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Higher risk of medication errors for seniors: Home health bigger challenge

Use guidelines specific to elderly, and monitor errors

Each year, more than 200,000 people die and another 2.2 million people are injured due to medication-related problems.[1] Because seniors between the ages of 60 and 65 fill an average of 13.6 prescriptions per year, and that number increases with age, seniors are more susceptible to medication-related problems.[2]

The challenge for home health agencies has been the lack of a systematic approach to monitoring and reviewing medications taken by home health patients, says **Dennee Frey**, Pharm D, project director for the Partners in Care Foundation, a Los Angeles-based, nonprofit organization that helps health care providers create new ways of delivering care. "Medication-related problems for home health patients include a greater risk of falls, confusion, incontinence, and psychiatric problems," she points out.

Frey headed up a research project that took a look at how medication could be better managed for home health patients.

"We started by reviewing the charts of 6,700 patients and discovered that between 19% and 30% had a potential problem with their medications," she says. Because the physiological changes that occur as a person ages can affect how medications are metabolized and medications can cause side effects in a senior that don't occur in a younger person, it is important to have medications reviewed by knowledgeable clinicians, she says.

After identifying the types of problems that can occur, Frey designed a randomized control trial that included agencies using an intervention program that incorporates the use of medication guidelines and access to a consultant pharmacist for home health clinicians. "Medication use improved in 50% of the intervention patients as compared to 38% of the control group patients," Frey says.

Because medication management skills vary among home health clinicians, the intervention project developed guideline software that enables the clinician to input the complete list of medications used by the patient. The software flags medications that may interact or create an unwanted side effect and alerts the consulting pharmacist. The nurse

and pharmacist discuss the medications and alternatives, and then the nurse contacts the patient's physician to suggest changes if needed, Frey says.

"Our nurses see the guidelines and access to a pharmacist as a great resource that can improve their clinical skills," says **Joan M. Marren**, RN, chief operating officer of the Visiting Nurse Service of New York in New York City, a participant in the pilot project. "Home health nurses don't have easy access to the patient's physician, and the patient may have multiple physicians prescribing medications. Also, our long-term home health patients average eight medications per patient, so it is difficult to monitor potential side effects," she adds.

"We used to rely upon our drug reference book but it doesn't always tailor side effects to the elderly," Marren says. By using the pen-tablet computer and software that are tailored to identify problems specific to elderly people, nurses can identify potential problems, she says. "The book is still used for extra reference, but the nurses like the software and the pharmacist backup."

Medication is one of the first areas that should be reviewed carefully if your patient experiences a fall, Frey says. "Mrs. Jones may be on several blood pressure medications that contributed to her fall." Often, a review of medications will identify duplicate medications, she adds. "The patient may have a generic and a brand name of the same drug and be taking both without realizing it," she says.

Patient education may be all that is needed in some cases, Frey points out. The physician may have never intended the patient to take two blood pressure medications, but the patient may not have realized that a new prescription was to be used in place of a previous prescription, she says.

"In our chart review, we discovered a lot of older patients taking benzodiazepine for anxiety or insomnia," Frey says. These patients were at a higher risk for falls and to develop confusion than patient not on these drugs, she adds. All psychotropic drugs increase a patient's risk for confusion and falls, she adds.

Even if the patient's physician changes the medications or decreases the dosage, you have to be sure to educate the patient as to the reasons for changes, Frey says. Not all patients understand that fewer medications may be better for them, she says. "In the case of psychotropic medications, the patient may have become habituated

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.

17. According to Dennee Frey, what is one challenge to medication management for elderly patients?
    A. Patients don't refill their medications in a timely manner.
    B. Older people metabolize medication differently than younger people, creating different side effects or interactions.
    C. Patients only will take medications at meal time.
    D. Patients think their medications all look the same.

18. Home health clinicians have to be careful when documenting suspicions of abuse or testifying at hearings, says Elizabeth E. Hogue. What does she recommend?
    A. Have another staff member corroborate your suspicions.
    B. Offer opinions only if you have many years of experience in home health.
    C Keep extra copies of your report in a safe place at your home.
    D. Limit your comments to what you saw or heard.

