AMERICAN HEALTH CONSULTANTS®

Hospital Home Health®

the monthly update for executives and health care professionals

INSIDE

■ **A hospital CEO speaks out:** His advice on forging hospital ties 3

■ **Surety bonds:** Are you due for a refund? 4

■ **Weathering winter storms:** What every successful emergency plan should include 6

■ **Patient priorities:** In an emergency, who needs your help the most? 8

■ ***LegalEase:*** When is home care appropriate? 9

■ **News Briefs:**
OIG conducts Y2K survey. 11
Tenet purchases eight hospitals 11
Deadline approaches for OASIS 11
Americans speak out on Mericare 12

■ **Inserted in this issue:**
Legal Review & Commentary

JANUARY 1999

VOL. 16, NO. 1 (pages 1-12)

American Health Consultants® is A Medical Economics Company

How to make your home care agency an integral part of hospital operations

Even if your CEO sees your agency's value, you still have to contribute

(Second in a series)

Not every hospital-affiliated home health director is as fortunate as **Laura Elliott**, RN, MS, vice president of North Mississippi Health Services in Tupelo. For unlike some of her peers, Elliott says, she is lucky enough to work with a CEO who believes strongly in the merits and value of home health care. **(See related story, p. 3.)**

While her job may be a bit easier because of her CEO's support, it is in no way simple. She may not have to work as hard at convincing hospital management that home health agencies are a benefit to the overall health service system, yet she and her staff work exceptionally hard at making sure the situation stays that way.

Here is a look at what the administrator of Mississippi's largest hospital-based home health agency has done to ensure that her agency, North Mississippi Medical Center Home Health Agency, remains an indispensable part of the hospital's system.

A study in justification

Elliott has a lot of resources at her disposal: Her home health agency is part of a hospital system that includes the 650-bed North Mississippi Medical Center (the largest hospital in the state and the largest rural hospital in the country) with which her agency is affiliated, a cancer center, a behavioral health facility, a women's hospital and family medical clinics, a nursing home, five affiliate hospitals, and a subacute unit. Her agency alone, which covers 17 counties and has 11 branch offices, brought in more than $350,000 last year from a client base of more than 5,000 patients.

Despite this, Elliott knows that she is not exempt from the worries and problems associated with the interim payment system (IPS). Nor is her agency immune to the wave of cost-cutting and downsizing in IPS's wake. But with more than 23 years of home health industry experience, she also knows a thing or two about keeping her agency up and running.

Perhaps nothing is more important in reaching this goal than communication between hospital and home health agency administrators. "Right now, one of the key things for directors of home care, going through changing reimbursement process from cost to IPS to PPS, is to

make sure they understand how they are performing financially under the new system," she says.

Toward that end, she developed an IPS reimbursement sheet that details monthly visits per branch office, both indirect and direct costs associated with these visits, and how "it positioned us with the IPS and per-beneficiary and per-visit costs."

With the numbers in place, she took that information public.

"We communicated it to all management staff so everyone would be knowledgeable of the facts. It has been very beneficial to the president and our CFO. They know we are aware of the changes and that we're functioning well under the system," she says. Elliott didn't stop with that, however. She also has developed a mock quarterly cost report "because home care was reimbursed this past fiscal year based on past cost limits which are much greater than what we'll have this year," she states. "The agency needs to make the president and CFO aware of this so they will see how much money they will need to pay back to Medicare."

Agency in action

Equally important as open communication between agency and hospital administration is taking action, setting out to prove home care's worth through a series of definitive actions other than cost shifting.

North Mississippi Medical Center Home Health Agency has not limited itself to the confines of its immediate responsibilities. Elliott says she believes, and has been proven right if her agency is any measure, that "it's important to link your agency up to almost every juncture of the hospital." Such a task, of course, cannot be undertaken at random and requires strategic planning among agency staff and key hospital personnel.

Among the programs Elliott has implemented are the following:

1. Agency-hospital liaison.

To keep the lines of communication open in both directions, Elliott has encouraged her staff to act as liaisons between the two facilities.

"We have a strong psych division and we have utilized some physician clinicians in a liaison role within the hospital to help when a physician needs to make a referral and determine whether that patient should be kept in the hospital or transferred to the behavioral health unit," Elliott notes. "Our liaison evaluates the patient and then coordinates the possible transfer of the patient."

