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IN THIS ISSUE

FEBRUARY 2002

VOL. 19, NO. 2 (pages 13-24)

Verifying physician licenses: Strategies for staying up to date

Tips for making sure doctors are legit

It might seem to be common sense to assume that physicians keep their licenses up to date. Unfortunately, that's not always the case. Much like everything else in the world, from getting one's car inspected to filing paperwork on time, some things fall by the wayside.

Whether it stems from poor organization or time-management skills, or in more serious cases, problems with the medical board, some doctors are practicing without current licenses. How does a home health care agency make sure that it's doing business with qualified, licensed medical practitioners? A few steps and a little organization can make sure you never find yourself working with an "expired" physician.

Verifying currently licensed doctors, says **Michele Quirolo**, president and CEO, VNA of Hudson Valley in Mount Kisco, NY, is a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issue, and as such, all home care agencies should be collecting expiration dates and generating reports prior to those days for follow-up.

In that vein, says **Greg Solecki**, vice president of Henry Ford Home Care in Detroit, his agency has a three-page policy that deals with incoming referrals and physician credentialing. "This was an area of concentration during our JCAHO survey and I was so glad we were prepared."

Henry Ford's approach to keeping track of physicians' licensure status attempts to balance many demands and rules with the agency's desire to protect itself and its patients through adherence to a policy, he says.

"If the physician is a Henry Ford Health System affiliate, which includes all the network physicians who participate in the Health Alliance Plan — our system's 650,000-member HMO — we assume the credentialing is already handled by the system," Solecki says. "For physicians who fall outside these parameters, we either call the state to verify or go on line to verify. If we notice that the physician's licensure will be expiring soon, we notify the branch office to check again upon recertification of the patient's plan of care."

According to **Susan Johnsen**, RN, MSN, director of clinical operations

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and services for Gentiva Health Services in San Bernardino, CA, the Internet is an excellent tool for keeping track of license status.

"Depending on your state, licenses can be verified on line at www.docboard.org. It's up-to-date and simple,"she says. Johnsen's agency prints out the listing and keeps it on file, showing the day the license was verified and the doctor's status on that date.

Set up a tickler file for your physicians

One home care staff member says her agency keeps a tickler file on all physicians it deals with on a regular basis, and a month before the doctor's license is set to expire, the agency runs a check. She says her state hospital association's web site is an excellent resource to check up on new physicians to the system as well as changes to licensure requirements.

Still another home care employee says that in Indiana, every licensed professional is listed with the State Health Professions Bureau. Once a year, for about $300, her agency purchases a computer readout of every physician and uses it as a reference. The agency subscribes to an on-line verification service that in addition to a small annual fee, charges about $1 per verification, she adds.

If the Internet isn't quite your agency's speed, manual labor does the trick as well. Use part-time help or even hospital volunteers to go through the list of doctors and accompanying information (licenses, addresses, etc.), and call the doctor's office to verify that the information is up-to-date.

[For more information, contact:

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CDC releases Interim Smallpox Response Plan

Local HCWs are the first line of defense

The Centers for Disease Control and Prevention (CDC) in Atlanta has released its "Interim Smallpox Response Plan and Guidelines," a working draft that outlines the CDC's strategies for responding to a smallpox emergency.

The plan, which was developed in conjunction with state epidemiologists, bioterrorism coordinators, immunization program managers, and health officials, was sent to all state bioterrorism coordinators, state health officers, state epidemiologists, and state immunization program managers for review.

Steps to be taken are outlined

The plan outlines many of the public health activities that would need to be undertaken in the event of a possible smallpox epidemic (with the exception of mass vaccination because of the risk of side effects). Those activities include response plan implementation, notification procedures for suspected cases, what responsibilities fall under the CDC and state and local governments, and the CDC's vaccine and personnel mobilization plans.

As part of the response plan, state, local, and private health officials are being asked to do the following:

• identify additional tools that would be useful to their state and local plans;

• identify and describe gaps in the overall plan, proposed activities, and guidelines;

• identify concepts, approaches, activities, or guidelines that need clarification or further explanation;

• assess the proposed strategies and guidelines with respect to state and local plans;

• assess resources and resource needs;

• identify additional elements, steps, or

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activities that should be undertaken in response to a smallpox emergency.

