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the monthly update for executives and health care professionals



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## Addition of process measures means more prep for OASIS C

*2010 implementation will require staff training; software changes*

**A**lthough the proposed OASIS C is often described as more user-friendly than the current OASIS, the addition of process measures will be a major change for many agencies. Other changes, however, will make completion of the OASIS simpler even though the initial implementation will require additional training for staff.

"Process measures look at certain points in time during the episode and ask home health nurses if specific tools were used to evaluate the patient and change treatment plans if indicated," explains **Judy Adams, RN, BSN, HCS-D, COS-C**, a Chapel Hill, NC-based home health consultant. Although many agencies may already use tools to

### EXECUTIVE SUMMARY

Initial reactions to the proposed OASIS C [Outcome and Assessment Information Set], which is scheduled for implementation in January 2010, are positive. The terms "user-friendly" and "outcome focused" are used to describe the draft for which comments were solicited in January 2009.

Even with the positive reaction to the data set and tool, OASIS C represents a big change for home health agencies from the previous form. OASIS C includes basically all of the information that home health nurses must collect from every patient admitted to home health in order for the home health agency to file for reimbursement with Medicare.

In addition to updating forms and software, home health agencies will need to plan staff training sessions for all staff members to introduce the changes.

- Many questions have been reworded, renumbered, and reorganized to simplify completion.
- Questions that did not relate specifically to outcomes have been deleted.
- Process measures, which require the use of assessment tools at different points of the episode, are required to better determine outcomes.

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evaluate pressure ulcers, depression, and other areas that OASIS C process measures address, quite a few agencies will need to identify tools to use and train staff members in their use, she says. **(For more information about process measures, see p. 15.)**

The comment period for OASIS C ended in mid-January, with the final data set and instrument planned for Spring 2009, for full implementation in January 2010. Although no one can accurately predict what the final instrument will look like, experts interviewed by *Hospital Home Health* are generally pleased with the draft.

Even with the positive changes, home health

managers will have a lot of work to do within their agencies to handle the new OASIS, says Adams. "Given the number of changes in the document, agencies and their information technology vendors will have to revise software used for point-of-care documentation, and all agencies will have to retrain staff members," she says.

Items in the current OASIS that are not used for determination of reimbursement or measurement of outcomes have been deleted from the proposed OASIS C, points out Adams. "For example, rather than asking if the patient can handle laundry, shopping, or house cleaning, the nurse now assesses if there is a change in the patient's ability to handle daily tasks that he or she handled prior to the home health admission," she explains. This makes more sense, because many patients, especially men, did not handle those specific activities anyway, she says.

Assessment items were simplified in many places in the proposed OASIS C, says Adams. This simplification involved rewording, renumbering, and changing the order of many questions, she explains. "This will present a challenge to agency trainers, because home health nurses are so familiar with the OASIS that they've been using," she says. "Although there were a few changes in 2002, some changes in 2003 with the addition of V-codes, and some minor tweaking throughout the years, we've basically had the same OASIS since it was introduced in 1999," she points out.

"I like the proposed OASIS C, because it is more like the [CMS Form] 485 than the current OASIS," says **Rhonda M. Will, RN, BS, COS-C, HCS-D**, senior clinical consultant for Fazzi Associates in Northampton, MA. "All of the information a clinician needs to develop a plan of care is in the OASIS C," she explains.

"Overall, the proposed form is more user-friendly, with wording that is easily interpreted," says Will. "As CMS redesigned the form, focus groups comprised of home health nurses who work in the field were asked for input," she says. This was an important step to take to ensure that nurses would be able to complete the form easily as they sat in a patient's home, she adds. "Home health nurses don't need a form that requires multiple reference books in order to answer the questions accurately," she points out.

Even though no one knows what the final OASIS C will include, it is important that home health managers start to plan what they need to do to be ready, suggests Will. "You can't do anything

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### Editorial Questions

For questions or comments, call **Karen Young** at (404) 262-5423.

definitive now, but every manager should be thinking about how information flows from one department to another and how changes in OASIS will affect admissions, billing, and quality improvement," she says.

