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IN THIS ISSUE

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Touch, music, and imagery can relieve stress, anxiety, and pain, report says

Complementary therapy moves into home health

Home health is an area that can benefit from a variety of complementary and alternative medicine techniques. That's one of the conclusions reached by a report issued in March 2002 by the White House Commission on Complementary and Alternative Medicine (CAM) Policy, according to **James S. Gordon**, MD, director of the Center for Mind-Body Medicine in Washington, DC, and chairman of the commission.

"During our 18 months of hearing testimony from different areas of health care, we heard from home health representatives, and it is clear that some complementary and alternative medicine approaches can fit the home-care setting," Gordon says. "Because home health patients are often isolated and overwhelmed by their situation, basic CAM techniques can help them with stress management and reduce their pain or anxiety," he adds.

Some of the key reasons that prevent health care providers from integrating CAM techniques include minimal research of the effects of CAM techniques; reluctance of payers to reimburse CAM services; questions about education, training, and licensure of CAM practitioners; and dissemination of information about CAM, Gordon says. "Our report addresses these areas with specific recommendations to improve research, reimbursement, and access to these techniques," he adds. *(To see the commission's final report, go to www.whccamp.hhs.gov.)*

Aromatherapy, therapeutic touch, and guided imagery are a few of the techniques that have been taught to home heath and hospice nurses by **Aurora S. Ocampo**, RN, MSN, clinical nurse specialist at the Beth Israel Center for Health and Healing in New York City. "Most CAM modalities require only five minutes to be helpful to the patient," Ocampo says.

"The proper technique can help with pain management, relieve anxiety, and reduce stress," she explains. While therapeutic touch or aromatherapy won't eliminate pain, patients have reported that pain medication works better after they have been taught breathing techniques that help them relax, Ocampo adds.

Music therapy has been an option for Haywood Medical Center Hospice patients in Clyde, NC, since 1997, says **Jenny C. Lockhart**, RN, MSN, CLNC, program manager.

"We present the therapy to patients and their family members upon admission, and if they are interested, we include it in the care plan for the physician to approve," she says. "Our music therapist assesses the patient's goals such as to reduce anxiety, breathe more easily, reminisce, express feelings, or just be entertained. We've even had patients who want to learn to play a new instrument as a diversion."

While the music therapist is an employee, Haywood also has volunteers who provide massage therapy and pet therapy, Lockhart says. The massage therapist is available to patients or to caregivers, she explains.

"The volunteer also gives a massage to one employee each month." Massage therapy is a good way to help patients, caregivers, or employees relieve the physical and emotional stress they are feeling, she points out.

While there hasn't been as great a demand for the pet therapist's services, there is an excellent response when the need is there, Lockhart explains.

"We've found that most 'animal people' have their pets, but we occasionally have some patients who have had to leave pets behind when they moved into a new home. They greatly appreciate the chance to hold an animal," she says.

Check training and certification

Even with volunteers who offer complementary therapies, it's important to require that they have special training in the modalities and show proof of the training and any licenses they may have, Lockhart says. For music therapy, she insisted on the certification and training because it was important that the therapist be recognized as a therapist, not just a musician.

Licensing and accreditation is one of the tough areas with implementation of CAM because there is no consistent approach or requirement, Gordon says. "CAM is a process of evolution, and we are just at the beginning. Licensing is really a state issue, but the commission report recommends that the states be given guidelines and information that can be used to develop licensing requirements in the future."

Home health agencies can use accreditations or certifications that are offered by professional associations of different therapies or by schools as one

CE questions

Save your monthly issues with the CE questions in order to take the two semester tests in the March and September issues. A Scantron sheet will be inserted in those issues, but the questions will not be repeated.

5. What is one of the symptoms or conditions that complementary therapy is most likely to affect, according to **Aurora S. Ocampo**, RN, MSN, clinical nurse specialist at the Beth Israel Center for Health and Healing in New York City?
   A. confusion
   B. coughing
   C. hard-to-heal wounds
   D. pain

6. One good way to prepare your staff for an accreditation survey, according to **Diane H. Flynn**, BSN, MBA, a consultant with Joint Commission Resources is to:
   A. conduct mock survey home visits
   B. prepare an extensive manual for employees to review
   C. offer bonuses to employees who answer questions correctly

