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INSIDE

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New privacy rules could pose challenges for home care industry

More rigorous standard may affect patient data transmission

It may be easy, in the crush of the prospective payment system, to put off thinking about the new privacy standard announced earlier this year as part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

But it's a good idea to now pull out the standard to see how your current privacy policies measure up to federal expectations, and to look for areas that may need beefing up in the two years before the enforcement of the new standard begins.

William Dombi, Esq., vice president for law at the Washington, DC-based National Association for Home Care (NAHC), says home health agencies may face special challenges in conforming to the new standard. In part, that's because of the unique nature of home care, which raises privacy issues — dealing with family caregivers, transmitting electronic data from the field to the home office — not seen in other health care settings.

Making sense of it all

But there's also the practical reality of coping with an entirely new payment system, while simultaneously trying to make sense of a complex new federal regulation.

"Because of this transition to prospective payment, Medicare home health agencies have been underwater, dealing with cash-flow problems and the like," Dombi says. "They haven't had the luxury of time to spend looking at HIPAA already. We've talked to quite a few home health agencies who are just saying, 'If I know what the acronym means at this stage, then I'm happy.'"

While agencies always have had policies in place to protect the privacy of their patients, the new standard will require an unprecedented attention to protecting access to confidential information. It also addresses a new

area of privacy concerns — the electronic transmission of data among agency personnel and from the agencies to vendors and other entities.

That's why agencies will need to put their operations under a microscope to look for any possible cracks in the security of patient information, Dombi says. "Anyone who assumes that their system meets the HIPAA standards is making a big mistake."

New rules: Too costly?

The privacy standards were developed by the U.S. Department of Health and Human Services and passed in the final weeks of the Clinton administration. Originally intended to address only the dissemination of medical data electronically (via computer modems, etc.), the standard grew to include all disclosures of medical information to outside sources.

The announced privacy standard prompted criticism from health care providers who said the new rules would be too cumbersome and costly to be workable. In fact, some hoped that with the new Bush administration, the standard would be withdrawn and completely reworked.

But in April, HHS Secretary Tommy G. Thompson announced that the privacy standard would be allowed to go forward, albeit with some modifications.

Thompson says those changes would ensure that health care providers would be able to consult with physicians and other specialists regarding a patient's care, and that care wouldn't be unduly hampered by a confusing or overly bureaucratic consent process.

However, Dombi says that still leaves room for the standard to have a significant impact on an agency's operations.

"Now they'll have to revisit [their privacy policies] and say, 'Is this consent the kind of consent that HIPAA requires? Is it done at the right time with the right frequency that HIPAA would require? Are the security measures compliant with HIPAA standards?'

"Flexibility certainly is there in parts of HIPAA, but they still have criteria that have to be met," Dombi says. "What we're advising is first do a gap analysis. Find out what does HIPAA require and second, find out what do you have in place as it relates to those requirements."

Dombi suggests paying close attention to certain areas of your agency:

- **Electronic security**

CE Questions

13. Access to patient records within a home health agency should be based on:
    A. the employee's position.
    B. the employee's experience.
    C. the employee's need to see the records.
    D. none of the above

14. The new privacy standard under the Health Insurance Portability and Accountability Act of 1996 specifically addresses the special privacy challenges facing home health organizations.
    A. true
    B. false

15. Some home care agencies are using clinical pathways as guidelines for clinical care. What is an important benefit to having these pathways?
    A. Clinical pathways encourage efficiency.
    B. Clinical pathways help to eliminate duplication of services.
    C. Clinical pathways can give staff a clear picture of which disciplines should be involved in a particular case and what their expected number of visits will be.
    D. all of the above

16. The Visiting Nurses Association Inc. of New Orleans has a community service program, HealthLink, that provides in-home services to people who need additional monitoring or guidance but do not qualify for home care services. Staffed mainly by student nurses, the program is free to clients. Which of the following is not one of the benefits of HealthLink?
    A. The program gives student nurses a glimpse at what it would be like to work for a home care agency and may therefore encourage them to seek home care employment at some time in their careers.
    B. The program results in many home care referrals and therefore generates more income for the agency.
    C. The program prevents clients from returning to the hospital or emergency department because student nurses often identify potential problems that can be handled by a home care nurse or physician before the problems become severe.
    D. The program provides peace of mind to clients and their families because someone is always calling or checking on the person to see if they are taking their medications correctly and if there have been any new health concerns to address.

Dombi says the standard is intended to be flexible and practical — no system is impervious to hackers, and the government wouldn't expect an agency's system to be hack-proof, either.

But it is important that the systems be reasonably secure, something that could be made possible with security software. In addition, Dombi says agencies need to look at their computer policies and procedures.

