

# the Educator



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*HCA talks with the winners of our Home Health Aide and Telehealth Nurse Champion awards to hear more about their stories of service to patients.*

## Promoting Excellence through Patient-and Family-Centered Care

By Tara LoCastro

Patient-and Family-Centered Care (PFCC) is not a new concept but one that continues to emerge as health care providers across the continuum seek to find new ways of engaging their constituents and ensuring patient satisfaction.

In the wake of health reform, patient satisfaction is more than just “the right thing to do.” Measurement of patient satisfaction will be one of the defining methods to determine how providers fare under Pay-for-Performance. PFCC – a system-wide transformation initiative being pursued by several large health systems across the nation – will be an important tool for providers in this new health care environment.

The Visiting Nurse Service (VNS) of Rochester and Monroe County, Inc. readily adopted PFCC as part of its affiliation with the University of Rochester Medical Center, which is embarking on full integration of PFCC principles, values and expected behaviors to continuously improve its patient care and service delivery. As an extension of this effort, VNS created a PFCC structure to formalize its commitment to

patient satisfaction and to make targeted improvements to enhance care services.

While there are various definitions and adaptations, PFCC is described by the Institute for Patient & Family Centered Care as:

an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. It redefines the relationships in health care. Patient- and family-centered practitioners recognize the vital role that families play in ensuring the health and well-being of infants, children, adolescents, and family members of all ages. They acknowledge that emotional, social, and developmental support are integral components of health care. They promote the health and well-being of individuals and families and restore dignity and control to them.

For more information, see <http://www.ipfcc.org>.

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PFCC is a differentiator for VNS in the local home care market. While this effort requires an investment of time and resources, it is a key component of the agency's strategic plan and community outreach efforts. PFCC has been integrated into several internal communications and marketing materials to reinforce that VNS is committed to this heightened level of engagement and partnership with its patients and families.

For example, VNS created a "PFCC ICARE Plan" which is an opt-in information summary that will be offered by case managers to new and existing patients and families. This simple form gathers non-clinical "person-centered" information that helps the provider get to know the patient as a person, not just their condition.

This simple method has proven to be a great success with extremely positive feedback from patients and families. Remarks such as "Thank you for taking time to care and to consider these things" affirm that this simple act of interest promotes the scope of caring we strive to provide.

Furthermore, many hospital systems have created an individualized Patient Advisory Council to directly engage patients and/or family members for feedback and partnership to improve their experience. This type of forum changes the dynamic by bringing stakeholders (staff, customers and/or patients and families) to the table for input on decisions or activities being pursued by the provider. VNS is proud to be one of the very few, if not the only, home care provider to have created an active Council in 2011.

PFCC is a means to promote the understanding and sensitivity required of health care providers in serving any community. It engages the person and seeks to include family for information, decision making and care needs. This approach considers the unique needs and preferences of the individual and their family, recognizing that health care is very much a two-way street.



*Pictured above are a few of VNS of Rochester and Monroe County's PFCC members, including: (back row, left to right) Loretta Murawski, Cindy Gleichauf, Ellen Avery, HCA Board Member and VNS President and CEO Vicky Hines, Margarete Michael-Ralston, as well as (front row, left to right) Carol Belluccio and Tara LoCastro, article author.*

*Tara LoCastro is Director of Patient Centered Care Initiatives at the Visiting Nurse Service of Rochester and Monroe County.*



## Using All the Right Words – And Actions – to Comfort Patients at Home

*HCA talks with the winners of our Home Health Aide award to hear more about their stories of service to patients.*

When Home Health Aide **Parbatie Dowlath** told her client that she had recently won an award, the patient struggled to find the right word to congratulate her.

For this patient, “congratulations” was no ordinary word. The effort it took to sound out just the first syllable alone represented an important milestone. It was also a symbol of the powerful bond which had formed between the patient and her caregiver.

Two years ago, the patient (who we will call Caroline) suffered a cerebral vascular aneurism resulting in loss of speech. The 51-year-old woman now receives services through South Nassau Communities Hospital’s Long Term Home Health Care Program (LTHHCP), including the care provided by Ms. Dowlath, who has developed a special kind of unspoken communication with Caroline.

