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Hospital Home Health®

the monthly update for executives and health care professionals

IN THIS ISSUE

AUGUST 2001

VOL. 18, NO. 8 (pages 85-96)

Sometimes working overtime is the only way to get the job done on time

A fair schedule? It's neither easy nor impossible

Working overtime is not the sole property of health care professionals or new hires eagerly climbing the corporate ladder. There is an understandable — and somewhat undesirable — aspect to putting in more than the 50 or 60 hours many home health professionals put in, especially when that extra time cuts into family time.

For home health care agencies venturing into the world of overtime, the problem is how to distribute the on-call hours evenly and how to fairly compensate employees.

Coming up with a win-win solution is not always as easy as breaking down the hours into even amounts. "It took a long time to work out a call plan that seemed fair. Although home care is a very different animal, our nurses needed to know that they were receiving the same treatment when on call as [someone working in] the lab or radiology," says **Teresa Craft**, RN, director / home care for Covington County Hospital in Collins, MS.

Lisa Sprinkel, director of Carilion Home Care Services in Roanoke, VA, knows firsthand how difficult establishing a good working system can be and what happens if you fail. "Our hospital-based agency was experiencing a considerable amount of turnover, which those leaving us attributed to the on-call experience. . . . We average about 3,000 admissions per year and are committed to expedient service, so we frequently have admissions that must be done in the evening. Occasionally, we'll have several visits that must be done at 8 p.m. for medication administration, etc."

Hiring for on-call duties exclusively

To make the on-call experience more palatable for all involved, she says, Carilion devised a novel approach and advertised for and hired two on-call positions. "One on-call nurse works Monday through Thursday from 2 p.m. until 8 a.m. She is paid a salary and is expected to see scheduled p.m. visits as well as any PRNs [as needed cases] that are called in.

NOW AVAILABLE ON-LINE! Go to www.ahcpub.com/online.html. Call (800) 688-2421 for details.

Our weekend on-call nurse works from 2 p.m. on Friday until 8 a.m. on Monday and sees scheduled patients, manages the beeper, and sees or assigns PRN calls to her backup nurses.

"We routinely staff at least four, sometimes five, nurses every weekend. In addition to our weekend on-call [nurse], we have one other full-time weekend RN and one full-time weekend LPN [licensed practical nurse]. Then our nursing staff rotate weekends, about one per month," she says.

Sprinkel says this new routine has "been a tremendous staff satisfier and has resulted in a decreased turnover rate. When it comes down to it, it's not really the work that's associated with on-call [duty] here. It's the perception of being chained to the beeper that's overwhelming."

Assigning weekend-only on-call duty

Carilion Home Care Services is not the only agency to assign nurses to weekend-only duty. Olympic Medical Home Health in Port Angeles, WA, also has a weekend nurse who takes calls from Friday evening to Monday morning, explains **Alberta Stamp**, RN, nursing supervisor. That nurse is paid for an eight-hour day both Saturday and Sunday, she says, plus a flat rate of $30 a night for the evening shift.

Other nurses share the rest of the call and are paid $30 a night and then hourly if they are called out, she explains, adding that it "amounts to one to two days a month of [working] on call."

Kathy Kieke, RN, MSN, care center director for St. Cloud (MN) Hospital Home Care and Hospice, says her agency has "a team of on-call nurses, five in all, who share the weekday and weekend on-call [duty]. We also have a nurse who works 1 p.m. to 9 p.m. Monday through Friday who takes the scheduled late-in-the-day visits and admits."

On-call nurses receive $4.85 an hour when they're just carrying the beeper, and [they receive] their regular wage, plus $1 an hour additional pay, when they are working. None of these staff are scheduled to work holidays, she says.

One former home care agency administrator says her agency had full-time, triage registered nurses on staff who took the calls from home on phone lines paid for by the agency. These nurses, she explains, worked from 5 p.m. to 8 a.m. and covered all programs from home care to private duty and hospice to DME/IV (durable medical equipment).

