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HIPAA deadlines approach: Are you ready, or in denial?

Extension for transaction standards, privacy deadline April 2003

A nurse in your agency is scheduled to see five patients during the day. She pulls the five charts, places them in her briefcase, sets the briefcase on the back seat, and heads to her first patient. In the driveway, she removes one chart from her briefcase, places it on the back seat of the car, locks the car, and goes in to see the patient.

Is the privacy security of the other four charts protected according to standards set by the Health Insurance Portability and Accountability Act (HIPAA)? This is only one of the many questions home health managers should be asking themselves as the implementation date of Oct. 16, 2002, for the first part of HIPAA — the transaction standards — approaches, say experts interviewed by *Hospital Home Health.*

Because the transaction standards have the earliest implementation deadline, most home heath agencies have focused upon them and may not be paying as close attention to the privacy and security standards, says **Heather P. Wilson**, PhD, president of Weatherbee Resources in Centerville, MA, and co-author of *The HIPAA Privacy Rule: Compliance Resources for Home Care Agencies*.

> *"While privacy is not a new concept in any health care setting, people do have to change the way they think about privacy. Privacy and security have to become part of an agency's culture, not just a policy to follow."*

"There are changes being considered for the privacy standards," Wilson says. **(See description of proposed changes in *LegalEase*, p. 71.)** "The security standards have not been finalized, so some home health managers may be lulled into the belief that there is no reason to work toward compliance with these standards yet," she adds.

There is a lot that can and must be done now, Wilson says. The privacy standards, in particular, can affect every aspect of a home health agency's operation. The best way to implement changes is in stages so

that employees are not overwhelmed, she adds.

"Make sure you are familiar with all three categories of HIPAA standards, and make sure a representative from the home health agency is on any committee set up within your hospital to meet HIPAA requirements," Wilson suggests.

Transaction standard deadline

Because the implementation date for the transaction standards is Oct. 16, 2002, make sure this issue is addressed now, says **Larri A. Short**, JD, partner in Washington, DC-based law firm Arent Fox Kintner Plotkin & Kahn.

"If a home health agency is not ready to bill Medicare electronically, according to the standards set by HIPAA, a request for a one-year extension can be filed," she says.

If the home health agency is considered a department of the hospital, the hospital can file for the extension, but if a home health agency has its own provider number, an extension for the home health agency must be filed separately. The home health manager should be coordinating activities with the appropriate hospital personnel to make sure the request for extension is filed prior to Oct. 15, Short explains.

At the same time, you should be talking with your vendors to find out how close they are to meeting the standards, she adds.

Be wary if your vendors assure you that they are fully compliant at this time, warns **Mark Sharp**, CPA, senior manager and consultant with the Springfield, MO, office of BKD, an accounting firm that offers a variety of consulting services to the health care industry.

"The Centers for Medicare & Medicaid Services [CMS] is currently addressing a problem formatting the admission date on the UB92," Sharp says.

Home health agencies also are currently using V-codes for electronic billing but the transaction standards don't recognize V-codes, he adds. Until CMS resolves these questions, vendors cannot be fully compliant, Sharp explains.

Internally, agency managers should be reviewing all forms that feed information into the billing system, Short suggests.

"The UB92 is to be replaced by the X837 so managers should become familiar with the new form and compare the information that is needed to the information that the agency is already collecting," she says. *(Editor's note: A copy of the form and detailed instructions can be found at http://aspe.hhs.gov/admnsimp/index.htm.)*

April privacy deadline

Even if you file for a one-year extension, you must be prepared to test your electronic billing system by April 16, 2003, Short points out.

"The definition of what constitutes a test is not well defined, but an agency cannot file for the extension and then continue to put off [its] efforts to implement electronic billing, according to HIPAA standards," she adds.

Also, the privacy standards implementation deadline of April 14, 2003, still is in place and probably will not be changed, Short adds.

The privacy standards are designed to protect unauthorized use of or access to a patient's health information, Short explains. The most obvious area for evaluation is the way in which charts or medical information on a computer is transported and stored when a clinician is visiting a patient, she says.