19. Tom Boyd recommends which cost-saving tip?
    A. Consider scheduling some nurses for weekend and evening visits.
    B. Ask nurses to work overtime to reduce total number of staff needed.
    C. Choose an insurance agent that represents only one firm.
    D. Offer employees a fixed dollar amount for travel expenses.

20. What is the main reason a home health agency might not file a Significant Change in Condition claim, according to Judy Adams?
    A. There is too much paperwork involved in the claim process.
    B. Reimbursement for a combination of service levels will be lower than one service level.
    C. The patient's condition improved rather than declined.
    D. Billing software won't handle the filing.

and may not want to give up the drug."

Medication errors also exist when the medication is given by IV pump, according to **Barbara Rosenblum**, president of Strategic Healthcare Programs in Santa Barbara, CA, a health care benchmarking firm. Her company has looked at IV medication errors and the reasons for those errors.

Using data from more than 300 home health agencies that use the same software, Rosenblum found a total of 1,154 IV medication errors between Jan. 1, 1999, and Dec. 31, 2001. **(See the statistical breakdown, at right.)**

Of these errors, 24% were related to pump programming errors, Rosenblum says. The reasons for medication errors due to pump programming errors ranged from wrong dosages or frequencies to wrong durations. Wrong dosage was cited as the reason for medication error when pump programming errors were involved most often 113 times or 41% of the total, during the three-year period, she says. This is significantly higher than the wrong dosage category for IV medication errors that were not due to pump programming errors, Rosenblum says. Out of 877 IV medication errors not due to pump programming errors, 222 or 25% of the total were due to wrong dosage, she says.

Although the problem has been identified through the benchmarking information, the solutions to the problems may differ from agency to agency, she adds.

"We've heard from our clients that a variety of approaches have to be taken to address the problem of pump programming errors," Rosenblum says.

Some of the solutions include:

- **Evaluate the IV pump.**
  Some pumps are less complicated to program, she says. Consider having more than one pump available to enable a choice that can be made on a case-by-case basis depending on the nursing experience, complexity of programming, patient location, and competence of family members, she suggests.
- **Provide quarterly training updates.**
  Don't rely on a once-a-year review of the clinicians' pump programming knowledge, Rosenblum advises. Training sessions should occur quarterly and focus on dosage, frequency, and rate, she says.
- **Designate specific nurses to program pumps.**
  If you limit pump programming to a select group of nurses, you can make sure more easily that each nurse is trained and up to date

IVs and Medication Errors

DOSAGE AND FREQUENCY MOST COMMON ERRORS FOR IV DRUGS

The total number of IV medication errors reported by more than 300 home health agencies in a three-year study conducted by Santa Barbara, CA-based Strategic HealthCare Programs was 1,154. In both categories of errors due to pump programming errors and errors not due to pump programming errors, wrong dosage and wrong frequency were the most common errors.

Total number of med errors from Jan. 1, 1999 to Dec. 31, 2001:	1,154
The number of all IV medication errors not due to pump programming:	877 (76%)
The number of all IV medication errors due to pump programming errors:	277 (24%)

REASONS FOR ERRORS NOT DUE TO PUMP PROGRAMMING

(Editor's note: Categories for types of medication errors changed in 2000, so some of the categories in 1999 were not collected after 2000 and vice versa.)

Medication given to wrong patient	6 (0.7%)
Other	105 (12%)
Wrong dosage	222 (25%)
Wrong dosage; wrong frequency	7 (0.8%)
Wrong duration	42 (4.8%)
Wrong frequency	224 (25.5%)
Wrong medication	75 (8.5%)
Wrong preparation of dose	162 (18.5%)
Wrong rate	21 (2.4%)
Wrong route	11 (1.3%)
Wrong route; wrong frequency	2 (0.2%)
Total	**877**

REASONS FOR ERRORS DUE TO PUMP PROGRAMMING

Other	11 (4%)
Wrong dosage	113 (41%)
Wrong dosage; wrong frequency	6 (2.2%)
Wrong dosage; wrong rate	3 (1%)
Wrong duration	25 (9%)
Wrong frequency	72 (26%)
Wrong preparation of dose	9 (3.2%)
Wrong rate	38 (13.7%)
Total	**277**

on each pump, Rosenblum says.

