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IN THIS ISSUE

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Improve therapy notes with measurable *and* functional goals to keep your dollars

Make sure your written therapy goals include an explanation of how the goals are important to the patient and how patient progress will be measured. Failure on either point means your documentation is insufficient, putting you at risk of having to repay Medicare for unsubstantiated visits.

Nearly two out of three home health records include therapy goal statements that fall short of CMS requirements, according to the Therapy STARS project conducted by Fazzi Associates, Northampton, Mass. The STARS project, based on a detailed audit of more than 1,500 records at more than 60 participating agencies, also revealed the following glaring statistic: 80% of the claims had at least one therapy visit not properly supported in the documentation, leading to an average risk per record of approximately $1,500, says Cindy Krafft, Fazzi's director of rehabilitation consulting services (*HHL 12/19/11*).

(continued on p. 7)

Innovation Advisors, Part 1

Home health, hospice innovation advisors' goal: 'Get the silos to talk'

New demonstrations and models for smoother care transitions have been frequent in recent years, but home health often has received the short end of the straw in mostly physician- and hospital-dominated programs.

Now, a small group of home health and hospice representatives hope to change that as they join CMS' Center for Medicare and Medicaid Innovation as so-called "innovation advisors." The advisors will bring their expertise to bear on the design of future care-transition demonstrations launched by the center.

The goal is to get the different "silos" of health care – hospitals, physicians, home health, hospice – to talk to each other and move them beyond just focusing on the CMS regulations each individual sector faces, says Janet Will, director of pediatric hospice Dr. Bob's Place in Baltimore, Md.

Will is one of 73 people chosen by CMS to participate in its innovation advisors program, and one of six who are actively working in home health or hospice now.

Would demos grow your patient census?

Another one is Nancy Roberts, president and CEO of VNA of Care New England in Warwick, R.I. Roberts' main interest lies in getting home health agencies and primary care physicians to talk more, she says. Roberts estimates that approximately 20% of the average primary care physician's patients qualify for home health. One way to improve the relationship between home health and physicians is for agencies to assign a dedicated nurse who can work closely with the physician on identifying and caring for those patients, she believes.

The VNA currently is collaborating with a physician practice in a so-called patient-centered medical home as part of an ongoing, primary-care centered CMS demonstration. The medical home employs a nurse care manager who facilitates communication between the physician and the agency and meets with the VNA's staff bi-weekly to coordinate care.

The collaboration was a result of persistent outreach by the VNA and has yielded consistent referral growth. The amount of referrals the VNA received from the practice rose from about one per week prior to the collaboration to an average of four per week now.

Within the innovation advisors project, Roberts is also eager to explore ways to get patients more engaged with their care through the use of questionnaires that could help screen for depression and other health risks.

Risk-screening efforts by dedicated care-transition specialists at the VNA have resulted in a 3% reduction in preventable hospitalizations among CHF patients over the fiscal year that ended Sept. 30, Roberts says. Patients are screened for risk factors that include the number of medications, number of hospitalizations in the past six months, oxygen saturation levels and other proven predictors of hospitalization risk.

Roberts plans to share any successes achieved in these demonstrations with the home health industry as a whole at state and national association conferences.

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Advisors could push concurrent care

Representatives of the hospice industry in the project also are hoping to bring ideas to the table that could change the way we think about hospice.

Will's demo idea: Offer hospice and curative treatments concurrently and show how that approach can be a money-saver for the health care system. While Will's intent is to focus the demo on pediatric hospice patients, she says the approach could be successful in all hospice settings. Concurrent care is unlikely to be a good fit for all patients, but a demonstration could supply valuable data on the limits of the concept, she notes.

The health care reform law included a mandate for a demonstration of concurrent care in Medicare hospice, but when that demonstration will launch remains unclear, says Jon Radulovic, a spokesman for the National Hospice and Palliative Care Organization (NHPCO). NHPCO has pushed for the demonstration to move up on CMS' priority list for several years, he notes.

More details about innovation advisors

The innovation advisors project will work along the lines of a research fellowship: Awardees will receive six months of intensive training at CMS and then begin to work on new care-delivery models within their organization and community, according to a CMS fact sheet. To do that, each advisor's "home organization" will receive a stipend of up to $20,000.

