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Hospital Home Health.

the monthly update for executives and health care professionals

IN THIS ISSUE

DECEMBER 2001

VOL. 18, NO. 12 (pages 133-144)

Bioterrorism and home health care: Develop your emergency plan now

Reacting and overreacting: A fine line

In 1999, the Centers for Disease Control and Prevention (CDC) in Atlanta felt there was a credible-enough chance of germ warfare that it earmarked $121 million for bioterrorism activities. Of that, $51 million has gone into stockpiling vaccines and other drugs to combat such diseases as anthrax and smallpox. Other funds were poured into laboratory support, enhanced communications systems with state and local health departments, and improved surveillance and epidemiology activities.

As part of this, the CDC also designed a four-tier system of labs designed to detect and identify bioterrorist agents. While the average home health care agency is unlikely to face an epidemic of anthrax among its patients, it is important that it develop at least a basic emergency plan to deal with the potential threat.

Bioterrorism: Are you ready?

Rose Williamson, RN, QI coordinator with Wilson (NC) County Home Health, has been putting together an inservice for her agency's staff on biological and chemical agents, symptoms of exposure, appropriate responses, and reporting procedures. **(See fact sheet, p. 136.)** Yet she has stopped and asked herself a question that is on a lot of peoples' minds: Am I overreacting?

"I want my folks to feel knowledgeable and as prepared for disaster as is possible to be without making things worse," Williamson explains.

As a health care provider, it is of paramount importance that all health-related incidences be taken into account when planning for disaster-related situations. But when the actual chance of exposure is still relatively low, you have to wonder if preparing for the worst is a waste of time.

Not necessarily, say many in the field. Even though the odds are low that any one of us will be infected with anthrax or another bioterrorism agent, it is considerably more likely than it was a year ago. Further, were such a disaster to occur, having a plan in place would save considerable

time that could mean the difference between life and death.

Bioterrorism "should be an integral part of any organization's disaster plan. The Sept. 11 event [should] serve as a reminder to us all to update and attend to our disaster response plans," says **Loretta Schlachta-Fairchild**, RN, PhD, president and CEO of iTelehealth Inc. in Frederick, MD. "The bioterrorism part is but one element that should be addressed."

Schlachta-Fairchild says to focus solely on bioterrorism would be an overreaction, but that creating a disaster plan response is something to be strongly considered by every home care agency.

Diane Henry, RN, program compliance advisor for Oklahoma City-based Professional Providers Solutions and author of *Health and Safety Compliance For Home Health Care*, shares that opinion.

"I feel very strongly that the health care infrastructure should be providing mass training on these [bioterrorism] measures and any others that we have identified since Sept. 11th," she says.

Henry's advice is being taken to heart by home care agencies across the country.

Susan Ezell, RN, RN-QI, AAA, SEA, quality improvement coordinator with the Area Agency on Aging of Southeast Arkansas in Pine Bluff, has also been hard at work putting together information for her agency's family disaster plan. In it, she is including information on a supplies kit and an emergency preparedness checklist.

But she admits to having her doubts about the project, not from a practical standpoint but because, "I don't want to cause undue panic. We've had enough of that for awhile."

Education through inservices

Alice Fritz-Warren, RN, BSN, MS, regional performance improvement director, Sun Plus Home Health in San Leandro, CA, says that developing an inservice on bioterrorism is a great project.

"As a matter of fact, we were asked if we had a bioterrorism response protocol when we were surveyed by the Joint Commission," she says. "We weren't dinged for not having a protocol specifically for bioterrorism, but I guess pretty soon we will all be expected to have one. I actually started a reference notebook at the time and got some good information from the CDC."

Although the tendency has been, at least within the home care field, to focus on natural disasters such as hurricanes or earthquakes, **Denise (Dee) McCarraher**, RN, audit nurse/case manager with IVNA of Richmond, VA, says it's time to enlarge the focus.

CE questions

9. Anthrax is transmitted in several ways, including:
   A. via a cutaneous (skin) method
   B. ingestion of spores
   C. sneezing
   D. A and B
   E. all of the above

10. Johns Hopkins recommends that syndromic surveillance procedures should be put in place to monitor and detect atypical disease presentations and clusters.
   A. true
   B. false

11. Many IEPs require the provision of therapy services, including speech therapy, physical therapy, and occupational therapy. Some school systems have a great deal of difficulty meeting the requirements of IEPs that require such therapy services because:
   A. They are unable to hire and retain enough therapists to meet students' needs.
   B. They are unwilling to hire employees other than teachers.
   C. They must provide separate medical facilities on campus, which is cost-prohibitive to most school systems.

