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On the job safety for home care workers: Caution goes a long way

Here's where to find it and how to get it

A 1992 study by the Department of Labor and Industries found that more nursing aides, health aides, health technicians, social workers, and nurses were attacked on the job than were police officers or prison guards. A year later, the Bureau of Labor Statistics data found that health care workers have the highest incidence of assault injuries.

On a daily basis, home care staff are going into some of the worst neighborhoods and into homes where violence is no stranger. Given the daily requirements of the job, what can home care workers do to protect themselves from violence in high-risk neighborhoods? *Hospital Home Health* takes a look in this two-part series at staying safe on the home care beat.

Uniforms: Friend or foe?

Depending on whom you ask about how to handle a threatening situation, you'll get a different answer. But the one constant is that home care professionals need to be alert to the many dangers they face. More than being alert, though, home care professionals need to be prepared to deal with a host of potentially dangerous situations and have a sound course of action in mind.

For example, if assaulted on the street, your best defense is to feign illness, drop to the ground, and scream that you are having a heart attack; people are more likely to help in medical emergencies than in cases of a perceived attack or threat of violence.

In some cases, professionals also recommend faking a sudden bout of insanity and tell of incidences where the intended victim dropped to the ground shrieking and began eating grass and dirt. Not a pleasant thought, but an effective one as the would-be attacker fled.

Just as the idea of calling attention to yourself upon the threat of an attack seems natural, it seems just as natural that you would want to avoid calling any undue attention to yourself when making home visits in high-risk neighborhoods. There is a debate within the home care

community whether it is better to be identified as a health care professional and looked upon favorably by the area's residents or whether it's just advertising your access to prescription medications.

Paul Dewhitt, RN, a home care nurse with Cuidado Casero Home Health in Dallas, says he frequently goes into inner-city slums to visit patients where drugs are being sold on the corner. "I am even hit up to buy. I have actually had to get down on the floor with family members on more than one occasion when gunshots were heard in some high-risk communities. It's a jungle out there."

Stand out or blend in?

It's no wonder then that Dewhitt says, "Inner-city nurses need to think twice about uniforms as they can make you an easy target for attack by desperate and dangerous types who are looking for an easy source of drugs or medical supplies. Uniforms are important to lend authority to the home nurse and enhance the reception of teaching and education as well as give a reassurance of competence.

"The policy at my agency is to wear scrubs or a lab coat, but in a dangerous situation, I fold up my light lab coat and put it in my bag, and then I put it on once inside the patient's home," he adds. "We all carry bags, and if we look like the doctor or nurse with syringes and drugs, we are asking for problems."

Dewhitt further attempts to blend in by wearing street clothes that are "tasteful and conservative and plain."

When it comes to going incognito, **Denise McCarraher**, RN, audit nurse/case manager, with the IVNA of Richmond, VA, is all for donning a lab coat once she is inside.

"Considering I work in some of our city's worst drug and shooting areas, I couldn't agree more," she says. "It is not difficult to figure out that we are nurses to start with if anyone asks their neighbors who the woman with the bag is that goes to the house in the middle of the block each morning. I certainly don't need a uniform to attract any more attention than my repeated presence causes."

It's an interesting parallel then that other home care nurses, such as **Alice Fritz-Warren**, RN, BSN, MSN, the regional performance improvement director for Sun Plus Home Health in San Leandro, CA, have found that their uniforms afford them a bit of protection in an otherwise less-than-safe neighborhood.

As she explains it, she has "worked in the inner city on and off for the last 10 years. I have been approached numerous times by drug dealers and groups of kids wearing gang colors. When they saw my scrubs or lab coat and realized that I was there to help, they backed off. I

CE questions

1. A 1992 study by the Department of Labor and Industries found that more nursing aides, health aides, health technicians, social workers, and nurses were attacked on the job than were:
   A. police officers
   B. prison guards
   C. U.S. troops overseas
   D. A and B
   E. all of the above

2. According to the Centers for Disease Control, those deemed as high risk for influenza are those:
   A. ages 65 years or older
   B. nursing home and other chronic-care facility residents
   C. adults and children with chronic disorders of the pulmonary and cardiovascular systems, including asthma; adults and children who required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic disease
   D. children and teenagers (ages 6 months to 18 years) who receive long-term aspirin therapy
   E. all of the above

3. Under the Fair Labor Standards Act, a non-exempt employee, such as an aide, is entitled to one and one-half times the regular rate for all hours worked in excess of 40 in any regular work week.
   A. true
   B. false

4. Fraud enforcers have taken the position that providers are required to provide reasonable, necessary and appropriate care. When health care providers fail to do so, especially in order to save money, they are engaging in fraud in the form of:
   A. misrepresentation
   B. underutilization
   C. embezzlement

have even come back to my car to find some rather forbidding-looking men guarding it."