The plan also provides state and local public health officials with a framework that would be used to guide smallpox planning and readiness efforts as well as guidelines for many of the general public health activities that would be undertaken during a smallpox emergency.

In such an event, the most important public health priority would be to control the epidemic.

As part of this effort, local health care officials, including physicians, hospital personnel, and home health care employees, would be the first line of defense and must be trained to spot symptoms of the disease, verify the diagnosis, and respond appropriately.

To aid in this, the CDC has produced a series of forms to help health care workers track the source of a patient's infection and symptoms. **(See source of exposure form, inserted in this issue.)** While designed to trace the path of a smallpox infection, the forms also can be used for other highly infectious diseases.

(Editor's Note: Forms 4A and 4B, which are referred to in the insert, can be found and downloaded from the CDC's web site at www.cdc.gov/nip/diseases/smallpox.) ■

Everything you need to know about smallpox

The Centers for Disease Control and Prevention (CDC) in Atlanta has released its smallpox guidelines with information and suggestions for health care providers. Here are some frequently asked questions regarding the disease. For more information, go to CDC's web site: www.bt.cdc.gov/DocumentsApp/FAQSmallpox.asp.

What should I know about smallpox?

Vaccination is not recommended, and the vaccine is not available to health providers or the public. In the absence of a confirmed case of smallpox anywhere in the world, there is no need to be vaccinated against smallpox. There also can be severe side effects to the smallpox vaccine, which is another reason the CDC does not recommend vaccination.

In the event of an outbreak, the agency has clear guidelines to swiftly provide vaccine to people exposed to this disease. The vaccine is securely stored for use in the case of an outbreak. In addition, Secretary of Health and Human Services Tommy Thompson recently announced plans to accelerate production of a new smallpox vaccine.

CE questions

17. As part of the government's plan to prevent a mass outbreak of smallpox, it will implement a mass vaccination program.
    A. true
    B. false

18. In the majority of cases, smallpox is spread:
    A. through the air
    B. by infected saliva droplets
    C. when a person comes in contact with an infected person's blood

19. In the event of an emergency, it is important for home care agencies to prioritize rtheir caseloads so that the most critical patients continue to receive care. According to ECRI, the following description describes which of the priority levels listed? "No significant adverse effects for the client are anticipated if services are postponed for two or more days. Examples include, but are not limited to: mother-baby visits, cardiopulmonary assessments on established clients with uncomplicated courses; HME clients requiring nonemergency equipment such as bedside commodes, CPM machines, or hospital beds."
    A. Priority 1
    B. Priority 2
    C. Priority 3
    D. Priority 4

20. A recent study looked at the relationship between physical activity and happiness among elderly women. It found that:
    A. The more physically active a woman over 60 is, the better her overall quality of life.
    B. Women who live on their own are more likely to be physically active.
    C. Women who live on their own report being happier than those in assisted-living facilities.
    D. A and B
    E. all of the above

Are we expecting a smallpox attack?

The CDC is not expecting a smallpox attack, but the recent events that include the use of biological agents as weapons have heightened the awareness of the possibility of such an attack.

Is there an immediate smallpox threat?

At this time the CDC has no information that suggests an imminent smallpox threat.

If I am concerned about a smallpox attack, can I go to my doctor and request the smallpox vaccine?

The last naturally acquired case of smallpox occurred in 1977. The last cases of smallpox, from laboratory exposure, occurred in 1978. In the United States, routine vaccination against smallpox ended in 1972.

Since the vaccine is no longer recommended, the vaccine is not available. The CDC maintains an emergency supply of vaccine that can be released if necessary, since post-exposure vaccination is effective.

Are there plans to manufacture more vaccine in case of a bioterrorism attack using smallpox?

Yes. In 2000, CDC awarded a contract to a vaccine manufacturer to produce additional doses of smallpox vaccine.

If someone comes in contact with smallpox, how long does it take to show symptoms?