"Who has access?" he asks. "When do they have access? How do they have access? Is [patient information] something that's easily accessible to anyone within a home care organization? Because you have to set those standards on access really on the basis of need."

As an example, Dombi points to the computer security within his own office. Many people in his organization know his computer access code since they've had to get information for him at times.

"A hacker actually would not have a hard time guessing what my code is," he says. "If I had patient information in here, I'd have to change the entire way that I deal with that."

The task of securing data becomes trickier when it comes to some of the newer technology being used in some agencies. Laptop computers and other point-of-care devices send data back to the agency via wireless transmissions, which are relatively easy to intercept.

"Now do we suspect that there's going to be some cadre of privacy infiltrators sitting on neighborhood corners waiting to hear about the decubitus ulcer of a particular patient? No, we don't," he wryly says. "But nonetheless, there will have to be some security measures taken on that."

The most likely fix: Encryption software, which scrambles the signals being transmitted so that anyone intercepting them won't be able to understand them. Dombi says there are several very effective encryption programs already available to the public.

Measuring up to standards

- **Business partners**

This is the term the standard uses to describe any entity that receives patient information to assist a health care provider in its functioning. Business partners can include consultants, data processing firms, billing firms, and other vendors.

An agency will have to ensure that its vendors have the same airtight privacy practices required of the provider.

Dombi says the vendors themselves will probably take the lead here, walking the agency through the privacy safeguards required, especially if data are to be transmitted over the Internet.

"I know we've put an emphasis on this with our technology partners, the various vendors who exhibit and advertise and sell their wares to our membership," he says. "We've had a strong relationship with them over the past several months focusing in on this particular issue of HIPAA compliance."

But it will be up to the agency to review contracts with all of its vendors and ensure that they will be compliant with the privacy requirements.

- **Consent forms**

Dombi believes the new HIPAA privacy standard won't lead to an escalation of paperwork, but could require that current consent forms be updated.

"If you look at the HIPAA standards, they set out specific criteria on what's an acceptable consent, what's an appropriate authorization," he says. "Agencies will just have to examine whether they meet them. I've looked at a few (forms) so far, and I'd say that they're either close or already sufficient."

- **Research**

As more agencies increase the use of benchmarking in their quality improvement efforts, it's important to note the difference between uses of data that require additional patient consent and those that don't.

The main factor, Dombi says, is removing any details from the database that would identify a specific patient. Without that patient specific identifier, he says, an agency generally doesn't need extra patient consent for use of his information in a research role.

This can sometimes create problems, because one of the privacy standard's lists of patient identifiers is geographic data.

He says some providers currently using OASIS data to do benchmarking with other agencies now are going through the process of extracting patient identifiers so they can share information without obtaining special patient consent.

"If they can't get to that point and still make the information useful, then they've prepared an authorization form for signature by the patients who are being admitted so they authorize the use of that data for that purpose," Dombi says.

"In some cases, the patient is going to say no; but I think in most cases, the expectation is that the patient will say yes," he says. "You can resolve a lot of these things with those authorization forms."

Sources

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- **Lynnette Rimkus**, Media Relations Specialist, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5000. Fax: (630) 792-5005. Web site: www.jcaho.org.
- The **Office of Civil Rights** will be responsible for enforcing the new privacy standard. For the latest information on changes to the standard or plans for its implementation, visit www.hhs.gov/ocr.

The new standard is not expected to interfere with the new ORYX initiative of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), says **Lynette Rimkus**, media relations specialist for JCAHO.

"[JCAHO] doesn't foresee any significant impact with relation to HIPAA because whenever we aggregate data, it's not identified by the patient," she says.

Special home care concerns

There will be privacy issues raised as a result of providing care directly in the home that don't come up in other health care settings, Dombi says.

For example, home care nurses are required to leave a care plan in the home. Dombi says the agency will either have to get the patient's permission to leave the care plan in the open where someone else in the household might see it, or devise some other way to deal with the liability for a possible disclosure of information.

Patient consent and authorization forms will have to address the question of passing patient information along to family caregivers, he says.

"When you look at the standards, you certainly can't see any recognition of some of these special aspects of home care," he says. "You just have to recognize where the risk areas are.

"I think home health is going to have some very special challenges as it relates to the privacy standard," Dombi says. "While the home health agencies have long recognized a need to protect the privacy and confidentiality of health care information regarding their patients, I think that the new rule for HIPAA will give a special focus on privacy unlike anything they'd seen before." ■

'Express path' gives necessary QI, PPS info

Agency reviewed top 20 diagnoses

Nearly a year ago, the president and quality improvement coordinator of United Home Health Services Inc. in Canton, MI, began the process of analyzing the home care agency's top diagnoses, costs, and outcome trends.