Training for the new OASIS also should include all disciplines to some extent, suggests Will. "Nurses should not be unduly burdened, because all disciplines are capable of assessing the patient," she says. "Also, there are times that a patient is discharged by a therapist rather than a nurse, so everyone should understand OASIS requirements," she adds. If your agency uses contract therapists, be sure that they have access to electronic medical records, so that they know what they need to document, especially in relation to the process measures, she suggests.

In some cases, a manager may just need to develop a flow sheet that lists items that are necessary and who is responsible for what activity, suggests Will. The key to successful implementation of OASIS C will be thinking about it now, so that once everything is approved, you are ready to proceed, she says.

"I believe that the attitude of managers and trainers will be important to the successful implementation within agencies," says Will. "One of the mistakes we all made when OASIS was first introduced was to present it to staff members as an awful burden on our daily jobs. This time we need to present it in a positive manner. It is improved, and we need to position it that way when we talk to staff." ■

## SOURCES

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To see a copy of the proposed OASIS C go to:  
[www.cms.hhs.gov/HomeHealthQualityInits/06\\_OASISC.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/06_OASISC.asp).

# Process measures require use of assessment tools

*Agencies must address all outcome areas*

The biggest challenge that home health managers will face with the proposed OASIS C is the addition of 30 process measures that will affect outcomes.

Even with the additional preparation and training that the process measures will require, they are a good thing for home health, says **Judy Adams**, RN, BSN, HCS-D, COS-C, a Chapel Hill, NC-based home health consultant. "The process measures follow the Centers for Medicare & Medicaid Services' (CMS) focus on patient outcomes and implementation of best practices," she explains. Many agencies already may use standardized tools to identify the need for additional intervention for certain risks or conditions, but there are also many that will have to incorporate the use of assessment tools, she says.

The process measures focus primarily on five areas, says Adams;

- pressure ulcers;
- foot care for diabetics;
- depression;
- falls prevention;
- heart failure.

With each area, home health nurses are expected to use standardized tools to identify risk factors, recognize symptoms, and incorporate best practices for the prevention and treatment of these conditions, says Adams. "Almost all home health agencies have tools to assess the risk of falls, and tools for the other areas already exist," she says. (See resource box, p.16.)

The addition of the process measures does mean that home health agencies that have focused only on one or two areas of Home Health Compare outcomes will need to broaden their scope, says Adams. "This will be a challenge for some small agencies," she admits.

"You do have the option of saying that you have not used an assessment tool," points out **Rhonda M. Will**, RN, BS, COS-C, HCS-D, senior clinical consultant for Fazzi Associates in Northampton, MA. One of the questions related to depression asks the nurse if a screening tool was used to assess risk of depression. "You can choose to answer no; yes; and yes, the patient exhibits symptoms of depression," she says.

## RESOURCES

- The Patient Health Questionnaire-2 is a simple, two-question screening tool for depression. Go to [http://www.cqaimh.org/pdf/tool\\_phq2.pdf](http://www.cqaimh.org/pdf/tool_phq2.pdf) to download an explanation of the tool and questionnaire.
- A wide range of assessment tools for home health can be accessed at [www.qualitynet.org](http://www.qualitynet.org). Select the "MedQIC" button at the top of the page, and then choose "home health" for a listing of tools and reference material.

"Even though you can answer "no," the question is there for a reason, which means that CMS wants us screening patients for the risk of depression," she adds. Screening tools don't have to be complicated, she points out. "As long as the tool is scientifically based and developed by a reputable source, it will work," she says. "In fact, there is a two-question screening tool for depression that works well," she adds. (See resource box, above.)

Even though the process measures will create a challenge for some agencies, CMS did select measures that were within the control of the agency, points out Will. "We can't control re-hospitalization, because ultimately a physician makes that decision, but we can control how early we identify a potential problem and intervene to prevent the problem — such as a fall — or treat depression earlier rather than later. The process measures will help improve the care we provide." ■

## HH aides earn rewards points; retention increases

*Points awarded for extra effort and good work ethic*

Don't you feel like you've given yourself a gift when you redeem those points that you earned with your credit card? A free flight, a no-cost hotel stay, or dinner at a restaurant you've always wanted to try, are all rewards offered by credit card programs in an attempt to keep you a loyal, paying customer.

Rewards programs can work with employee retention, as well.