The incubation period is about 12 days (range: seven to 17 days) following exposure. Initial symptoms include high fever, fatigue, and head and back aches. A characteristic rash, most prominent on the face, arms, and legs, follows in two to three days. The rash starts with flat red lesions that evolve at the same rate. Lesions become pus-filled after a few days and then begin to crust early in the second week. Scabs develop and then separate and fall off after about three to four weeks.

Is smallpox fatal?

The majority of patients with smallpox recover, but death may occur in up to 30% of cases.

How is smallpox spread?

In the majority of cases, smallpox is spread from one person to another by infected saliva droplets that expose a susceptible person having face-to-face contact with the ill person. People with smallpox are most infectious during the first week of illness, because that is when the largest amount of virus is present in saliva. However, some risk of transmission lasts until all scabs have fallen off.

Contaminated clothing or bed linen also could spread the virus. Special precautions need to be taken to ensure that all bedding and clothing of patients are cleaned appropriately with bleach and hot water. Disinfectants such as bleach and quaternary ammonia can be used for cleaning contaminated surfaces.

If someone is exposed to smallpox, is it too late to get a vaccination?

If the vaccine is given within four days after exposure to smallpox, it can lessen the severity of illness or even prevent it.

If people received the vaccination at a time when it was used routinely, will they be immune?

Not necessarily. Routine vaccination against smallpox ended in 1972. The level of immunity, if any, among persons who were vaccinated before 1972 is uncertain; therefore, these persons are assumed to be susceptible. For those who were vaccinated, it is not known how long immunity lasts. Most estimates suggest immunity from the vaccination lasts three to five years. This means that nearly the entire U.S. population has partial immunity at best. Immunity can be boosted effectively with a single revaccination. Prior infection with the disease grants lifelong immunity.

How many people have not had the vaccination?

Approximately half of the U.S. population never has been vaccinated.

Is it possible for people to get smallpox from the vaccination?

No, smallpox vaccine does not contain smallpox virus but another live virus called vaccinia virus. Since this virus is related to smallpox virus, vaccination with vaccinia provides immunity against infection from smallpox virus.

How safe is the smallpox vaccine?

Smallpox vaccine is considered very safe. However, some people with pre-existing conditions such as eczema or immune system disorders have a higher risk for having complications from the vaccine. Adverse reactions have been known to occur that range from mild rashes to rare fatal encephalitis and disseminated vaccinia. Smallpox vaccine should not be administered to

persons with a history or presence of eczema or other skin conditions, pregnant women, or persons with immunodeficiency diseases, and among those with suppressed immune systems as occurs with leukemia, lymphoma, generalized malignancy, or solid organ transplantation.

Is there any treatment for smallpox?

There is no proven treatment for smallpox, but research to evaluate new antiviral agents is ongoing. Patients with smallpox can benefit from supportive therapy (e.g., intravenous fluids, medicine to control fever or pain) and antibiotics for any secondary bacterial infections that may occur.

Is there a test to indicate if smallpox is in the environment like there is for anthrax?

Various agencies currently are validating tests designed to test for the smallpox virus in the environment.

If smallpox is discovered or released in a building, or if a person develops symptoms in a building, how can that area be decontaminated?

The smallpox virus is fragile and in the event of an aerosol release of smallpox, all viruses will be inactivated or dissipated within one to two days. Buildings exposed to the initial aerosol release of the virus do not need to be decontaminated. By the time the first cases are identified, typically two weeks after the release, the virus in the building will be gone.

Infected patients, however, will be capable of spreading the virus and possibly contaminating surfaces while they are sick.

Therefore, standard hospital grade disinfectants such as quaternary ammonias, which are effective in killing the virus on surfaces, should be used for disinfecting hospitalized patients' rooms or other contaminated surfaces. Although less desirable because it can damage equipment and furniture, hypochlorite (bleach) is an acceptable alternative. In the hospital setting, patients' linens should be autoclaved or washed in hot water with bleach added.

Infectious waste should be placed in biohazard bags and autoclaved before incineration.

What should people do if they suspect a patient has smallpox, or suspect that smallpox has been released in their area?

They should report suspected cases of smallpox or suspected intentional release of smallpox to your local health department. The local health department is responsible for notifying the state health department, the FBI, and local law enforcement agencies. The state health department will notify the CDC.

