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IN THIS ISSUE

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Private duty transport: Know where your agency stands with insurance

Should your agency provide patients with transportation?

One home care agency reports that its private duty agency transports patients on a variety of errands, from visits to the doctor's office to the grocery store and the barber. These trips might be made in the client's car or the home care nurse's vehicle.

If it's the employee driving his or her own vehicle, the agency requires a copy of the employee's license as well as proof of liability insurance. If the trip is made in the patient's car, the client must prove that he or she has up-to-date car insurance. An agency staff member admits to being uncomfortable with the arrangement, but is at a loss for how to handle it. The clients want it and the agency feels, accordingly, it is a service it must provide.

There are consequences for an agency that fails to limit its liability. Failure to keep tabs on staff driving records or otherwise limit liability can force an agency's insurance premiums to skyrocket. In a worst-case scenario, insurers may refuse to provide coverage for some staff drivers. Needless to say, that can spell not only layoffs and transfers, but can place a severe strain on already short-staffed home health care agencies.

Private duty transport is a Catch-22 in many ways and one that plenty of agencies find themselves in. Should home health care extend to taking patients on errands and to medical appointments? It depends on whom you ask.

To drive or not to drive

Neil Drucker, RN, president of Omni Healthcare Consulting of Moore, OK, says that all his private duty agency clients "provide transportation for their patients." Omni Healthcare Consulting also obtains a vehicle release from liability from the client upon admission.

It's an entirely different story for **Kathy Kieke**, RN, MSN, care center director of St. Cloud (MN) Hospital Home Care and Hospice. "Staff are not allowed to transport clients, but they can accompany them on public transportation, taxis, and so forth," Kieke says.

Sometimes the decision whether to transport clients may not be left

to the agency but comes under the rubric of state regulations. One such state is Tennessee. **Vicky Tataryn**, RN, BS, quality improvement consultant of Nashville-based Healthcare Consultants, says that under Tennessee state law, "people who transport someone for payment . . . must have a special chauffeurs license." Putting state regulations aside for a minute, Tataryn comes down on the side of prudence when it comes to transporting patients. It's her opinion that the risks far outweigh the gains. "I know the patients want it but . . . take them in a taxi or not at all."

Tataryn is not alone in her opinion. **Merridee Hansen Farr**, MPA, director of regulatory affairs/compliance at Rocky Mountain Home Care of Salt Lake City, notes that her agency recently wrestled with the same problem, but when all was said and done, decided against private duty transport. "We decided that the risk is not worth any possible benefit," she says.

Hansen Farr's advice: check with your insurance broker or carrier regarding a hired and non-owned liability clause, which provides auto liability coverage for vehicles that are leased, hired, rented, or borrowed from anyone other than an agency employee or partner. These policies typically provide auto liability coverage for vehicles that are not owned, leased, hired or borrowed but that are used in connection with a particular business. An example: employees using their vehicles for company business.

This provision was "never meant to cover employees transporting patients during the scope of their employment," she explains. "Our carrier indicated this provision was not intended for that kind of service, and we would not be covered in case of an adverse event. Also, if any of [an agency's] employees' insurance providers found out they were using their vehicles for business purposes, they may cancel the policy since it probably would not cover this particular employment duty.

"We called three major insurance carriers — Allstate, Farmers, and State Farm — and they all stated that they would not cover someone to do this as part of [his or her] job. We felt we had a responsibility not to put our employees at risk with their insurance providers. If an accident did occur, the investigation by the insurance company could very well reveal the circumstances of the trip, i.e. transporting a patient while working for an employer."

For the moment, Rocky Mountain Home Care offers company-owned vehicles to those offices that provide a substantial amount of private-duty

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. Cite practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

CE questions

13. By having a patient sign a waiver to hold the agency harmless in the event of an accident, home care agencies can prevent liability issues involved with private duty transport.
    A. true
    B. false

14. Some suggestions for limiting private-duty transport liability include:
    A. conducting an annual in-service on driver safety
    B. conducting your own driver's education course complete with a road test
    C. conducting annual DMV checks on all staff who drive in connection with their jobs
    D. A and D
    E. All of the above

15. Written reports of investigations into patient clams of fraud/abuse should include, at a minimum, the following information:
    A. description of how the alleged fraud and abuse was identified
    B. photographs of those involved in the claim
    C. Recordings from when the event occurred.

16. To keep laptops from becoming sources of infection, home health care professionals advise:
    A. washing the laptop with hot soapy water
    B. wiping only the keyboard down with an antibacterial wipe
    C. B and C
    D. A and C
    E. A and B

transport and who can "demonstrate it is a 'profitable' service. Otherwise, we do not transport at all."

Also, says Hansen Farr, if agencies decide to go ahead with private-duty transport, either with the employee's or client's vehicle, "it would probably be in their best interest to have extensive policies in place that would govern employee driving record reports, background and drug-screening checks, defensive driving and safe driving in-services, etc. Of course, you could also have the patient sign a waiver, which would attempt to hold the agency harmless in the event of an accident, although these often do not hold up in a courtroom setting."

Limiting liability for drivers

Regardless of your agency's policies on private duty transport, insurance agencies are taking a closer look at liability factors related to on-the-job driving. **Raymond Helms**, MPH, executive director at Pathways Home Care of Concord, NC, says that the liability firm for his hospital-based home care agency recently asked for the drivers license numbers all of the agency's employees — nearly 300 in all.

"Subsequent to that request," he says, "we received notice from them that several members of our staff are to be placed in 'non-driving' positions, based on items on their driving records from the state [Department of Motor Vehicles] DMV. They have not disclosed to us which items they consider to meet their elimination criteria, but indicate that prior accidents, whether the employee was at fault or not, are part of the criteria. They did say that if we could provide proof that they were not at fault in prior accidents, they would consider removing them from the nondriving restriction.

"This could lead to job losses at the worst, or transfer into other 'nondriving' positions in our hospital for some of our very talented staff members. Our hospital risk management is immediately soliciting other vendors for our liability insurance, but says they hear that this is a growing trend across the country."