Caroline has an Alphabet Sheet with rows of letters that she will often point to as a means of expressing herself. From these visual cues, Ms. Dowlath surmises what each letter might signify – be it a request, an answer, a question or an observation from Caroline.

As time has passed, “[Caroline] has been learning to say some more words and she is doing so much more now,” Ms. Dowlath explained about Caroline’s progress. A friendship has formed between the two, a bond which became all the more important when Caroline’s daughter had to move away, leaving Caroline alone in a small apartment.

Communication is a critical part of the interaction between patients and caregivers. With elderly clients especially “you always have to have a smile on your face,” Ms. Dowlath explains. “And you never say ‘no,’” at least not in the explicit sense of the word.

This affirmative approach is evident in Ms. Dowlath’s work with another client, who suffers from dementia. Ms. Dowlath says the patient frequently insists that she wants to “go downtown, but in her area, there is no downtown.” To ease the patient – and help, in some small way, to honor her request – Ms. Dowlath will offer

instead to walk with her down the stairs from her home, take a stroll around the block, have a chat, and then head back home.

“It’s a very rewarding job in the long run. I like the challenge,” Ms. Dowlath added when asked about her reaction upon receiving HCA’s Home Health Aide Award in November. “Whatever you do, though, you have to have a sense of humor ... and treat the patient like you would want to be treated.”



**Parbatie Dowlath**, Home Health Aide at South Nassau Communities Hospital Home Care, and winner of HCA’s 2011 Home Health Aide Award.



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**Geraldine Davis,**  
Home Health Aide at  
HHH Home Care Inc.,  
and winner of HCA's  
2011 Home Health  
Aide Award.



**Geraldine Davis** has a similar view of how to approach patient care in her work as a Home Health Aide, where communication and compassion are twin assets that she relies upon daily.

"With people who are sick, the best thing to do is keep a smile on their face, tell them jokes," she says; or, if a patient is noncompliant, "help them think that they came up with the answer on their own" for how they can improve their health or make the right decisions.

Ms. Davis was presented with HCA's Home Health Aide Award this past November in part for her work assisting an elderly couple from their entry into home care to the transition to hospice, all the while offering support to the surviving family, with whom she still keeps in contact.

"In the beginning, they both worked together, were really there for each other," Ms. Davis said about the couple. The wife played piano. To maintain a routine for the couple, particularly while Ms. Davis was preparing their meals, she would encourage the wife to play songs on the piano to "exercise her fingers" as her husband sang.

"But as they got older, they really needed more care," she added.

Ms. Davis described how she would often make the husband chocolate milkshakes with Ensure to help him maintain his weight and provide for adequate nutrition. "When introducing new foods [to a patient], I'll always blend it with something else that they like," she said.

For this couple, one of the most important gifts that Ms. Davis provided was continuity: the husband and wife were able to remain together in their home and transition together through the different levels of care.

But their case isn't the only one where Ms. Davis has maintained a lasting presence. Now she is caring for a 99-year-old patient who recently had to enter a nursing home. Ms. Davis assisted the woman when she was in home care and will continue to do so in the nursing facility. "The family said they wanted me to care for her in the nursing home," Ms. Davis explained.

Caregivers like Parbatie Dowlath and Geraldine Davis provide exceptional care every day, and HCA is proud to recognize them and their peers during National Home Care Month.

To learn more about Ms. Dowlath and Ms. Davis, please see HCA's award program bios at <http://www.nationalhomecaremonth.com/2011HomeCareMonthAwardsProgram.pdf>.

## Six Questions with Telehealth Nurse Kathleen Salvaterra, RN

*In an interview with The Educator, HCA's Nurse Telehealth Champion of the Year Award Winner offers insights on how to develop and maintain a successful telehealth program*

In November, as part of National Home Care Month, HCA recognized **Kathleen Salvaterra, RN**, of the Visiting Nurse Association of Central New York, with our Nurse Telehealth Champion award. The award recognizes a nurse who has been instrumental in implementing home care technology with proven results in improved quality of care and who has served as a role model for others in furthering telehealth.