How can we stop the spread of smallpox after someone comes down with it?

Symptomatic patients with suspected or confirmed smallpox are capable of spreading the virus. Patients should be placed in medical isolation so that they will not continue to spread the virus. In addition, people who have come into close contact with smallpox patients should be vaccinated immediately and closely watched for symptoms of smallpox. Vaccine and isolation are the strategies for stopping the spread of smallpox. ■

Where does home care end and day care start?

Ambiguity raises billing questions

Last year, the Centers for Medicare & Medicaid Services (CMS) made a change in the homebound status for patients who spend their days in licensed adult day-care facilities.

However, some home care professionals are still questioning whether they can provide services, such as a dressing change, to patients while they are at the day-care facility and still be able to bill under Medicare Part A.

With patients spending as many as 12 hours a day in a supervised day-care center, the lines can blur a bit between what is and what isn't reimbursable. Even so, it long has been the understanding that any services that are provided by a home care agency would take place in the home.

"Home health services must be provided in the patient's residence," explains **Beth Schoonmaker**, director for Weirton (WV) Medical Center Home Health.

"A patient's residence is wherever he makes his home, such as his own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. As a patient does not live at a day-care center, you can not provide services at that facility," she adds.

In an effort to further clarify the issue of whether home health services can be provided and covered when administered in a day-care setting, CMS has

produced the following Q & A on its web site at www.hcfa.gov/medicare/hbqanda.rtf.

Can a home health agency (HHA) provide covered Medicare home health services to a beneficiary within the day-care center if the beneficiary is attending a licensed/certified day-care center?

The law does not permit a HHA to furnish a Medicare-covered billable visit to a patient under a home health plan of care outside his or her home, except in those limited circumstances where the patient needs to use medical equipment too cumbersome to bring to the home. The only statutory change to the home health eligibility requirement is to sections 1814(a) and 1835(a) of the Social Security Act (the Act), which was amended by the Beneficiary Improvement and Protection Act (BIPA).

BIPA did not amend section 1861(m) of the Act, which stipulates that home health services provided to a patient be provided to the patient on a visiting basis in a place of residence used as the individual's home. A licensed/certified day-care center does not meet the definition of a place of residence.

May a HHA allow its staff to go to the day-care center to see a patient who is under a home health plan of care if it is not considered a billable visit?

Although, as indicated above, a HHA generally may not furnish a Medicare-covered billable visit in the adult day-care center, this does not preclude home health agency staff from providing a noncovered service to a beneficiary. Such a visit would not affect payment.

HHAs must remain cognizant of relevant state and local laws governing health care practice to assure that they are furnishing services consistent with their legally authorized activities.

If a HHA is providing skilled therapy services (physical therapy, speech language pathology, occupational therapy) to a beneficiary who is under a home health plan of care, can the patient also receive therapy in a day-care center?

As mentioned above, an HHA generally may not furnish a Medicare covered billable visit in the adult day-care center.

BIPA did not amend section 1861(m) of the Act, which stipulates that home health services be provided to the patient on a visiting basis in the individual's home or in an outpatient setting (such as a skilled nursing facility, a rehabilitation center, or a hospital) when the patient needs to use medical equipment too cumbersome to bring to the home.

A licensed/certified day-care center does not meet the definition of a place of residence or the listed outpatient settings.

In responding to this question, it must be assumed that the HHA is aware of the requirement that it furnish directly or under arrangement all the medically necessary skilled therapy services required under the plan of care, including physical therapy, speech language pathology, and occupational therapy.

Consolidated billing rules require the HHA to bill for the episode and reimburse the entity providing therapy.

The entity providing therapy cannot bill Medicare for their services while the beneficiary is under a home health plan of care.

If therapy services are provided at the adult day-care center, then those services may not be services required under the plan of care or billed to Medicare. Consolidated billing rules would apply in that situation.

[For more information, contact:

*• **Beth Schoonmaker**, Director, Weirton Medical Center Home Health, 601 Colliers Way, Weirton, WV 26062. Telephone: (304) 797-6495.]* ■

Prioritizing care: Set up a winter weather checklist

When winter weather comes, not everyone has access to snowmobiles or a four-wheel drive. For more than a few home care agencies, this becomes a critical situation in inclement weather because staff may end up risking their lives trying to complete their rounds.