One home care nurse in Cleveland says that she has found more cooperation and respect when dressing in scrubs or at least a lab coat that clearly identified her as a nurse. **Barb Johnson**, administrator for Progressive Home Care in Cleveland, says that one of the biggest mistakes a home care professional can make is to carry a bag, or a purse, for that matter as that is "definitely asking for trouble." She advocates keeping it simple: a lab coat, stethoscope around the neck, and necessary supplies in the pocket, period.

"Somehow, even gang members who have grandmas appreciate the help you're giving and will often escort you to and from the door," she says. "I wouldn't drive a new car or go down there after dark though. My mama didn't raise a total fool."

Whereas Dewhitt would like to be able to keep his scrubs on while on the street, he says he doesn't "feel that the male nurse would be afforded the protective response that some female nurses have experienced. I wish I could wear [scrubs], but I think of the reports of just these types of attacks and an inservice done by a police detective who discouraged just this practice. . . . When I'm on the street, it's street clothes for me."

Situations beyond your control

While the decision to don scrubs outside the home is something home care nurses can control, the atmosphere of violence both in and out of the home is not. One such case is that of a Maryland home care nurse who fell victim to a hit man who was hired to kill the patient and his mother.

"The case involved the estranged husband who hired a hit man who went into the home of a patient, shot and killed the mother and the home care nurse, and then disconnected the child's respirator, says Elizabeth Hogue, a home care attorney from Burtonsville, MD. Perhaps the case is a bit extreme, but it well illustrates the dangers that home care nurses and aides face on a daily basis.

Hogue has received all types of calls. One she remembers in particular was from a home care agency that called about its nurse. The woman had locked herself in a closet with her cell phone and was calling for help because on the other side of the door stood the patient's father, brandishing a knife and threatening to kill her. It's hard to imagine that the very person there to help could become the victim of violence, but it's not so hard when one considers the pressures family caregivers face.

"One thing I've noticed," she says, "is that a lot of anger that patients have is displaced on home care workers especially because they are on the patient's turf where they feel they have authority. The family doesn't put the home care worker's role into perspective. They're exhausted, worried, and afraid, and the home care workers catch it."

So what choices do home care staff have in instances where they are afraid, whether it be because of gang violence in the neighborhood or patients who keep guns under their pillows?

Providing a safe workplace

"If you're talking about independent contractors," says Hogue, "they can refuse to go into a situation. But if you're looking at employees and the boss insists, then they must go."

"Any boss who insists on an employee going to a dangerous situation would be very foolish indeed," she adds.

"If home care workers are afraid, you must take that very seriously. Help them articulate why they feel that way, but knowing [home care workers] and their propensity to deny threats of danger, you really have to pay a lot of attention, otherwise you are open to a lot of liability," Hogue says.

"I'm not only referring to straightforward negligence but OSHA [Occupational Safety and Health Administration] issues as well. The general clause under the OSHA statute requires employers to provide a safe working environment for employees.

"There's an old legal adage that says, 'Every dog is entitled to one bite.' Once workers say they are afraid, the dog has had its bite. If you make them go back, you're asking for it. The highest obligation of providers is to protect their staff. The highest obligation — there isn't anything that is more important than that," she points out.

Greg Solecki, vice president of Henry Ford Home Health Care in Detroit, agrees. Solecki's agency, he says, has a standing policy whereby "because of our mission and the area we serve, personal safety is high on our list of priorities. First and foremost, we always stress to staff that they are never to make a home visit in a situation where they feel unsafe. We value their intuition, and our policy is to support their decision when they feel unsafe. Interestingly enough, I think this

empowerment has resulted in very few staff refusing to go anywhere."