While password protection for computer information, storage of medical charts in the trunk rather than a back seat, or even keeping records in a locked box, may be the right answer for your agency, it is important to look at what you are doing now as compared to the standards, she suggests. While you may not have to make changes or major changes in all policies, you must look at each one, Short adds.

Remember, too, that HIPAA standards are scalable and written for all types of health care organizations, Wilson points out.

It is not necessary, or practical, for home health agencies to enact the same type of privacy policies that a hospital might implement, but all of the home health policies should meet the HIPAA

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standards as a baseline, she adds.

Protecting the privacy of your patients' health information starts even before a clinician takes a chart on a visit, Short says. "An agency has to develop a mechanism that ensures that the minimum amount of information necessary for the recipient to do a job is given," she says.

This means that your billing department does not need the whole medical record for billing, your home health aides may not need the entire record, or your physical or occupational therapists may only need access to part of the record, she explains.

"You can develop a role-based access system that defines who gets access to the whole record, and who gets access to specific parts of the record," she says.

Put processes in place for documentation

One of the more difficult changes an agency may have to make is the patients' right to receive an accounting of how their medical records are used, Short says.

"An agency must have a process in place to document out-of-the-ordinary uses, such as reports to a public health agency in the case of a tuberculosis infection, a subpoena for the record, or use of the record in a research project," she explains.

"This means that the nurse who calls the public health department must document in writing that a report was made to a specific place on a specific date," Short explains. The documentation has to be distinctive enough that someone making a report to the patient easily can see it, she adds.

The key to successful HIPAA compliance is to make sure your policies reflect the reality of your agency's practice and can accommodate changes, Short says.

As you review and change your policies, don't forget to address these changes in employee orientation programs and employee handbooks, Short adds.

Implement these changes in small steps, making sure you educate your staff well, Wilson says.

"While privacy is not a new concept in any health care setting, people do have to change the way they think about privacy," she says. "Privacy and security have to become part of an agency's culture, not just a policy to follow."

The security standards address protection of a patient's health information from loss, destruction, or unauthorized access, Sharp explains. Security differs from privacy because it focuses more on the electronic systems that collect, store, and transmit the information, he explains.

While the rule has not been finalized, it is not realistic to hope that it will be eliminated, Wilson says. "Some people hope that implementation of the privacy standards will take care of security, but it is important to address security even without a final rule," she adds. Publication of the security standards is expected in Summer 2002.

"Look at the proposed rule and compare the requirements to what your agency is already doing," Wilson suggests.

"Some agencies have addressed the security of their computer systems and access to computerized records as part of their normal business operations," Sharp admits.

"It is still important for the home health agency to take an active role to make sure that its specific needs are addressed for employees who routinely access or input information remotely," he adds.

Get started now

Passwords for login, passwords to access specific information, and firewalls within the system, are all common ways to address security, Sharp says.

Although some requirements may be burdensome, it is important to begin addressing all HIPAA requirements now, Wilson says.

HIPAA Resources

The following web sites offer updates, forms, instructions, and other details related to the Health Insurance Portability and Accountability Act (HIPAA):

- ✔ **www.ahima.org**.
  Maintained by the American Health Information Management Association in Chicago. The site offers updates on HIPAA, a web-based training course titled How to Achieve HIPAA Compliance, sample position statements, and sample job description for privacy officers.
- ✔ **www.hipaadvisory.com.**
  Sponsored by the Montgomery Village, MD-based information technology consulting firm Phoenix Health Systems, the site contains a wide range of articles, updates, and information on HIPAA.

"Don't delay your preparation, but don't be overwhelmed," she says.

"This isn't rocket science. Evaluate the standards, plan your changes, develop your policies and forms, and educate your staff," Wilson emphasizes. "Throughout all of this, remember that these changes are good for the patients and we are all potential patients."