Where to start

Deciding who should get care before others in the face of a blizzard or ice storm is a difficult decision to make. To make sure those who need care the most are receiving it, it's a good idea to assign patients a treatment status upon admission, and keep that list on file and constantly updated.

If you're unsure how to classify some of your patients, ECRI in Plymouth Meeting, PA, a non-profit international health services research agency, has printed a criterion level developed by the Daughters of Charity National Health System in St. Louis. Of course, this criterion level doesn't apply for cold weather only. It's a useful guide in other emergency conditions, such as tornadoes or hurricanes.

Listed below are suggested priority levels for determining the provision of service:

• **Priority 1**

The life or well-being of the client may be significantly jeopardized if services are not provided that day. Examples include, but are not limited to:

— complicated wound care, insulin injections, IV medications, or total parenteral nutrition when there is no available, capable caregiver, or when the client cannot perform independently;

— new referrals already discharged home from a facility with acute needs;

— Home medical equipment (HME) clients on ventilators, or oxygen-dependent and needing STAT delivery.

• **Priority 2**

No significant adverse effects for the client are anticipated if services are postponed for one to two days. Examples include, but are not limited to:

— clients scheduled to receive services who are capable of self-care or have a willing and capable caregiver who could be coached over the phone (if available);

— phototherapy clients with Tbili level less than or equal to 15 with a documented downward trend;

— HME clients needing servicing of apnea monitors, photo-therapy equipment, internal feeding pumps, or oxygen.

• **Priority 3**

No significant adverse effects for the client are anticipated if services are postponed for two or more days. Examples include, but are not limited to: mother-baby visits, cardiopulmonary assessments on established clients with uncomplicated courses; HME clients requiring nonemergency equipment such as bedside commodes, CPM machines, or hospital beds.

• **Priority 4** (skilled-shift program only)

No significant adverse effects are anticipated for the client if services are postponed for the duration of the emergency or disaster. Examples may include, but are not limited to:

— clients receiving respite care;

— clients receiving basic pediatric nursing care. ■

Survival strategies: Pack light and pack right

For many across the country, winter got off to a slow start with near-springlike temperatures running well into November and, in some areas, into December.

While it made getting into the holiday spirit a bit more difficult, it also had the effect of lulling many of us into a false sense that winter's bluster and cold might never arrive — a nice idea that many people around the country have now discovered certainly was not a realistic one.

There is an old Chinese proverb that says, "Fool me once; shame on you. Fool me twice; shame on me." To avoid being caught as a fool out on the road in an unexpected blizzard, take a few tips from the Illinois State Police.

The Illinois State Police department in Springfield uses the following emergency kit:

• a two- or three-pound coffee can with three, evenly spaced holes punched in the top edge;

• a 60-inch piece of twine cut into three equal pieces. These will be used to suspend the can;

• two large safety pins to suspend the can;

• a two-inch diameter candle, that will be placed under the suspended can to melt snow;

• a sharp pocketknife or pair of scissors;

• three pieces of bright cloth, roughly 2 inches by 36 inches, to tie to the antenna and door handles;

• a small package of peanuts and a small package of fruit-flavored candy (avoid chocolate);

• pair of cotton athletic socks;

• pair of cotton glove liners;

• two books of matches;

• a sun-shield blanket or two large plastic leaf bags (the bags will reflect body heat and reduce heat loss from the wind);

• a pen light and batteries (kept separately);

• personal medications;

• if space available, adhesive bandages, aspirin, and a small radio. ■

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Understanding Laws, Rules, Regulations

Home care agencies: Coping with terrorism

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

The events of the last several months have precipitated numerous discussions about how home health agencies should respond in the event of an act of terrorism.