The advisors also will help CMS design new demonstrations which the federal Medicare agency then will roll out on a national basis. – *Tina Irgang (tirgang@decisionhealth.com)*

Editor's Note: *This article will be the first in a long-term series that follows the progress of the innovation advisor project, its home health and hospice participants and the project's overall impact on the industry. In part 2, learn how statistical research into the causes of hospitalization could shape the future of home health care.*

HHS, Joint Commission move to improve your staff's flu shot rates

The Joint Commission has adopted new home health standards that would require accredited agencies to bring staff vaccination rates up to 90% and HHS is seeking comments on a report that could lead to a similar requirement throughout the health care sector.

Down the line, you could see flu vaccination programs for home health staff become a condition of participation, believes Mary McGoldrick, a home care and hospice consultant with Home Health Systems, Inc. in Saint Simons Island, Ga.

Even if your agency isn't Joint Commission-accredited, consider stepping up your efforts to educate workers about the benefits of getting a flu shot, she says.

There's both a business case and a health case for doing this. First, the business case: Staff members who are out sick with the flu will create a ripple effect throughout the agency, adding to the workload of others and wreaking havoc in your scheduling department, McGoldrick says. Estimates on lost productivity throughout the U.S. economy due to flu illnesses vary, but are generally put between $5 billion and $10 billion per flu season.

Workplace health consulting firm TriWellness in Carlsbad, Calif., estimates that the average return on investment for each vaccine dollar spent is $2.86 in lost productivity the employer has prevented.

The health case: The flu is contagious up to two days before the first symptoms set in, meaning your staff could be passing on the illness to their colleagues or even to your patients before they know they're sick, McGoldrick says.

More details on new flu shot standards

HHS is working toward its goal of a 90% vaccination rate among health care personnel by 2020. The federal agency is currently seeking comments on a draft report that outlines steps toward achieving that vaccination rate, including the establishment of comprehensive influenza prevention programs in every health care workplace.

For Joint Commission-accredited agencies, such programs will become a requirement as soon as July 2012. Some of the key requirements of the new Joint Commission standard for home health:

- Offer vaccinations to employees annually at accessible sites and times.
- Include improvement of vaccination rates as a goal in your infection control plan.
- Establish incremental goals that will enable your agency to meet the 90% vaccination goal by 2020 (takes effect in July 2013).

Evaluate at least annually the reasons employees give for declining a flu vaccination.

Tips to raise staff vaccination rates

Note that your efforts to raise vaccination rates might encounter a number of common objections, such as fear of illness caused by the vaccine or the argument that the staff member has never had the flu before, McGoldrick says. Free online resources can be helpful in dealing with those objections, she notes (*see tip, below*).

Note that if you decide to require staff to get flu shots, you must allow for exemptions on religious or medical grounds (*HHL 10/4/10*).

Use these strategies to encourage staff members to get vaccinated:

- **Pay for the vaccine.** The Centers for Disease Control and Prevention (CDC) list prices per flu vaccine of around $20 or $25. And the cost of a vaccine is a low price to pay to avoid long absences by sick staff members that lead to a decline in your agency's visit count, McGoldrick says.

- **Make it as convenient as possible to get the shot.** The best way to do this is to offer the flu shots onsite at your agency. Try combining the flu shots with an all-staff meeting to avoid calling back your field staff to the office for the shot alone, McGoldrick recommends.

- **Educate staff members about the benefits of the vaccine.** Free online resources can help you outline the health benefits of the vaccine and deal with common objections, McGoldrick says. Find a free educational audio program developed by McGoldrick at *www.homecareandhospice.com*. A fact sheet that addresses common misconceptions about flu shots is at *www.cdc.gov/flu/about/qa/misconceptions.htm*.

- **Make the financial case to staff who are paid per visit.** People who get the flu will be contagious for up to a week after they develop symptoms, according to the CDC. For field staff who are paid per visit, even just a few days off work can mean a significant financial loss, says Thelma Bowen, CEO and owner of HealthCare Compliance Services in San Antonio.

- **Offer free flu shots to staff members' families,** Bowen suggests. If that's not an option, you could try to bolster your education about vaccine benefits this way: Point out that a vaccination will make it less likely that staff members' families will be exposed to the flu virus or complications that can follow the flu, McGoldrick says. Those complications could include pneumonia, for example. – *Tina Irgang (tirgang@decisionhealth.com)*

Editor's Note: *To view the full HHS draft report, go to www.hhs.gov/nvpo/nvac/subgroups/nvac_adult_immunization_work_group.pdf. For instructions on how to comment, see the Federal Register notice at www.gpo.gov/fdsys/pkg/FR-2011-12-19/pdf/2011-32308.pdf. A full list of the new Joint Commission requirements is at www.jointcommission.org/assets/1/18/Home_Care_Bulletin_4_2011.pdf.*

More nursing grads want home health work – screen applicants carefully

If your agency is getting more job applications from nurses than you anticipated, watch out. Their RN degrees are no guarantee they have the experience home health nursing requires.

