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Financial Disclosure:
Editor Sheryl Jackson, Managing Editor Karen Young, Associate Publisher Coles McKagen, Board Member Elizabeth Hogue, and Consulting Editor Marcia Reissig report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

JUNE 2008

VOL. 25, NO. 6 • (pages 61-72)

Technology study shows growing use, increased satisfaction with telehealth

Benefits: Better outcomes, fewer hospitalizations, compliant patients

More than 88% of home care telehealth providers report that the service has produced an increase in quality outcomes for their agencies by reducing hospitalizations and emergency department visits. These home health providers shared their feedback in a national study that looked at the use of technology in home health.

"This is an important statistic as home health agencies look at reimbursement under a pay-for-performance system," says **Jill Christians**, senior marketing services manager for Philips Home Healthcare Solutions in Bothell, WA. Philips underwrote the *Philips National Study on the Future of Technology and Telehealth in Home Care*, which was conducted by Fazzi and Associates, a Northampton, MA-based research and consulting firm that specializes in home health, and co-sponsored by the National Association for Home Care and Hospice. "Almost 1,000 home health agencies responded to the survey that asked about use of four different technologies," she explains. Billing systems, point-of-care technology, electronic health records, and telehealth were addressed in the survey. (See resource box, p. 63, for instructions on how to receive copy of the study.)

Over 17% of respondents report using some type of telehealth system, but among larger agencies the percentage is higher, with 32% of large agencies reporting the use of telehealth, says Christians. (See p. 63, for more results of the study.) "We also found that hospital-based or hospital-owned agencies offer telehealth less often than nonhospital agencies," she says. The survey did not identify reasons for this difference, but being part of a larger system, having to coordinate systems and budgets with other hospital departments, and different geographic locations might be reasons for not adopting telehealth, she says.

"We installed our telehealth system 14 months ago," says **Krista Kelly**, RN, BSN, assistant executive director of home health for Integrity Homecare in Springfield, MO. Her agency has seen a 3% decrease in rehospitalizations, a 1% decrease in ED visits, and a 2% drop in urgent care visits, since the start of the telehealth program. "We've also been able to reduce our visits by about one visit per episode," she adds.

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Although the decrease in nursing visits is a benefit to the agency, it should not be the primary reason for adding a telehealth service, points out Kelly. "Telehealth is just one more tool in our toolbelt to give us more information to enable us to better care for our patients," she says. Forty-one percent of respondents to the study identified improvement of overall quality as the primary goal of telehealth, and 33% of respondents cited reduction of unplanned hospitalizations and ED visits as their primary goal. Only 9.6% of respondents said that reduction of nursing visits was a primary goal.

Although slightly more than 61% of respondents say that their telehealth service is a part of a disease

management program, Kelly's agency takes a different approach. "We assume that all patients are candidates for telehealth until the nurse excludes them," she says. Nurses may not recommend patients for telehealth if they have no landline phone service in their house, if the home is infested with bugs that can interfere with equipment, if the patient is unable to use the equipment and has no steady caregiver in the home to manage the equipment, and if there are mental conditions that will be aggravated by the equipment. "We do have some psychiatric patients that might view the telehealth system as 'big brother' watching them, and the system would exacerbate their paranoia," she explains. Other patients might refuse the equipment because of their discomfort with the technology, she adds.

At this time, 50 patients are on the telehealth system, which represents 10% of the agency's caseload, says Kelly. Telehealth patients monitor their blood pressure, weight, oxygen level, and heart rate every day and transmit it to the agency, she says. "Some of our cardiac patients also have the electrocardiogram (ECG) feature on their systems," she adds.

Success increases staff acceptance

The ECG feature and the ability to identify a problem for a patient that warranted medication changes actually helped Kelly garner more support for telehealth throughout the nursing staff. "One patient told our telehealth coordinator that he felt funny, so she suggested that he use the ECG feature," she says. The ECG strip did show palpitations, so the telehealth coordinator sent the information to the patient's physician who then changed the patient's medications. This patient's nurse was a member of staff who was skeptical about the value of telehealth, but after this incident she became a proponent of the technology, she adds.

An important component of implementing any telehealth system is to have staff members and patients buy into the value of the service, says Kelly. In addition to staff educational sessions prior to implementation, telehealth is kept top of mind in all case conferences in which every new patient's case is reviewed and the question "Why was telehealth not recommended?" is asked, she points out.