Given the state of our nation, such discussions certainly are appropriate, even necessary. That said, there is a tendency among agency staff members to take on more responsibility for patients than is warranted from a risk management point of view and, in many cases, even practical. Such actions can cause problems for home care agencies down the road. Given these parameters, there are certain things home health care agencies should bear in mind:

1. **There are limitations on the ability of home health agencies to assist their patients in the event of another terrorist attack.**

Staff should be meticulous about drafting policies and procedures on coping with emergencies and, in turn, interacting with patients and their families in ways that do not impose unrealistic, risky responsibilities and expectations on home health agencies. For example, an agency located in an area prone to hurricanes announced that it was the responsibility of home health agencies to evacuate their current patients from the coastal area. The agency drafted a disaster plan that included an obligation on the part of the agency to relocate patients inland in the event of hurricane evacuation. While a noble idea, there is a problem insofar as if agencies with similar disaster plans failed to fulfill this difficult, if not impossible, responsibility, the agency and staff members could be liable for any injuries sustained by patients as a result.

The moral of this story is that agencies should be very careful not to self-impose responsibilities that are unrealistic to fulfill. To help in drafting appropriate steps with regards to patients and emergencies, agencies should visit the Centers for Disease Control and Prevention (CDC) web site at www.cdc.gov/ncidod/hip/Bio/bio.htm.

2. **Agency managers should educate staff members about the signs and symptoms of possible disease processes that may be related to bioterrorism.**

Staff should be prepared to consider the possibility that patients exhibiting signs and symptoms that ordinarily would be attributed to the flu in fact may be caused by inhalation anthrax. The telltale "black" lesions of skin anthrax also should be recognizable by home care staff. Staff may also benefit from preliminary information regarding smallpox, plague, and other agents of bioterrorism that have recently been presented in the media. For more information on these diseases and their symptoms, agency staff should visit www.bt.cdc.gov.

3. **Consistent with the general obligation imposed on agencies by the Occupational Health and Safety Act, agency staff should be educated about how to protect themselves from attack, including bioterrorism.**

There is no higher obligation of agencies than to protect their own staff members from harm. For this reason, it is vital that staff be given instructions and guidelines on what steps they should take to protect themselves and their families.

4. **The possibility of additional attacks should reinforce for staff the important role that primary caregivers have to play for patients who cannot care for themselves.**

In the event of another terrorist attack, it is highly likely that the responsibility to protect patients will fall on primary caregivers. This means that during admission visits, staff should identify multiple primary caregivers who may be available to assist patients in the event that the primary caregiver is unable to do so. If the primary caregivers who are initially identified become unreliable, staff members should act promptly to identify other reliable primary caregivers so that as many patients as possible have multiple primary caregivers. These caregivers obviously should be included in any efforts to educate patients regarding protection in the event of other attacks.

Before the events of Sept. 11, few home care providers could imagine the need to be concerned about the protection of patients in the event of terrorist attacks. In view of what has been learned about such attacks since then, it is clear that the threat is real and may occur anywhere in the country. As always, home care providers will

want to be prepared to take realistic steps that do not involve unnecessary risks for agencies and staff members to help ensure that patients are not harmed.

Resources

The Joint Commission on Accreditation of Healthcare Organizations has published *The 2002 Self-Assessment Checklist: Hospitals*. This book was written to help hospitals prepare for Joint Commission surveys or improve their performance. In addition to covering every standard in the *2002 Comprehensive Accreditation Manual for Hospitals*, the new publication includes revised standards regarding patient safety, restraint and seclusion, medical staff, and staffing effectiveness. The book features a test question section, allowing hospitals to identify areas of poor compliance, note actions taken, and track compliance progress. A tutorial instructs on important aspects of conducting a mock survey. The book is available for $65, using order code SAC-02, by calling the Joint Commission Customer Service center at (630) 792-5800 between 8 a.m. and 5 p.m. Central time, weekdays.

HIN publications out

The third edition of *Grant Funding for Elderly Health Services* now is available from the Health Information Network (HIN). The publication provides information on trends and changing interests of federal, foundation, and corporate grantmakers and shows health care organizations how to write grant-winning proposals. Included in the publication is a listing of available grant funds from federal agencies, charitable foundations, and corporations to health care companies that provide services to the elderly. The cost is $91.50.