Certainly the agency has responsibility for the safety of its employees, but as Hogue notes, a large degree of responsibility also lies with the employees themselves. "One of my overriding concerns is that home care providers ignore their own fear because they so badly want to take care of patients and help them that they ignore symptoms they should not.

Report criminal activities to police

"So many agencies and staff are afraid to notify police when patients and family members engage in criminal conduct. Not so much because of fear of reprisals, but the attitude that, 'Oh well, the patient didn't mean it,' and they downplay the seriousness so much that they convince themselves there's no need to report. I would encourage them to always go to the police," she stresses.

As Hogue sees it, one reason behind this hesitancy to report situations to the police and the tendency to downplay what are often serious situations lies in the fact that "if they didn't cope with their vulnerability through denial, they might not be able to do what they do. If they would just pay attention to that much, it would help them. They don't want to alienate the patient and their family, so they end up asking themselves, 'How can I have the kind of relationship with patients if I say and do these kinds of things?'"

While there are no easy answers, there is a steadfast rule, which every home care employee would be well-advised to heed, says Fritz-Warren. "The bottom line is to do what helps you feel comfortable in dangerous areas. Always pay attention to those hairs on the back of your neck or the butterflies in the pit of your stomach. If they tell you not to go there — don't."

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Personal Safety on the Job

- ✔ **Every employee should understand the concept of "universal precautions for violence,"** i.e., that violence should be expected but can be avoided or mitigated through preparation.
- ✔ **Employees should be discouraged from wearing jewelry to help prevent possible strangulation in confrontational situations.** Moreover, employees such as home care workers should carry only required identification and money.
- ✔ **Trust your instincts when it comes to avoiding threatening situations,** and exercise extra care in elevators, stairwells, and unfamiliar residences. If there is a hazardous situation, leave the premises immediately, and if necessary, request police assistance.
- ✔ **Be familiar with your employee contract and your agency's workplace safety program** (if applicable) so that you are clear on how visits will be conducted, the rules involving the presence of others in the home during the visits, and the refusal to provide services in a clearly hazardous situation.
- ✔ **If possible, carry a cell phone.** At the very least, use a call-in system to verify your time of arrival at a home and your time of departure.
- ✔ **Keep a daily work program and keep a designated contact person informed about your whereabouts** throughout the workday. In the event you fail to report in, the contact person should follow-up.

Source: Occupational Safety and Health Administration, Washington, DC. Web site: www.OSHA.gov.

Help your patients to beat the flu

What you and the government are doing

Although the total supply of flu vaccine for this year is expected to exceed that of last year, some delays in arrival are anticipated, which might have a substantial effect on your patients and in determining who does and doesn't get vaccinated early.

Predictions place the amount of available vaccine at 79.1 million doses, which is more than were available in 2000.

By the end of October, 47.8 million doses will be available for delivery, approximately 26 million fewer doses of influenza vaccine than were available by the end of October 1999, with the balance expected to be available over the course of November and December.

Because of the 2001/02 influenza season vaccine delay and the large number of doses projected for distribution in November and December, the Advisory Committee on Immunization Practices (ACIP) has developed supplemental recommendations to prioritize and phase use of the vaccine for the 2001/02 influenza season. **(For more tips, see guidelines and recommendations, pp. 114 and 115.)**

Higher-risk groups come first

Such a plan, it is hoped, will ensure that people at greatest risk receive the vaccine early and will increase the overall protection of those at greatest risk for severe influenza and its complications.

According to the Centers for Disease Control and Prevention (CDC), those deemed as high risk are the following:

- those age 65 or older;
- nursing home and other chronic care facility residents;
- adults and children with chronic disorders of the pulmonary and cardiovascular systems, including asthma;
- adults and children who required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes), renal dysfunction, hemoglobinopathies or immunosuppression, including that caused by medications or human immunodeficiency virus;
- children and teen-agers (6 months to 18 years) who receive long-term aspirin therapy;
- women who will be in the second or third trimester of pregnancy during the influenza season.

In light of this, how will your home health agency handle this year's flu season?

