Click here to playback the recording (ARF) – please select “playback” and be patient while the file loads; it is a large file and may take several minutes

David Wenner: We know the relationship and collaboration between physicians and home care nurses can at times be both challenging and complex. It’s part of our mission to share best practices and look for ways of sharing these with the participants of the HHQI National Campaign as well as a broader audience. We are fortunate today to have with us two very, very special people who have developed a quite unique and special collaborative relationship, the collaborative relationship that can exist between a practicing primary care physician and a home care nurse. Today presentation Integrating Home Care into Primary Practice to Improve Patient Outcomes is the journey of the two speakers showcasing their communication, collaboration and lessons learned over the past five years in caring for their patients. At this time, I would like to introduce our two speakers, first Linda Murphy.

Linda is a registered nurse and is currently the Executive Director for Almost Family, a regional home health care consortium. Her current responsibilities include operations, sales and business development for a 15-county North Central Florida region. Linda became active in home health care as a field nurse and then became Director of Professional Service for Care Tenders Home Health in Gainesville, Florida. In a highly competitive environment, she has had dramatic success in five short years, with an initial census of 50 patients to a current volume exceeding 60,000 patient visits per year. Linda attributes much of her success to creating a culture of continuing education and patient-centered teamwork in her employees.

Dr. Alan Goldblatt is a graduate of St. George’s University School of Medicine. He is board certified in internal medicine, geriatric medicine and hospice & palliative medicine. He has been in active practice 25 years and is currently the founder and Medical Director of Senior Healthcare Center at Crown Point in Gainesville, Florida. His caring for patients on both an inpatient level in nursing homes and in outpatient settings as well as doing home visits have given him a clear appreciation for the need to organize patient care in a model the avoids the confusion, frustration and danger to patients that in this increasingly compartmentalized system usually entails. As the Medical Director for Caretenders, Dr. Goldblatt has worked with Linda Murphy over the past five years. At the conclusion of the talk today, I have also ask Dr. Goldblatt (time permitting) to touch on how and where he sees home care fitting in with the medical home model. Following the presentation today from both Linda and Dr. Goldblatt we will have a lot of time for questions. As has been stated earlier, as you generate your question during the presentation, please forward them to hhqi@wmi.org. Without further delay, we will get started, and I would like, at this point, to turn the call over to Linda and Dr. Goldblatt.

Linda Murphy: Good afternoon everyone.
Dr. Goldblatt: Thank you for asking us to speak. I will begin by expressing my appreciation for our introduction. It is true that Linda and I have worked very well together for the last few years, while she has been instrumental in creating a tremendous resource for our community as much as home care, which we in primary care medicine, particularly those of us who are responsible for taking care of elderly patients, are increasingly depended upon. I will go over the objectives on this slide in front of you. Our main concern in giving people a message about home care is that in private practice or in clinical practice of medicine particularly involving geriatric medicine – and my experience in the North Central Florida region is emblematic of this – we see patients in the office for a very short slice of time, and we make fairly important clinical decisions on the basis of a rather brief interview and hopefully a thorough evaluation. But the follow up or the outcome from whatever clinical decisions we make, may not fit into the time frame of when patients are able to come back in to be seen. In large rural populations, particularly a relatively immobile population given the problems associated with transportation and old age not to mention the increasing cost of gasoline, we can take advantage of one the main benefits of home care, which is having people out in the field who can act as a set of eyes and ears and can actually report back us the impact of whatever clinical decision s we make. So home care utilization does expand the physician clinical options and should expand the physician confidence in his ability to practice medicine, knowing that he does so in a teamwork kind of a milieu. We emphasize teamwork in geriatrics at many levels, but home care is certainly one of the more import ones. We have a patient outcome improvement program that Linda has developed, and the other objective for today’s presentation will be the discussion of the more recent change in regulatory requirements that have accompanying additional responsibility for physicians to document face-to-face encounters within a time frame of when patients receive home care.