This review led to a special project in which the agency's staff helped to develop a list of best practices that clinical staff would follow for each patient with a specific diagnosis. These best practices or clinical pathways, called Express Paths, give nurses guidelines about how to handle patients from a clinical perspective and serve as a reminder that the agency now works in a prospective payment system (PPS) environment in which there are not unlimited funds for patient visits.

"We have always looked at the patient's needs first, and not just look at the visits," says **Gloria Bruhowzki**, RN, BA, president and administrator of the freestanding, hospital-affiliated agency that serves western Michigan.

"But now we use Express Paths as a framework of where to begin," Bruhowzki adds. "Express Paths make us look at what would be more efficient for a case instead of doing visits exactly as we have done them in the past."

Pathways appear to be successful

Some of the Express Paths are complete and being used, and so far, patient outcomes are consistent with what they were under the interim payment system (IPS) and before IPS, says **Lynn Lariviere**, RN, CRRN, quality improvement and rehab coordinator.

Also, patient satisfaction surveys have continued to come back with 100% satisfaction ratings, so by that measurement, the pathways have been successful.

Here's how the agency developed its clinical pathways:

1. Analyze top diagnoses.

They identified the agency's top diagnoses and assigned them to supervisors and other staff to research for trends per diagnosis, such as the number of visits, disciplines involved, and costs.

Everyone was assigned one or two diagnoses with the instruction to look for any patterns or

trends, as well as to check outcomes, whether patients met goals, whether there were problems with hospitalization, and other problems, Lariviere says.

"We estimated how much we thought we'd be paid under PPS," Bruhowzki says. "Then we determined that we needed a plan for the future and so we met with a multidisciplinary team to look at the cases from all aspects of care."

The team researched and studied best practices for each discipline, including nursing, therapy, social work, and dietary.

2. Develop profile of typical patient.

Using 23 elements of OASIS data that affect payment, they began to develop a profile of a typical patient.

"The majority of patients are Medicare age, and a lot are from rehab," Lariviere notes.

Team members wrote descriptions of the characteristics of typical patients, based on their own experience and the OASIS information about what a majority of people under a particular diagnosis would have in common. Once a description was written, the teams could begin to develop best-practice recommendations for each of those typical patients. The patient profile, called a "patient picture," is described with a brief phrase above the goals and problems on each of the Express Paths. (**See sample Express Path, inserted in this issue.**)

For example, a description of a typical hip fracture patient might read: a therapy patient, frail, elderly, history of falls and balance difficulties.

"Initially, we didn't have the descriptive part in there, but we determined we needed it to know the typical patient," Bruhowzki says.

While developing the pathways, the team referred to published information about interdisciplinary care plans. The team also created additional paths for various treatment needs. For instance, the patient with congestive heart failure would be listed on one path with therapy and on another without therapy.

3. Sketch characteristics of patients with additional problems.

"We also described what a patient would look like who didn't fit into our plan," Bruhowzki says. "For example, if the patient had a hip fracture and also an infected wound then that case wouldn't be typical and would require more visits."

The pathways describing typical patients were used as a launching pad for determining the resources and staff that would be required for any particular case, she adds.

Express paths list potential problems that might make the patient's care more involved and complicated, and these include infected wounds and comorbidities. Under a category for treatment, all disciplines that should be involved are listed and their duties are outlined. Each path lists a range of planned visits per episode, and the frequency and duration of these visits per discipline.

The pathway encourages efficiency and helps to eliminate duplication, Bruhowzki says. For example, on a particular case, it might be more efficient to have the occupational therapist initiate treatment first; and then a week later, the physical therapist will begin treatment, instead of having all therapists start on the same week, she explains.

The Express Paths are a page long, serving as a quick snapshot for nurses to review with each case. "We wanted the intake nurse to have all of these at her disposal, and when she was referring to a patient, she could use this template of what we expect the care might be," Bruhowzki says. "Then the nurse or therapist or whoever opens the case could come back and say whether the patient fits the profile."

4. Encourage debate over path recommendations.

During team meetings about the Express Paths, various members discussed and debated path recommendations. "We'd have a lot of dialogue between members," Bruhowzki says. "They'd say, 'I think physical therapy can accomplish this,' or the OT might say, 'I need 12 visits, not 10, and can't do it in less than that.'"

So the pathways were developed with input from all disciplines and were created with the goal of giving patients exactly the amount of care they needed in order to reach desired outcomes. The debate and team input into creating the pathway recommendations also helped to give the team ownership in the finished product. This way, team members could encourage other staff to follow the guidelines and trust that the recommendations were developed with the best of intentions.