John Beard, CEO of Alacare Home Health and Hospice of Birmingham, AL, says his agency has worked to minimize such risk management problems by working proactively with the carrier. For starters, he notes, his agency screens new hires for driver safety records and conducts an annual in-service on driver safety. Alacare also mandates that any driving accident, be it personal or job-related, be reported along with any tickets an employee might receive. His agency takes it a step further, Beard says, by conducting an annual check with the Alabama DMV on all staff that drive in connection with their jobs. And for those employees who fail to follow Alacare's driving policies and procedures, a system of progressive discipline is used.

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Seven steps for surviving a public health care crisis

Proven techniques for dealing with disaster

Keeping the public calm, disseminating information, and ensuring public safety are among the most important tasks to be undertaken in a crisis. But one expert says preparations often go undone until the crisis actually occurs. **Peter Goelz**, senior vice president and director / worldwide crisis communications for Washington, DC-based APCO, says the health care community, including hospitals and home health care agencies, should be ready with a plan in the event the worst happens.

So, in light of Sept. 11, who did well?

According to a straw poll taken during a recent meeting of public affairs and relations

professionals from around the country, the White House, and the New York City mayor's office rose to the occasion; the Postal Service did an excellent job of containing the threat of anthrax but was weak in several arenas; and public trust faltered slightly because of poor communication. The Centers for Disease Control and Prevention in Atlanta also stumbled when it came to getting the word out to people who feared they might be infected with anthrax.

The health care industry, says Goelz, "needs to work at providing more information not less in times of crisis, and the recent anthrax cases are a prime example. No one knew who should be tested and when, how accurate the tests were, or where to go to get tested. They should have had more sources of information and better communicated to people that this is the health profile of someone with a possible infection, if you meet these criteria you need to follow these steps.

"No one in the health field is ready on this level," he says. "The health care system must prepare itself to address future threats and determine how it will communicate plans to the public."

Planning for an unknown crisis may seem daunting, but there are a few basic rules all agencies should have as part of their plans:

• **Be prepared.** The best plan allows for your company to keep vulnerability away, Goelz says. A hospital should implement security checks of all visitors and even staff, as well as develop plans for direct and indirect threats (i.e. pinpointing possible areas from where infection could spread). "It boils down to due diligence in terms of the systems you implement," he says.

• **Educate your people**. A hospital should be certain that its staff are familiar with the new safety procedures and feel comfortable acting on them, for example, questioning people without an ID badge or who are on the wrong floor. "It's also vital that there be 24-hour assistance and a number that employees can call if they need information or have something to share," explains Goelz.

• **Define ways to get accurate information to people.** This means both your staff and the public at large, Goelz notes. If you're worried about getting the information out — and noticed — by staff members, take a page from **David Chilcote's** plans. Chilcote, an administrative director with Community Home Services Inc. in (Naples, FL), says he uses a variety of methods to spread the word about policy changes and the like. "We encourage participating members to share the word with their co-workers and test pilot the change with a small group and make updates to ease the burden."

Chilcote also makes use of his agency's communications vehicles including using the voice mail program and the monthly in-house newsletter to mass notify all staff members that there has been a policy change. Additionally, Community Home Services requires that all changes are included in orientations and competency trainings.

Laresa Boyle, RHIA, business office / medical records coordinator, at CRH Home Health Agency in Cushing, OK, also has a suggestion for getting information out to staff. "Our clinical supervisor makes up a coordination of service [COS] memo weekly with any changes, updates, etc., and every employee is given one in their box and a copy is kept in a three-ring notebook as well. All clinical staff meet once a week for COS and the memo is then read out loud."

• **Develop scenarios that will help your agency or hospital deal with a given crisis.** Be it something as basic as stopping the spread of infection or as unlikely as coping with a terrorist attack, preparation is essential to a smooth running and successful crisis plan.

Seven crisis communication principles

Once you have a plan in place, half the battle is won. With any luck you'll never face the second half — dealing with a crisis in a public arena. If you suddenly find that your agency or hospital is in the public spotlight, don't panic. There are proven steps that can help you weather the storm and come out on top.

• **Act in the public interest.** Now is not the time to worry about your agency's bottom line, says Goelz. "You have to put the public interest before economic interest. If you don't, you can be sure that you will be held accountable for it down the road."

• **Lead, don't follow**. With a plan in place you can hit the ground running in the event that your agency is struck with a public health crisis, such as being the point of contamination for a highly infectious disease. Step up to the plate, he advises, announce your plan, implement it and keep the public informed as to how it's going.

• **Move quickly.** Your agency or hospital should be the one to come out and admit there is a problem, rather than wait for the media to expose one. Rumors move quickly and dispelling them not only can take up energy that should be devoted elsewhere, but can prove to be the downfall of a company.

• **Fix the problem.** If your agency is determined to be a point of contamination, take every step to see that that outlet is shut down.

• **Communicate forthrightly.** If your agency is to survive, he cautions, you must be honest about what happened and why. The public has a little patience for misinformation and half-truths, he notes, but a long memory when it comes to deception.

• **Show compassion.** The public welfare should be a company's first concern and that care should be communicated through every action a company takes following a crisis.

• **Restore credibility**. Demonstrate your agency's viability by continuing with strong safety measures or strict anti-infection policies. Remember actions, at times, do speak louder than words.

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• ***Peter Goelz**, Senior Vice President, Director, Worldwide Crisis Communications, APCO, 1615 L St. N.W., Suite 900, Washington, D.C. 20036. Telephone: (202) 778-1000.]* ■

Useful tips to disinfect your laptop computer

As home care agencies become more technologically advanced, laptops are increasingly becoming as commonplace as a nursing bag. While useful for tracking patient cases and completing OASIS records, there is the problem of keeping a laptop clean without short-circuiting the system. Short of dipping in a vat of disinfectant, what steps can you take to keep your laptop from being a point of contamination? Here's what some home care agencies have to say on the matter:

• Treat them like you would the bottom of a nursing bag — if it's visually contaminated or you suspect contamination due to possible contact with contaminated surface, disinfect the exposed area. Other than that, employ normal cleaning with an appropriate cloth.

• Provide staff with an antibacterial wipe to use on the keyboard only. A few words of caution: If the moisture seeps into the keyboard membrane, you may void the warranty of the laptop. Also, with some of the antibacterial wipes, the chemical will react with the plastics that make up the keyboard.

• In the home setting, use a disposable barrier protection underneath.