There are so many statistics that we can point to demonstrating the need for some restraint in the costs of our health care system and simultaneous need for improvement in some of the services that we offer that are (perhaps) less expensive. Looking at both the 2010 Medicare benefit payments pie chart as well as the projected pie chart 10 years from then, we can see that home health takes up approximately 4% of the entire pie, and as such, it represents a relatively low cost though an increasing percentage of cost of the Medicare dollar. What we would like to see is the utilization of home health services in an attempt to reduce (perhaps) some of the incredible expense associated with hospital inpatient services, emergency services and what-have-you, and [home health care] functioning as a conduit for information in patients who are going to different portions of the health care system, whether they are going to visit an outpatient clinic, being hospitalized, or placed in nursing homes or what have you. We see that home care also has the benefit in carrying information, functioning as a conduit and thus reducing the cost of health care and confusion with regard to the compartmentalization that was mentioned earlier. Those of us who care for older people know that we don’t have to ask people where they want to be. Older people, for that matter everyone we take care of, prefer
to be at home, and we bend over backwards and practice, as do the people that work with us – our case managers, social workers, and home care representatives – to do what we can to maintain independence for older people as long as feasible. Given the costs of health care in different milieu, which you will see on the next slide, you can see that the daily costs for providing health care to an individual in a hospital is estimated to be $1500 per day, nursing home $325, and home health approximately $150 a day. Would providing the level of care at home health allow a lot of the patients who, at the current time, feel that they need hospitalization [realize that they do not need hospitalization]? Or perhaps even more importantly, [enhance] our ability to influence physicians who take care of patients to be able to practice with some degree of confidence, recognizing that home health care represents a reasonable alternative for patients who otherwise would be hospitalized with any complications. So lower cost per day is important; lower cost to the Medicare program in general is important to us and [so are] the home health nurses who have the ability to help our patients avoid some of the more common complications, such as medication errors, that often result in what I would consider unnecessary emergency room visits or hospitalization. The cost:benefit ratio for home care is dramatic as far we can see. Now given the fact that home care seem like such a good idea and that those of us who practice medicine (particularly those of us who practice geriatric medicine) could use the help, why would physicians object to the implementation of home care in their practice? The answer to that probably goes back, in part, to our training because I don’t recall any effort being made throughout medical school, residency, or afterwards to formally introduce me to the idea that we practice medicine better when we see the community within which we practice in as a team, as a group. When we look around and find out who in our community provides services that we feel are competent and compassionate for our patients, we really want to team up with those kinds of people. A physician objections are largely logistical – additional paperwork, additional office oversight, additional employees charged with taking information on the phone from home care nurses and then communicating that to the treating physician – these are all considered additional responsibilities given the fact that we come to the office to see patients and try to be as efficient and accurate as possible. Some physicians actually perceive home health care as unnecessary benefit, or we run into physicians who are meticulous and thoughtful doctors who feel that the home care industry has been painted with a fairly broad brush to suggest that there is something malevolent about home care or durable medical equipment, or it’s difficult for them to differentiate between the bad actors and the good actors, so they kind of lump everybody into one category. We feel it is really important for physicians to understand, as I said in the beginning, that the home health care can improve their quality of service to their patients. Home health benefits are not unnecessary, in fact, they represent significant opportunities to provide additional services such as palliative care services, in-home care services, and working with other providers in the community, they allow us to offer a broader repertoire of reaction to geriatric problems in our practice. Home health care agencies are not all alike. In a small college community like [the one] we practice in, I would say there is a
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handful of home health agencies, all of which compete vigorously for the home health business, but in fact, physicians can influence this competition in a positive way by trying to determine advantages that certain home care agencies may have in certain fields. We may have differences in skill level in different home care agencies, whether it’s the care of short-term orthopedic patients or more longer term patients with multiple co-morbidities like the elderly patients or the palliative care patients, and if we can have a niche identified, then there really is room for more collaboration than competition in the home care arena. That may be a bit naive on my part, but I really do believe that the best use of home care, is to find who does what best and to refer accordingly. Hospital discharge planners have a vital role in determining where patients go when they leave the hospital and what (if any) home care is offered to them. This is a role that is often advocated by physicians because they may not have the knowledge of the resources that are available or they may not care about that particular part of the patient’s health care. We feel that it’s really important that when we delegate a huge amount of responsibility that has an impact on our patients in the future, we know who we are working with and what our options are. So physicians in practice need to be able to speak to their discharge planners. They need to address the rather confusing regulation that says that patients are allow to choose their own home health organizations. Obviously, if a patient who was in the hospital has been at home and receiving care from a home care agency and are happy with that, they should be given every opportunity to go back that home health care agency. But in the majority of situations where the patient is faced with a list of names on a piece of paper and are asked to pick the one that they like, the likelihood of them making the most well-informed choice is rather slim. So that also requires that we know what resources are available in our community, and hopefully, we can lend a little guidance at this point. My own practice here is the Senior Health Care Center. I have been fortunate enough to work in collaboration with North Florida Regional Medical Center in developing an outpatient geriatric clinic where we have onsite social services and case management services available. We have a geriatric pharmacist who has literally saved our patients millions of dollars a year in the cost of drugs with an in-depth knowledge of Medicare part D and other insurance coverages and what medications work well in different situations, allowing us to provide the best medication that is the least expensive for a given medical problem. All of our physicians at the Senior Health Center emphasize the same two main prejudices that we hold in the practice of geriatric medicine. The first one being that generally speaking, the fewer pills you take, the better off you are, and the second one being that over time in the care of elderly patients, their functional capacity becomes really the key objective that we’re paying attention to. If their cholesterol level is a little high or low it becomes so much less important than their ability to get out of bed under their own power in the morning and go about their daily life.

Linda Murphy: When we were first asked to do this talk, it took me a few minutes to gather my thoughts. I was actually on a plane when it came to me, and I thought back over the last five years on how we had gotten to the point where we have been able to implement some great
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pilot studies and programs in our territory. So I would like to paint a little bit of our story, and I think there were some things we have to put in place in order to get to this point. So this looks a little bit like Maslow’s Hierarchy, and that’s what I would like to talk to a little bit right now, but let me give you a little bit of history first.

I fell into home care about eight years ago after a year of cancer treatment. I worked for a very small nurse-owned and run operation. I absolutely fell in love with home care. I could not believe how we could enact change and collaboration with patients and physicians in our territory. I worked as a PRN nurse, and let me tell you, I still talk to Patty (who was my boss at that time) and don’t know how in the world she got me – at $25.00 a visit – to code my own charts, get all my own literature, and spend hours at night on the internet trying to find any educational pieces for my patients, but I absolutely loved it. As we all know, home care is not a 9 to 5 job. It really envelops your whole life, and that’s what we really look for in folks who are really successful in home care. So I came up after a few years and assumed the director roll in our Gainesville office where we had a census of about 50 patients if you counted our discharge patients. I do realize how fortunate I was. Dr. Goldblatt was already in place as the Medical Director of our agency. I had no management experience when I stepped into the director roll, and I remember the first time we were meeting him. My VP and my Executive Director were with me, and I was nervous nelly. At that time, I said as long as I don’t have to talk to him, and they said, “Don’t worry. We will handle the whole meeting.” I can still remember as they talked, Dr. Goldblatt just kind of put his hand up as if to say “hold on a second” and turned in his chair around to me and said, “So what is your plan for this agency?” I won’t tell you what I said at that time because my thoughts have certainly changed since that point, but I did realize I had to put some building blocks in place for us to be successful, and that’s where I came up with these six C’s. The first one, of course, is to Cultivate. We are going to talk about each of these. Culture Change and Competency kind of run together for me. Consistency, Communication, and of course, the top of my hierarchy is Collaboration.

