



IHO Update

Bi-weekly News for Hospice Professionals in Iowa

July 6, 2007

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Data-Driven Management Workshops A Success

More than 80 hospice professionals from across the state participated in the IHO Regional Workshops on Data-Driven Management June 26-28. Hiawatha, Storm Lake and Des Moines were hosts to the workshops presented by Martha Tecca, from OCS. Thank you to those who participated in these important sessions that were both an extension of the NHPCO Manager Development Program hosted by IHO on June 4-5 as well as an additional learning opportunity focused on what hospices need to do to comply with the QAPI condition of participation.

Are You on Board?

Those who attended the Regional Workshops received a review of the Iowa QAPI Snapshot benchmark results that now more than two dozen IHO members are currently participating in.

The effort is based on the OCS QAPI Snapshot nationwide benchmarking program and includes 22 performance measures that are important for all hospices and that are currently captured by most hospices. The measures span all areas of analysis required by the proposed hospice QAPI Condition of Participation, as well as the 10 components of quality cited by the NHPCO Quality Partners Initiative. Further, QAPI Snapshot includes a review of an agency's success in reporting data and performing in all 10 Quality Partners components.

The QAPI Snapshot is a one-page benchmark report that includes a comprehensive set of performance measures including the following: quality outcomes, patient volumes and mix, quality operations and quality practices. For each report, you complete an online survey

and, after a short processing time, download the completed benchmark report. If you want baseline and trends in your first report, you can enter 2005 and 2006 data.

Special Member Pricing

IHO has worked with OCS to bring IHO members this entire program for **\$500** annually per reporting location.

Online Resources

Go to www.iowahospice.org, and click on the Data Tab. Here you can access the following:

- **Downloadable survey.** You may download a PDF version of the online annual survey in order to prepare your systems and staff for data submission.
- **QAPI Snapshot Order Form.** Download an order form, complete it and fax it to OCS.

Questions?

If you are just getting started with data submission, QAPI Snapshot will help you build your systems and capabilities so that you are well-prepared when the new CoPs are final.

If you have any questions, call 603-795-4802 or email QAPI@ocsys.com

Celebrating Your Hospice

In celebration of IHO's 25th Anniversary this year, we want to showcase our members achievements, milestones, staff members, new initiatives and any other event or recognition that helps other hospice professionals get a visual perspective on how your hospice has changed throughout it's history.

Posters will be displayed at the 2007 Fall Conference on Oct. 24-25 in Ames. Poster presentation applications have been sent to all hospice directors and are also available on the IHO Web site at www.iowashospice.org under the "Calendar" Tab. Please submit only *one* application per agency location. For questions, contact Natalie Wilson, IHO, at 515.243.1046. **Application deadline is August 1.**

IHO Fall Conference to Showcase Honored Volunteers

It's that time of year to nominate that certain volunteer or volunteer team in your agency that goes the extra mile and sets a positive example for all volunteers. The honored volunteer recognition ceremony will begin the day at this year's Fall Conference on October 24 in Ames. A special ceremony will be held with recognition, music and storytelling.

All nomination forms have been sent to your agency's volunteer coordinators. If you did not receive a nomination form, please visit the Web site at www.iowahospice.org under the "Awards and Recognition Tab." Download the form on the Web site and mail for fax back to IHO. A nomination form and a hospice statistics form are also enclosed with this week's issue of the *IHO Update*. **Applications are due August 10, 2007.**

Upcoming CMS Home Health, Hospice & DME Open Door Forum

Date:

July 18, 2007

Start Time:

2:00 p.m. Eastern Daylight Time (EDT)

Conference Leader(s):

Carol Blackford
Martha Kuespert
Verlon Johnson
Natalie Highsmith

Instructions:

Participate by Phone:

Dial: 1-800-837-1935 & Reference Conference ID: 2467910
(Persons participating by phone do not need to RSVP.)

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here <http://www.consumer.att.com/relay/which/index.html>. A Relay Communications Assistant will help.