• If a patient is infectious, laptops are not to be taken inside the home

• Don't allow gloves to touch the keyboard and mandate that staff thoroughly wash their hands before using the laptop. ■

LegalEase

Understanding Laws, Rules, Regulations

Set parameters for fraud and abuse investigation

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

Allegations of fraud and abuse from patients and their families should be treated very seriously. Case managers who receive such complaints should bear in mind two primary goals: 1) Case managers must demonstrate adherence to their internal compliance plans; and 2) Case managers must conduct a thorough investigation so that complainants are satisfied that there is no need to go to outside regulators and investigators because all that should be done has already been done internally.

The time for case managers to wonder whether they should have a fraud and abuse corporate compliance plan has long gone. These days, the reality is that case managers working for organizations that do not have such plans in place and effectively implemented are quite simply playing with fire. Among other things, corporate compliance plans should specify what is necessary to conduct a proper and thorough investigation of reports of possible fraud and abuse.

At a minimum, corporate compliance plans should specify a time limit for completion of investigations. Under most circumstances 60 days will be sufficient.

(Continued on page 9)

Get the facts on anthrax: A patient guide in Spanish

The specter of anthrax still looms. Frightening for those who understand the reports and even more so for those patients who are not native-English speakers. To help ease your Spanish-speaking patients' fears, *Hospital Home Health* is furnishing the following patient handout on anthrax — what it is, how it's contracted and transmitted, and what treatments exist.

¿Qui Es El ántrax?

El ántrax es una enfermedad infecciosa aguda causada por la bacteria que se llama *Bacillus anthraci* que forma esporas. El ántrax ocurre con mayor frecuencia en los vertebrados menores, silvestres y domésticos (ganado vacuno, ovejas, chivos, camellos, antílopes, y otros herbívoros), pero también puede ocurrir en seres humanos cuando tienen contacto con los animales infectados o el tejido de animales infectados.

¿Por qué hay mucho interés sobre el ántrax en la actualidad?

Debido a que el ántrax es considerado un agente que puede ser usado en una guerra biológica, el Departamento de Defensa (DoD) ha empezado el proceso obligatorio de vacunar a todo el personal militar activado que pudiera verse involucrado en combate.

¿Es común el ántrax y quién puede contraerlo?

El ántrax es más común en regiones agrícolas donde los animales tienen la enfermedad. Estas regiones incluyen Sudamérica, Centroamérica, Europa del sur y del este, Asia, África, el Caribe y el Oriente Medio. Cuando el ántrax afecta a los seres humanos, es normalmente por causa de exposición ocupacional a los animales infectados o sus productos. Los trabajadores que están expuestos a los animales muertos y a los productos de otros países donde el ántrax es más común, podrían resultar contaminados con *B. anthracis* (ántrax industrial). En los Estados Unidos se han registrado casos de ántrax en ganado salvaje.

¿Cómo se transmite el ántrax?

La infección de ántrax puede ocurrir en tres formas: cutánea (piel), por inhalación, y gastrointestinal. Las esporas de *B. anthracis* pueden vivir en la tierra por muchos años, y los seres humanos pueden resultar infectados con ántrax al tocar los productos de animales infectados o por inhalar las esporas de los productos de animales contaminados. El ántrax también puede contraerse al comer carne de animales infectados que no fue suficientemente cocida. Es poco común encontrar animales infectados en los Estados Unidos.

¿Cuáles son los síntomas de ántrax?

Los síntomas de la enfermedad dependen de la forma en la que se contrajo, pero normalmente los síntomas se presentan dentro de los primeros 7 días.

Cutáneo: La mayoría (casi 95%) de las infecciones de ántrax ocurren cuando la bacteria entra en una lesión o abrasión en la piel, como por ejemplo cuando se toca lana, pieles, cuero u otros productos de pelo de animales infectados (especialmente pelo de chivos). La infección de piel empieza como una protuberancia similar a la de un piquete insecto pero que en 1 a 2 días se convierte en una bolsa llena de líquido y después en una úlcera sin dolor, usualmente de 1 a 3 cm. de diámetro, con una característica área negra y necrótica (en el proceso de morir) en el centro. Las glándulas linfáticas en el área adyacente se pueden hinchar. Aproximadamente un 20% de los casos que no reciben tratamiento médico contra el ántrax cutáneo provocarán la muerte. La muerte es poco común si se recibe una terapia antimicrobiana apropiada.

Inhalación: Los síntomas al principio pueden confundirse con los de un catarro común. Después de varios días, los síntomas pueden empeorar y convertirse en problemas graves de respiración y shock. El ántrax de inhalación generalmente es fatal.

Intestinal: La forma intestinal del ántrax puede ser el resultado de haber consumido carne contaminada y los síntomas incluyen inflamación severa del tracto intestinal. Los primeros síntomas de nausea, pérdida de apetito, vómito, y fiebre son seguidos por dolor abdominal, vómito de sangre, y diarrea grave. En 25% a 60% de los casos de ántrax intestinal el resultado final es la muerte.

¿Normalmente, dónde se encuentra el ántrax?

El ántrax se encuentra por todo el mundo. Es más común en los países en vías de desarrollo o en los países sin programas de salud pública veterinaria. Ciertas regiones del mundo (Sudamérica, Centroamérica, Europa del sur y del este, Asia, África, el Caribe y el Oriente Medio) reportan más ántrax en los animales que en otros países.

¿Puede ser transmitido el ántrax de persona a persona?

El riesgo de que el ántrax se contagie de persona a persona es muy poco probable. No tiene que preocuparse de contraer la enfermedad si está a cargo de o si visita a un paciente que tiene el ántrax inhalado.

¿Hay manera de prevenir la infección?

En los países donde el ántrax es común y los niveles de vacunación en los animales son bajos, los seres humanos deben evitar el contacto con el ganado y los productos animales así como evitar el comer carne que no ha sido procesada y cocinada adecuadamente. También, existe ya una vacuna aprobada contra el ántrax para usarse en los seres humanos. Se estima que la vacuna es eficaz en 93% de los casos para la protección contra ántrax.

¿Qué es la vacuna contra el ántrax?

La vacuna contra el ántrax es fabricada y distribuida por BioPort Corporation, Lansing, Michigan. La vacuna es una vacuna filtrada para eliminar las células, lo que significa que en la preparación no se usa bacteria viva ni muerta. El producto final no contiene más de 2.4 mg. de hidróxido de aluminio. Las vacunas de ántrax para animales no deben ser usadas en seres humanos.