CE questions

17. When utilizing on-line sources of health care information, the Centers for Disease Control and Prevention (CDC) recommends that people:
    A. put greater trust in sites created by major medical centers, national organizations, universities, and government agencies
    B. look for the most professional-looking web sites
    C. look for sites with the most recent or current information
    D. determine if qualified professionals review the content
    E. A, C, and D

18. According to the CDC, the following vaccinations are among those recommended by age 2 and can be given over five visits to a doctor or clinic:
    A. three doses of polio vaccine
    B. three doses of hepatitis B vaccine
    C. one dose of pneumococcal vaccine
    D. A and B
    E. all of the above

19. According to a recent survey, more than 75% of health care organizations have yet to complete the assessments of their current environments and risks that are necessary to comply with the Health Insurance Portability and Accountability Act transaction regulations, which are due to be implemented in less than 18 months.
    A. true
    B. false

20. The Health Care Financing Administration has changed its name to:
    A. Medicare and Medicaid Accounting Services (MMAS)
    B. Center for Medicare and Medicaid Administration (CMMA)
    C. Centers for Medicare and Medicaid Services (CMS)
    D. Medicare/Medicaid Health Care Services (MHCS)

These nurses did not make visits, she says, but program staff worked rotating shifts to cover those visits and were paid time and a half from the time they left home until the time they returned.

When full-time goes on call

Not every agency can afford or wants to hire nurses solely to cover the on-call hours. In these cases, as all too many home care professionals know, it is left to the full-time staff to take over.

Having a plan that is the same for everyone across the board has "made it much easier to establish a workable call-back plan." Craft says.

At Covington County Home Care, she says, "nurses rotate call, which starts Monday at 8 a.m. and runs for seven days. When a LPN is on call, there is a RN assigned to backup call. The call schedules are posted three months at a time, so everyone can plan accordingly, and weeks can be swapped between staff, if needed. This has been our policy for several years and works well."

Covington call staffers are paid "$10 a shift for all shifts that do not fall into the regularly scheduled working hours of 8 a.m. to 4 p.m. which is $160 a week. We get time and a half for everything over 40 hours, which is basically what the hospital does."

Helen Eriksen, PPS nurse auditor at Abington Memorial Hospital Home Care in Willow Grove, PA, explains that all her agency's full-time nurses take call duty, which usually adds up to about two to three weeks out of the year.

For their extra work, they are paid $2.50 an hour, plus the hourly rate if any visits are made. Specialty teams, Eriksen points out, handle their own call hours separate from the general home care patients.

Another supervisor, whose agency has a similar program, says her agency's nurses, if they are called out, are paid an hourly rate for a minimum of two hours in addition to the $2.50 an hour they are already earning on call.

Another supervisor explains that her regular nurses are on call and rotate through the cycle about once every three months for primary call and again for secondary call duty. Visits, she says, are paid on a per-visit basis in addition to what nurses are earning as a base call rate.

Peggy Ford, performance improvement coordinator at Via Christi Home Health in Wichita, KS, explains that her agency, after analyzing several options, recently went to a case manager model whereby the agency's "field staff are divided into disease management teams. Each team has a salaried case manager who coordinates the clinical and financial aspects of care. Then there are between two and four visiting staff assigned to each case manager to do the routine visits. The case managers do not take call."

Using appropriate staff for routine needs

As for evening and weekend call duty, Via Christi has continued to use a noncase manager system.

Under this program, she says "the noncase manager staff obtain the open paperwork, review the patient's rights with them, etc., but the case manager completes the initial assessment within 48 hours and completes the OASIS [outcome and assessment information set] and 485 paperwork.

"The full-time visiting RNs rotate call one week at a time and receive $2 an hour in addition to receiving their per-visit pay for time worked while on call. We also track phone time by hours and minutes and convert it to per-visit pay," Ford continues.

"Opens that must be done on the weekend are handled by the visiting staff on call, and then the case manager on Monday completes 485 and OASIS. We also have RNs assigned to work weekends," she explains. "Each RN will work every fifth weekend to handle scheduled weekend visits for which they are paid per visit and entitled to take a day off during the week."

The maternal/child team, Ford adds, are paid on the same scale as the general RNs, but as there are fewer of them to share the responsibility, they are on call more often.

No rest for the weary

While full-time nurses and LPNs earn overtime pay for their call duty, rarely is this the case for administrative call. Only one home care manager said that she was paid for her call duty (about one night every three weeks) for which she received a flat fee per night. Kieke and others say that being on administrative call is part of their job description, and hence they don't see any additions to their paychecks.

Kieke says she is fortunate in that she shares her duty with that of the hospital staff and so it comes up only quarterly.

