**Nebraska Home Care Association Listening Tours Summary**

* ***Advocacy:***Emphasized the importance of members collecting and telling stories of how they provide care to patients, keep them at home, avoid rehospitalization and allow them to remain independent and receive quality care and services. The more members the association has, and the more engaged members are, the stronger the Nebraska Home Care Association’s voice can be in advocating for home care patients. A strong voice can continue to advocate for increases in Medicaid reimbursement rates and other issues.
* ***Electronic Visit Verification (EVV)***: One agency currently uses EVV. Employees clock in with GPS and have to be within so many feet of the patient’s residence. Clinical team charts at the end of the shift. The information automatically downloaded into the system and sends a notification. Staff clocks in and out with photos. Patient signatures are collected. Nebraska DHHS hasn’t decided if patient signatures will be required. If the patient can’t physically sign, HHA staff can verify the shifts with the patient. Agency employees access the EVV software like an app and login with a username and password, which is protected by employees. If the patient can’t physically sign, then they verify the shifts with the patient. A W-2 is used since some home health aides work for multiple agencies.

V2Verify representatives attended the Omaha and Lincoln listening tours. They’re an associate member. V2Verify offers a biometric component that allows the verification to be done through a voice. The employee calls into a bridge if they don’t have a mobile phone. Agencies can track and verify that it’s the staff. They can also onboard patients through voice identification and verification. Real-time notification is provided when the provider arrives at the patient’s home. A notification can be sent out family when the provider arrives and leaves the patient’s home.

One provider would like to integrate their EVV system into invoicing and payroll and separate private pay clients and waiver clients. The provide is using the caregiver’s tablet or phone. If they don’t have one, they call from the client’s landline. One agency is getting a new EMR that will have the ability to enter data in a tablet without Internet access. It will run on the data plan for the phone It should take less than one gigabyte to run on a tablet each month.

* ***Recruitment and retention*:** It’s an ongoing challenge. Providers in Omaha identified a growing need for home care services and opportunities for providers. Find the right personality to fit the patient’s care and needs. Compensation is a challenge. If agencies could pay a CNA more than $12 an hour, it would help with their transportation and vehicle maintenance. One agency requires staff to work a certain number of hours a week to be eligible for PTO and holiday pay, insurance and 401k with a match.

One agency does a precept program and paid summer internships with the UNMC nursing program.
* ***Patient compliance:*** There are ongoing challenges with getting patients to focus on their care plans and what they’re being asked to do to improve. Some patients call the ER instead of their HHA. Some agencies have face to face huddles with therapists and nurses, care conferences and case conferences to discuss patient care and needs. There are EMR providers that will provide educational materials that can be given to the patient.
* ***Healthcare needs and issues:*** Agencies seeing more patients with diabetes, malnutrition, dementia and Alzheimer’s.
* ***Authorization of patient visits:***There’s a challenge with visits only being authorized for two hours for home health visits, but patients need more time for services and support. The MCOs are cutting the number of hours and think the CNA is covering the care and the patient doesn’t need as many nursing hours. There’s a concern that DHHS wants to push patients to waiver. The patient can’t find a caregiver through PAS or CHORE at the quality the patient needs.

Nebraska Total Care visits the patient in the home and audits them to see if they need home health services and is trying to push patients to fewer respite hours or waiver, particularly for children. Nebraska Total Care cut authorizations to 56 hours of respite. Waiver doesn’t cover nursing hours. There are issues with reducing services for children on trachs and vents that require high tech visits. One agency serving children is concerned that when the children age out, they don’t have other resources to receive private duty services.