¿Quién debe ser vacunado contra el ántrax?

El Comité de Consultoría Sobre las Prácticas de Inmunización ha recomendado la vacunación de ántrax para los siguientes grupos:

Las personas que trabajan directamente con el organismo en el laboratorio.

Las personas que trabajan con pieles de animales importadas en áreas en las que las medidas de seguridad e higiene no son suficientes para prevenir la exposición a las esporas de ántrax.

Las personas en áreas con altos incidentes de ántrax que tocan los productos animales que podrían estar infectados. (Son bajos los incidentes en los Estados Unidos, pero los veterinarios que viajan a trabajar en otros países deben pensar en vacunarse).

El personal militar enviado a las áreas con alto riesgo de exposición al organismo (cuando se usa como arma en guerra biológica).

Puede comunicarse con el Programa de Inmunización de la Vacuna contra el Ántrax de la U.S. Army Surgeon General's Office al 1-877-GETVACC (1-877-438-8222) www.anthrax.osd.mil. (en inglés). Las mujeres embarazadas sólo deben vacunarse si es absolutamente necesario.

¿Cuál es el itinerario para la vacuna de ántrax?

La inmunización consiste de tres inyecciones subcutáneas dadas cada dos semanas, seguidas por tres inyecciones subcutáneas adicionales dadas a 6, 12, y 18 meses. Después, se recomienda la aplicación de inyecciones de refuerzo cada año.

¿Hay reacciones desfavorables a la vacuna de ántrax?

Se presentan reacciones locales leves 30% de los vacunados y consisten en poco dolor y rojez en el lugar de inyección. Las reacciones locales graves son poco frecuentes y consisten en una hinchazón extrema del antebrazo además de la reacción local. Las reacciones del sistema ocurren en menos de 0.2% de los vacunados.

¿Cómo se diagnostica el ántrax?

Se diagnostica el ántrax por el aislamiento de *B. anthracis* de la sangre, lesiones de piel, o las secreciones respiratorias o mediante la medida de anticuerpos específicos en la sangre de las personas posiblemente afectadas.

¿Hay tratamiento para el ántrax?

Los doctores pueden recetar antibióticos efectivos. Para ser eficaz, el tratamiento debe comenzar temprano. Si no se atiende, la enfermedad puede ser fatal.

¿Dónde puedo obtener más información sobre una decisión reciente del Departamento de Defensa que requiere que los hombres y mujeres en los servicios armados se vacunen contra el ántrax?

El Departamento de Defensa recomienda que el personal militar se comunique con su cadena de mando para cualquier pregunta sobre la vacuna y su distribución. Puede comunicarse con el Programa de Inmunización de la Vacuna de Ántrax de la U.S. Army Surgeon General's Office al 1-877-GETVACC (1-877-438-8222) www.anthrax.osd.mil.

Source: Centers for Disease Control and Prevention, Atlanta. Website: www.cdc.gov/ncidod/dbmd/diseaseinfo.

Datos sobre el ántrax y la viruela

Datos sobre el ántrax

El ántrax es una enfermedad infecciosa de carácter agudo causada por la bacteria esporulenta Bacillus anthracis. El ántrax afecta generalmente a los mamíferos con pezuñas pero también puede presentarse en el ser humano.

Los síntomas de la enfermedad varían según la forma en que se haya contraído, pero generalmente se presentan alrededor de siete días luego de la exposición. Las formas más graves de ántrax en el ser humano son: por inhalación, contacto cutáneo e intestinal.

Los síntomas iniciales de infección del ántrax por inhalación pueden ser similares a los del resfriado común. Luego de varios días, los síntomas pueden complicarse y se presentan trastornos graves de la respiración y shock. El ántrax por inhalación es con frecuencia fatal.

La enfermedad intestinal causada por el ántrax puede presentarse luego de consumir alimentos contaminados y se caracteriza por una inflamación aguda del tracto intestinal. Los síntomas iniciales de náuseas, pérdida de apetito, vómitos y fiebre dan paso a dolores abdominales, vómitos con sangre y diarrea severa.

La propagación del ántrax de una persona a otra es muy poco probable y prácticamente imposible. Por lo tanto, no es necesario inmunizar ni proporcionar tratamiento alguno a las personas que tienen contacto con los enfermos de ántrax, tales como los que comparten una vivienda, amigos o compañeros de trabajo, a menos que hayan estado expuestos a la misma fuente de infección.

En el caso de las personas expuestas al ántrax, la infección se puede prevenir por medio de un tratamiento con antibióticos.

Es esencial tratar el ántrax con antibióticos a tiempo. La demora disminuye la posibilidad de supervivencia. Generalmente el ántrax es sensible a la penicilina, doxiciclina y fluoroquinolonas.

También puede utilizarse una vacuna contra el ántrax para prevenir la infección. La vacunación contra el ántrax no se recomienda para el público en general, ni tampoco está disponible.

Datos sobre la viruela

La viruela fue erradicada del mundo en 1977.

La viruela es causada por el virus variola. El período de incubación es de alrededor de 12 días (oscila entre 7 y 17 días) luego de la exposición. Los síntomas iniciales incluyen fiebre alta, fatiga y dolor de cabeza y espalda. Luego de dos a tres días aparece un sarpullido característico, más visible en el rostro, brazos y piernas. El sarpullido comienza como lesiones planas de color rojizo que evolucionan al mismo ritmo. Las lesiones se llenan de pus y se comienzan a cubrir con costras a principios de la segunda semana. Las costras van sanando y luego se separan y desprenden al cabo de tres a cuatro semanas. La mayor parte de los enfermos de viruela se recuperan, pero un 30% fallece.

La viruela se propaga de una persona a otra a través de gotas diminutas de saliva, por lo que cualquier persona que tenga contacto cara a cara con un enfermo puede contraerla. Los enfermos de viruela son más contagiosos durante la primera semana, porque es durante este período cuando hay la mayor cantidad de virus presentes en la saliva. Sin embargo, existe un leve riesgo de transmisión hasta que todas las costras se han desprendido.