Home health aides at Neighbors Home Care in Bronx, NY, earn points toward movie tickets,

transit passes, gift certificates to restaurants, hair salon certificates, American Express gift certificates, and even an Apple Ipad, says **Jordan N. Shames**, BS, president and CEO of the agency. "Employees earn points for working their schedules and showing up on time, working additional shifts or weekends, referring friends as clients, or referring friends to our training program," he says. Other ways to earn points include receiving a "Lifesaver Award" from a front-line supervisor for extraordinary efforts, such as covering another aide's shift at the last minute when the aide calls in sick. "Employees who have no absences in a quarter receive extra points, and working holidays will also earn additional points," he explains.

Quarterly statements are prepared by the agency, so employees can keep track of their points. The statement includes a description and pictures of the awards that are available, says Shames. "The last page of the statement explains the form to complete to redeem the award," he adds.

Employees who are still in their probationary period are not eligible to redeem awards, and employees can lose bonus points during the quarter for some activities, says Shames. Visit sheets that don't match the plan of care, substantiated client complaints, or verbal warnings from supervisors, all will result in the loss of points, he explains.

The program, which began in 2006, has worked well, but the agency continues to evaluate it and

## EXECUTIVE SUMMARY

Credit card companies have used reward programs to build customer loyalty for years. Now, a New York home health agency uses a point system and catalog of rewards to recognize employee contributions to the agency's success and to increase employee satisfaction.

- Employees earn points for schedules worked, extra shifts, weekends, client and supervisor compliments, and referral of friends to the aide training program.
- Quarterly statements keep the employee up to date on point balance and available awards.
- Gift certificates to restaurants, movies, and hair salons, along with items such as an Apple Ipad, are included in the gift catalog.

## SOURCE

For more information about the employee rewards program, contact:

• Jordan N. Shames, BS, President and CEO, Neighbors Home Care, 2532 Boston Road, Bronx, NY 10467.  
Telephone: (718) 515-2200. E-mail: jshames@neighborshomecare.com.

find ways to improve, says Shames. "We've added extra opportunities to earn points, and we also take away points from employees who don't work any weekends during the quarter," he says. The penalty for no weekends is based on the agency's policy that all employees are required to work a certain number of weekends, he explains.

The cost of administering the rewards program is about \$7,000 annually, says Shames. "This is the cost of purchasing the rewards, because we split the administration responsibility among several managers," he says. As the program has grown, it has become more labor intensive to track and report points for all 250 aides, so Shames is evaluating software that will make it easier to flag items that earn points.

In addition to retaining aides, Shames has been able to retain 63% of the aides who enter the agency training program, he points out. "We have established our agency as a good place to work, because we recognize our aides' effort," he says. Other retention tactics used by Shames include: affordable insurance for employees, recognition of employment anniversary dates, recognition of "Lifesavers" at luncheon, English as a Second Language scholarship program at a local college, year-end bonuses, overtime, and the ability to purchase transit cards with pre-tax dollars.

It takes time to develop a rewards or recognition program that helps with retention, but it can be done with input from supervisors and employees, says Shames. "We are not a Medicare agency, so we have more flexibility in how we are reimbursed and how we pay employees, but a Medicare agency can also find ways to show employees how they are appreciated," he says. "I'd suggest pushing the envelope to try a new program, but first, make sure it is meaningful to your employees." ■

## CMS strengthens fight against waste and fraud

*Final rule requires surety bonds*

The Centers for Medicare & Medicaid Services (CMS) now requires certain durable medical equipment (DME) suppliers to post a surety bond.

CMS issued a final surety bond regulation, required by the Balanced Budget Act of 1997, that makes certain suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DME) post a \$50,000 surety bond. Existing suppliers must comply with this requirement by Oct. 2, 2009, while newly enrolling suppliers must meet this requirement by May 4, 2009. This requirement was due in part to the large number of improper and potentially fraudulent payments to medical equipment suppliers for furnishing medical equipment and devices to people with Medicare, according to CMS. The 2007 Medicare error rate report found approximately \$1 billion in improper payments for medical equipment and supplies.

Suppliers who have had certain adverse legal actions imposed against them in the past also may be required to post a higher bond amount. All newly enrolling suppliers that meet the requirements of the rule will be required to have a surety bond before they can enroll in the Medicare program. More information about the new regulation can be found at [www.cms.hhs.gov/MedicareProviderSupEnroll](http://www.cms.hhs.gov/MedicareProviderSupEnroll).