7. It is important to be proactive in setting up contracts with outpatient rehab providers and to educate them for what reason, according to **Katie Riley**, vice president of clinical for Advocate Home Health Services in Oakbrook, IL?
   A. The home health agency is responsible for coordinating the patient's care.
   B. Outpatient therapy is a consolidated billing process for home health.
   C. The outpatient clinic may not be reimbursed without a prior agreement.
   D. all of the above

8. To what change does **Susan A. Flow**, RN, BA, BS, MSN, project manager for the wound, ostomy program and Medicare case manager for the Denver-area for Centura Home Care & Hospice, attribute her program's 63% decrease in the cost of budgeted wound care supplies for one group of managed care patients?
   A. new group of referring physicians
   B. exclusive use of ET nurses for wound care
   C. standardization of care protocols, education, and supplies
   D. new group purchasing agreements

CAM Resources

- ✔ **American Holistic Nurse Association**, P.O. Box 2130, Flagstaff, AZ 86003-2130. Telephone: (800) 278-2462 or (928) 526-2196. Fax: (928) 526-2752. Web site: www.ahna.org. Web site offerings include conference information, holistic nursing certification program information, and a list of other certificate programs endorsed by the association.
- ✔ **American Music Therapy Association**, 8455 Colesville Road, Suite 1000, Silver Spring, MD 20910. Telephone: (301) 589-3300. Fax: (301) 589-5175. Web site: www.musictherapy.org. The web site includes information about education and certification programs, and answers frequently asked questions.
- ✔ **Beth Israel Center for Health and Healing**, 245 Fifth Ave., Second Floor, New York, NY 10016. Telephone: (646) 935-2220. Fax: (646) 935-2272. Web site: www.healthandhealingny.org. The web site includes a library of related web sites, books, audiotapes, and other educational material related to a variety of complementary therapies.
- ✔ **National Center for Complementary and Alternative Medicine (NCCAM)**, P.O. Box 7923, Gaithersburg, MD 20898. Telephone: (888) 644-6226 or (301) 519-3153. Fax: (866) 464-3616. Web site: www.nccam.nih.gov. Part of the National Institutes of Health, the center was established to research and evaluate complementary/alternative therapies in order to determine their effectiveness and safety and to communicate this information to the public and the health care community. The web site contains information about complementary/alternative medicine (CAM), news and events, FAQs, classification of CAM practices, fact sheets, consensus reports, clearinghouse, clinical trial awards data, and clinical trial opportunities.

way to assure that therapists are qualified, Ocampo suggests. Local health care organizations with integrated medicine programs may also be able to provide training or certification, she adds.

Her therapeutic touch students undergo classroom education as well as monitored patient treatments. "We also certify aromatherapists in the same way," she says.

Therapies such as massage, Reiki, and therapeutic touch rarely are reimbursed by payers, generally because there is little scientific data to prove safety and effectiveness, Gordon says. As more data become available and payers can see the benefits, the reimbursement picture should improve, he adds.

There are options for reimbursement, Lockhart says. "Our music therapy is covered under [the prospective payment system] as a visit," she explains. When she first started the program, however, she used a grant from the hospice foundation to underwrite the therapist's salary. This grant gave her a chance to evaluate the reaction to music therapy and the benefit to the patients.

Ocampo also points out that if a nurse knows the technique, she can perform aromatherapy or therapeutic touch as a small part of the overall visit. She adds that not all nurses can be trained in complementary therapies and be effective. "You can teach the hand movements, but the real healing benefit comes from the practitioner's compassion and ability to focus upon making the patient feel better."

[For more information about the use of complementary therapies in home health, contact:

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*• **Aurora S. Ocampo**, RN, MSN, Clinical Nurse Specialist, Beth Israel Center for Health and Healing, 245 Fifth Ave., Second Floor, New York, NY 10016. Telephone: (646) 935-2220.*

*• **James S. Gordon**, MD, Director, The Center for Mind-Body Medicine, 2934 Macomb St., N.W., Washington, DC 20008. Telephone: (202) 966-7338. Web site: www.cmbm.org.]* ■

Avoid anxiety: Start early for accreditation survey

Use preparation as self-evaluation

Survey. Audit. Review. It doesn't matter which word is used — any time someone from another organization comes to your agency to evaluate how you do your job, it is nerve-wracking.

The best defense against accreditation survey jitters is good early preparation, says **Karen Cober**, RN, MSN, administrator of Medical Center Home Care & Hospice in Johnson City, TN.

In addition to the paperwork preparation of the New York City-based Community Health

Prepare your organization for CHAP accreditation

The Community Health Accreditation Program (CHAP) in New York City offers a comprehensive self-study guide that walks the organization through the four chapters of standards, says **Terri Ayer**, RN, MS, CNAA, interim president and chief executive officer.