This month, the *Educator* caught up with Ms. Salvaterra and asked her some questions to gain insights on the successes of the VNA's telehealth program and to help illuminate ways that other providers can develop or enhance a telehealth program.

To learn more about Ms. Salvaterra, please see HCA's award program bios at <http://www.nationalhomecaremonth.com/2011HomeCareMonthAwardsProgram.pdf>.

### 1 Tell us about your reaction in learning that you were nominated to receive HCA's Nurse Telehealth award? What does receiving this award mean for you?

*I was honored that the administrative team at the Visiting Nurse Association of Central New York thought enough of my work and the entire program to nominate me: to me that was as good as winning the nomination. To know that your efforts and the program matters to the company is rewarding in and of itself. Receiving this award was actually the biggest honor of my working life. I realize it takes the consistent work and attention of the entire telehealth team, the support of administration, as well as collaboration with the physicians in the community, the nurses in our agency, and our patients to make the program successful.*



### 2 In what ways has home telehealth been most effective for the health outcomes of patients served by the VNA? Specifically, does a particular type of patient or clinical situation benefit most from this technology?

*It is our belief at the VNA of Central New York that every patient can benefit from telehealth, from whatever clinical situation they are in or whatever level of care they are in need of.*

*Whether it is the generally healthy adult with a one-time injury, such as a knee replacement or hernia repair, telehealth allows patients to get to know themselves a little better and increase their awareness in how their diet, pain levels, medications and activities affect their well-being. These patients are usually on the service for a very short period of time.*

*Then we have patients with a new diagnosis of diseases, such as diabetes, COPD or CHF, who require a lot of initial teaching and monitoring. Telehealth is a tool that helps confirm what they are learning about their disease and the telehealth nurse is a partner with the in-home clinician teaching the same education. Often these patients are on a new medication regime and telehealth is useful in monitoring how the patient is tolerating and/or adhering to his or her medication schedule.*

*And, of course, there is the patient that requires chronic disease management where telehealth is the tool that helps clinicians manage the patient's symptoms and disease process by intervening and collaborating with physicians and the home clinician to keep the patient within his or her own parameters and keep the disease controlled.*

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**3 What have been/are some of the biggest challenges you've encountered in developing the VNA's telehealth program?**

*Probably the biggest challenge has been the buy-in of the home care case manager, the physician, and the patients themselves. What we have found that works the best is to utilize what telehealth can do for each specific group to make their lives easier and consistently demonstrate the benefits to them. We work with the case managers by supplying them with information and trends about their patients and collaborate with them in making physician contact. In reporting to physicians, we give specific trends and not just a one-time reading. We use SBAR reporting to be clear about what is occurring and what we are requesting. And with the patient, we provide comfort in knowing that someone is monitoring them, providing assistance and information to promote independence.*

**4 Can you provide an anecdote/case-scenario about a patient who showed excellent improvement in health management as a result of home telehealth? What factors contributed to this patient's success?**

*We have a current patient admitted with new CHF, Stage 2, who was put on numerous new medications by the cardiologist – a diuretic, ace inhibitor, angiotensin II receptor blocker (ARB). About a week after being home from the hospital on these new medications, the patient developed a symptomatic blood pressure of 82/66. The patient was short of breath and had extreme fatigue. On the day this occurred, the cardiologist was contacted and the diuretic and the ARB was discontinued. Telehealth worked closely with the in-home case manager and physical therapist, and, over a few days, the patient started to gain fluids again and have increased edema. The cardiologist added a beta blocker daily and a diuretic every other day. The patient is doing very well currently. These important medication changes occurred without the patient going back to the emergency department and without a home care nurse visiting every day. Telehealth continues to monitor for changes and communicate with the patient, physician and case manager about the patient's symptoms.*

**5 What three pieces of top advice do you have for other home care organizations that are just starting to implement or are considering starting a home telehealth program**