While this regulation requires most suppliers to obtain a surety bond, some companies or organizations that supply these items are exempt from the surety bond requirement, including certain physicians and non-physician practitioners, physical and occupational therapists, state-licensed orthotic and prosthetic personnel, and government-owned suppliers.

In addition to suspending payment, CMS is:

- implementing extensive pre- and post-payment review of claims submitted by ordering/referring physicians;
- validating claims submitted by physicians who order a high number of certain items or services by sending follow-up letters to these physicians;
- verifying the relationship between physicians who order a large number of home health services and the beneficiaries for whom they

ordered those services; and

- identifying and visiting high-risk beneficiaries to ensure they are appropriately receiving the services for which Medicare is being billed. ■

## CMs, DMs coordinate care for Advantage members

*System integrates support, avoids duplication*

At Regence, a health insurer in the northwest mountain state region, case managers and disease managers work hand in hand and share an electronic care management software system that allows them to seamlessly manage the care of their Medicare Advantage members.

The health plan implemented a new software system in May that allows the disease managers, the case managers, and the behavioral health staff to operate on the same platform.

"We have easy access to information on any member. This enables us to integrate the support that we offer our members and avoid duplication," says **Sharon Arneson**, RN, CCM, manager of case management and disease management.

Before the new software was implemented, the case managers and disease managers communicated by telephone and e-mail.

"Now, we can move between the programs to meet whatever is the need of that member at that particular time," she says.

The health plan's goal is to ensure that members get the right services at the right time and in the right place, says **Doug King**, MSW, LCSW, MBA, manager of supplemental programs.

Members can be in disease management and have a case manager at the same time, he adds.

Case managers provide complex care management services for members who are in the hospital or a post-acute facility; who have an illness or injury that requires a complex treatment plan; or who have been diagnosed with serious medical conditions such as cancer and need help choosing the best treatment options, King says.

"Members don't have to be chronically ill to qualify for case management. They just have to be in a situation in which they need a health care advocate," King says.

Regence offers disease management programs for individuals with congestive heart failure, chronic obstructive pulmonary disease, asthma,

diabetes, and coronary artery disease.

They screen these members for depression and anxiety, since there are high comorbidities for people with chronic conditions, and may refer them to the health plan's behavioral health team.

If a member in disease management is having an acute issue or other complex needs or ends up in the hospital, the disease management team calls in a case manager.

"Sometimes we will co-manage the member, or the disease management nurse will just be in a holding pattern while the case manager works with the member," he says.

At the same time, when the case managers are working with members with complex needs and determine that they have conditions covered by the disease management program, they make a referral to the disease management team.

The disease managers and case managers also can refer members for health coaching if they need to lose weight, stop smoking, or need help with other lifestyle issues.

"If members need to be co-managed, having all the information on one platform makes it much easier. When the nurses or behavioral health specialists document in the case notes, the disease managers have instant access to it. We can see the treatment plan, what goals have been set, what interventions have occurred, and when the case manager has contacted the member last," Arneson says.

Members also like the process, since they no longer have to repeat the same information to the case managers that they gave to the disease manager, she adds.

Members are referred to case management when they are hospitalized or have an emergency department visit, and from the company's utilization review nurses when providers request certain types of complex services. In addition, members may refer themselves for case management, or family members may refer them.

"If it's a self-referral or a family referral, they receive automatic approval for the program. If members request it, we will enroll them and help them with whatever issue they have," King says.

The health plan also uses predictive modeling to identify members who could benefit from case management.

For instance, members who have an orthopedic issue and a history of falls would be triggered for case management.

"We would make sure they have the right durable medical equipment and that they receive occupational therapy or physical therapy if

appropriate. Our purpose is to reach out and make positive interventions to prevent future health care problems from emerging,” King says.

When members are hospitalized, the Regence case managers work closely with the hospital utilization staff to ensure that the members get the care they need, he adds.

“We use Milliman Care Guidelines to examine what condition the member has, what care is being provided, and to actively and assertively assist in driving the care,” he says.