Most importantly, make sure you create an environment that fosters reporting of medication errors, she says. "Historically, error reporting has been punitive, but we have to make sure that employees feel comfortable reporting errors so our processes can be reviewed . . . to prevent further errors," she points out.

Now, all health care agencies are realizing that it is difficult to protect patient safety when employees are afraid of reporting errors, Rosenblum adds.

Frey's organization has developed a tool for home health agencies to help them avoid medication errors. "We used the information and experience from our trial studies to develop a series of free web-based tools that home health agencies can use to better manage their patients' medications," she says.

The web site (www.homemeds.org), scheduled for launch at the end of July, as we go to press, offers guidelines, drug protocols, cost/benefit information, and technical assistance, she says.

Frey also plans to include monthly chat sessions and miniseminars through the site to provide ongoing assistance and information exchange among participants.

Both Frey and Rosenblum explain that addressing the issue of medication errors is not a simple task, but benchmarking, reviewing practices, and using available tools to improve management of medications will improve patient safety.

[For more information about medication management programs and benchmarking, contact:

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1. Ernst FR, Grizzle AJ. Drug-related morbidity and mortality: Updating the cost-of-illness model. *J Am Pharm Assoc* 2001; 41:192-199.

2. American Association of Retired Persons. *Issue brief.* Washington DC; 1991. ■

Spotting patient abuse: Signs can be easy to miss

Policies and training protect patients and agency

There is no food in the refrigerator, so the home health aide comments that it is time to go grocery shopping. "Oh no. Sybil takes care of that for me," says the patient. When the aide asks what the patient means about Sybil, her daughter, taking care of grocery shopping, the patient responds, "I give her $500 each week, and she brings me what I need."

$500 for one person with no food in the refrigerator may indicate financial abuse of this patient. What is the home health staff member's responsibility at this point?

"Financial abuse is the most difficult type of abuse for home health workers to identify because it takes months for signs of the abuse to develop," says **Forrest Hong**, PhD, LCSW, director of training and education at LivHome, a home care provider in Los Angeles.

"A well-trained home health worker will notice things like unpaid bills, lack of groceries, discussion about a change in a will, and the patient's defensive or protective behavior about the family member or other caregiver who is supposed to handle finances," he says.

Whether it's financial, physical, emotional abuse, or even neglect, if a home health worker suspects abuse, it must be reported within 24 hours according to California statutes, Hong says.

"Our agency policy gives our staff members 10 hours to report their suspicions to their supervisor, then agency personnel help the staff member complete the paperwork and ensure the report is made properly," he says. In California, if a staff member who provides service to a client does not report a suspicion of abuse, it is a misdemeanor with a jail sentence of six months or a fine, he adds.

"It is mandatory that every home health agency have a policy that addresses reports of client abuse and that the policy follows state statutes," says **Elizabeth E. Hogue**, an attorney based in Burtonsville, MD.

While agency management cannot serve as a screening tool to determine whether the report should be filed, most home health agencies

(Continued on page 90)

Is Patient Suffering Abuse?

Know the warning signs

While abuse of a home health patient may be subtle and difficult to identify in one or two visits, home health clinicians need to recognize the different types of indicators that may represent abuse. The following indicators, by themselves, do not necessarily signify abuse or neglect. They may be clues, however, and thus helpful in assessment of abuse.

Possible indicators of physical abuse

- Cuts, lacerations, puncture wounds
- Bruises, welts, discoloration
- Any injury incompatible with history
- Any injury that has not been properly cared for (Injuries are sometimes hidden on areas of the body normally covered by clothing.)
- Poor skin condition or poor skin hygiene
- Absence of hair and/or hemorrhaging below scalp
- Dehydration and/or malnourished without illness-related cause
- Loss of weight
- Burns that may be caused by cigarettes, caustics, acids, friction from ropes or chains, or contact with other objects
- Soiled clothing or bed

Possible indicators of psychological/emotional abuse

- Helplessness
- Hesitation to talk openly
- Implausible stories
- Fear
- Withdrawal
- Depression
- Denial
- Confusion or disorientation
- Anger
- Agitation