While some organizations approach completion of the guide differently, Ayer suggests that it be used as a self-evaluation tool. A consultant can help you go through the process, but it should be people from the agency actually answering the questions, she adds.

Once completed, the guide is sent to CHAP to be evaluated prior to the site visit.

"When our site visitors arrived, they were already familiar with our agency and had specific issues to discuss," says **Doris Mosocco**, RN, CHCE, director of quality management for Riverside Hospital Home Care Division in Newport News, VA. This resulted in a very efficient, very focused survey, she adds.

While there are no single areas that show a preponderance of recommendations over other areas, Ayer and other CHAP-accredited agency managers suggest that the following areas receive attention:

- ❒ **Proof of diploma and license**
  Every personnel file for a professional staff member not only should include verification of a valid license but also a copy of the employee's diploma or transcript. "This differs from Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards that only require verification of license," says Cober. "We require the diploma or transcript as an extra measure to ensure that the employees are who they say they are," Ayer adds.
- ❒ **Employee self-evaluation**
  CHAP also requires that employees complete an annual self-evaluation in addition to the supervisor's annual evaluation, says **Karen Cober**, RN, MSN, administrator of Medical Center Home Care & Hospice in Johnson City, TN. Copies of the self-evaluation must be in the personnel file, she adds.
- ❒ **Financial information**
  Unlike JCAHO, CHAP evaluates the financial viability of the organization. "We want to make sure that agencies have not only the clinical and human resources to provide quality care but also the financial resources to assure patients that they will be around to continue providing care," Ayer says. Documentation for financial resources includes budgets, audited financial statements, and proof of cash reserves or credit lines to support the agency in difficult times, she explains.
- ❒ **Performance improvement**
  CHAP does not require presentation of one major performance improvement project but does look for evidence that performance improvement is ongoing in all aspects of the agency, Mosocco says. You can meet this standard by showing simple things, such as changing a form to make it easier to use and clearer in meaning, she adds. Another item that Cober points out is accessibility. "We regularly check the response time of our answering service, but every agency needs to know that a site visitor will make a call after hours to see how much time passes before a response is received. Make sure you've remembered to check out your answering service as well as all your other areas." ■

Accreditation Plan (CHAP) self-study guide, Cober's agency holds review sessions with staff members prior to the CHAP visit. "We ask questions about our strategic plan, our policies, and other issues that the CHAP site visitor may ask to give everyone a chance to answer or hear the answer in a safe, group setting," she explains. "We also videotape the meetings so employees who are unable to attend can review the information as well."

Preparing staff for home visits with surveyors also is important, suggests **Diane H. Flynn**, BSN, MBA, a St. Louis-based consultant for Joint Commission Resources in Oakbrook Terrace, IL.

"Conduct mock surveys as you accompany staff members on site visits," she says. "Ask them questions that a surveyor might ask about infection control, emergency policies, or other aspects of their jobs. Be sure your staff members know that they can admit that they don't know and have to ask a supervisor," Flynn explains. "It is better to admit that they have to ask, rather than having them make something up."

Home health and hospice agencies seek accreditation by either CHAP or the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), for a variety of reasons.

In addition to serving as a seal of approval to reassure community members that the organization sets high goals for quality and meets those goals, the accreditation also may eliminate the need for other audits or surveys to achieve "deemed status" for Medicare participation. Although some hospital-affiliated home health

agencies believe that JCAHO accreditation is necessary if the hospital is JCAHO-accredited, that is not necessarily true, Cober says.

"Because we have multiple hospitals and multiple home health agencies as well as a durable medical equipment (DME) company and pharmacy, we had to prepare for and undergo nine separate JCAHO surveys," Cober explains. Not only was this expensive in terms of accreditation fees, but also in terms of staff time, she adds.

Because JCAHO and CHAP have had an agreement since 1996, which states that JCAHO will recognize CHAP accreditation as a substitute for JCAHO-focused surveys for community programs such as home health, hospice, and DME, Cober approached CHAP about reviewing the home-care division as one entity instead of individual agencies. "We were able to streamline the accreditation process by preparing as one organization with one survey time," she adds.

By choosing to obtain "deemed status" as part of the CHAP survey, **Doris Mosocco**, RN, CHCE, director of quality management for Riverside Hospital Home Care Division in Newport News, VA, was able to eliminate state surveys for her home health agency. "We still undergo the state survey for our hospice since our state regulations require it, but the CHAP survey meets our state requirements for home health," she explains.