One tip that Kelly offers other home health managers is to include therapists in the telehealth training. "I did not include therapists in the ini-

Hospital Home Health® (ISSN# 0884-8998) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304 and at additional mailing offices. POSTMASTER: Send address changes to **Hospital Home Health®**, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: customerservice@ahcmedia.com. World Wide Web: <http://www.ahcmedia.com>. Hours: 8:30-6 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), \$499. Add \$17.95 for shipping & handling. Outside U.S.A., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are \$83 each. (GST registration number R128870672.)

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Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

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tial training, and that is one thing about our implementation that I would change," she says. "There are telehealth patients who receive therapy, and the therapist needs to be familiar with the equipment in order to use it, or to answer questions," she explains.

Patients realize the value as they use the equipment, says Kelly. A patient who did not take her diuretic regularly because she didn't think she needed it could easily see herself gain weight from fluid retention as she weighed herself every day, she explains. Because the patient knew the nurse was expecting her to monitor herself each day, she would take her blood pressure and weigh herself, she says. "The everyday weight gave the patient the opportunity to see exactly what happened when she didn't take her medication, and she better understood the relationship between the medication, her diet, and her fluid retention," she explains. Because the patient saw the proof that the medication helped, she became more compliant with her medication schedule, she adds.

Patient satisfaction improves with the use of telehealth according to over 71% of study respondents, and over 79% report that patients and family members are reluctant to disconnect the telehealth equipment. "Patients become more involved in monitoring their symptoms and self-management," says Kelly. This may be due to

more consistent education as the nurse reinforces education and refers to telehealth reports and trends, and it may be due to the patient feeling that he or she has some control over their medical condition, she adds.

The telehealth experience at Integrity Home Care has been positive, and Kelly recommends that every home health agency evaluate the possibility of adding the service. "Telehealth can be as simple as telephone calls to patients who have a blood pressure cuff, a scale, and a glucometer in their home," she points out. The patient can just report the findings to the nurse who tracks it on a chart, she explains. "Whichever system you choose, telehealth is a good tool to help prepare for pay for performance." ■

Stats give clear picture of telehealth use

The 117-page report on the *Philips National Study on the Future of Technology and Telehealth in Home Care* includes a wide range of information on different technologies used by the almost 1,000 home health agencies that participated in the survey, but the greatest amount of information focuses upon telehealth.

Some of the key findings include:

- 83.9% of agencies stated that fewer than one in 10 patients refused the system. Nearly two-thirds reported that fewer than one in 20 refused.
- 71.3% of agencies responded that telehealth services improved patient satisfaction. No agency reported that it reduced patient satisfaction.
- 97% of agencies answered that they had criteria for which patients should use telehealth services.
- 49.7% of agencies reported that the use of telehealth services were offered reduced the number of visits per patient.
- 45.2% of agencies for which telehealth services led to an increase in referrals.
- 88.6% of agencies reported that telehealth services led to an increase in quality outcomes.
- 76.6% of agencies stated that telehealth services led to a reduction in unplanned hospitalizations.
- 42.8% of agencies stated that telehealth services led to a reduction in cost. Another 48.2% reported it had no impact.
- 89.1% of agencies reported that given

SOURCES/RESOURCE

For more information about telehealth and the telehealth study, contact:

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everything they know today, they would still have started their telehealth service.

- 41.3% of agencies stated they use specific strategies to educate and obtain manager and supervisory buy-in.
- 57.2% of agencies stated they used specific strategies to educate and get clinical staff buy-in.
- 66.7% of agencies used a “nurse champion” to help get clinical staff buy-in.
- 56.9% of agencies reported that their nurses were very receptive to having a telehealth service after one year as compared to 36.6% at the beginning of the program.
- 63.3% of agencies reported using specific strategies to get physician buy-in to the services.
- 35.7% of agencies lease rather than purchase their system.
- 90%+ agencies list the same three specific core components as part of their telehealth system (blood pressure, pulse oximetry, scales).
- 16.2% agencies plan on replacing or upgrading their telehealth systems in the next 12 months. ■

Nurses’ bags play key role in infection control

Steps taken to ensure no pathogens

Wash hands, wear gloves, and clean equipment. All home health nurses know that these are the basic steps to take to protect patients from infection. What about the nurses’ bag? How clean is it and does it pose an infection threat?