For instance, if a member has a pacemaker installed on Friday and is being kept in the hospital over the weekend for monitoring, the case manager intervenes if evidence doesn’t show that the patient needs to be monitored in an acute care setting.

“In this case, we would make sure that the member needs continuing acute care and isn’t just sitting in the hospital over the weekend. It’s a matter of ensuring that our members are getting the right care at the right time,” he says.

They conduct concurrent reviews to ensure that the patients are receiving the services that they need and are in the right level of care.

“We look at whether a member could get the care he or she needs at a skilled nursing facility or a long-term acute care hospital. If we can get the member the right care in the best setting, we can help lower their out-of-pocket expenses or copayments,” he says.

Case managers interact with members and their families as well as providers.

### ***Explaining continuum of care***

“We try to address the issue of continuum of care, explaining to the family why members are at the current level of care, and when and where they should receive care in the future. We work with the discharge planners at the facility to help the member transition between levels of care,” King says.

Often, the case managers educate family members about the various levels of care, explaining why patients need to be discharged from the acute inpatient setting and helping them understand what kind of care they will receive at the next level of care.

“We explain why the member needs to go to the next level of care and show them their financial responsibility if they continue to stay in a facility that Medicare won’t pay for. We support the hospital decision to discharge when the chart shows that the patient is ready to go. We don’t want the hospital discharging people too early

because they come right back,” he says.

The case managers advocate for the members with the clinical staff in the hospital to ensure that the member receives recommended care.

If a member is experiencing frequent readmissions for the same condition, the case managers intervene and conduct an assessment to determine the cause. It may be that the member doesn’t understand the treatment plan or is unable to follow it and needs help from a health coach or a disease management nurse. Or the case manager may find out that the members didn’t receive the post-acute services that were prescribed or that they were inadequate, or, in some cases, the patient was discharged from the hospital too soon.

“We try to be as proactive as we can. The more we are involved, the more it’s a win-win effort. If we can help members avoid future episodes of care, it reduces health care costs, reduces their out-of-pocket expenses, and improves the quality of life for our members,” King says.

The health plan uses a data mining tool to identify members who are eligible for the disease management program and uses a three-pronged strategy to help them manage their conditions.

Low-risk members are those with chronic conditions who are managing well with no gaps in care and no inpatient stays or emergency department visits associated with the condition or disease.

They receive a welcome letter along with a brochure describing the program and regular educational newsletters. The low-risk members also are offered the opportunity to opt in to the program if they think they need support from a nurse. A low-risk member who chooses to opt in to the program might be someone who is concerned because of changes in his or her blood sugar level or needs support to get on a diet and exercise program.

“Our role is to help the members set healthy lifestyle goals and to provide support for the physician’s treatment plan,” Arneson says.

Members at moderate risk have a gap in care, such as not receiving a cholesterol screening or a hemoglobin A1c test.

“Every quarter, we have campaigns set up that focus on members with care gaps. We encourage them to talk with their provider about evidence-based care guidelines to ensure that our members receive the full range of services to address their health conditions,” she says.

All of the disease managers are RNs and have earned the Certified Chronic Care Professional (CCP) designation.

When a member agrees to participate in the disease management program, the disease management nurse completes a disease-specific assessment over the telephone. The assessment includes information about the member's condition, knowledge of his or her treatment plan, and risk factors.

For instance, if the member has asthma, it's important for the nurse to know if he or she smokes, something that doesn't readily show up in claims data.

They screen all members for depression and coordinate their care with the behavioral health team if needed.

The disease management program for high-risk members is individualized. The frequency with which the nurses contact the members depends on the members' needs and preferences.

For instance, if a member has experienced an exacerbation in his or her condition or has started on new medications, the nurse may call in frequently. Then, as goals are met, the nurse contacts the member every few weeks, then every few months. ■

## Follow-up care helps avoid readmissions

*Team helps patients navigate health care system*

With the number of uninsured patients increasing rapidly, the case management and social work staff at North Broward Medical Center are faced with the challenge of making sure patients receive the follow up they need to stay healthy and out of the hospital.

"In North Broward County, our hospital case managers and social workers work with the district clinics and other providers to make sure our patients have continuity of care after discharge. We try to focus as much as possible on preventive care so these patients manage their health care and reduce readmissions," says **Gavin Malcolm**, LCSW, coordinator of social services and trauma social worker at the Deerfield Beach, FL, medical center.