Participate in Person:

RSVP is required:

Please send your reply to HOMEHEALTH_HOSPICE_DMEODF-L@cms.hhs.gov by 2:00 p.m. EDT, July 16, 2007. Include the words “**Home Health**” in the subject line of your message, and send us your name, organization or representation and phone number. Please arrive no later than 1:30 p.m. EDT. Upon entrance to the building you will be required to show government-issued identification to Security officers and you may be subject to baggage search. **ADDRESS:** Hubert H. Humphrey Bldg., 200 Independence Avenue S.W., Washington, D.C. 20201. Map & Directions: <http://www.hhs.gov/about/hhhmap.html>

ENCORE: 1-800-642-1687; Conference ID# 2467910

Encore is an audio recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conf. ID., beginning two hours after the conference has ended. The recording will expire after three business days.

For Forum Schedule updates, Open Door Forum Mailing list and Frequently Asked Questions please visit our Web site at www.cms.hhs.gov/OpenDoorForums.

**A New Focus on Easing the Pain:
Palliative Care Helps The Very Ill. It May Also Keep Costs Down.**

(article posted on washingtonpost.com)

*By Joanne Kenen
Special to The Washington Post
Tuesday, July 3, 2007; HE01*

David Thibault grows orchids as a hobby, but the elegant flower on his bedside tray did little to lift his spirits. He stared out the window of his room at George Washington University Hospital (GW), waiting for lab results that could tell him if he had months, weeks or maybe only days to live.

A month earlier, in April, Thibault and his wife, Judy Thibault Klevins, had been preparing for a trip to Japan when he felt pain that was different from the pain he had long experienced from Crohn's disease, an inflammatory bowel ailment. It turned out to be small-bowel cancer. If the disease weren't so rare, he now ventured aloud, maybe more research money would have gone into it, maybe he wouldn't be facing death at age 67.

Joan Panke, a nurse practitioner, listened intently. The coordinator of GW's Palliative Care Service, Panke and her team ease the pain of those with serious or terminal illness.

About a third of U.S. hospitals now offer some form of palliative care, which adapts aspects of the hospice philosophy without requiring patients to forgo curative care or to have a life expectancy of six months or less. Late last year the American Board of Medical Specialties recognized palliative medicine as a specialized field – a move that will expand training, said Cameron Muir, a palliative care physician at Capital Hospice, the Washington area's largest hospice organization, and the president of the American Academy of Hospice and Palliative Medicine, based in Glenview, Ill.

Throughout the Washington region, palliative care is also taking root. Interdisciplinary palliative care teams, such as GW's, often devote much of their time to working with the dying – and helping them face death, a skill that many doctors lack. But as palliative care programs expand and mature, the teams often begin to see patients earlier in the course of disease, creating a continuum of care from diagnosis on.

The main goal is to improve a patient's quality of life. But at the same time, by moving patients out of intensive care – and even out of the hospital – sooner and by managing pain, nausea or respiratory problems better, palliative care teams often keep hospital costs down. "We save a lot of money by providing the right care to the right patients at the right time," said Sean Morrison, director of the National Palliative Care Research Center at New York's Mount Sinai School of Medicine.

Not all health economists or policymakers are yet persuaded that those savings are substantial or that they occur in all cases. (Savings, some note, may prove elusive in certain settings, such as cancer clinics.) But Diane Meier, head of the Center to Advance Palliative Care, which is also based at Mount Sinai, said the field's explosive growth shows that hospital administrators see bottom-line benefits.

"Hospital CEOs are voting with their feet," she said. "We are way past the tipping point."

The GW team – currently two palliative care nurses, a social worker and residents and fellows who rotate through palliative care – is available to inpatients only. But five of GW's geriatricians also have certifications in palliative care. They use this expertise in their office practices, and they can bring these skills into the hospital when needed.

"There are a lot of conditions that people don't automatically think of as terminal but they have a very poor prognosis," said Katalin Roth, one of those geriatricians. "Metastatic cancer is terminal. But end-stage liver disease, severe congestive heart failure, severe emphysema, these conditions actually have very limited survival and often have worse prognoses in terms of time than cancer."