Mosocco points out that these requirements differ from state to state, so a home health manager needs to check his or her state regulations.

One part of your preparation for a JCAHO survey should be to pay attention to your surveyor's background, suggests **Greg Solecki**, vice president of Henry Ford Home Health Care in Detroit. The surveyor for his November 2001 survey was an infusion nurse who had a special interest in and knowledge of infusion and infection control. While she reviewed policies and practices in relation to JCAHO standards, she did emphasize her two areas of expertise, he says.

"We were surprised by one infection surveillance recommendation," Solecki says. "We thought we had covered every JCAHO characteristic in our pre-survey review. We had never heard of a requirement to check and document the TB incidence rates in the counties we service and establish our staff TB testing frequency accordingly," he explains. "Frankly, we thought it was a significant enough achievement that everyone had [his or her] TB tests on time and that the documentation was in the personnel records."

Solecki admits that the surveyor's approach was constructive, and his agency easily was able to accomplish the task and will be able to update it regularly. **(For other JCAHO tips, see story, below.)**

"We try to make our site visits educational," says **Terri Ayer**, RN, MS, CNAA, interim president and chief executive officer for CHAP. **(For tips on CHAP surveys, see story, p. 52.)** "We also realize that organizations are going to be anxious because we are disruptive just by being there," she says. "We aren't looking for perfect; we are looking for organizations that are working hard to do things right. We like to see organizations that recognize their own problems and are working toward solutions."

[For more information on accreditation surveys, contact:

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• ***Doris Mosocco**, RN, CHCE, Director of Quality Management, Riverside Hospital Home Care Division, 11833 Canon Blvd., Newport News, VA 23606. Telephone: (757) 594-2656. E-mail: doris.mosocco@rivhs.com.*

• ***Greg Solecki**, Vice President, Henry Ford Home Health Care, One Ford Place, 4C, Detroit, MI 48202. Telephone: (313) 874-6500. E-mail: gsoleck1@hfhs.org.]* ■

Help is on the way for JCAHO accreditation

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, will produce a new accreditation manual for 2003 with the manual available for review in fall 2002, says **Diane H. Flynn**, BSN, MBA, a St. Louis-based consultant with Joint Commission Resources. There won't be any significant changes, but requirements for meeting standards will remain high, she says.

This means that there are some standards that make it easy to receive a Type 1 recommendation that requires a follow-up focused survey. "For example, Standard TX.2 addresses having and following physician orders 100% of the time," Flynn explains. If a clinician uses a different dressing than specified on an order, or flushes an IV with 5 cc of saline rather than 3 cc of saline as specified on the order, he or she has not met the standard, she says. If an agency is compliant only 95% to 99% of the time, it will result in a Type 1 recommendation.

Other standards agencies need to focus upon to avoid Type 1 recommendations include:

- **Competency assessment (HR.4 and HR4.1)**

Because not all home-care employees must have competency assessments, sometimes an agency forgets to assess the competency of those who require them, Flynn says. "Most often an agency forgets to document competency assessment for a supervisor who usually doesn't make home visits but might occasionally fill in for someone on vacation," she points out. Remember, if the staff member ever makes a home visit, document the competency.

Also, don't confuse competency assessment with performance evaluation, Flynn says. A competency assessment is documentation that through a written or verbal test, or observation by a competent individual such as a supervisor or a peer, the person has the capacity to do the right thing, she explains. A performance evaluation (HR.7) is documentation that the person did the right thing over a period of time, she adds.

- **Performance improvement**

"Don't produce slides, storyboards, or elaborate presentations to demonstrate your performance improvement project," says Flynn. "Limit the presentation to 10 minutes, and keep it clear and concise," she says.

The points to highlight include involvement of staff members closest to the problem that is addressed and data that show an improvement, she suggests.

"I always recommend that an organization work on two or three projects even though it only has to present one," Flynn says. This ensures that at least one will show results that meet the standard, she adds.

Also, be aware that the benchmarking standard (PI.4.2) doesn't require that an organization benchmark against an outside organization, just that it occurs if it is feasible, Flynn says. This means that you can benchmark against yourself in a specific area by showing statistics over a period of time, which indicate performance improvement.

- **Employee orientation**

The human resource standard that addresses orientation (HR.5) includes a list of topics that must be covered with new employees, Flynn says. The best way to meet this standard is to use the list as a guide to develop or evaluate your orientation program, she suggests. Also, be sure your orientation session is interactive and gives employees a chance to ask questions. "It is not enough to hand an employee a manual," she says.

