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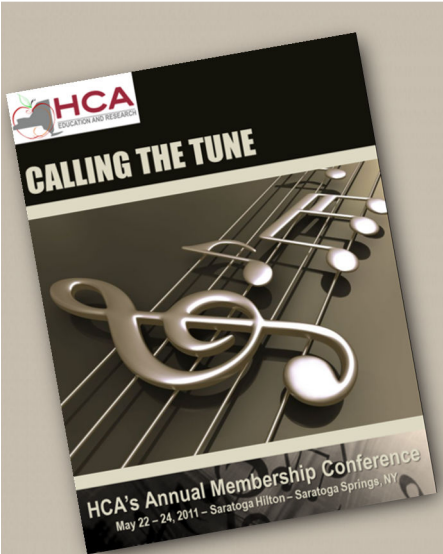


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## Home Care Program Provides Vital Postpartum Intervention for Newborns and Mothers

By Loretta Gambino

In 2009, Winthrop University Hospital Home Health Agency (WUHHA) launched a joint initiative with the hospital's maternity nurses in response to a growing concern for postpartum mothers who were potentially at high risk for depression or "Postpartum Mood Disorder" (PPMD). The Director of Nursing for Maternal Child Services, Administrator for Home Health, and the assistant Vice President for Case Management coordinated efforts to put a process in place for home care referrals and community services for mothers and their newborns.

As part of this process, the hospital nurses are empowered to initiate referrals to social work and home care if their nursing assessment scored a mother at high risk for Postpartum Mood Disorder, at which point a physician order is generated for a home care evaluation along with a notification to the infant's pediatrician to alert the provider that the mother may have post-hospital needs for services.

First, the home health agency's intake nurses interview the mothers after an order is received prior to hospital discharge. (Intake nurses are on site seven days per week.) They advise mothers that WUHHA has a telephonic program in which the mother can be followed after discharge from the hospital.

Home care staff will call to see how the mother is doing, to assess concerns, needs, and any issues she may have about postpartum emotional issues. The nurses will also interview mothers who appear to have had other known associated risk factors of Postpartum Mood Disorder such as a history of other mental illnesses, a history of substance abuse, any current life stressors (uninvolved family, etc.) or medical issues (self or infant).

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Frequently, the mothers who are interviewed have had some history of emotional issues in the past themselves either with anxiety or depression or with Postpartum Mood Disorder (Depression) or have had a close family member with the same, (usually a sister or a mother). Women who have been on psychotropic medication – and, perhaps, who have come off the medication during pregnancy – also may have an episode. Women who have had a difficult pregnancy, labor or delivery also are a red-flag to the Intake Nurse.

The intake nurses explain the program and set up a time for a call. Usually, the call range is three to four weeks after discharge, but earlier timeframes have been set to accommodate someone's request. Calls are made to Nassau, Suffolk, and Queens, but home care services are offered to Nassau residents only (Winthrop's area of service) if criteria are met. Out-of-county residents are offered referrals to services in their respective county.

Once the patient leaves the hospital, a Licensed Clinical Social Worker from the home health agency contacts the patient at the scheduled time. The three-to-four-week timeframe is significant, as this is often when Postpartum Mood Disorder manifests itself. If intervention can be offered early on, the severity of symptoms may be lessened and the episode may be shortened.

In calling the patient, the social worker identifies herself as a WUHHA employee and reminds the patient of

the follow-up program. This identification itself is purposeful, as the title of "social worker" can invoke fear or panic in a vulnerable mother who may feel she is doing a poor job with parenting. It is important that the mother sees the social worker in a helpful role, not a punitive one. The social worker must be able to assess not only what the patient is saying but also certain verbal cues, such as how the patient's voice sounds, to determine mood, specifically her tone of voice.

*"Home care for postpartum patients provides a unique perspective. When a team is in the home, they generally get a strong idea of that patient's daily experiences ... Home care can help ensure that there is a safe plan for the mother and the baby in place, and that their medical and emotional needs are being met."*

If the patient is willing and feels there is a need, the social worker will pursue a more in-depth assessment but will take her cues from the patient regarding the continuation of outreach. If the patient would like a second call, this could be arranged, as needed.

The social worker assesses the risk factors that could contribute to Postpartum Mood Disorder. Again,

those risk factors may include: lack of social supports or social isolation, financial issues, significant losses (jobs, deaths, etc.), medical issues (mother or baby), multiple births, a high-need baby, poor environment, abuse and premenstrual problems.