The goal is to unite the aide and the nursing staff so that they work jointly on whatever the DRG losers are. The sooner the patient is out of the hospital the better, she points out, and home health aides are in a perfect position to assist with that. "We want to get the patient into an area where they are best taken care of, whether it's in home care or in a nursing home. We can help the hospital identify what will work earlier on and work with [hospital staff] toward that goal."

2. Specialization and disease state management.

Elliott and her staff have made themselves a vital part of the hospital "by cross-training and our willingness to hook up with the hospital and complement them in the different areas in which they need staffing," she explains. "All our aides and nurses are specialists in one of our top referring areas — oncology, wound care, cardiac, and so forth. A clinician is assigned to each division and linked with their counterparts in inpatient services."

So integral is her agency's staff that "they're visible on the congestive heart failure continuum team and the end-of-life and infection control teams. Home care has linked up with every top DRG category in the hospital that has been identified as being a loser as far as Medicare money. [The teams] meet weekly and collaborate on discharge planning and are involved in meeting the patients' needs from Day One of admission."

3. Hospital services education.

Some of Elliott's staff have been trained in nursing home care as well as specific areas, such as caring for ventilator-dependent patients.

"If a patient is ventilator dependent and comes into the system, we can take them in a home setting, or if they need a higher level of care, they can be seen in the nursing home. Our job here is to complement the nursing home with staff," she says. "If their staff [level] gets too low to handle that type of care, we will take some of our staff who've been trained in that and switch them over."

Elliott is careful to point out that any time a home health aide or nurse "switches" to the nursing home or any other of the hospital's units, those hours are not billed to Medicare. "We shift

that cost to whatever unit they are supporting," she notes. Some aides have been cross-trained so that they end up performing a double function. For example, several aides have been taught to draw blood. As a consequence, when these aides are making their patient visits, they will also visit other homebound patients to draw blood samples that will later be taken to the hospital's blood lab for testing.

"They're already out in areas seeing home care patients," she says, "and so for half a day they float some of their salary time to the lab for patients that are homebound but need lab work done. This helps out the lab and has helped us in home care to shift some hours."

Clinicians also farm out hours to oncology, the diabetes treatment center team, and the women's hospital, where nurses specialized in pediatrics and newborns shift some hours. The advantage lies in that this relationship "keeps the lines of communication strong between [the hospital] and home health," she says, adding that being visible in the community helps to bring in referrals while reducing her agency's salary expense.

"If a patient in the community becomes homebound, we might get that referral," she points out. "But if the patient goes into the clinic, then we can still help the clinic by shifting hours to them."

Bringing disease prevention to the community

Another benefit of being a renaissance home health aide is that she is also able to go into the community in a teaching capacity. Some of North Mississippi's therapists are shifted to the hospital's family medial centers (FMC) to "train their staff on more specific things, like foot screenings and wound care. It helps in the overall prevention of disease in the community, helps bring more referrals in, and helps the FMCs to have more educational programs," Elliott points out.

4. **Care guides.**

Through her staff's specialization has come the development of a series of care guides similar to critical care maps. Working in close conjunction with the inpatient divisions of the nursing services, the guides "are developed so they're specific to what's going on. Inpatient and outpatient services are teaching the same thing," Elliott explains, adding that they are all written at a sixth-grade level for clarity and so they will be easily understood by all home health aides.

SOURCES

Laura Elliott, RN, MS, Vice President, North Mississippi Health Services, 600 W. Main St., Tupelo, MS 38801. Telephone: (601) 841-3611.

No matter what course you choose to follow, Elliott can't overemphasize the importance of showing the hospital administration that you are coping well with the IPS. "In your utilization review," she advises, "you want to make sure the CEO knows all the specializations and high-tech expertise you have. You want to be visible and they know that the value there is in keeping the system and the community well." ■

From the CEO's desk

A hospital administrator talks about home care

When it comes to maintaining your agency's hospital-affiliated status, nothing beats support from the top. While agency directors have more than a few ideas of how to garner it, perhaps no one has greater insight on how to accomplish this than "the top" itself.

As president and CEO of Tupelo-based North Mississippi Medical Center, **Jeff Barber**, PhD, is solidly behind his hospital's home care agency. For those home health agency directors who find themselves in a the less-than-enviable position of having to convince their CEOs of home care's merits, he offers a bit of advice.

Barber explains that the success or failure in maintaining a positive relationship between the hospital and the home health agency rests with the management of both entities.

"It really boils down to how strong a relationship the home health agency director has with the counterpart directors of their institution," he says. "The importance of that relationship is that for the continuum of care to be effective and get patients into the home health care environment, there need to be clear, concise communication channels and procedures, and a process to make it all work."