The hospital has seven full-time social workers, an emergency department social worker, and a trauma social worker, in addition to 20 case managers.

"We work as a team. The case managers and social workers are unit based and work together to determine the patients' needs and how to meet them," he says.

Non-compliance with follow-up care is a huge issue with uninsured patients for many reasons. One issue is that people don't want to go to a clinic and wait for hours, Malcolm says.

South Florida has a large population that doesn't speak English. The hospital has some bi-lingual staff and uses a telephonic certified service to talk to people who do not speak English.

After the hospital implemented a process improvement project to increase compliance with follow-up visits, the percentage of uninsured patients who follow up with their scheduled initial appointment with the clinic rose from 7% to 15%.

"It's still miserably low but it has doubled," he says.

The social workers and case managers use a central scheduling line to set up a primary care appointment before people leave the hospital.

"Because of sheer numbers, there is a long wait for appointments so we try to set an appointment as early in the process as possible. Once they get established in the clinic, they can go there for medication refills without having to have an appointment," he says.

The social workers obtain contact information at assessment and confirm it at discharge so the clinic can call to confirm the appointment, but often, the patients can't be contacted for follow-up.

"Contact information can change on an almost daily basis," he says.

If preventive care is not possible, Malcolm encourages patients to go to an urgent care center, where care may be covered by tax funds, instead of coming to the emergency department. The urgent care centers and primary care clinics result in lower financial burdens on the patients and focus more on the patient's history while the emergency department has to stabilize the patients as efficiently as possible, he says.

"When we make the follow-up appointments, we give the phone number of the patient to the clinic so they can call to confirm the appointment," he says.

Malcolm talks to patients about the benefits of seeing a primary care physician, rather than visiting the emergency department for treatment.

"I point out that they will rarely get the same doctor or the same treatment at the emergency department and that a physician who is familiar with them will give more consistent care. I also point out that the cost of follow up at the emergency department is more than at a clinic," he says.

Once patients get established in a clinic, they tend to follow up at the clinic, rather than going

to the emergency department, Malcolm says.

"The health care system is confusing for people who work in it every day. It's totally bewildering to other people, especially if there is a language barrier. Giving them education and connecting them with community resources keeps them out of the emergency department and keeps them from being readmitted," he says.

Any patient who indicates he or she is self-pay is screened to determine if he or she is eligible for Broward County Tax Fund assistance, a program that provides medical care for patients who do not have any type of health insurance, including Medicaid.

"It can take up to six months to get a patient approved for Medicaid. This makes it difficult to discharge patients in a timely manner. The county programs can issue approval the next day so we can ensure that patients have follow-up visits whether it's with the cancer center, a primary care physician, or a specialist," Malcolm says.

In addition to the financial and medical requirements, to qualify for Medicaid, a patient has to prove residency for five years. The Broward County Tax Fund requires the same financial information but proof of only 30 days residency in Broward County for people to qualify for the Star Card assistance program, he says.

"For people who have immigrated and lived here less than five years or who are undocumented, the Star Card would be the primary option," he says.

The program covers people whose income is up to 300% of the poverty level. Patients pay copays based on their income level.

The benefits include assistance with medications and outpatient, inpatient, and acute rehabilitation services and provides home health through a partnership with a home infusion and home health care agency.

"It's essentially set up like an HMO once they qualify," he says.

People are ineligible for Medicaid if they have savings or other assets, he adds.

"In addition, people have to have medical issues before they can apply for Medicaid. The Star Card fills that gap. When I'm meeting with families, I encourage them to apply for the Star Card and get care at the clinics before they get so sick they have to be hospitalized," he says.

If people are undocumented, they can apply for tax fund assistance but not Medicaid.

"When a patient is in the hospital, I try to talk to the whole family. I tell them that I'm not inter-

ested in their immigration status, I just want to get them resources," he says.

Malcolm reports varying degrees of success in trying to help undocumented workers. Many times people say they don't remember their address or how long they've lived in the area for fear that they will be turned into the Immigration and Naturalization Service.

