

## **EDITORIALLY SPEAKING**

**By Larry L. Breeding  
IAHC Executive Director**

### *MEDICAID UPDATE/ROTUNDA REPORT*

#### **Iowa Medicaid Enterprise (IME)**

IAHC members should have received by e-mail from our office the following DHS information regarding IME Training:

- 1) Informational Letter #409 advising of the IME transition training sessions scheduled for 8 locations in May and June. IAHC members are encouraged to attend one or more of these training sessions as it would appear to be impossible to be too over-educated on this fiscal intermediary transition.
- 2) Informational Letter advising of the ICN Training for case management changes to the Iowa Foundation for Medical Care (IFMC) on 5 of the 6 Medicaid waivers (for political and turf reasons, the Elderly Waiver for the near term is staying with the Area Agencies on Aging). This is part of the IME contract wherein medical eligibility, wherever possible, will be under the purview of IFMC. Again, members are encouraged to attend these training sessions even if you don't participate in all of the waivers to be converted. The fact that IFMC is not case managing the Elderly Waiver program now does not mean same will not transpire in the future.

#### **Legislature**

As of this writing, the Iowa Legislature has not yet adjourned their 2005 session. Following is the current status of legislation affecting home health care. After adjournment, we will advise members of final action.

#### **Medicaid Funding/Home Health Agency Prospective Payment System**

The DHS/DOE/DPH Appropriations Bill HF825 has passed each chamber but in slightly different versions. The 3 provisions relating to home health agency funding,

i.e. removal of the 3% cut in effect over the last 3 years; eliminating the waiting list on all HCBS waiver services; and the establishment of a prospective payment system for home health agencies under the Medicaid program effective July 1, 2006 are the same in both versions and are not expected to be changed. The DPH Elderly Wellness grant program received the same level of funding established in 1992

House Files

**HF 617**

Directs the DHS to request waivers from Medicare-Medicaid to add assisted living services to the Medical Assistance Program for elderly home and community based services waiver. This legislation has been signed by the Governor.

**HF 781**

Directs the DPH to appoint a Direct Care Worker Task Force to review direct care worker education and training requirements. The 12-member task force includes representatives of direct care workers, health care providers, consumer and disability advocates, and educators of direct care workers. This legislation has been signed by the Governor.

**HF 786 NURSING HOME ALTERNATIVE SOURCES**

Allows nursing homes to provide other services (such as community-based services) to non-residents. Prohibits DIA from limiting a facility's ability to provide these alternative services. Directs the State Fire Marshal to set criterias for the approval of these alternative services in a designated portion of the nursing home. Adds language to ensure nursing homes won't compete with hospital medical and laboratory services. This legislation has been signed by the Governor.

**HF 841 UPDATE ON MEDICAID REFORM (IOWA CARE ACT)**

Over the last year, we've been updating you about the problems facing Medicaid. Iowa can no longer use Intergovernmental Transfers (or IGT's) to draw down additional federal Medicaid dollars. About 15 states total do this to help add to their Medicaid budgets, and the Federal government is putting an end to it. That leaves

Iowa out about \$170 million total. To fix this problem, Iowa has worked with the Federal government to come up with an innovative Medicaid Reform proposal (HF841) that would allow the state to fill this hole. One provision has a direct home care impact.

A very significant provision of HF841 has the potential to substantially change Iowa's long-term care delivery system as relates to Medicaid and to move beneficiaries out of nursing homes into home and community-based services. By way of background, one of the flaws of the Federal requirement for Medicaid waiver is that the beneficiary must be eligible for nursing home care before they can apply for any of the 6 waivers. The issue, of course, is that home care many times is too late to assist those individuals because of their deteriorated health condition. A more appropriate requirement would allow home care services before the beneficiaries' health has declined to reach nursing home level of care. What this legislation does, with approval of CMS, is to establish 2 separate admission triggers for the waivers and for nursing homes. After July 1, 2005, a Medicaid beneficiary seeking admission to a nursing home will not be admitted unless they meet any of the following 3 criteria:

1. The individual requires the physical assistance of one or more persons on a daily basis with 3 or more activities of daily living which may include but are not limited to locomotion, dressing, eating, hygiene, or toileting, or
2. The individual requires the establishment of a safe, secure environment due to chronic confusion or mental illness, or
3. Individual has established independency requiring residency in a mental institution for more than one year

The admission criteria for a Medicaid beneficiary being allowed home and community-based waiver services is different. Beginning July 1, 2005, a Medicaid beneficiary applying for any of the 6 Medicaid waivers must comply with either of the 2 following criteria:

1. The individual requires hands-on assistance, not including cueing, or setting up, on a daily basis of 1 to 3 activities of daily living which may include but are not limited to personal grooming, such as dressing or hygiene, or
2. Individual requires the establishment of a safe, secure environment due to chronic confusion or mental illness.

The legislation further provides for a safety net in the event that a person applies for waiver services, and same are not available in the community, then the individual may be admitted to a nursing facility.

While it is impossible to know at this time the exact potential this could have in reducing nursing home admissions, the figure I hear that seems to have the most credibility is that if this criteria were in place over the last 18 months, 40% of admissions to Iowa nursing homes would have been denied because they did not meet the medical criteria established in this legislation.

The big issue that this raises is the assessment system that DHS will have to employ to cover all 6 waivers. Certainly the necessity of a universal assessment system, which has been talked about for the last 3 years, gains significance with this legislation. This legislation has been signed by the Governor.

### **SF 341 LONG TERM LIVING SYSTEM**

Creates a long-term living system in order to lowans a comprehensive guide to cost-effective long-term living options. Requires the DHS, the DEA and DPH to work together to give people access to this information. Requires a report to the Governor and the Legislature by October 2005.

In addition, it requires the DHS, DEA, DPH and the Insurance Division to work on long-term living uniform assessment tool and to report to the Governor and Legislature by November 1, 2005.

This bill has passed both chambers, but is held up in the senate on a motion to reconsider.

### **SF 416 CIGARETTE TAX & PROPERTY TAX RELIEF**

**Cigarette Tax:** Increases the cigarette tax by 36 cents to 72 cents. Makes these provisions effective on the first day of the month that begins following enactment of the bill. **Levy:** Changes the community college operations levy to establish an optional supplemental amount above the base levy. Requires the additional amount to be certified every year and sets limits on how much the optional levy can be (20% of designated employee-related contributions, utility costs and projected revenues in FY 2007; 33.32% in FY 2008, 46.45% in FY 2009, and 59.68% in subsequent years.) Sets maximum amounts, in dollars, that each community college merged area can collect. Authorizes the establishment of local workforce and economic development funds. Authorizes expenditures from the fund to include projects under the ACE (accelerated career education) program. Contains other related provisions. Effective July 2005.

*IAHC members' note: None of the cigarette tax increase money will go to the Medicaid program. This bill has passed the senate but is being held up on a motion to reconsider.*

## **District Elections Complete** **Board of Directors Selection Process**

The IAHC Spring District Meetings completed the selection process for the 2005-06 Board of Directors.

The following were elected representatives from their respective districts:

**Central District**

Janice Jensen

Dallas County Public Health Nursing Service

Perry, IA

**Northeast District**

Joyce Friederich

Palmer Home Health Agency

West Union, IA

**Southwest District**

Lorilyn Schultes

Cass County Memorial Hospital Home Care

Atlantic, IA

**Southeast District**

Lynelle Diers

Wapello County Public Health

Ottumwa, IA

IAHC congratulates these individuals on their election and is appreciative of each volunteering their time, effort and talent to serve on the Board of Directors. The 2005-06 Board assumes responsibilities following the June 7, 2005 board meeting.

## **'National Action Plan' Released for Falls Prevention; Drawn From Findings of December Summit**

Each year, nearly 20,000 deaths are caused by injuries in the home. In response to growing concern related to falls among the aging population, the National Council on Aging, with funding from the Archstone Foundation and the Home Safety Council, sponsored a summit early last December to address issues surrounding older adult falls. As a result of that summit, the groups drew together experts' findings and recommendations into a new "monograph" titled "Falls Free: Promoting a National Falls Prevention Action Plan."

Participants in the summit included representatives from government agencies -- including the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) -- provider and professional organizations, industry, and advocacy groups for the elderly.