If that works effectively, says Barber, the home health agency can benefit the hospital and itself by floating staff into areas of the hospital which are experiencing unusually high bed occupancies

or staffing needs, while keeping its own overtime costs to a minimum. But, as Barber points out, such seamless cooperation is rare. "For all this to happen it takes really good communication," he says, "and where most facilities fall down is on the adequacy of communication channels."

Barber finds hospitals that try to manage both home health agencies and clinics "do both equally badly because hospital and department administrators haven't been trained in how to manage clinics or home health care." Barber concedes this is a generalization but says his hospital has avoided the trap of taking someone from the hospital and putting that person in charge of the home health agency.

"We took someone from the outside who had experience in running home health. She meets weekly with hospital directors and established the processes to evaluate what the agency is doing and to maintain open channels of communication," he explains.

A tool for better community relations

As Barber sees it, home health agency directors would be well-served to point out home care's many benefits — not just to the hospital's bottom line, but also as a community relations tool. He notes home health care benefits hospitals in the following ways:

❒ **Providing an opportunity for the hospital to cut the length of stay and save on Medicare DRG reimbursement.** "The point of managing care through the hospital," he notes, "is getting patients out in an appropriate time to another appropriate setting. It's very important. We haven't always, but we're now doing it effectively and that has helped us become better at what we do."

❒ **Acting as a referral source for additional patient hospitalization.** Says Barber, "[If] patients already have a relationship with the home health nurse and then require further hospitalization, they may think of us first."

❒ **Reducing patient costs in the long run and improving a community's overall quality of health.** "Community-owned hospitals have a better sense of what's right for the community, and a home health agency is the right thing," he says. "These agencies provide a better health care environment for the types of patients they treat and at less cost to the patient, so it actually improves the health status of the population. Without [the agencies], people would be getting sicker."

Barber encourages hospital administrators to look at the big picture in assessing the value of home care. "When you look at it as a piece of the continuum that if you don't have it, you'll have increased costs over the long haul." The agency may not be a money-maker, but it does reduce the amount that otherwise would be lost on long-term care if patients remained in the hospital.

❒ **Acting as an placement option for hospital employees laid off as a result of downsizing.** Barber suggests that home health agency administrators consider hiring employees downsized by the hospital as agency aides and nurses. "The home health agency should look at the employee pool from the hospital . . . as an opportunity to create a flex pool," Barber explains. "Here is an opportunity to take good employees. [Agency directors] know they're reliable and committed. It's better to have a flex pool from hospital employees than from an outside agency." ■

Surety bonds: Where they are, where you stand

Checking up on the status of HCFA's requirement

They're on. They're off. They're postponed. When it comes to surety bonds, no one — not even the Health Care Financing Administration (HCFA) — seems able to give a definitive statement on whether they will be reinstated and, if so, in what form. What people can agree on, however, is that home health agencies have been granted, at the very least, a temporary reprieve.

These questions beg to be answered: How long will it last? And when the reprieve ends, then what? Here, some experts in the field of home health offer their suggestions and prognostications.

On July 31, 1998, HCFA agreed, under pressure from Congress, to postpone the effective date of any surety bond requirement until Feb. 15, 1999, or the end of a 60-day notice and comment period (whichever is last). As it stands, HCFA is

awaiting the results of a study conducted by the General Accounting Office (GAO), looking into subsequent surety bond regulations.

In the interim, agencies that have not yet secured bonds are free from penalty, and those who have already obtained bonds (some 40% of home health agencies, according to HCFA) are "being notified by a bulletin that if [agencies] want to get their bond returned to them and therefore apply to the surety bond company for a refund, they need to write a letter to their intermediary," says **Mary St. Pierre**, director of regulatory affairs with the National Association for Home Care (NAHC) in Washington, DC.

Will agencies get their money back?

Whether agencies will be successful in having their funds returned is another matter. **Ann Howard**, executive director of the American Federation of Home Health Agencies (AFHHA) in Silver Spring, MD, says that agencies may not find the reimbursement process easy.

"Agencies can apply to get their money back but that doesn't mean the surety companies will give it back," she says. "Some agencies' bonds were written to last until the beginning of the new fiscal year, and the surety companies will say, 'We covered you, and now we'll hold onto it.' I just don't know how much luck people will have getting their money back."