With the exception of people who have both criminal and medical issues and patients with tuberculosis or other public health risks, hospital staff do not notify the authorities of a patient's immigration status.

In the past year, there's been a huge increase in self-pay patients who previously had insurance, Malcolm says.

"People who were doing OK a year ago have lost their jobs and they are scrambling to find health care for their families. And, there are a lot more people who are just one paycheck away from being homeless," he says. ■

## Tough times present challenge for fundraisers

*Donations, grants available, but you need time*

**D**iversification is not only sound investment advice during these rocky economic times, but it also is sound fundraising advice. While a financial advisor will recommend a mix of cash, short-term savings such as certificates of deposit and stocks in a variety of industries or types of companies, fundraising experts for hospice recommend a development plan that addresses passive and active efforts as well as short- and long-term activities.

"There are many stories of small, not-for-profit organizations, not always hospice, that lose an annual grant upon which they relied for operational and program funds," says **Pam Brown**, CFRE, executive vice president for community development at Alive Hospice in Nashville, TN. "You don't want to rely on one source of funding for any program."

For this reason, her development program includes grants, special events, individual donors, and endowments. A direct mail twice each year to former donors asks for individual gifts, and the hospice receives memorial gifts or thank-you gifts from family members throughout the year. "We

also receive funding from United Way, which includes a three-year grant, as well as directed gifts from individual donors who ask that their entire pledge be given to the hospice," explains Brown.

Even with diversification, the current state of the economy is affecting fundraising. "I am noticing that the number of gifts from our direct-mail campaign is not decreasing, but the dollar amount of each gift is less," says **Mike Blanchard**, vice president of development for Hospice of Wake County in Raleigh, NC. Even grants from major foundations are affected, he says. Although grants that already have been announced will be paid, Blanchard received a letter from one foundation that wanted to let recipients know that the foundation staff were taking a close look at funds and would not be awarding any new grants. Although foundations have money set aside, grants are usually awarded from the earnings on the principal foundation funds, he explains.

"When the stock market dropped, foundations lost earnings just as individuals did," he says.

Blanchard also experienced smaller sponsorship levels for a fundraising special event. The event volunteers had to work hard to find more sponsors to raise the same funds that they raised last year, he explains. "Attendance at the event was also down slightly from previous years," Blanchard adds.

Alive Hospice coordinates two major special events during the year to raise funds, but the agency often is the beneficiary of events sponsored by third parties, says Brown. "If we know about the event, we ask that our special events coordinator be included in the planning," she says.

### **Larger gifts require staff involvement**

While individual gifts and special event funds are important, larger gifts usually are the result of efforts to obtain grants, solicit major gifts from individuals, or endowments, points out Blanchard. "Endowments can be considered long-term savings," he says.

While some family members, board members, or individuals in the community might ask a hospice for advice on how to make a bequest in their will to the hospice, many times a hospice does

not know in advance about the gift, says Brown. "Just this week, we received a check from an estate that we never anticipated," she says. Last year, the hospice received a six-figure gift from an estate that also was a surprise. "For every one endowment about which you know, there are four or five that you don't know," Brown adds.

Alive Hospice is opening a 16-bed hospice unit and palliative care center in a local hospital, and it is funding the renovation costs with grants and major donor gifts, Brown says. A recent \$150,000 grant from a local foundation will be used for the renovation, she says. "Most of our grants are local because our staff grant coordinator is very familiar with local organizations that provide grants," Brown says.

At Hospice of Wake County, "about 8% of our operational support is provided by grants," says Blanchard. The grants designated for operational support are used for indigent care and support of the hospice's family grief center. "Bereavement programs are an active area of growth for hospices and their fundraising efforts," he points out. "Medicare requires that bereavement services be offered to families of hospice patients, but no reimbursement for the service is provided."

Blanchard and Brown have a staff grant writer who researches grant opportunities, prepares the applications, and produces the follow-up reports required by some grant sources. "Our grant writer spends time calling foundation staffs to make inquiries to be sure that our program is a good match for their funding priorities," says Brown. Matching your goals to the goals of the organization offering the grant is key to your success, she says. "You have to be creative as you look at grant opportunities," Brown says. "Don't just type in 'hospice' as you search the Internet for potential grants, because you limit yourself," she adds. If your bereavement program has a children's component, or a summer camp, look for grants focused on services for children, she explains.