So let’s talk about how we got to that Cultivation. When I came on, I had one marketer or account executive or patient liaison that worked in our territory. So the first thing I did was to hire a good friend of mine who had actually just completed her masters in health, science and education through the public health arena. She’s actually currently working on her PhD. She would come in, and she had so much energy; she had done her third Iron Man. She was saying, “Linda, do realize how much the community has no idea what real home care is?” Even after going through all the educational programs, she really didn’t have a clear understanding of what home care was, and her father was a physician and her mother was a hospice nurse. So our objective at that point was to really shift the prospective of the community at large and work on educating folks – not just consumers but physicians and the community – to what home care is. So we started off with an Ask A Nurse series in the newspapers and all the senior magazines. We started educational advertising; we talked about depression, fall prevention,
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diabetes, palliative care and patient choice. We really started trying to educate physicians, educating our consumers and even our staff members on what we were truly trying to accomplish here. We also looked at access to care. We do live in a very rural area, and I find where the disparities are greatest, those patients don’t have a lot of access to physicians. I can’t tell you how many 93 and 94-year-old patients I am seeing who have actually ended up in the hospital under some kind of crisis but had never seen a physician in their life. So again, we started talking about well-being. About this time, a lady from FMQAI came into my office, and she was amazing. She introduced me to OBQI results and initiatives. She introduced me to HHQI. I started to implement their initiatives, and I will tell you, within one year, we were able to reduce our hospitalization rate from 31% to 17%. The Florida initiative at that time was reducing re-hospitalization and dyspnea, and we were unbelievably successful. I love stats; I love the numbers. It was very interesting to really see how risk adjustment and all the other factors played into the care that we where providing. I say this because these initiatives do work, and if you have the time to really implement them, they do make a difference.

So that, in turn, started to learn to my *Culture Change*. This was a tough concept for me to grasp. I basically thought every home health care nurse is a good home health care nurse. We’re all social workers, cardiac nurses, pulmonary nurses, palliative nurses, endocrine, renal. We have to specialize in all of these different areas to educate our patients the way we need to. But I realized that not all of our nurses can work 22 hours a day or we are going to burn them all out. So I experienced some great turnover in those first couple of months that I was working here in the Gainesville office, which I never expected. I remember even walking into my first staff meeting and I was pretty appalled at some of the care we were providing at that time. So I said, “If you’re not here for the right reason, I really need you to go find your happiness elsewhere because these folks don’t deserve anything but a 110% of what we can give to them.” So it was kind of changing not just my nurses but our therapy staff as well, from that culture of task-oriented minds that where going to go in and do this, to more of that coaching model. At that point, they didn’t call it Self-Management Support or Coaching Model. It was just our thought process on how we all needed to do holistic care. What would you do if this was your mom and dad? And that’s really been our philosophy from day one. How would you care for this patient if it was your mom and dad. So I did start to establish that we need to give our staff tools to succeed, and that is where those care pathways, clinical protocols and specialized programs come into place. It’s our job as a manager to figure out how to inspire our staff to be the best that they can be, but we have to have those tools in place to allow them to give a 110% for the patient’s benefit.

*Competency* kinds of goes along with this, and you really have to start from the very beginning. Re-evaluate your hiring processes. I use this example when I tell folks about the therapists I like to hire. If you have a class of physical therapist who are just getting ready to graduate and you ask how many are going into orthopedics, maybe half of the class will raise their hand. If you
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ask how many are going into sport medicine, another third of the class might raise their hands. Then when you ask how many are going into geriatric medicine, you may have 2 or 3 people raise their hand. Well, those are the people we want in home care. Those are the folks we want taking care of mom and dad. We started doing group interviews; we usually have a 3 to 5-interview process with everyone. It’s a team decision. We do the first interview usually with our director or whoever is hiring for that position, and then all the members that are involved in working with that patient come for the second interview which is a team interview. Our third interview is actually pretty interesting. The applicant comes into a group interview, and we usually do some kind of activity that requires them to function in a group setting so we can see how the people actually interact with each other. So by the time we are done with our application/hiring process, we really hope we have seen the true person we are inviting to join our family and our group. And then, of course, incorporating your values at that point and on through, but you would be surprised how quickly the group that interviews those folks and are responsible for hiring that person mentor them and want ensure their success. If you look at any organization, I think that professional growth is more important than anything. I know it is high on my priority list to provide education on hire and ongoing. I recently had an OT working for me for about the last year, and I was so proud when he came to me one day and said, “I’ve worked in the hospital setting for 10 years, and I have learned more in the last year working in home care then I did in 10 years in the hospital.” That is the type of environment we really want to provide. As you get larger, you can add some staff members that really have some specialties like WNC, dieticians, palliative nurses, oncology nurses. I think we have the clinical ladders to retain and promote those with clinical expertise. We need to stay abreast of evidence-based practices by going to conferences and knowing what’s out there and the best practices to put in place. We need to recognize resources. Again, we are at the University of Florida, so I have been very fortunate to use graduate internships. We’ve brought on some pharmaceutical students. Usually I bring on a couple of interns each year, and you can get these guys for very cheap, sometimes free. A few years ago, we were able to establish a caregiver support group. Back in 2006, we started a tele-health analysis, a data to decrease hospitalization. So it was very interesting to get some of those items done.