- 1. The Administration needs to be completely involved in the setting up of the program and processes. Decisions as to what patients will be targeted and who will install the monitors are important decisions. Start small and build.*
- 2. The telehealth nurse is pivotal. He or she should be positive and able to communicate well with all parties involved.*
- 3. Don't be discouraged by poor initial buy-in by all – this is a change to the status quo and takes explanation and demonstration as to how it will benefit the user.*

**6 Your award nomination mentioned the VNA's Heart Smart program. Can you tell us more about this program and the role of home telehealth in it?**

*Any patient that is admitted with the primary or secondary diagnosis of CHF is admitted into our Heart Smart program. A Heart Smart nurse, who has specialized training in CHF, is assigned as case manager. This nurse carries the extra tools of a cardiac stethoscope and oximeter and understands the physiology of cardiac medications. The patient also has an evaluation from a Physical Therapist for strengthening and increasing cardiac endurance; an Occupational Therapist for energy conservation; a Registered Dietitian teaching low sodium, low cholesterol diets and food choices as ordered; and the patient is put on telehealth to monitor his or her progression. All team members work together to educate and promote maximum function and to keep patients out of the hospital. This program was developed as we saw the rise of rehospitalization rates of our CHF patients and have found a significant reduction in those rates since using this program.*

## 2012 PPS Updates: Planning for Upcoming Changes

By Trish Tulloch

CMS posted the Final Rule for the Home Health Prospective Payment System (PPS) on October 31, 2011 to take effect January 1, 2012. In it, CMS reduced episodic payment rates, recalibrated the case mix weights for the four-equation model, and provided detail for several other changes as well.

An agency's success with the revised PPS model hinges on a clear understanding of the clinical revisions.

### *Hypertension code changes*

Two hypertension diagnosis codes will no longer be designated as case mix in the 2012 PPS model. This revision was finalized after a second year of study which indicates the diagnoses of non-essential hypertension (401.9) and benign hypertension (401.1) do not require additional care resources. The impact of this change may adversely impact clinical domains, case weights and agency episodic reimbursement.

According to the research, hypertension prevalence more than doubled between 2005 and 2008. CMS indicates that the increase was not associated with a statistical increase in care and resources, contending that the elimination of these two hypertension codes is necessary to address nominal case mix changes in the home care industry.

CMS, however, has maintained the case mix status of other hypertension codes that specify etiology or associated co-morbidity. It is important for agencies to ensure that clinical staff and agency coders understand the mandates regarding the accurate selection and reporting of **all hypertension codes**. Providers can capture a range of \$130 to \$730 per episode when hypertension is coded accurately.

### *Other case mix changes*

Case weights of other designated case mix diagnoses have been re-calculated as well. Common home health diagnoses, including neoplasms and depression, have been assigned changed case mix status in the four-equation model.

Therapy remains on the "Hot Seat" in 2012, as audit entities continue to explore low and high therapy red flag indicators that impact medical necessity and accurate allocation of Medicare reimbursement for therapy services. Agencies should take note of these changes, as reimbursement for therapy thresholds has also been revised to decrease incentives for what CMS indicates is "unneeded higher therapy services."

*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 or other topics you'd like addressed to Trish at [educator@hcanys.org](mailto:educator@hcanys.org).*

### *Prepare now to succeed in 2012*

Agencies should **ensure that leadership and staff have the essential tools to succeed with the 2012 PPS updates**. Here are some tips to help your agency succeed in 2012:

Read the Final Rule at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-04/pdf/2011-28416.pdf>.

Ensure clinical staff and leadership discuss and apply the 2012 PPS updates by participating in **HCA's 2012 PPS Updates Webinar** scheduled for December 13, 2011. (A brochure is available at [www.hca-nys.org/events.cfm](http://www.hca-nys.org/events.cfm)).

Visit RBC Limited's website at <http://www.rbclimited.com/education.php> to review other programs and services that will enhance your success with these critical 2012 updates.