More RNs are looking for work because of the recession (*HHL 4/27/09*) and because the number of nursing school graduates surged 62% between 2002 and 2009, as researchers reported in the December 2011 issue of the journal *Health Affairs*.

But many of those grads may not be the "autonomous, critical thinkers who match clinical skills with heart, compassion and empathy," that are best suited for home health work, says Santa Rosa, Calif.-based consultant Lucy Andrews.

One test question to ask RN applicants: Describe a clinical emergency they faced and what they did to resolve it. The answer might reveal whether the applicant panicked or how well she managed an emergency, Andrews says (*see below for additional hiring tips*).

No hospital experience, no job

These days, Interim HealthCare in Greenville, S.C., won't hire nurses unless they have at least a year of medical-surgical experience, says Odete Watson, assistant human resources manager for the 1,000-patient agency.

"Back in 2002 or 2003, it was hard to find qualified nurses," Watson recalls. "Now, with all those nurses graduating, we don't have a problem."

In fact, it's the new grads that may have the problem. In November 2011, 38 new and experienced RNs applied to Watson's agency. But the agency filled its need by only hiring one of the experienced nurses. The new RN grads told of being turned down by hospitals because the hospitals didn't want to train them, Watson says.

In November 2008, when hospitals were starting to lay off thousands of nurses (*HHL 4/27/09*), Interim HealthCare got 64 RN job applications. Of the 64, it decided to interview 12 that appeared qualified and ended up hiring three, Watson relates.

The agency regards hospital experience as useful training for care of its Medicare patients, who typically are elderly and recently discharged from hospital stays caused by their acute medical or surgical needs, says Connie McCammond**,** executive director of patient services.

Meanwhile, the VNA of Boston is seeing turnover benefits from the abundance of new RNs. Its nurses these days remain on payroll for 10 years, on average, compared with seven to eight years only two years ago, says Janice Sullivan, VP for external affairs. Another benefit of the nurse glut is that the agency no longer needs to pay the signing bonus it was offering several years ago.

Also no longer needed: The "infrastructure of support and training" the VNA needed then to train new nurses for home health work. In today's market, "we can hold out for nurses with experience," Sullivan says.

The *Health Affairs* study of nursing school graduation rates notes that the decline in the 1980s and 1990s of women ages 23 to 26 choosing nursing as a career raised concern that there would be a serious RN shortage in the future. But instead, the surge of young people entering nursing over the past 10 years means "the nurse workforce will grow faster over the next two decades than previously anticipated," according to the study.

Questions to ask for good hiring results

Look for these attributes in RN candidates to ensure you make the best hiring decision in an expanded applicant pool, Andrews recommends:

- **Try to learn whether RN applicants know when to bring in reinforcements –** when to call the primary care physician, the family and other professionals to create and manage a patient's home care experience successfully. RNs need to understand that a successful team approach can change a patient's outcome.

- **See if the job candidate understands the relationship between assessment goals and final clinical outcomes.** Home health RNs need to know the relationship between quality care and the limited dollars patients and payers have to spend on health care. Also ask the candidate to explain how a home health agency gets paid for patient care related to the OASIS assessment.

- **Ask candidates how they'd manage a professional team as case manager.** A home health nurse must be the advocate, watchdog and clinical driver for successful patient outcomes.

- **Ask candidates to tell you a story of a crazy day in their professional life** and how they were able to see the humor in it. A great sense of humor is a critical but often underrated attribute. The amazing, interesting and sometimes bizarre things that happen on field visits demand that nurses have the ability to laugh every day. *– Burt Schorr (bschorr@decisionhealth.com)*

CMS updates agencies on HH-CAHPS, outlier issues

Check with your Medicare Administrative Contractor (MAC) if you're still waiting for a decision on your Home Health Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS) reconsideration request.

Letters informing agencies of their appeal decision went out between Dec. 22 and 28, CMS officials told listeners during a Jan. 11 open-door forum call.

Many of the agencies who had received HH-CAHPS noncompliance notices felt they had fulfilled all the requirements and decided to ask for a reconsideration. CMS had pledged to return decisions on all requests before the new year (*HHL 10/10/11*).