The social worker also explores what symptoms the mother has been having. Symptoms associated with Postpartum Mood Disorder include: panic/anxiety, sad mood, crying spells, obsessive thoughts, thoughts of hurting self or child, appetite changes, sleep disturbances, anhedonia, and a feeling of guilt, especially due to a feeling that motherhood was not as joyful as they expected (in other words, if the mother does not feel maternal or "in love with her baby," and she is afraid someone might notice). In addition, other symptoms that could be observed: bonding issues (lack of overcompensation), irritability, fatigue, feelings of worthlessness, not wanting to take care of self, and trouble concentrating or with decision making.

When the assessment is completed, the mother is educated about resources available to her for maternal and postpartum services. If both the social worker and mother determine that home care would be beneficial, and the criteria are met, the agency's intake department obtains physician orders and schedules a home visit. The patient will be admitted to home care usually within 24 to 72 hours, at which time an RN and a social worker become available for home visits.

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Home care for postpartum patients provides a unique perspective. When a team is in the home, they generally get a strong idea of that patient's daily experiences. Since insurance companies do not qualify postpartum stays beyond generally two days, the hospital personnel do not have the time to observe or diagnose postpartum symptoms or depression properly. Another factor is that the symptoms may not have manifested yet. After all, anxiety may not be so prevalent when everyone is bringing flowers and visiting the mother in the hospital, and while people are taking care of the mother and baby; it can be seen more easily when the mother has to spend the first day alone with the baby, and when the mother has not slept for a long period of time and begins to feel inadequate, or afraid.

The home care agency can act as the first step in early intervention, beginning to provide post-hospital care, when symptoms may first be manifesting. Home care can help ensure that a safe plan for the mother and the baby is in place, and that their medical and emotional needs are being met. Also, since mental health agencies have waiting lists for appointments, and other resources may be difficult to obtain, home care can be a bridge to these services, helping stabilize the situation until services can be put into place.

Another role for the home health team is to help the patient communicate effectively with OB/GYNs and the Pediatrician to help them understand the mother's social and emotional condition, as it impacts both the mother and baby. In the case of the pediatrician, who may be treating other children in the family, obtaining this information is important, especially in instances of non-bonding or potential abuse. Any issue concerning the mother's emotional needs would affect the baby and the pediatrician should be aware of it.

With a team in place communicating from the hospital to the home – including medical and mental health professionals – the severity of Postpartum Mood Disorder and its duration may be lessened, decreasing the need for future medical care.

*Loretta Gambino is Social Work Manager for Winthrop University Hospital's Home Health Agency. For questions about Winthrop's program, please contact Ms. Gambino at (516) 663-9487.*



## The Growing Importance of Revenue Cycle Management

By Ed Buckley with Tim Rowan

Lost revenue and poor compliance go hand in hand. They infiltrate a home health care agency together.

Managing your revenue cycle means improving compliance as much as it means ensuring complete and accurate billing processes and A/R follow up procedures.

Compliance is the responsibility of all staff, especially those with clinical and financial responsibilities. In today's Medicare environment — and it is not much different if a provider's primary payer is insurance or the patient — mere automation is insufficient. Quality Revenue Cycle Management (RCM) processes are required today more than ever.

In fact, RCM is the number one key to meeting today's home health compliance challenges. Considering the current regulatory environment — where we are seeing sharp increases in ADRs, the imminent rise of collection agencies such as Recovery Audit Contractors, and intensive, relentless MAC, MIC and Z-PIC audits — home health care processes and systems dare not fall short of the challenge.

Compliance must be built into RCM processes, and not treated as an afterthought or a luxury. Patient care is a complex proposition. Building in compliance requires that communication and interdisciplinary coordination are part of a plan of care that manages a patient's medical needs. There are four key components to the process of building compliance into a plan of care:

- technology
- documentation
- coding
- billing



These four business pillars support RCM and form a foundation for compliance. Think of RCM as permeating the entire life cycle of a patient care episode, from referral to assessment to plan of care to patient record and finally to the revenue derived from that care. When a plan of care is carefully developed and managed through compliant systems and processes that all talk to each other, a complete management cycle results. When done right, the benefit of this cycle is that it provides the agency with a comprehensive, dynamic, profitable, accurate and compliant home health care business. Most importantly, it results in the ability to provide the highest possible level of patient care, making an agency the first choice among doctors, hospitals and care planners.

### **Technology only part of the answer**

In order to achieve compliance in the contemporary regulatory environment, home health care providers must employ more than just point-of-care technology and a centralized billing/coding system. It is imperative to utilize the RCM processes in order to verify assessments, review clinical processes and reconcile resulting data as part of compliant revenue generation. Incorporating RCM processes as part of an overall business strategy often results in improved reimbursement, bullet-proof billing compliance and stellar clinical outcomes.