Panke moves through the hospital sporting a button on her white lab coat that reads, "Actually there is something we can do." She can barely walk 10 or 15 feet across a busy med-surg hospital floor without a doctor's hailing her for advice. At first the requests came largely from the younger doctors, whose training had touched on some end-of-life concerns, but now Panke and her team receive consultation requests from doctors throughout the hospital. Even the psych floor called the other day. "Everyone thinks we are theirs," Panke said.

Tough Choices

In an intensive-care room, a family prayed at the bedside of a man in his 50s. High-tech medicine had saved the patient repeatedly during the years that his kidney disease progressed. He had come into the hospital the previous night as a "full code," meaning he wanted everything possible done to keep him alive, including resuscitation. But his hands were getting cold, his fingertips blue, his pulse weakening despite the tide of drugs being pumped into him to raise his blood pressure.

Panke and social worker Bea Leibson helped the family understand that this was not a temporary crisis. The patient was dying. Alert and communicative, he was able to make choices. He and his family decided he should stay on the blood pressure drugs for as long as they worked, as long as he was comfortable. But when the drugs failed, there would be no rib-crushing attempt at resuscitation, no machines that might possibly extend his life for hours or days but would prevent him from sharing last words with his family. With the help of Panke and Leibson, and a hospital chaplain, he died peacefully with his family at his side that evening.

Lana Baueserman, 58, had come to the hospital four days earlier with back pain that turned out to be a fast-moving pancreatic cancer. Overwhelmed, Baueserman took her pain drugs and retreated into sleep, while her sister Wanda Reyes kicked into high gear. A lawyer made sure she was empowered to make health-care and financial decisions on behalf of her sister if necessary. Reyes planned to move into her sister's home to take care of her; hospice will help. "My condo is on the third floor, lots of stairs," she said. "Lana's house is better. And she's got a screened-in sun porch; I can take her out there." But for all her take-charge efficiency, Reyes was reeling. "Things are moving too quickly," she said. She gestured at Panke and Patricia Ladisa, a resident rotating through the palliative care service. "I couldn't get through this without them."

Not all patients receiving palliative care are this sick. One 72-year-old woman said she "sailed through" her double mastectomy a year ago. Chemo was tougher, causing severe neuropathic pain syndrome affecting her hands and feet. The pain persists. "This is real. I haven't been able to button a blouse for a year," said the woman, who lives alone in Northwest Washington and asked that her name be withheld because she hasn't confided in her co-workers. When she went to one local emergency room, she said, the staff told me I was a drug addict looking for morphine and sent her home untreated. Finally she landed at GW.

Panke had started the patient on a new mix of drugs but would have to titrate the medications over several days to avoid side effects. The relief might be modest at first. The patient voiced some skepticism about the outcome but said she was relieved that Panke was listening more than her oncologist had.

Humor and Resignation

People often associate palliative care with cancer, but Panke and Leibson see all kinds of diseases and all kinds of family dynamics. They recently treated a middle-aged woman with advanced AIDS whose family wasn't ready to "give up" on the daughter from whom they had long been estranged but who could no longer communicate with them. A diabetic woman spent weeks in the ICU, her will to live gradually sapped by a rare "flesh-eating" bacteria.

A 12-year-old boy, struggling to understand why dialysis could no longer keep his father alive, reflected on how fast he outgrew his sneakers. "I'm the size of a man – size 11. I don't want my feet to grow any more," he said, unaware, perhaps, of how well his imagery called up his preparation to step into his father's shoes as the man of the family.

Under Panke's care, Thibault was feeling a bit better this morning. He had been distraught when an overnight nurse didn't come quickly to refill pain medication; Panke switched him to a pump he could control himself. The nausea drugs worked; Thibault ate his first meal in days, so he was now less at risk for dehydration and kidney failure. When Panke asked if he needed anything for a dry mouth, he joked: "Beer."

Panke still worried about the emotional strain on the couple, but Thibault Klevins called her the "ray of sanity" illuminating their choices. Thibault was trained as a scientist, worked as a businessman and was trying to be dispassionate, analytical. He would not grasp for miracles; he will opt for hospice. He wants to die at home, with his family, among his orchids.

Joanne Kenen has a media fellowship from the [Kaiser Family Foundation](#) to report on hospice and palliative care. Comments: health@washpost.com.