- **Licenses**

"If you do nothing else to prepare for JCAHO, be sure to have current validation of licenses for all of your clinicians (HR.3.1)," Flynn says. "The absence of a valid license is an automatic Type 1 recommendation." This also applies to verification of physician licenses (TX.2.1), which must occur before care is rendered, she explains.

- **Contracts**

The best way to make sure you meet Standard LD.1.1, which applies to contracts with other organizations or suppliers, is to have someone who doesn't work with contracts on a regular basis review them, suggests Flynn. "There is a laundry list of items that must be addressed in each contract that should be compared to each of your contracts." Someone with a fresh pair of eyes is more likely to spot items that are not included, she adds.

- **Documents notebook**

Appendix A of the standards manual contains a four-page list of documents that should be assembled for the survey. "The best way to prepare this notebook is to follow the list and place the documents in the same order," Flynn says.

The assembly of the manual did require a great deal of time but facilitated a smooth survey, says **Greg Solecki**, vice president of Henry Ford Home Health Care in Detroit. "It has also served as a useful tool for our annual program evaluation."

When you are reviewing policies for inclusion in the survey manual, be sure they reflect reality, Flynn suggests. Don't write a policy that describes an ideal situation when you know that reality is less than ideal. "You should say what you do and do what you say," she adds.

A final reminder from Flynn, "Don't forget to place your 30-day notice in local newspapers, offices, and notes to patients. You'll receive your survey packet 45 days prior to your survey, so address the notification issue immediately to avoid a Type 1 recommendation." ■

Set up rehab contracts to avoid headaches

Define responsibilities, fees, and timelines

(Editors note: In this first part of a two-part series, we discuss issues related to rehab therapy within the home environment and in outpatient settings. In next month's issue, we'll give you specific tips on how to negotiate contracts with outpatient rehab providers.)

Implementation of the home health prospective payment system (PPS) has increased attention to effective care plans that achieve the desired goals while making the most effective use of resources.

Surprisingly, this may mean adding a service rather than decreasing types of service, says **Wanda Koerner**, BSN, MS, administrator of Hays (KS) Home Health & Hospice Center.

"We are beginning to recognize that the use of rehabilitation therapists can impact the patient's outcome in an efficient and effective way." For this reason, it is important to identify rehab therapy needs as soon as possible, she adds.

The first step to improving assessments of therapy needs was to educate her staff, Koerner says.

"Therapists use terms that are unfamiliar to nurses and vice versa. We began to include all therapists, staff and contract, in case management meetings and encouraged the therapists to speak up when they had suggestions or ideas that might help patients," she adds.

The ongoing communication helped nurses who were assessing patients upon admission identify issues that could be addressed by the therapists, she explains.

Make a 'cheat sheet'

Koerner also developed a "cheat sheet" for both nurses and therapists that lists appropriate reasons for referral to therapists and to skilled nursing services. **(See list, p. 56.)** The combination of the case management meetings, the cheat sheet, and the encouragement for both sets of clinicians to offer suggestions and ask for advice has worked well, Koerner says.

"All of us have expanded the scope of our thinking to include therapies as another way to help our patients," she says.

If your patient requires therapy that is not feasible in the home environment, PPS does allow for therapy to be provided in an outpatient clinic.

"If the therapy requires equipment that is too cumbersome for the home, such as parallel bars or therapy related to wound care, our patients go to outpatient clinics," explains **Katie Riley**, vice president of clinical for Advocate Home Health Services in Oakbrook, IL.

If your patient has to go outside the home for therapy, there are several actions you need to take to make sure you can bill and be reimbursed properly for the care, Riley says.

Educate providers on proper billing

"First, be proactive in setting up contracts with rehab providers in your area," Riley suggests. Not only does the contract process enable you to define who is responsible for different activities, but it gives you a chance to educate providers in your area, she adds.

"When we first started setting up contracts prior to implementation of PPS, there were many rehab providers that did not realize that outpatient therapies are a consolidated billing process for home health patients," Riley explains.

"We made sure they understood the process and realized that they could not bill Medicare on their own; they have to provide the service and bill us as the coordinator of the patient's care," she says.

In fact, home health agencies are not responsible for reimbursing rehab providers that provide services without the home health case manager's knowledge or a contract in place, Riley says.