Possible indicators of financial abuse

- Unusual or inappropriate activity in bank accounts
- Signatures on checks that do not resemble the older person's signature, or checks signed when older person cannot write
- Power of attorney given, or recent changes or creation of will, when the person is incapable of making such decisions
- Unusual concern by caregiver that an excessive amount of money is being expended on the care of the older person
- Numerous unpaid bills or overdue rent, when someone is supposed to be paying the bills for a dependent elder
- Placement in nursing home or residential care facility that is not commensurate with alleged size of estate
- Lack of amenities, such as TV, personal grooming items, appropriate clothing, that the estate can well afford
- Missing personal belongings such as art, silverware, or jewelry
- Deliberate isolation, by a housekeeper, of an older adult from friends and family, resulting in the caregiver alone having total control

Possible indicators of neglect by caregiver

- Dirt, fecal/urine smell, or other health and safety hazards in elder's living environment
- Rashes, sores, lice
- Elder inadequately clothed
- Elder malnourished or dehydrated
- Elder with an untreated medical condition

Possible indicators of abuse from caregiver

- Elder not given the opportunity to speak for him or herself, or see others, without the presence of the caregiver (suspected abuser)
- Attitudes of indifference or anger toward the dependent person, or the obvious absence of assistance
- Family member or caregiver blaming elder inappropriately (e.g. accusation that incontinence is a deliberate act)
- Aggressive behavior (threats, insults, harassment) by caregiver toward the elder
- Previous history of abuse to others
- Problems with alcohol or drugs
- Inappropriate display of affection by the caregiver
- Flirtations, coyness, etc. as possible indicators of inappropriate sexual relationship
- Social isolation of family, or isolation or restriction of activity of older adult within the family unit by caregiver
- Conflicting accounts of incidents by family, supporters, or victim
- Unwillingness or reluctance by the caregiver to comply with service providers in planning for care
- Inappropriate or unwarranted defensiveness by caregiver

Source: Reprinted with permission. *Elder Abuse Prevention*, 1000 MacDonald Ave., Suite C, Richmond, CA 94801. Telephone: (510) 233-3427. Fax: (510) 233-3459. Web site: www.oaktrees.org/elder.

require a clinician to report the suspicion to a supervisor so that the agency knows what is being reported and makes sure it is reported accurately and in a timely manner, Hogue says.

In almost all cases, the initial report to the state agency is verbal with a written report faxed after the verbal report, she says. "Make sure your documentation and your written report is specific and focuses on direct observations," Hogue says. "If a clinician suspected that the caregiver was not changing a bed-bound patient's diapers as often as necessary, the clinician might clean and change the diaper and mark an "X" on one of the tabs at one visit," she suggests. "At the next visit, if the same diaper, with the "X" is still on the patient, it's a clear indication that the caregiver is not giving the patient proper attention," she says. The report would describe the actions taken by the clinician to determine if the diaper was changed and the clinician's observations on the second visit, she adds.

"Even after a report is filed, we will send a case manager or social worker to visit the caregiver and patient," says Hong. Some observations of neglect may be a lack of understanding on the caregiver's part or an inability of the caregiver to provide the care needed, he says. In these cases, other resources are evaluated to help the caregiver, he says.

Document suspicions

It's important that all home health staff members understand that proper documentation and reporting of abuse may in fact protect them from the same allegations, says Hogue. "If the patient develops eight stage-four pressure ulcers, is it because the home health agency did not monitor the patient and develop an appropriate care plan, or is it because the family caregiver never turned the patient?" she asks. To defend against these questions, nurses need to document how often they move the patient and whether or not the patient is always in the same position when they visit, she adds.

If no action is taken to talk with the caregiver and document the observations of the clinicians, the family members could say the home health agency caused the ulcers as a result of improper care, she says.

Even if you have a clear policy regarding reporting abuse, make sure your staff members understand the policy and that they have received some training related to identifying potential abuse, Hong says. "I suggest using a variety of methods, including updates in newsletters, classes, and reports at staff meetings," he says. "We also require all employees to read our policy on elder abuse and sign it to indicate they understand," he says.

There are several types of abuse and each type has specific indicators that should alert clinicians to the potential for abuse, Hong says. **(See indicators, p. 89.)** Only the most severe cases of abuse can be identified in one or two visits, so Hong says that clinicians need to stay alert to patterns that might represent abuse. His area of special

Resources on Abuse

For more information and resources to help you identify abuse and develop policies, contact the following organizations:

- **National Center on Elder Abuse**, 1201 15th St., N.W., Suite 350, Washington, DC 20005-2800. Telephone: (202) 898-2586. Fax: (202) 898-2583. E-mail: NCEA@nasua.org. Web site: www.elderabusecenter.org. The web site contains fact sheets, publications, caregiver resources, state statutes, research, and links to other resources on elder abuse.