So you have gotten to this point, and we all know we have to be consistent in what we provide. Knowing that harmony is consistency and knowing that consistency is enlightenment, when we are all working together and all on the same line we can achieve great things. So we’ve all become this great organization. We’ve got great outcomes; we’re home care elite; we’re doing all these wonderful things. How do we communicate that back to the physician? And that’s really the big question. About a month ago, I was on an airplane heading up to Kentucky, and there was a lady sitting next to me. When I was talking to her, telling each other what we did, I said I was a home care nurse, and she said “Oh my gosh! You guys are the best people in the world! I am actually heading back up to visit my mom, but I was there for almost 3 months last year because she’d had a stroke.” She went on to tell me everything that had occurred, but her
point was the home care nurse was invaluable to her. She said her mom had been with a physician most of her life, and she came out of the nursing home on 36 different medications. She was depressed and having a really difficult time getting through anything. She said when the nurse came through and assessed the issues, it was really interesting to watch her develop a relationship with the physician and the physician’s nurse on the phone. She said when they first started, she [the home care nurse] really thought some of the medications where being taken because of the side effects of the other medication. She was trying to communicate that to the physician office, so one day she said, “I’ll tell you what, why don’t I go with you on your next appointment?”. The lady I was sitting on the airplane with said, “I had no background in medications and didn’t know how to commentate to the physicians, but my home care nurse actually came to the doctor’s appointment with us, and we sat down and went through everything and were able to decrease her pills from 36 pills to 8 pills.” She said her mom now is independent because she can take the medications herself. There was no way she could do all those beforehand, and the physician was thrilled, and she said she called her to check on how she was doing, and she said that physician is now one of her best advocates out there.

**Dr. Goldblatt:** I would just add at this point, as far as the physician motivation with this whole “collaboration with health care” idea, physicians in general practice are really looking for positive patient outcomes, and we have well-defined patient outcomes. When we have a patient come into the office and comment positively about their interaction with a home care agency, that really goes a long way to not only make us feel better but also increase the value of our practice. The most significant home care interaction that I’ve had, in terms of avoiding unnecessary treatment and hospitalization, came less than a year ago. I was on-call and received a call about a patient of mine who suffered from mild cognitive impairment and had recurring systems of pneumonia. We had been through this many times in the past. At 10:00 on a weekend’s night, the wife called and explained the symptoms that her husband was having. He was relative immobile, and they had expressed the desire to never be back in the hospital if there was any way that could be avoided, which is what we hear all the time. I was able to make several phone calls and arrange to have a visiting nurse come out to see the patient, have intravenous antibiotics therapy, breathing treatments, oxygen, and the works. It was taken care of within several hours in the patient’s home, and he recovered to the point that he was able to regain his previous level of function. But certainly as a physician on-call getting a problem like this late at night, it would be much easier to say take the patient to the emergency room. It requires a mindset that is geared to keeping people at home and a tremendous collaborative relationship with a home care agency or several home care agencies to be able to affect that change in your practice. That creates tremendous loyalty for physicians with home care, for patients with their physicians, for families with the physicians. These kinds of moments really make the whole system seem like it works correctly. With regard to the comments Linda made earlier about the philosophy of education she has around this office, it’s very evident in discussing patient problems with nurses or therapists that the degree of expertise is really
phenomenal. And the fact is that people stay in a job like this for a long time. The only reason people really would be motivated to do that (given the options that are available to them now) is if there is something more valuable than a paycheck at work. I really think her initiative in continuing education at all levels of the organization is what allows her to keep the best people in place.

**Linda Murphy:** Yes, we have been very fortunate. We have a waiting list for full time nurses and therapists now. Who has a waiting list for therapist in their territory? I think it’s because of the programs we have been able to implement here through our corporate structure. To bridge that gap, we have to do it in multiple different ways, and of course, bringing back our evidence-based outcomes to our physicians so they see we are truly doing something here in the home. I have great respect for PTs and speech therapists, but quite honestly, I probably utilize OT in our territory more than any of our other therapies. It’s amazing what a good occupational therapist can do for our geriatric population. We have a “Living Life to the Fullest” presentation that my two OTs do (my rehab manager and another phenomenal OT that I have in our territory), but we try to take that to residents. We take it to med students. We take it to medical societies, and we present so they can really see the picture of the changes that we do, and we do it through case studies. We basically talk about these patients and what we have been able to do. Again, we’ve got some great pictures of an MS patient that was bed-bound for 3 years and how we were able to get her back using mobility, and she is out riding the bus now. When you bring those stories of impactful changes back to the physicians, I think that really starts to change them from satisfied to loyal partners. Also with your patient liaisons, they need to come to case conferences. They need to bring those “hero moments” back to our physicians and to those offices so they really see the picture and understand the value of what we can do. Like Dr. Goldblatt said, there is nothing better than when your patient comes back and tells your physician about what a great job you are doing.

So at the top of our pyramid, we’ve gotten to that point where we can actually have that collaborative relationship. We recognize that between all parties — between the patient and the physician, our multi-disciplinary team, and particularly between us and our medical director in our territory — we’ve really been able to establish some programs that I feel are raising the bar in our territory. When we raise the bar and our competition all raise the bar, who benefits? It’s the patient, and that is really what we want. We have been able to do a palliative pilot study. We have transitional care programs and behavior health programs. We have had a couple of different pilot studies along the way, and basically, they have given us the ability to implement best practices in our territory, but I would like Dr. Goldblatt to talk a little about our palliative pilot study that we started about two years ago.