If you do end up with an invoice for therapy provided outside your care plan, you may have to judge whether or not to pay it based upon your relationship with the referring physician, the patient, or even the rehab provider, she says.

Identification of patients who require therapy in an outpatient clinic should be made at the initial admission assessment, Riley suggests. "If no rehab provider has been specified by the physician or requested by the patient, we refer them to a provider with whom we have a contract," she says. If, however, either the physician or the patient requests a noncontract provider, Riley will contact the rehab provider, explain the agency's policy, and see if the provider is willing to enter into an agreement.

"We do encounter organizations that don't want to contract with us for several reasons,"

Riley says. In an urban environment, a hospital may not want to contract with a multitude of home health agencies because of the complexity of managing many contracts or the hospital may not be willing to turn over documentation. "We will offer to have the patient sign a release of records form, but one hospital we contacted just did not want to turn over the documentation for our records," Riley says.

In this particular case, the rehab department of the hospital did treat the patient but chose to write off the cost of therapy, she adds.

Another issue with outpatient rehab is when the physician recommends it to the patient or the family and arrangements are made without the home health agency's knowledge, Koerner explains.

"We try to prevent this by educating the patient and the family that we need to know as soon as any change in care is made. We stress that they should not assume the physician will let us know and they should tell us," she says.

"We also educate the physician," Riley points out. Many times physicians are unaware of the consolidated billing and don't realize that the home health agency has to coordinate the care in order to assure reimbursement, she adds.

[For more information about rehab services under PPS, contact:

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*• **Wanda Koerner**, BSN, MS, Administrator, Hays Home Health & Hospice Center, 2501 E. 13th St., Building Four, Hays, KS 67601. Telephone: (800) 248-0073 or (785) 623-5000. E-mail: wkoerner@hays med.com.]* ■

Therapy cheat sheet for clinicians and therapists

One way that staff at Hays (KS) Home Health & Hospice Center improved their knowledge of how rehabilitation therapy and skilled nursing could work together to improve patient outcomes was using a simple list of when it is appropriate to refer a patient to a therapist, says **Wanda Koerner**, BSN, MS, administrator of the agency.

Because it is easy to think in terms of your own area of expertise, the following list reminds therapists and clinicians that certain patient symptoms or concerns might warrant an assessment from the other perspective, Koerner says.

APPROPRIATE NURSING-TO-THERAPY REFERRALS

Physical therapy
- Decreased ability to ambulate
- Transfer difficulty
- Poor balance or endurance
- Diminished strength
- Safety issues
- Physical limitations of lower and upper extremities
- Decreased bed mobility
- Contractures
- Pain management related to mobility
- Wound care

Occupational therapy
- Activities of daily living/adaptive equipment needs
- Cognitive skills such as memory or sequencing
- Home management skills such as orientation, safety awareness, and problem solving
- Functional mobility/transfers
- Vision perception
- Physical limitations of upper extremities
- Stress management
- Energy conservation/work-simplification training

Speech therapy
- Dysphasia/swallowing difficulty
- Impaired cognitive function
- Communication difficulty
- Impaired auditory comprehension
- Poor verbal expression or unusual vocal quality
- Significant weight loss

APPROPRIATE THERAPY-TO-SKILLED NURSING REFERRALS

- Patient with primary rehabilitation diagnosis that develops skilled nursing needs after admission to therapy service
- Knowledge deficit regarding disease process and management
- Multiple medication changes
- Knowledge deficit regarding diagnosis/patient with multiple questions about diagnosis
- Demonstrated knowledge deficit or change in caregiver that affects care
- Patient education needs
- Patient who requires close coordination of nursing and multiple therapy services in order to meet maximum rehabilitation potential ■

Standardization cuts costs of wound care program

Standing orders, quicker debridement effective

Standardization of care, products, and staff education resulted in an 56% decrease in the number of wound-care visits from the first quarter to the fourth quarter for Centura Home Care & Hospice in Denver.

The decrease in the number of visits translated to a 63% decrease in the cost of budgeted supplies, or a savings of $8,160, for one pod of managed care business, says **Susan A. Flow**, RN, BA, BS, MSN, project manager for the wound, ostomy program and Denver-area Medicare case manager for Centura.

Because Centura Health System comprises multiple hospitals and their affiliated home health agencies, wound care techniques and supplies differed from place to place, Flow says. The hospitals and home health agencies worked together to develop a protocol for wound care that would be used in both the acute care and home health setting. "We also conducted product trials to allow physicians and staff members to evaluate different supplies."