These are questions asked and answered by a study conducted by **Irena L. Kenneley**, PhD, APRN-BC, CIC, infection control consultant and assistant professor at Case Western University School of Nursing in Cleveland. “We recruited four home health agencies to participate in the study and cultured the inside and outside of their nurses’ bags along with the patient equipment in the bags,” she explains.

Nurses were told to bring their bags to the next staff meeting but were not told why, says Kenneley. “When the meeting started, we explained the research project and asked them to sign an informed consent before we tested their bags,” she explains. “Not many nurses opted out of the study, because most were eager to find out if their bags were contaminated and how they

could better prevent transmission of infections,” she adds.

More than 450 cultures were collected from 127 bags. “Overall, 66.7% of cultures collected from the outside of the bags, 48.4% of cultures collected inside the bags, and 22.3% of cultures collected from the patient care equipment tested positive for infectious agents,” she adds. Pathogens include gram-negative bacilli, *E. coli*, and multidrug-resistant organisms (MDRO) such as methicillin resistant *Staphylococcus aureus* and vancomycin-resistant *Enterococcus*.

In the first agency tested, the number of cultures that tested positive for pathogens was in the upper 80% range, says Kenneley. “After the bags were thoroughly cleaned and used for two weeks, we re-cultured them,” she says. The level of pathogens present on the bags dropped by 31% in the retest, she says. “This raised the question of cleaning protocols and how they affect the number and type of pathogens on the bags,” she explains.

To address this question, researchers asked nurses at the next three agencies to complete a survey about cleaning practices and care of the bag, says Kenneley. “The survey answers were linked to the results of the cultures to identify different practices and types of bags and how they impact the presence of pathogens,” she says.

The survey showed a wide range of cleaning practices, admits Kenneley. “One nurse had owned her bag over 10 years and never cleaned it,” she says. Others cleaned their bag when they appeared soiled or at irregular intervals. “The best practice is to clean the bag weekly,” suggests Kenneley.

The cleaning products used for the bags were not always effective, points out Kenneley. “Many nurses used Formula 409, Windex, or Lysol to clean their bags because they were cleaning them at home and had those products available,” she says. The study shows that the most effective cleaning solutions are institutional-grade cleaners that contain bleach, she adds.

Leather better than cloth

The type of material used for the bag also affected the likelihood that pathogens were present, says Kenneley. Multidrug-resistant organisms and pathogens were most likely to be present on cloth bags and least likely to be present on leather bags. “This is in line with the Centers for Disease Control and Prevention Guidelines that recommend that porous materials

SOURCE

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not be used for surface materials in healthcare settings, she points out. Nonporous materials are less likely to absorb and retain pathogens that can be spread to areas in the patient's home and to patient care equipment in the bag, she adds.

Another correlation found in the study is that the presence of MDROs and pathogens on the outside of the bag significantly increases the likelihood that MDROs and pathogens will be found inside the bag and on patient care equipment within the bag, says Kenneley. "Even though nurses' bags are considered noncritical equipment, when considering infection control practices, this study does point out that the condition of the bag affects the equipment inside," she adds.

Several issues were identified as necessary to reduce the risk of contamination by the bags, says Kenneley. The need to standardize or set parameters for the type of bag carried by nurses is important, she says. "Home health care nurses work autonomously as part of their everyday job, so it is not common for agencies to tell them what type of bag to carry," she admits. However, the data from the study is so convincing that some of the participating agencies are setting parameters for the type of bag that nurses must use, she says.

One agency took standardization a step further and provides the bag for the nurse, points out Kenneley. The same agency ensures a thorough cleaning of the bag by requiring the nurse to bring it to the agency once a month for cleaning by a staff member who is trained in the proper protocol to clean the inside and outside of the bag. "Standardizing cleaning protocols and providing the proper cleaning solutions is important for nurses' weekly cleaning of their bags, but the required once a month cleaning is an added measure of safety," she says.

Even after setting parameters for the type of bag used and establishing clear guidelines for cleaning procedures, ongoing education is the key to making sure that the nurses' bags don't

harbor pathogens, says Kenneley. "People are enthusiastic at the beginning of any new program, but they get lax," she admits. "Ongoing education will keep the awareness high and help the agency avoid managing a potential crisis such as an MDRO outbreak." ■

Hospices hit Medicare cap, legislation for moratorium

Hospices disagree and call for other solutions

Legislation introduced by Oklahoma lawmakers U.S. Sen. James Inhofe and U.S. Rep. John Sullivan calls for a three-year moratorium on efforts by the Centers for Medicare & Medicaid Services (CMS) to collect overpayments for hospice patient care.