12. The best way to find submission errors or unclaimed bills is by checking your agency's records against Medicare's because:
   A. Medicare is always right.
   B. The system either will give a pay date or will say the particular claim doesn't exist.
   C. It will tell you what mistakes, if any, were made.

"I think it's time for all of us to review and update our policies and ourselves," she says. "Bio incidents are not what we have generally looked at in the past nor are terrorists acts. And while I agree we should not take this education to our elderly patients and frighten them, we must prepare ourselves to provide the care they need under these circumstances."

Creating a plan: What you should do?

The first step in developing an emergency plan for bioterrorism or any type of emergency is to clearly define what measures must be taken and rank them in order of importance. **(See "Enhancing bioterrorism preparedness and response," p. 139.)**

Which patients, for example, must be seen or taken to the hospital in the event home care aides or nurses cannot get to their homes?

From there, it's solid advice to assign specific tasks to your staff with the understanding that they will be responsible for implementing them once the go-ahead has been given.

These procedures should be reviewed and updated regularly so that all staff remain clear on their given tasks and any changes that might have been made to the plan since the last review. For example, staff turnover may necessitate changing staff responsibilities — something you don't want to decide in the throes of a crisis.

A good idea is to set up a phone tree to make certain that everyone involved is notified as quickly as possible, and have the last person on the phone tree contact the first as a means of double-checking its effectiveness.

Don't overlook background material, says Henry. "In developing or reviewing their emergency management plans, home health agencies should include emergency management and bioterrorist information."

Consider creating fact sheets for your patients and their families to inform them of what they should do in case of emergency and a basic outline of how your agency plans to deal with the crisis — will staff visits be reduced? **(See box, at right.)** Will only certain patients receive home care visits? Such a fact sheet should include a list of supplies that should be kept on hand and a list of emergency phone numbers including the local hospital's emergency department.

If you are looking to develop a plan specifically to deal with bioterrorism, consider talking with your local Federal Emergency Management Agency representative.

If you are near a military base, "try contacting the medical folks [there]. It is the medics and corpsmen who teach biohazard-related things," says **Dean Smith**, BSHS, RN, C, PHN, clinical

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Broad Generalizations of Safety Measures to Follow

- Protection of airways is the single most important factor in aerosolization of chemical or biological agents.
- Many agents are heavier than air and stay close to the ground. Find an upward safe haven, such as an upstairs room.
- Once indoors, close all windows and exterior doors and shut down air conditioning and/or heating systems.
- Cover your mouth and nose. Use surgical masks, pollen masks, or gas masks if available. If these are not available, an improvised mask can be made by soaking a clean cloth in a solution of 1 tablespoon of baking soda in a cup of water. This will provide minimal protection and some relief.
- If you know you or someone has been exposed to a biological or chemical agent, decontaminate as soon as possible.
- Thorough scrubbing with large amounts of warm soapy water or a mixture of 10 parts water to one part bleach will greatly reduce the possibility of absorbing an agent through the skin.
- If water is not available, use talcum powder or flour. Sprinkle the flour or powder liberally over the affected skin area, wait 30 seconds, and brush off with a wash cloth, or gauze pad. (Note: powder absorbs the agent so it must be brushed off thoroughly.) If available, rubber gloves should be used.
- Biological agents are generally not transmitted from person to person. Exception: smallpox and pneumonic plague.
- Health care facilities should follow universal or standard precautions.
- Have your state emergency contact information and numbers listed in your emergency management plan (i.e., surveillance and epidemiologist, state public health department, state emergency management agency, and bioterrorism contact person).
- Include federal emergency information: Federal Emergency Management Agency — (940) 898-5399 — and the FBI office in your area.

Source: Bureau of Diplomatic Security, Washington, DC.

Anthrax: A Fact Sheet

What is anthrax?
Anthrax is an acute infectious disease caused by the spore-forming bacterium *bacillus anthracis*. Anthrax most commonly occurs in wild and domestic lower vertebrates (cattle, sheep, goats, camels, antelopes, and other herbivores), but it can also occur in humans when they are exposed to infected animals or tissue from infected animals.