**Dr. Goldblatt:** Two years ago, we started a program based on literature that we had been following from Kaiser Permanente and other collaborative institutions. In this literature, they
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depicted a model of care for palliative care patients that involved providing routine home care, such as you would with any elderly patient with several different illnesses and/or disabilities needing the services of visiting nurse, therapist or what have you. In addition to that, we had extra components to this program which included mandatory visits. The initiation of the palliative care project began with an explanation to the patient and the patient’s most valued ally of what exactly palliative care was. For us, we defined it as a recognition. This is more than just words on a piece of paper. We recognize that patients who are aging and develop a number of different illnesses reach a point in their life where they really don’t foresee curative medicine as creating the best benefit. Our goal is to do an excellent job of symptom management, of pain control, of nausea, shortness of breath, and mitigating symptoms with the idea in mind that we don’t have to work every problem up to its maximum conclusion. If the patients understand that they are actually being given the reins and we are there as consultants and to help, we ask the patients how much health care they want, and we provide that much and no more. When patients and families are confronted with the idea that their physician is going to be there to listen to what they want and that this home care team is put together in order to provide the amount of care they want and no more, they immediately become much more relaxed with whatever their illness are. We adjust advanced directives early on in the course of the process. We provide care that is geared towards symptom management and improvement in functional ability. It’s not a great deal different from the routine home care that you would normally provide, but our goal is to adhere to what patients want. So for instance, a large number of our patients have exacerbations of congestive heart failure, which is the most common cause of re-hospitalization of Medicare patients. If we have home medications available for them to take in case of an exacerbation in the middle of the night and they can call a trained nurse or their attending physician and be talked through administration of medicine, oxygen (etc.) at home, these patients have a fairly good chance of reducing their symptoms to a point where coming to the hospital is no longer considered necessary at that time. One event like that not only saves the medical system all together a considerable amount of money but also empowers the patients to know they have some ability to impact their own symptoms. It makes family members realize that not everything requires a call to 911. Working in collaboration with visiting nurses, we can provide a tremendous level of care to patients with the idea in mind that this is not necessarily end-of-life care, but we have a mutual agreement that optimal medical care at a certain point and time is not geared towards working up every medical problem to its most clinically demanding answer. We try to reduce the use of tests; we reduce medications; we aggressively pursue managing toxic symptoms, and we empower the patients. This has really gained a foothold, and perhaps it has because the pilot study, using data collection that was already prescribed by the Missoula Vitas tool, allows us to go back and check and see whether or not objectively we are accomplishing what we want, which is generally increasing patient satisfaction and a reduction in unnecessary hospitalization. We have been very impressed with the results of this palliative care program.
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**Linda Murphy:** Alright as I look at the time, I see that we should be moving on a little bit. I was just going to address a little bit on Face-to-Face Regulations. Hopefully everybody on this call is well aware that April 1 has come, and all patients must have a physician encounter within the 90 days prior or within the 30 days afterwards and that has to be documented. Spring training is over; April 1 has arrived and our industry did get that change. At this point, we really all need to be on the same page as an industry. There has to be a positive presentation to help our industry get this accomplished the way it needs to be. Education of our hospitals, our case managers, and ultimately, referral forms that include face-to-face documentation is what we need to do. Again we have talked about this collaborative relationship. The only way to be successful in our industry is to have a collaborative relationship with our physicians. So we started off with asking our physicians on how they wanted to handle this. We talk about if there are some patients you have not seen in the last 90 days. Do you usually see them in the office within 30 days? Do have any problem with our staff calling and arranging those appointments? Do you have a designated contact person? Do you have a visiting home care physician? We don’t have that many options in our territory for visiting home care physicians, but I do know in a lot of the larger cities and a lot of areas this is a growing practice. Again ask your physician, do you have someone you prefer, that if you are unable to get them back into your office, would you be okay if someone was to see them in their home? Hospitalists-- we all know that we can use hospitalists to document this piece as well. Some of our physicians do have hospital privileges as well, but I find a lot of our primary practicing physicians give this over to hospitalists.

**Dr Goldblatt:** This transition is a little bit dicey too because we want the physician who is primarily responsible for their patient to be involved in the home care documentation, but by the same token, having hospitalists file out this kind of form may or may not appeal to physicians in their own practices. On the one hand, they don’t want to feel dumped on by having to do other people’s paperwork. On the other hand, we want them to have an active role in the certification process. I can tell you that physicians’ perspective with regard to compliance with these regulations is basically that the regulations in as much as they would like home care not to be an automatic order that physicians have no responsibility for, we see the need for some regulation but documentation of encounters with patients that include all the data that is already present on the ubiquitous 485 form seems redundant. The fact that having to write things out by hand in an era where we are trying to automat as much as possible and use electronic medical records where possible seems to be counterproductive. We’re perplexed somewhat by the need for this new kind of documentation, and we would like to suggest for hospitalization, nursing home admissions, ordering diagnostic procedures, etc. there is no need for this additional handwritten documentation. Because all the information is already available on a form with the possible exception of the data of the office visit, we would appeal to the decision makers, and we would appeal to fellow physicians to mention to their congressman or their state and county medical society’s people who are interested in this initiative to appeal to
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their legislators to change the regulation to allow us to continue to document the need for home care but to do so in a manner that is more conducive to the way we are modernizing our practices, our electronic medical records, etc.