While experts throughout the hospice industry agree that the Medicare hospice cap needs to be re-evaluated, there is disagreement about the need for a moratorium.

"A moratorium has the potential for unforeseen consequences," says **Jonathan Keyserling**, JD, vice president of public policy and counsel for the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA. "We have to be cognizant of the federal budget process, and while the cap is a crude tool to contain expenses, it does provide some control," he says.

A moratorium would remove all controls and potentially place hospice organizations that do admit primarily long-stay patients at greater financial risk, he adds.

Another risk of a moratorium is the reduction of payments to hospice organizations across the board, says **Greg Wood**, LBSW, executive director of the Hospice of North Central Oklahoma in Ponca City and president of the Oklahoma Hospice Association. A moratorium might save money for some of the hospices that owe CMS now, but in the long run, CMS might reduce hospice payments in order to control costs and manage the budget, he says.

Wood questions the data that lawmakers Inhofe and Sullivan used as proof that Oklahoma hospices were in trouble. "The statement that 40% of Oklahoma hospices have hit the cap is not accurate," he says. There are 157 hospices in Oklahoma, with 99 of them handled by one Medicare intermediary and 58 handled by

another, he explains. Forty percent of the 99 hospices have hit the cap, but there are no data released about the other 58 hospices, he says.

Based on feedback from association membership and leadership, the Oklahoma association does not support the moratorium, says Wood. The cap is not new, he points out. "It is described in the Conditions of Participation to which we all agree," Wood says.

In 1982, CMS began paying hospices a flat fee for care of hospice patients but designated a cap on the total amount that a hospice can be reimbursed for a patient's care. "It is an aggregate payment level, so we look at all patients admitted and multiply the cap level by total number of payments to get the total reimbursement for that year," says Wood. The cap was \$21,410 per patient in 2007, he points out.

In 1998, limits on the number of days that a patient could receive hospice care were removed, which increased access to hospice for terminally ill patients with diseases other than cancer, says Wood. "Although a hospice may care for some patients longer than six months, most hospices care for a wide range of patients and the patients who are in hospice care for less time will bring the average number of days and the reimbursement level down below the cap level," he points out.

Smaller providers benefit from moratorium

One of the supporters of the moratorium is **Lois Armstrong**, president and chief operating officer of Sojourn Care in Tulsa, OK, and one of the organizers of the National Alliance for Hospice Access (NAHA), an advocacy group committed to study and revision of the hospice cap.

"This issue became important to my partner and I when our hospice hit the Medicare cap in 2005," she says. "We received a demand letter for \$2 million 18 months after we provided care for patients who did meet Medicare admission criteria," she says.

Armstrong and her business partner organized NAHA to pull together hospice organizations that might not be part of larger organizations and might feel the effects of the cap more dramatically, she explains. "If you are part of a larger organization or part of a chain, you can afford to pay money back to Medicare, but smaller, independent hospices have already spent the money on patient care and don't have the financial resources to meet the demand for repayment,"

she explains.

A key component of NAHA's advocacy effort is the moratorium that would stop the calculation of any 2006, 2007, or 2008 cap overpayment that has not yet been calculated, and stop collection of any cap overpayment that already has been calculated but not collected by CMS, says Armstrong. Review of the hospice cap and any changes to the cap might take two to three years, and independent providers cannot survive that length of time if they do not have a moratorium in place, she adds.

Four trends identified

The percentage of hospices that have exceeded the cap has grown from 1% to 6.8% in the past five years, admits Wood. Medicare fiscal intermediaries have reported four distinct trends that contribute to a hospice reaching the cap, he says. Reasons range from premature admission to hospice, to long lengths of stay and lack of administrative processes to handle discharges and financial monitoring. However, there are several ways that hospice managers can reduce their hospice's risk of reaching the cap, Wood adds.

(See article, p. 67, for more information.)

The federal cap on hospice payments is an issue that needs to be reviewed in the context of all issues affecting hospice payments, Keyserling says. "The NHPACO has submitted a proposal that looks at all four levels of hospice care and adjusts geographical reimbursement rates," he says.