Why is it an issue?
Because anthrax is considered to be a potential agent for use in biological warfare, the Department of Defense has begun mandatory vaccination of all active duty military personnel who might be involved in conflict.

How common is it and who can get it?
Anthrax is most common in agricultural regions where it occurs in animals. These include South and Central America, Southern and Eastern Europe, Asia, Africa, the Caribbean, and the Middle East. When anthrax affects humans, it is usually due to an occupational exposure to infected animals or their products. Workers who are exposed to dead animals and animal products from other countries where anthrax is more common may become infected with *B. anthracis* (industrial anthrax). Anthrax in wild livestock has occurred in the United States.

How is it transmitted?
Anthrax infection can occur in three forms: cutaneous (skin), inhalation, and gastrointestinal. *B. anthracis* spores can live in the soil for many years, and humans can become infected with anthrax by handling products from infected animals or by inhaling anthrax spores from contaminated animal products. Anthrax can also be spread by eating undercooked meat from infected animals. It is rare to find infected animals in the United States.

What are the symptoms?
Symptoms of disease vary depending on how the disease was contracted, but symptoms usually occur within seven days.

- ***Cutaneous:*** Most (about 95%) anthrax infections occur when the bacterium enters a cut or abrasion on the skin, such as when handling contaminated wool, hides, leather, or hair products (especially goat hair) of infected animals. Skin infection begins as a raised itchy bump that resembles an insect bite but within 1-2 days develops into a vesicle and then a painless ulcer, usually 1-3 cm in diameter, with a characteristic black necrotic (dying) area in the center. Lymph glands in the adjacent area may swell. About 20% of untreated cases of cutaneous anthrax will result in death. Deaths are rare with appropriate antimicrobial therapy.
- ***Inhalation:*** Initial symptoms may resemble a common cold. After several days, the symptoms may progress to severe breathing problems and shock. Inhalation anthrax is usually fatal.
- ***Intestinal:*** The intestinal disease form of anthrax may follow the consumption of contaminated meat and is characterized by an acute inflammation of the intestinal tract. Initial signs of nausea, loss of appetite, vomiting, fever are followed by abdominal pain, vomiting of blood, and severe diarrhea. Intestinal anthrax results in death in 25% to 60% of cases.

Where is it usually found?
Anthrax can be found globally. It is more common in developing countries or countries without veterinary public health programs. Certain regions of the world (South and Central America, Southern and Eastern Europe, Asia, Africa, the Caribbean, and the Middle East) report more anthrax in animals than others.

Can it be spread from person to person?
Direct person-to-person spread of anthrax is extremely unlikely to occur. Communicability is not a concern in managing or visiting with patients with inhalational anthrax.

Is there a way to prevent infection?
In countries where anthrax is common and vaccination levels of animal herds are low, humans should avoid contact with livestock and animal products and avoid eating meat that has not been properly slaughtered and cooked. Also, an anthrax vaccine has been licensed for use in humans. The vaccine is reported to be 93% effective in protecting against anthrax.

What is the anthrax vaccine?
The anthrax vaccine is manufactured and distributed by BioPort Corp. of Lansing, MI. The vaccine is a cell-free filtrate vaccine, meaning it contains no dead or live bacteria in the preparation. The final product contains no more than 2.4 mg of aluminum hydroxide as adjuvant. Anthrax vaccines intended for animals should not be used in humans.

Who should get vaccinated?
The Advisory Committee on Immunization Practices recommends anthrax vaccination for:

- People who work directly with the organism in the laboratory.
- People who work with imported animal hides or furs in areas where standards are insufficient to prevent exposure to anthrax spores.
- People who handle potentially infected animal products in high-incidence areas. (Incidence is low in the United States, but veterinarians who travel

(Continued on next page)

to work in other countries where incidence is higher should consider being vaccinated.)
- Military personnel deployed to areas with high risk for exposure to the organism (as when it is used as a biological warfare weapon).

Contact the anthrax Vaccine Immunization Program in the Army Surgeon General's Office at (877) 438-8222. Web site: www.anthrax.osd.mil. Pregnant women should be vaccinated only if absolutely necessary.