One goal of the gathering was to unify efforts to help raise awareness of and reduce the occurrence of falls among the elderly. By bringing together national experts, the summit sponsors had aimed to resolve problems resulting from lack of "a champion for a focused and strategic national marketing, public and professional awareness, and education campaign."

They also hoped to identify opportunities for collaborative professional educational initiatives and the development and dissemination of clinical guidelines related to falls prevention. Additional objectives included identifying partnerships for consumer education, creating opportunities to engage construction and manufacturing industries for improving product designs to help prevent falls, promoting research and grant funding, and developing policy on the issue at the local, state, and national levels.

The "Falls Free" action plan is the first step in implementing a comprehensive and coordinated effort to reduce falls among seniors. The plan includes recommendations made by summit participants for strategies and action steps for five major topic areas:

- Physical mobility,
- Medications management,
- Home safety,
- Environmental safety in the community, and
- Cross-cutting or related issues.

Summit participants identified several common strategies for addressing all five topics, which called for development of assessment and educational tools as well as web-based tools and programs tailored to professionals, the elderly, and their caregivers. Cross-cutting strategies focused on community involvement, with an emphasis on developing a public policy agenda to promote falls prevention.

Two of the major preventable causes of falls identified are (1) decreased physical mobility and (2) medication side effects -- both areas of interest to home care providers. **Strategies detailed in the "Falls Free" report for supporting physical mobility include:**

- Creation of national web-based clearinghouses to disseminate consumer and professional information;
- Increasing awareness among older adults of factors that contribute to decline in physical mobility;
- Increasing the use of physical mobility programs for seniors; and
- Developing reimbursement options under Medicare and other payers to cover physical mobility and fall prevention services.

Strategies recommended for reducing falls caused by medication side effects include providers assessing patients' medications periodically, development of software to identify possible medication interactions based on patient characteristics, and improving professional education on the interrelationship between medications and falls.

According to the report, further work in implementing strategies and action plans will depend on available funding. **Should adequate funding be secured, the next steps planned are:**

- Encouraging adoption of the "Falls Free National Action Plan" strategies;
- Broad dissemination of the plan through conferences and websites;
- Collaboration of key stakeholder organizations to further disseminate and implement strategies and action steps;
- Work with organizations to support public policy initiatives; and
- Development of a follow-up report to the action plan.

The work of the Home Safety Council is closely related to that of home health providers, given that "emergent care for injury caused by fall or accident at home" is one of the home health adverse event outcomes. CMS has identified this adverse event as one that could result in surveyor action related to the Medicare conditions of participation (CoP).

Specifically, CMS advises surveyors that when reviewing agencies, they should look at the comprehensive assessments performed to determine if any identified safety hazards were discussed with the patient. Surveyors also should review plans of care to determine whether safety measures necessary to protect against injury -- as required under the CoP -- were instituted. Surveyor's reviews are to include determining whether an agency made appropriate care planning decisions in light of the patient's condition, diagnosis, medications, and plan of care.

Moreover, careful consideration should be given to the "Falls Free" action plan resulting from the falls prevention summit in light of the fact that falls often result in emergent care and hospitalization, two additional home health adverse events. Updates in the works for the home health CoP include requirements for Outcome Based Quality Improvement (OBQI) measures, so that home health agencies with a high incidence of adverse events due to falls would need to demonstrate steps taken to make improvements.

## **Rural Home Health Therapy Service Use Growing, But Lags Behind Growth in Metro Areas, Study Finds**

During several periods, rural home health agencies have experienced less growth or greater decline than urban agencies have, demonstrates a recently issued study from the Walsh Center for Rural Health Analysis in the University of Chicago's National Opinion Research Center (NORC). The study, "Home Health Payment Reform: Trends in the Supply of Rural Agencies and Availability of Home-Based Skilled Services" (March 2005), examines the availability of home health services and the supply of home health agencies in rural areas against a backdrop of trends for more urban areas.

For the report, the center assessed the supply of home health agencies for three periods: (1) the years prior to passage of the Balanced Budget Act of 1997 (BBA); (2) the time during which the interim payment system (IPS) was in place; and (3) the period since implementation of the Medicare home health prospective payment system (PPS). Additionally, the center examined changes in the proportion of agencies offering occupational therapy (OT), physical therapy (PT), speech therapy (ST), and medical social work services.

### **Supply of Agencies**

From 1995 to 1997, rural home health agencies showed less growth when compared with their urban counterparts (8.8 percent, as opposed to as high as 18.8 percent growth for metropolitan area agencies), among other trends the report describes. Under the IPS, rural agencies declined by 18.9 percent, which was less dramatic than the decrease in number of agencies in more urban areas for the same period.

For the most recent years studied, however (2001 to 2003), rural agencies show the highest rate of decline with a drop of 6.0 percent -- and the loss of a rural agency may have a more noticeable impact on a community, study researchers observe. "Closure of a rural agency may have a greater impact on access since many rural communities are experiencing critical shortages of providers," the study notes.

Also considered is the expiration last Thursday (March 31) of the temporary 5 percent home health add-on applied to episodes of care in rural areas. The study determines that the post-PPS decline in rural agencies "suggests the need for continued monitoring of the financial impact of the home care payment system, particularly as the rural add-on is set to expire in 2005."

## Availability of Services

Addressing delivery of a select group of services (OT, PT, ST, and social work), the center found that while the availability of PT services has increased between 1997 and 2003, about 7 percent of rural home health agencies do not offer PT services -- *despite* significant financial incentives under the home health PPS to do so.

The number of rural agencies providing OT services increased by 27.2 percent between 1997 and 2003, and those offering ST increased by 10 percent during the same time period. Meanwhile, the availability of social work services from rural home health agencies actually declined between 1997 and 2003, from 43.6 percent to 40.4 percent.

Study findings indicate that rural agencies were the least likely to offer the services examined. The center concludes that "large disparities in access to home-based therapy and social services continues [sic] to exist," and as causal factors points to therapist and social worker shortages as well as variance in physician practice patterns for prescribing home-based therapy.

## **Request for Proposals for First Round of Contracts in QIO 8th Scope of Work Issued**

The Centers for Medicare & Medicaid Services (CMS) put out a request for proposals for the first round of quality improvement organization (QIO) contracts for the QIO "8th Scope of Work" work plan (Iowa's QIO is IFMC). Announcing the request, CMS invited interested parties to submit proposals for providing utilization and quality control peer review services according to requirements of the Social Security Act. Funding of the 8th Scope of Work is pending final authorization from the Office of Management and Budget.

QIOs will be required under the 8th Scope of Work to engage in global as well as provider-specific tasks with nursing homes, home health agencies, hospitals, critical access hospitals/rural hospitals, and physician practices. The first item on the agenda is "Assisting Providers in Developing the Capacity for and Achieving Excellence." QIOs will be evaluated on collecting data, identifying and developing materials, and facilitating collaboration.

Home health subtasks require QIOs to promote transformational changes in the measure for acute care hospitalization and two additional publicly reported Outcome and Assessment Information Set (OASIS) measures among one subgroup dubbed "identified participant group" providers. A second subgroup of these providers must be identified to work with the QIOs in implementing emerging telehealth technologies to help reduce acute care hospitalizations. QIOs will work with this second subgroup "to build capacity" for these technologies and "improve organizational culture" for adopting them.

Finally, QIOs will be required to focus on reducing acute care hospitalizations and one additional publicly reported OASIS measure. Another aim is to increase the number of home health agencies that assess patients for influenza and pneumococcal immunizations on a statewide basis of all providers.

CMS identified a few specific recommendations related to systems improvement and organizational culture changes. Included in the telehealth measures, QIOs will be evaluated on their success in increasing utilization of telehealth tools to reduce rehospitalizations. The telehealth tools will cover telemedicine (audio consultation, phone messages) as well as telemonitoring (audio/video/data consultation). CMS will release guidelines containing specific criteria that must be met.

QIOs also will be required to use a survey tool approved by CMS to conduct "organizational quality culture" studies that will focus on organizational practices. These studies will address issues such as staff satisfaction, care practices, and home health agency systems and processes. The next step in influencing organizational change will require QIOs to implement a plan of action for each agency.