Batten down the hatches

"Our private-duty division, Henry Ford Extended Care, is involved with influenza vaccinations in a big way," says **Greg Solecki**, vice president of Henry Ford Home Health Care in Detroit.

"It has contracts with our system's HMO as well as corporations in the community to vaccinate employees at their work sites. Concurrently, Henry Ford Health System offers the vaccine to all home health care and extended care staff as well," he explains.

Despite the close coordination with other community groups and HMOs, Solecki says the "past few years have been challenging in terms of obtaining serum in time for the flu season. Accordingly, we have a system workgroup that meets prior to the anticipated flu season. It has done a good job of building consensus regarding the distribution of the vaccine when it finally arrives," he adds.

"Patient and employee groups are assigned priorities [e.g., immunosuppressed patients first, staff who provide care to immunosuppressed patients next, etc.]. Staff who have no patient contact are assigned the lowest priority but eventually are offered the opportunity for vaccination when the supply permits," Solecki says.

St. Cloud (MN) Hospital Home Care and Hospice also participates in communitywide planning when developing its vaccine program, says **Kathy Kieke** RN, MSN, care center director.

"Last year, the county called a meeting including major health care providers, parish nurses, etc.," she explains, noting that the same approach will be used again this year. "They work with the media to publish the community plan, and everyone is asked to participate."

Occupational health and the infection control nurse represents St. Cloud, she says.

The results of the meeting determine who will get the vaccine on a priority basis. "Generally, home care patients, the elderly, and pediatric patients are in the top-priority groups," Kieke says, adding that nursing home residents usually

Guidelines for Mass Influenza Vaccination Campaigns During a Delay or Shortage

- ❒ Develop liaisons with community groups representing the elderly and those with chronic diseases (e.g., offer incentives for groups to attend clinics, ask for volunteers to help promote and run clinics).
- ❒ Share information about your campaign with other clinics/facilities providing flu vaccine in your community. As needed, inform clients about other locations where vaccine is available.
- ❒ Schedule and publicize special senior clinics when only elderly or other high-risk patients will be accepted.
- ❒ Schedule flu vaccine delivery during daytime hours when the elderly, and other high-risk patients, have less need to compete with younger, healthy clients for a place in line at the vaccination location.
- ❒ Offer vaccination to elderly and chronically ill employees and relatives of employees in workplace campaigns.
- ❒ Promote the flu vaccination campaign by publishing public service announcements in local media stressing a commitment to first serve the high-risk population and asking healthy people to cooperate by waiting for availability of vaccine. Include up-to-date information about expected availability of more vaccine and about flu activity (or lack thereof) in the community.
- ❒ Share vaccine with other providers (e.g., hospitals, nursing homes, physicians) who see high-risk patients.

VACCINATION LOCATION

- ❒ Establish criteria for identifying high-risk individuals and health care workers, and give these individuals top priority when vaccine is first available.
- ❒ Provide a brief questionnaire or checklist to enable prospective vaccines to determine their risk status, and encourage those not at high risk to return in November or later.
- ❒ Post notices (or personnel) asking healthy people to defer their flu shots so high-risk people can be protected with available vaccine. Give people the opportunity to defer before they have started to wait in line.
- ❒ Establish express lanes for elderly and high-risk patients to reduce the amount of time they have to stand in line to receive the vaccine.
- ❒ Keep customers informed. Post notices informing clients of hours of flu vaccine clinics and of the need to vaccinate high-risk patients first. Establish hotlines or web sites containing relevant information. Assure customers (if appropriate) that additional shipments of vaccine are expected. Post information about other locations where vaccine is available.

Source: Centers for Disease Control and Prevention, Atlanta. www.cdc.gov/nip/flu.

are included in this group as well. "After this group is vaccinated, then come health care workers, and then the general population."

While many agencies are gearing up for the flu vaccination season, some agencies have found that their service area is already well-covered. **Kim Stout**, RN, BSN, home health director at McAlester (OK) Regional Health Center Home Health, says her agency has stopped providing flu vaccines, unless specifically ordered by a physician for one of the homebound patients.

"This decision was made after a project we did two years ago . . . with the state of Oklahoma in an effort to get everyone vaccinated. After all was said and done, we found that approximately 90% of our active patients had already received their influenza vaccine at their physician's office or during a hospital stay," she says.