Lost revenue and poor compliance go hand in hand because OASIS and coding errors are often the result of incomplete and incongruent assessments. Billing mistakes typically occur because visit activities vary from physician orders. Data errors are frequently triggered by hurried keying into point-of-care and EMR systems. A well-developed RCM system as part of operations, implemented in real time, can mitigate most of these costly mistakes.

With compliance comes control and peace of mind. Compliance leads to more positive patient outcomes, fewer hospital readmissions, more retained revenue, greater efficiency and more predictable cash flow, while providing peace of mind that comes only when patient outcomes match plans of care. A home health agency's business depends on the quality of patient care provided. Doctors, hospitals, and care planners need an agency they can trust to deliver quality care and outcomes, period.

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### ***What RCM is and is not***

RCM begins with a complete data capture and error mitigation philosophy affecting every staff member and virtually every aspect of a health care provider's business operations. This includes:

- accurate patient assessments, the cornerstone
- correct OASIS documentation
- clean patient data
- physician order monitoring
- visit reconciliation
- clinical coding with review
- QI oversight
- A/R management and collections follow-up

*"Accurate and compliant coding is not only the image of your standard of care that you broadcast to the community. It is the cornerstone of your ability to receive and retain revenue. Getting it right is the best way to grow your business and increase patient and doctor satisfaction with your plans of care."*

Systems must be designed into processes that identify errors prior to revenue generation. Catching up with after-the-fact chart audits is no longer an adequate process in today's environment. Operations must have built-in processes that catch incongruence in real time while it is occurring ... not after the bill has flown out the door. RCM systems monitor all administrative and clinical components that contribute to the capture, management and collection of patient service data.

The heart of the RCM process is a team of specialists charged with the responsibility of establishing and implementing policies, procedures, and performance measures and standards.

### ***RCM begins and ends with clinicians***

In order to obtain compliance within the RCM process, coding accuracy is indispensable. For the average home health care agency, however, achieving the necessary level of accuracy on a consistent basis is often an impossible dream. Among the most prominent roadblocks to coding success is the speed with which codes change. Dozens of alterations take place each year, seemingly in the blink of an eye. In 2009 alone, a total of 290 new codes were established.

Coding errors create even more vexing challenges, the majority of which are related to documentation accuracy and completeness. Co-morbidities are missed during this phase, opening the floodgates to improper sequencing and inaccurate primary diagnoses. Clearly, RCM must begin with management's confidence that assessments are accurate. Crucial to this phase are clinical tools. It is management's responsibility to assemble the tools — especially comprehensive and ongoing training programs — that will properly channel the critical thinking skills required and expected of field staff.

Then, even with confidence in your staff's coding and documentation skills, you can better ensure excellence by assigning RN coding experts to review every assessment to see that every plan of care reflects the best use of ever-changing codes and regulations.

Accurate and compliant coding is not only the image of your standard of care that you broadcast to the community. It is the cornerstone of your ability to receive and retain revenue. Getting it right is the best way to grow your business and increase patient and doctor satisfaction with your plans of care.

Clichéd though it may be, there is a bottom line to consider here. Management's focus on strong patient outcomes through compliance means greater revenue retention and the lowest audit risk. Clearly, effective RCM is a timely solution providing agencies with a foundation for a strong bottom line, a solid grip on financial activities, freedom to focus on priorities, and a welcome relief from compliance anxiety.

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Editor's note: This article first appeared in the April 6 issue of "Tim Rowan's Home Care Technology Report," [www.homecaretechreport.com](http://www.homecaretechreport.com), and is reprinted here by permission; further reproduction is prohibited except with permission of the publisher, Rowan Consulting Associates, Inc. (RCAI), Colorado Springs, CO. Write to RCAI at [editor@homecaretechreport.com](mailto:editor@homecaretechreport.com).

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## OASIS-C & Care Management

By Trish Tulloch

The OASIS-C provides a wealth of data for providers and regulators. Care Management, M2100, directs the clinician to determine the level of a family or other informal caregiver's ability and willingness to provide assistance, if assistance is needed.

New York State providers rank in the top third for Response Number "1" on M2100, indicating "Caregiver(s) currently provides assistance" on this new OASIS-C item. This response indicates that the family or other informal caregiver (hereafter referred to as "caregiver") provides safe and reliable care, and does not need additional training or education to provide this care.

The rating of "1" also indicates that the caregiver does not need any education or training to safely provide the required care, including transfer into the car for outpatient therapy, or instruction regarding the administration of medications or wound care.

Why the Focus on Care Management?

- The U.S. Centers for Medicare and Medicaid Services (CMS) is currently assessing this quality outcome for all providers. While this is not currently a reported or posted outcome, CMS is evaluating the agency's ability to improve the caregiver's ability to provide safe and reliable care.
- Medical review is also focusing on this OASIS-C item as well. If an individual has a willing and able caregiver to provide all necessary care, then paying for home care providers to extend this care is in question.