La vacunación rutinaria contra la viruela fue suspendida en 1972. No se conoce con precisión el nivel de inmunidad, en caso de haberlo, de cualquier persona vacunada antes de 1972; por lo tanto, se supone que estas personas son susceptibles a contraer la enfermedad.

No se recomienda la vacuna contra la viruela al público en general, por lo que la misma no está disponible.

En el caso de las personas expuestas a la viruela, la vacuna puede disminuir la severidad de la enfermedad e incluso prevenirla si se administra dentro de los cuatro días siguientes a la exposición. La vacuna contra la viruela contiene otro virus vivo denominado vaccinia. La vacuna no contiene virus de la viruela.

En los Estados Unidos se cuenta en la actualidad con suministros de vacuna contra la viruela para casos de emergencia.

No existe tratamiento comprobado contra la viruela pero en la actualidad se están evaluando nuevos agentes antivirales. Los enfermos de viruela pueden beneficiarse de una terapia de apoyo (fluidos por vía intravenosa, medicamentos para controlar la fiebre y el dolor, etc.) y antibióticos para combatir cualquier infección bacteriana secundaria que pudiera presentarse.

Source: Centers for Disease Control and Prevention, Atlanta. Website: www.cdc.gov/spanish/bt/preguntas.htm#hacer.

Preguntas Frecuentes

Q) *¿Qué debo saber sobre la viruela?*

Viruela. No se recomienda la vacunación, y la vacuna no está disponible para los proveedores de salud ni para el público. Puesto que no hay un caso confirmado de viruela en todo el mundo, no hay necesidad de vacunarse contra la viruela. También, pueden haber efectos secundarios graves a la vacuna de viruela, y por eso, no recomendamos la vacunación. En caso de que haya una epidemia, los CDC han establecido directrices efectivas para vacunar a las personas que han estado expuestas a esta enfermedad. La vacuna está almacenada en forma segura para usarla en caso de una epidemia. Además, el Secretario de Salud y Servicios Humanos, Tommy Thompson, recientemente anunció planes para acelerar la producción de una nueva vacuna contra la viruela.

Q) *¿Qué debo saber de ántrax?*

Ántrax. Después de la exposición a la población civil nuestras medidas de prevención contra el ántrax serían los antibióticos. No se recomienda la vacunación contra el ántrax y la vacuna no está disponible para los proveedores de salud ni para el público en general. En este momento no recomendamos que los médicos receten los antibióticos para ántrax. En la actualidad tenemos suficientes antibióticos para prevenir la enfermedad en 2 millones de personas expuestas al ántrax, lo que nos permite hacer llegar rápidamente la medicina preventiva a los que pudieran verse afectados por esta enfermedad. El ántrax no puede trasmitirse de persona a persona.

Q) *¿Qué debo hacer para prepararme?*

Preparación. Continuamos escuchando reportes de personas que compran máscaras antigás y que acumulan medicina en anticipación de un posible ataque químico o de terrorismo biológico. No recomendamos que haga ninguna de estas cosas. Como dijo recientemente el Secretario Thompson, las personas no deben de asustarse y pensar que necesitan una máscara antigás. En el caso de una emergencia de salud pública, los departamentos locales y estatales de salud le informarán al público sobre las acciones o precauciones que las personas deben tomar.

(Continued from page 5)

Corporate compliance plans should also require completion of written reports within the time frame specified above. Written reports of investigations should include, at a minimum, the following information:

- Description of how the alleged fraud and abuse was identified and the origin of the information that led to the disclosure.
- A detailed description and chronology of the investigative steps taken including: a list of all individuals interviewed, the dates of those interviews, the subject matter of each interview, business and home addresses and telephone numbers of each witness interviewed, and the positions and titles of those in the organization both currently and during the relevant time period.
- A description of the files, documents, and records reviewed.
- A summary of auditing activity undertaken and a summary of the documents relied upon in support of cost impact determinations, if any.

In addition to compliance with internal compliance plans, case managers should also take practical steps to ensure that those patients and their families who make allegations are satisfied insofar as believing sufficient internal steps have been taken. In doing so, case managers are protecting their agencies — patients and their families will be less likely to be tempted to go outside provider organizations and other investigative agencies. That said, it is at this point that it is necessary to sound a strong note of caution.

The experience of many case managers has demonstrated that allegations of fraud and abuse from patients and their families may often be based in a lack of understanding of reimbursement systems and inaccurate memories of events and/or applicable standards of care. Instances in which patients and their families claim that they never received services are classic examples of the need for caution.

So while case managers must take allegations of fraud and abuse very seriously, they must also keep an open mind until investigations are complete. Case managers must remember that staff and contractors have the right to a fair, impartial investigation as outlined above before adverse action is taken against them. Perhaps the real bottom line, regardless of conclusions reached, is to satisfy patients that such allegations are treated seriously and thoroughly investigated in order to avoid additional action by patients and their families.

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

Estrogen may prevent Parkinson's disease

According to a recently released study conducted by the Mayo Clinic and published in the September issue of *Movement Disorders*, women who have undergone hysterectomies are three times more likely to develop Parkinson's disease than those who have not had the surgical procedure. Women who receive estrogen replacement treatment following menopause are 50% less likely to develop the disease than those not receiving estrogen replacement are.

These findings, researchers say, indicate that an early loss of estrogen may increase a patient's risk of developing Parkinson's disease, a progressive condition that causes impaired movement and tremors. The study examined the medical records of 72 women who developed Parkinson's disease between 1976 and 1995. The study examined the link between the development of Parkinson's and menopause, be it surgical or natural, age at menopause and the use of postmenopausal estrogen replacement treatment. Researchers also found a higher incidence of Parkinson's in men than women — men are one and half times more likely to develop the disease — indicating again the role that estrogen may play in the prevention of the disease. Researchers cautioned, however, that the study's findings should not in any way influence a woman's decision to have a hysterectomy if that is the recommendation of her physician and that the chances of developing Parkinson's, remains small regardless of whether a patient has a hysterectomy.

Approximately 1 million Americans suffer from Parkinson's. ▼

New funding in battle to fight Alzheimer's

The National Institute on Aging (NIA) awarded a $54 million grant to the Alzheimer's Disease Cooperative Study, a national consortium of 83 medical research centers and clinics throughout the United States and Canada.