## **QIOs Meet with Providers to Showcase Best Practice “Change Packages”**

The quality improvement organizations (QIOs) selected to carry out a pilot project directed by the Centers for Medicare & Medicaid Services (CMS) to establish "evidence-based change packages" for improving care have initiated provider education sessions across several states. The results of these short-term projects will aid CMS in preparing for execution of the QIOs' latest work action agenda, the "8th Scope of Work."

As lead QIO, the Delmarva Foundation held its first meeting with providers on the best practices "change packages" late in March. QIOs from Tennessee, New York, Washington, Idaho, Michigan, Utah, Virginia, Louisiana, and Rhode Island also have held meetings, aiming to establish best practices for reducing acute-care hospitalization rates in home health care.

An analysis of Outcome and Assessment Information Set (OASIS) data from the April 2003 through March 2004 period shows that approximately 28 percent of all home care episodes ended with an acute-care hospitalization. In addition, studies have shown that many of these hospital admissions are avoidable.

### **Delmarva has identified five "change domains" that will be used to improve acute care hospitalization:**

- Promoting patient self-management;
- Implementing evidence-based practices and guidelines;
- Using systems and technology to promote effectiveness and efficiency;
- Improving care delivery systems / mobilizing community resources; and
- Creating a culture of quality.

Strategies associated with each domain are geared toward one of four stages of care a patient may be receiving. For instance, a strategy used to "promote patient self-management" would be different at the start of care than later during the care episode. These strategies are broken down further into action steps that agencies can utilize based on their specific needs.

Quality Insights of Pennsylvania also recently held its first meeting for providers to introduce its plans for implementing the "Quality Medication Administration Project" (Q-MAP). Quality Insights was selected as the sole QIO involved in the project for providers across Pennsylvania.

Recent OASIS data have shown that the national average for home care patients who improve in their management of oral medication is 39 percent. That rate is considered well below an acceptable level for this quality outcome measure.

Quality Insights presented elements of its "change package," including tools that assist providers with assessment and intervention strategies aimed at improving medication management. **Specific tools have been designed for:**

- Patient medication assessment;
- Staff assessment of medication non-adherence;
- Patient self-assessment for medication management;
- Medication teaching/instruction;
- Medication simplification;
- Medication compliance aides; and
- Oral medications care planning.

Patient needs can be identified and interventions employed appropriately using tools from Quality Insights' change package. The materials will be available online at [www.qipa.org](http://www.qipa.org).

The hospitalization reduction and medication administration projects are intended to give providers the tools required to effect change in improving outcomes. Successes under the program will be studied and shared, and the "change packages" that prove to have a positive impact on targeted goals will be made available to all QIOs for provider use.

## **Ask the Experts: Coding OASIS M0490 for Patient Requiring Ventilator**

*NAHC Responds to Members' Inquiries and Concerns*

**Q:** *How should Outcome and Assessment Information Set (OASIS) item M0490 be coded for a patient who requires a ventilator?*

**A:** **From the Centers for Medicare & Medicaid Services (CMS):** "For any patient who requires a ventilator, we are confident that assessment of the patient's respiratory status is being performed. M0490 asks when the patient is noticeably short of breath. In the response options, examples of shortness of breath under varying levels of exertion are presented.

One component of a respiratory status assessment would be to evaluate if (and under what circumstances) the patient becomes short of breath. The questioner does not indicate whether ventilator use is continuous or intermittent. If the continuously ventilator-dependent patient never becomes short of breath, regardless of level of exertion, while on the ventilator, then response '0' applies.

The other responses reflect varying levels of exertion, all the way to shortness of breath even while at rest. If ventilator use is intermittent, then the level of [the patient's] shortness of breath should be determined without the ventilator."

**Note:** *The National Association for Home Care & Hospice has written to CMS expressing concern that OASIS data may not be providing an accurate picture of a patient's disease state, limitations, needs, and outcomes with this response. NAHC asked CMS to consider whether this response actually identifies measurement of a person's ability to breathe independently or the adequacy of the machine to sustain breathing.*

*NAHC recommends the addition of a response to M0490 specific to persons requiring continuous ventilator assistance, because to say that a person on continuous ventilator assistance is "never short of breath" leaves a false impression. In addition, selecting "0, never" fails to capture the resource needs required for care of these patients under the PPS case-mix system. Although there is an OASIS item that reflects ventilator use, it is not included in the case-mix.*

## **Don't Miss Barn Raising V and Your Chance to Celebrate 125 Years of Public Health for the State of Iowa**

Mark your calendars now for July 28-29 and plan to attend the 2005 Governor's Conference on Public Health. The conference, "Barn Raising V: Building Iowa as a Healthy Community," will be held at Drake University and it coincides with the 125<sup>th</sup> anniversary of the founding of public health efforts in the state of Iowa.

"Those who attend can expect to return to their communities revitalized and energized with new perspectives and information," said Mary Mincer Hansen, R.N., Ph.D., director of the Iowa Department of Public Health. "I encourage health professionals and others to join us as we celebrate our past and examine our present efforts so that we can set the course for building healthy communities in our future."

The conference offers nearly 50 breakout and training sessions with respected leaders in the public health field, and CEUs for attendees. **The Nursing Home Administrator Examiners, Professional Licensure, of the Iowa Department of Public Health has approved this program for 12 hours of CEUs for long-term care administrators.** The complete list of CEUs available is on the Iowa Public Health Website ([www.@idph.state.ia.us](http://www.@idph.state.ia.us)) under conferences.

The registration fee for the two-day event is \$50. Registration information is included in the brochure to be distributed in May. On-line registration is also available.

For more information about the conference, contact Mary Weaver at [maryweaver@prairienet.net](mailto:maryweaver@prairienet.net) or 515-360-8046. For more information about registration, contact Training Resources at [www.trainingresources.org](http://www.trainingresources.org) or 515-309-3315.

Two special training sessions—one on depression and the other on mandatory reporting requirements—will be offered July 27 and 28 for registered conference participants. The registration fee is \$20 for each of the two sessions and covers training costs and materials, CEUs, and a light supper.

“Beyond Depression: Best Practices for Treating Major Depression: Training for Medical and Community Providers” is offered from 2:30 to 8:00 p.m. on July 27. Joan Blundall, MCA, HCA, and Carol J. Hodne, Ph.D., MA, both of Higher Plain Inc. are the presenters for the session, which is designed to increase the knowledge of best practices in treating major depression.

The target audience includes physicians, physician assistants, nurse practitioners, nurses, and human service providers. For more information, contact Blundall at 319-643-5628 or at [joan-blundall@higherplain.org](mailto:joan-blundall@higherplain.org).

Kimberly Groves, LBSW, will conduct the session on child abuse reporter training, “Abuse Mandatory Reporter Training” from 6 to 8 p.m. on July 28. The session meets the state’s requirement for training mandatory reporters who are required to report child abuse only. The Abuse Education Review Panel has approved this curriculum (#401) for child abuse mandatory reporter training.

A dependent adult abuse mandatory reporter training is also offered by Diana Nicholls-Blomme, R.N., of the Iowa Department of Public Health from 8 to 10 p.m. on July 28. This workshop meets the state’s requirement for training mandatory reporters who are required to report dependent adult. The Abuse Education Review Panel has approved this curriculum (#163) for dependent adult abuse mandatory reporter training. For more information, contact Nicholls-Blomme at 515-281-3347 or [dblomme@idph.state.ia.us](mailto:dblomme@idph.state.ia.us).

*Note: Mandatory reporters for children and dependent adults will need to take both parts of the training.*

## **Some State-to-State Disparities Emerge in National Home Health Hospitalization Reduction Study**

The ongoing Briggs National Home Health Hospitalization Reduction Study, cosponsored by the National Association for Home Care & Hospice and Fazzi Associates, has released a breakdown by state with some notable findings on the number of agencies whose hospitalization scores were 19 percent or less. These top-scoring agencies are the focus of the study.

This study is a national effort directed at identifying best practices that agencies have employed most effectively to lower unplanned and/or preventable hospitalizations of home care patients. To accomplish this, the study will use data from Centers for Medicare & Medicaid Services (CMS) sources to focus in on the top 10 percent of agencies that have the lowest hospitalization rates. While the national average for hospitalization from the home health care setting is 28 percent, agencies involved in this study have hospitalization rates averaging 19 percent or lower, as recorded in their March 3, 2005, Outcome-Based Quality Improvement (OBQI) and Home Health Compare scores.

