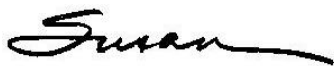


Best Practices *in Home Care*

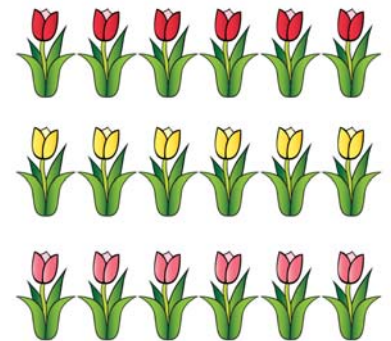
Best Practices is not just for providers of skilled home health services. There are also articles that will be of interest to private duty agencies, HR managers, risk management staff and others. Something for everyone in this month's issue!

On May 25 and 26, hundreds of home care providers from around New England will be traveling to Newton, Massachusetts for the first-ever New England Home Care Conference & Trade Show. This event represents one of the best educational experiences you'll have the opportunity to enjoy—and share with your staff—this year. And, it's also one of the best deals going, especially if you take advantage of the early bird discount available through April 15. See the information on pages 4 and 5 for more on the content, including Stephen Tweed's Private Duty Academy on May 25.

As always, I welcome your comments and suggestions on this and future issues of *Best Practices*. Happy Spring!



Susan M. Young, Executive Director



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Special Interest Groups—Meeting Updates

CQI Group

Upcoming Meetings:

Dates: April 21, 2011 and the third Thursday of each month except for July and August

Time: 9:30-11:30 am

Place: NHHEAF
4 Barrell Court
Concord

Rehab Therapy Group

Upcoming Meetings:

Dates: May 24, 2011

Time: 1:00-3:00 pm

Place: Concord VNA
30 Pillsbury St.
Concord

Clinical Directors Group

Upcoming Meetings:

Dates: April 14, 2011
June 9, 2011

Time: 9:30-11:30am

Place: NHHEAF
4 Barrell Court
Concord

CQI Group:

Andi Steel, facilitator; Deb Berntsen, Board Liaison

The CQI Group continues to focus on best practices, tools and educational strategies related to management of oral medications, evidence-based coaching and transitions among providers. The last two Best Practice Intervention Practice (BPIP) packages released by HHQI specifically address patient transitions.

HHQI research indicates that the root cause of patient readmission to hospitals relates to three system gaps: 1) lack of engagement of patients and families in self-care management; 2) lack of standard and known processes among providers transferring patients; and 3) ineffective or unreliable sharing of important clinical information. The more home care agencies can collaborate with those who are transferring patients and/or to whom they are transferring patients, the better outcomes we will achieve. The recent collaboration between the Home Care Association, NH Hospital Association, the NH Medical Society and the Medical Group Management Association on the Face 2 Face Encounter regulation is an example that this kind of collaboration can happen.

The CQI group also discussed another barrier to patient outcomes that is gaining more traction nationally, namely health care literacy. A recent article in the *Washington Post* referred to a 2006 study done by the US Department of Education that indicated that 36% of Americans require discharge instructions to be given at a 5th grade level or below; that 52% had intermediate skills and could figure out instructions on medication labels; and that only 12% were considered proficient in that they could search a complex document and find necessary information. Poor health literacy disproportionately affects the elderly, the poor and recent immigrants and is linked to higher rates of hospital re-admission, expensive and unnecessary complications, and death. A 2007 study estimated this problem costs the US as much as \$238 billion annually.

Based on the identified system gaps leading to hospital readmissions, the CQI group will devote some attention to developing a common tool to be used during patient transitions between health care providers and will also develop a list of resource materials and tools related to health coaching and

Clinical Interest Groups—continued

motivational interviewing. Finally, the CQI group will investigate health literacy further to determine whether there are resources that can be provided to our member agencies.

The agenda for the April 21st meeting will include:

- Discussion of implementation of F2F and any barriers/challenges
- Development of a tool to be used with patient transitions
- Development of resource list on health coaching, motivational interviewing and health literacy

Rehab Therapy:

Deb Mullen, facilitator; Karen Michel, Board Liaison

Over 20 therapy managers convened on March 22 to discuss the requirements for the 13th, 19th and 30-day reassessments. Agencies brought samples of reassessments to share. The group also discussed process flow and methods of tracking the therapy visits. The Delta Excellence in Therapy Report was reviewed as well. The agenda for the May meeting will include: 13/19/30 reassessments, functional tests and measures, competencies, best practices, eval/visit documentation. The Rehab Group has decided to continue meeting beyond the next meeting on May 24. Details on their activities will be reported in minutes sent to all rehab managers and clinical directors.