Also out from HIN is *When Disaster Strikes*, a publication written by health care professionals about how to deal with a variety of disasters, from natural disasters to man-made disasters, such as chemical spills and violence. The cost is $103.95. To order either publication, call (888) 446-3530.

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

New dates for PS&R and provider cost reports

HHS implements program changes

The Department of Health and Human Services has announced amended production dates for the Provider Statistical and Reimbursement (PS&R) reports. **(See PS&R schedule, below.)** On Dec. 31, the Centers for Medicare & Medicaid Services sent fiscal intermediaries Version 27.0 of the PS&R program that reflect changes that were created as a result of the implementation of the Home Health Prospective Payment System and the Outpatient Prospective Payment System.

Fiscal intermediaries will begin processing PS&R claims through the new system no later than March 1. Meanwhile, all home health agencies, hospitals, skilled nursing facilities with a provider-based

Provider Statistical and Reimbursement Reports (PS&Rs) Dates

Cost Reporting Year-Ending Dates	Claims Processed Through Dates	PS&R Mailed to Provider by Dates *	Cost Report Due Dates *
August-Sept. 30, 2000	Dec. 31, 2000	April 12, 2002	May 27, 2002
October-Dec. 31, 2000	March 31, 2001	May 3, 2002	June 17, 2002
January-March 31, 2001	June 30, 2001	May 24, 2002	July 8, 2002
April-June 30, 2001	Sept. 30, May 2001	June 21, 2002	Aug. 5, 2002
July-Sept. 30, 2001	Dec. 31, 2001	July 19, 2002	Sept. 2, 2002
October-Dec. 31, 2001	March 31, 2002	Aug. 9, 2002	Sept. 23, 2002
January-March 31, 2002	June 30, 2002	Aug. 30, 2002	Oct. 14, 2002
April-May 31, 2002	Aug. 30, 2002	Sept. 21, 2002	Nov. 5, 2002

* Arkansas Part A Standard System (APASS) user fiscal intermediaries and providers are allowed an additional 30 days from these dates to mail the PS&Rs and to submit cost reports.

home health agency, and community mental health centers now are required to file their cost reports according to the schedule. Providers have 38 days to complete the cost report and have been given an extra week to allow for mailing. ■

Exercise shown to benefit elderly women's health

Not that this comes as any surprise, but a recent study published in the November issue of *Women's Health Issues* found that the more physically active a woman over 60 is, the better her overall quality of life. Although these findings were found to be true regardless of whether a woman lives alone or in an assisted-living facility, it was found that women who live on their own are more likely to be physically active — perhaps because they don't have help with daily household activities — and therefore report being happier with life and better physical health.

The study examined 60 women over the age of 60; 70% lived on their own. The study was supported by a year 2000 Jacobs Institute of Women's Health and Ortho-McNeil Pharmaceutical Scholar in Women's Health Care Grant. ▼

DC health care alliance reports $15M surplus

Despite dire predictions of financial shortages made by Washington, DC-city officials in the wake of the closing of D.C. General Hospital and the privatization of the city's indigent health care system, the city now finds that it has a $15 million surplus. Originally, $40.4 million had been set aside to fund D.C. Healthcare Alliance, the private health care program designed to treat the city's indigent, but so far, far fewer people have taken advantage of the new program than originally expected.

Call (800) 688-2421 or (404) 262-5476 to register now!

To easily attend this *audio conference*, you simply phone in from your home or office, whichever is convenient for you.

Disaster Planning and Bioterrorism: Is Your Hospital Ready?

Wednesday, March 6, 2002 2:00-3:00 p.m. EST

An Audio Conference
Presented by Bettina M. Stopford, RN and Robert E. Suter, DO, MHA, FACEP

You will learn:

- How to satisfy JCAHO requirements for emergency preparedness.
- Ways to expedite communication among your clinicians for identifying and reporting disease clusters or symptoms of bioterrorism in a timely manner.
- Protocols for patient management, including increased patient flow, isolation, transport, placement and discharge.
- How to manage the decontamination process to prevent further spread and who to consult to determine if decontamination should even be considered.
- Strategies and steps to take for triage and to safely house a large number of affected individuals. And more.