**Bottom Line:** Care Management, M2100, needs to be assessed and scored to accurately reflect caregiver abilities and the required education and training that the provider will ensure during the episode of care.

### OASIS-C Clarity: CMS's OASIS Q&As

CMS's April 2010 Question and Answers documentation notes that "if a patient needs assistance with multiple tasks included in one of the broad categories of assistance, the response selected should be based on the area requiring the most need."

In its January 2011 Q&As, CMS poses the following question and answer:

**Question: What is the appropriate response for M2100 in cases where the physician has ordered the RN to provide the treatment, e.g. a wound VAC procedure?**



*Response: "3 – Caregiver(s) not likely to provide" indicates that the caregiver(s) has/have indicated an unwillingness to provide assistance or that the caregiver(s) is/are physically and/or cognitively unable to provide needed care. Response 3 is the appropriate response for M2100, Types and Sources of Assistance, in situations where the physician has ordered the skilled clinician perform a treatment or procedure. In this situation, the patient needs assistance and the physician has indicated by his/her order that it must be performed by a skilled clinician, in which case the caregiver should be considered unable to provide the needed assistance."*

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***Home health considerations***

- Clinicians tend to shortcut this item to save visit and documentation time; however, clinician understanding of the significance of this item remains critical to accurate assessment and scoring.
- Share the Agency Patient Characteristics Report from the CASPER System with clinicians on a quarterly basis. Review critical OASIS-C score items, including the response set for each of the M2100 subset.
- Compare this response set to the national reference rate. Does your agency score lower on this response set, indicating caregiver education and training is not needed for this care?

***OASIS-C and care management drives the plan of care***

- This OASIS-C item categorizes the types of assistance needed for patient care.
- Ensure your clinicians select the scores that reflect caregiver abilities and education needs.
- Educate your clinicians to score this item based on caregiver abilities and willingness to provide this critical care item.
- Ensure the physician Plan of Care details the education and training required to support the caregiver's efforts to provide safe, reliable care.

Does your care enhance the caregiver's ability to provide safe patient care? Ensure that your agency consistently documents the education and skilled care provided to both the patient and caregiver. Capturing clinical complexity and reflecting provider skilled care is critical for accurate outcomes and provider audit risk management.

*Trish Tulloch is a Senior Consultant for RBC Limited, a national health care and management consulting firm in Staatsburg, New York. Please address all questions and comments about this article to [educator@hcanys.org](mailto:educator@hcanys.org).*

**Trish Tulloch to Present  
OASIS and Documentation Workshops on June 22**

Trish Tulloch will be presenting two half-day workshops on June 22 in Newburgh on *OASIS Best Practices: Refining Practice to Reflect Excellence* and *Clinical Documentation for Effective Risk Management*.

Sign up for one or both programs – the fee includes Trish's presentation, handouts, and lunch.

For a brochure, visit [www.hca-nys.org/events.cfm](http://www.hca-nys.org/events.cfm) or call HCA Education and Research at (518) 426-8764 and we will be happy to e-mail one to you.

## Best Practice Intervention Packages Assist Provider Care Transitions Programs

To assist providers with establishing effective care transitions programs, the federal Home Health Quality Initiative (HHQI) has developed a series of best practice intervention packages (BPIP) that include free, comprehensive tools for implementing and improving care transitions programs. The BPIPs are organized into three themes:

- Cross Setting I (Working and Aligning with Other Health Care Providers/Communication) released on October 28, 2010;
- Cross Setting II (Chronic Care/Telehealth) released on January 28, 2011; and
- Cross Setting III (Medical Homes) to be released on April 28, 2011.

All three BPIPs focus on improving care across provider settings and more efficiently managing patients in all provider settings; however, each one has specific individual goals. The goals of the Cross Setting I BPIP are to provide:

- Home care leaders with guidance for selecting best practices for improving care transitions and aligning with other health care providers to work together to decrease avoidable hospitalizations and improve quality of care; and
- Clinicians with best practice tools and resources to assist them with improving care transitions for their patients.