Per diem reimbursements vary according to geographical location, Wood says. A hospice providing services in an urban area might receive a higher per diem than a hospice operating in a different part of the state, he explains. "Even though per diem rates vary, the cap is the same for all hospices," Wood says. This variation means that providers receiving the higher per diem are more likely to reach the cap sooner than providers receiving the lower per diem, he explains.

"Solutions to this problem would be the same per diem for all hospice organizations or a cap that is based on geographical differences," Wood says.

In addition to adjusting reimbursement rates or the cap itself, Wood also would like to see some long-term changes in the hospice Medicare program to ensure that potential problems within hospices are identified before they reach a crisis stage. "We should have more surveyors and more frequent surveys for hospice," he says. Hospices are not surveyed frequently, with some undergoing surveys every 10 years, and we've had an

explosion of new hospice organizations, he says. The rapid growth of hospice means that surveyors don't get back to resurvey organizations in a timely manner, he says. "Home health agencies are surveyed every 36 months, and hospice should have the same oversight," he says. "This will require hospice managers to stay up-to-date on financial reports, monitoring quality of care, and documentation requirements."

Even without surveys, hospices should consider Additional Documentation Requests (ADR) from CMS as red flags to carefully review practices and processes, suggests Wood. The key is to address small problems before they become big ones, he adds.

Because many patients see hospice as a source of palliative care, many hospice owners and managers would like CMS to consider funding palliative care services separately, says Wood. "You may have a multiple sclerosis patient who would benefit from palliative care, but they might not be considered terminal for years," he says. "If CMS offered a palliative care benefit, we could still care for these patients and keep hospice care for terminally ill patients."

The hospice cap is a looming issue that needs to be addressed now, says Keyserling. The percentage of the total population of Medicare decedents who die of noncancer-related causes is 70%, and the percentage of Medicare decedents in hospice care that die of noncancer-related causes is 54%, Keyserling says. "As hospice moves toward the 70% of noncancer-related deaths, there will be longer stays and an increase in the number of hospices reaching the cap if no changes are made," he says. ■

Trends help hospice managers avoid the cap

Four key items contribute to financial woes

Every hospice is different with varying populations to serve, but an analysis of the reasons that 40% of the 99 hospices in Oklahoma served by Palmetto Government Benefit Administrators (GBA), a Medicare fiscal intermediary, hit the hospice cap shows four predominant reasons, says **Greg Wood**, LBSW, executive director of the Hospice of North Central Oklahoma in Ponca City and president of the Oklahoma

Hospice Association:

- **Premature admission to hospice.**

Even if a patient has a terminal illness, there is a period of time that other health care services, such as home health, can meet the patient's needs, says Wood. Just because a physician signs an order that the patient has a terminal illness, hospice may not be the only option or even the best option, he points out.

"In some cases, a physician may state that a patient is terminally ill to qualify them for admission to hospice when the physician is an owner or financially tied to the hospice organization," says Wood. While this is not the case for many physicians and patients, it does raise the issue of enforcement and places the burden on the Centers for Medicare & Medicaid Services (CMS) to enforce the rules, he adds.

- **Long length of stay.**

A hospice often will have patients who live longer than others, so it is important that care is taken to ensure a mix of patients that will keep the aggregate number of days of care below the cap, Wood says. Achieving this mix requires careful review of the patient's needs upon admission and at any recertification point, he adds.

A hospice's patient base should reflect the community, says **Jonathan Keyserling**, JD, vice president of public policy and counsel for the National Hospice and Palliative Care Organization (NHPCO) "There should not be a disproportionate number of short-stay, midstay, or long-stay patients," he explains. "Hospice providers may need to redouble their efforts to attract short-stay patients."

- **Inadequate discharge planning process.**

Even patients with terminal illnesses may reach a point during their illness that they don't require hospice services, Wood says. Unfortunately, many hospices don't have discharge planning processes in place to make sure that these patients are referred to home health or other services if their disease is in remission or if the decline in their health has stopped, he says.

"I had a conversation with one hospice provider who told me that his hospice didn't believe in discharging Medicare beneficiaries because they've earned the benefit," Wood recounts. "I don't advocate abandoning patients, but if they can be well served by other providers, discharge them to those providers and readmit them to hospice when appropriate."

- **Lack of knowledge regarding cap and financial performance.**

Hospice managers must monitor their reimbursement levels to determine how close they are to reaching the cap, says Keyserling. "Providers should be monitoring their financial data on a monthly basis," he recommends.