Clinical Directors:

Pat Osimo, facilitator; Julie Reynolds, Board Liaison

In March a number of HCANH members, along with Pat Osimo, attended a train-the-trainer program on chronic care management. Pat, Julie and others who attended will share what they learned at the next meeting of Clinical directors on April 14.

CMS Posts Fact Sheet on New Therapy Requirements

The Centers for Medicare and Medicaid Services (CMS) has posted to the Home Health Center Page (<http://www.cms.gov/center/hha.asp>) a “Fact Sheet” detailing the new therapy assessment and documentation requirements that were included in the Home Health Final Rule that started April 1. CMS’s Fact Sheet can also be downloaded at: http://www.cms.gov/HomeHealthPPS/Downloads/Therapy_Requirements_Fact_Sheet.pdf.

HHQI Save the Dates!

Upcoming Home Health Quality Improvement National Campaign events:

- **April 13th, 2011, 2 – 3pm:** **Webinar: *Integrating Home Care into Primary Practice to Improve Patient Outcomes.***

See the flyer <http://homecarenh.org/events/HHQI%20Outcomes%20Webinar%20Flyer.pdf> for details. Listen to a discussion between a nurse and a primary care physician about current home health issues. This event is FREE, but space is limited so register now at <http://www.homehealthquality.org/hh/resources/webinar/april.aspx>

- **April 15th, 2011, 2–3 pm:** **LiveChat** with the entire HHQI Team. Admission is FREE. To set a reminder, go to http://www.homehealthquality.org/hh/resources/chat_help.aspx

- **April 28, 2011: Cross Settings III BPIP Release**
This is the 3rd of a series of three Best Practice Intervention Packages focusing on innovative ideas. Be one of the first to download the BPIP and remain in the running for Go for the Gold award.

Calling All Financial Managers!

The New England Home Care Conference and Trade Show has an exceptional line-up of workshops for financial managers. One of the highlights for CFOs will be the Financial Managers Forum, led by Bill Dombi, VP of Law at the National Association for Home Care & Hospice and liaison to the Home Care & Hospice Financial Managers Association.

In addition to the networking opportunities presented by the Forum, check out these sessions:

- ✓ The Role of Leadership in Charting the Course to Excellence: Utilizing the Quality Compass to Achieve Outstanding Quality, Satisfaction and Financial Health (A-2)
- ✓ Optimizing the Home Care Revenue Cycle (A-5)
- ✓ Choosing the Right Paths to Financial Success (C-4)
- ✓ Wage and Hour: An Overview (D-2)
- ✓ Variations in Medicare Claims Data (D-4)
- ✓ Billing Compliance Essentials: Strategies to Minimize Reimbursement Risk (E-5)

Every good financial manager is always looking for the best bang for their buck. The NEHCC clearly offers a great return on investment.

Register today!



NEW ENGLAND HOME CARE CONFERENCE & TRADE SHOW

May 25 and 26, 2011
Boston Marriott, Newton, MA

Dozens of Workshops on the Hottest Issues in Home Care Today:

Agency Management
Clinical Topics and Transition Care
Financial Management
Marketing
Human Resources
and

Stephen Tweed's Private Duty Academy



Don't miss the Early Bird Special available only to members of the New England State Associations—register by April 15 for discounted full-conference registration rates.

For more information, go to:

http://www.homecarenh.org/events/NEHC%20Attendee%20Brochure%202011_Final.pdf

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Benchmarks and Best Practices for Private Pay in Home Health

By Stephen Tweed

Did you know that ...

- The median size private duty company in 2008 was \$1,466,731 in total client revenue?
 - The median size franchise company was \$637,796 and the median size independent company was \$802,434 in revenue?
 - Private duty companies affiliated with Medicare Certified Home Health Agencies were larger - \$2,118,048 – but were less profitable and grew more slowly than either franchises or independents?
 - There are 15,000 companies providing non-medical private pay home care in the United States?
 - The median net profit and owners income was 13% of total revenue for “benchmark companies”?
- The most frequent caller to a private duty home care company is the oldest daughter of a senior calling on behalf of mom or dad?