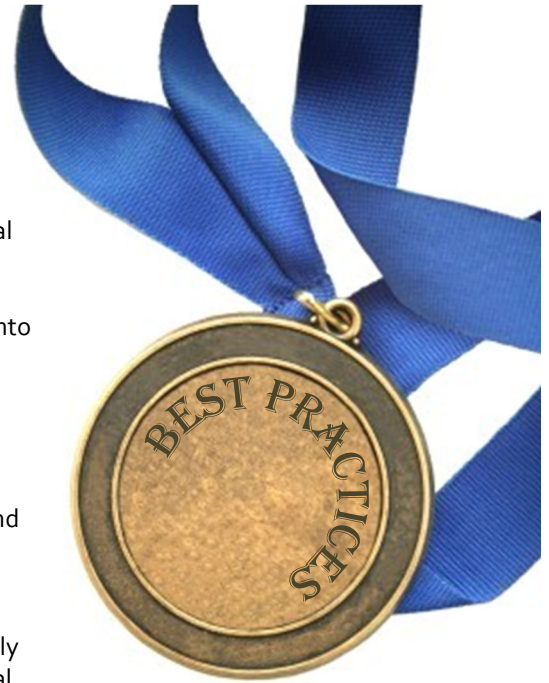
The goals of the second BPIP are to provide:

- Home care leaders with guidance for selecting best practices for improving care transitions with chronic care patients through disease management, self-care management support and telehealth; and
- Clinicians with best practice tools and resources to assist them with improving care to patients with chronic disease.

The third and final cross setting package is due to be released on April 28. It will focus on care transitions using the Medical Homes model.

The best practice materials are prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Campaign, under contract with the U.S. Centers for Medicare and Medicaid Services (CMS).

The complete packages are available at: <http://www.homehealthquality.org/hh/default.aspx>.



## Are You Connected?

By Thomas Peth

### ***Connected care – necessary to thrive***

Connected care will quickly become a necessary mindset to deliver quality patient-centered care. Agencies that are equipped to share patient information with the entire spectrum of health care providers will improve patient care and have a competitive edge, which will position them to succeed.

There is a national campaign for connected care and New York State has joined this cause with its dedication to improve the coordination of health care through the use of health information technology. In September 2010 New York State announced that \$109 million in state grants would go towards this effort.

### ***Connected care expands with health information exchanges***

The federal government granted \$548 million to enable the exchange of health information across the health care system through the State Health Information Exchange Cooperative Agreement Program. This program has jumpstarted Health Information Exchanges (HIEs) across the nation. HIEs provide a solution to transport clinical information through multiple providers and information systems. This secure approach to access and retrieve clinical data in a quick and efficient way allows physicians and clinicians to provide a high standard of care through multiple providers.

The \$109 million in New York State grants will support projects that help build health information technology infrastructure, improve delivery and coordination of patient care with a focus on mental health, long-term and home care in New York State. The funding for these grants is being provided by the state Department of Health (DOH) and the Dormitory Authority of the State of New York (DASNY) through Phase 17 of the Health Care Efficiency and Affordability Law of New York (HEAL NY) and the Federal State Health Reform Partnership (F-SHRP), which supports efforts that improve the efficiency and affordability of New York's health care system.

*"In this new world of connected care, one thing is certain: rapid connectivity, participation, coordination and communication are key to ensuring quality care transitions between providers."*

One beneficiary of the above mentioned grant is the Long Island Patient Information Exchange (LIPIX) [www.lipix.org](http://www.lipix.org). LIPIX, an independent not-for-profit corporation established to develop a Regional Health Information Organization (RHIO), was awarded \$20 million from this grant.

LIPIX is the first independent HIE to electronically transfer live data across multiple unaffiliated health care organizations in the New York metropolitan area. The organization currently works with about 25 hospitals/health care systems and has access to 3 million patient records across Nassau, Suffolk and Queens. Currently, more than 2,000 clinicians have access to the LIPIX system.

### ***Connected Care, HIEs and home care – putting the pieces together***

HCA Member Gurwin Jewish Nursing & Rehabilitation Center LTHHCP ([www.gurwin.org](http://www.gurwin.org)), located in Commack, NY, will soon experience the benefits of connected care via its electronic medical record (EMR) technology and LIPIX.

Gurwin has been in operation since 1997 and serves about 125 home care patients throughout Suffolk and Nassau counties. In order to consider partnering with a Health Information Exchange (HIE), Gurwin first needed to implement an EMR system that supports data exchange to an HIE. In 2008, Gurwin selected Thornberry Ltd ([www.thornberryltd.com](http://www.thornberryltd.com)) as its technology partner and rolled out the company's EMR software NDoc®. They selected NDoc® based on its robust clinical functionality and its rapid information exchange technology, NCompass.

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As Gurwin was establishing its new EMR system, LIPIX was gaining momentum. The HEAL NY-Phase 17 grant encouraged LIPIX to focus on educating home care agencies on the advantages of its health information technology infrastructure and the benefits for delivery and coordination of patient care. Gurwin quickly recognized the capabilities of LIPIX and the advantages it would offer their agency.