The 17-month process resulted in a standardized set of products and protocols that reflected national standards, she explains.

Physician and staff education was an important part of the process, Flow admits. Staff members attended inservices that addressed three specific topics: principles of wound healing, pressure ulcers and surgical wounds, and venostasis and arterial ulcers. "We also held a product fair after each inservice that enabled staff members to get hands-on experience with the products we discussed in the inservice," she adds. The inservices were mandatory for nurses, but Flow found that all of the physical therapists, occupational therapists, and some speech therapists attended the sessions as well.

Physicians received information about wound care protocols in a mailing that explained the basis for the protocol. They were asked to give permission for the hospitals and home health agencies to begin treatment of wounds according to the protocol upon admission by signing standing orders. "The first mailing went to 90 of our referring physicians in the Denver area, and we received a 60% response rate, which meant that 54 of the physicians signed the standing order," explains Flow. These standing orders mean that there is no delay in treatment as the nurse waits for physician orders, and that means fewer visits and better outcomes, she adds.

New techniques, fewer visits

Many home health agencies are looking carefully at their wound care programs primarily because of changes that result from the prospective payment system (PPS), says **Corena LeGalley**, RN, CWOCN, enterostomal therapy (ET) field nurse for the Visiting Nurse Association of Houston.

"We've had to return the day-to-day responsibility for health care to our patients, while nurses are serving more in a teaching and advisory role," she explains. "We have to select treatments and products that can be easily used by caregivers between our visits."

"We've moved away from traditional wet-to-dry wound treatments and use techniques such as vacuum-assisted wound closure as well as foams," LeGalley says. "We also chemically debride sooner than we might have in the past, and we will send a patient back to a physician for a sharp debridement in a shorter timeframe if needed." These techniques all result in faster-healing wounds, she adds.

Two studies performed by Centura Home Care show that the use of newer techniques improves healing time. "When we compared four patients who had been treated on our standardized protocol using vacuum-assisted closure to four patients who had similar nonhealing wounds on conventional treatment, we saw . . . the total number of visits drop from 580 visits over 325 days for the conventionally-treated patient group to 68 visits over 182 days for our protocol-treated group," Flow says.

"The costs for treating the conventional patients totaled $60,000, while the vacuum-assisted, closure-treated patients costs totaled $7,300 in nursing time and supplies," she adds.

Flow points out that vacuum-assisted wound therapy is not appropriate for malignancies, wounds that open into a body cavity, wounds with active bleeding, or wounds for which the cause is unknown.

The other study compared the differences between patients with venostasis disease who were treated with and without compression boots. "The three patients treated with a multilayer compression boot required a total of 40 visits over 199

days for a total cost of $4,300, while the patient group treated without compression boots required 120 visits over 130 days for a total cost of $13,000," Flow says.

Another high-tech treatment that can reduce the number of nursing visits required is noncontact normothermic wound therapy, says **Joan E. Halpin-Landry**, RN, MS, CWCN, clinical support therapist for Eden Prairie, MN-based Augustine Medical, manufacturer of the technology. Nurses place a wound cover over the wound, insert the warming card into the cover, and activate the temperature-control unit; nurses don't have to return for three days, she explains.

"Nursing visits for a patient undergoing Warm-Up wound therapy average 1.6 times per week, with costs running between $10 and $13 per day," Halpin-Landry adds.

While the therapy is effective on most wounds, it is not indicated for third-degree burns, some arterial ulcerations, and any wound for which the cause is unknown, she explains.

Flow points out that a key to a successful wound-care program is having an expert on staff. "While we have trained all of our nurses to assess and treat wounds, we use our ET nurses as staff experts to consult on difficult cases or offer advice when a wound is not responding to treatment."

LeGalley agrees that it is important to have a certified wound care specialist oversee your program, either as a staff member or as an outside consultant. "Someone who is interested and knowledgeable in this area will be able to focus upon and keep up with new techniques and new products that can improve care for all patients."