If you do see that you are close to the cap or exceeding it at any point, be prepared to set aside some funds to be available for future repayment, suggests Wood. This will ensure that the hospice will not be harmed financially by a demand from CMS, he adds.

Another basic problem is the lack of knowledge about the cap itself, says Wood. "A hospice provider once admitted to being in business for 10 years and not knowing that there was a cap on Medicare payments," he says. "Although it is only one little paragraph in the conditions of participation, it was also one of the first things I was taught when I was hired to run a hospice." ■

Don't put up roadblocks when callers want info

Correctly handled calls can bring 30% of admits

"I just have a few questions." "I'm calling to get some information." "I don't need an appointment now. I'm just making a call for a family member."

How many times have the receptionists or customer service people in your hospice heard these statements? How many of these inquiries or information-only calls do they turn into new clients?

"Every hospice is missing opportunities for new referrals if these information-only calls are not properly handled," says **Polly Rehnwall**, president of Polly Rehnwall Inc., a consulting firm in Salt Lake City. When addressed correctly, inquiry calls can represent as high a percentage of admissions as referrals from professional sources, she says.

Not all hospice organizations know how to handle these calls, admits Rehnwall. "My firm offers a 'mystery caller service' to make calls to different hospices to see how the person answering the phone handles the request for information only," she says. "Often we hear the hospice representative say that a doctor's order is needed, the patient must have a terminal illness, and that a brochure can be mailed." None of these responses

will help turn a call into an admission, she points out.

When her hospice began treating all calls as potential admissions, there was a significant increase in admissions and referrals, says **Terri McEntee**, RN, BSN, CHPN, associate director for referral services at Delaware Hospice in Wilmington. "All calls, emergency and information only, are handled the same way by our referral center staff," she explains. Obviously, emergency or professional referrals require a visit by a nurse, but information callers also are offered a visit by a hospice staff member, McEntee says. "We explain that we can easily schedule an information visit at the callers' convenience."

The hospice staff member answering the phones should say, "I'll be happy to give you some help. Tell me why you are calling," suggests Rehnwall. "Then listen patiently in order to build trust." Rather than putting up barriers such as doctor's orders, the staff member can open the door to setting up a visit, she points out.

Information-only visits, as opposed to clinical visits, are scheduled, explains McEntee. Staff members who make the visits don't have to be clinicians, points out McEntee. In fact, a nonclinician often makes the family more comfortable, she adds. Often the caller has very general questions about the services or medical equipment that hospice provides, but some may have specific clinical questions, McEntee says. "If the staff member making the visit cannot answer a question, he or she calls the supervisor and gets the answer before leaving the home," she says.

"Traditional health care people don't always have the attributes needed for a service representative or customer service staff position," Rehnwall says. "Many health care employees are used to following a rule book and working within a highly regulated industry. I've found that people with real estate, sales representative, or even wedding planner experience have made excellent service representatives." The key to finding the right person is to look for someone who is "infinitely curious," she says.

Gather info, paperwork during visit

Paperwork completed during the visit should include information sheets with patient's name, insurance, place of employment, contact information, family member information, and any other information you might normally collect, says Rehnwall.

“Leave all signed paperwork with the family, and explain that this will make the admission process simpler when they are ready,” she says.

In addition to information about hospice services, be sure the service representative can talk about all services that might help the caller and the family, suggests Rehnwall. “Meals on Wheels or home health care might be more appropriate services for the family at the time of the visit,” she points out. “Your goal is to help the initial caller care for someone in the family, even if it means pointing them to another provider because it is the right thing to do.”

Don’t be afraid to refer someone to another provider because you already have earned their trust by listening and offering them resources, says Rehnwall. “When the family reaches the point at which hospice is right for the patient, you’ll be remembered,” she says.

A shift in culture

Creating a successful program to turn inquiries into referrals requires a shift in organizational culture, admits Rehnwall. At first, hospice managers assume that most of their admissions are due to referrals from other providers because they don’t get consumer calls, she points out.

“In fact, some of my hospice clients have discovered that 30% of their calls come from family members, not doctors or hospitals,” Rehnwall says.

The number of calls coming from family members or friends makes it important to move away from the strictly clinical focus of scheduling patients for admission to hospice, says Rehnwall. “Hospices need to return to their social roots, using chaplains, social workers, volunteers, and nonclinicians who can take on some responsibilities for giving information and support to people who ask for help,” she suggests. “Nursing case managers don’t have to do it all.”