Despite the potential for rejection, **William Cadigan**, JD, an attorney with MacKelvie & Associates in Chicago, recommends that agencies give it a try. "Insurance companies, as is common when people try to make a claim on car insurance, aren't all that eager to refund premiums and, in this case, home health providers are going to face a similar problem."

His advice is to check "the terms of the bond and see if there is any provision that allows [the agency] to recoup any premiums after the time they're needed. If a bond says that it was purchased for a certain amount of time, I think it will be difficult for them [to recoup], but it can't hurt to look." Cadigan recommends agency owners and directors "consult counsel if they are confused, and in any event, consult an attorney on anything that involves liability, especially Medicare liability."

As for agencies concerned about leaving themselves vulnerable after a refund only to have HCFA proceed with the implementation of a new deadline, Cadigan believes that agencies in good standing will fare just fine. "A common sense approach should prevail," he says. "If the providers have no history of violations, then I think they will be in good shape after Congress and HCFA are done. They will want to have [surety bonds] apply to providers that actually pose a risk."

The saga continues

As for what the future holds, it's anybody's guess, says St. Pierre. "There's no movement at all right now, and there will be no regulation until February. Even then we're not exactly sure where it will go."

At the moment, Department of Commerce staff say Congress is more concerned about moving toward PPS and coming up with a case-mix adjuster rather than focusing on surety bonds.

Howard says she is especially fearful of the future paring of home care and surety bonds. "I am enormously concerned based on the fact that HCFA hasn't entered into a cooperative mode with the home health industry to get the input on what surety bonds meant the last time around.

"I'm concerned they will use the bankruptcy of potentially more than several home health agencies [resulting from IPS] as an excuse to come back with the same model and say, 'See, we told you so.' I think they set us up for this and are going to come back with a very unreasonable situation. We think it's going to take congressional intervention," she adds.

Editor's note: For a look at the findings from the House Government Reform & Oversight Committee's July 22 hearing on surety bonds, go to: www.house.gov/reform/hr/reports/homehealth. ■

SOURCES

William Cadigan, JD, Attorney, MacKelvie & Associates, 333 W. Wacker Drive, Suite 950, Chicago, IL 60606. Telephone: (312) 332-0533.
Ann Howard, Executive Director, American Federation of Home Health Agencies, 1320 Fenwick Lane, Suite 100, Silver Spring, MD 20910. Telephone: (301) 588-1454.
Mary St. Pierre, Director of Regulatory Affairs, National Association for Home Care, 228 Seventh St. S.E., Washington, DC 20003. Telephone (202) 547-7424.

Battle strategies for blizzards

Emergency plans that will weather the storm

When it comes to emergencies such as earthquakes, fires, and tornadoes, no one is ever truly immune. Nor can anyone ever be totally prepared since those phenomena usually strike out of nowhere, leaving you only a few hours or seconds to prepare. The good news is that those kinds of emergencies are fairly rare. However, that's not true when it comes to winter weather emergencies.

If you live in an area that frequently experiences heavy snow or ice storms, having a winter weather emergency plan in place can be invaluable, providing it's the right plan. Here some winter weather experts share their thoughts and tips for coping with subfreezing temperatures and blowing snow.

HCFA, JCAHO require emergency strategies

As both the Health Care Financing Administration and the Joint Commission on Accreditation of Healthcare Organizations require health care agencies to have written emergency plans and procedures in place, it's a good bet your agency has implemented an all-purpose emergency plan. But what some agencies don't have, unless they are in areas such as flood zones, are plans geared to specific emergencies. The variety of disasters precludes tailoring emergency response plans to meet each one.

Having a winter emergency plan, however, is a good idea. After all, most areas in the country are at risk of some sort of winter storm, although the severity of storms may vary. As meteorological conditions vary, so does a community's level of preparedness.

If you are starting the process of designing a winter emergency plan or decide that yours could do with some updating, the best place to start is by asking others for their advise. Consult a panel of emergency experts, suggests **Amy Goldberg-Alberts**, senior risk management analyst with ECRI, a nonprofit international health services research agency based in Plymouth Meeting, PA. She recommends involving people not just from your agency and hospital but from the community at large.

Employees of the local Red Cross, police officers, firemen, and representatives from the local utility companies can serve as an excellent resource and sounding board. After all, coping with disasters is a major part of their jobs. Another good idea, says Goldberg-Alberts, is to include members of the local media in your emergency preparedness planning committee. In the case of a natural disaster, for example, having a media contact can facilitate getting messages out to not only your patients but your staff as well.