"The county health department also holds free influenza clinics at all of the communities and local senior citizens centers, in addition to making home visits upon request to administer vaccine. We ended up wasting several vials of vaccine and decided that we would no longer provide this type service," she adds.

"We felt like our service area had appropriate access to the vaccine. In the event that a patient does not have access, we go to the physician's office and obtain the dose and administer it to the patient. This worked out very well for us last season and have plans of doing the same this season," Stout points out.

If your agency does plan to distribute flu vaccines, but is concerned that area shortages may prove problematic, take heart. "One interesting phenomenon we observed last year was those who received vaccinations earlier than others [such as October or November] were more susceptible to

acquiring the flu later in the season [such as February or March], Solecki says. During the prolonged wait for the serum, there were no reported outbreaks of influenza, so in essence, the late shipment of serum did not appear to adversely impact anyone — contrary to everyone's concern — and may have actually positively impacted folks toward the end of the flu season."

[Those home care providers and hospitals that find themselves with excess vaccine or extreme shortages are urged to call or e-mail their state health contact person. CDC officials note that while the total supply of influenza vaccine is already booked, it's expected that some overbooking occurred, in which case your agency might be able to access supplies available later in the season. For a listing of state health contacts, see: www.cdc.gov/nip/flu/state-contacts.htm.

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ACIP Supplemental Recommendations

VACCINE PROVIDERS

- Providers should target vaccine available in September and October to people at increased risk for influenza complications and to health-care workers. The optimal time for vaccinating high-risk people is October through November. To avoid missed opportunities, vaccine also should be offered to high-risk people when they access medical care in September, if vaccine is available. Vaccinating high-risk people early can be facilitated through reminder and recall systems, in which such patients are identified and encouraged to come into the office for a vaccination-only visit. Additional information that may help providers implement a system for reminder/recalls is available at www.cdc.gov/nip/flu.
- Beginning in November, providers should offer vaccine to contacts of high-risk people, healthy people ages 50 to 64, and any other people wanting to reduce their risk for influenza.
- Providers should continue vaccinating patients, especially those at high risk and in other target groups, in December and should continue as long as there is influenza activity and vaccine is available. To increase vaccination rates, health care organizations are encouraged to assess their providers' influenza vaccine use and provide feedback on coverage among those age 65 or older and other high-risk patients.

THE PUBLIC

- People at high risk for complications from influenza, including those age 65 years or older and those younger than 65 who have underlying chronic illnesses, should seek vaccination with their provider when vaccine is available. The optimal vaccination period is October through November but may include September if vaccine is available. Unvaccinated high-risk people should continue to seek vaccine later in the season.
- People who are not at high risk for complications from influenza, including household contacts of high-risk people, are encouraged to seek influenza vaccine in November and later. Those who are unsure of their risk status should consult their provider to determine whether they should receive vaccine earlier and, if so, whether vaccine will be available. When additional vaccine is available, providers are encouraged to send a reminder to people deferred from vaccination.

HEALTH DEPARTMENTS AND OTHER ORGANIZATIONS

- Organizers of mass vaccination campaigns not in workplaces (e.g., at health departments, clinics, senior centers, and retail stores) should plan campaigns for late October or November or when they are assured of vaccine supply and make special efforts to vaccinate elderly people and those at high risk for influenza complications. Information that may be used in a campaign setting is available at www.cdc.gov/nip/flu.
- Influenza vaccine service providers should develop contingency plans for possible delays in vaccine distribution. In a delay or shortage, communications among partner organizations

and potential redirection of vaccine to high-risk people in the community will be important. State and local health departments can provide guidance that is appropriate for their population and systems of care.
- As preparation for the 2001/02 influenza season proceeds, updates on vaccine supply and other information about influenza vaccination that may be helpful to providers and health departments, will be available at www.cdc.gov/nip/flu.

Source: Centers for Disease Control and Prevention, Atlanta. www.cdc.gov/nip/flu. ■

Try working overtime to stay on the good side

Keeping ahead of overtime regulations isn't easy

"The Fair Labor Standards Act [FLSA] is a nondenominational-type law, but there are a couple of issues that affect home care specifically," says **Lucian Bernard**, a partner with Covington, KY-based law firm Pearson & Bernard.