The team also benefits from working together to decide what kind of care each patient needs and setting standard goals. This teamwork approach has carried over to their use of the pathways, and now therapists, nurses, and other clinical staff are communicating more closely about their schedules and treatment, Lariviere says.

For example, the agency has encouraged staff to think of patient visit scheduling in terms of Monday through Saturday instead of the same two or three days each week. Now team members may ask one another which day they will be

visiting the patient so that a different discipline could make a point of visiting the patient on an entirely different day, Lariviere explains.

"We feel [as if] our care has done nothing but improve, and the statistics and patient satisfaction surveys show that to be true," Bruhowzki says. "Our supervisors feel very comfortable defending any case on why we did so many visits."

5. Use paths for both financial and clinical purposes.

In addition to the clinical Express Paths that are used by the visiting staff, the agency has a separate pathway that has additional information about reimbursement, costs, and planned episodic payment. (**See pathway with reimbursement information, inserted in this issue.**)

"We decided to keep the financial information within the management group," Lariviere says.

During a trial period, the agency wanted to see how well the pathways would work for both clinical and financial purposes; only managers didn't want the staff's judgment to be contaminated by the reimbursement information, she explains.

"They might not be as objective if they knew that if they made one or two more visits, the agency wouldn't be paid," Lariviere says. "We didn't want the staff to make decisions in that way."

Managers, however, go over the income statement and balance sheet and talk about the typical case and what it would cost based on various disciplines providing care, Bruhowzki says.

"The key to managing under PPS is you have to have more involvement with the supervisor than you would under other systems," Bruhowzki says. "The supervisor needs to say to an employee, 'Most staff that care for a patient with this diagnosis are able to reach an outcome within 20 visits, and I notice you're already at 30, and you are only two weeks into the case. So what's going on here?'"

In this example, the nurse might explain that the patient in question has an infected wound, and this would lead the supervisor to ask for the documentation for the wound and to suggest the patient see a wound care specialist, Bruhowzki says.

Each case will have some variations off the pathway, and this is expected, Lariviere says.

However, it's the overall picture that is important and the Express Paths help to make this clearer. The computerized pathway financial information provides managers with a comprehensive look at the disciplines involved in each case, the number of visits that were made, the reimbursement paid, and other pertinent data, Lariviere says. "So you can see how much you were paid and with the information about the number of visits made you can see how much you've already spent." ■

Sources

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Use OASIS education to report adverse events

Show nurses how to answer OASIS questions

Has your agency been seeing unusual numbers of adverse event reports with the introduction of the Outcome and Assessment Information Set (OASIS)?

If so, the problem may not be the quality of your care. The answer may be as simple as teaching nurses to more carefully answer the OASIS questions to better reflect the patient's true condition at admission, says **Jean Arias**, RN, CHCE, administrator at Baptist-South Miami Home Care. "I think across the nation, people are finding that their adverse event reports have picked up some problems in their agencies. And basically, some of those problems are simply the nurses not answering the OASIS questions correctly."

Arias and **Mervita Byer**, RN, director of professional services for the agency, have been developing educational and auditing tools to help pinpoint nurses' difficulties with the OASIS questions and resolve them.

They say an agency should be looking carefully at every adverse event — regardless of whether the agency's numbers exceed average — to determine the cause of the problem.

In fact, Baptist-South, which admits about 3,000 patients a year, is working to pick up potential problems even sooner — by auditing all charts on discharge and looking for adverse events before a report is even generated.

Not only will this help find cases that are improperly labeled as adverse events, but it helps point to real problems that should be promptly addressed.

Unexpected death reports

As an example of how a closer examination of adverse event reports might help an agency, Arias and Byer cite the most extreme of adverse events — an unexpected death.

Often, they say, patients whose deaths are classified as unexpected are those who nurses knew were declining and likely could die sooner than six months after admission. However, because a doctor had not formally given the patient a terminal diagnosis, they were answering the key OASIS question, M0280, by stating that the patient had a life expectancy of greater than six months.

"Because [the patient] hasn't been labeled 'terminal,' the nurses won't put that they expect death in six months," Arias says. "And in fact, the patient dies. Well it's no big surprise, however, it is an adverse event."

This did, in fact, happen with a patient at Baptist-South, Arias says, prompting the agency to look at how nurses answer the M0280 question.

Now, nurses are taught to use their own judgment to answer that question, based on the diagnosis and other factors.

For example, Byer says, if a nurse admits a patient with chronic obstructive pulmonary disease (COPD) who is clearly declining, although not formally labeled terminal, she could choose to answer on M0280 that she believes the patient has a life expectancy of less than six months.