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It takes time and patience to build agency referrals

Simple referral process keeps sources happy

Successful marketing for home health agencies doesn't require large budgets, billboards, radio and television commercials, or frequent newspaper advertisements. It does require a commitment to customer service, targeted marketing efforts, and the support of all staff members.

Before you develop a marketing program or hire a marketing person, make sure your agency provides the best customer service possible, says **Michael Ferris**, chief executive officer at Access Health Education, a consulting firm in Chapel Hill, NC, that specializes in marketing and customer service programs for home health.

"Your current patients, staff, and caregivers are a good source of referrals, so you have to make sure that they are happy with the agency," he explains.

In fact, Ferris recommends that rather than rely upon only one person to market your agency, turn your entire staff into marketers.

"Give all of your employees business cards and encourage them to distribute them to people they meet who either need home health now, or might need it in the future," Ferris says.

Not only do you increase the number of people who will hear the name of your agency but you also create a great sense of pride among the staff, he adds.

While professional staff members often have business cards, your billing staff, receptionist, and home health aides may never have had one, points out **Robert Fazzi**, president of Fazzi & Associates in Northampton, MA.

"I had one client who told me that one of her home health aides actually cried when she was given her own cards," he says.

The business cards make it easy for an employee to talk with a neighbor whose husband might need home health after a hospital stay because the employee can say, "The nurses at my agency are great, and if you need home health, here's the telephone number you can call," Fazzi explains.

The neighbor is more likely to call her friend's agency because there is a personal connection, he adds.

A marketing person for the agency is an important role, Ferris says. "Someone has to coordinate marketing efforts and make calls on referral sources, but a manager needs to make sure the marketing person is also part of the team," he says.

"This means that the marketing office needs to be in the midst of the agency, not down the street in a vacant office," Ferris explains.

What to look for in a marketing position

While a clinical background might be helpful for a marketing person, it is not necessary, Ferris says.

"The person must present [himself or herself] well, be ethical, focus on delivering consistent good service to referral sources, and understand how to sell an intangible product," he explains.

The marketing person needs quick access to a clinical person in case a referral source has a clinical question, Ferris adds.

Because marketing is different from other activities in home health, some agency managers are uncomfortable supervising them.

"Marketing people should be responsible for reporting how many calls they make, how many referrals come from those sources, how much time they spend on follow-up with referral sources,

and in general, how they spend their time," Ferris says.

Managers need to review these reports and make sure that the marketing person isn't wasting time by visiting "friendly, fun offices" rather than making a tough cold call or visiting physician offices that are less friendly, he points out.

Track conversion rates

As important as tracking the number of referrals from sources, be sure to track the conversion rate, Fazzi says.

The conversion rate reflects the number of referrals that turn into admissions, he explains. "Our research has shown that conversion rates range from 75% to 98% for home health agencies," he says.

The financial incentive to improve conversion rates is significant since inappropriate referrals still require a nurse to visit the patient for an assessment, Fazzi says.

"If a nurse's assessment visit costs you $104, and the nurse discovers that the patient is not an appropriate referral, you lose money," he points out.

If your agency admits 2,500 patients each year, but you are only converting 95% of your referrals to admissions, you've spent $13,000 on assessments for inappropriate patients, Fazzi explains.

"If you only convert 85% of your referrals, the loss increases to [more than] $41,000," he adds. That's a significant impact on an agency, so we took a look at how agencies can improve those conversion rates," he says.

First, you have to remember that developing a referral source means developing a relationship, Fazzi points out. This requires time, communication, and effort on the home health agency's part to meet the needs of the referral source, he explains.

Tips for developing a good relationship include:

- **Have a clear admission policy.**

Make sure the referral source knows which patients fit your admission requirements, Fazzi says. Educate the physician, the office staff, or the hospital discharge planner as to what services you offer, he adds.

- **Make it easy for the referral source.**

"Ask your referral source how he or she prefers to handle a referral," Ferris says. Set up a special telephone line, a dedicated fax line, or even a specific person to receive referrals.

Keep the referral process simple and don't require that a huge document filled with details accompany the referral, Ferris says. A one-page fax cover sheet should be enough, he adds.