Gurwin is working with its EMR partner, Thornberry, to develop an interface to easily exchange information with LIPIX. According to Joanne Parisi, Chief Information Officer for Gurwin Jewish Nursing & Rehabilitation Center, the expected benefits include improvements in efficiency, automation, quality of care and patient safety.

“The transition of care will be drastically enhanced; Gurwin staff will have immediate access to patient information such as testing, lab results and other pertinent information. This will provide our clinicians with accurate patient health information and save dollars on performing unnecessary repetitive tests. LIPIX will also be able to automatically inform our staff when a patient has been admitted to the hospital. We believe these benefits along with others will improve patient quality of care as well as increase agency efficiency,” said Joanne Parisi.

In this new world of connected care, one thing is certain: rapid connectivity, participation, coordination and communication are key to ensuring quality care transitions between providers; a crucial adjunct to that effort involves agencies choosing an EMR system that can achieve tight integration, enabling connectivity to the entire health care continuum. Home health and hospice organizations must critically examine their ability to connect to the full continuum of care – or risk being unable to compete in the marketplace.

*Thomas Peth is the President of Thornberry Ltd., creator of NDoc® home care and hospice management software. Thornberry will be exhibiting at the upcoming HCA Annual Membership Conference on May 22 to 24. Visit them at booth No. 4.*

## **Gold STAMP Program Announces Additional Regional Meeting Dates**

The Gold Stamp Pressure Ulcer collaborative has announced dates and locations for two additional regional meetings:

**Binghamton – Thursday, June 2, at Our Lady of Lourdes Memorial Hospital Home Care**

**Stony Brook – Tuesday, June 28, at Stony Brook University Medical Center Hospital/Nassau Suffolk Hospital Council/ GNYHCFA.**

Registration information will be sent out to providers as soon as it is available. The Program has also updated its resource guide, available at: <http://www.hca-nys.org/documents/GoldSTAMPResourceGuide031711.pdf>.

The Gold STAMP Program to Reduce Pressure Ulcers in New York State is a coalition of organizations convened to provide resources and education across the continuum of care in New York State in order to improve the assessment, management, and prevention of pressure ulcers. Gold STAMP stands for “Success Through Assessment, Management, and Prevention.”

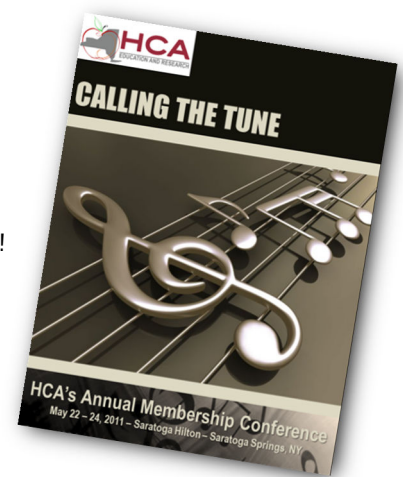
For more information, contact Lexi Silver at (518) 810-0658 or [asilver@hcanys.org](mailto:asilver@hcanys.org).

## Clinicians, Educators, Performance Improvement Staff will be Rock Stars after Attending HCA's Annual Member Conference in Saratoga Springs

The HCA Annual Conference is just around the corner, on May 22 to 24, and you are invited!

HCA's Annual Conference offers several learning opportunities for home health agency leaders, clinicians, educators, performance improvement supervisors and managers as well as other staff supporting those roles. Included in the three days of education, participants will hear from nationally renowned presenters and state policymakers as well as learn about new products and services from nearly 50 vendors.

The knowledge you will gain from networking with your peers will also prove to be invaluable as your share ideas and explore new opportunities. Also included in the discounted registration fee for members (see special offer later in this article) are several meal functions and world-class entertainment.



### ***Newly added sessions focus on state budget aftermath***

With the enormous impact of New York's state budget on the mind of every home health agency leader across New York, HCA has invited policymakers responsible for developing the state's health care budget to provide an overview of the direction for home health – an important recent addition to the conference program.

HCA aims to help you get the answers you need on what this budget means for your operation and the patients you serve. As new information emerges related to this extraordinarily complex and system-changing budget, and as implementation of the new legislation unfolds, it will be necessary for agencies to continue to focus on the quest to capture every reimbursement dollar through greater efficiencies, proper documentation and audit-readiness. To support you in those efforts, HCA is pleased to offer a free pre-conference workshop and several breakout sessions that will expand your knowledge in these areas.

In a special pre-conference session, Outcome Concept Systems, Inc. (OCS) will have their Director of Education, Sue Blockberger-Miller, MSN, RN, and their Director of Program Management, Roger Herr, presenting a complimentary two-hour workshop on *Using Data to Improve Your Performance*. This workshop will help you develop a solution-based roadmap to improve your organization's performance using a wide range of home health quality data.