"If it's someone with end-stage COPD who the nurse has seen before, who is progressively going downhill, you know that person can really get into trouble at any point," Byer says. "At that point, I could say, I'm going to give this patient six months or less.

"If I'm wrong, fine, because the patient is still going to live and is going to be OK," Byer says. "But if I see that the patient continues to deteriorate and I don't do this, then it's going to come to me as an adverse event because the patient really could go within six months."

Another red flag would be a patient whom the doctor refers to hospice, but who refuses hospice care. "That is telling me that this should really be looked at because the doctor or the social services at the hospital think that hospice is warranted, but the patient is refusing, because of denial or whatever," Byer says.

She would choose to answer M0280 by stating she believes the patient has less than six months to live, "because this was foreseen by somebody else, even if the patient or the family were not really accepting it."

In fact, Healthcare Financing Administration's (HCFA) own instructions on answering question M0280 call for the interviewer to use past health history, observed health status and other sources as well as the physician's expectations, to form a judgment regarding life expectancy.

Instructing nurses to make these kinds of judgments required inservicing that went into detail on all of the OASIS questions having to do with adverse events. "We educated nurses as to the standard and what HCFA really meant, what was really meant when OASIS was developed," Arias says. "So now we're clear, and we feel that the answers the nurses will give will be accurate."

Byer says it can be a challenge to get nurses into the mindset that they can apply their own judgment to the OASIS assessment. "The nurses are becoming more accustomed to taking hold of something like that and making a decision that is only really for the OASIS outcome."

Nurses who seem to have the most problems with OASIS are assigned to an OASIS instructor who deals in small classes of two people for about half a day.

Byer says the instructor has told her he has seen tremendous improvement in those nurses who have gone through the intensive training.

Develop policy for handling adverse events

Baptist-South's audit program also points to situations in which an adverse event report may be warranted, but isn't the result of poor care, Arias says.

For example, she says, a patient may be discharged while unable to take medication unassisted, but may have family members or caregivers in the home who administer the medication.

"On admission, we have it documented that the patient's family or caregiver is administering those medicines," Arias says. "Then on discharge, the family or caregiver is still administering those medicines. Yes, that OASIS question will show that the patient has not improved, however, when the surveyor comes out to review the chart, he or she will see that it's justified. The patient was in fact, safe on discharge and we did not underutilize in the visits."

Sources

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Arias estimates that of the 13 adverse events, some agency in the country is having problems with at least one of them. "We just came from a meeting in Washington, and some agencies have problems with almost all of them," she says.

She says agencies trying to get a handle on adverse event reporting should first figure out a consistent process for dealing with the reports as they come up.

In each case, the agency should deal with the chart and with the nurse or therapist involved. Then, if a problem is uncovered, it should be disseminated to the entire staff, since the issue will probably come up again. "If it's only a documentation error, or an error in the concept of how the nurse should answer the OASIS question, then that's a simple one to deal with," Arias says.

Another guideline is to use the Joint Commission on Accreditation of Healthcare Organizations' standard for dealing with sentinel events.

Most importantly, Arias says: Use the adverse events reports as a guide to educate staff and don't be afraid of them. "Anytime we know the surveyors have information and they're going to come and survey us, it creates fear," Arias says. "But if you're working on it and you put a program in place to work on it, and use the Joint Commission criteria toward the adverse events, your program should work out pretty well." ■

Student program may improve quality of care

'HealthLink' used for nonhomebound patients

The Visiting Nurses Association (VNA) Inc. of New Orleans, has developed a unique program that provides a continuum of care for home care patients who no longer qualify for Medicare home care services, but still need some assistance in order to prevent rehospitalizations.

Called HealthLink, the program is offered free to patients and is not costly to the home care agency because it's provided by student nurses.

"Our mission is to assist clients to promote good health and to control their disease and to help them develop, maintain, and use their family and community support system," explains **Katherine France**, RN, MN, executive director.

When the VNA started the program two years ago, managers thought it would reduce hospitalizations, but might result in more patient referrals to home care services, France says.

Instead, the program has worked so well in preventing problems that only two patients have needed referrals for home care services, and rehospitalizations or emergency room visits also have been prevented, France says.

"Have we generated more Medicare patients as a result of the program? No, but that just goes to show how good the students have been doing, and it's a wonderful community resource that helps us do what we're supposed to be doing in keeping people healthy," France says.

Here's how the program works:

• **Establish relationship with nursing college.**

The New Orleans Visiting Nurses Association has established a relationship with the Louisiana State University Medical Center's nursing department so that the school's professors help to operate the HealthLink program. The school's bachelor's degree nursing students must complete a community rotation, which fits in ideally with the VNA's HealthLink program, so this is offered to students as one option.