Also, set up a "care plan" for the referral source, he suggests. Build a profile after asking the source for suggestions on how the agency can make it easy.

Find out if the source wants reports on a weekly, monthly, or as-needed basis; if the reports should be hand-delivered or mailed in a special envelope; or how the physician should be reached after hours or on weekends, Ferris explains.

Then make sure the file on the referral source is accessible by any person who has contact with the source, he adds.

Answer the phone!

Remember, too, that discharge planners and physician offices will move on to the next agency if anything causes difficulty or delay with the referral, Fazzi says.

"We found in our surveys that if a telephone line is busy, if a person who can't take the referral answers the line, or if they get an answering machine, the referral source just hangs up and calls the next agency on the list," he says.

- **Respond quickly.**

Send a note by mail or fax to your referral sources, letting them know you received and appreciate the referrals and be specific, Fazzi says.

You can say that you saw the patient within 24 hours of receiving the referral, or that you already have scheduled their assessment visit, he says.

Whichever way you handle it, be sure to show that you responded promptly and efficiently, Fazzi adds.

- **Survey your referral sources.**

Be sure to conduct regular surveys to see how you're doing, Ferris says.

"Send a cover letter along with a list of the patients who came from the referral source and include a simple one-page, multiple-choice survey," he says.

Include at least one open-ended question such as "If you could change one thing about how we work with you, what would it be?" You also can change the open-ended question to gather information about potential success of new services such as pain management or pediatric care that you might be investigating, Ferris explains.

- **Have senior management available for complaints.**

Make sure that senior management is accessible if the referral source has a problem or a complaint, says Ferris. By giving senior managers' direct line, pager, and cell phone numbers to a referral source, you're saying that commitment to customer service starts at the top in your agency, he says.

- **Differentiate your agency.**

Offer services that other agencies don't offer, Fazzi says. Promise response within 24 hours, have your referral line open until 6 or 7 p.m. on Fridays, schedule weekend assessment visits, or add services that are not available in the community, he says.

Also, home health agencies that are a part of or affiliated with a hospital should let the discharge planners know that they don't just assume the hospital's patients are coming to them, Ferris says. "Let the discharge planners know that you are going to treat them as well as you treat other referral sources," he says.

- **Talk about your agency.**

In addition to educating physician offices and discharge planners, be sure you go to the community, Fazzi says. Community organizations such as the local Rotary Club always are looking for speakers and are a good forum to let people know what you offer, he says.

No matter how you market yourself, be sure the commitment to customer service always is there, Ferris says. "You want your agency to be the agency to which you would refer your own friends and family."

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Inotropic drug infusion provides one last dance

Procedure keeps patients out of hospital longer

The 78-year-old woman's goal was to dance at her daughter's wedding, but she suffered from end-stage heart failure and had been in and out of the hospital for months. By working with her physician, the home health agency was able to provide continuous inotropic drug infusion that kept her out of the hospital long enough to dance at the wedding.

Ann K. Frantz, BSN, RN, an independent health consultant and cardiac educator, sees the need for home care agencies that provide inotropic infusion growing.

"While there is still controversy among the medical community, the truth is that there is a population of patients for whom this provides time to resolve issues prior to death and to enjoy being at home with friends and family," she says.

Inotropic drug infusion is covered in the home by Medicare with noninvasive hemodynamic monitoring that measures parameters such as contractility, cardiac output, and fluid status, Frantz says.

"Our agency is high-tech, so we purchased our own mobile monitor, but patients can also be monitored in the physician office," she adds.

Inotropic drug infusion is not the first-choice treatment now because there have been many advances and there are better oral treatments than there were in previous years. But there is a need for the service, says **Lisa A. Gorski**, RN, MS, CS, CRNI, clinical nurse specialist for Covenant Home Health in Milwaukee.

"There is a small group of patients for whom other treatments don't work and for whom transplants are not possible," she explains. "We began offering inotropic infusion in the home in 1988, and while we haven't seen huge increases in the number of patients we treat, we have seen a steady volume."