One home care supervisor says not only is she on call 24/7 for her agency but she is on administrative call for her agency's hospital roughly every six weeks.

"Administrative call for me rotates each week," says Ford. "Intake has [people] on call to handle referrals that come from the hospitals on the weekends. They work eight hours on Saturday, then receive the on-call rate for Sunday for the eight-hour shift."

At Olympic Home Health, explains Stamp, "We have four management levels that share on a two-week rotating basis. We are on for administrative backup, i.e., if the answering service cannot reach the nurse or there is an administrative problem. There's no pay involved, it is just a part of our duties."

No matter what system is used, it may feel to many home care professionals whether they are in the field or in the agency office, that they are always, in some sense, on call.

Becky Massey, director of home health services for Thomas Memorial Hospital in South Charleston, WV, sums it up like this: "I am on call 24/7 except when I'm out of town."

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An Internet guide to immunizations

Here's a reliable source for the latest vaccines

One of the best features of the Internet is the wealth of information it provides, but that wealth can also be its worst feature. With so much information, it's hard to wade through it all, let alone determine what is and isn't useful or credible.

With a subject as important as immunization, home care workers can't afford to take the wrong advice. The Mayo Clinic in Rochester, MN, and MayoClinic.com have compiled a list of helpful and common-sense hints in determining whether a web site should be added to your list of bookmarks or noted as a bad information source.

• **Get to the source.**

Put greater trust in sites created by major medical centers, national organizations, universities, and government agencies.

• **Check your background.**

Is the content based on published medical research? Try to determine if qualified professionals review the content.

• **Check to see if the information is current.**

Thanks to new research, health information is

(Continued on page 91)

The importance of being immunized

With schools about to reconvene, it's important that children be properly immunized. Each state requires that children be vaccinated against the major childhood diseases.

Log on to www.immunizationinfo.org for specific listings. If you suspect your patients or their children have not been properly vaccinated and are hesitant because of fear of side effects or because they are unaware of the importance of early immunization, two fact sheets in English and Spanish from the Centers for Disease Control and Prevention in Atlanta **(see pp. 89-90)** might help clear the way. ■

10 Facts About Immunization

1. **Why should my child be immunized?**
   Children need immunizations (shots) to protect them from dangerous childhood diseases. These diseases can have serious complications and even kill children.
2. **What diseases do childhood vaccines prevent?**
   Measles, mumps, polio, rubella (German measles), pertussis (whooping cough), diphtheria, tetanus (lockjaw), *Haemophilus influenzae* type b (hib disease — a major cause of bacterial meningitis), hepatitis B, varicella (chickenpox), and pneumococcal disease (causes bacterial meningitis and blood infections).
3. **How many shots does my child need?**
   These vaccinations are recommended by age 2 and can be given over five visits to a doctor or clinic:
   - 4 doses of diphtheria, tetanus, and pertussis vaccine
   - 4 doses of hib vaccine
   - 3 doses of polio vaccine
   - 3 doses of hepatitis B vaccine
   - 3 doses of pneumococcal vaccine
   - 1 dose of measles, mumps, and rubella vaccine
   - 1 dose of varicella vaccine
4. **Do these vaccines have any side effects?**
   Side effects can occur with any medicine, including vaccines. Depending on the vaccine, these can include slight fever, rash, or soreness at the site of injection. Slight discomfort is normal and should not be a cause for alarm. Your health care provider can give you additional information.
5. **Can they cause serious reactions?**
   Yes, but serious reactions to vaccines are extremely rare. The risks of serious disease from not vaccinating are far greater than the risks of serious reaction to a vaccination.
6. **What do I do if my child has a serious reaction?**
   If you think your child is experiencing a persistent or severe reaction, call your doctor or take the child to a doctor immediately. Write down what happened, and the date and time it happened. Ask your doctor, nurse, or health department to file a Vaccine Adverse Event Report form or call (800) 338-2382 to file this form yourself.
7. **Why can't I wait until my child starts school to have him or her immunized?**
   Children under age 5 are especially susceptible to disease because their immune systems have not built up the necessary defenses to fight infection. By immunizing on time (by age 2), you can protect your child from disease and also protect others at school or day care.
8. **Why is a vaccination health record important?**
   A vaccination health record helps you and your health care provider keep your child's vaccinations on schedule. If you move or change providers, having an accurate record might prevent your child from repeating vaccinations he or she has had already. A shot record should be started when your child receives his/her first vaccination and updated with each vaccination visit.
9. **Where can I get free vaccines?**
   A federal program called Vaccines for Children provides free vaccines to eligible children, including those without health insurance coverage, all those who are enrolled in Medicaid, American Indians, and native Alaskans.
10. **Where can I get more information?**
    You can call the National Immunization Information Hotline at (800) 232-2522 (English) or (800) 232-0233 (Spanish).