Greg Solecki, vice president of home health care for Henry Ford Health System Home Health in Detroit, uses two local AM stations to announce that his agency has shifted to a winter emergency plan and ask that his staff call to check in. "We've picked the stations with the highest power signals. It's my responsibility to make sure we're delivering a consistent message to our staff and patients and letting them know we'll keep them posted as things change."

Know who's who among your patients

Whereas nursing homes and hospitals have their patients all under one roof, home health agencies face the challenge of reaching and communicating with patients and nurses spread over a broad geographic area, some of which may be hit harder than others. In some cases, certain neighborhoods or towns may be nearly impossible to reach physically thanks to unplowed roads and high drifts or, in the case of power outages, by phone or e-mail.

The last thing an agency manager wants to do then is sit down and start sorting through which patients will need ongoing care throughout the winter storm and which patients may be able to wait until the weather has improved. **(See related story on putting your priorities in order, p. 8.)**

Make it a practice to identify all patients upon admission for such factors as susceptibility to extreme temperatures, reliance on any electrically powered equipment, daily medicine needs, and the like. Says **Cynthia Runner-Heidt**, RN, MSN, administrator of Lehigh Valley Home Care and Lehigh Valley Hospital Patient Care Service in Allentown, PA, "We identify urgent care patients. We have to know who's who."

Let your patients know what you're doing and why. In the end, this list can help local authorities should they need to come to the aid of any of your agency's patients. It's a good idea to keep a record on file at the local department

Survival in a Can

The Illinois State Police uses the following emergency kit:

- ✔ A 2- or 3-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 2-inch diameter candle that will be placed under the suspended can to melt snow.
- ✔ A sharp pocket-knife or pair of scissors.
- ✔ Three pieces of bright cloth, roughly 2 inches by 36 inches, to tie to the car antenna and door handles.
- ✔ A small package of peanuts and a small pack of fruit-flavored candy (avoid chocolate.)
- ✔ A pair of cotton athletic socks.
- ✔ A 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 room allows, adhesive bandages, aspirin, and a small radio.

of emergency services; therefore, it's vital that it be kept updated as patients' situations change.

Even meticulous records won't do any good if no one knows you're operating under emergency plans. The key to a successful emergency preparedness plan, says Solecki, is good communication.

When parts of Detroit lost power for three days last year, Solecki and his agency were ready to hit the airwaves — with cell phones and pagers. Solecki, along with the clinical and operations directors, relied on "a well-understood and routinely maintained telephone tree," he says. Together the three directors set the agency's emergency plan into action.

"We knew who to call because we each have updated versions of the telephone tree and organizational charts at home," he says. "The tree is updated every month, and while some months it seems like something you'd just as well skip, I can't tell you how happy I was to have it in my briefcase when the emergency actually hit." To make sure the word trickled to every employee, Solecki's telephone tree requires the last person on the list report to the first.

Because phone service was nonexistent in those areas affected by the power outage, Solecki says he "learned to make sure the tree includes pager numbers, cell phones, and car phones so we could get hold of people in a variety of ways. When I couldn't reach one person on the phone, I paged her."

Agency directors may also want to consider a dedicated information line, such as the one used by Lehigh Valley. "We have a phone tree but don't use the radio to broadcast schedule changes because we don't want to give our patients the idea that we're closing. Instead, we have a dedicated phone line that people can call to get information," says Runner-Heidt. No matter the communication method, she points out, patients and physicians need to be informed of the agency's plans as well.

In Solecki's case it was obvious that his agency should switch to its emergency plan. But when it comes to weather, it's not always so clear.

Runner-Heidt and her staff stay tuned to the radio and weather channels for constant updates on moving storm fronts and road conditions. If you're unsure whether to call a state of winter emergency, determine in advance at what point you will put your plan into action. Will it be when the National Weather Service classifies a storm as a blizzard? Or when the Highway Patrol urges motorists stay off the road?

Prepare both staff and patients

Preparing your patients for a storm is equally as important as preparing your staff. "Let your patients know that their visits may need to be rescheduled because of severe weather," says Runner-Heidt. She also encourages her nurses to help their patients ready their homes for winter.

"We tell [patients] not to let their supply of heating fuel get too low and to keep extra blankets and food on hand," she says. Her staff also teaches self-help skills — such as wound care — to the patients' families so that in a storm they can pitch in to help if aides are unable to make their visits.