- **National Committee for the Prevention of Elder Abuse**, c/o Amie Cloutier, Matz, Blancato & Associates, 1101 Vermont Ave., N.W., Suite 1001, Washington DC, 20005. Telephone: (202) 682-4140. Fax: (202) 682-3984. E-mail: acloutier@erols.com. The organization offers a variety of publications including, *Trainer's Manual: Elder Mistreatment: Ethical Issues, Dilemmas, and Decision-Making*, that can be purchased for $25. Other publications for sale are displayed at www.elderabusecenter.org/publication/ncpea.html.

- **Clearinghouse on Abuse and Neglect of the Elderly** (CANE), Department of Consumer Studies, University of Delaware, Newark, DE 19716. Telephone: (302) 831-3525. Fax: (302) 831-6081. E-mail: cane_ud@udel.edu. The organization offers the nation's largest computerized collection of elder abuse resources and materials. With more than 3,000 holdings, CANE is able to perform customized searches of more than 100 keywords, producing annotated bibliographies available to the professional communities and the public. To reach the clearinghouse, go to www.elderabusecenter.org/publication/cane.html.

interest is financial abuse of older people by family members or friends who offer to help with their financial obligations, Hong says.

The only way a home health worker will learn about this type of abuse is by developing a relationship in which the patient trusts him or her enough to talk about things in the patient's life, he says. "If patients express concern that they no longer have access to their money, or that they don't understand a new will they have signed, or if personal items in the home are missing, there is a need for further investigation," Hong says.

Home health employees may be reluctant to report abuse because they often continue to see the patient, he says. "These reports are confidential, and they are important to protect patients and home health workers," he adds.

A good, clear policy on accepting gifts or additional cash from patients or their family members is another protection for the home health agency when it comes to financial abuse, Hong says.

"Our policy is that no employee can accept cash or gifts from a patient or family member. We are their employer, not the family, so it is not appropriate for the family to offer any type of bonus," he says.

Prepare carefully for testimony

If the report results in a hearing, be careful about your testimony, Hogue says. "Attorneys like to call home health workers to the stand and treat them as expert witnesses who can offer opinions," she says. "If you are called to report what you witnessed, be sure to answer questions with statements that begin with, "I saw this, or I heard this," she says. Avoid offering opinions as to whether or not the situation you observed constitutes abuse, and don't offer opinions as to why the situation occurred or what may have happened when you weren't there, she adds.

The most important thing to stress to employees is that there is no liability for the reporter if the report is made in good faith, says Hogue. She adds, "If it is documented well, actual observations are reported, and the report is not made in anger, the staff member and the agency are protected from liability."

[For more information about reporting abuse, contact:

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Examine staff costs to help bottom line

Happy employees can reduce costs

(Editors note: In this second part of a two-part series on cost-cutting strategies, we discuss travel and staff costs. In last month's issue, we discussed cost-cutting strategies for supplies and overhead.)

As every home health manager looking for ways to cut costs knows, staff costs make up a major part of any home health agency's expenses.

Because staff costs are a major expense for every agency, **Tom Boyd**, MBA, principal at Boyd & Nicholas, a Rohnert Park, CA-based financial consulting firm that specializes in home care, suggests that agencies look carefully at that area.

"Find ways to keep your staff motivated and happy, so you have a stable staff and don't have to spend money on recruitment and training," he says. **(For tips on effective recruitment and retention, see "Effective recruiting = successful retention," *Hospital Home Health*, March 2002, p. 29.)**

"Many health care employees leave because of the overwhelming paperwork and constantly changing regulations and requirements of their jobs," Boyd says.

Help employees deal with these by making more educational seminars that are easy for them to attend such as audio or teleconferences, offer contact with a clinical consultant who can answer their questions, install user-friendly software for all clinical applications, and limit responsibility for Outcome and Assessment Information Set (OASIS) documentation to certain staff people, he suggests.