### ***Spotlight on federal issues, Medicare***

HCA is also very pleased to be joined by Arnie Cisneros, PT and President of Home Health Strategic Management, who will present a workshop on *Succeeding with 2011 Home Health Changes*. Mr. Cisneros, a popular presenter at several HCA education programs in the past, will show you what protocols need updating to improve clinical outcomes and productivity under the 2011 Medicare regulations.

With audits expected to intensify under the Patient Protection and Affordable Care Act, particularly in the areas of fraud and system integrity, all agency leaders must become better attuned to compliance target areas, find ways to eliminate risks, and create greater efficiencies. Presenter Patricia Tulloch, RN, BSN, MSN, HCS-D, a Senior Consultant with RBC Limited, will share her expertise and provide useful take-aways for attendees to address audit concerns. (See Ms. Tulloch's column in this month's edition of *The Educator*.)

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### **Teambuilding, leadership, communication**

Whether you are an executive, supervisor, manager or someone just beginning to climb the career ladder in home health, you will have an opportunity to enhance your teambuilding, communications and leadership expertise through several exciting sessions at this year's conference, including a fun program that will take you on an adventure in making music. More information on this session will be provided at the conference – please be assured, you won't want to miss it!

Also, on the last day of the conference, attendees will continue to enhance their leadership potential through *Emotional Eloquence: The Lost Language of Leadership*. During this session, international presenter Doug Stevenson will show you how to motivate your team or persuade others, all through the art of storytelling – a skill that can be used on the job, at home or in your community.

Based on conference evaluations over the years, one of the top reasons why members attend the HCA Annual Conference is the opportunity to learn from their peers through the many networking events planned throughout the conference. In visits over lunch, during breaks and at receptions, HCA's Annual Conference is a perfect place to share ideas and experiences, find solutions to problems, and relax with new friends and old.

Much akin to the conference theme – “Calling the Tune” – you are sure to be a rock star in writing a new songbook for your organization through the knowledge you gain at HCA's Annual Conference.

And, as a special bonus, subscribers to *The Educator* and their staff are welcome to continue taking advantage of the early-bird rate – which has already expired, on April 21 – by adding the word “EDUCATOR” next to the total on your registration form. Sign up today!



### **Ready to shop?**

Where else can you test out a new technology, discover ways to make your operation more efficient, enhance patient care, augment staff productivity and more, all under one roof? HCA's Annual Conference uniquely provides a forum for you to take advantage of one-stop shopping, explore new ideas, and interact with your peers about your successes with various products or services. HCA is grateful to the nearly fifty vendors who have committed to attend the Annual Conference in support of existing clients and introduce themselves to potential clients in a fun, festive atmosphere.

One great supporter of home health care and the 2011 Annual Conference is Sandata Technologies. Through their generous sponsorship and exhibitor support, Sandata aims to inform members of their services to streamline agency operations including scheduling, billing, reporting, tracking, payroll, and accounts receivables. Sandata will be at all of HCA's signature events in the coming months as well.

Joe Prasad, Vice President of Government Services at Philips, and his team have also been longstanding

supporters of HCA. Each year they provide the latest in technologies to support patients in their homes as well as save staff time. At this year's conference, Philips will be displaying Philips Home Monitoring Solutions, including Telehealth, Lifeline, Lifeline with Auto Alert, and the Philips Medication Dispenser. Mr. Prasad says: “The HCA Annual Conference is a must-attend event that offers a rich networking and learning experience.” On behalf of the members, HCA wishes to thank Philips for hosting the first night's reception at the Annual Conference as well.

In addition, Mobipen is a new technology that will make its debut at the conference. The Mobipen allows you to transmit handwritten data from paper directly to the IT system of your home health agency. Amazing!

HCA wishes we could highlight every new technology and timesaving or patient care service vendor who will be in attendance at this year's conference, but we hope you will view the entire list of exhibitors on HCA's website at <http://www.hcanys.org/anconf.cfm> to help you make your list of what vendors to meet with before you attend as well as to find links to each vendor's website.

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Also, during lunch on May 23, conference attendees will be able to hear a series of brief two-to-three-minute presentations in our "It's Just Lunch" exhibitor showcase. Patterned after the popular dating service by the same name, attendees will get to interview and learn more about an exhibitor's product or service over lunch. Then, after five minutes, a new vendor will step up to the table, for its interview. Come with your questions and have your business cards handy for the great raffle prizes vendors are offering. There will be plenty of time for networking with your peers during this showcase, too.