Although large grants are nice, don't overlook small grants, suggests Blanchard. "We received a letter from a church that had money available for grants, but the letter was almost apologetic and pointed out that they were a small organization

## **COMING IN FUTURE MONTHS**

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with a small amount of money to offer as grants," he says. After submitting a request for \$1,000 to offset one-fifth of the cost of their children's bereavement camp, Blanchard's hospice received a check. "The letter not only thanked us for giving them the opportunity to support our program, but it also thanked us for recognizing their financial limits and asking for such a reasonable amount," he says. ■

## Journal Reviews

### HH aide job satisfaction affected by safety

*Retain aides by limiting unsafe environments*

Although independence is an attractive feature of working in home health, job satisfaction can be affected negatively if the home health worker does not feel safe. Because home health aides work in the patients' homes as opposed to a clinic or central healthcare facility, it is important that agencies' address the safety risk factors within their control to improve the work environment and retain valuable employees, according to a recent study.<sup>1</sup>

Survey data collected from 823 New York City home health agencies was analyzed to determine how the perceived safety of the work environment affected retention. Household and job-related risks, environmental factors, threats, verbal and physical abuse, and potential for violence were significantly correlated with a decrease in job satisfaction and an increase in home health aide turnover, according to the authors.

The authors conclude that agency management that is receptive to employee concerns and takes action to reduce the risk of unsafe job assignments will experience higher job satisfaction rates and improved retention. **(For more information about addressing unsafe HH workplaces, see "Methods to improve home health employee safety," Hospital Home Health, January 2006, pg. 5.)**

#### Reference

1. Sherman MF, Gershon RR, Samar SM, et al. "Safety factors predictive of job satisfaction and job retention among home healthcare aides." *J Occup Environ Med.* 2008; 50(12): 1430-1441. ■

## CNE questions

5. What can home health managers do now to prepare for implementation of OASIS C, according to Rhonda M. Will RN, BS, COS-C, HCS-D, senior clinical consultant for Fazzi Associates in Northampton, MA?  
A. Nothing  
B. Begin training staff on anticipated changes, then plan follow-up training.  
C. Think about changes in forms, assessment tools, flow sheets, and software that will be needed and make checklist to organize activities once OASIS C is finalized.  
D. None of the above
6. In which of the following areas are process measures required in the proposed OASIS C, according to Judy Adams RN, BSN, HCS-D, COS-C, a Chapel Hill, NC-based home health consultant?  
A. Pressure ulcers  
B. Heart failure  
C. Depression  
D. All of the above
7. Why did Neighbors Home Care in Bronx, NY develop a rewards program for employees, according to Jordan N. Shames, BS, president and chief executive officer of the agency?  
A. To let employees know their efforts are appreciated  
B. To make up for a weaker benefit package than other local agencies  
C. To encourage retention and referral of friends to the HH aide training program.  
D. A and C
8. What is the amount of the surety bond that will be required in by October 2009 by The Centers for Medicare & Medicaid Services (CMS) for certain durable medical equipment (DME) suppliers?  
A. \$25,000  
B. \$50,000  
C. \$75,000  
D. \$100,000

Answer Key: 5. C; 6. D; 7. D; 8. B.

# Home-based rehab effective for COPD patients

*Study shows care at home matches clinic care*

A one-year study that followed 252 patients with moderate to severe chronic obstructive pulmonary disease (COPD) shows that home-based rehabilitation can produce the same results that outpatient hospital-based rehabilitation.

Patients in both the home-based group and the hospital-based group began with the same four-week education program. Patients underwent rehabilitation for another eight-week period, and then researchers followed their progress for another 40 weeks to complete the study. Effectiveness of the two interventions was based on the change in Chronic Respiratory Questionnaire dyspnea subscale score at one year. At the end of the study, researchers found the difference in improvement of dyspnea to be small and clinically unimportant, according to the authors.

## Reference

1. Maltais F, Bourbeau J, Shapiro S, et al. "Effects of home-based pulmonary rehabilitation in patients with chronic obstructive pulmonary disease: a randomized trial." *Ann Intern Med.* 2008; 149(12): 869-78. ■

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## CNE objectives

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

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

## CNE instructions

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