Take a look at your benefits, Boyd says. Stretch out the period of time in which new employees become eligible for benefits, he says. "For example, instead of having a new employee eligible for health benefits after 30 days, make it 60." In addition, cut the cost of health insurance by dropping dependents, implementing a copay, creating a

higher deductible, or offering a health maintenance organization," he says.

It is very important to use an insurance broker who represents a variety of products and is not tied to just one company or one product, Boyd says. This will give you more flexibility in designing your health benefits program, he explains.

Scheduling can be another area in which your agency can control costs, Boyd says. "Both rural and metropolitan agencies need to schedule a clinician's visits based upon geographic location." This cuts down on travel time and enables a clinician to visit more patients in the day, he adds.

One tip Boyd offers from one of his clients is to ask employees to list odometer readings on their expense reports rather than total number of miles. If you just ask an employee to list a number of miles, the number may be an educated guess, or may include errands run on the way to a patient's home, he says. His client's agency asked employees to write down odometer readings as a way of obtaining more accurate expense reports, he says. "The amount of money spent on transportation went down as employees had to become more precise in their record keeping."

Evaluate the days and hours your clinicians work, Boyd suggests. "Some nurses prefer working after hours or on weekends because their spouse is home to care for children. This means the nurses are not dealing with traffic jams and can see patients for whom the day of the week doesn't matter."

Not only does this free up the time of weekday nurses to see new patients, but it also gives employees a chance to choose a work schedule that fits their personal schedule and increases employee satisfaction, he adds.

[For more information about cost-cutting tips, contact:

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To file or not to file: SCIC is hard to define

Evaluate claims on financial and clinical basis

Most home health workers have heard the definitions of Medicare's significant change in condition (SCIC). Simply stated, it is any unexpected improvement or decline in the patient's condition, or a change in the treatment plan. But identifying a SCIC situation and deciding whether to submit a SCIC adjustment for reimbursement is not a simple process, say experts interviewed by *Hospital Home Health.*

Home health agency staffs are confused about whether or not to file SCICs because there are no clear definitions of what "significant" means, says **Mary St. Pierre**, BSN, vice president of regulatory affairs and membership services for National Association for Home Care (NAHC) in Washington, DC. "If you look at the situation logically, any change in the treatment plan is unexpected, so that would make it significant," she explains.

Because there is no standard definition for a significant change and the reassessment that must occur, it is left up to each agency to define the situations in which a patient must be reevaluated, says **Judy Adams**, RN, BSN, consultant with Larson Allen Health Consulting in Charlotte, NC. Because assessments are conducted at the initiation of service, transfer to hospitals, transfer back to home health, and every 60 days for recertification, home health staff members have trouble keeping up with extra assessments, she says.

"Agencies wrote policies that specify the addition of a therapy service, the development of a new wound, or a combination of Outcome and Assessment Information Set (OASIS) factors to define a decline in condition," Adams explains. The problem with identifying a wide range of factors that initiate a SCIC assessment is that it becomes too difficult for staff members to follow, so the policy isn't followed, she adds. "It's better for an agency to write a simple policy that is easy to follow so you don't get into accreditation or regulatory trouble for not following policies," she says.

Basically, if there is a change in the OASIS score that was not anticipated at the beginning of care, if new physician orders that alter treatment were not anticipated and if the new OASIS code changes the grouper code, you can qualify for a SCIC claim, Adams says. Even if you can file a SCIC claim, the real issue is whether you want to file the claim, she adds.

Filing a SCIC claim isn't mandatory if the patient's condition declines, Adams points out.

It is mandatory if the patient's condition improves and the home health agency is using fewer resources for the patient's care, she says.

Why wouldn't an agency file for a payment adjustment if more resources are required to care for the patient? To understand, it's important to think about how the payment is calculated, St. Pierre says.

For example, you may have a diabetic patient that you have planned to see for 10 visits over 20 days. You see the patient for the initial assessment and a second visit at five days. On the third visit, at the 10-day point, the patient's blood pressure is out of control and requires a change in medication by the physician. An adjusted payment would be calculated as payment for five days of service in the original grouper, no payment for days six through nine because there were no visits, and payment for days 10-20 in the new grouper, St. Pierre explains.