What is the protocol for anthrax vaccination?
The immunization consists of three subcutaneous injections given two weeks apart followed by three additional subcutaneous injections given at six, 12, and 18 months. Annual booster injections of the vaccine are recommended thereafter.

Are there adverse reactions to the vaccine?
Mild local reactions occur in 30% of recipients and consist of slight tenderness and redness at the injection site. Severe local reactions are infrequent and consist of extensive swelling of the forearm in addition to the local reaction. Systemic reactions occur in fewer than 0.2% of recipients.

How is it diagnosed?
Anthrax is diagnosed by isolating *B. anthracis* from the blood, skin lesions, or respiratory secretions or by measuring specific antibodies in the blood of persons with suspected cases.

What's the treatment?
Doctors can prescribe effective antibiotics. To be effective, treatment should be initiated early. If left untreated, the disease can be fatal. Three types of antibiotics are approved for anthrax: ciprofloxacin, tetracyclines (including doxycycline), and penicillins. For people who have been exposed to anthrax but do not have symptoms, 60 days of one of these antibiotics is given to reduce the risk or progression of disease due to inhaled anthrax.

Where can I get information about the recent Department of Defense decision to require men and women in the Armed Services to be vaccinated against anthrax?
The Department of Defense recommends that servicemen and women contact their chain of command on questions about the vaccine and its distribution. The anthrax Vaccine Immunization Program in the U.S. Army Surgeon General's Office can be reached at (877) 438-8222. Web site: www.anthrax.osd.mil

Source: National Center for Infectious Diseases, Atlanta, GA.

application specialist for San Diego-based UCSD Home Care. Maybe they will share, as most of the stuff is unclassified. Besides, many servicemen and women have spouses in the medical fields as well. You should be able to find someone to chat with easily."

While having an emergency plan in place is certainly a good thing from a patient perspective, it is also required by law, Henry says. "All businesses are required by [Occupational Safety and Health Administration] regulation to provide a safe work environment for employees. This includes training in specific areas like exposure control, bloodborne pathogens, and emergency management. You should have an emergency management plan in place along with exposure control plan, respiratory protection program, hazard communication plan, just to name a few.

"I personally think it would be a good time for your safety committee, human resources department or administrator to review your emergency management plan to ensure the plan provides procedures to follow in all emergency situations," she adds. "If we have these required programs and plans in place, and staff are instructed and trained on the procedures provided, then that would be sufficient. It may be a good time to provide an inservice and review the emergency management plan and procedures with the staff. It may help relieve some of the fears employees are experiencing and give a sense of security in knowing the agency is concerned with the safety and welfare of their employees."

[For more information, contact:

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Handling anthrax, other biological agent threats

Many facilities in communities around the country have received anthrax threat letters. Most were empty envelopes; some have contained powdery substances. The purpose of these guidelines is to recommend procedures for handling such incidents.

Do not panic.

Anthrax organisms can cause infection in the skin, gastrointestinal system, or the lungs. To do so, the organism must be rubbed into abraded skin, swallowed, or inhaled as a fine, aerosolized mist. The disease can be prevented after exposure to the anthrax spores by early treatment with the appropriate antibiotics. Anthrax is not spread from one person to another person. For anthrax to be effective as a covert agent, it must be aerosolized into very small particles. This is difficult to do, requiring a great deal of technical skill and special equipment. If these small particles are inhaled, life-threatening lung infection can occur, but prompt recognition and treatment are effective.

Suspicious unopened letter or package marked with threatening message such as "anthrax":

1. Do not shake or empty the contents of any suspicious envelope or package.
2. Place the envelope or package in a plastic bag or some other type of container to prevent leakage of contents.
3. If you do not have any container, then cover the envelope or package with anything (e.g., clothing, paper, trash can, etc.) and do not remove this cover.
4. Then leave the room and close the door, or section off the area to prevent others from entering (i.e., keep others away).
5. Wash your hands with soap and water to prevent spreading any powder to your face.
6. What to do next:
   — If you are at home, then report the incident to local police.
   — If you are at work, then report the incident to local police, and notify your building security official or an available supervisor.
7. List all people who were in the room or area when this suspicious letter or package was recognized. Give this list to both the local public health authorities and law enforcement officials for follow-up investigations and advice.