## Tips to Prepare You and Your Patients for the Winter Months

With winter right around the corner, it's important that home care staff prepare in advance to protect themselves and their patients before the snow and ice hit the ground.

Caregivers should take heed of important tips for all travelers during winter months by: making sure you always have at least a half-full tank of gas; keeping the essential fluids in your car full; ensuring a fully-charged cell phone and using a cell phone charger that plugs into your car's cigarette lighter; making sure someone knows your route and schedule; and signing up for NY-Alert or local emergency messaging services. It is also a good idea to keep a winter driving kit at hand in your car.

Winter can be especially hard on vulnerable patients at home, and several proactive steps should be taken to ensure that they are prepared, especially if access is impaired by unsafe driving conditions. Here are some tips:

- Ensure your patients have adequate heat sources. Check on heating assistance programs in your area, such as the Home Energy Assistance Program (HEAP): <http://otda.ny.gov/programs/heap/HEAP-contacts.pdf>.
- Keep an eye on portable heaters for proper functioning, and make sure these units are kept away from furniture, curtains, clothing and other possible flammable items. Also, check the electric outlets to make sure that they are not overloaded or plugged into an extension cord, causing a possible fire hazard.
- Make sure the patient has working smoke and carbon dioxide detectors in the home.
- Call patients daily during especially cold weather to ensure they are safe, warm and dry.
- Reinforce with patients the need to keep medications on hand so as to never run out in case bad weather prohibits travel.
- Encourage patients to keep on hand some bottled water, flashlights, batteries and foods that do not need to be cooked, in case severe weather limits their ability to leave home or the ability of caregivers/meals on wheels to reach patients.
- Make sure your patients know about warming centers and shelters and know how to access transportation to a shelter should they need one in case of a power outage.

By following these common-sense tips in advance, you can help ensure a safe winter season for you and your patients.





## Education Update

### *Education Opportunities to Support You in 2012*

Are you and your staff preparing for policy, operational and clinical changes that may affect your organization in 2012? HCA supports your efforts through several useful upcoming education programs. Registration for each of these programs is at [www.hca-nys.org/events.cfm](http://www.hca-nys.org/events.cfm).

Here's what's in store:

- **HCA Regional Briefings.** In December, HCA is holding three regional Member Briefings throughout New York State to provide in-person updates and to discuss regional issues affecting providers. The sessions include meetings on **December 1 in Patchogue** for the Long Island region, **December 2 in Manhattan** for downstate members, and **December 14 in Syracuse** for members in upstate New York.
- With the approaching state legislative/budget cycle, HCA's Member Briefings are a vital opportunity for HCA staff to visit and discuss these issues with you in your region. These members-only sessions allow for a two-way exchange of information and perspectives about the state and federal budget landscapes, recent and pending actions of the state's Medicaid Redesign Team (MRT), HCA's policy and advocacy initiatives, and any local issues that may be affecting providers. There is no charge for members attending HCA's briefings, but members must register in advance.
- **PPS Update for Home Health — Prepare Now to Succeed in 2012.** This program, brought to you by webinar on **December 13** from 10 to 11:30 a.m., will provide the nuts and bolts of the final 2012 Home Health PPS updates that most impact agency success.
- **Educational Teleconferences for Hospice Aides.** HCA is pleased to offer the following teleconferences that will benefit the hospice aide:
  - On **December 13, 2011**, HCA offers *Patient Centered Care for the Hospice Aide*. Learn what patient centered care is, how to improve your practice by providing patient centered care and what the advantages are.
  - On **January 10, 2012**, HCA offers *Top 10 Resolutions for Excellence in Aide Performance*. At the beginning of the year, many people make resolutions to improve some aspect of their lives. This presentation will discuss resolutions that could help you improve or maintain excellence in your work area.

**Please also mark your calendars for HCA's signature events designed expressly for members:**

- May 9 to 11: HCA's Annual Membership Conference – Saratoga Springs
- September 12 to 13: HCA's Senior and Financial Managers Retreat – New Paltz
- November 7 to 8: HCA's Quality and Technology Conference – Location to be announced soon.



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## 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: **January 15.**

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