Source: Centers for Disease Control and Prevention, Atlanta. Web: www.cdc.gov/nip/publications/fs/gen/shouldknow.htm.

Diez Cosas Saber Sobre las Vacunas

1. **¿Por qué debo vacunar a mi hijo?**
   Los niños necesitan vacunas para protegerlos de enfermedades infantiles peligrosas. Estas enfermedades pueden tener complicaciones graves y provocar incluso la muerte.
2. **¿Qué enfermedades evitan las vacunas?**
   Sarampión, parotiditis (paperas), polio, rubéola, pertussis (tos ferina), difteria, tétanos, hepatitis B, varicela, *Haemophilus influenzae* tipo b (meningoencefalitis).
3. **¿Cuántas vacunas necesita mi hijo?**
   Se recomienda administrar las siguientes vacunas antes de cumplir los dos años. Se pueden administrar durante cinco visitas al consultorio médico o a una clínica:
   - 4 vacunas contra la difteria, tétanos y pertussis
   - 4 vacunas contra la Hib (una de las causas principales de la meningitis espinal o meningoencefalitis)
   - 3 vacunas contra la polio
   - 3 vacunas contra la hepatitis B
   - 1 vacuna contra el sarampión / parotiditis / rubéola
   - 1 vacuna contra la varicela
4. **¿Son seguras las vacunas?**
   Es muy raro que las vacunas produzcan una reacción seria, pero puede suceder. Sin embargo, los riesgos de contraer una enfermedad grave por no administrar la vacuna son mucho mayores que el riesgo de que la vacuna produzca una reacción seria.
5. **¿Tienen las vacunas efectos secundarios?**
   Sí, las vacunas pueden tener efectos secundarios, dependiendo de la vacuna: fiebre leve, sarpullido o dolor en el lugar de la infección. Una ligera incomodidad es normal y no debe ser motivo de alarma. Su médico le puede proporcionar mayor información.
6. **¿Qué debo hacer si mi hijo tiene una reacción seria?**
   Si usted piensa que su hijo está experimentando una reacción persistente o seria, llame a su médico o lleve a su hijo al consultorio médico inmediatamente. Escriba lo que sucedió así como la fecha y hora en que ocurrió. Pídale a su médico, enfermera o departamento de salud que llenen un formulario de Informe de reacción adversa a las vacunas o llamen al (800) 338-2382.
7. **¿Por qué no puedo esperar hasta que mi hijo empiece el colegio para ponerle las vacunas?**
   Las vacunas deben empezar al momento del nacimiento y haber terminado en su mayor parte a la edad de dos años. Al vacunar a su hijo a tiempo (antes de los dos años) usted lo puede proteger de infecciones e impedir que contagie a otros en la escuela o guardería. Los niños menores de cinco años son muy susceptibles a contraer enfermedades porque sus sistemas inmunológicos no han desarrollado las defensas necesarias para luchar contra las infecciones.
8. **¿Por qué es importante tener un registro sanitario de vacunas?**
   Un registro sanitario de vacunas le ayuda a usted y a su médico a administrar las vacunas a tiempo. El registro debe empezar en el momento del nacimiento, cuando el niño debe recibir su primera vacuna, y debe ser actualizado cada vez que el niño reciba la siguiente. Esta información le será útil si usted se muda o cambia de médico, y también en el momento de inscribirlo en una guardería o cuando empiece el colegio. Recuerde llevar el registro cada vez que lleve al niño al médico.
9. **¿Dónde puedo obtener las vacunas de manera gratuita?**
   El programa de vacunas para niños proporciona vacunas de manera gratuita a los niños necesitados. Pueden beneficiarse del programa todos los niños sin cobertura de seguro médico, todos los que están inscritos en Medicaid, los indios americanos y nativos de Alaska.
10. **¿Dónde puedo obtener más información?**
    Usted puede llamar a la línea de Información nacional de vacunación para obtener mayor información: (800) 232-0233 (Español); (800) 232-2522 (Inglés).