This just-released breakdown reveals that a number of states, primarily in the West and Mountain regions of the country, have significantly higher numbers of agencies achieving the 19 percent or lower hospitalization rates. Other states in the Northeast (particularly New England) have lower numbers of agencies now performing at this threshold.

In releasing the breakdown, study Co-Director Dr. Robert Fazzi noted that the numbers clearly indicate there may be other factors beyond practice influencing hospitalization rates. "It may be the rural nature of some of the states or the effects of managed care penetration that might affect the outcomes -- or something that we have yet to look at," Fazzi said. "What is clear is that we will need to look at other factors beyond just practice as the study proceeds."

In an effort to ensure that all factors are considered in the study, the project is exploring ways for professionals in the home care field to make suggestions on which practices and other issues they believe should be addressed. "Our goal is to involve the entire field in helping to shape the focus of the study and later the dissemination of the findings," explained Cyndi Rohret, a clinical consultant with major study sponsor Briggs Corp. She continued, "While our ultimate goal is to identify and share best practices for reducing hospitalization with the field, we also want to develop insights that can help explain some of the differences we are finding."

An announcement is expected from the project shortly on how agencies can make recommendations for areas they believe should be investigated. The "study phase" of the project is expected to run from June through September, with resultant findings and best practice strategies slated to be shared across the home health field during the fourth quarter this year.

The state by state breakdown is as follows:

## National Hospitalization Reduction Study, State Breakdown

Number and Percent Eligible by State			
State	Total Agencies recorded	Total Low Hosp	% Low Hosp
AK	12	5	41.7
AL	139	6	4.3
AR	164	5	3.0
AZ	62	11	17.7
CA	506	116	22.9
CO	108	14	13.0
CT	80	4	5.0
DC	12	1	8.3
DE	12	0	0.0
FL	433	102	23.6
GA	92	11	12.0
HI	13	3	23.1
IA	156	13	8.3
ID	48	9	18.8
IL	274	21	7.7
IN	143	12	8.4
KS	114	15	13.2
KY	99	1	1.0
LA	218	6	2.8
MA	105	0	0.0
MD	42	2	4.8
ME	29	4	13.8
MI	217	22	10.1
MN	162	17	10.5
MO	145	21	14.5
MS	57	4	7.0
MT	33	12	36.4
NC	161	5	3.1
ND	25	10	40.0
NE	60	12	20.0
NH	32	0	0.0
NJ	51	1	2.0
NM	48	8	16.7
NV	43	9	20.9
NY	185	6	3.2
OH	291	16	5.5
OK	176	6	3.4
OR	58	23	39.7
PA	225	32	14.2
P.R.	45	2	4.4
RI	21	2	9.5
SC	64	1	1.6
SD	38	17	44.7
TN	133	7	5.3
TX	956	56	5.9
UT	43	10	23.3
VA	144	10	6.9
VT	12	0	0.0
WA	53	15	28.3

WI	102	12	11.8
WV	61	8	13.1
WY	24	2	8.3

**Source: National Home Health Hospitalization Reduction Study**

## **New Nationwide OASIS Cost and Benefit Survey Launched**

Recently, some 1,200 home health agencies across the country received a letter from the Centers for Medicare & Medicaid Services (CMS) notifying them that they have been selected to participate in a survey on the costs and benefits of Outcome and Assessment Information Set (OASIS) data collection. The survey aims to gather the information necessary to develop a more accurate estimate of the costs of OASIS data collection and increase understanding of how agencies use the data, particularly for non-Medicare and non-Medicaid patients, CMS says.

The agency also plans to use the results of the survey to develop a recommendation to Congress on whether the temporary suspension of OASIS data collection for non-Medicare and non-Medicaid patients -- in effect since December 2003 -- should be rescinded or made permanent. CMS contracted with Abt Associates Inc., a Cambridge, MA-based research firm with years of experience working with Medicare home health issues, to conduct the study.

The survey is the first large-scale study of OASIS-related costs since collection of the data was required for Medicare-certified agencies in 1999. It is the result of a congressional mandate that directs CMS to study the value and burden involved in OASIS data collection for non-Medicare and non-Medicaid patients among large and small home health agencies.

Specifically, Section 704 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates that a study be conducted to examine "whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and ... the value of collecting such information by small home health agencies compared to the administrative burden related to such collection."

In the next few weeks, home health agencies in the nationally representative sample selected for participation in the study will receive a survey packet from Abt Associates containing an "OASIS Cost and Benefit Survey" and additional information. Questions in the survey relate to agency OASIS-collection practices, staff time spent collecting assessments, costs for other OASIS-related activities, and agency uses of OASIS data.

Participants are asked to estimate costs based on their best available data and to provide opinions on the value of OASIS data to their agencies. Although the survey is directed toward agency administrators, other staff knowledgeable on OASIS costs and benefits should contribute CMS notes.

It is estimated that the survey will take about 90 minutes to complete. Abt Associates is providing an email address and staffed toll-free number for addressing any questions agencies have as they complete the survey.

The selected agencies are not required by CMS to complete the survey but are strongly urged to do so, since the largest number of participants will make the survey results as representative as possible of all home health agencies. Also, home health agencies that participate will receive a benchmarking summary of their individual responses on key survey items compared against those of all responding agencies.

## **Ask the Experts: Therapies Provided at Wound Clinics**

### NAHC Responds to Members' Inquiries and Concerns

**Q:** *Many of the therapies provided at wound clinics have HCPCS codes that are included on the list of services bundled to home health agencies. Must home health agencies pay wound clinics for these services and bundle them into the home health claim?*

**A:** **From National Association for Home Care & Hospice Regulatory Affairs:** No. Home health agencies would pay wound clinics only for contracted therapy services that require equipment too cumbersome to be brought into the home. Wound clinics that attempt to bill Medicare for therapies that are listed under home health consolidated billing while the patient is under a home health plan of care will have their claims rejected. Physician services provided in a wound clinic, even if they are therapies included in home health consolidated billing, may be billed by the clinic.

The Centers for Medicare & Medicaid Services (CMS) does not pay for "wound clinic" services. Rather, CMS pays for "professional" services (physician, incident to physician, or rehabilitation therapy) under the Medicare Part B medical benefit. Physical, occupational, and speech therapy services provided outside of the home are the only professional services that may be subject to bundling for home health agencies, and then only if specific regulatory requirements are met.

According to CMS regulations at 42 CFR 409.47, home health services must be furnished in the patient's place of residence. The only exception is when home health services must be provided outside of the home that, according to 409.47(b)(1), "require equipment that cannot be made available at the beneficiary's home." Furthermore, according to 409.47(a), sites where these services may be provided are limited to hospitals, skilled nursing facilities (SNFs), and rehabilitation facilities.

Only when all of these conditions are met, and the home health agency has a contract with the hospital, SNF, or rehabilitation facility, is a home health agency permitted to bill Medicare for these bundled services. Many of the professional therapies included in the HCPCS code list do not meet the "equipment that cannot be made available in the home" requirement. When these criteria are not met, the therapies designated in the HCPCS code list must be provided by the home health agency in the patient's home. The only exception to this is when the designated therapies are provided by a physician or are incident to physician services.

According to the latest CMS update of HCPCS codes used for home health consolidated billing enforcement ([Medlearn Matters MM3525](#)), *"With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this [HCPCS] list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode."*

## **Home Telehealth: State of the Technology**

*Issues and concerns have upgraded since last year*

Last month's annual meeting of the American Telemedicine Association (ATA) in Denver was replete with reports of new studies showing the effectiveness of remote electronic patient monitoring. Evidence of provider and payer cost savings as well as improved patient outcomes served to settle some old questions once and for all, though new ones were quick to follow. The industry's leading concern going forward appears to be how, rather than whether, to deploy a home telehealth (HT) program.

Few of the meeting's scholarly or anecdotal discussions appeared to be aimed at convincing providers that electronic remote patient monitoring is effective. Rather, the unspoken strategy seemed to be to convince regulators, legislators and payers. Perhaps symbolic of the industry's readiness to look beyond evidence of efficacy to the next step was a question from the floor during a home telehealth-oriented workshop. The questioner put a presenter on the spot with, "How long do you predict it will be before healthcare providers who do not offer telehealth can be cited for substandard care?"