Providers Urged to Verify NPI Data and Protect Sensitive Information

The Centers for Medicare & Medicaid Services (CMS) has finally published a noticed rule authorizing the release of the National Plan and Provider Enumeration System (NPPES). The NPPES is an electronic database that not only uniquely identifies health care providers, but

populates the database with the information submitted when the provider applies for a National Provider Identifier (NPI).

Health care providers that are covered entities are required to share their NPIs with trading partners for use in conducting standard transactions. The NPPES will allow anyone to locate NPIs and other NPPES health care provider data under the Freedom of Information Act (FOIA). After reviewing the FOIA and the Privacy Act, the Department of Health and Human Services (HHS) will not release the following data elements to the public:

- Social Security Numbers (SSN)
- Internal Revenue Service individual taxpayer identification numbers (TINs)
- Date, state or country of birth

HHS has determined the remaining data elements in the NPPES are required to be disclosed under the FOIA. NPPES health care provider data that are required to be disclosed under the FOIA will be made publicly available June 28, 30 days after the publication date of the rule. The disclosable data will be made available in an initial downloadable (comma-separated CVS) file with monthly update files, also downloadable, from the Internet at www.cms.hhs.gov/NationalProvIdentStand/. In addition, there will be a query-only database where users can look-up NPI or provider names.

IHO encourages hospices and health care practitioners to review their NPPES data at this time and make any necessary updates or corrections *prior to the end of the 30-day period* to ensure that information is accurate when disclosed by CMS. In particular, health care providers that have been assigned an NPI will want to ensure:

- Legacy identifiers in the “Other Provider Identifiers” field include UPIN (if applicable).
- SSN and TINs are **not** in the “Other Provider Identifier” field as this field will be made public.

Health care providers that wish to delete any NPPES data that was not required to be furnished in order to obtain an NPI, may do so prior to the end of the 30-day period, if they prefer those data elements not be disclosed by CMS.

Pain & Symptom Management Certificate Program

The Hospice of the Florida Suncoast will offer a Pain & Symptom Management Certificate Program September 19-21, 2007 in Clearwater, FL. Participants will learn the latest in pain and symptom management, practical and advanced solutions, and complementary therapies for adjunct management. For more information and to register, see the brochure enclosed with this week’s issue of the *IHO Update*.

Upcoming Part A Medicare Training

- FISS 201: Exploring Eligibility & Mapping Hospice Claim Entry Webinar

Date: July 18, 2007

Time: 1:00 p.m.–3:00 p.m. CT

Registration Deadline: July 13, 2007

Intended Audience: Hospice providers and staff

Description: This webinar will show how to check a Medicare beneficiary's eligibility for Medicare-covered hospice services. It will also cover how to use the Fiscal Intermediary Standard System (FISS) to submit Notice of Election (NOE) and hospice claims.

- FISS 301: The Billing World Series Webinar

Date: July 24, 2007

Time: 1:00 p.m.–3:00 p.m. CT

Registration Deadline: July 19, 2007

Intended Audience: All Medicare Part A providers and staff

Description: This webinar will discuss Fiscal Intermediary Standard System (FISS) resources and shortcuts. It will also cover how to determine whether Medicare is primary or secondary and how to use FISS to submit the most common types of Medicare Secondary Payer (MSP) claims.

- FISS 401: Did I Do That?!? Webinar

Date: July 31, 2007

Time: 1:00 p.m.–3:00 p.m. CT

Registration Deadline: July 26, 2007

Intended Audience: All Medicare Part A providers and staff

Description: This webinar will show how to use FISS to correct claims that have gone to the Return to Provider (RTP) file, adjust claims and cancel claims.

- Dial In & Win With Timely Medicare Payments: Ask-The-Contractor Teleconference (ACT)

Date: August 2, 2007

Time: 1:00 p.m.–2:00 p.m. CT

Registration Deadline: July 26, 2007

Intended Audience: All Medicare Part A providers and staff

Description: This ACT will include information about the most common reasons why Medicare Part A claims are rejected or sent for correction.

Enclosures

IHO Fall Conference Volunteer Nomination Form
IHO Fall Conference Volunteer Program Statistics Form
Pain & Symptom Management Brochure