Gorski adds that there is research that supports use of inotropic drug infusions as a way to reduce hospitalizations and keep patients at home.[1]

Risk of sudden death

The use of dobutamine and milrinone to stimulate an injured or weakened heart to pump harder and relieve the symptoms of heart failure does carry a risk of sudden death, Gorski says.

To minimize these risks, it's important to assess patients thoroughly, chose patients carefully, and ensure that the nurse overseeing the patient's care is appropriately trained, she adds.

The most important aspect of evaluating a patient for this treatment is to make sure there is a caregiver who is readily available to the patient, Frantz says.

For patients who cannot change IV bags or manage the pump on their own, a caregiver should be in the home, but that is not always required, she adds.

"I've had two patients who had their next-door neighbors act as caregivers, and I had one patient whose daughter was a RN who stopped by his house every day to check everything for him," Frantz says.

"If the patients' goal is independence, you need to respect that goal and let them be as independent as they can safely be," she explains.

Consult best-practice recommendations

Frantz is a member of the Washington, DC-based Home Healthcare Nurses Association committee that has developed best-practice recommendations for inotropic drug infusion.

"We've written the recommendations, and they are currently under review," she says. "We took a look at everything that would contribute to the best possible outcome for these patients."

The proposed recommendations include:

- **Presence of a central-line or peripherally inserted catheter**

"Peripheral lines for infusion cause necrosis of soft tissue and aren't appropriate for patients who will receive drug infusions over time," Frantz explains.

- **Presence of a caregiver**

"The caregiver is important because we teach our patients self-management techniques that may require assistance from a caregiver," Gorski says.

- **First dose in hospital setting**

"It's important to make sure the first dose is given in the hospital because if the patient is going to have an adverse reaction to the medication, it will be with the first dose," Frantz points out.

- **Careful physical assessment**

"The nurse must listen to the patient's lungs, check the IV site for infection, and assess any cardiac arrhythmias," Frantz says. This full assessment must be performed at every visit, she adds.

- **Use of cardiac-trained nurse**

"The best outcomes are found when the nurse has five or more years in a cardiac care unit," Frantz says. "You must have a nurse [who] is proficient in cardiac assessment, understanding heart tones, listening to lungs, and understanding the effect of the drugs used for these patients," she adds.

If you are considering the addition of inotropic drug infusion to your services and you don't have an expert on staff, consult with a specialist in this area to make sure you hire the right nurses, establish the best guidelines, and ensure good outcomes, Frantz suggests.

"You also need to make sure the patient understands that the treatment is palliative not curative," Gorski says. "The physician must make sure the patient understands all options, if any are appropriate, before allowing the patient to choose this treatment."

The patient also needs to understand that while the medications have the capability of improving his or her quality of life, they also can cause sudden death, Gorski says.

End-stage heart patients who are receiving inotropic infusions make up 5% to 10% of patients for the Fort Worth, TX-based Cardiovascular Home Care, says **Bridgette Campbell**, RNC, BSN, executive director of the agency.

Need for inotropic infusions could increase

The need for this service is likely to increase as the population ages, as heart failure patients stay alive longer, and as more people want to avoid hospitalizations, she says. "It is one way that you can help patients make the most of their lives."

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Reference

1. Boger JE, DeLuca SL, Watkins DF, Vershave KK, et al. Infusion therapy with milrinone in the home care setting for patients who have advanced heart failure. *J Intrav Nurs* 1997; 20(30):148-154. ■

Create a win-win rehab contract for both sides

(Editors note: In this second part of a two-part series on contracts with outpatient rehab providers, we discuss specific items to include in your contracts. In last month's issue, we discussed the issues that surround identification of patients for rehab and relationships with providers.)

The best way to make sure you maintain good relationships with rehabilitation providers in your area and ensure that everyone is properly reimbursed for therapy provided in an outpatient clinic or hospital outpatient department is to have a structured agreement in place before the patient needs a referral, explains **Katie Riley**, vice president of clinical for Advocate Home Health Services in Oakbrook, IL.