### **NEW ISSUES**

#### **HT as service**

Previous ATA meetings heard endless discussions of the absence of telehealth equipment purchase reimbursement from CMS and other payers, including opinions of whether and when that may change. This year, a more resigned attitude was in evidence. Many presenters proposed accepting the cost of telehealth equipment and starting to think of remote monitoring as a service that happens to require the acquisition of certain equipment rather than a capital expense that happens to be used to provide a service.

#### **Cost report anomaly**

For home care, there is still the issue of Medicare categorizing the equipment for cost report purposes as an administrative expenditure, equivalent to office computers, rather than treating HT as a patient-oriented clinical tool along the lines of a stethoscope or portable pulse oximetry sensor. However, a number of home care presentations mentioned optimism that that policy may soon change.

#### **HT is for everybody**

Signs of the industry's maturing approach to telehealth were evident in frequent references to the technology as "one tool among many" in a nurse's or physician's arsenal. Another sign was a new answer to the perennial question about which diagnoses are appropriate for telehealth services. Replacing complex formulae about co-morbidities in specific combinations was new advice to simply monitor everybody, or at least every patient mentally and physically capable of

operating the device. For those who are not capable, it was explained, there will soon be passive monitoring devices that will require little if any patient competence.

### **To be seen or not to be seen**

Clearly, the industry is finally realizing that the term “telemedicine” does not convey the same image to everyone. Some vendors offer home telehealth devices that replace in-person visits with virtual, video visits. Others offer computer-like screens instead of cameras; with patients viewing displays with large-type words and images customized to their diagnosis and care plan. Some have neither video nor display screens but instead speak instructions to patients. The simplest do not communicate with patients at all; patients must be trained to hold a stethoscope and fix a blood pressure cuff at specified times and nurses use the telephone when two-way communication is necessary.

Perhaps the most cogent advice of the week came from McKesson’s Karen Utterback, who participated in a panel discussion on disease management. Her recommendation is to incorporate home telehealth decisions into care planning for each patient. Instead of choosing a vendor based on whether it uses video-conference or not, choose more than one vendor or choose a vendor that offers options. Then decide, patient by patient, whether to use video or other monitoring systems.

### **Home care may have waited too long**

One last issue that surfaced during the meeting involved a set of assumptions more implied than spoken. There are 12 special interest groups (SIGs) which ATA members can join. This year, the home care SIG emerged as the largest and fastest growing of the twelve. There were constant reminders, however, that it is still only one among twelve, still dwarfed by the combined membership of the other eleven SIGs and still deserving to be treated as a healthcare industry afterthought.

The other SIGs represent the interests of hospitals, disease management organizations and large, multi-physician clinics. An attitude that appeared to be shared among them is that there is no reason to wait for local home care agencies to jump on the home telehealth bandwagon. These other provider groups are moving forward and are purchasing telehealth equipment in substantial numbers. Some are establishing their own monitoring centers, staffed 24/7 with either trained telehealth nurses or low-cost, hourly employees who have access to on-call nurses if needed. The vast majority of presentations reporting findings of fewer re-hospitalizations, reduced office visit and emergent care use and improved patient outcomes, made no mention of home health care services.

### **Politics makes strange bedfellows, even in home care**

NAHC president Val Halamandaris reported to the ATA home care SIG about his member's annual trek to Capitol Hill during last month's Policy Conference. In spite of the "left-handed compliment" nature of what he heard from various agency administrators who managed to schedule audiences with their Representatives and Senators, he did offer one new reason for hope. Apparently, several elected officials who have been steadfastly against home care budget expansion in the past listened with interest when home telehealth technology was explained to them. When they heard that it records and digitally certifies every patient encounter, virtually eliminating any new fraud opportunity as well as hampering the use of legacy fraud methods, many of these traditional opponents reportedly said, "Sure, I can get behind paying for that!"

### **FOLLOWING LEADERS**

While many ATA presenters apologized for the limited scope and duration of their studies – most reported on small, pilot projects that show good results but have been in place for less than a year – two stood out because of their sample size and study length.

One was a recent self-assessment by the healthcare arm of the federal Department of Veterans Affairs. The Veterans Health Administration (VHA) offers telehealth services at 21 Veterans Integrated Service Networks (VISN), a program that began in early 1999. Dr. Faith Hopp, Ph.D. presented results of a recent staff satisfaction survey at the Indiana VISN, which has served over 850 patients since implementing its remote monitoring program two years ago. Hopp believes administrator, clinician and referring provider feedback may offer useful insights to civilian providers.

A second report with significant participation and duration came from Strategic Healthcare Programs, LLC (SHP). The Santa Barbara, California benchmarking services company reported on an analysis it conducted comparing monitored patients with a control group served by agencies that do not use home telehealth monitors. The study was conducted over a 27-month period and included 478 home health agencies in 41 states. SHP reported that the study was based on analysis of "millions" of OASIS assessments already stored in its databases from its benchmarking customers.

### **Surprising user reactions**

The VHA's phone-based staff survey established a base line this year and will be repeated in one year for comparison. It included both open-ended and closed-ended questions designed to elicit staff opinions of telehealth across several domains including:

- Technical Issues
- Advantages to staff
- Advantages to patients
- Training/support
- Communication/rapport
- Clinical applicability, and
- Perceived outcomes

Acknowledging the assumption that “home telehealth has the potential to profoundly influence the way in which health care staff members deliver clinical services,” VHA’s Dr. Hopp warned that that potential may be challenged by staff acceptance or non-acceptance. “Initial results indicate that all three stakeholder groups (administrators, clinicians and referring providers) perceived potential for telehealth at the VA,” Dr. Hopp began. “However, there were also group differences in perceptions and priorities.”

She explained that administrators often focus on their budgetary responsibility to make sure telehealth resources are adequately prioritized vis á vis other facility needs. Referring providers were enthusiastic about time saved by reducing the number of patient clinic visits. On the other hand, they were frustrated with organizational problems leading to delays and challenges. Hopp found that nurses were the most enthusiastic about long-term impact on patient outcomes but noted that telehealth’s learning curve was underestimated and detrimental to implementation.

“Data from this study indicate the importance of recognizing the wide variability in perceptions among key internal stakeholders,” Hopp concluded. “Input and support from these groups are needed to address potential barriers to implementation and ensure successful program development.”

#### Some good comments

Administrators were cautious and budget-oriented, Hopp said. Their concerns revolved around program viability depending on adequate resource allocation and fiscal realities such as federal hiring freezes and budget deficits. Primary care providers, on the other hand, expressed more enthusiasm, speaking appreciatively of newfound ability to detect early evidence of patient condition changes and to take action before hospitalization became necessary. Physicians were also pleased to note that remote monitoring seemed to inspire patients to pay more attention to their own care.

Home care nurses offered the most positive comments, particularly when expressing their hope that more patients will be monitored in the future, especially patients with multiple conditions. Some emphasized the educational role some monitoring devices can play, teaching patients about their condition and any appropriate lifestyle and dietary changes it may have made necessary.

### Some bad

No researcher expects, or wants, 100% positive responses and Hopp was not disappointed in this regard. Physician dismay centered on being kept informed. They requested better information about which patients are given monitors and which are not, what happens to a patient after referral to the home telehealth program and about the devices themselves. Physicians want to know enough about telehealth equipment so they can explain it to patients themselves.

Nurse complaints were slightly different. Many said they were not adequately prepared for home telehealth equipment's learning curve. Some worried that productivity would be decreased rather than enhanced at first. Others thought success would never come if they were not properly trained from the beginning. The strongest assertions, however, had to do with inappropriate referrals. One typical commenter complained, "I don't think that the people who are doing referrals are familiar enough with the equipment and what it can and cannot do in order to make the appropriate referrals."

Hopp concluded her revealing presentation with comments from all three respondent categories about outcomes tracking. Administrators, referring providers and nurses want to know aggregate statistics about re-hospitalizations, ER and intensive care usage and condition improvement. They want to know how costs and patient improvement are affected in contrast with non-monitored patient groups.