Build a campaign that makes it easy for patients and their families to tell their story to lawmakers. Patients need to understand their choices for waiver, home health, long-term care and insurance.
* ***Blue Cross Blue Shield*:** The CEO indicated that 30% of their costs come from hospitals and long-term care. There’s a push to direct beneficiaries to home and community based care. Blue Cross Blue Shield needs more education about the services. Blue Cross is requiring homebound status for coverage of home health services.
* ***Reimbursement for telehealth services****:* DHHS isn’t adjudicating the claims for remote telemonitoring for Medicaid. An agency is still waiting to be paid for claims.
* ***Medicare Advantage*:** The plans are challenging because they reimburse agencies less than the Medicaid reimbursement rate. Hospital discharge planners are complaining that they can’t find providers to accept the Medicare Advantage plans. It doesn’t cover the cost of visits. For example: cost is $130 per visit and Medicare Advantages reimburses $60 per visit. They’re cutting the length of stay, which drives patients back to the hospital. A Medicare Advantage patient had to go to a wound care facility to get care. They wouldn’t cover it through home health.
* ***Eastern Nebraska Office on Agency (ENOA)*:** concerns that they are directing patients to certain providers, instead of explaining patient choice and sharing a list of providers. How can we better educate families on patient choice and their rights? How can they be advocating for themselves when they don’t know what their options are? Non-medical providers indicated that that they’ve seen a list given to clients from Aging Partners with a star next to certain providers.
* ***Physician Education:*** Some physicians refuse to sign face to face documentation or won’t do home health referrals because of the F2F requirements. Work with patients to see their physician immediately following hospital discharge. One agency uses the referral date as the last date they received documentation from the physician. Continuation orders after the start of care is an issue. Physicians need education that the continuation orders are required from every discipline in order to continue services in the patient’s home. Hospitalists can do the face to face and enter it into the hospital system. They can also call a community physician to sign the face to face. It’s taking multiple weeks to get the doctors to review, sign and return in some areas. Call the physician’s office and ask if they will accept the referral on home health orders before admitting the patient. Submit the F2F and documents as an addendum to the certification to help get it approved.
* ***Patient referrals*:** Agencies are getting more referrals, but the patients aren’t homebound or skilled. Is there a cost comparison of taking care of a patient in the home vs. rehab? What can be done to remove the homebound requirement? Spread out the admission visits over 2-3 days so that it’s less overwhelming for patients.
* ***Dual Complete Plans:*** UnitedHealthCare is not reimbursing at the Medicaid rate.
* **Homemaker service providers:** Request that they must have aides on staff to provide some services.
* ***PDGM*:** NAHC webinars have been very helpful. Diagnosis coding with PDGM is needed. Decision Health is a trainer for that. It’s a 2-day training and the 3rd day is a certification exam. Billing departments need information. There are concerns about submitting claims and documentation within 30 days. There are concerns about completing therapy visits in the first 30 days. Front loading can be done by nurse, aide or therapist. Thee are concerns about having to change processes because of PDGM.
* ***Podcasts:*** Topics requested included:
	+ Home health minute for nurses, OTs and PTs
	+ Can it be set up that members have to verify log-in and that they watched the podcast to earn CE?
	+ Set up a YouTube Channel with the podcasts and sell advertising space to vendors.
	+ Review each of the CoPs.
	+ Review each of the OASIS items and GG codes and ADLs.
	+ Review new medications on the market.
	+ Discuss regulatory changes and updates when they’re released.
	+ Offer humorous topics.
	+ PDGM for clinicians (the financial managers session for clinicians in Chicago was really good – are there speakers that could present?).
	+ OASIS items and the GG codes.
	+ How to write short-term and long-term goals for patients and interventions (for nurses)
	+ Medication reconciliation and what that actually looks like and what it means.
		- Writing home health orders. It’s different from writing orders on the hospital floor
* ***Emergency preparedness plans****:* the state surveyors are asking to see your state and local government contacts. They’re also reviewing to ensure home health conditions of participation and emergency preparedness plans are well documented. They want to see a description of what’s in the home for the patient to be prepared, what the patient needs to have in the home and who would assist the patient with evacuation. They also want the local, state and federal emergency management contacts listed as well as a tribal contact even if your agency doesn’t serve tribes.

Home health agencies in the flooded areas made sure patients had access to a flashlight, called and asked their patients if they needed assistance with evacuating. Provide patients a document outlining what they need to do to prepare for a natural disaster and put a copy in the patient’s chart. Assess if the patient is high or low priority response during a natural disaster or other emergency. Document in patient notes after you’ve reviewed with them how to prepare for a snowstorm or disaster.It was challenging to serve Plattsmouth and Fremont patients during the recent flooding.

If your home health agency office and staff are anticipating a natural disaster, require them to take home their equipment, laptops or iPad, bags and supplies. If you work for a hospital-based system, find out if you’re supposed to report first to the hospital or the home health agency. During recent floods, nurses were advised to ensure that outpatients were safe and stable first.

During a tornado warning or other situation when cell towers go down, how do you communicate with your staff? There are apps such as Cortex that can be used for communications when Internet service isn’t available. Blackboard Connect is another option.