Envelope with powder spills out onto surface:

1. Do not try to clean up the powder. Cover the spilled contents immediately with anything (e.g., clothing, paper, trash can, etc.) and do not remove this cover!
2. Leave the room and close the door, or section off the area to prevent others from entering (i.e., keep others away).
3. Wash your hands with soap and water to prevent spreading any powder to your face.
4. What to do next:
   — If you are at home, then report the incident to local police.
   — If you are at work, then report the incident to local police, and notify your building security official or an available supervisor.
5. Remove heavily contaminated clothing as soon as possible and place in a plastic bag, or some other container that can be sealed. This clothing bag should be given to the emergency responders for proper handling.
6. Shower with soap and water as soon as possible. *Do not use bleach or other disinfectant on your skin*.
7. If possible, list all people who were in the room or area, especially those who had actual contact with the powder. Give this list to both the local public health authorities so that proper instructions can be given for medical follow-up, and to law enforcement officials for further investigation.

Question of room contamination by aerosolization. For example: small device triggered, warning that air-handling system is contaminated, or warning that a biological agent released in a public space.

1. Turn off local fans or ventilation units in the area.
2. Leave area immediately.
3. Close the door, or section off the area to prevent others from entering (i.e., keep others away).

4. What to do next:
   — If you are at home, then call 911 to report the incident to local police and the local FBI field office.
   — If you are at work, then call 911 to report the incident to local police and the local FBI field office, and notify your building security official or an available supervisor.
5. Shut down air-handling system in the building, if possible.
6. If possible, list all people who were in the room or area. Give this list to both the local public health authorities so that proper instructions can be given for medical follow-up, and to law enforcement officials for further investigation.

How to identify suspicious packages and letters
Some characteristics of suspicious packages and letters include the following:

- Excessive postage
- Handwritten or poorly typed addresses
- Incorrect titles
- Title, but no name
- Misspellings of common words
- Oily stains, discolorations, or odor
- No return address
- Excessive weight
- Lopsided or uneven envelope
- Protruding wires or aluminum foil
- Excessive security material such as masking tape, string, etc.
- Visual distractions
- Ticking sound
- Marked with restrictive endorsements, such as "Personal" or "Confidential"
- Shows a city or state in the postmark that does not match the return address

Source: Centers for Disease Control and Prevention, Atlanta. Web site: www.bt.cdc.gov/Agent/Anthrax/Anthrax.asp.

Enhancing bioterrorism preparedness and response

In the wake of Sept. 11, the Johns Hopkins Center for Civilian Biodefense Studies in Baltimore received many requests for specific guidance regarding bioterrorism preparedness and response.

In answer to these requests, the center has provided the following list of suggestions for hospitals, physicians, and public health practitioners.

HOSPITALS

- Review all relevant disaster response plans and assure appropriately designated staff are familiar with the contents and strategies.
- Establish internal and external lines of communication. Assure that medical staff are aware of the need to report suspicious cases of illnesses to public health authorities, and are familiar with who these authorities are. Have in place dedicated staff, phones, and fax machines to support rapid reporting.
- Hospital leaders should establish collaborative strategies for communicating with neighboring hospitals, civic leaders, and public health authorities.
- Quantify pharmaceutical and antibiotic supplies, both at central and satellite facilities. Routinely update this list.
- Assess routine staffing and emergency call-up plans and assure that these are supported with communication and transportation strategies. Update the roster of essential personnel.
- Maintain ongoing primary and redundant communication systems.
- Assure that appropriate health care professionals (e.g., emergency department and urgent care department personnel, infection control, and infectious diseases professionals) are aware of the importance of reporting unusual disease presentations, disease clusters, and atypical patterns of hospital use and know the mechanisms to do reporting.

PHYSICIANS

- Develop an increased awareness of the ongoing threat of bioterrorism.
- Become familiar with and develop a working knowledge of the most likely and dangerous pathogens as viewed by the Centers for Disease Control and Prevention (CDC). **(See web sites and phone numbers in the web site information section, p. 140.)**
- Become familiar with relevant lines of communication, and important phone numbers, such as the hospital epidemiologist, state epidemiologist, local health department (city or county), and the CDC emergency number.
- Monitor disease patterns and patient volumes in clinics and offices. Immediately notify the

appropriate authorities if you suspect an unusual event or need medical guidance.
- Patients can also be referred to the CDC public inquiry phone number **(see CDC numbers below right)** regarding information about infectious diseases and bioterrorism preparedness response efforts. Have referral numbers for mental health and support services as needed.
- The CDC is aware that a number of physicians have received requests for prescriptions for antibiotics to be used in the event of a bioterrorist attack. It should be known that CDC maintains a national pharmaceutical stockpile of large quantities of antibiotics and vaccines that could be distributed in the event of an epidemic brought on by an act of bioterrorism.