### **Sizable study confirms smaller ones**

As noted, one of the universal cries at the ATA meeting was from lobbyists who reported that CMS and other payers say they will not be convinced to pick up part or all of the tab for home telehealth equipment until long-term studies of sizable populations, showing cost- and outcome-effectiveness, are completed and verified. A study released at the meeting by SHP and Honeywell HomMed may soon find its way into the portfolios of those lobbyists.

SHP was hired by Honeywell HomMed to determine whether remote monitoring affects outcomes and costs over the long term. By analyzing its large database of OASIS assessments, submitted by its own benchmarking customers between January 1, 2002 and March 31, 2004, SHP was able to draw relatively immediate conclusions based on volumes of historical data instead of having to begin a study and wait 27 months before being able to analyze it.

The SHP study compared outcomes from 178 home health agencies that use Honeywell HomMed monitors against patients served by 300+ agencies that do not use home telehealth systems. Patients were selected for the study if they had one or more of the following diagnoses: Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Diabetes or Chronic Obstructive Pulmonary

Disease (COPD). Some had more than one of these diagnoses; many had them in combination with other conditions. Patients with multiple co-morbidities were more likely to be chosen for monitoring by agencies offering home telehealth services, which weighted the monitored sample generally sicker than the control group.

Results confirmed previous anecdotal evidence – including most of the small, work-in-progress studies presented at the same meeting – that monitored patients use less emergent care, are admitted to the hospital less often, visit their doctor's office with less frequency and become more medication compliant. One factor, though minor, may prevent full comparison of this study's results with those reported by medical clinics, hospitals and disease management companies. Many of those providers had selected other home telehealth devices, with equipment that offers video conferencing, either exclusively or as an option alongside remote vital sign monitoring. Honeywell HomMed does not offer a video option; its devices measure and transmit patient vital signs only.

### **THE SHP FINDINGS\***

#### CHF average rates

- Hospitalization, not monitored: 10.1%; monitored: 6.2%
- 29 agencies showed zero hospitalization rates
- ER visit, not monitored: 8.8%; monitored: 4.5%
- 39 agencies showed zero CHF ER visits
- ADL Improvement/stabilization, not monitored: 71.8%; monitored: 75.9%
- IADL improvement/ stabilization, not monitored: 58.2%; monitored: 69.1%

#### Diabetes average rates: (50% of monitored patients also have CHF)

- Hospitalization not monitored: 2.4%; monitored: 0.6%
- 109 agencies with 2,316 monitored patients showed zero hospitalizations
- ER visit, not monitored: 1.8%; monitored: 0.3%
- 109 agencies with 2,316 monitored patients showed zero ER visits
- ADL improvement/stabilization, not monitored: 70.4%; monitored: 77.2%
- IADL improvement/stabilization, not monitored: 59.4%; monitored: 70.7%

#### CAD average rates:

- Hospitalization, not monitored: 15.7%; monitored: 11.2%
- ER visit, not monitored: 12%; monitored: 7.9%
- ADL improvement/stabilization, not monitored: 70.4%; monitored: 77.2%
- IADL improvement/stabilization, not monitored: 59.4%; ADL, monitored: 70.7%

COPD average rates:

(42% of monitored patients, 24% of control group also have CHF) (57.9% of monitored patients, 46% of control group have “any other co-morbidity”)

- Hospitalization, not monitored: 16.8%; monitored, 8.3%
- ER visit, not monitored: 13.1%; monitored: 4.5%
- ADL improvement/ stabilization, not monitored: 71.8%; monitored 80.3%
- IADL improvement/stabilization, not monitored: 60.8%; ADL, monitored: 77%

\*SHP did not include some agencies in its reported averages, explaining, “Certain [monitoring] agencies are intentionally excluded from the population for a particular metric. Factors that contribute to a[n]... agency’s exclusion are related to issues such as, a) insufficient data within a diagnosis category, b) insufficient experience with monitoring, and, c) factors that render the agency an ‘outlier.’ ... the report documentation also indicates instances where, if the ‘outlier’ agencies are included, there is no adverse effect on the results.”

Any study funded by the organization most likely to benefit from the exact findings that the study produces is always quoted with disclaimers but this one offered results in line with other reports presented at the ATA meeting. It appeared as one of thirteen briefings in a focused educational track titled, “Telemedicine Success Stories.” Exhibitors and their customers were given 20 minutes to describe their standout programs. Though only two had a home care orientation, all 13 claimed drastically reduced hospitalizations, virtually eliminated ER use and less frequent physician office visits.

Sentara Home Care Services of Chesapeake, VA discussed its use of ViTel Net’s “ViTelCare™” system and the VNA of Somerset Hills, NJ offered results of four years of virtual videoconference visits with CHF patients using units from American TeleCare, Inc. Sentara’s results were similar to those reported by SHP. The 100 year-old VNA’s list of home telehealth benefits expanded to include improved patient satisfaction, shortened home care lengths of stay, improved compliance with medical regime and diet and reduced depression and feelings of isolation through active participation in their own care.

Brief summaries of home telehealth companies are as follows:

More telemedicine companies than ever demonstrated an interest in home telehealth at the traditionally hospital- and physician-oriented American Telemedicine Association annual meeting in Denver last month. Here is our rundown of who was present and what they were saying about themselves, along with our objective interpretation.

One insight that should jump off the page is that there is still no single, neat definition of “Home Telehealth.” Technical device variations combined with wide-ranging pricing models make vendor evaluation and selection a complex process. Some may decide that a combination of vendors is a sensible choice. Others may look for one vendor with a variety of technical features or multiple business models. Many will be concerned first about price, hopefully also about cost-effectiveness. Here is a list of other variations to consider as you read through these summaries.

- Purchase or lease vs. rent: You will either own the equipment (and hire sufficient staff to deliver, pick up and disinfect it between uses) or order it to be sent via FedEx from the vendor directly to each new patient. Consider: obsolescence, repair and replacement; unused units gathering dust, the ability to quickly respond to multiple unexpected admissions.
- Video vs. vital sign monitoring: They are both called home telehealth but they are as different as planes, trains and automobiles. Do you need all of one or the other or a mix? Consider: video is most like an in-person visit, saving nurse travel time but requiring one-on-one attention; vital sign monitoring allows one nurse to evaluate a range of measurements with dozens, even hundreds of patients but only offers a view of digital data, not the patient.
- One-way vs. two-way communication: Attach a stethoscope, scale and BP cuff to a phone line and you receive information about a patient. Put a small computer screen at the patient’s bedside and you can deliver customized instructions, teaching materials and warnings. Consider: what is your typical patient population, age, education, income-level, rural distance factor? What diseases and conditions do you plan to select for your monitored patient category? Budgetary restrictions are important here.
- Standalone vs. integrated/ interfaced data: One home care software vendor has produced its own home telehealth system, another has incorporated an existing one into its family of products. Alliances are becoming more frequent between home telehealth companies and billing and clinical software developers. Most implementations still exist in silos, keeping telehealth data separate from core systems, sometimes keeping the monitoring station entirely off the network. Consider: how important is it to you to incorporate patient vital sign data into your primary clinical and billing system? Have you developed a clear list of pros and cons before talking to vendors?
- Owned vs. hosted data: Some systems establish direct connections from each patient’s home to an application residing on an agency PC or server.

Others have the home unit dial an 800 number and transmit to a central, secure web server or server farm. Agency clinicians and designated primary care physicians access patient data on a web site. Consider: isolated data can only be accessed from one computer in the agency; web-based data can be viewed anywhere, by anyone. Does your care model call for consultations between your field nurses and the patients' primary care physicians or nurse specialists? Are your referring physicians likely to check on their patients on a web site? Would that feature be a marketing advantage on which you could capitalize?

**ADT Home Health Security Svcs Palm Harbor, FL** A division of **ADT Security Services, Inc.**, a **Tyco** company, **ADT** more often sells its emergency response service directly to the consumer, though it will work through hospices and home care providers. In addition to a 24/7 call center, ADT places small, wireless, motion sensors throughout the home. The central computer behind the sensors "learns" normal patterns of daily activity and reports abnormalities. Following a triage algorithm, call center staff notifies emergency response services, home care or hospice nurses or family caregivers by phone, secure web page, text message or pager.