"One of the main reasons is that a lot of agencies are paying nurses on a per-visit basis. For years, the Department of Labor [DOL] has maintained that paying nurses per visit was not appropriate, and where that has gone to court, in very few instances, the courts have disagreed. It's a very rocky road to try and travel and has to be trodden correctly," he explains.

When it comes to who qualifies for overtime, the laws are complicated, he says. Typically, employees whose work is considered to fall under the categories of executive, administrative, or professional are exempt from overtime regulations. Their pay stays the same regardless of whether it takes them 40 hours or 50 hours a week to complete their jobs. To give it a real-life spin, he uses the example of a painter who gets paid $15,000 to complete a portrait no matter how long it takes to finish.

Even with seemingly clear-cut rules, the lines can get a bit fuzzy, Bernard notes.

"If, for example, you take an RN whom by education would be exempt because of her training, it doesn't end the inquiry as to her exemption. The FLSA regulation requires that the exempt person is paid a salary or on a fee-basis of payment. In other words, if you pay them hourly, they are hourly employees and get overtime no matter what their responsibilities.

"A lot of home care nurses are paid on a per-visit basis, but the actual requirement describes Schedule C payments as unique and cannot be tied to length of time or amount of work. . . . The DOL has long maintained that nurses doing visits don't perform a unique function each time, rather they're doing the same thing, just done over and over again."

Based on the few court cases that have arisen from this issue, to stay on the good side of the FLSA, Bernard says, "It's almost mandatory that there be a written agreement between the nurse and agency that states they will be compensated on a per-visit basis. Within that agreement, there are many different activities involved with the visit including paperwork and case management, and those should be clearly listed.

Does the rule fit in a service economy?

"It's my opinion that it's the most complicated piece of legislation Congress has passed," Bernard continues. "The FLSA worked real well for what it was designed for: people working on an assembly line. But as our economy has evolved into a service economy, it's like putting a square peg in a round hole. It's long overdue for an overhaul."

Until that overhaul comes, if in fact it ever does, here are some facts to keep in mind regarding the overtime requirements of the FLSA:

- A nonexempt employee, such as an aide, is entitled to 1½ times the regular rate for all hours worked in excess of 40 in any regular work week.
- The regular rate is calculated by dividing total remuneration by total hours worked in any regular work week.
- Overtime is calculated by multiplying the regular rate by 1.5.
- An employee may not waive his or her rights under the FLSA. You can't give employees bonuses in lieu of overtime.

"The employee can take it and even sign a contract, but then they can turn around and sue you anyway because they cannot waive their rights," Bernard says.

- The employer is responsible for maintaining time records for all hours worked by employees.

"In home care, it's common practice for nurses to do documentation at home at night, but the FLSA

says the agency must pay the employee for all hours 'worked, suffered, or permitted' so the agency has to track the employee's hours spent tracking her hours and pay her for it," he notes. To avoid trouble on this issue, Bernard advises agencies to have written policies and an agreement whereby the employee must complete any paperwork in the agency and not at home.

• The FLSA mandates that the employer always has the burden of showing that an employee is exempt.

• The Companionship Services Exemption may be on its way out, but in the meantime, each employee working under this exemption should be required to maintain a daily log of his or her activities, since there are strict limits as to the amount of time spent doing nonpatient related activities.

• Any employee claimed to be exempt must meet two requirements:

— 80% of the employee's job responsibilities must satisfy the exemption.

— The employee must be paid under the salary basis of payment or the fee basis of payment.

• Compliance does not stop with the FLSA, he explains. "The burden of proving an employee is exempt is always on the employer. It's assumed that everyone is nonexempt and the employer must prove otherwise with convincing evidence that the employee is in fact exempt. But when you're dealing with FLSA, you cannot stop there," Bernard says.

Look at your state laws, too

"Each state has a law usually referred to as Wage Payment Statute that requires additional requirements over the FLSA," he continues.

"For example, under the FLSA, all nonexempt employees get time and a half for all hours worked in excess of 40 in a regular workweek. California, though, requires that all nonexempt employees are paid time and a half for each hour worked over eight in a given workday," Bernard adds.

