will be "used as a recert" (i.e., used to determine payment for the upcoming 60 day episode), then the ROC data will be necessary to define a case mix (payment) group, in which case the total number of therapy visits planned for the upcoming 60 day episode should be reported. ■

Transitional care tools available

The final package of best practice intervention tools for transitional care coordination is now available from the Home Health Quality Improvement Organization Support Center. Best

CNE *questions*

1. What was the first step taken in her agency's efforts to increase their score in the improvement in dyspnea measurement, according to **Penny Martin,** RN?
   A. Smoking cessation program
   B. Patient education packet
   C. Staff inservice on OASIS documentation and scoring
   D. Addition of respiratory therapist to staff

2. How does the client development staff at New Dimensions Home Health spend the majority of their time, according to **Josie Lightfoot,** president and CEO of the agency?
   A. Knocking on doctors' doors
   B. Making telephone calls to potential patients
   C. Working with insurance company case workers
   D. Talking directly with community members

3. Priority Health saved about how much in 2005 when actual costs and expected costs were compared?
   A. $1 million
   B. $1.5 million
   C. $2 million
   D. $2.5 million

4. Since the case management program began at Great-West Healthcare, the NICU has seen a 42% reduction in readmissions for premature infants.
   A. True
   B. False

Answer Key: 1. C; 2. D; 3. B; 4. B.

practice intervention packages are free and include educational tools and resources, guidelines, success stories, and best practice education to assist agencies in reducing avoidable hospitalizations.

The campaign resources are available on the Home Health Quality Improvement web site at www.homehealthquality.org. In addition, campaign resources are available on Medicare Quality Improvement Community web site at www.medqic.org. ■

On-line bonus book for *HHH* subscribers

Readers of *Hospital Health Management* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2008 Healthcare Salary Survey & Career Guide*.

The report examines salary trends and other compensation in the hospital, outpatient, and home health industries.

For access to your free 2008 on-line bonus report, visit **www.ahcmedia.com**. ■

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 **April** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■