Make sure all staff members throughout the hospice understand the switch to service representatives and giving all callers the same level of service, says Rehnwall. Because you never know who will answer a phone, have a question asked of them in the community, or meet a friend of a patient at the patient’s home, all staff members need to know that simple information-only requests can matter significantly to the hospice, she says. “You have to approach every inquiry with the thought that this inquiry is an admission until proven otherwise,” Rehnwall says. ■

Nurses learn to ‘speak the language of ethics’

Program helps nurses add to ethics discussions

Some of the language of ethics doesn’t come naturally to nurses, according to a nurse-ethicist. But an initiative by Indianapolis-based Clarian Health aims to make ethics training and discussion second nature to the 5,000 nurses working there.

Lucia Wocial, RN, CCNS, PhD, nurse ethicist at Clarian’s Charles Warren Fairbanks Center for Medical Ethics, says, “All nurses will encounter ethical issues, and as a new nurse, you develop experience on a continuum from novice to expert. You become more aware of ethical issues as you gain more experience, and by centering our ethics training around the units where they work, their ethics training develops along with their experience.”

Predictably, nurses that deal with death are creating the most demand for the unit-based ethics discussions. “When you’re facing the issues of patients dying, the nurses who are exposed to dying patients for hours a day have a higher need for ethics conversations,” Wocial says.

The Fairbanks nursing ethics program focuses particular attention on the system’s intensive care units, where severe illness and high-tech medical care often raise important ethical questions for hospital staff, patients, and families. Through staff education, consultation support, and research, Clarian’s nurses will have support in managing ethical conflict and emotional distress that can result from carrying out a plan of care that sometimes contradicts their beliefs about what is in the best interest of the patient.

Nurses confront ethical dilemmas, too

Wocial says while “nurses don’t drive the bus” when it comes to treatment decisions, they often are the people patients and families have the most frequent contact with. They often get asked difficult questions while carrying out prescribed treatment.

“Doctors are in charge, and one of the challenges I’ve seen as nursing has come into its own is that nurses talk about nurse ethics in an adversarial way [to physician ethics], and that’s counterintuitive,” Wocial explains. “We need to introduce nurses as an interdisciplinary team member. The initial grant from the Methodist

Health Foundation to begin the program in nursing ethics is consistent with Clarian's desire to bring nurses to the ethics table as equal partners. The most recent \$5.4 million gift from the Richard M. Fairbanks Foundation will support this program and others at the Fairbanks Center."

Nurses don't establish plans of care, she continues, "but we have input and an ethical perspective; as a nurse, you have a completely different relationship with patients than physicians do, so you have a different perspective that can be extremely valuable."

For example, a do-not-resuscitate (DNR) order is a physician's order, so a nurse can't have "the DNR talk" with families to actually establish the order, Wocial says. However, nurses are in a good position to talk with the family about what to do when the patient can't speak for himself and generally prepare the family to talk with the doctor about the DNR order. "And when you help teach nurses to speak the language of ethics, they can make more of a contribution to the health care team," she adds.

Discussions on individual units

The nursing ethics program at Clarian centers around unit-based discussions; the nurse ethicist and other faculty from the Fairbanks Center go to individual nursing units to conduct conversations in ethics. The topic of the conversation is driven by those who come to the conversation, typically a patient situation happening on the unit, or a type of situation often encountered. The goal of the conversation is to provide a morally safe space for participants to discuss their concerns and identify strategies for managing their distress or resolving ethical problems.

"The unit-based discussions can give them real-time opportunities to learn to speak about ethics in an effective way, to harness emotions they feel about ethical issues, and channel it into a constructive approach to the issue," Wocial suggests. Each unit-based session is an hour long. Early this year, Wocial, who has been on the job since July 2007, already had 80 such sessions scheduled.

"What we know is that nurses who participate

in the discussions go back and participate on a different level with their patients at the bedside," she says. "They take the skills and thinking that we role model during the discussions, and they take that back to the bedside."

The discussions aren't just changing how nurses interact with their patients, Wocial adds. "We're starting to see how it affects how nurses communicate with physicians," she says.