Imagine what it might be like to have access to industry benchmarks and best practices, and to be able to apply this information to grow your private pay home care business.

Private Duty Home Care is the fastest growing segment of health care in America, and the launch of the Patient Protection and Affordable Care Act is creating new interest and new opportunities in this sector.

Several factors have contributed to the explosive growth of non-medical home care over the past five years. They include:

- The rapidly aging population
- The increase in the number of seniors over age 65 with multiple chronic conditions
- Busy baby boomers who are stressed out trying to find care for mom or dad
- The significant net worth of many seniors who have the ability and the willingness to pay for home care rather than move into a facility
- Increasing awareness of the availability of home care services to aging seniors and their daughters

What does it take to be successful in the business of non-medical home care? What are the best practices for attracting new clients? What are the most effective techniques for finding and keeping high quality caregivers?

These are some of the questions addressed in the **2010 Private Pay in Home Health Care Benchmarking and State of the Industry Survey**, conducted by Leading Home Care. This unique industry study has helped us to better understand the benchmarks and best practices that make for a highly successful home care company.

For example we learned that:

- Networking in the community and making direct sales calls to key referral sources are still the most effective ways to grow this business
 - Your web site is a critical ingredient in the marketing mix of a successful home care company
- Four year nursing schools, employee referrals, and faith based recruiting are the best places to find high quality caregivers.

You'll learn more about these benchmarks and best practices when you attend **The Academy for Private Duty Home Care**, being presented as a part of the **New England Home Care Conference & Trade Show** at the Boston Marriott Newton on May 25, 2011.

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About the Author: Stephen Tweed is a nationally known health care and business strategist, professional speaker, author, and publisher. He's currently CEO of Leading Home Care ... a Tweed Jeffries company where he works with home care leaders who want to grow their businesses, and with home care organizations that want to get ready for the future. Stephen is the Editor and Publisher of the **2010 Private Pay in Home Health Care Benchmarking and State of the Industry Report**. He can be reached at www.leadinghomecare.com or www.privatedutytoday.com.

NH Board of Nursing Update: The Road to Recovery

By Karen Baranowski, DNSc, RN

The NH Board of Nursing is governed by an 11 member Board appointed by the Governor. The Board meets monthly from 8-4 pm, and the meetings are open to the public. The Board is made up of five RNs, two LPNs, two LNAs and two public members. There is currently an LPN vacancy on the Board. The present Board includes two members from the arena of home care/hospice.

The Board has five major tasks:

1. Educational oversight of all nursing programs in New Hampshire
2. Administering licensure for all RNs, LPNs, LNAs and APRNs
3. Developing practice standards
4. Developing policies, administrative rules and regulations governing nursing practice in the state
5. Addressing violations of the Nurse Practice Act through disciplinary action for those who do not maintain standards of professional nursing practice as set forth in the Act.

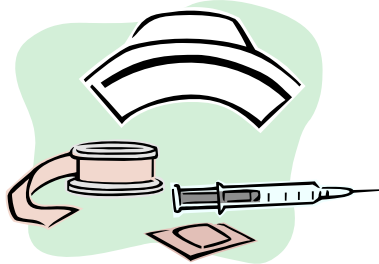
The four actions that can be taken on a license are:

- a. Letter of concern
- b. Probation
- c. Suspension
- d. Revocation

Reportable behaviors that are mandated to be reported to the Board include:

- Being impaired by drugs or alcohol while working
- Stealing from a patient/client, including medications
- Providing care outside of the scope of practice for the discipline
- Falsifying records
- Boundary issues, including abusing a patient physically or sexually
- Involvement in criminal conduct.

One of the least understood programs at the Board comes under the rubric of discipline, and is used as a means of disciplining a licensee when a nurse or LNA becomes involved with either alcohol, narcotics or any controlled substance.



The Road to Recovery was formed by the Board of Nursing to allow a nurse to continue to work and receive health benefits, while undergoing a treatment program for either alcohol or drug use or abuse. The criteria for entry into the program is ***the nurse must self-report to the Board of Nursing their issues with dependence prior to any damage to a client, or reportable action taken at the place of employment due to the drug or alcohol use.*** Further, the licensee must have fitness for duty as verified by a medical professional.