<http://www.adt.com>

**AMD Homecare Lowell, MA**

*CareCompanion* is an FDA-approved, two-way monitor that records vital signs via wireless peripherals and transmits patient information to a server through a standard phone line. It delivers customized assessment questionnaires and event reminders to the patient through a large-type, touch screen. AMD offers an optional video phone but most off-the-shelf video speaker phones are supported. On the agency side, *Nurse Station Software* analyzes and stratifies vital sign data on a standard Windows PC.

<http://www.amdtelemedicine.com>

**American TeleCare, Inc. Eden Prairie, MN**

The home telehealth pioneer has been around since 1993. Today, in addition to its flagship video phone system, it offers options that cover nearly the entire decision matrix outlined above. Members of the FDA-approved **ATI** product family include simple, one-way, stethoscope over phone line units, two-way bedside units with large-print touch screens, wired and wireless peripherals, and both in-house server and hosted web server options. Two-way audio/video virtual visits can be combined with real-time medical peripheral operation. For wound-care, ATI's *Video Patient Station* can download high-resolution digital snapshots.

<http://www.americantelecare.com>

**Carematix, Inc. Chicago, IL**

Founded in 2001 by three engineers, Carematix markets its system mostly to disease management companies, insurance companies and self-insured employers, though it does have a few home care and hospice provider clients. The *Carematix Wellness System* is a low-cost, one-way vital sign measurement and transmission system that features wireless peripherals and an open systems design that permits interfaces with multiple device brands. Patients already using a glucose monitor can often continue using the same one. A centrally located wireless hub can communicate with peripherals up to 100 feet away, allowing the patient to leave the bathroom scale in the bathroom. Data is forwarded to a web site for caregiver monitoring. Patient interaction can be done via Interactive Voice Response (IVR) or standard video phone.

<http://www.carematix.com>

**Cybernet Medical Ann Arbor, MI Remember Tang? Cybernet Systems**

**Corporation** develops products for NASA and the U.S. military and then spins off commercial corporate divisions when one of its creations is deemed to have a wider market application. **Cybernet Medical** offers the *MedStar™ Remote Data Collection System*, originally built for astronauts. It collects and transmits blood pressure, weight, pulse oximetry, respiration values, blood glucose and EKG from the patient's home to the caregiver, either via a web-based clinical information system or directly to a standalone system. A companion product, *PALStar* (for Patient Activity Log), allows for two-way communication of customized questions and answers between caregiver and patient. Decision matrix logic selects subsequent questions based on patient answers.

<http://www.cybernetmedical.com>

**Health Hero Network, Inc. Mountain View, CA**

The *Health Buddy* system is a two-way communication device that forwards patient vital signs to a central web server and provides the patient visual and sound reminders, customized questionnaires and disease or condition education through a large-print touch screen. The system includes content development tools so caregivers can customize content for each patient. Two monitoring devices are available, *Health Buddy* and *Health Buddy II*. The newer device, which received FDA approval last month (see page 15), is smaller but offers more peripheral connection ports, including four USB ports, so patients no longer have to swap cables in and out of one port to perform multiple measurements.

<http://www.healthhero.com>

### **Honeywell HomMed Brookfield, WI**

The *Honeywell/HomMed Health Monitoring System*® consists of two FDA Class II

medical devices. *Sentry*, the full-featured model, and *Genesis*, the more economical version, are one-way communication monitors with voice prompts that guide patients through the use of attached peripherals up to four times per day. Both models can also be programmed to ask a series of subjective, disease-specific questions which patients answer by touching buttons. *Sentry* accepts multiple peripherals attached simultaneously, including glucose meter, peak flow meter/FEV 1, spirometer, PT/INR and ECG. A multiple-user card reader for multi-resident environments, a digital camera or videophone can also be attached. *Genesis* measures heart rate, blood pressure and weight. Units can be upgraded in the home through Smart Media Card technology.

<http://www.hommed.com>

### **LifeLink Monitoring Lake Katrine, NY**

A creative business model makes **LifeLink** a consideration for providers who want to start a home telehealth service but do not want to invest capital in home telehealth equipment. Once they determine a new patient is appropriate for monitoring, LifeLink customers submit a one-page enrollment form to the company. LifeLink delivers its monitoring kit to the patient by FedEx. If necessary, a nurse can set it up and train the patient in its use but many patients can follow the large-print, laminated instruction card and do it themselves. Setup involves little more than attaching the unit to a phone line. The battery-powered unit is about the size of a cigar box and the peripherals are wireless. Patients send their vital signs with a single button and then pick up the telephone handset to answer subjective questions via an IVR system, which has been customized to their disease or condition. At discharge, the patient or nurse re-boxes the equipment and calls FedEx for pickup. LifeLink sanitizes equipment between uses.

<http://www.llmi.com>

### **Patient Care Technologies Atlanta, GA**

The first home care software application vendor to develop its own home telehealth system, **PtCT** offers *well@home*®, an FDA-approved, two-way communication system. Patients interact with an 8" touch screen to answer subjective questions and receive education and instructions based on their physician's plan of care, as well as reminders tailored to his/her plan of care and daily routine. The *well@home* bedside device includes BP, Pulse Oximeter, Temperature and ECG measurement devices and contains a modem for communication with a web browser management system. Ports enable connection with other external physiologic measurement devices such as a digital scale or glucometer and battery backup for portable use or use during power failures.

<http://www.ptct.com>

**SCOTTY Technology of the Americas, Inc. Wilmington, NC** SCOTTY is an international videoconference technology company that has recently introduced a home telehealth system, *CareStation*. FDA 510, Class II Medical Device certified, the *CareStation* product line includes video phones with vital sign measurement connection ports. One model connects over standard telephone lines and another over public IP or H.323 PSTN video conference systems. A PC-based agency application receives and organizes patient records. Available peripheral measurement devices include Peak Flow, Stethoscope/ Stethophone, BP, Weight Scale, Blood Glucose, Fetal Monitor and Pulse Oximeter.

<http://www.scottysgroup.com/telehealth>

**ViTel Net, Inc. McLean, VA**

ViTel Net established itself in hospital telemedicine before developing a home telehealth version of its ViTelCare™ system. ViTelCare *Turtle* is a one-way communication, touch screen device with peripherals for measuring SpO2, blood pressure, pulse, temperature, blood glucose, and weight. A video camera can also be attached. ViTelCare *Patient Care Management* is a desktop PC application that receives transmissions from patient homes and creates a database that can serve as an electronic health record. ViTel Net also offers transport monitoring, clinic/hospital telemedicine, telerehabilitation and assisted living health kiosks.

<http://www.vitelnet.com>

**Viterion TeleHealthcare LLC Tarrytown, NY** Viterion Telehealthcare, a Bayer-Panasonic Company, offers two in-home units, one with more features, the other lower-priced. Both are two-way communication, FDA-approved devices that transmit patient vital sign measurements to a secure web site. The *Viterion 100 Home Telehealth Monitor* is a bedside unit that measures BP, Blood Oxygen, Blood Sugar, Weight, Temperature and Peak Flow. Case managers can change measurement schedules and patient instruction materials through a web connection. The *Viterion 500 Home Telehealth Monitor* adds real-time video conferencing, digital photography, stethoscope and ECG. Both models offer personalized advice messages, schedule reminders and a large-print touch screen user interface. Physicians can be given access to their patients' information on a secure web site.

<http://www.viterion.com>

**WebVMC Conyers, GA** WebVMC, LLC has put a Windows PC into the typical home telehealth bedside device form factor, enabling customizable, two-way

communication and software enhancements without requiring equipment

change. WebVMC's *RemoteNurse*<sup>™</sup> system monitors **ECG, Blood Pressure, Weight, Pulse-Ox, Blood Glucose, Peak Flow and PT/INR**, up to four connections at a time. The *RemoteConsult*<sup>™</sup> model adds two-way voice and video communication and can be set to provide threshold alerts when patient measurements go outside a set range. WebVMC is also the first home telehealth company to have announced the addition of the *Zoe*<sup>™</sup> skin resistance monitor for CHF patients.