**Linda Murphy:** For the time being, what are the items we need to incorporate in order to meet the regulation? As we know, it is the encounter date, medical conditions, clinical findings, the services needed, homebound status and the physicians signature. So in just going through these very quickly, we understand what’s the date that we need to put on this. I think this is what we talk to how easy it would be if we could just incorporate the documentation of this date on our 485 on the face-to-face encounter. Medical conditions or diagnoses – basically those conditions that are specific to the home care orders. Clinical findings support the need for home care, and I have just put a little bit of a list up here of some of those examples of clinical findings. Surprisingly enough, we would think that this would be an easy form to fill out, but a lot of times it is not as easy as we think. We are used to the language because we do 485s, but when educating our physicians or those responsible for filling out forms for our physicians, it sometimes can be quit challenging for those folks. I use Dr. Goldblatt’s office for example. He has a social worker who writes up the referrals for the physicians, and there are 4 geriatricians in that office. When we first had the new regulation, and I was talking to Cheryl about it, she said, “I am spending half my day just writing out these addendums and forms for face-to-face documentation. This is crazy!” How many of are dealing with that? I had one of my patient liaisons come in the office up north this past week, and when she went in there, the MA in the office had filled out the face-to-face documentation and she was getting the 485 signed. When the physician saw the face-to-face was filled out and he was going to sign it, he said, “No way!” He tore it up and said, “The other agency said I could just attach my HMP to this form, and that’s what I’m going to do. I’m not filling out another form.” Again, it gives us the opportunity to come back and communicate and try to educate, but there’s been a lot of push back from physicians out in the community, and I think the reality of that situation is that we have implemented this regulation as of January 1, so we have had 4 months of experience in implementing it, but we all need to be on the same page. I know the interpretation of the law is pretty frank and the questions that have been put in there, but we all need abide by those regulations when they are in place.

Homebound status: I think this is a wonderful opportunity for us as a group to re-educate physicians on what homebound status is and the key factors in consideration in making a medical determination of homebound status. Do they have a medical condition that restricts their ability to leave their home without supportive devices such as crutches? Do they need special transportation or the assistance of another person? Would leaving their home be medically contraindicative? Again, this is an opportunity for education. Do we want to look at the glass half full or half empty? It’s our perspective, and I think in order to work together as an industry, we all need to be on the same page. I did include an example of our fax referral form
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because I think most people have a referral form that includes all of this information. It’s basically what you get on a referral form. So if you can come up with your own referral form (and feel free to use these) that includes the five components, I think it will be a lot easier on our physicians. Other possible solutions to this is to acknowledge their frustration. The first thing I did with Cheryl who is our account executive was to acknowledge frustration. I can only imagine how hard it is with all the other paperwork that they have to do in their office to add another additional addendum to this. Assure them the value of what we provide is worth that extra effort. Assist them with developing forms for the hospital to use or within their own offices. Show your physician representative where the information can be obtained on the 485 for reference so that they understand the language and what needs to be incorporated in the regulation. It is acceptable for the physician to dictate the face-to-face encounter form.

At this point, again, I’d like to say I realize how incredible lucky I am to have Dr. Goldblatt to work collaboratively with and that we certainly wouldn’t be in the place that we are at this point to really have some great practices without him. Dr Goldblatt and I have had the opportunity to go out on Sunday mornings and do some in-home palliative care consults as we have tried to develop our programs and figure out the best ways, and I can tell you, in my career, those where some of the best moments I have spent providing patient care. But I would like him to talk to this slide which are words out of his own mouth.

Dr Goldblatt: Well, out of my own pen anyway, but they can come out of my mouth. In writing about home care for another publication, I pulled out this paragraph, “With the collaborative effort of ethical health care organizations in our community, all things seem possible.” That is true. We are fortunate to have a university nearby. We have an active private practice community. We have a lot of initiatives toward improvement in healthcare in our community. The disparate and at times competitive models of academic medicine, private practice in an era of dwindling resources cannot be sustained. Optimal care strategies for the elderly require attention to the transitions with declining functional capacity as we age. I allude to the medical home model which deserves greater attention, and with that, home care becomes a crucial part of our management armamentarium. I really appreciate the opportunity to participate in this kind of a forum because I really believe that to the extent we can provide some pragmatic advice for our colleagues and we can become more popular with our patients at the same time and we can reduce the cost of medicine while improving the quality of healthcare – I think all these goals are very achievable, and I think home care is an important part of that.

Linda Murphy: And just for those on the call, on a weekly basis, I get to expand my English vocabulary, and that last word has become our word of the week. Deb, my rehab manager, loves the word. She has told everybody she knows, but Dr. Goldblatt would you give the definition of that word for everybody.
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Dr. Goldblatt: Actually, if I don’t have a word to fit the situation, I allude to my favorite poet Ogden Nash, and I make one up. We have a number of different strategies for providing optimal care, and that is what I was alluding to in that last sentence.

Linda Murphy: Thank you and I guess we can open for questions.

David Wenner: Well, Linda and Alan on behalf of everybody on the call, thank you very very much for just an unbelievably exciting and special presentation. I think at this point we are ready for questions. I know that we are a little past the top of the hour, but we are going to remain on the line and take questions. So for those of you who are able to continue to be with us, certainly please go ahead and send your questions to HHQI@wvmi.org. We will take as many as we can. For those of you who can’t remain on the line, as a reminder, this webinar is being taped and archived, and both the audio version and slides will be able to be viewed probably by mid-afternoon tomorrow. So without further ado, Shanen I think we are ready for questions.

Shanen Wright: Thank you so much, Dave. Our first question comes for a participant named Amy who asks, “What is the tool that was used to evaluate the palliative care program?”

Dr. Goldblatt: I can answer that. First of all, the genesis of the palliative care program was based on an article demonstrating improvement in patient satisfaction with the use of palliative care added to a home care service. The specific tool that we used is called the Missoula Vitas Quality of Life Index.