You could have employees who only work 30 hours in a given week, but their schedules are such that they work three 10-hour days and would be eligible for overtime under California law. "Whenever you look at pay practices, you also must look to state laws as well as federal laws," he notes.

• Red flags for the DOL include the use of "independent contractors" and potentially "joint employers," such as an organization that maintains both certified and private duty agencies. "The area of independent contractors is a big trap that employers fall into from time to time with financially disastrous results," notes Bernard.

"Courts and the IRS use tests that look at range of factors including who controls the employee's schedule, whether they use their own equipment, can they participate in the process, and so on," he adds. "There's no single factor they look at and the potential penalties are devastating.

"Normally when there's a violation, the courts can relate back two years from date of filing to determine damages, but if there is an intentional violation or a repeat offender, they go back three years for damages. In addition to unpaid overtime damages, there are also liquidated damages, which double the penalty, and then you have to add in attorney fees and civil penalties as well. You can get wiped out. All you need sometimes is one disgruntled employee."

Bernard cites the example of a "staffing company that contracted with independent contractors but didn't really control their schedule. One employee complained and went to court, and the courts went back two years to look through their wage records. In the end, the agency had to pay all these people $700,000 in overtime pay all because the court ruled that the nurses were employees."

To protect themselves, Bernard says, agencies must document everything and review pay practices at least annually, "especially over past years when so many agencies have revamped themselves."

Another tricky area lies with volunteers. Even though seemingly straightforward, the definition of volunteer can take on new meaning — and a new status under the FLSA — given certain factors. "If these people are truly volunteering and donating their services for activities of a humanitarian or public service nature, then generally they are not considered to be employees. But if their actions benefits the agency economically, then you have a problem. Then, you must pay them like employees or get rid of them," he says.

• Do not contact an investigator for the DOL to assist you in compliance. "It's the kiss of death," says Bernard. "Their job is to find and sanction violators, not help employers. Some know what they're doing and are reasonable, and others are only looking for notches on their belt. Call your attorney first, not the agency."

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LegalEase

Understanding Laws, Rules, Regulations

When it comes to PPS, beware of underutilization

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

Home health agencies have been under fire for several years to reduce utilization. Overutilization as a form of fraud and abuse in the Medicare and Medicaid programs has been at the forefront of agency managers' thinking because of the extraordinary emphasis placed upon this issue by many regulators and enforcers.

A federal statute known as the False Claims Act has historically served as the basis for fraud enforcement in the area of overutilization. That is, enforcers have taken the position that whenever providers send claims to the government in order to receive payment, they promise that the care they provided was reasonable, necessary, and appropriate. If the government determines that care provided did not meet these criteria, the claims are false claims even though everything written on the claim form is true.

An agency may, for example, be ordered by a patient's physician to apply Betadine to the patient's pressure ulcer. Providers know that the application of Betadine is no longer considered to be consistent with current standards of care. Nonetheless, field staff visit the patient and follow the physician's orders.

When the agency submits a claim to the fiscal intermediary for payment, everything written on the claim form is true. The physician ordered the application of Betadine, and agency staff followed the physician's orders. The claim, however, is still a false claim because the care that was provided was not considered to be reasonable, necessary, and appropriate as it was inconsistent with applicable standards of care.

Likewise, fraud enforcers have taken the position that providers are required to provide reasonable, necessary, and appropriate care. When health care providers fail to do so, especially in order to save money, they are engaging in fraud in the form of underutilization.

While home health agencies focused on overutilization, managed care organizations that contract to provide care to Medicare beneficiaries are very familiar with false claims in the form of underutilization. Specifically, these so-called "Medicare HMOs" are required, at a minimum, to provide the same benefits that Medicare beneficiaries would receive if they remained in the fee-for-service Medicare program in exchange for a flat monthly fee per beneficiary. In view of these circumstances, it is clear that HMOs can save money if they fail to provide services.

Home health agencies have experienced underutilization by HMOs. Staff have taken note of instances, in which patients were receiving a variety of services, for example, including skilled nursing services, home heath aides, and at least one therapy. Agencies have received no denials for these services.

Medicare patients who decide to enroll in an HMO may see a precipitous drop in services authorized for payment by the HMO despite the fact that Medicare did not deny any of the services that the patient received prior to enrollment. In other words, on the day prior to enrollment, patients received a certain number of services.