Items that should be addressed in your contract include:

- **Identification of responsibilities**

Even when the home health patient is in outpatient therapy, it is the home health agency that coordinates care, Riley points out.

Her agency contracts specify that the rehab provider must contact the home health case manager to discuss changes in therapy and also must report to the case manager either on a weekly or biweekly basis, depending on the patient's status.

"One of our responsibilities is to continually assess homebound status as defined by Medicare to make sure the services will still be covered under the home health benefit," she adds.

If the patient's homebound status changes, the agency discharges him or her from home health and lets the rehab provider know that the billing arrangement must be changed.

Documentation and fees

- **Specific timeframe for documentation and billing**

Rehab providers must provide a copy of their documentation before the bill will be paid, Riley says. "If charges on the invoice are not supported by the documentation we receive, we don't pay them."

While Riley accepts copies of the documentation, **Wanda Koerner**, BSN, MS, administrator of Hays (KS) Home Health & Hospice Center, requires the original documentation. "Since we are the coordinator of care, we believe we should maintain the originals," she says.

Billing for rehab services in an outpatient clinic often is made in 15-minute increments rather than visits as in home care, Riley says.

Because therapy visits in outpatient can be counted as visits toward the service-utilization component of the home health-related group, you don't want to count a 15-minute increment as a visit when you can count three increments as a visit, she explains.

This is allowed with Medicare's definition of a therapy visit equating to 48 minutes, she adds.

You also want to make sure the rehab provider bills you in a timely manner, Riley adds.

"No one wants to handle a large bill submitted a year after service." Because many hospital outpatient therapy departments are slow to bill, be sure to accrue the charges and keep track of them as potential bills so you can plan on them arriving and not be surprised, she adds.

- **Agreed-upon fees for services**

Negotiating fees requires a good deal of planning and has to be done on a provider-by-provider basis, Riley says.

"I've used three different formulas for determining the fees I will pay," she explains.

Paying a percentage of charges is the easiest to manage, she says. If you choose this formula, make sure you know what the typical charge for the service is in your market as well as what your expected reimbursement from Medicare, Riley adds.

Other ways are to pay the Medicare allowable or a percentage of the Medicare allowable, Riley adds. These methods usually are more appropriate for smaller providers, she adds.

Whichever method you choose to determine fees, be sure you stay on top of typical charges in your market as well as Medicare allowables. Riley also recommends that you review your agreements on a regular basis to be sure fees are in line with current charges and allowables.

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Neonatal home program saves money, helps babies

NICU-experienced nurses manage babies' care

By sending prematurely born babies home an average of 3.5 weeks earlier than the average preemie, Carolinas Medical Center's nursery staff and home care agency was able to save more than $3.3 million in the first 18 months of a neonatal home management program.

"In addition to the shortened length of stay and cost savings, we discovered that the babies gain an average of 32 g to 37 g per day as compared to premature babies in the hospital who gain an average of 20 g per day," says **Martha J. Whitecotton**, RN, MSN, vice president and chief nursing executive of Carolinas Medical Center in Charlotte, NC.

The program was implemented in 1998 after a two-year period of development, Whitecotton says. "We needed to reduce the length of stay in our neonatal intensive-care unit [NICU] in order to handle the number of babies we get, and we also learned through research that babies do better in the home," she says.

The long period of development was needed for several reasons, not least of which was changing a long-term practice of defining when the babies were ready to go home.

"To go home, a premature baby has always needed to be able to maintain a stable body temperature in an open crib and eat and gain weight," Whitecotton says.

However, the NICU nurses typically didn't even put a baby in an open crib until he or she weighed 4 lbs., she explains.

Now, the practice is to evaluate each baby on an individual basis, and if the baby is stable in the isolette and has no other condition that precludes being in an open crib, he or she is moved, even if the baby weighs as little as 3 or 3.5 lbs., Whitecotton says.

"By weaning the babies from the isolette earlier, we are able to consider more babies for the home care program," she adds.