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If the trend continues, city officials say they could have as much as $25 million in surplus funds. The money is expected to be extended to private groups who haven't already entered the program. The alliance is run by the Greater Southeast Community Hospital and includes D.C. Chartered Health Plan, Unity Health Care, George Washington University Hospital, and Children's Hospital.

Currently, the program counts more than 17,000 low-income residents as members and more than 11,000 patient visits each month. To qualify as a member, enrollees must provide proof that they live in the District of Columbia, have a household income under 200% of the poverty level, and no other health coverage. ▼

GAO reports that HMOs still leaving Medicare

Investigators from the General Accounting Office (GAO) are reporting that despite two years of increased payments to HMOs, they continue to leave the Medicare program and few are returning. Medicare payments for the average HMO increased approximately $16 a person per month to $431. The government had anticipated that with higher payments, HMOs might be persuaded to stay in the program.

Worse news still, those that have indicated they will stay with the program are reporting that they will dramatically increase premiums, copayments and other fees. UnitedHealth Group has announced its intention to charge Medicare beneficiaries in Wisconsin $295 for each day they spend in the hospital, up to a year limit on all out-of-pocket expenses of $4,800.

The GAO reported that HMOs, rather than improve services for the elderly, used increased fees to increase payments to hospitals and other health care providers. HMOs claim the reason behind this is that health care inflation has far surpassed the increases they have received with Medicare reimbursement.

Currently, 5.6 million people out of a total 40 million enrolled in Medicare receive health care through HMOs. On Jan. 1, more than 500,000 elderly were dropped from their HMOs as they withdraw from the Medicare program. Last year, 933,600 elderly were dropped, in 2000 327,000 were dropped, and in 1999 407,000. ▼

Tenet offers to extend services as part of buyout

To ease Los Angeles-area residents' concerns about an impending buyout of two area hospitals that would convert them from not-for-profit to for-profit, Tenet Healthcare Corp. in Santa Barbara, CA, has announced that it will bolster services and follow the Ethical and Religious Directives for Catholic Health Care Services. Tenet currently follows this directive in at least eight of its hospital properties.

As part of this action, Tenet will keep emergency services at Daniel Freeman Memorial for at least five years; at the Inglewood hospital, Tenet has agreed to continue providing obstetrical and neonatal intensive care services for at least five years. These promises are up from a minimum

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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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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Editorial Questions

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guarantee of two years and three years, respectively, from when Tenet first proffered its offer. The company also agreed to invest $50 million in the two hospitals during the next 10 years.

Tenet has offered $55 million for two Daniel Freeman Hospitals — the 360-bed Daniel Freeman Memorial Hospital, in Inglewood, CA, and the 138-bed Daniel Freeman Marina Hospital in Marina del Rey, CA. They lost $23.9 million on operations for the year ended June 30, 2001, on $183.8 million in revenue. ▼

CMS changes could cause big trouble for hospitals

If the Centers for Medicare & Medicaid Services (CMS) goes ahead with planned changes to its hospital outpatient payment before it is ready to pay claims, many hospitals are saying substantial problems will result.

Of primary concern, say hospitals, is the fact that paperwork problems and restricted cash flow are likely to arise coinciding with payment cuts to hospitals that the American Hospital Association has estimated at $1.5 billion.

Should the new regulation be implemented before the CMS can pay claims, hospitals won't be the only victims, say hospital groups.

Beneficiaries, fiscal intermediaries, and other payers such as state Medicaid programs will suffer as well.

CMS Administrator Thomas Scully publicly has said that CMS won't be able to process claims before April 2002. In an effort to work around this, Scully has said CMS is considering either asking Medicare to hold all hospital outpatient claims or pay the claims at 2001 rates and then make up the difference once the new CMS payment program is running.

Opposing groups claim that a delay in Medicare payments will hamper hospitals' ability to get beneficiary copayments from other payers, while paying at 2001 rates and later reconciling those fees would pose an undue administrative burden.

Under the proposed new system, hospitals will lose about $1 billion in 2002 in outpatient pass-through payments for procedures using new technology, while for procedures that don't involve medical technology, hospitals will receive 8% less in payments. ■

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CE objectives

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

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