Road to Recovery participants are not reported publicly and work with designated Board staff and a recused Board member, their private primary care provider, LADC counselors, AA and/or NA participation and regular random urine testing which is reported to the Board for oversight. The participants sign a five year contract to be abstinent from all drugs and alcohol. With continued abstinence for five years, the oversight is removed. Failure at any part of the contract results in a Board appearance, public censure, and often suspension or revocation of licensing privileges.



About the Author: Dr. Karen Baranowski is the President/CEO of Home Health & Hospice Care in Merrimack, NH. She is presently Vice Chairperson of the New Hampshire Board of Nursing.

OASIS-C and Drug Regimen Review

By Trish Tulloch, RN, RBC Limited

The Centers for Medicare and Medicaid Services (CMS) continues to clarify the application of the new and revised OASIS-C items, addressing complex and subtle definitions based on actual patient scenarios. The Drug Regimen Review (DRR), item M2000, is one item with industry-wide variation in understanding and accurate completion. Industry benchmark vendors and 2010 audit initiatives indicate that home care providers rank Response Number “2” indicating “Problems Found during Review” more than 46% of the time. In fact, several agencies indicate this response more than 60% of the time, on a Start of Care or Resumption of Care OASIS Assessment. *This response indicates that a review of the patient’s medications poses the presence of potentially clinically significant problems.*



up to 48% of community dwelling older adults have medication-related problems, and over \$170 billion is spent annually on drug-related morbidity and mortality for seniors alone. Recent studies further indicate that over 25% of the hospitalization rate for seniors is due to adverse drug events.

Bottom Line: Reducing preventable medication errors is a national health initiative and a high priority for CMS.

OASIS-C Clarity

CMS states in the July 20th OASIS-C Questions and Answers that when completing this item, “the determination of whether a medication issue meets this threshold (of potentially clinically significant problems) *should be based on the clinician’s judgment in conjunction with agency guidelines and established standards for evaluating drug reactions, sides, interactions, etc.*”

Why the focus on Drug Regimen Review? It does not surprise home care clinicians that studies conducted by the Institute of Medicine indicate that 1.5 million *preventable* Adverse Drug Events occur annually, with 7,000 deaths attributed each year to medication errors in the United States. Additionally,

Herein lies the home health challenge. Many agencies are using medication software that identifies “potential adverse medication issues.” Therefore many clinicians are directed to respond to this item per the software response, regardless of specific patient clinical assessment or medication history. The subjective “based on the clinician’s judgment” becomes secondary to a response as indicated by a medication software review. Other clinicians, not using medication software triage, remain conflicted over what is “potentially clinically significant” for their specific patient. Complex pharmacological interactions with home care’s clinically complex population are significant. Clinical logic for this OASIS medication item is advanced and requires additional agency education and support measures.

New Hampshire Nursing Assistant Day 2011 Is June 2!



Don’t forget to nominate one of your best LNAs in recognition of the important contributions made by all of your front-line healthcare staff who have earned the LNA designation.

Applications are due April 29. Contact Chloe Roe at 225-5597 or croe@homecarenh.org for more information.

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Face to Face Encounters by Medical Directors

By Elizabeth E. Hogue, Esq.

Effective April 1, 2011, providers may not be paid for services rendered if patients have not had appropriate face-to-face encounters with physicians during required time periods. In order for home health agencies and hospices to be paid for services provided, documentation of these encounters must also meet applicable requirements. Many staff members of agencies and hospices have read communications from CMS, fiscal intermediaries, and other sources that seem to state that Medical Directors cannot provide face-to-face encounters and documentation of them in order to meet applicable requirements. This conclusion is stress-provoking for staff members because Medical Directors often refer a number of patients to them. If it is true that Medical Directors cannot complete face-to-face encounters and documentation of them, the new requirements are more likely to be problematic to implement.

On the contrary, Medical Directors and other referring physicians who receive payments from providers for their services may complete face-to-face encounters and documentation so long as the requirements of both the personal services and management contract safe harbor and the contractual exception are met, as described below.