Expert staff essential

One of the key hurdles to overcome was pediatricians' acceptance of the program, Whitecotton says.

"The community-based pediatricians follow the babies once they move to home care, so we needed to reassure them that the nurses were experienced in caring for these tiny babies and that the pediatrician would not see an increased number of calls from these parents," she says.

Hiring experienced NICU nurses and training them for home care overcame everyone's objections. Not only are the pediatricians not seeing an increase in the number of calls they receive, they also have fewer office follow-up visits because the nurses are taking care of many things in the home, Whitecotton says.

"I don't get many calls from parents because we provide excellent patient education when we make our visits," says **Barbara Samartino**, RN, a field nurse for the neonatal nurse management program.

"We see the babies within 24 hours of their discharge to home, then call the parents every day for the first week," Samartino explains.

"The average number of visits is two per week for two weeks," she adds.

At the beginning of the program, eight visits were planned, then dropped to an average of five to seven and now the number of visits averages four, Samartino says.

"Most insurers easily pay four visits, but we re-evaluate the baby at the two-week point to see if there are any reasons to justify more visits," she says. If there is a need for more visits, the home health agency handles the contact with the payer, she adds.

Neonatal nurses are instrumental

The neonatal nurses also are instrumental in identifying babies that qualify for the program. In addition to making sure the baby can maintain body temperature, eat, and gain weight, the nurses look for motivated parents who are able to learn and are willing to accept responsibility for the baby's care, Samartino says.

Hiring the right nurses was a challenge for the home health agency, says **Dianne Wingate,** RN, BSN, assistant vice president of Carolinas Home Care.

In addition to having experience with preemies, Wingate says she looked for nurses with excellent communication skills, good assessment skills, and the ability to make sound judgments on their own in the home care environment.

"Home care nurses don't have the backup that hospital NICU nurses [have], so we wanted

people who could work on their own and inspire confidence in the parents and pediatricians," she explains.

Home care training required

After choosing the nurses for the neonatal home management program, the home health staff provided an intensive education in regulations, paperwork, Medicare and Medicaid coverage issues, safety, and information on community resources, Wingate says.

The neonatal nurses also accompanied home health staff on home visits and experienced home health nurses accompanied the neonatal nurses on the first several visits until everyone was comfortable, she adds.

"I definitely had to handle things I never encountered in the NICU," Samartino says. Upon arrival at one home, she discovered that the baby was ice-cold even though it was a warm July day and there was no air conditioning in the apartment. "The teen-age mother could not drive, and her mother was at work and couldn't be reached," she says.

The baby and mother needed transportation to the clinic but did not require an ambulance, and Samartino knew that she could not assume the risk of taking the baby in her car. "I called the clinic, explained the situation, and the clinic nurse sent a cab," she adds.

Another unexpected obstacle for parents taking their babies home was a medication that most of the babies are taking, Whitecotton says.

"We discovered that local pharmacies did not know how to mix a caffeine compound we prescribed, so our parents were having to drive back to the hospital pharmacy to get the medication," she explains. Once this was discovered, a hospital pharmacist developed instructions for local pharmacists to use for both the caffeine compound and a diuretic commonly prescribed for premature infants.

Everyone involved in the Carolinas Medical Neonatal Home Management Program agrees that the secret to success is the close collaboration between hospital and home health personnel. Wingate, however, adds one more piece of advice: "Don't try to utilize existing home health nurses in this program. This is such a different population for home health that you must tap into the clinical expertise of the NICU to ensure the safety of these babies and good outcomes for everyone."

CE questions

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

9. Why might the patients' right to ask for an accounting of the use of their medical records as provided for by HIPAA, create problems for home health agencies, according to Larri A. Short, JD?
   A. The request means staff time to look for a medical record.
   B. A process to document out-of-the-ordinary uses such as reports to public health departments must be developed.
   C. Employees have to be trained to fill these requests.