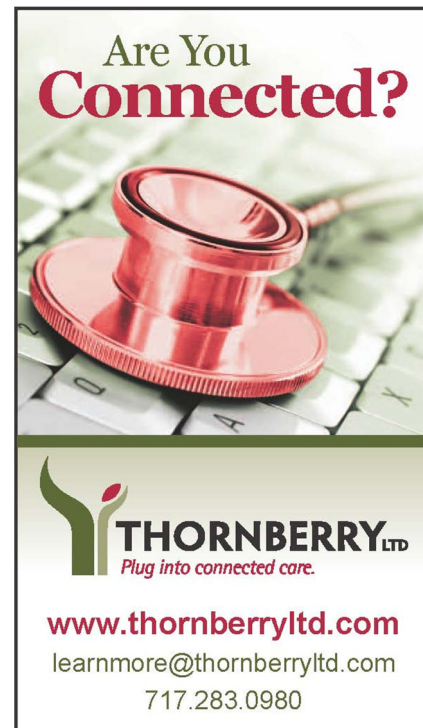


HCA appreciates the support of our vendors and generous sponsors whose contributions make it possible for HCA to offer an event that is both informative and affordable to members. Please share your thanks to them when you attend the conference. Sign up today, and take advantage of the special rate to subscribers of *The Educator*.



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## Education Update

### *Scheduled Learning Opportunities*

May 3 – Webinar – Dr. Jo Manion

**Creating Commitment in Your Workforce – Appreciative Leadership Series**

May 10 – Teleconference

**Infection Control Practices for the Hospice Aide**

May 24 – Webinar – Dr. Jo Manion

**Cultivating the Leadership Relationship – Appreciative Leadership Series**

May 22-24 – Saratoga Springs

**HCA Annual Membership Conference – A Signature Event**

June 1 & 2 – Mount Kisco – Sparkle Sparks, OASIS Answers

**The Art of ICD-9-Coding – Intermediate and/or Advanced**

June 14 – Webinar – Dr. Jo Manion

**Communication for Strategic Success – Appreciative Leadership Series**

June 15 & 16 – Albany

**Blueprint for OASIS Accuracy – COS-C Exam on June 17**

June 22 – Newburgh (two half-day programs) – Patricia Tulloch, RBC Ltd.

**OASIS Best Practices: Refining Practice to Reflect Excellence Clinical Documentation for Effective Risk Management**

July 20 – New York City – Tim Ashe, Fazzi Associates

**Supervision/Plus™**

July 20 – New York City – Tim Ashe, Fazzi Associates  
**Supervision/Plus™**

August 16-17 – Bayside

**Blueprint for OASIS Accuracy – COS-C Exam on August 18**

*September 13-14 – New Paltz*

**HCA Senior and Financial Managers Retreat**

September 15 – Webinar – Patricia Tulloch, RBC, Ltd.

**ICD-9-CM Code Updates: Prepare Now for Required Fall Changes**

September 22 – Albany – Arnie Cisneros, Home Health Strategic Management

**Strategies and Tools for Rehab Programming and Documentation**

*September 27 – Nanuet – Patricia Tulloch, RBC Limited*

**ICD-9-CM & OASIS Coding Back to Basics and Beyond HCS-D Exam – September 28**

*November 2-3 – Troy*

Quality & Technology Conference – A Signature Event

Visit [www.hcanys.org/events.cfm](http://www.hcanys.org/events.cfm) for weekly updates on learning opportunities. (Brochures are available for programs in bold.)

For more information on any of these webinars, programs or events, contact Lynda Schoonbeek at (518) 810-0656 or email her at [lschoonbeek@hcanys.org](mailto:lschoonbeek@hcanys.org).

## Submitting an Article

*Interested in submitting an article for an upcoming issue of **The Educator**?*

The editors are looking for non-commercial articles on topics that inform readers about ways they can save time and money and enhance patient care at their organizations.

### Submitting an Article Idea

Please fill out an article submission form prior to writing your piece. If your idea is selected, we will provide you with the guidelines for preparing your article. Just contact us at [educator@hcanys.org](mailto:educator@hcanys.org) to receive the submission form, and you could be headed toward achieving recognition as one of our authors.

### Placing an Ad

To reach HCA members about a product, service or potential employment opportunity, we invite members, associates and friends to place advertising in this publication. Just contact us at [educator@hcanys.org](mailto:educator@hcanys.org) or Lynda Schoonbeek at [lschoonbeek@hcanys.org](mailto:lschoonbeek@hcanys.org). In keeping with our educational mission, all advertising monies will go towards scholarships for HCA member employees who want to further their career education in home health. Scholarships will be awarded at the HCA Annual Conference on May 22-24 in Saratoga Springs.

### Submission Deadline

The deadline for submitting article ideas and advertising in the next issue of **The Educator** is: **May 15.**

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