Linda Murphy: There are 15 or 25 questions, and it is all available free on the site. You just have to log in, and you just give them your documentation or your results for each of your surveys or questionnaires. It’s a wonderful graph system. We do it every 30 days with our patients. We do it on admission and then every 30 days afterwards. It basically measures systems, functions, interpersonal well-being and transcendence. It’s a wonderful tool. We meet on a bi-weekly bases with Dr. Goldblatt, and we case conference all of our patients so that we have all these results and our graphs also as we go through what we are doing with our patients. We also have a whole team that is very specific to palliative care. We find it much more successful that way.

Dr. Goldblatt: We can leave the reference or the article that we developed our program around before we sign off. We will have the references.

Shanen Wright: We have another question about palliative care. This one is from Katherine who asks, “How is palliative care reimbursed?”
Dr Goldblatt: I can address this, I think, because to the extent that palliative care is reimbursed through home care evaluation and management services which are used for the frail elderly, and Linda can speak to the industry perspective on this. For physicians, palliative care is not reimbursed any differently than other primary care physician services whether it be in office, hospital or home. Although proper coding by physicians is necessary in order to capture the correct reimbursement, and palliative care by nature requires longer conversations and a little bit more patience, a little bit more setting up of strategies to allow in-home patients to know what to do in certain situations. So the physician reimbursement I can speak to is the same as any other home care reimbursement or outpatient or inpatient reimbursement.

Linda Murphy: And again we are getting these patients on the home care perspective. It is just regular home care reimbursement for the exacerbation or the disease process that we are actually in there treating for the patient. We have a tendency to have a higher visit count with these patients, so again, margins probably aren’t as high, but our outcomes are very good, and we are taking great care of the patient. A social worker is a key factor. We have a full-time social worker in our area, so they are a part of this team that sees the patients as well. So your reimbursement, your margins probably aren’t as high on these patients, but I feel it’s the care that we need to provide, and as an industry, if we don’t start providing that kind of care, we are not going to be able to bring outcomes back that make a difference.

Dr. Goldblatt: It’s also important, in a program like this, to have a good working relationship with your local hospices or hospice organization because there are times when there needs to be a transfer of care, and it should be a smooth hand off if at all possible.

Linda Murphy: We partner very closely with our hospice in our territory as well, and the whole purpose of this is to transition patients to hospice when the time is appropriate and that it seems seamless as well. So again, I think you have to have a really good working relationship with your local hospice for this program to be truly successful.

Dr. Goldblatt: Let me just add one other point, and that is that the constraints that hospice Medicare presents to patients in terms of their ability to access therapy. When we feel additional physical therapy or occupational therapy will lead to improved – if temporary – outcomes, if patients are in a hospice program [prematurely perhaps] and they can’t access those services, I think we lose an opportunity to provide the best quality of care.

Linda Murphy: And our program really grew through the ALS Association. We had several patients that we took care of, and again I have to say, we have tremendous therapist that work in our territory, and the head of the ALS Association for the state of Florida had actually approached us because of the care that we had provided. That actually really helped our program grow even more in its development piece because we understood how difficult those
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patients are to care for and how many services they really do need. I have a sense that a lot of agencies will tend to shy away because of the difficulty and the expense and all the other pieces it takes to take care of those patients the way that we need to.

Shanen Wright: Our next question comes from Maureen in California. This is a two-part question for you, Linda. Her first part asks, “Is Caretenders Medicare-certified?” and the second part is, “Are your nurses part of a union?”

Linda Murphy: First, yes we are Medicare-certified, and no, we don’t have a union. Our Caretenders office is part of the Almost Family entity.

Shanen Wright: Our next question is from Brenda who asks, “What is the clinical pathway you found most helpful?”

Linda Murphy: Well, to be honest with you, it depends on the programs we’re running. We have clinical pathways now, whether it be COPD, CHF, oncology program, our palliative program. I think the point, in fact, was just that in order to make our staff members successful, clinical pathways helped to keep everybody on track on what needs to be done and helps make us accountable for the care we’re providing. I have some that are very extensive; I have some that are short. It all depends on what the specialty and what the program or what we are trying to achieve with that patient.

Dr Goldblatt: But which one would you say is your favorite.

Linda Murphy: Of course, my favorite is our oncology program, but you have to remember I’m a cancer survivor so that will always be close at heart. I still do patient care every once in awhile. I think it helps keeps me connected and understand what our staff members are going though, especially when we have new paperwork. It really helps if you do it up front. A few years ago, I was out on a Friday evening, and it was my first encounter with a particular patient. She was a young 56-year-old lady who had esophageal and lung cancer, and I was just there for a 5 f/u takedown. This was a private-pay patient, but she was going through a huge organization. She had an oncologist, but she wasn’t even sure who her oncologist was at that point. She was in denial; the family was in denial. It was 10 o’clock on a Friday night, and she hadn’t eaten for 3 days. She had been going through radiation the previous 5 days. The only drug had in the home was Compazine. She was going to end up in the emergency room because she was sick as a dog, and the last place an immunocompromised patient needed to be was in the emergency room. So at that point I thought, wow we need to do something to provide better care to oncology patients. That is when I went through chemo certification and I was like wow, I didn’t know what a neutropenic diet was; I didn’t know the side effect of this. I went through 8 months of chemo and I’m a nurse, so how do we expect our poor geriatric population
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to know some of these things if we’re not better educated to teach them, and in the 5 or 15 minutes when you have Benadryl and everything else on board, you are not able to really except or understand what you are being taught. So I think that the home is a perfect venue for that education, and their outcomes are better in the long run.

Shanen Wright: Next, Paula asks, “I’ve rarely done a third interview and think it’s an excellent idea. What types of activities do you do during this group interview?”