Source: Centers for Disease Control and Prevention, Atlanta. Web: http://www.cdc.gov/spanish/inmunizacion/debesaber.htm.

(Continued from page 88)

dynamic and subject to change. Reliable web sites date the content they publish.

• **Look for the logo of the Health on the Net (HON) Foundation.**

Sites that display this logo agree to abide by the HON Code of Conduct. This code includes eight principles, among them that a site must provide information from medically trained professionals, list its funding sources, and distinguish advertising from editorial content.

When it comes to references on immunizations, MayoClinic.com recommends:

• National Immunization Program (NIP), **www.cdc.gov/nip**;

• National Vaccine Program Office (NVPO), **www.cdc.gov/od/nvpo/default.htm**.

Both programs are administered by the Centers for Disease Control and Prevention in Atlanta. The NIP provides leadership for the planning and coordination of immunization activities in the United States.

The NVPO helps coordinate federal, state, and local agencies, health care providers, and private-sector entities that play a role in immunization programs.

The NIP site offers national immunization program news, updates on flu vaccines, a searchable database, childhood immunizations schedules, adult-recommended vaccines, and more. The NVPO site offers a look at immunization laws, and the U.S. national vaccine plan.

• National Network for Immunization Information (NNii), **www.immunizationinfo.org**. As a nonprofit organization of doctors and medical researchers, the NNii offer immunization information to the general public, legislators, and health care providers. The site's offerings include a state-by-state list of vaccination requirements and a Q&A about school immunization laws.

• Immunization Action Coalition (IAC), **www.immunize.org**. A nonprofit organization, IAC, is dedicated to improving immunization rates and preventing disease. This site also offers immunization information in a variety of languages, including but not limited to: Arabic, Cambodian, Croatian, Farsi, French, German, Hmong, Japanese, Punjabi, Russian, Spanish, Somali, Turkish, and Vietnamese.

• Association of State and Territorial Health Officials, **www.astho.org/state.html**. This site links views directly to state health departments for immunization information. ■

There is a way to dress properly for home health

Where to draw the hemline

Today it seems that anything goes when it comes to clothing styles, hair color, and jewelry. No longer must hair colors be found in nature, and earrings have ventured into what was once forbidden territory. All these changes can leave a home care agency manager or supervisor at a loss when it comes to setting appropriate limits on what staff wear while also allowing personal freedom and choice.

When it comes to body piercing in places other than earlobes, one Department of Veterans Affairs-based home care agency has a simple policy: "If it's pierced, keep it covered." Still, there is some dispute over whether a tongue piercing is considered covered; it is covered, until someone opens his or her mouth. The general rule of thumb in these cases is that any piercing shouldn't be visible to the patient, says **Linda Westerman**, RN, MN, education director for Home Health Management Inc. in Florence, SC.

Kathy Kieke, RN, MSN, care center director for St. Cloud (MN) Hospital Home Care and Hospice, says her agency sticks to the policy that "a minimal amount of jewelry [no more than two fingers on each hand with rings; two earrings per ear] worn while performing duties is OK. Visible pierced jewelry, except for earrings, aren't allowed, and excessive tattoos must not be visible while on duty." **(For a detailed description of St. Cloud's policy, see box, p. 92.)**

Don't take a Band-Aid approach

Kieke notes that some aides have tried covering their eyebrow jewelry with a Band-Aid, "but that is not acceptable, and they must remove the jewelry while working."

So far, this hasn't been too much of a problem, she says, noting that "I did have a discussion with an employee who had four earrings in her ear, so it is helpful to have a hospitalwide policy to fall back on. Now, she removes two of the earrings while she is working."

Jewelry, of course, isn't the only issue covered by a dress code, and in either case, dress codes must be specific. What about capri pants, clamdiggers, or pedal pushers? In order to be fair to everyone,

Dress for Home Care Success

INAPPROPRIATE ATTIRE:

- Sundresses, strapless or sleeveless tops
- Tube or crop tops
- Pants that are pinned, rolled, or tucked into socks
- Skorts
- Shorts
- Sweatpants
- Spandex/stretch pants or leggings
- Windpants
- Undergarment-type T-shirts
- Sandals or open-toed shoes
- Denim pants of any color
- Sweatshirts that are not part of the departmental uniform
- Short skirts
- Discolored clothing of any type
- Face coverings (e.g. scarves, veils)
- Hats (head coverings on top of head that are part of a religious/cultural dress are acceptable)
- Skirts touching the floor