PUBLIC HEALTH
- Local and state public health agencies should collectively review bioterrorism response plans. Attention should be given to assuring the integration of response plans, including mechanisms for sharing resources and personnel as needed.
- Syndromic surveillance procedures should be put in place to monitor and detect atypical disease presentations and clusters. Both passive and active surveillance systems should be examined and refined across public health agencies and with reporting sources.
- Establish and maintain capacity to accept reports of unusual disease events 24 hours a day, seven days a week. Assure systems of continual, bi-directional communication between public health agencies and hospitals under their purview.
- Appropriately trained disease investigation staff should be available for immediate mobilization and deployment as needed. Staffing levels should be reviewed and plans put in place to determine nonurgent public health functions and clinics should it be necessary to pull additional clinical and field staff for urgent investigation activities.
- Assess communication systems, including procedures for immediately contacting public health and political leaders. Systems should be assessed to assure that appropriate authorities could be contacted at the outset of an emergency. Mechanisms for maintaining ongoing communication, including pagers, cell phones, and wireless e-mail systems, should be assessed and tested. All staff who provide on-call and disease investigation response and decision making should be adequately resourced for 24/7 communication.
- Hold regular meetings with all appropriate government and nongovernment agencies and organizations to continually review and refine plans.

MUNICIPAL LEADERS
- Ensure that leaders are generally familiar with what a bioterrorism attack might demand of civil authorities, and what resources are available to meet these demands. Identify and, if feasible, meet with public health and medical experts who might provide guidance to key decision makers during a public health emergency.
- Put in place primary and backup communication systems to assure that civil authorities can contact key medical, public health, and emergency response workers 24/7 in the event of a public health emergency.
- Assure that civil authorities can quickly broadcast emergency messages, health alerts, and educational information across multiple media including radio, television, and web sites. If older civil alert systems, e.g., air horns, etc., are available, educate the public regarding their possible use and meaning.
- Identify existing gaps in linkages, coordination of response and communication between hospitals, public health agencies, and emergency response workers.
- Develop transportation plans that facilitate movement of emergency vehicles, entrance to and egress from hospitals and care centers, and rapid deployment of essential health care workers from their homes or off-site locations to primary hospital and health care sites.
- Designate a dedicated point of contact to receive information from medical and public health agencies in the event of a bioterrorism attack.

IMPORTANT WEB SITES, INFORMATION
- CDC Emergency Number: (770) 488-7100
- CDC Emergency Chemical and Biological Hotline: (770) 424-8802
- CDC Public Inquiry Number: (404) 639-3534, (800) 311-3435
- CDC bioterrorism web site: www.bt.cdc.gov

Source: Johns Hopkins Center for Civilian Biodefense Studies, Baltimore. Web site: www.hopkins-biodefense.org/interim.htm.

Time's running out for some Medicare claims

Here's how to keep future claims from stacking up

If you've put off submitting, or in some instances resubmitting, your Medicare claims from Jan. 1, 1999, through Sept. 30, 2000, your time is running out. They're due by Dec. 31, 2001.

As most home health care agencies know, Medicare claims can get lost in the shuffle. Even when they don't, your agency might not be reimbursed for some claims, although Medicare will hold onto claims with known errors for up to 60 days.

If no corrective action is taken within that time, these files are deleted and your agency is back to square one. Sometimes, even when your intermediary sends notification of a claim error, these notices can find their way to the bottom of a tall stack of to-do's, never to resurface again.

According to **Christine Cloutier**, RN, owner and president of Christine Cloutier Consultants in South Portland, ME, if you're looking to submit your back claims, "this is the last minute."

"A claim very often will be paid, but when we go back and compare what Medicare paid and the actual charges, we'll find that it's $2,000 off."