The group, coordinated by the University of California, San Diego will use the funds to develop enhanced diagnostic tools and to test a variety of drugs that may slow the progression of the disease or even prevent it altogether. Among the studies to be conducted over the course of the five-year grant are:

- An ongoing prevention trial to determine whether vitamin E and donepezil (an agent that slows the breakdown of the neurotransmitter acetylcholine) may keep patients with mild cognitive impairment from converting to Alzheimer's.
- A study to determine the role cholesterol may play in the development of the disease and whether taking a cholesterol-lowering statin drug may slow the progression of the clinical signs of Alzheimer's.
- An 18-month clinical trial to examine the effects of high-dose folate/B6/B12 supplements on the cognitive decline of people who have already developed the disease.
- A 2-year study that will look at whether low doses of valproate, an anti-psychotic drug, can delay the emergence of agitation and psychosis in patients in the advanced stages of Alzheimer's.
- A study of the safety and tolerability of Indole-3-Propionic Acid, a highly potent, naturally occurring anti-oxidant that has been shown to interfere with the action of enzymes contributing to amyloid plaque formation, a hallmark of Alzheimer's.
- An ongoing project to develop and improve measures for evaluating the clinical effectiveness of drugs used and tested in the prevention or treatment of Alzheimer's. ▼

COMING IN FUTURE MONTHS

- Helping patients cope with pain
- Using patient satisfaction surveys
- A PPS financial model you can use
- Can you make a day-care visit?
- Pre-admission screening

Telehomecare provides cost-effective treatment

Substituting interactive video sessions for up to half of a home care nurse's patient visits with post-surgical or chronically ill patients can be a cost-effective means of providing care, according to the results of a Pennsylvania State University study.

The study followed a group of 171 diabetic patients released from the hospital and referred to a visiting nurses program. Half were randomly assigned to receive a patient telecommunication system while the remaining half received traditional home care visits. The patient system, which operates over ordinary phone lines, involved a computer and monitor equipped with a blood pressure cuff and stethoscope, voice capability and a video camera. Patients are able to see and speak with their nurses, while the caregivers, in turn, also are able to see and hear the patients in addition to being able to take basic vital signs.

The study found that those who used the system tested higher on positive outcomes of the treatment, had fewer rehospitalizations, and required fewer visits to the hospital emergency room. Additionally, researchers found that over the standard 60-day course of treatment, savings of $300 could be realized when telehomecare is substituted for seven regular in-home visits and $700 in savings could be found if half of home care visits were done via telehomecare.

Even so, says **Kathryn Dansky**, associate professor of health policy and administration, who led the study, "Video visits are not a complete substitute for in-home nursing care. You are always going to need home visits because patients benefit from the personal touch." ▼

No easing of inspections for nursing homes seen

In spite of earlier reports from the White House, regulatory requirements that would reduce the frequency of nursing home inspections will not go into effect.

President Bush rejected a proposal by Thomas Scully, head of the Centers for Medicare & Medicaid Services (CMS), which would soften CMS nursing home inspection requirements and limit penalties. Previous reports from the White House indicated that the president favored easing requirements, allowing so-called "good" nursing homes to be inspected less frequently, with the idea that the inspections process would be made less burdensome.

Under the proposed CMS plan, "bad" nursing homes eventually would be inspected twice as often as those that had received god compliance records and would be subject to stricter criteria would. In spite of the support of CMS and the Department of Health and Human Services, **Sen. Charles Grassley**, former chairman of the Senate Special Committee on Aging and the senior Republican on the Senate Finance Committee, which has authority over Medicaid and Medicare, says, "The quality of care can change suddenly, even for facilities with good track records. Today's good nursing homes could become tomorrow's poor performers." ▼

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Editorial Questions

For questions or comments, call **Lee Landenberger** at (404) 262-5483.

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Alternating drug regimen may help HIV+ patients

A new study from the National Institute of Allergy and Infectious Diseases (NIAID) shows that for some HIV-positive people, a drug regimen of one week on, and one week off may prove beneficial. This approach is known as "structured intermittent therapy."

Ten patients participated in the study and who, at the start of the program, were being treated with highly active antiretroviral therapy. During the study they switched to an intermittent program, meaning they were given a week of the intensive HIV medication combinations followed by a week without any medications. Results showed that the patients not only suffered no ill-effects on their health, but experienced a reduction in some side-effects. If such therapy programs pan out, not only will patients benefit, but the cost involved with supplying and administering the medications could be reduced. Researchers will report their findings in the Proceedings of the National Academy of Sciences. The bulk of the research was conducted within the NIAID Laboratory of Immunoregulation. ■

THE EXECUTIVE'S SUPPLEMENT TO *HOSPITAL HOME HEALTH*

HOME HEALTH BUSINESS QUARTERLY

Via Schroder, Sunrise expands assisted living to homes

Sunrise Assisted Living of McLean, VA, has expanded its joint venture agreement with Schroder Ventures Life Sciences (SLVS), a health care-focused venture capital firm, for At Home Assisted Living by Sunrise. SVLS will provide Sunrise with $5 million for a second round of funding to expand Sunrise's At Home program, which provides assisted living services to seniors in their own homes in the Washington, DC, metropolitan market, to the additional markets of Philadelphia, Boston, northern New Jersey, and Long Island, NY.

The joint venture originated in October 2000 when SVLS provided an initial $5 million in capital funding that allowed Sunrise to establish the At Home program's infrastructure and conduct a pilot for the program and its services. At Home services include personal emergency response systems, home care, and homemaker visits, telephonic and video monitoring, medication dispension and reminders, vital signs monitoring and other home support services. The pilot was introduced in the Washington, DC, metropolitan market in February 2001 and approximately 400 customers have received services through the program to date. ■

COMPANIES IN THE NEWS

Med Diversified acquires Tender Loving Care

Med Diversified of Jacksonville, FL, a provider of home health care products and home health services, will acquire Tender Loving Care Health Care Services Inc. (TLCHCS) of Lake Success, NY, through a cash merger.