ADDITIONAL CRITERIA:

- Clean, neat, well-cared-for attire is required.
- Hair is to be clean, neatly groomed, and arranged so as not to interfere with job duties.
- Standard, unaltered hospital identification must be worn so that names are visible to patients, visitors, and co-workers. (Unaltered is defined as no pins, tape, stickers, ribbons, etc., on the badge.)
- A minimal amount of jewelry may be worn while performing regular duties. (Minimal amount is defined as no more than two fingers per hand with rings and two earrings per ear.) No visible pierced jewelry other than earrings are to be worn while on duty. Excessive tattoos must not be visible while on duty.
- Fingernails are neatly groomed and appropriate to care/job duties.
- Good personal hygiene is required. (Use of fragrance is discouraged.) Staff will not smell like tobacco products.
- No tobacco chewing during work hours. No gum chewing while interacting with any customer.
- Casual-day guidelines must adhere to the criteria identified in this policy.

Source: St. Cloud (MN) Hospital Home Care and Hospice.

clearly specified rules must be set out and adhered to. For hospital-based home care agencies, what may be considered acceptable in a home care environment might not be considered appropriate for the hospital floor. This can often prove problematic, as Kieke notes. "I have many staff who wear appropriate sweatshirts in the winter, and I had to work with the hospital to include that as OK," she says. "Originally, they had excluded sweatshirts as appropriate attire."

In summer, especially, when some staff may be tempted to wear as little as possible, dress code problems can pop up. Westerman notes, that in the past, her agency has had trouble with beach attire — short-shorts, midriffs, sandals — being worn by clinicians making home visits. More recently, Westerman says her agency had a complaint from a patient about a physical therapist wearing short-shorts. It begs the question: When it comes to shorts, what is considered too short? Should skorts — half shorts, half skirt — be considered skirts or shorts?

Home Health Management dealt with this issue by setting out the exact length of shorts that are considered acceptable. In her agency's dress code policy, she notes, "we added that shorts could be worn but no higher than two inches above the knee and, if worn, must be worn with hosiery."

The hosiery clause, especially in a place such as South Carolina where spring and fall can be extremely warm and summers unbearable at times, was added as a compromise as a patient had complained about bare, unshaven legs. "The same logic was applied to their regulations banning sleeveless tops," Westerman says.

Sandals, too, have proven to be a touchy subject. St. Cloud forbids home health staff to wear sandals, and originally Home Health Management did as well. Explains Westerman, "Someone thought it was an [Occupational Safety and Health Administration] reg to not wear open-toed shoes, but that's not so in our line of work, so that will be removed."

Westerman says her agency's dress code policy was six months in the making and notes, "I can't begin to tally up how many hours my agency has spent on this dress code thing."

She is now pushing for her agency's dress code to say only "clean and professional attire" will be worn during working hours and while seeing patients. It's my opinion that if your clothes are clean, in good repair, and fit you and your job function, it should be OK."

It's bound to happen no matter how stringent your agency's dress code policy. One day, one patient will complain about [an employee's] manner of dress. In those cases, what do you do? Tell the caregiver to change his or her style or change the caregiver's assignment.

Westerman notes that in today's world the politically correct thing to do is that "if it offends a patient to be cared for by someone with a nose ring, change the caregiver. The same goes if the patient doesn't like someone with purple hair.

"Patient complaints are handled just like any others. If they don't want a male nurse or a nurse with a nose ring, we change caregivers, but the patients are made aware that the 'offending' clinician may need to visit on call or after hours if they require a visit," she says. "And the clinicians are always made aware of the nature of the patients' concerns. After a while, if you want to work, you may need to remove the ring."

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LegalEase

Understanding Laws, Rules, Regulations

It pays to get all your confirmations in writing

By **Elizabeth E. Hogue**, Esq.
Burtonsville, MD

[Editor's note: This is one of a continuing series about legal and ethical issues related to the implementation of the prospective payment system (PPS)]

The implementation of the Balanced Budget Act of 1997 (BBA) has understandably raised a number of issues for home health agencies for which there do not appear to be any clear regulatory direction. This means that providers are tempted to pick up the telephone and call representatives of the Centers for Medicare and Medicaid Services (CMS; formerly the Health Care Financing Administration) and/or their carriers in order to obtain clarification. Agency staff also may fear that if they fail to get clarification, they may inadvertently be engaging in fraud and abuse.