Agency staff also need to be reminded of the worth of an ounce of prevention. Runner-Heidt sends out a memo reminding her staff to plan

ahead for winter weather. "I remind them to wear appropriate clothing. People need to wear heavy, insulated clothing — boots, gloves, layers." she says. "They should have ice cleats on hand and the car should be stocked with a shovel and kitty litter. And they should never allow the gas tank to get below half-full." **(See "Survival in a can," p. 7.)**

Runner-Heidt points out that inclement weather can make people do things they otherwise wouldn't do. "You'd be surprised at the number of staff that locked themselves out of the car during winter storms," she says. "They wouldn't be able to find a parking spot and would keep the car running and would end up locking themselves out. They put themselves at risk."

To prevent such incidents, she keeps a log of staff that have four-wheel-drive vehicles and allows for double staffing, so that while one nurse goes into a home to care for a patient, the other can stay with the car.

Runner-Heidt has other ways to ease employee stress. "On a severe weather day, I tell staff they are paid from the time they initiate patient care, which includes phone calls and charting done at home. For those of us who have to stay in the office and work a full day, we keep supplies like food and blankets on hand in case we get stuck."

She allows staff to adjust their hours to allow for digging their cars out of snow, for example, or if icy conditions are predicted for the late afternoon, to reschedule patients so that they are all seen in the morning.

Better safe than sorry, says Runner-Heidt, referring to why she encourages employees to get off the road if they deem conditions are too dangerous. "I will follow what the state police decide. I won't put my employees at risk."

Runner-Heidt is only too familiar with the dangers of winter storms. She has experienced the loss of one of her employees who died when the car she was driving hit a patch of ice and crashed into a tree. The bottom line, she says, is, "You always want to be mindful of caring for your employees." ■

Take time to put your priorities in order

Determining who needs your care the most

In the wake of a natural disaster such as a tornado or flood, some patients are going to be difficult to reach. Having a reliable database is an essential tool to weathering the storm successfully. With the right information, patient care can be prioritized and assigned to aides who either live closest to the patients or are best able to reach them.

Remember, in an emergency it's not important which aide pays a visit, but simply that one does. Take the case of Henry Ford Health System Home Health in Detroit, a city that isn't typically paralyzed by snow, but where it has happened. "In general, it takes a lot of snow to paralyze this town," explains **Greg Solecki**, vice president of Detroit-based Henry Ford Home Health Care. "The snow thing really doesn't throw us for a loop. It takes a lot to keep us home."

While members of Solecki's staff have gone "off-road" to reach patients in need of care, not everyone has access to snowmobiles or four-wheel-drive vehicles. 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, a nonprofit international health services research agency based in Plymouth Meeting, PA, has printed a criterion level developed by the Daughters of Charity National Health System in St. Louis.

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

☐ **Priority one**
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 TPN when there is no available capable caregiver or client cannot perform independently; new referrals already discharged home from a facility with acute needs; Home medical equipment clients on ventilators, or oxygen-dependent and needing STAT delivery.

☐ **Priority two**
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 that are capable of self-care or have a willing

SOURCES

Amy Goldberg-Alberts, Senior Risk Management Analyst, ECRI, 5200 Butler Pike, Plymouth Meeting, PA 19462-1298. Telephone: (610) 825-6000.
Cynthia Runner-Heidt, RN, MSN, Administrator, Lehigh Valley Home Care and Lehigh Valley Hospital Patient Care Services, 2166 S. 12th St., Allentown, PA 18103. Telephone: (610) 402-7300.
Gregory P. Solecki, Vice President, Henry Ford Home Health Care, 1 Ford Place, 4C, Detroit, MI 48202. Telephone: (313) 874-6500.

and capable caregiver and could be coached over the phone (if phones are available); phototherapy clients with Tbili level less than or equal to 15 with a documented downward trend; HME clients needing servicing of apnea monitors, phototherapy equipment, internal feeding pumps or oxygen.

☐ **Priority three**
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 four (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 or basic pediatric nursing care. ■

LegalEase

Understanding Laws, Rules, Regulations

When is home health care appropriate?

By **Elizabeth E. Hogue**, JD
Health care attorney
Elizabeth Hogue, Chartered
Burtonsville, MD

Across the country as the home health industry comes to terms with IPS, agency administrators are doing everything in their power to trim costs and keep budgetary expenses at a minimum. Part of this increased attention to cost-effectiveness has resulted in the spotlight being turned on patients, namely what it will cost to properly care for them. It's not surprising then that one of the most significant issues facing agency managers today is determining whether a patient is even appropriate for home care services.