<http://www.webvmc.com>

### **ZOE OMNI Medical Supply Walled Lake, MI**

The *ZOE*<sup>™</sup> *Personal Impedance Monitor* is a new peripheral device that will soon be available with many of the above monitors. It checks fluid levels to detect an impending CHF attack earlier than existing methods. By measuring thoracic base impedance or "ZO" – the time it takes a small frequency electric current to travel from the top to the bottom of the thorax – the *ZOE*<sup>™</sup> monitor detects fluid congestion or dehydration two weeks before weight gain occurs or breath capacity decreases. An FDA-approved product, *ZOE*<sup>™</sup> is being marketed by **OMNI Medical Supply, Inc.** of Walled Lake, Michigan, primarily to other home telemedicine vendors to be incorporated as a peripheral into their systems.

<http://www.omnimedicalsupply.com>

### **Vendor Watch**

Alacare switches software systems. Alabama's oldest and largest privately-owned home care and hospice provider has signed a deal to convert its point-of-care and billing systems to one of home care's newer market entrants, **Homecare Homebase**. Birmingham-based **Alacare** will help the Dallas-based software developer design a hospice application, Alacare president John Beard told HCAR. Homecare Homebase offers a web-enabled application and handheld, Pocket PC point-of-care system, which will replace Alacare's current laptop/notebook field computers.

Alacare's 20 offices are located throughout Alabama; the provider employs over 300 field staff and more than 200 office workers. Since 1970, Alacare has provided home care, hospice and palliative care, diabetes education, rehabilitation services, wound care, nutritional services and infusion therapy. Implementation is set to begin during the third quarter of 2005.

<http://www.hchb.com>

<http://www.alacare.com>

**Cerner BeyondNow adds electronic signatures.** The home health care subsidiary of **Cerner Corporation** (Nasdaq: CERN) has inked an agreement with **SecureCARE Technologies, Inc.** (OTC-BB:SCUI) of Austin, Texas, to provide paperless document exchange for home care and hospice providers. Cerner BeyondNow will use SecureCARE's Internet-based document exchange and e-signature technology to provide its clients with the ability to capture electronic signatures from physicians, reducing paper use. According to Cerner home care director Lisa Cone, several BeyondNow clients were using the SecureCARE system. "Now we are able to offer this functionality to all of our customers." SecureCARE Technologies offers a Microsoft ".NET" application, *SecureCARE.net*, for managing forms and authorizations online and providing physicians with a way to track and report patient oversight time spent. Longtime HCAR readers will remember SecureCARE under its pre-Chapter 11 names, **eClickMD**, **Venture Information Systems** and **Link-dot-com**.

<http://www.beyondnow.com>  
<http://www.securecaretech.com>

**Misys to host Brailer and Gingrich.** Former House Speaker **Newt Gingrich** and National Health Information Technology Coordinator **David Brailer, MD** will present keynote addresses at this summer's **Misys Healthcare Systems** Annual Conference and Expo in Orlando, Florida. The annual event is open to hospital, physician and home care customers of the Raleigh, North Carolina software vendor. Brailer will speak on "The National Agenda for Health Information Technology Adoption" at a general session; Gingrich is scheduled to appear at an "invitation only" Executive Summit during the conference to discuss his vision for the future of U.S. healthcare. Misys indicated it expects more than 1,000 healthcare professionals at this year's meeting, set for July 21-24 at the Walt Disney World Dolphin Hotel.

<http://www.mysishealthcare.com>

**Procura to offer Innovative Pathways.** Vancouver-based **Procura** and its U.S. subsidiary **Procura, LLC**, have completed an agreement with **Innovative Healthcare Solutions, Inc.** (IHS) of Naperville, Illinois to integrate 96 Care Pathways into its home care billing and clinical application. IHS is a subsidiary of **VNA First**, based in nearby Willowbrook, and offers homecare and hospice agencies business solutions for disease management, case management, OBQI/M and documentation. Their products and services include *VNA FIRST Home Care Steps® Protocols*, *Steps to Health™* patient education, telecourses and consultation services.

Procura president Warren Brown said he believes this joint venture will provide *Procura* software users with the ability to increase the quality care they provide,

particularly organizations focusing on disease management services. Protocol integration work will begin immediately at several U.S. and Canadian customer sites. Procura's U.S. sales offices are located in Detroit, Baltimore, Chicago, Tampa, Los Angeles and New Orleans.

<http://www.goprocura.com>  
<http://www.innovativehcs.com>

**FDA approves new Buddy. Health Hero Network** made two announcements last month. On April 11 the Mountain View, California company said it had received FDA clearance for its next-generation home telehealth appliance, *Health Buddy II*. A smaller version of the original *Health Buddy*, the new device offers multiple USB and serial ports to enable simultaneous peripheral connection, reducing the need for patients to handle cables. The appliance measures and transmits patient vital signs and returns customized reminders and instructions to patients through a high-resolution touch screen and large response buttons.

Health Hero Network also announced that a home telehealth study with CHF patients is being conducted by the Henry Ford Health System, using its *Health Buddy* system. Preliminary results, reported at last month's ATA annual meeting in Denver by Health Hero Network medical director Julie Cheitlin Cherry and Jonathan Ehrman, Ph.D. of the Henry Ford Health System, indicate 92% patient satisfaction, 88% patient compliance and early indications of decrease in ER visits and hospitalizations. Henry Ford will add a weight management study and is currently recruiting participants in the South Eastern Michigan area.

<http://www.healthhero.com>

**Private duty software vendor hopes to raise its profile. Kaleida Systems, Inc.** has over 300 clients, most of them **Comfort Keeper** franchises, but they have kept a low profile until recently. Based in Matthews, North Carolina, the vendor offers a web-enabled application for scheduling private duty nurses, aides and non-medical home care assistants. According to VP Barry Dupstadt, the Windows .NET system, *electronic Resource Scheduling Pro*, is commonly known as *eRSP*.

[www.kaleidasystems.com](http://www.kaleidasystems.com)

## **For Hip or Knee Replacement Patients, Home Health Setting Producing Best Outcomes, Is Most Cost-Effective, Researchers Find**

At a recent meeting of the Medicare Payment Advisory Commission (MedPAC), commissioners were presented data from a RAND Corp. study that finds the home health benefit ranks highest regarding outcomes and cost-effectiveness for patients who have undergone a hip or knee replacement. The study compares care delivered in the home health setting with skilled nursing facility (SNF) and inpatient rehabilitation facility (IRF) care.

RAND determined that some 35 percent of the knee and hip replacement patients studied were discharged from acute care to home for either home health rehabilitation, outpatient therapy, or no formal continuing care; the remainder of the patients was split evenly in discharge to IRF or SNF care. To measure the health outcome from the care received, RAND factored in mortality rates and whether patients were institutionalized 120 days after being discharged from acute care.

The study finds that patients who received IRF or SNF care were more likely to be institutionalized than were patients discharged to home. For mortality rates, however, the study finds no difference across the three patient groups.

RAND considered post-acute care payments and also total episode payments -- including the cost of the initial hospitalization for joint replacement -- in its examination of cost-effectiveness of post-joint replacement care. SNF episode costs were found to be more than \$3,500 higher than care for patients discharged to home, and an IRF episode of care was determined to cost about \$8,000 more than care provided to patients at home. The care costs studied did not include Medicare Part B payments to physicians.

In the study, about 63 percent of patients discharged to home received home health care as opposed to outpatient therapy. Hip fracture patients were excluded from the study, because these patients automatically are considered eligible for care at an IRF. As noted by RAND in its discussion at the MedPAC meeting, current assessment instruments do not allow full comparison of functional improvement across care settings; if "institutionalization" of the patient was necessary, this served as an indicator of a poor outcome.

In a related study, a panel of orthopedic surgeons recommended that most major joint replacement patients be discharged to their homes for rehabilitation,

either from a home health agency or on an outpatient basis. Panel members indicated that between 50 and 85 percent of their patients were discharged to home.

**The surgeons outlined several characteristics they said might indicate that a patient should be discharged to an IRF or SNF, including if a patient is:**

- Limited in weight-bearing ability,
- Unable to walk 100 feet,
- Obese,
- Suffering from comorbidities,
- Impaired by one or more joints that have not been replaced,
- Shown to have diminished presurgery functioning,
- Restricted by architectural barriers at home, or
- Without an informal caregiver at home.