Med Diversified will acquire all of the issued and outstanding stock of TLCHCS for $1 per share in cash, rather than $12 per share in stock as previously announced. Closing is subject to regulatory approval, approval of the board of directors of both companies and the shareholders of TLCHCS, and new employment agreements for its executives. Tender Loving Care provides home health care services at 87 locations in 22 states and the District of Columbia. ■

New York Health Care in Biotech Balance swap

New York Health Care (NYHC), a home health care agency based in Brooklyn, NY, has acquired The Bio Balance Corp. in a stock-for-stock exchange. Bio Balance shareholders received 19.3 million shares of NYHC common stock after a 1-for-1.5 reverse split of the NYHC shares. The biotechnology company researches and develops probiotic agents — live microorganisms that stimulate the growth of healthy bacteria in an animal or human host — to treat irritable bowel syndrome and other gastrointestinal diseases.

Sales of an effective IBS treatment could exceed $1 billion a year, according to pharmaceutical company data. ■

Option Care acquires portions of Healix Health

Option Care Inc. of Bannockburn, IL, has acquired certain assets of Healix Health

Services Inc., a Texas-based provider of home infusion and respiratory therapy. Details of the agreement were not disclosed.

"The Healix acquisition marks a significant step toward strengthening our position in the state of Texas and expanding our network outside of established markets, marked by our entry into the state of New Mexico. Importantly, this acquisition also establishes our diversification into respiratory therapy," said **Raj Rai**, Option Care's president and CEO.

Option Care provides pharmacy services on behalf of third-party payors a nationwide network of 133 owned and franchised pharmacy locations and three regional specialty pharmacies. ■

Pediatric Services returns to listing on the Nasdaq

Pediatric Services of America Inc. of Norcross, GA, has been relisted on the Nasdaq National Market and its common stock began trading Sept. 5, 2001, under the symbol PSAI.

"We believe that listing on the Nasdaq National Market will generate broader interest among institutions and potential investors for our common stock," said **Joseph Sansone**, president and CEO.

Pediatric Services provides comprehensive pediatric home health care services through 101 branch offices in 22 states. ■

Tyco to seeks a buyout for device maker C.R. Bard

Tyco International Ltd. (Hamilton, Bermuda) expects to buy out medical device maker C.R. Bard Inc. of Murray Hill, NJ, in 1Q02. The Tyco conglomerate's health care and specialty products unit generated $8.83 billion in revenue for the fiscal year ended Sept. 30, 2001. Bard, whose medical products include catheters and urology devices, reported about $1.1 billion in total sales in 2000.

The estimated $3.2 billion deal is being held up as the companies negotiate with the Federal Trade Commission over potential divestitures. Tyco chairman **Dennis Kozlowski** said there is about $235 million in cost reductions to be made at Bard. He said Bard will add 5 cents per share to Tyco's earnings during the first 12 months of the acquisition. ■

CORPORATE LADDER

Carl Camden, chief operating officer for Kelly Services Inc. of Troy, MI, has been promoted to company president. He will also serve on the board of directors of the staffing service until March.

Camden joined the company in 1995 and has been senior vice president of marketing; executive vice president; executive vice president, field operations, sales, and marketing; and executive vice president, chief operating officer. Before joining Kelly, he was senior vice president of corporate marketing services for KeyCorp, co-president of Wyse Advertising co-founder/owner of North Coast Behavioral Research Group, and an associate professor of communications at Cleveland State University. ■

Option Care of Bannockburn, IL, which provides pharmacy services to patients on behalf of third-party payers, has appointed **Leo Henikoff**, MD to its board of directors. Henikoff is currently the president and CEO of Rush-Presbyterian-St. Luke's Medical Center (Chicago); president and chairman of the Rush System of Health, a six-hospital system in the Chicago area; president of Rush University; and a professor of medicine and pediatrics. He has also served on the boards of directors for Bankmont Financial Corp., the Harris Trust and Savings Bank, Harris Bankcorp, the United Way, and Centel Cable Television Co. ■

Patrick F. Kennedy has been named interim chief executive officer of Alterra Healthcare Corp. of Milwaukee), which operates freestanding Alzheimer's/memory care residences in 26 states. A senior executive and director of Holiday Retirement Corp., Kennedy will serve as Alterra's CEO throughout its restructuring.

Kennedy, a business lawyer, practiced transactional law for 15 years with firms in New York and Seattle before 1995, when he joined Holiday Retirement, which manages more than 70,000 independent living retirement units in the United States, Canada, and Europe. At Holiday, he has been a senior vice president and a member of the board of directors.

New chief financial officer **Ulf M. Schneider**, MD, former group finance director for Gehe UK in Coventry, England, has joined the management board of Fresenius Medical Care AG, of Bad Homburg, Germany. Fresenius is a worldwide integrated provider of products and services for people with chronic kidney failure. ■

ASSISTED LIVING UPDATE

Third quarter and year-to-date results

Alterra Healthcare Corp. (ALI) of Milwaukee reports 3Q01 revenues of $126.1 million, a 3% increase over revenues in 3Q00. It reported a net loss of $42.8 million.

During the quarter, the company operated 450 stabilized residences — those that have reached 95% occupancy or have been open for 12 months — that had revenues of $142.4 million. It operated 373 residences that were stabilized for the third quarter of 2000 and 2001. For these residences, third-quarter revenues were $112.1 million.

Alterra is in the process of restructuring. Its disposition plan includes selling 82 residences. During the third quarter, it restructured two lease portfolios that included 52 residences. It sold two residences representing 85 beds for $2.2 million and three parcels of land for $1.8 million, and repaid $3 million of debt or lease obligations for a net gain on sale of $88,000. It also terminated three leases. In the fourth quarter, Alterra has sold 10 residences and one land parcel for a total of $28 million, repaying approximately $35 million of debt. Alterra operated or managed 351 residences as of Sept. 30, 2001.

American Retirement Corp. (ACR) of Nashville, TN reports that its 3Q01 revenues grew by $12.7 million to $66.1 million, an increase of 24% when compared to the same quarter in 2000. Resident and health care revenues were $64.8 million, compared with $52.4 million in 3Q00. The company had a quarterly loss of $4.4 million or 26 cents per share, compared with a loss of $1.9 million or 11 cents per share for the prior third quarter. Net income was $18.3 million, compared with $15.4 million in the third quarter of 2000. EBITDAR was $13.1 million for the 3Q01 compared to $11.8 million for the prior corresponding period.