[For more information about cost-effective wound care programs, contact:

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For information about guidelines and clinical protocols, contact:

• ***Wound, Ostomy and Continence Nurses Society**, 4700 W. Lake Ave., Glenview, IL 60025. Telephone: (888) 224-9626 or (866) 615-8560. Fax: (866) 615-8560. Web site: www.wocn.org.*

• ***American Academy of Wound Management**, 1255 23rd St., N.W., Washington, DC 20037. Telephone: (202) 521-0368. Fax: (202) 833-3636. Web site: www.aawm.org.*

• ***Agency for Healthcare Research and Quality Publications Center**, P.O. Box 8547, Silver Spring, MD 20907-8547. Telephone: (800) 358-9295 or (410) 381-3150. E-mail: ahrqpubs@ahrq.gov. The agency offers a series of booklets related to the treatment of pressure ulcers:* Pressure Ulcer Treatment. Quick Reference Guide for Clinicians *(AHCPR 95-0653);* Treatment of Pressure Ulcers. Clinical Practice Guideline Number 15 *(AHCPR 95-0652); and* Treating Pressure Sores. Consumer Guide *(AHCPR 95-0654) Spanish-language booklet (AHCPR 95-0655). You must include both the title and publication number in your request. Single copies are free.*

For more information about products, contact:

• ***Augustine Medical**, 10393 W. 70th St., Eden Prairie, MN 55344. Telephone: (800) 733-7775 or (952) 947-1214. Fax: (952) 918-5214. Web site: www.augustinemedical.com. Manufacturer of Warm-Up therapy for wound management.*

• ***KCI**, P.O. Box 659508, San Antonio, TX 78265-9508. Telephone: (888) 275-4524 or (210) 524-9000. Web site: www.kci1.com. Manufacturer of the V.A.C. for vacuum-assisted wound closure.]* ■

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State Medicaid programs target home care

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

State Medicaid Programs have increasing concerns about the fiscal burden of caring for elderly and chronically ill patients. These concerns were certainly enhanced by the Balanced Budget Act of 1997 (BBA). *The New York Times* reported Feb. 2, 2002, that at a recent conference of governors, participants "pleaded" with the federal government for financial help with ever-increasing spending for Medicaid programs.

It now appears that state Medicaid programs may try to reduce reimbursement for home care services and/or recoup past payments in order to save money. In some instances, officials of state Medicaid programs may attempt to characterize the activities that produced alleged overpayment as fraudulent. For example, the Medicaid program in North Carolina recently tried to implement changes to reimbursement for home-care services that might have drastically reduced payments to home health agencies and, most importantly, reduced access to home-care services by Medicaid recipients. Specifically, the North Carolina Medicaid Program proposed the following changes in reimbursement:

- If agencies initiated services based on attending physicians' verbal orders, these verbal orders

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must be signed by physicians and returned to agencies within 30 days of the date of admission. If agencies did not receive the signed verbal orders within the 30-day time period, agencies would not be paid for services provided to patients.

• If patients eligible for services paid for by both the Medicare and Medicaid programs, so-called "dually eligible" patients, began receiving Medicare home-care services, they could no longer receive Medicaid home-care services even though those services were not provided on the same day as home health services.

Agencies in North Carolina first learned of these changes in reimbursement when they were published in bulletins from Medicaid.

At the same time, the Medicaid program in North Carolina conducted a series of audits and attempted to recoup money based on those changes.

The Association for Home and Hospice Care of North Carolina went to court and obtained a Temporary Restraining Order (TRO) that prohibited the Medicaid program from implementing these changes or recouping money based on the likelihood that the association would prevail at a hearing. The association then successfully converted the TRO into one that remains in effect until a hearing is held.

Agencies should be concerned that Medicaid programs in other states will follow the lead of the program in North Carolina as they shoulder ever-increasing costs of caring for elderly and chronically ill patients. Instead of direct cuts in reimbursement, programs may attempt to save money through the back door by changing payment criteria and auditing retrospectively to recoup money based on modified payment criteria. When these audits result in allegations of fraud and/or abuse, the potential consequences for agencies are even more serious.

Home-care providers legitimately may wonder why they are the target of many attempts to save money when other segments of the health care industry, such as long-term care providers, for example, may receive funds from Medicaid in far greater amounts than those received by the home-care industry. The answer may be that when long-term care facilities close, state officials are left with the problem of what to do with the patients. But when home health agencies close, the patients seem to just disappear.

Although this may seem like a practical explanation that at least borders on cynicism, some regulators occasionally have verbalized this rationale. In other words, home-care providers and patients may be "easy pickings" as compared to institutional providers.

The next major area of concern for home-care providers may be the payment, audit, and recoupment practices of state Medicaid programs.

Providers and their representatives must remain vigilant on this front.

[A complete list of Elizabeth Hogue's publications is available by contacting: Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Telephone: (301) 421-0143. Fax: (301) 421-1699. E-mail: ehogue5@comcast.net.] ■

CE objectives

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

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. ■