"The university faculty members review all documentation with us, and we have an RN coordinator and an LPN who also work with HealthLink," France says. "We also have duties descriptions for senior nursing students, plus a confidentiality agreement they must sign."

The VNA's clerical employees answer all incoming HealthLink calls and enter HealthLink patients into a computer database, as well as make copies of all forms used by students and faculty members.

The agency's licensed practical nurse (LPN) assigned to HealthLink is responsible for conducting phone interviews every two weeks to patients and completing a questionnaire for the RN coordinator and student nurses to use in planning patient educational and health screening needs. The LPN also may visit patients under the RN coordinator's guidance, and the LPN is

VNA's HealthLink senior nursing students' duties

The New Orleans-based Visiting Nurses Association Inc. has devised this summary and responsibilities list for student nurses participating in the agency's HealthLink program:

Duty Summary:

The student nurse is responsible for the assessment of patient's needs, contributes to the plan for fulfilling patient's needs, implements a plan, evaluates and engages in outcome measurements as related to patient's outcomes, and provides education community resources to patients and caregivers.

Responsibilities:

- Conducts biannually assessments on patients.
- Implements the plan of care with goals mutually established with the patient, caregiver(s).
- Provides education regarding diagnosis, medications, safety precautions, preventive procedures, health promotion strategies, and self-care needs to the patients and caregivers in accordance with the plan of care.
- Evaluates the patient, caregiver(s), home environment, and family structure to determine what assistance, health teaching, and services will be required, as well as what assistance will be available from the family/caregiver(s).
- Evaluates the patient's condition and support system to determine if a referral to another community resources is required.
- Develops and begins implementation of the initial plan of care with input from the patient and/or caregiver(s).
- Reports patient's condition, medication changes, and care needs to the university's faculty member and RN coordinator or his/her designee at the end of the patient's visit.
- Evaluates the effectiveness of care and makes revisions based on the patient's changing physical and psychological, environmental, and spiritual needs, including but not limited to reactions to medications and treatments.
- Submits total documentation to the University's faculty member for review. The student places their documentation in the designated section of the patient's HealthLink chart.
- Performs a complete nursing assessment including a head-to-toe physical examination of the patient, including all systems, each visit and regularly re-evaluates any present and/or potential problems and needs related to the health of the patient, family/caregiver, and community.
- Functions as patient advocate and facilitator for the patient.
- Makes changes/updates to medication sheet on the same day the changes occur.
- Utilization of resources in the community to assist the patient, family/caregiver, and the community. ■

supervised by the HealthLink RN coordinator.

The HealthLink RN coordinator is a registered nurse who supervises all aspects of the program, including providing assistance in assessing patient's needs, contributing to patients' care plan, and evaluating care plans and outcome measurements. Also, the RN coordinator provides orientation and job training to students, university faculty members, and nursing service personnel.

- **Develop protocol.**

HealthLink has three different service levels once a referral is made. **(See story on VNA's HealthLink mission and procedures, p. 82.)**

The first is a telephone call made by VNA office staff. They contact HealthLink clients once every two weeks and follow a telephone triage protocol.

"Every week, we make a telephone call to them to find out how they're doing and whether their living arrangement has changed," France says. "We ask if they have all of their medications and we make sure that they know what their medications are for, including side effects, food and drug interactions."

Next there is a profile visit, which is the initial evaluation visit that is done biannually with a comprehensive assessment. Students, accompanied by faculty members, conduct these evaluation visits and obtain all the necessary information about the client.

The last service level is the maintenance visit, which is in response to what is discovered during the profile visit or through a weekly telephone call. The student nurses make the maintenance visits in pairs, so no one is ever alone in the home. Student nurses assess patient's needs, implement a plan, and evaluate outcome measurements. **(See nursing student's duties list, above.)**

A client might be an 80-year-old woman who needs to be reminded daily to take her medicine. Otherwise, the woman is independent. So HealthLink will place those daily calls, and if other problems are discovered then the agency will send a nurse out to evaluate the woman's situation.

- **Have students conduct assessments.**

Students work for the agency two or three times a week, traveling in pairs to client homes. During school sessions, the VNA might have as many as

About HealthLink

The Visiting Nurses Association (VNA) Inc. of New Orleans has developed a free comprehensive service that provides health monitoring for people who because of age and/or disease need some in-home assistance but do not qualify for Medicare, Medicaid, or private insurance-paid home care services.

1. Mission:

The HealthLink program assists clients to promote good health, control their disease, and minimize the impact of their disease. It also helps clients develop, maintain, and use their family and community support systems.