Making this determination early on is critical for a host of reasons, but perhaps none is more basic — and more obvious — than the simple fact that caring for patients, no matter their status, is extremely costly, utilizing not only financial resources but time and staff energy as well. Now, in light of the reductions in reimbursement for Medicare home care services and the new aggregate beneficiary limits, agency directors cannot afford to take on patients that will act as drain on the agency's precious resources.

Still, it's more than just the depletion of resources that should concern agency managers. There is also the matter of legal liability. By caring for patients that they need not be treating, or worse still, are unqualified to treat, agencies are opening themselves up to an increased chance of being named the defendant in a lawsuit.

Perhaps even more frightening is the very real likelihood that an agency submitting claims for patients who are inappropriate to receive home care will be charged with fraud and accordingly may find itself on the receiving end of both civil and criminal penalties.

Deciding factors

Clearly, determining a patient's appropriateness for home care must be done before an agency agrees to take on the client. When working to assess a potential patient's status, staff should be aware of the possibility that the referring party arranged for home care without being certain that it is what the patient truly needs.

Although it can be difficult for staff to judge a patient's appropriateness, in general a patient is

considered ill-suited for home care if:

• the patient's clinical condition requires services at a different level of care;

• the patient cannot care for himself or herself and there is no reliable volunteer or paid primary caregiver to meet the needs of the patient in between home care visits;

• the patient's home environment will not support the provision of home care services.

In order to receive home care services, a patient must be able to care for him- or herself between home care visits. If they are unable to do that themselves, it may be necessary to hire a primary caregiver or, if they are fortunate, patients may find primary caregivers who will volunteer to take responsibility for the patient's care.

Finding reliable caregivers

No matter the situation, the main criteria is that the primary caregiver be reliable. For example, should primary caregivers be required to care for patients' wounds, staff must speak directly to them about their willingness to provide care that many may find repugnant (especially if the wounds are in the advanced stages).

Granted, it can be extremely difficult for staff to effectively evaluate primary caregivers during the initial assessment. In fact, sometimes all that can be said for certain is that the individual is vertical and breathing. Even so, providers need to work harder at this evaluation than they have in the past.

Evaluation doesn't stop with the patient: Agencies must also evaluate patients' home environments to make certain that they will support home care services. Such an evaluation should take into account the differences in lifestyles and cultures that staff may encounter and that some patients may choose to live differently than the professionals caring for them.

One example is the so-called "path patient" where, because of all the clutter in a home, staff must pick their way along a path from the front door to the patient's room.

Staff members must also be prepared to accommodate religious, cultural, and ethnic differences and realize that these differences are not always barriers to home health services.

The importance of documentation cannot be stressed enough. Exchanges with primary caregivers, home inspections, a change in a patient's status — all should be recorded in the patient's chart.

When it comes to assessing the patient's home, it is important that documentation not be couched in terms of "safety," which can mean anything from the belief that there are too many scatter rugs on the floor which pose as a potential trip hazard to an observation of rats chewing on ventilator tubing. Rather, staff must specifically state that patients' home environments will not support home care services and the precise reasons for this determination.

Once a patient is on board, it is the agency's duty to monitor that person on an ongoing basis to determine whether that status holds true, and should a change occur, agency managers are then justified in terminating services. Although it may be tempting at first glance to continue providing those patients with home care, a second look at this complex issue shows the inherent risks, both legal and financial, in doing so.

Whereas once Medicare-certified agencies operated with a "big tent" mentality, in which all beneficiaries were welcome, this is no longer the case. Now, agencies must be extremely careful about whom they admit and how long they continue services for those patients. When it comes to freedom from malpractice suits, the honeymoon is over for home care providers.

Editor's note: To receive a copy of Preventing Fraud and Abuse, *including information on the issues related to Medicare/Medicaid fraud and abuse, send a check for $25 payable to Elizabeth E. Hogue at 15118 Liberty Grove, Burtonsville, MD 20866.* ■

COMING IN FUTURE MONTHS

- How small agencies are coping with IPS
- Auto expenses: Are agencies still reimbursing for them?
- A look at OASIS scanning software
- OIGs provider self-disclosure protocol

NEWS BRIEFS

OIG conducts Y2K survey

The Office of the Inspector General (OIG), and the Health Care Financing Administration are in the process of conducting a survey examining health care providers' system readiness.