It is important to note that the above requirements do not apply only to so-called “Medical Directors.” This requirement applies whether referring physicians who provide paid consulting services are called “Medical Directors,” “Medical Advisors,” “consulting physicians” or another title. In other words, the prohibition applies to all physicians who make referrals and are paid for services, regardless of their title.

In order to meet the requirements referenced above, Agreements between agencies and hospices and physicians who make referrals and receive

payments for consulting services must generally comply with the following:

- Enter into a written agreement with physicians, that is signed by providers and physicians, which specifies the services covered by the arrangement.
- The arrangement must cover all of the services to be furnished by referring physicians to providers.
- Aggregate services provided do not exceed those that are reasonable and necessary for the legitimate business purposes of providers.
- The term of each arrangement is for at least one year. To meet this requirement, if an arrangement is terminated during the term with or without cause, the parties may not enter into the same or substantially the same arrangement during the remainder of the first year of the original term of the agreement. This latter requirement applies only to home health agencies; not hospices.
- Compensation paid over the term of the agreement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

The implications of failure to comply are very serious. Prior to the effective date, if the above requirements are not met, then providers risk enforcement action under the Stark Law and/or the federal anti-kickback statute. If the above requirements are not met beginning on April 1, 2011, providers risk non-payment for services provided. They also risk violations of the federal False Claims Act, since all requirements for payment have not been met when claims are submitted.

As a practical matter, this means that providers must:

1. Develop standardized or “form” agreements and use them consistently with all referring physicians who receive consulting fees from them. **These Agreements should provide that physicians are paid on an hourly basis in order to meet applicable requirements.** Providers cannot afford utilization of a variety of different agreements that may not meet the requirements described above. Staff must understand that they can use only the standard approved agreement and cannot modify it without advance written approval from a designated, knowledgeable individual.
2. Documentation of services rendered and the amount of time spent in these activities is crucial. Providers should develop and implement policies and procedures that permit payments to physicians only after appropriate documentation to support payments has been received and reviewed.
3. Providers should not have agreements for consulting services with physicians whose services they do not actually use, even if they make no payments to them. Providers should terminate the agreements if they do not need the services covered by the agreements. Otherwise, it may appear that the only purpose for the agreements is to induce referrals, as opposed to a documented need for services.
4. Although there are technically no limits on the number of consulting physicians/ medical directors that providers can have at



any given time, a large number is likely to invite scrutiny by regulators and should be avoided. How many is too many? The number should certainly bear some relationship to the size of the provider organization and the geographic area served. Beyond this general guideline, common sense must prevail. The “bottom line” is: Does the Agency have legitimate work for every consulting physician?

5. The commercially reasonable services consulting physicians are asked by providers to perform cannot be related to the volume and value of referrals made. Providers cannot, for example, ask referring physicians to assist with quality assurance activities that entail review by consulting physicians of the charts of patients they referred to the provider so that the more referrals made, the more money consulting physicians make.

Providers cannot use “sample” or “template” agreements to meet the above requirements because they must also meet

applicable state requirements which, of course, vary from state to state. Providers who are unsure that their Agreements meet all federal requirements and requirements of the state(s) in which they do business must seek legal assistance to ensure compliance.

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Want to Get the Jump on Spring? Jump into Spring Cleaning

by Pat Gipps, Senior Loss Control Consultant, FutureComp

Every year around this time the approach of spring reminds us of the need to tackle some of those housekeeping tasks that may have been pushed to the back burner over the past few months. A good spring cleaning can enhance safety at your workplace if it's done with an eye to eliminating hazards.

De-Clutter

Over time, clutter builds up in most work areas. The problem is that clutter creates hazards. Flammable clutter, for example, is a fire hazard. General clutter may create tripping and blocked-exit hazards. De-cluttering, then, is not just for looks, it also improves safety.

Spring cleaning is the perfect time to dispose of:

Trash: Anything that's not in use that has piled up should be removed from the site. This will reduce fire hazards, when combustible materials are removed; tripping hazards, when items that are blocking walkways or taking up valuable storage space go away; and pest harborages, when unused materials that make good nesting areas are hauled off.