2. Goals:

The HealthLink program helps nursing students facilitate and support the patient's own efforts to maximize health and minimize illness. It also empowers students to use their own judgment, collaboration, and problem-solving skills during the care planning process. The program also will increase the student's assessment skills of the patient's environment, physical, financial, social, and spiritual needs, and it provides them with professional growth opportunities and participation in outcome measurement.

3. Procedures:

• The RN coordinator reviews the record after a referral has been made to HealthLink, and the coordinator sees if the referral meets the criteria.

• Within 10 days, if the client meets the criteria, the RN coordinator schedules an initial evaluation visit, and after this profile visit the patient's plan of care is established.

• Telephone visits begin and continue every two weeks, using a special questionnaire along with any other important questions specified by the RN coordinator or the student nurses.

• Students assess and evaluate the patient's needs and adjust the plan of care for maintenance visits.

• If the patient is found to need some skilled nursing or therapy treatment, then a referral is made to the home care department.

• Students are given space in a VNA conference room where they can make telephone calls and hold conferences with faculty members.

• If a patient's condition has changed, the student reports this to the university faculty member and the RN coordinator at the end of the visit.

• The university faculty member prepares the student's assignment sheet and the student's daily activity log with the RN coordinator a week in advance.

• Students call patients the evening before the visit to confirm the appointment.

• Students complete additional records and documentation, including a client demographics record, a visit record, a Lawton-Instrumental Activities of Daily Living Scale, a Folsteins Examination, and a HealthLink log.

• Students report on the patient's condition and medications to the university faculty member and the RN coordinator and they may report any changes in the patient's condition, medication, and care needs.

• At the end of the day, the student submits documentation to the university faculty member for review. ■

eight students working for HealthLink each day.

The assessments are designed to take a thorough look at the client's living situation and the client's ability to be independent. If a student discovers that a patient needs something, such as a cane or walker, then the student will talk with the HealthLink coordinator about the need, France says. **(See story on student nurses learning about home care, p. 84.)**

"This teaches students how to do a full assessment in the home, including assessing physical, emotional, and spiritual aspects," France says. "They ask clients about whether they are attending a church or have a support group, and they'll also assess the home environment to make sure it's safe."

However, if the student finds that a patient has had serious problems, such as falls or injuries, then the agency's director of nursing also will get involved to evaluate the situation, France adds.

"The VNA coordinator will contact the family and say there is a problem and that the client needs to be paid a home care visit by a nurse, or the patient will need to see a doctor," France says. "That evaluation can be a Medicare or Medicaid visit or be paid by private insurance."

• **Provide follow-up to students' observations.**

"Students have discovered so many potential problems, many of which they could handle alone," France says. "Many times, elderly people are very confused, so when they get a new medication, they

COMING IN FUTURE MONTHS

■ Instill managerial skills and spirit into staff

■ National pain management project offers much to home care

■ Better manage home health patients by assigning them to risk groups

continue to take the old one, and may end up in the hospital due to an overdose. When student nurses go into the home, they have the patients bring out all of the medications they are on and let them know if there are some medications they are no longer supposed to be taking."

Also, students have helped to avert medical emergencies among diabetes patients by talking with them and finding problems that needed to be corrected before the patient's diabetes went out of control, France adds. "The patient will ask the student what he or she should do, and the student will say that the patient needs to go see the doctor."

Other times, students will identify problems that can be resolved by having a home care nurse visit the home.

To make certain that clients gain the most from the program, the agency teaches students how to gain patient buy-in to HealthLink services.

"I tell student nurses all the time that they may want to go in there and do great things, but if the client doesn't want them to do it, it won't get done," France says. So students are taught to inform clients that they will visiting the home for X amount of weeks, and then they ask the client what the client hopes to have accomplished by the end of that time period.

Clients might say they want to learn all about their disease, or maybe they want reading material or someone to read to them. Students have helped patients understand their prescriptions by reading them the pamphlets about side effects and drug interactions, France says. "Especially in this area, students often find that the reason people don't take their medications correctly is because they can't read."

- **Make schedule to cover student holidays.**

The only drawback to a community service such as HealthLink is that is dependent on the schedules of nursing students, and during holidays and school breaks there will be no coverage.

The VNA provides the service year-round, so during the summer break, VNA staff provide the visits, although they may visit patients fewer times than would the students, France says.

Typically, the agency relies on the telephone calls to clients to assess their need for a home visit and to make sure they are following through on health care plans, she explains.