CMS also announced to listeners that an outlier cap issue which has been causing underpayments to many home health agencies has been resolved. The underpayments were due to a processing error that assumed outlier payments were included in Medicare payment amounts that did not in fact include them (*HHL 5/16/11*).

CMS is still working to resolve a separate outlier cap issue which had led to overpayments to some agencies. As a result, agencies soon might see "adjustments" to their payment amounts, officials said on the call. Agencies were encouraged to contact their MAC with any questions about the fix. *– Tina Irgang (tirgang@decisionhealth.com)*

'Employee' or not? Government has its eye on classification errors

Take a close look at the particulars of your contract if your agency uses outside therapists who are not subject to the tax withholding that applies to payroll staff.

Uncle Sam has been scrutinizing contracts for more than 25 years with the goal of identifying tax evaders. But now the hunt for misclassified employees is heating up, as evidenced by the agreement the IRS and the Labor Department signed in September to share information about potential federal labor law violations when employers use contractors, as well as federal taxes owed but not paid.

Because occupational therapists commonly work from home, agency contracts with those therapists are the most likely targets for scrutiny, says John Gilliland with the Gilliland Law Firm in Indianapolis, who specializes in labor law compliance by providers.

"Agencies think that merely calling someone an independent contractor makes them one, but it doesn't," Gilliland says. Also, a worker's status can be different for different purposes. For example, "someone may not be an employee for IRS purposes, but is an employee for wage-and-hour purposes," he cautions (*for more details on the different classifications, see subhead below*).

This month, Colorado became the 11th state to join with the Labor Department in the hunt for violators. In 2010 the hunt yielded $4 million in back wages for minimum wage and overtime violations from employees being misclassified as independent contractors or otherwise not treated as employees, said Nancy Leppink, deputy administrator of the Labor Department's wage and hour division, in her announcement of the agreement with Colorado.

BENCHMARK of the Week

Therapy audit shows agencies risk losing $1,500 per record

With anticipation of increased external therapy audits in 2012, the initial results of a nationwide therapy documentation report are disconcerting to all agencies. The Therapy STARS (Standardized Tools, Assessment and Reassessment Strategies) project is a 10-month study that began with detailed initial audits at more than 60 volunteer agencies. Below are some of the initial results, but a more thorough report will be released in the spring following a second follow-up audit at each of the agencies. (Agencies interested in learning more about hot therapy topics from Fazzi can sign up for the monthly Home Care Therapy Roundtable series at *www.fazzi.com/home-care-therapy-roundtable.html*.)

Problem revealed in audit	Breakdown
Financial risk of more than $1,500 per record.	More than 60 participating agencies combined for a total financial risk of $1.9 million due to faulty therapy documentation.
80% of claims had at least one flaw.	Of the more than 1,500 records reviewed, four out of five included visits that were not properly substantiated, putting the agency at risk of giving back money to CMS.
61% of records had improper goal statements.	This was the most prevalent problem revealed in the entire audit project, contributing to a large portion of the 80% figure mentioned above. Biggest therapy goal deficiency: Goals were either measurable or meaningful, but not both (*see related story, p. 1*).
33% of records had issues with the reassessments by at least one therapy.	Agencies falling in this 33% category wrote reassessments that were either not done in the correct timeframe or had content insufficient to meet the standard or both.
Daily visit notes are also a recurring problem.	The major issue here is a lack of clear patient-specific interventions in the daily visit notes.

Source: Fazzi Associates, Northampton, Mass.

Other states that have agreed to work with the Labor Department in identifying misclassified employees: Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Missouri, Montana, Utah and Washington.

A written contract helps – to a point

Other things Gilliland says home health agencies need to keep in mind:

- A written contract stating the agency and an occupational therapist intend their relationship to be that of principal and independent contractor is useful as evidence of their intention – but not conclusive. Indeed, the IRS says that if the relationship is that of employer-employee, calling the employee an independent contractor or something else other than employee "is of no consequence," Gilliland points out.

- If a desire to avoid withholding income tax, Social Security/Medicare and unemployment insurance is the only reason a business treats workers as independent contractors, there's a good chance the independent contractor characterization "probably is artificial," Gilliland says.

