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the monthly update for executives and health care professionals

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Tumbles cause more than just a few bruises: Spot patients at risk for falls

Reduce falls with thorough assessment for risk

The statistics are alarming:

- One out of every three people over the age of 65 falls each year.[1]
- Among people age 65 and older, falls are the leading cause of death due to injury and serious injury.[2]
- Of people older than 65 who fall, 10% to 25% suffer a serious injury such as hip fractures.[3]
- Between 15% and 25% of hip fracture patients will die within a year of their injury.[4]
- Half of older adults hospitalized for hip fractures do not return to their prior level of function.[5]

These statistics and a desire to reduce the number of falls experienced by her agency's patients were the impetus for **Linda J. Coccia**, BS, OT, occupational therapist at Adventist Home Health Care and Hospice in Hanford, CA, to develop a falls risk assessment program. "We are dealing with patients who are at risk for falls because of their age, the medications they take, and their physical illnesses," Coccia says. "We can minimize the risk with early identification of patients who are more likely to fall," she adds.

Audio conferences tackle critical compliance issues for sharps safety, pain management

Don't run the risk of fees or losing your accreditation

Health care organizations today are challenged by more than just providing quality patient care. Compliance issues can create headaches for facilities that aren't prepared. How well does your facility meet certain regulations? Are your staff properly armed with the most up-to-date information? To help you prepare, American Health Consultants offers two upcoming audio conferences dealing with current, hot-topic compliance issues: pain management and needle safety.

(Continued on page 106)

After researching the factors that contribute to falls, Coccia worked with other home health staff to develop an assessment tool for the nurse to use on the admission visit. "You have to look at several factors when assessing risk," she says. "We look for history of neurological problems, diabetes, or stroke, as well as medication use, emotional status, and the environment," she adds.

Some of the factors that increase the risk of falls include:

• **Use of multiple medications, or medications such as psychotropics, sedatives, hypnotics, diuretics, or anti-hypertensives.** Combinations of medications or the use of some medications can cause dizziness, Coccia explains. When that is a problem, the nurse usually works with the physician to review the patient's prescriptions and make changes, she adds. **(*Hospital Home Health*, August 2002, p. 85.)**

• **Incontinence.** "Patients who are incontinent may rush to the bathroom or may slip on urine on the floor if they had an accident before reaching the bathroom," points out Coccia. In this case, nurses and occupational therapists can work together to address the patient's needs, even adding a bedside toilet if necessary, she says. **(See *HHH*, July 2002, p. 77.)**

• **Sensory deficit such as vision or hearing problems.** If patients can't see where they are going, they might trip on the edge of rug, or something lying on the floor, Coccia points out.

• **Previous falls.** According to the National Center for Injury Prevention and Control in Atlanta, an older person who falls once is two- to three-times more likely to fall again within a year, she says.

• **Fear of falling.** One factor that affects a person's overall quality of life in addition to increasing the risk of falling is fear of falling, says **Pamela Toto**, MS, OTR/L, BCG, an independent occupational therapist who works with Family Home Health Services in Pittsburgh. One-third to one-half of older people have a significant fear of falls even if they've never fallen, she says.

Because these people then limit their activities to avoid any risk of falling, they actually increase their risk because their limited activity increases the likelihood that they will lose balance, she adds.

Her agency's form clearly identifies factors that contribute to the risk of falls and assigns point values to each factor, Coccia says. **(See Falls Risk Assessment Tool, p. 100.)** "If a patient scores three or higher, physical therapy and occupational therapy are brought in to assess the patient," she says. There are some factors, such as unsteady gait, sensory deficit, history of falls, and diagnoses that contribute to unsteady gait, that warrant immediate referral to physical and occupational therapy, she adds.

The assessment form developed by Toto, measures the same factors but does not assign a point value. "The nurse uses the responses to the 13 questions and clinical judgment to rate the patient's risk of falling as low, medium, or high," she explains.

Environmental safety in the patient's home is an important aspect to evaluate, but it is not the predominant cause of falls, points out Toto. "We spend a lot of time and energy with home safety checklists," she says. "They should not be eliminated, but we need to be sure to point out to nurses and family caregivers that addressing items on the checklist is just part of what we have to do to protect the patient," she says.

Toto also points out that there are several mobility tools for assessment that are not designed just for occupational and physical therapists to use, although therapists are the ones to administer the tests in most cases. "Both the timed 'Up and Go' test[6] and the Tinnetti Balance and Mobility Assessment[7] are fairly straightforward and easy to use," she says. Her agency allows therapists to choose whichever test they prefer when asked to assess a patient's mobility and risk of falling, she adds.

The key to success in developing a falls risk assessment program that works is to be realistic, Toto says. "Staff members had mixed feelings about the program when we introduced it because nurses believed that they already knew how to identify patients at risk for falls and they did not want to spend time doing more forms,"

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she says. Because the form takes very little time to complete and does identify more factors that increase risk of falls than most clinicians typically think about, nurses were more receptive after inservice education.

Once patients are identified as at risk for falls, the entire team of nurses, aides, and therapists meets once a month to review and plan care, says Coccia. "There is no cure for falls, but we can make sure we've covered as many bases as possible," she says. As goals for each discipline are met, visits are decreased and discharge plans are developed, she adds.