The survey is expected to include approximately 1,000 randomly selected home health agencies as well as hospitals, medical equipment suppliers and others in the health care field. If all goes according to plan, results are due out in March 1999. Once completed, the OIG plans to release the survey itself for use as a compliance assessment tool. ▼

Tenet acquires eight hospitals, university

Santa Barbara, CA-based Tenet Healthcare Corp. has announced the purchase of eight Philadelphia area hospitals as well as that of the Allegheny University of the Health Sciences — all from the Allegheny Health, Education and Research Foundation — in a deal worth an estimated $345 million.

The 3,000-student university, which consists of both medical and nursing schools as well as schools of public and allied health, is to be renamed MCP Hahnemann University of the Health Sciences. It will remain affiliated with the newly acquired hospitals and is due to be restructured as a not-for-profit organization under the management of Drexel University, Tenet officials state.

The eight hospitals, each of which had been operating as debtors in possession under federal bankruptcy laws since July, bring a total of 2,484 licensed beds to the Tenet system in addition to annual revenues of approximately $1 billion. The newly renamed hospitals are: Hahnemann University Hospital (618 beds), Medical College of Pennsylvania Hospital (465 beds), Graduate Hospital (330 beds), City Avenue Hospital (228 beds), Parkview Hospital (200 beds), Elkins Park Hospital (280 beds), Warminster Hospital (180 beds), and St. Christopher's Hospital for Children (183 beds). ▼

Midnight at OASIS

With the deadline for OASIS implementation drawing near, the Health Care Financing Administration (HCFA) has released an estimated time line for OASIS-related activities pending publication of the regulations.

The expectation was that the OASIS User's Manual was to be available for downloading from the organization's Web site by the end of October, while HAVEN software was due out on Nov. 9. (CDs were to be available by Nov. 18.) Several deadlines were slated for December: OASIS regulations would clear the Health & Human Services Secretary and the Office of Management and Budget, and agencies would begin to collect OASIS data with assessments. According to HCFA, the

Hospital Home Healthfi (ISSN# 0884-8521) is published monthly by American Health Consultantsfi, 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**fi, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: custserv@ahcpub.com. World Wide Web: http://www.ahcpub.com. Hours: 8:30-6:00 M-Th, 8:30-4:30 F, EST.

Subscription rates: U.S.A., one year (12 issues), $383. Approximately 18 nursing contact hours annually, $419; Outside U.S.A., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $192 per year; 10 or more additional copies, $115 per year. Call for more details. 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 $64 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultantsfi, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Centers Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@medec.com).
Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Production Editor: **Ann Duncan**, (404) 262-5463.

Editorial Questions

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

submission of test data to the individual states will begin this month, whereas live data transmission will be up and running in February. ▼

America speaks out on Medicare

The results of a survey conducted by the Kaiser Family Foundation and the Harvard School of Public Health were recently released and offer some interesting statistics, among them the fact that 84% of Americans oppose Medicare beneficiaries paying more out-of-pocket expenses, although 64% say they are against increasing payroll taxes to fund Medicare.

Sixty-three percent say they oppose raising the Medicare eligibility age to 67, while 60% of Americans feel that people 62 to 64 years old should be allowed to buy into Medicare early. Managed care isn't a big favorite with those polled: 56% are against encouraging beneficiaries to move into it. Long-term care coverage was favored by 69% of Americans, and almost as many (68%) are for expanding the current benefits package to include prescription drugs. Finally, 48% are against cutting payments to doctors and hospitals. ▼

Join the AHC listserv

Want to stay in touch with other quality managers and discuss such topics as benchmarking, case management, compliance, and documentation? It's easy as reading your e-mail. Just subscribe to one of American Health Consultants' Web-based listserv, which are online forums for health care professionals. Here you will find answers to questions you've asked and maybe some you hadn't thought to ask. Our listservs are provocative, informative, and free!

To subscribe to this free service, send an e-mail to listserv@listserv.com. In the body of the e-mail, type SUBSCRIBE HOMECAREQUAL then type your first name and last name and send the e-mail. If you wish to subscribe to the listserv for private duty home care managers, it's the same process: send an e-mail to listserv@listserv.com. In the body of the e-mail, type SUBSCRIBE HCARENURS then type your first name and last name and send the e-mail. ■

CE objectives

After reading the January 1999 issue of *Hospital Home Health,* CE participants will be able to:

1. State the current status of surety bonds.
2. List ways for agency directors to convince their hospital administration of home health's value.
3. State the criteria a patient must meet before being classified as priority one in case of an emergency.
4. List criteria for determining when a patient is inappropriate for home care. ■