- Simple IRS status rules governing payroll collection for income tax, Social Security and Medicare declare clinicians wouldn't be self-employed independent contractors if they perform services "that can be controlled by an employer (what will be done and how it will be done)." (*See: http://www.irs.gov/businesses/small/article/0,,id=99921,00.html*)

- Contractor/employee classification under the work week and overtime rules of federal labor law is more complex. For contractors, considerations include opportunities for profit and loss. Classification as an employee, on the other hand, depends on "the nature and degree of control retained or exercised by the principal," Gilliland advises. – *Burt Schorr (bschorr@verizon.net)*

Improve therapy notes

(continued from p. 1)

There are multiple ways agencies can fall short on therapy documentation, but goal statements are a major contributor to the problems (*for a more detailed analysis of the STARS project's initial results, see benchmark, p. 6*). The emerging pattern from the audits is that even though PPS 2011 required both measurable and meaningful goals, agencies end up only doing one or the other, Krafft says. Example: A goal to walk 150 feet, without an explanation of where the patient needs to go and how this distance would improve his or her life.

The keys to improved goal-writing

Don't waste time searching for a template to use as the perfect agency-wide cure to teach therapists to write goals for all patients. Even searching for such a solution shows failure to design patient-specific therapy plans, Krafft says.

Instead, begin by focusing on the first of CMS' two required components of goals: Measurability. Here are

the types of details that, if included in your note, will help the goal pass muster:

- **Identify who is the focus of the training or instruction – the patient or the caregiver,** says Diana Kornetti, president and co-owner of Integrity Home Health Care, Ocala, Fla.

- **Classify the deficit based on a standardized instrument.** "You can't just say, 'They're weak,'" Kornetti says. Instead, name the instrument you used to objectively quantify the deficit. This allows you to then frame your goals by writing what kind of improvement you are looking for based on that deficit.

- **Avoid over-use of strength as the deficit.** Frequently, therapists write strength goals even though the patient may not be having trouble with weakness, Krafft says. If the issue instead relates to confusion or vision, make sure that is the issue identified in the measurable goal.

- **Document the goal's function by considering what daily activities the patient needs to complete,** Kornetti says. Example: Does the patient need to traverse stairs to get to the bathroom?

Get clinicians on board with goal reform

The power to improve this component lies with clinicians, who must write statements that explain how the goal contributes to patients' lives in ways that are meaningful to them, Krafft says.

Administrators shouldn't assume that therapists are incapable of writing proper goals or lazy. "Therapists just haven't taken the time to learn the rules of the home care game," Kornetti suspects.

Even worse, faulty software systems present therapists with pre-written goals that were likely not written by therapists and don't necessarily meet the CMS standard, Kornetti says. Therapists can't assume those are the only goal options they have to choose from.

To drive home the point about the risk of writing poor goals, Krafft suggests telling your clinicians "this is not a slap on the wrist situation." Present them with the Therapy STARS finding that each record has an average risk of $1,500. "We're finding that people need to see that [financial] component because it's not an issue of, 'I think you give bad care.'" Rather, "the gaps you leave in the note present a risk that in some agencies could shut them down." – *Ben Penn (bpenn@decisionhealth.com)*

Discharge notes

- **Correction:** The story "New wage & hour rule would end agencies' use of the companionship exemption" in the Jan. 9 issue incorrectly gave the name of Stephen Zweig, with the New York office of Ford & Harrison, as Stephen Hess.

- **Congressional leaders from both houses have appointed conferees for a panel that will negotiate a longer-term "doc fix."** The panel could turn to payment cuts for home health and hospice as one way to pay for the cost of the fix, the National Association for Home Care & Hospice (NAHC) fears. The panel will include four Senate Democrats, three Senate Republicans, eight House Republicans and five House Democrats.

Upcoming educational opportunities

- **Surviving the transition to ICD-10: Practical strategies for home care** on Jan. 31. Prevent productivity losses and protect your agency's revenue stream with a comprehensive transition plan. Learn more at *www.decisionhealth.com/conferences/A2206*.
- **Reap referral rewards from regulatory changes** on Feb. 8. Learn how to grow referrals in the age of ACOs and HH-CAHPS and get strategies to repair the referral damage caused by the face-to-face requirement. Find more information at *www.decisionhealth.com/conferences/A2203*.
- **Build internal audits to reduce compliance risks** on Feb. 22. Learn how to assess the strength of your internal audits, determine your compliance risks and reduce your risks with tips to build an audit program. Find more information at *www.decisionhealth.com/conferences/A2214*.
- **Adopt disease management protocols for Alzheimer's patients** on Feb. 28. Improve clinical outcomes, and make your agency a more attractive referral partner by adopting proven disease management protocols for patients with Alzheimer's, dementia and other memory deficits. Learn more at *www.decisionhealth.com/conferences/A2209*.

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