Equipment: That frayed sling or wobbly ladder may have been taken out of service, but if it can't be readily repaired, why is it still hanging around? If it's there, even if it has a "do not use" tag on it, someone in a hurry or not paying close attention might use it anyway—and regret it

afterward. Equipment that has been removed from service and won't be promptly—or ever—repaired should be permanently removed from the premises.

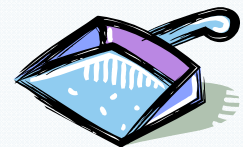
Chemicals: Old or unused chemicals create unnecessary workplace hazards. They may be flammable or toxic, and many chemicals that are not dangerous when purchased can become so as they deteriorate over time. Dispose of chemicals that are no longer in use, have passed their use-by dates, and have missing or illegible labels. Be sure employees dispose of chemicals properly according to the requirements of the MSDS.

Clean and Repair

Besides clearing out the clutter, your spring cleaning can address infrequent needs that will boost worker safety and health. For example, maybe it's time to clean and/or service:

Heating, ventilation, and air conditioning (HVAC) systems:

A health hazard evaluation conducted by the National Institute for Occupational Safety and Health found that properly maintained HVAC systems were associated with a decreased incidence of lower respiratory symptoms, allergies, and asthma among building occupants. Proper maintenance controls mold, bacteria, allergens, and other contaminants within the system.



Continued on page 11

Get Accurate Solutions Now to Your Medicare Claim Questions

You can find plenty of answers to your Medicare questions. Find the accurate ones from the Medicare Learning Network® (MLN).

Billing and coding professionals need Medicare information at their fingertips. That is why CMS experts developed the “Medicare Learning Network® Suite of Products and Resources for Billing and Coding Professionals.” The Suite contains easy-to-understand, accessible, and free Medicare Program information.



To access a detailed listing of all of the products you need to correctly submit claims the first time, visit the MLN Educational Web Guides web page at <http://www.cms.gov/MLNEdWebGuide> and, on the left hand side of the page, click on the “Medicare Learning Network Suite of Products and Resources for Billing and Coding Professionals.”

Equip yourself today with critical reimbursement solutions from the official source for Medicare Fee-For-Service Provider information.

Jump into Spring Cleaning

continued from page 10

Signs and labels: Signs and labels are important for workplace safety, warning workers of low clearances, identifying machinery controls and power sources, and much, much more. But they also take a lot of abuse. Replace damaged signs and illegible labels, clean signs that have become too grimy to read, and re-hang signs that have been knocked askew.

Offices: University of Arizona researchers famously found that office phones, computer keyboards and mice, and desktops harbor 400

times more infectious bacteria than office toilet seats. Yet in most offices, vacuuming and emptying the trash are the only regular cleaning performed. Encourage workers to take disinfecting wipes to office surfaces—not just once a year but daily if possible—to reduce infectious illness transmission in the workplace. Also have your cleaning crew do an extra thorough job from time to time.

FutureComp®

11 things you should resolve not to do at work in 2011

1. Excessive complaining
2. Gossiping
3. Heartlessly criticizing others
4. Beating yourself up
5. Taking yourself too seriously
6. Stagnating
7. Isolating yourself
8. Blending into the woodwork
9. Blabbing unnecessarily
10. Burning bridges
11. Wasting time via social media

By Monster

<http://career-advice.monster.com>

Considerations

Does your agency have clear guidelines, beyond your software capacity, for evaluating drug reactions, side effects and interactions for this OASIS-C item? Consider refining your protocols per home health specific available resources. Visit www.homemedics.org to access a Medication Management Toolkit with guides for home health medication education and protocol updates. Ensure your clinicians are scoring this item based not only on software triage, but also within the context of expert guidelines, that enhance clinical judgment and ensure greater clarity for patient medication education and clinical safety.

Finally, ensure you have a protocol that supports clinician review of patient medications. Access to a seasoned supervisor, and/or a pharmacist

provides clinical expertise to address this item with clarity and accuracy.

Trish Tulloch RN, BSN, MSN, HCS-D, is a Senior Consultant for RBC Limited, a Healthcare & Management Consulting Firm that works with health care agencies across the country. Please send comments and questions to Trish at rbc@netstep.net.



Don't miss Trish Tulloch's workshop at the New England Home Care Conference & Trade Show: [2011 PPS Essentials: Efficiencies, Compliance and Outcomes](#)

(Session A-4 on May 25)