"They are thinking more about what's happening, rather than just reacting to the situation. It's very easy to just react to something you hear about, but when you step back and think about it and sort it through, you can see that there's an ethical decision being made there, when before you might have been so busy that you didn't recognize it. And that's what we're encouraging nurses to do." This step is important, she says, because as a profession, nurses make up the largest proportion of members on Clarian's hospital ethics committee. ■

NEWS BRIEFS

CMS requires some findings be treated as deficiencies

COP-related findings should not pose problems

When the Centers for Medicare & Medicaid Services (CMS) granted The Joint Commission's deeming authority for another six years, some news reports pointed to a change in the way in which supplemental findings are handled as detrimental to a home care organization's ability to achieve accreditation.

"These reports were inaccurate," says **Debra Zak**, PhD, RN, executive director, Home Care Accreditation Program of The Joint Commission.

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“A small subset of Joint Commission standards correspond to CMS’ Conditions of Participation (COP),” she explains. Joint Commission surveyors who are conducting deemed status surveys along with the accreditation survey will evaluate the organization’s compliance with The Joint Commission standards that correspond to CMS’ Conditions of Participation (COP). While a surveyor can record a supplemental finding for Joint Commission standards, CMS requires that organizations respond to all findings related to COPs as they would a deficiency. This means that a home health agency must respond to the finding, file a plan of correction and submit follow-up information, she explains. This requirement by CMS does not differ from the surveys conducted by state agencies, so home health agencies are not being penalized for seeking a deemed status survey, she adds.

A significant number of The Joint Commission standards require more than CMS’ COPs, says Zak. For this reason, most home health agencies are already meeting higher standards than required by the COPs, so they are most likely to meet the CMS requirements, she says.

Home care agencies that have previously undergone deemed status surveys with The Joint Commission in the past do need to be aware that CMS now requires responses to all findings related to COPs, but it is not expected to affect the overall accreditation effort, says Zak. “This change related to COPs is CMS-driven but should not be a problem for our accredited organizations.” ■

Report shows satisfaction with home care increasing

HH nurses rank high as patients evaluate their care

More than 210,000 patients treated by 541 home health agencies nationwide provided the data included in the *2008 Home Care Pulse Report: Patient Perspectives on American Health Care*. The report, produced by South Bend, IN-based Press Ganey Associates, a research and performance improvement firm, shows a continued upward trend in patient satisfaction with high ratings for home health nurses.

A few of the key findings include:

- Patients report the highest satisfaction with their nurses, pointing to a strong relationship between provider and patient.

CNE questions

9. What percentage of telehealth users participating in the *Philips National Study on the Future of Technology and Telehealth in Home Care* say their telehealth service is part of a disease management program?
 - A. 50%
 - B. 57%
 - C. 61%
 - D. 64%
10. What cleaning product proved to be most effective in the infection control study of nurses’ bags conducted by Irena L. Kenneley, PhD, APRN-BC, CIC?
 - A. Lysol
 - B. Soap and water
 - C. Alcohol hand wipes
 - D. Institutional-grade cleaners with bleach
11. What time of day did patients report their highest level of satisfaction for visits, according to the Press Ganey 2008 Home Care Pulse Report: Patient Perspectives on American Health Care?
 - A. Morning
 - B. Afternoon
 - C. Evening
 - D. No time preferred over another
12. There is broad agreement that a three-year moratorium is necessary for CMS’ efforts to collect overpayments for hospice patient care.
 - A. True
 - B. False

Answer Key: 9. C; 10. D; 11. A; 12. B.

- Nurses are the highest-rated provider involved in the home care experience followed by therapists, and lastly by home health aides.

- Challenges in working with the home care office and addressing specific concerns are the lowest-rated aspects of home care.

- Patients are notably more satisfied when their nurses visited in the morning, particularly between 8 a.m. and 10 a.m., vs. in the afternoon.

- Satisfaction levels peak in the first three months of using home care and are at its lowest levels beyond 10 months of care.

“It’s clear the home care industry is making important improvements to increase their quality of care as evidenced by the trend we have seen over the past several years,” says **Melvin Hall**, PhD, president and CEO of Press Ganey. “Continuous improvement becomes increasingly important as competition and quality initiatives play a larger role

in home care.”

“Home care providers who actively work to improve their patients’ experiences are finding strong correlations with favorable clinical outcomes and financial results,” said **Lisa Cone-Swartz**, Press Ganey’s vice president of home health services. “Committed agencies can make a meaningful difference in their patients’ lives and at the same time improve the health of their organizations.”

The *2008 Home Care Pulse Report: Patient Perspectives on American Health Care* now is available at www.pressganey.com/cs/pressroom. ■

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CNE objectives

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

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

CNE instructions

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