An example of a situation for which an agency would want clarification concerns adult diapers or the so-called blue pads. Some intermediaries have indicated that home health agencies must supply all diapers and blue pads to patients for the duration of care provided by agencies so long as these items are medically necessary (as opposed to being used as a convenience). On the other hand, CMS officials state that agencies are required to furnish only those items that were covered on a cost basis. Translation: Agencies must supply the diapers and pads they utilize while providing services to patients.

For example, when agency staff change a diaper during a visit, they are required to supply the diaper used to perform this care. What's more, agencies are specifically not required to leave boxes of either diapers or blue pads in patients' homes between visits for patients to use.

In another example, some intermediaries also apparently have told agencies that patients may not use their own supplies so long as they are receiving services from a home health agency, even though agencies would otherwise be required to provide such supplies.

On the contrary, CMS officials state that agency staff must make it clear to patients that the agency is required to provide the supplies.

If patients, nonetheless, decide to utilize supplies they already have (as opposed to those that agencies would supply), they may certainly do so. Agencies should, of course, document that they made it clear that they are required to provide the supplies and that patients declined to utilize such supplies.

When home medical equipment (HME) companies provide items that are not required to be provided by home health agencies or which patients elect, they may bill for them directly. But providers must exercise extreme caution when they raise issues and receive answers that are inconsistent with information they previously received. As an example of the lengths to which agency staff will go to document and protect themselves, some managers have, for example,

written their question on a piece of paper. Then they telephone CMS or an intermediary and read the question to a member of the staff.

They wait for 30 minutes or so and then call CMS or the same intermediary again. They repeat the question they initially asked word-for-word to another staff member and get a completely different and inconsistent response.

Same question, several very different answers. Then what is a home care professional supposed to do?

Relevant court decisions make it clear that providers should not rely on information they verbally receive from regulators and/or representatives of CMS and the carriers unless they confirm the information in writing. The best advice for agency staff, therefore, seems to be "Don't call; don't ask" unless you are prepared to confirm information you receive in writing.

Furthermore, providers should recognize that it is their responsibility to confirm information in writing. Staff should not ask regulators to reduce their verbal communications to writing. Specifically, staff should parrot to regulators what they were told verbally. Managers should be very careful not to put words in the mouths of regulators or modify what they were told in any way, even though the answer they received is not the one they hoped or expected to receive.

It is, however, wise to conclude confirmation letters with the following language: "If we have misunderstood our conversation in any way, please notify us immediately in writing." Regulators should certainly correct any misstatements in writing.

Confirmation letters should be faxed. It is not necessary to send them by certified or registered mail. In fact, use of certified or registered mail may slow down the process of confirming information at a time when clarity is crucial. Providers may, however, wish to send a copy of the letter through the regular mail in addition to faxing it. Proof of mailing may be obtained at any U.S. post office in the form of a certificate of mailing that costs approximately 60 cents per item.

Remember, when you have itchy fingers to pick up the telephone and seek clarification, make sure your fingers are itchy enough to follow up with a letter. Otherwise, your efforts have been wasted. ■

NEWS BRIEFS

Health care lags in HIPAA compliance

According to a recent survey, more than 75% of health care organizations have yet to complete the assessments of their current environments and risks that are necessary to comply with the Health Insurance Portability and Accountability Act (HIPAA) transaction regulations which are due to be implemented in less than 18 months.

This according to Gartner Inc., which conducted the survey, could spell for a last-minute crunch in the coming months as companies scramble to meet the deadline or risk high penalties. Gartner Inc. also found some good news when it learned that there has been some improvement in the past quarter with respect to the number of health care organizations that have begun the HIPAA-required early awareness tasks. On another positive note, the survey noted that there is an overall increased awareness of the significance of HIPAA.

Among the other findings were:

• 27% of companies have begun preliminary budgeting efforts for their compliance activities.

• Less than 30% of health care organizations have begun formal HIPAA education programs for their employees.

• 9% of health care organizations have completed privacy assessments.

• 11% of health care organizations reported any activity toward obtaining vendor contractual

COMING IN FUTURE MONTHS

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commitments for HIPAA compliance.