The next day, services are reduced dramatically even though there has been no change in the patient's clinical condition that would justify such a reduction in services.

This is a classic example of underutilization by HMOs. Agencies should be attuned to this issue and may even wish to explain to the staff of such

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HMOs that this conduct may constitute fraud and abuse.

In addition, managers must recognize that the spotlight of underutilization will be turned squarely upon home health agencies under the prospective payment system (PPS).

As a Centers for Medicare and Medicaid Services, formerly HCFA, official said recently, the "junkyard dogs" are already out sniffing around, and they tend to see issues of underutilization in terms of "black and white" as opposed to the nuances that always surround determinations about appropriate care.

This means that it is time for agencies to transfer their attention to this new issue of fraud and abuse within the home care industry. What the government requires of agencies is that they cannot either underutilize or overutilize services. Instead, they are required to be right down the middle, i.e., providing all care that is reasonable and necessary for their patients.

Of course, the key difficulty with this requirement is that it is difficult, if not impossible, to articulate what is reasonable, necessary, and appropriate care in terms of national standards of care. This means that such care is often in the eye of the beholder, i.e., the result of subjective determinations by a variety of regulators who may not agree with each other.

Nevertheless, agency staff must take a hard look at this issue under PPS. Consistent care to patients with the same clinical diagnosis utilizing clinical/care pathways will undoubtedly help agencies justify their stance that care provided was reasonable, necessary, and appropriate. A word to the wise will surely suffice. ■

Canadian home care earns a low score

Canada's Association for the Fifty-Plus (CARP) has given the Canadian home care system low marks according to *Home Care by Default, Not by Design*, a report card recently issued by the group. CARP, Canada's largest senior group, called the home care system there woefully inadequate in spite of government assurances to devote more time and finances to the system. "Improved government funding" earned only a C grade, with the group saying that there has been insufficient changes despite a slight increase in home care during.

The group claims that when taken in the broader context, the increase is too little to make a significant difference. Staffing also fared poorly, bringing home a grade of E, a negative change, with the group citing a lack of national standards, poor training, and underpaid, overworked home care staff. Nor did service delivery score high marks. It earned only a D- grade from the group in part because of the wide variations in service from province to province — some provinces charge user fees and many have weekly and/or monthly limits on how often home care staff can visit.

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Among the group's recommendations were that the country establish: a national home care program; a governmental framework in which national standards and guidelines are developed; a source of targeted funding; a work force and education strategy whereby issues such as low compensation, poor training, and international home care practices are addressed; and country-wide incentives for family caregivers in the form of tax breaks, financial compensation, training, and job security. ▼

15% cut may be eliminated

A Republican Party internal memo, portions of which were recently published by the Bureau of National Affairs, reveals that thanks in part to President Bush's new tax cut coupled with a rapidly shrinking federal budget surplus, the final elimination of the 15% home health cut is in danger.

According to some industry observers, the home health care cut, which was scheduled to take place on Oct. 1, 2002, might fall victim to already committed outlays, (which includes the $1.35 trillion tax cut) provided that Congress dips into the Medicare Part A Trust Fund surplus to cover them.

Estimates place the cost of doing away with the home health care cut at $14 billion over the next 10 years. The memo predicts that any forecasted budget surplus, which had been estimated to be as much as $38 billion in non-Medicare / non-Social Security funds for fiscal year 2002, is nil. ▼

FL Medicaid law angers drug companies

A new Florida law that would limit Medicaid patients' access to a number of costly prescription drugs has pharmaceutical producers angry. So irate in fact that the Pharmaceutical Research and Manufacturers of America (PRMA) has filed suit in a U.S. District Court in Tallahassee, FL, claiming that the new law violates federal Medicaid rules and asking for a preliminary injunction against the law until a full challenge can be made.

The law in question, which establishes a formulary for Medicaid drugs in an attempt to save the state $214 million in Medicaid spending, requires that physicians seek prior state authorization before prescribing more than 1,000 drugs. PRMA's attorneys say that Florida failed to appoint a committee to review and implement changes to Medicaid formularies as mandated by federal Medicaid rules. ■

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. ■