Because Medicare payments are based on 60-day episodes, you would receive a total of 5/60 of the payment on the first grouper and 11/60 of the payment on the second grouper. Financially, this may not be as much as the payment you would have received if you just filed the entire episode under the first grouper, she explains.

The key to determining if it is financially feasible to file a SCIC claim is to look at when the change in condition occurred and what extra resources are needed, Adams says. "Ninety-five percent of the changes in condition occur as a result of a hospital admission. This means that the home health agency will not receive any payment for those days and that may be a significant enough drop in payment that it is better to file the claim with the original grouper," she says.

The best way to evaluate whether or not you should file a SCIC is to review changes in OASIS status from both a clinical and financial perspective, Adams says.

"Some billing software programs automatically file the SCIC if there is a change in condition without giving the agency a chance to decide if SCIC is the best way to proceed," she says. For this reason, you need to make sure you can override the automatic adjustment feature if necessary, she adds.

Adams recommends that one or two people with a combination of clinical and financial expertise be responsible for reviewing all charts in which there is a change in OASIS codes before claims are filed. "By using software such as CMS [the Centers for Medicare & Medicaid Services] Pricer Software, which can be downloaded from the CMS web site for free, the reimbursement for both codes can be evaluated, and an informed decision can be made as to whether . . . to file a SCIC," she says.

[For more information about SCIC claims, contact:

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For additional resources, visit these web sites:

- ***www.hcfa.gov/medicare/nm75ght/pricdnld.htm**. CMS publishes a PC version of the Pricer software that calculates claim payments under the home health prospective payment system. The free software is available via download at this site. CMS updates the download file of the current year PC Pricer quarterly to reflect the most current changes.*
- ***www.hcfa.gov/medicare/hhqanda.htm**. The web site, sponsored by CMS, answers frequently asked questions and groups answers by topic. Go to web site and choose SCIC for answers to questions related to significant change in condition.]* ■

LegalEase

Understanding Laws, Rules, Regulations

How can you tell who is right for home care?

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Both Medicare-certified and private-duty home health agencies must manage their patient mix in order to be economically viable. Thus, all home health agencies carefully must control admission and continuation of services.

Admitting patients who are not appropriate for home care gobble up resources with an ultimate adverse effect on the ability of Medicare-certified

agencies to provide care at a cost that is below the episodic payment and on the bottom line of private duty agencies. In addition, providing services to patients who are inappropriate for home care enhances the likelihood of legal liability in this so-called litigious society.

Consequently, staff must evaluate every patient for general appropriateness for home care services before they are admitted. Just because patients meet the criteria of payer sources, such as the Medicare, does not mean that they should be admitted.

Likewise, patients continuously must be monitored in terms of these criteria. Patients who fail to meet one or more of the criteria prior to admission should not be admitted. Services should be discontinued to patients who met these criteria upon admission but no longer meet them later.

To be appropriate for home care services, patients must continuously meet the following criteria:

- The patient's clinical needs can be met at home.
- The patient could take care of him or herself, or there is a paid or voluntary reliable primary caregiver to meet the needs of patients, in between home care visits.
- The patient's home environment supports home care services.

The ability of home care providers to care for medically complex patients has been greatly enhanced in recent years. As a result, it is rare that the clinical needs of patients cannot be met at home. These rare instances may involve, for example, patients who are prematurely discharged from an institutional setting. In addition, patients must be able to self-care or there must be a paid or voluntary reliable primary caregiver prepared to meet the needs of patient when agency staff members are not present. Staff may encounter significant difficulties with this as follows:

- When staff members evaluate patients for admission, they certainly will identify a potential primary caregiver. But realistically speaking, about all they can tell about potential primary caregivers during the admission visit is that they are vertical and breathing. The competence and reliability of primary caregivers only can be assessed over a period of time.
- Staff members often are working uphill against the expectations of patients and their families. Specifically, discharge planners in institutional settings are under so much pressure to move patients out of the institution that they rarely explain to patients and their families what their role in home care must be. Because of this, patients often are referred to home care with the expectation that nurses will take care of everything, just like they did in the institution. This expectation further is enhanced by the general lack of understanding by many patients and their families about home care. In addition, in the face of illness, it is only human for vulnerable patients and families to want agencies to simply step in and take care of everything.
- In addition, some of the tasks that primary caregivers may be expected to perform are repugnant to them. The "big three" such tasks are: wound care, changing diapers, and giving injections. When these tasks are involved, the reliability of primary caregivers may be sorely tested.