FEMA brought one agency a brochure and wanted them to distribute brochures with Meals on Wheels delivery. The brochure needs to be in packets given to patients in rural areas. Get them in the hands of Aging Partners, Meals on Wheels and other partners. FEMA brought a brochure for community readiness packet to share. Print the information from the READY.gov website.
* ***Patient rights campaign:*** Develop a campaign on what patients and their families need to know as a Medicaid waiver or home health patient. Provide a list of questions patients should ask when they’re in the hospital and before signing any forms. Provide patient choices. A recommendation was made to develop materials that members can share with their patients that are endorsed by the Nebraska Home Care Association. It was also suggested to provide our state senators with a directory of members and services they provide. They are good advocates for services. Remind patients to go their annual physical. That’s another intervention to keep patients out of the hospital.

Charles Drew and OneWorld Community Health need education for their patients about home care services. OneWorld requires a sliding scale for agency fees for patients with limited budgets. Neighborhood clinics are resources that need to be contacted. Educate physicians and their staffs on patient options for home care services. Give information to all patients about home health.

* ***Medication disposal guidelines:*** The state of Nebraska will send out free envelopes that patients can use to mail unused medications. Call (800) 772-5657 to request envelopes.
* ***Pain medication contracts for patients using opioids:*** Request sample contracts.
* ***Medication management:*** One agency does home rounding where the administration goes to the patient’s home to review medication requirements and request feedback. A journal is kept in the patient’s home for each clinician to leave notes for the next caregiver.
* ***Supply management:*** Nurses forget and leave supplies in their bags in vehicles. Contract with programs such as that bill per patient. Set up a monthly log and inventory of supplies.
* ***CGS:*** There are inconsistent responses given when calling the staff to follow-up on unpaid Medicare claims.
* ***Employee-owned insurance plans***: PHI negotiates contracts with providers, but after enrolling, PHI changes the amount they will pay the provider and how much the patient is responsible for paying.
* ***Medicaid managed care organizations (MCOs):*** UnitedHealthCare is requesting charts for every patient on the 45th day and requesting money back on the 47th day. Nebraska Total Care responds to authorization requests two weeks after providers submit requests. Home health agencies are taking the risk of not being paid but feel obligated to start service and care for the patient within 48 hours. There was overall positive feedback about WellCare of Nebraska’s responses to authorization requests and payments. There are issues with reimbursement for plans where Medicare is the primary payor and Medicaid is secondary. Prior authorization processes change frequently. NTC requests the physician signed 485 within 3 days. Evicore is very slow in authorizing PT visits.

Agencies have to wait to request PRN authorization until the end of the 60 day certification period from NTC. WellCare and UHC will authorize the PRN visits at the beginning of the certification period. Nebraska Total Care isn’t paying correctly for the skilled nurse daily cap limit. They also aren’t paying the updated 2018 rate.

Notify UHC that they need to remove their fax number from the standard prior authorization form. They no longer accept faxes.
* ***Hospice services:*** Some agencies that provide hospice services in the nursing homes reported that it’s difficult to manage due to inconsistency of care and turnover of staff in the nursing homes. The nursing homes don’t notify the home health agency that the patient died.
* ***Professional development/education requests:***
* How to avoid medical ADRs.
* Interpretation of new hospice regulations and what it takes to operationalize them. Medicare Advantage is probably coming to hospice.
* Co-morbidities patients with schizophrenia and diabetes – difficult to work with patients that have both conditions. Keeping the patients out of the hospital is a challenge. When the patients are readmitted to the hospital it’s usually for psych needs.
* OASIS-D training, review of GG codes and offer the certification exam.
* Coding training and PDGM changes and impacts on billing.
* Wound care – Cindy Miller from Acelity can present on wound types and treatments and offer wound stations with hands-on supplies and training on how to apply a dressing and what type of dressing to use. Ask if Iowa Western can offer the CE through the association.
* What a LUP entails and how to gear your care plan around that (cover this in the conference for new home health directors, administrators, nurses and therapists). How to create a budget and basic accounting.
* Case managers class – review regulations, OASIS, VA requirements, complicated wound vac (how to do it and chart it), different payor rules.
* ICD-10 training – intermediate and advanced levels
* Roundtable networking events for billers
* Patient compliance
* Value-Based Purchasing: how to interpret the reports with the Total Performance Scores, how to increase your TPS. If you make a change to address a specific outcome, your score might improve, but then goes back down.
* Online education is preferred because of limited financial resources. Continue to offer webinars with recordings so that patients can log in and watch after patient visits.
Note: Home Care Coders OASIS and PDGM is a Facebook group with great resources.
* VA – what’s required for billing and contracts and what’s changing with Tri-West and Optum.

In the Omaha metro area, members are aware of two physicians and a nurse practitioner that does home visits.