• Payers are almost four times as likely as providers (42% vs. 11%, respectively) to have completed transaction/code set assessments. ▼

TV maker to offer telephone service

Home health agencies will now have another vendor from which to choose their telephony programs, now that Panasonic, one of the world's largest manufacturers of televisions, video and other electronic equipment, has developed an Internet-based telemedicine system for the home health market. The company's new Telehomecare System has three major components:

• **patient terminal**, which will measure vital signs, including blood pressure, pulse, temperature, blood sugar, and oxygen saturation, and comes equipped with a stethoscope, electrocardiograph device, and a scale, featuring an interactive touch screen, a video camera, and voice and picture guidance;

• **network-server software**;

• **doctor-terminal software** that will enable health care professionals to access patient data stored on the server, and communicate with the patient through either e-mail or a videophone.

The system, while not yet for sale, has been tested by Focused Health Solutions Inc. and VA Connecticut Healthcare System. ▼

The agency formerly known as HCFA

As of June 14, health care professionals kissed the Health Care Financing Administration goodbye. Citing its negative image, President Bush announced that the organization will now be known as the Centers for Medicare and Medicaid Services. As part of its new and improved image, the newly named organization will introduce later this year a toll-free hotline to answer people's questions about Medicare 24 hours a day, seven days a week.

The number — (800) MEDICARE — now is open to take calls from 8 a.m. to 4:30 p.m. Monday through Friday. Also on tap for the agency is a $35 million national media campaign to highlights the health insurance options available to the elderly. Among them are health maintenance organizations, fee-for-service Medicare, and private insurance to fill gaps in Medicare and medical savings accounts. Secretary of Health and Human Services **Tommy G. Thompson** said of the organization's new image, "We're making quality service the No. 1 priority." ▼

No PPS adjustment for therapy codes

The Centers for Medicare and Medicaid Services (CMS) has announced that it will not adjust the prospective payments for seven therapy codes it added to its consolidated billing list

Hospital Home Health® (ISSN# 0884-8521) is published monthly by American Health Consultants®, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Home Health**®, P. O. Box 740059, Atlanta, GA 30374.

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Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: customerservice@ahcpub.com. World Wide Web: http://www.ahcpub.com. Hours: 8:30-6 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $427. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $342 per year; 10 to 20 copies, $256 per year. For more than 20 copies, call customer service for special arrangements. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $71 each. (GST registration number R128870672.)

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Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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earlier this spring. In its Questions and Answers on Consolidated Billing page (www.hcfa.gov/medicare/hhfaqupdate1.htm), CMS says it considered such a rate adjustment but determined that use of the services was so low that it would have "no impact" on home health prospective payments system rates. Nor will CMS seek to reverse Part B payments based on claims submitted prior to July 1 for any of the seven therapy services. ▼

Proposed PPS change gets cautious approval

Under the prospective payment system (PPS), the Centers for Medicare and Medicaid Services (CMS) has proposed a 2.4% increase in funding for skilled nursing facilities, based on a marketbasket adjustment that called for a 2.9% increase in funding. This number was later reduced by 0.5% per the Benefits Improvement and Protection Act of 2000.

Even with the increase in funding, the American Association of Homes and Services for the Aging (AAHSA), says it may not be enough to alleviate the financial burdens long-term care providers face. "We're pleased that [CMS] has recognized the need to update the marketbasket, which is currently based on data from 1992," says **Susan Polniaszek**, AAHSA's senior reimbursement policy analyst. "However, the proposed increase is based on 1997 data, which does not account for the dramatic increases in liability insurance and wages." AAHSA consists of more than 5,600 not-for-profit nursing homes, continuing care retirement communities, assisted living, and senior housing facilities, and community service organizations and serves more than 1 million patients daily, she explains. ▼

Six states add cancer coverage for women

Uninsured women in Utah, Idaho, South Dakota, Illinois, Indiana, and Montana now are eligible for medical coverage for breast and cervical cancers, as each state has taken advantage of the federal Breast and Cervical Cancer Prevention and Treatment Act. The federal legislation, which was signed into law in October 2000, allows states to offer medical benefits to uninsured women suffering from either cancer who have been diagnosed through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program. Other states participating in the program are Rhode Island, New Hampshire, West Virginia, and Maryland. For more information, go to www.hcfa.gov/Medicaid/bccpthm.htm. ■

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CE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

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