10. According to Robert Fazzi, why is it important to track conversion rates as well as referral rates?
   A. The more numbers on your marketing reports, the better.
   B. Conversion rates help you determine how to budget your marketing efforts.
   C. Conversion is a technical term that your board members will understand.
   D. Conversion rates help you discover how much staff time and money you invest in inappropriate referrals.

11. For what reason is a specific timeframe for documentation and billing important to include in a rehab contract, according to Katie Riley, vice president of clinical for Advocate Home Health Services?
   A. to ensure that you are able to file accurate and timely claims
   B. to help you identify ethical contractors
   C. to make sure that your billing department has a steady flow of work
   D. to protect your patient's medical record

12. In addition to saving $3.3 million with their neonatal home management program, what other benefit did managers at Carolinas Medical Center and Carolinas Home Care notice after implementing the program?
   A. positive press coverage
   B. more referrals to their hospital NICU
   C. increased number of nurses applying for employment
   D. faster weight gain at home than at the hospital for babies in the program

[For more information about Carolinas Medical's Neonatal Home Management Program, contact:

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LegalEase

Understanding Laws, Rules, Regulations

HHS proposes changes to HIPAA requirements

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

On March 27, 2002, the U.S. Department of Health and Human Services (HHS) published proposed changes to the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements that may impact providers as follows:

- Providers with direct treatment relationships with individuals no longer would be required to obtain an individual's consent prior to disclosing information about the patient for treatment, payment, and health care operations. Providers may, however, obtain consent if they choose to do so.
- Providers that choose to obtain consent will have complete discretion in designing the consent process.
- Except in emergency situations, providers with direct treatment relationships with individuals would be required to make a good-faith effort to obtain patients' written acknowledgement of receipt of providers' notices of privacy practices at the time of first service delivery. The form of such acknowledgements is left up to the discretion of providers. If providers cannot obtain acknowledgement, they must document their good-faith efforts and the reasons for failure.
- Incidental uses and disclosures consistent with the minimum-necessary standard would be permitted.
- Certain existing contracts with business associates would be "grandfathered." That is, providers would be required to bring contracts with business associates into compliance when the provider renews or modifies the contract after April 14, 2003, or April 14, 2004, whichever is sooner.
- Authorization would be needed for uses and disclosures for marketing purposes, except for items of nominal value, but not for treatment purposes.
- State statutes would govern release of information to the parents of unemancipated minors. If state law permits a minor to obtain care without the consent of a parent, but is silent as to whether the parent can access the related medical records of the minor, then the provider may provide access or deny access to the parent, if such denial of access is consistent with state law.
- The list of items that must be included in authorizations would be standardized.
- Sharing of information as part of due-diligence

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process related to a sale, transfer, merger, or consolidation, including the transfer of records, generally would be permitted.
- Providers could include sample language in contracts with business associates to ensure compliance.

If these proposed changes are finalized, what should providers do?

1. Providers should continue to obtain consent to release of health care information. Even though this requirement may be dropped from the final regulations, it is good risk management for providers to obtain consent anyway. Since providers historically have obtained consent, continuation of this practice unlikely will be burdensome.
2. Whether the proposed changes are adopted or not, providers should continue to take a common-sense approach to HIPAA privacy requirements. It has been suggested that without the proposed modification, providers who receive referrals would not be permitted to contact patients to provide services without patients' consent because contacting patients would be a "use" of information without patients' consent. Commentary that's been received on the proposed modifications, as well as old-fashioned common sense, suggest that this result is not acceptable.
3. If written acknowledgement of notice is required, providers should include such an acknowledgement in forms they already ask patients to sign upon admission. No new forms are necessary to meet this requirement.
4. Providers should review the model language in the appendix to the proposed changes that addresses the issue of obligations of business associates. Providers should utilize this model language in revised contracts to the extent it is applicable to specific relationships with business associates.
5. Providers may be concerned about distinguishing between marketing activities and treatment activities. The key for providers seems to be that concerns about these differences should not impede access to care or quality of care.

Providers must continue to monitor additional developments with regard to compliance with the HIPAA compliance requirements.

[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 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. ■