* ***Veteran Services:*** The VA is trying to staff nurses in home health but has limited staff. The VA is requiring home health agencies to submit an OASIS for home health patients. Agencies must contract with Tri-West for services such as wound care and medication set-up. There’s uncertainty about what changes will happen after agencies have signed contracts with Tri-West. Non-medical providers are challenged with getting the VA to pay timely. Non-medical providers have received timely payments from DHHS for Medicaid waiver clients. They’ve had challenges in getting authorizations from the League of Human Dignity. Common denials have been issued for supervision, pet care and watering plants in a client’s home.
* ***Medicaid Fee for Service:*** Telligen is requiring agencies to submit the signed 485 from the physician within two days. They won’t start the certification until the next period if a signed 485 isn’t submitted within two days.
* ***Readmission Rates:*** Agencies are experiencing higher readmission rates because patients are being discharged from the hospitals before they should be, or therapy and other essential services aren’t being authorized by insurance companies.
* ***Growing Demand for Home Care Services:*** Providers are experiencing a continual increase in patient volume. Rural agencies are challenged with staffing to meet the needs. Weekend nursing includes on-call by RNs and LPNs and paying time and a half. There was discussion about whether nurses should be paid the same rate on the weekend as weekday if they are taking calls on the weekend and offer clinical judgment. Documentation of the initial patient assessment is an average of 2 hours. Additional visits take about 3 hours to document. Daily staff huddles to review referrals from the prior day and other topics are done by some agencies.
* ***Staff and Caregiver Recruitment***: It’s difficult to compete with hospitals in providing benefits and compensation. Offer continuing education and allow staff to invest in competencies. One agency implemented a new culture program that would incentivize people to want to work at your agency or company. Wear your name badge, say hi and ask employees how they are doing. One home care provider has a caregiver success team program that’s devoted to making sure caregivers are a good match with the clients they serve. The office staff does evening quality assurance visits with the patients to check on them. That’s worked well. One agency has a quarterly staff meeting. Gift cards are provided for staff appreciation. One agency sends out a bi-weekly update is done every two weeks with fun information. It includes staffing updates with photos. One provider sends a Friday email with positive feedback about caregivers, highlights goals that were met and includes educational information. It is sent as a brightly colored post-it note in an email. One agency sets aside Friday afternoon as protected staff time where they must take time for themselves to catch up in their offices.

How do you a do good job of building effective relationships with your caregivers and staff and your patients? Focus on the value of the whole person and understanding the role in that and everyone you work with to care for the patient. Employees are your best recruiters and marketers. Ensure they understand your vision. Agencies use the Studer program. One agency developed a WOW program where staff had to create a WOW initiative or goal. Wearing a name tag in the home helps with patient satisfaction and HHCAHPS. Treat everyone as your customer.

* **PTAs and OTAs**: Medicare will allow home health agencies to use PTAs and COTAs, but Medicaid does not. From a quality standpoint and cost reduction, it would be a benefit to use PTAs and COTAs. One PT can supervise two PTAs. The Nebraska Home Care Association Medicaid Task Group is asked to address this with DHHS.
* ***Telehealth:*** Very few agencies are using it because of the low reimbursement and technology costs. The VA uses it.
* ***Partnership between home health agencies and home care companies:*** The value of home health and home care is working together and collecting and reporting statistics on the outcomes. The data on the patient outcomes, avoiding readmissions, etc. needs to be tracked. Bring together the staff focused on quality outcomes, improvement and measures in the agencies and companies. When patients’ home health services conclude because Medicare no longer covers it as a benefit, the non-medical providers are left with caring for patients with medical needs. Before rehospitalization happens, non-medical providers need to get home health agencies involved. Educate the private duty home care providers on what to look for that doesn’t require medical judgment. Educate staff to think reactively rather than proactively for the patient. HHQI has a stop report for change in condition for aides to look for that identifies changes in patient behavior. Use technology to work together to document what’s happening with the patient and develop a care plan with agencies and non-medical providers. The long-term care provider notices things about the patient that a therapist who’s there for short visits or a short period may not notice.
* ***Discharge Planning –*** workwith the discharge planner and case manager at the hospital to make sure the patient is getting the transition and right care needed. Educate the discharge planner on what questions the patient needs to ask about provider and care options.
* ***Prescription Access:*** Patients don’t have access to medication in rural areas when they’re discharged on a Friday evening and the pharmacy isn’t open on the weekends. There needs to be better planning and coordination of patient medication.
* ***Accountable Care Organizations***: Agencies can partner with a physician and help improve quality for patients and reduce rehospitalizations. Agencies are receiving referrals of patients that have had hips and knee replacements because the ACOs are telling patients they don’t need therapy and are keeping the money.