For the nine-month period, revenues grew by $40.8 million to $189.8 million, a 27% increase over the period in 2000.During the quarter, the company acquired a 196-unit retirement centering Oak Park, IL, for $13.2 million. Since then, it has closed on the sale/leaseback of two assisted living communities, one in Boca Raton, FL, for $10.8 million and one in Arlington, TX, for $12.1 million. Part of the proceeds were used to repay $9.3 million of bankline debt and $7.4 million of mortgage debt, but the transactions will mean a $3.1 million loss in the fourth quarter.

American Retirement currently operates 66 senior living communities in 14 states.

ARV Assisted Living Inc. (SRS) of Costa Mesa, CA, reported total revenue for 3Q01 of $36.7 million, compared with $34.4 million for 3Q00. It had a net loss of $700,000 or 4 cents per share, compared with a net loss of $1.6 million or 9 cents per share for the same quarter in 2000. Total operating expenses were $35 million, compared with $34.2 million for the same quarter last year. Operating income was $1.7 million 3Q01, compared with $200,000 in 3Q00.

For the nine-month period total revenue was $108 million, compared with $104.3 million for the same period last year. Year-to-date net income was $1.7 million or 10 cents per share, including an extraordinary gain of $1.6 million and a $2.9 million gain on the sale of partnership interests, compared with $13.7 million for same period last year, including an extraordinary gain of $20.4 million. Net loss was $2.7 million or 16 cents per share, compared with a $6.7 million loss or 39 cents per share for the nine-month period in 2000. Total operating expenses were $103.9 million, compared with $105.8 million previously. Operating income was $4.1 million, a $5.6 million improvement over the $1.5 million loss from operations for the period previously.

ARV operates 57 assisted living communities containing approximately 6,800 units in 10 states.

Capital Senior Living Corp. (CSU) of Dallas, reported 3Q01 revenues of $17 million compared with $16 million for 3Q00. Net income of $1 million equaled earnings of approximately 5 cents per share. Net income plus depreciation was $2.8 million or 14 cents per share, compared with $2.5 million or 13 cents per share in the quarter of 2000. EBITDA for the quarter was $4.5 million, compared

with $5.8 million for the same period previously.

For the year to date, the company reported revenues of $53.4 million, compared with $40.9 million in the first nine months of 2000, and net income of $2.1 million or 10 cents per share, compared with $3.9 million or 20 cents per share. Net income plus depreciation was $7.3 million or 37 cents per share, equal to the comparable period previously.

For the fourth quarter, the company expected to close on the sale of Amberleigh Retirement Community and retire the notes issued by NHP Retirement Housing Partners I Ltd., generating approximately $7 million of proceeds. It also expects to close the sale of three parcels of land for approximately $2 million. The company last two planned developments under construction are expected to open in the first quarter of 2002.

Capital Senior Living currently owns and/or operates 49 communities in 20 states.

ElderTrust (ETT) of Kennett Square, PA, reported revenue of $6.3 million for 3Q01, compared with $6 million for 3Q00. Net income was $400,000, or 6 cents per basic and diluted share, compared with a net loss of $600,000 or 8 cents per basic and diluted share for the third quarter of 2000. Operating income was $2.8 million or 39 cents per basic share and 37 cents per diluted share, compared with $1.8 million or 26 cents per basic and diluted share.

For the year to date, revenues were $19.1 million, compared with &19.5 million for the same period in 2000. Net loss was $200,000 or 3 cents per basic and diluted share, compared with $26.8 million or $3.76 per basic and diluted share for the previous nine-month period. Operating income was $7.4 million or $1.04 per basic share and 99 cents per diluted share, compared with a loss of $19.4 million or $2.73 per basic and diluted share in the same period previously. The nine-month results of operations included bad debt expenses of $20.3 million, compared with $42,000 of bad debt expense recorded during the same period in 2000.

In October a $10.2 million mortgage loan receivable was repaid and the proceeds used to reduce the balance outstanding on the company's bank credit facility to approximately $22.8 million. Also, ElderTrust tenant Genesis Health Ventures Inc., which has emerged from bankruptcy, may repay approximately $12.2 million in mortgage loans before its June 2002 due date.

ElderTrust is an equity health care REIT with direct and indirect interests in 32 buildings and outstanding loans of $12.2 million in construction and term financing on four additional health care facilities. Emeritus Assisted Living (ESC) of Seattle, reported revenues of $34.9 million for 3Q01, compared with $30.8 million for 3Q00. Third-quarter loss was $846,000 before preferred stock dividends, compared with a $4.9 million loss in the comparable period. Operating income for the quarter was $953,000, compared with $492,000 for the same quarter in 2000.

For the nine-month period, operating income was $4.2 million, compared with $260,000 in the same 2000 period. Net loss was $9.2 million for the period, compared with $17.5 million for the nine-month 2000 period.Emeritus currently holds interests in 134 communities in 29 states and Japan.

Greenbriar Corp. (GBR) of Dallas, reported revenues of $8.2 million in 3Q01, compared with $10.3 million in 3Q00. Net loss for the quarter was $480,000 or 6 cents per common share, compared with a $1 million or 21 cents per share loss in the comparable quarter. Operating income was $2.8 million, compared with $4 million for the 2000 quarter, due to six fewer operating communities.

Greenbriar settled with LSOF Pooled Equity by trading 11 assisted living properties and $4 million in cash to reduce Greenbriar's total debt and financial obligations by $64 million and its outstanding common shares by 1,054,202 shares. A 25-for-1 reverse stock split occurred Dec. 1. Greenbriar owns or manages 17 communities in 10 states.

Manor Care Inc. (HCR) of Toledo, OH, reported 3Q01 revenues of $688 million, compared with $605 million for 3Q00. Net income was $31 million, compared with $20 million for the quarter in 2000. Diluted third-quarter earnings were 30 cents per share, compared with 20 cents in 3Q00.

For the year to date, net revenues were $2 billion, up 13% compared with the prior year, and net income per share was 83 cents, up 38% compared with the same 2000 period, before charges.

During the third quarter, Manor Care acquired for $58 million the full rights and privileges of the lenders for 13 Alzheimer's assisted living facilities that were part of a development joint venture with Alterra Healthcare Corp. Manor Care will contribute to Alterra's management of the facilities and begin improvements during the fourth quarter following final transfer of ownership. During the quarter, Manor Care also purchased just over 1 million shares of stock, approximately 1% of the outstanding shares. ■