Linda Murphy: It’s a good question actually. I laughed because we recently hired a new clerical person in our team. I walked into the office when my DPS had the whole team of clinical managers in, and they had narrowed it down to four candidates. They had this group interview where the four of them had to build a tower, and all they had was newspaper and tape, and the tower had to hold a cup with coffee in it. It had to be 18 inches tall, and they didn’t have a way to measure it, but it was quite interesting. If you go on the internet, there are lots of different activities. This is really a new way that a lot of companies are starting to use to interview, and you can see the interactions between the groups and how they are going to interact under pressure. So that was the last one I saw, but I know that in each of the offices our DPSs have different ways that they like to implement that third interview.

The other piece that I really love is doing PIs or personality profiles on our management staff or sometimes just on staff coming into the office. If anybody has had the opportunity to do true colors which is another way of looking at different people’s personalities. We were able to do that with the entire team, and it’s really pretty interesting when you learn who your blue folks are and who your gold folks are within the office. When you understand where people are coming from and what their personalities are like, you can interact and work together in a much more collaborative relationship.

Shanen Wright: Our next question is from Lucy who asks, “Do you think all chronic care patients would benefit from a palliative care consultation?”

Dr. Goldblatt: I guess the answer is a qualified yes. I think that the concept of palliative care is defined as the management of patients with active, progressive or far-advanced diseases for whom the prognosis is somewhat limited and the focus of care is quality of life. That definition appeals to me in dealing with elderly patients with multiple comorbidities. I guess the answer to the question is yes. I think that in an ideal world, palliative care would not stand out as an exception to routine care but would be incorporated in everybody’s thinking as we age and as we see the necessity of living with more and more age-related medical impairments. Some things we need to try to treat, and some things we need to learn to cope with. I think in terms of the relief I see on people faces when you tell them they don’t have to have another colonoscopy or another barium enema if they don’t want it, I think the idea of empowering
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patients that have multiple medical problems and a lot of experience with the current health care system, I think the advantages are much broader than just good patient care. I think you provide a better milieu for the way people think about their own health. So I guess my answer is yes.

Shanen Wright: Alright, our next to last question comes from Ruth Ann in Pennsylvania. First of all, she comments she likes the phrase “hero moments.” She wants to know, “What if you can’t get your foot in the door to share these?” She adds that she agrees the actual practice of the nurse working with the physician to keep a patient at home will make an impact, but again she asks, “How do we share this with others to win their support or garner their interest?”

Linda Murphy: That’s very tough, and I’ll give you an example. A couple weeks ago, I had a nurse who was really trying to get some antiemetic ordered for one of her patients that she knew was going downhill and was going to end up in the emergency room. She made multiple calls to the physician but couldn’t get past the MA. In the end, when she did finally get an order from the MA that said basically “No, the physician doesn’t want to do that,” she was like – now mind you, she is an English nurse who’s very outspoken and married to a physician which I think when you are married to a physician, it makes you think you have the opportunity to say more, but she said, “Could you put him on the phone right now so I can talk to him?” Well, I’m not quite sure that was expressed as well, but of course, he was very upset by that. But she and I decided to go over and sit at the doctor’s office and see if he will talk to us face to face. Sometimes you need to do that, and like I said, I can’t tell you how many times I have gone to a physician’s office with my patient because we really felt strongly about what needed to be done. Even recently, I had a patient who was very tied to her occupational therapist, and they had some cognitive impairment, but when they went into the physician’s office, the physician went to order something, and the patient said, “Um... hold on. I got to checkout with Sunshine to make sure this order is okay.” That’s not what we want our patients to say. I actually had to go in with my occupational therapist and sit down and talk with the physician. That’s, of course, not the way we would want to present we’re a collaborative relationship, but these patients do become dependent on us a little bit and really do respect our opinions because we have made hopefully some significant changes in their lives. So, I know that’s difficult sometimes. I have sat with my marketers for three and four hours in a doctor’s office, waiting to talk to a doctor that I really feel I need to talk to and be impactful. We’re starting something new in our area. We’re going to have Dr. Goldblatt have dinner with physicians on a quarterly basis, and especially those physicians that I sometimes think don’t quite value what we’re doing, and I’m having some difficulty getting the point across. I can tell you that I have used Dr. Goldblatt when all else fails. I have had Dr. Goldblatt call a physician or two, and say, “Could you help me? I can’t get him to understand this point for this patient.” And again, when our objective is really about good patient caring and doing the best for our patient, it eventually comes across.
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**Shanen Wright:** Our final question comes from Woody who says he would like a recording of this webinar to play at a multi-provider meeting that he has every month. “Will a recording of today’s session be available?”

**Dr. Goldblatt:** We were lead to believe that there might be one available. Won’t this webinar be archived?

**Linda Murphy:** Dr. Wenner, I think this will be archived and available, correct?

**David Wenner:** That is correct.

**Shanen Wright:** Ok. That wraps up the Q & A. Dave, would you like to deliver today’s closing comments?

**David Wenner:** Thanks, Shanen. On behalf of all our participants on the call today and the Home Health National Campaign team, I really would like to again extend our appreciation to both Linda and Dr. Goldblatt for this very informative and very beneficial presentation.

We’d like to encourage all the participants to visit the website for the national campaign. That website again is [www.HomeHealthQuality.org](http://www.HomeHealthQuality.org). We’re currently working on our next webinar. Actually, I’ve already made some notes. I think it would be a great idea to have both Linda and Dr. Goldblatt again just for a Q&A period because this information is so valuable and their experiences are so positive and really get to the heart of what we’re really all about, which is taking care of patients.

As I mentioned earlier, today’s presentation including the slides will be archived and available to be downloaded from our website. This should be accomplished by mid-afternoon tomorrow. Thanks again for your participation today, and we at the Home Health Quality Improvement National Campaign hope that the rest of your day is a great one. Thanks again to all.