Identifying capable primary caregivers

What can agency staff do to increase the likelihood that they can identify capable, reliable primary caregivers?

- During the admission visit, staff should be direct with primary caregivers about the role they must play. They further must make it clear that if primary caregivers fail to fulfill their role, services may be discontinued. This very direct discussion and potential primary caregivers' agreement or refusal to perform required tasks must be documented.
- If it appears that there is a reliable caregiver and the patient is admitted, staff must continue to monitor for reliability. Staff specifically must document every instance of noncompliance by primary caregivers. It is not sufficient to document that the caregiver generally is noncompliant. Rather, staff must document specific instances of noncompliance. Then staff must reteach primary caregivers and, if appropriate,

get a return demonstration that also must be documented. This process should encourage reliability by caregivers.

Finally, the patient's home environment must support home care services. Documentation related to this issue often is provided in the form of safety in the patient's home.

The term "unsafe" is vague and can mean everything from too many scatter rugs on the floor to rats gnawing on intravenous tubing. So staff members should be careful to document that the patient's home environment will not support home care services for specific reasons.

Home care providers must, however, be cautious with regard to assessment of this point. First, there are many people who choose to live differently than home care staff.

So-called "path patients" illustrate this point. There is so much rubble and debris in the patient's home that workers can only pick a path from the front door to the patient's bedside. These patients, however, are not necessarily inappropriate for home care services.

In addition, our society increasingly is diverse. Home care providers must be prepared to accommodate this diversity without drawing erroneous conclusions about the appropriateness of patients' home environments.

Staff members who provide services to patient on tribal lands or Indian reservations have encountered instances when patients and their families refused to answer the door when they knocked.

Staff later learned that it was the custom in those tribes for visitors to wait in their cars until they were acknowledged in some way such as the raising of a shade or the opening of a door before they walked to the door of patients' homes. These were not homes that would not support home care services. Rather, these were cultural and ethnic differences that must be accommodated by home health providers.

When patients meet all of these criteria, it is appropriate to admit them for services. Patients who no longer meet them are not generally appropriate for home care, and services may be discontinued. Agencies ignore these criteria at their own risk.

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NEWS BRIEFS

Dialysis in the morning increases length of life

Elderly patients with renal failure who undergo dialysis treatment in the morning live more than a year longer than patients who receive treatment in the afternoon, according to a group of researchers at Emory University in Atlanta.[1]

The researchers followed 242 patients, ages

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60 and older, for 11 years or until the patients died.

The patients underwent treatment at 59 dialysis centers in different areas of Georgia. Of those patients, 167 were seen during the morning and 75 were seen in the afternoon.

"Patients who received dialysis during the morning survived, on average, for 941 days after entering the study compared to 470 days for patients receiving dialysis during the afternoon," says **Kathy Parker**, PhD, RN, associate professor of nursing at Emory University School of Medicine and co-author of the paper.

"To our knowledge, this is the first time an association between renal failure and time-of-day treatment has been studied," says **Donald Bliwise**, PhD, associate professor of neurology and co-author of the study.

Reference

1. Bliwise DL, Kutner NG, Zhang R, Parker KP. Survival by time of day of hemodialysis in an elderly cohort. *JAMA* 2001; 286:2,690-2,694. ▼

CDC: Vaccinations for tetanus can resume

Routine vaccination against tetanus and diphtheria can resume now that supplies of the vaccine have increased.

In May 2001, the Centers for Disease Control and Prevention (CDC) in Atlanta recommended that routine booster doses be deferred due to a shortage that occurred when one manufacturer stopped making the vaccine.

Aventis Pasteur in Swiftwater, PA, the sole manufacturer of tetanus and diphtheria toxoids adsorbed (Td) for the U.S. market, has produced enough of the vaccine to enable the CDC to rescind the recommendation.

The CDC's Advisory Committee on Immunization Practices recommends that adolescents and adults receive a booster dose of Td every 10 years.

According to a report published in the May 7 *Annals of Internal Medicine*, about 53% of U.S. adults in 1988-1994 lacked sufficient antibodies to tetanus and diphtheria to protect against those diseases. ■

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. ■