"Sometimes, the patients have already been seen under Medicare or another insurance provider, but they still need to be monitored, and so we'll go out there to see what's happened," France adds. "Often, they just need to be reminded about when

CE objectives

After reading each issue of *Homecare Quality Management*, the quality manager will be able to do the following:

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

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their next appointment is, and right after they go to the doctor, we call them to let them know that we're here if they need anything or if they don't understand something their doctor said." ■

Internships key to future for home care nurses

Homecare exposure builds good relations

The home care environment is more than a little daunting for nursing students, and it often continues to be a more intimidating work environment to nurses who work in hospital settings.

Suppose then, that a home care agency had the opportunity to give fledgling nurses a brief exposure to the benefits and importance of home care nursing. It possibly could plant seeds that will come to fruition sometime within the next five to 10 years, and as the medical field faces severe nursing shortages in coming decades, this could be just the advantage a home care agency needs.

At least that's a potential side benefit to a program called HealthLink that uses student nurses to make visits to certain clients of the Visiting Nurses Association (VNA) Inc. of New Orleans. The program is free to clients who have already received home care services and no longer qualify and to other clients who do not qualify for home care services but need additional support and guidance.

"When we first get the student nurses, they are scared and afraid to do a visit, even though they travel in pairs," says **Katherine France**, RN, MN, executive director. "To the students, these clients are strangers and they don't know anything about them. Of course, we teach them that safety comes first, but when they visit patients' homes, they are hit with the reality that people are living on $500 a month and have trouble paying their rent or that their home may not be immaculately clean."

While the home visits may be shocking at first, students soon learn that this also is an exhilarating way to provide nursing services. The home care nurse has the opportunity to help patients in ways that a hospital nurse never could.

For example, one of the VNA's student nurses visited a multiple sclerosis patient for whom the student could do little to aid medically. However, the student had been taught to ask the patient an open-ended question of "What is it you would like me to do for you?" This patient had a very specific request: "She told her that she'd like the student to help her get a high school diploma," France recalls. "The student made phone calls and then referred the client to where she could attend a community college to receive her GED."

The student also asked the Tulane University engineering department for a special engineering device that would enable the patient to get into and out of bed on her own, and the student obtained a free computer for the woman.

Not only was the experience helpful to the patient, who worked for her GED and then continued with taking community college courses, but it was extremely gratifying to the student nurse who made it all possible.

"This gives nursing students an introduction to home care, which in view of our nursing shortage is a good idea," France says. "It gets them used to the idea of being independent and making decisions and analyzing problems on their own."

France says she hopes these student nurses will remember their home care experiences after they graduate and begin to work in hospitals, so that they might one day decide to return to the home care environment. ■

United Home Health Services Inc. Agency Protocol

Diagnosis: Knee Replacement

Anticipated HHRG(s) Low C1 F1 S2 1.6752 High C2F3S3 2.2429

ICD-9 code: 716, 717

Patient Picture: Primarily a therapy patient. Pain, ambulating with walker, incision, edema ▼ ROM & strength.

*** GOAL(S)**

1. Safe functional mobility, gait, transfer with independent hom exercise plan (HEP).
2. AROM of knee 0˚-95˚ in sitting position.
3. Strength WFLs in affected extremity.
4. Stable management of medical needs in a safe environment.
5. Safe follow through of all medical precautions, i.e., bleeding.

PROBLEMS

1. Noncompliance with Med regimen/blood draws.
2. Infected wound.
3. Inadequate resources.
4. ▲ risk factors & comorbidities.

TREATMENTS

Pt Assess surgical wound, transfer/bed mobility, functional walking through progressive, gradual success-oriented mobility, therapeutic exercise, balance/coordination and HEP.

SN* (If needed) Evaluate vital signs, blood draws, staple removal; educate/teach med regimen & s/s infection.

Planned visits per episode: 16-20

Frequency and duration of visits

	Initial period	
Discipline	***Frequency/duration***	
SN (if needed)	1 wk	2-4
PT	3 wk	2
	2 wk	4
	1 wk	2

16-20 visits

*If physician orders for staple removal on admission, Nursing is the primary discipline.

Source: United Home Health Services, Inc. Canton MI.

United Home Health Services Inc. Agency Protocol

Diagnosis:
ICD-9 code

Anticipated HHRG(s) Low C F S
High C F S

Possible Reimbursement Range $

Patient Picture

*** GOAL(S)**

1.
2.
3.

PROBLEMS

1.
2.

TREATMENTS
SN
PT
OT
MSW
HHA
RD

Discipline	***Frequency/duration***	***Cost***	***Planned episodic payment***	***Variance***
SN				
PT				
OT				
MSW				
HHA				
RD				
	Total Visits	***$_____***	***(Range) C F S + or - $***	***C F S + or - $***

*If physician orders for staple removal on admission Nursing is the primary discipline.

Source: United Home Health Services Inc., Canton, MI.