Her consulting company, she says, "recently [has] gone into an agency and left one of our staff there on full-time basis. We're finding claims with literally hundreds of visits that have never been billed."

While it might sound like gross negligence on the part of this agency, that's not the case, Cloutier says. "I think most agencies are regularly going through their claims. It's not neglect at all, but it really takes a full-time person to at least review suspense files daily, make corrections, reconcile things, and review the postings.

"That very often can be a huge problem because in any given agency, it might be short-staffed or still doing manual postings," she adds. "And with the new PPS [prospective payment system], I honestly feel sorry for [that agency]."

Being short-staffed, while adding to an agency's workload, isn't the only reason Medicare claims may have errors or go unbilled.

"There are so many varying issues, but a lot start in intake when someone transposes an insurance number," explains Cloutier. "The claim will go through the system until that number is picked up. There have been many times when we have found months of service billed under the wrong insurance number."

OASIS data could cause problems

Outcome and Assessment Information Set (OASIS) data also can be the source of problems, she notes, especially where the nursing staff does the intake.

"It's so essential that they complete the OASIS correctly so that it merges with their internal data system," she says. "Another thing under the new PPS is that a nurse might admit a patient on Oct. 1, but won't sit down to do the OASIS paperwork until a few days later. Then the start-of-care date will show up as Oct. 3, for example, although it really began two days before."

What's more, she says, is nurses need to be careful when filing discharges.

"A patient might be discharged within the 60-day rule," she says, "but if for some reason that date gets deleted, it will appear that treatment was ongoing."

In some cases, the biller, maybe a home care aide, is not really experienced and will bill a 4-unit increment (one hour or service) when in fact it was two hours and should be billed as an 8-unit increment, she explains.

"In these cases, you get into the hourly vs. per-visit issue, and people simply aren't doing the conversion correctly," she says.

Another large problem area lies with adjustments from the Medicare side. "A claim very often will be paid, but when we go back and compare what Medicare paid and the actual charges, we'll find that it's $2,000 off."

Watch out for software glitches

Patience and accuracy may be virtues, but they won't always help when computers are factored in. Cloutier points out that while human error is the cause of some Medicare billing issues, so is an agency's software.

"A lot of problems stem from the fact that many providers use software systems that are still working out the wrinkles," she says. "Many issues like status codes and dates were not properly instituted by software vendors or simply

didn't merge with existing systems."

In such cases, she advises running, not walking to your software provider. She recounts the story of one agency for which she was consulting recorded every problem and glitch staff encountered.

"When we approached the vendor, it was more than willing to work with us and quickly remedy the problem," she says.

Vigilance is the key

To keep claim errors at bay, Cloutier urges agencies to run regular checks.

"The way to correct and catch an error is to go into suspense files every day after recent a submission of claims," she suggests. "If you do this, you'll find the errors."

She encourages her clients to run regular aged receivables reports through the Medicare system. "It's the first thing we ask them to do. Then we look at the bottom line. Agencies should test their claims and the best way is on the Medicare system because the system either will give you a pay date or will say that the particular claim doesn't exist."

Dana Strong, owner and president of Strong Consulting LLC in Scarborough, ME, also recommends that agencies make sure their Medicare cash receipts tie back to the agency's records.

"In my experience, it's well worth it to take all these steps," says Cloutier, whose firm has recently started a contingency-based Medicare claims processing and review program.

"We have found millions of dollars in unclaimed bills, and even in smaller agencies, amounts up to $40,000," she says. "That translates to the agencies. It translates to a few salaries."

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LegalEase

Understanding Laws, Rules, Regulations

Diversify your business within confines of PPS

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

Under a system of cost-based reimbursement from the Medicare program, it was reasonable for many home health agencies to focus the majority of their attention on the Medicare home care benefit. As a result, many agencies had a very high percentage of patients whose payer source was the Medicare program.

Many consultants and others who help home care agencies plan for the future have advised agencies to diversify their lines of business beyond Medicare in response to implementation of the prospective payment system (PPS). This recommendation is certainly sound.

Home care providers are professionals at providing community-based services in patients' homes. The skills necessary to provide these services will stand managers in good stead when they plan to provide other services that are community-based.

Agency managers now may be ready to move beyond a general recommendation to specific actions to help them meet this goal. But they may be stymied by uncertainty about how to achieve diversification.

What are some reasonable options? How

COMING IN FUTURE MONTHS

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should agencies go about identifying and following up on opportunities to plan for the future through diversification of programs and sources of payment for services provided?

Certainly the first step is to evaluate needs for additional services in the communities in which agencies operate. Home care providers are professionals at providing community-based services in patients' homes. The skills necessary to provide these services will stand managers in good stead when they plan to provide other services that are community-based.

Some agencies, for example, have identified needs for both child care and adult day care centers and have successfully provided such services in the same location with structured interaction between the generations.

Agencies may also be wise to look at recent court decisions for guidance about how to diversify their businesses.

When the courts mandate the provision of community-based services, home care providers are prime candidates to step in to offer assistance in meeting these mandates.

The Supreme Court decided two cases in the 1998-99 term that provide opportunities for home health agencies. These two cases are *Olmstead v. L.C.* and *Cedar Rapids School District v. Garret F.*

In the *Olmstead* case, the court decided that states must place certain mentally disabled people in community homes rather than hospitals. The basis of the court's decision was that it is illegal discrimination to segregate the mentally ill simply because of their disabilities.

What's the 'least restrictive' environment?

This decision is consistent with a legal principle commonly known as "least restrictive alternative." This legal principle says disabled individuals must be cared for in the least restrictive environment possible.

Ideally, this means patients will be cared for at home since it is considered to be the least restrictive environment possible. Specifically, home health agencies may have opportunities as states implement this court decision to provide psychiatric and other services to patients in their homes to assist states to meet this mandate.

Home care providers may also wish to develop home settings for patients, such as group homes, to help meet the needs of disabled individuals who cannot live on their own or with family members.

Many state governments are forming task forces to plan for implementation of the *Olmstead* case. The home health industry should have representation on these task forces. State home care associations may also wish to establish internal task forces to develop strategies for implementation that will assist the industry.

In the *Cedar Rapids School District* case, the court decided that, under a federal law intended to improve the educational prospects for the disabled, public schools must provide a wide array of medical care for disabled children attending classes.

Federal laws related to education of handicapped children began with passage of P.L. 94-142. Among other requirements, this statute requires schools to provide educational services to children in the least restrictive environment possible based upon an Individualized Educational Plan (IEP) for each child.

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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According to the court, when patients have medical needs that must be met in order to receive schooling in the least restrictive setting possible, school systems must meet these needs.

A common example of such a medical need is providing staff to suction students who are ventilator dependent so that they can attend regular classes.

In many states, according to state practice acts, only registered nurses (RNs) can suction patients. This means school systems are required to provide RNs on a daily basis to disabled students to make it possible for them to receive education in the least restrictive environment possible. Home health agencies are in a unique position to meet this need.

In addition, many IEPs require the provision of therapy services, including speech therapy, physical therapy, and occupational therapy. Some school systems have a great deal of difficulty meeting the requirements of IEPs that require such therapy services because they are unable to hire and retain enough therapists to meet students' needs. As such, many school systems contract with home health agencies to provide these therapy services when their own employees have too large a workload to handle.

Home health agencies should, therefore, educate themselves about the requirements of P.L. 94-142 and other mandates for educational services to disabled children. They should begin an active dialogue with local school systems to identify needs that agencies can meet as "pros" at providing community-based services.

A note of caution, however, may be helpful at this point. Surveyors may have difficulty shifting from the requirements of the Medicare program to account for other payer sources. Agencies serving students by providing RNs on a daily basis to accompany them to school to meet their medical needs may face deficiencies based on their failure to meet the requirements of the Medicare program.

We know of an agency that was, for example, cited for providing RN services to a disabled student at school under contract with the local school district because there was no "endpoint" to the student's care.

Agencies should be aware of the difficulty that some surveyors have in accounting for requirements of other payer sources and work hard to communicate these differences during surveys. The advantages of diversification are likely to clearly outweigh any miscommunication regarding survey criteria.

Now is the time for agencies to get serious about diversification of their businesses in ways that will help to ensure what is obviously a very bright future for home care and other community-based services.

[Elizabeth Hogue lives and works in Burtonsville, MD. A complete list of her publications is available. Call (301) 421-0143 or fax a request to (301) 421-1699.] ■

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. ■

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