Fall prevention does require change, Coccia points out . "The patient may need environmental assistance such as handrails in the shower, the physician may have to review medications, extra light sources may be needed in some rooms, and the patient and family members need to be educated," she says. If funding is a problem for families who need to purchase equipment, the agency social workers try to find resources, she says. "We also adapt items such as an inexpensive lawn chairs that can serve as a shower chairs."

Once a falls risk assessment program is developed, you must conduct inservice education for all staff members, says Toto. If your agency uses contract therapists, you need to add your expectations for the identification and addressing problems of patients who are at risk for falls to the therapists' evaluation forms, she suggests. If you want the timed "Up and Go" or the Tinnetti test performed on every patient, build that into your agreement, she adds.

"Fall prevention and identification of risk is one competency for which all of our nurses and aides are evaluated each year," Coccia says. "We've made the assessment easy for nurses because it comes up as a screen in OASIS [Outcomes and Assessment Information Set], so it is just one more part of the admission visit."

A home health agency also needs to make it easy for staff members to report falls, suggests Coccia. Home health staff always document unattended falls, but if the fall occurs while they are present, the documentation may not be completed because they fear punitive actions, she says. "You have to allow for falls and make sure employees report all falls so the patient's care can be evaluated," she adds.

The most important reason to look at a falls risk assessment program is that it is a way to improve patients' quality of life and make sure they stay at home, Coccia says.

CE questions

This concludes the September-April 2002 semester. A Scantron sheet is in this issue, as well as a survey form. Fill out and return in the enclosed envelope.

21. According to Linda J. Coccia, BS, OT, occupational therapist at Adventist Home Health Care and Hospice in Hanford, CA, which of the following is not typically a factor that increases a home health patient's risk of falling?
    A. use of multiple medications
    B. incontinence
    C. sensory deficit
    D. use of a walker
    E. previous falls

22. If you don't have a telephony system to track staff members' hours and locations, how can you increase the accuracy of time records, according to Liz Pearson, Esq., president of Pearson and Bernard, a law firm in Covington, KY?
    A. Have employees document travel and visit time separately.
    B. Require employees to turn in time sheets each day.
    C. Have supervisor make follow-up quality assurance calls to patient's home.
    D. A and B
    E. A and C

23. What is one way physicians can make filing claims for care plan oversight simpler, according to Albert deMartino, MD, medical director for the Visiting Nurse Services of Westchester in White Plains, NY?
    A. Take time to develop documentation forms to place in home health patients' charts.
    B. Have employees perform most of the care plan oversight duties.
    C. File all claims once per quarter.
    D. A and C

24. According to Elizabeth E. Hogue, Esq., a Burtonsville, MD, attorney, the provider-patient relationship in home health begins when?
    A. when the referral has been received by the agency
    B. at the completion of the third visit
    C. after agency personnel has completed the initial assessment and determined that the patient is appropriate for home care
    D. once the admission nurse has entered the patient's home

Falls Risk Assessment Tool

The following risk assessment tool for determining the risk level for falls in home health patients was developed by **Linda Coccia**, OTR, and **Karen Little**, RN, of the Adventist Home Health Care & Hospice in Hanford, CA.

Risk Factors: Circle factors that apply

Postural Hypotension (≥ 20 mm Hg drop or < 90 mm Hg on standing)	1 pt.
Use of sedatives/hypnotics/diuretics/anti-hypertensives or psychotropics	1 pt.
Use of more than four prescriptive medications	1 pt.
Environmental hazards (stairs, floor surfaces, clutter, bathroom, lighting, pets, furnishings blocking walkways, rugs). Two or more hazards to score **	1 pt.
Patient with unsteady gait, weakened lower extremity strength, foot problems **	3 pts.
History of falls/fear of falling	3 pts.
Sensory deficit — hearing, low vision, peripheral neuropathy **	1 pt.
Diagnoses — diabetes, neurological, orthopedic, arthritis **	1 pt.
Incontinence of bowel/bladder	1 pt.
Noncompliance with safety instructions	1 pt.

Total: _____

Comments: _____

**Refer to physical therapy/occupational therapy

Score: 0-2: Low risk for falls. Action: Reinforce safety instructions in Safety Teaching Guide.

Score greater than 3: High risk for falls. Action: Inform patient/caregiver; reinforce safety and refer to physical therapy/occupational therapy.

Patient Name _____ Patient # _____

Signature _____ Date _____

Source: Adventist Home Health Care & Hospice, Hanford, CA. Reprinted with permission.

No program, however, can prevent falls completely because there is one factor that no one can change, she adds. "We can't change gravity, and gravity will get all of us one day."

[For more information about development of falls risk assessment programs, contact:

- ***Linda J. Coccia**, BS, OT, Occupational Therapist, Adventist Home Health Care & Hospice, 823 W. Lacy Blvd., Hanford, CA 93230. Telephone: (559) 585-3425, ext. 1134. Fax: (559) 585-3420. E-mail: linda-synchronics@prodigy.net.*
- ***Pamela Toto**, MS, OTR/L, BCG, Occupational Therapist, Family Home Health Services, 2510 Mosside Blvd., Monroeville, PA 15146. E-mail: PEToto25@aol.com.*

For falls assessment program resources, contact:

- ***National Center for Injury Prevention and Control**, Mailstop K65, 4770 Buford Highway N.E., Atlanta, GA 30341-3724. Telephone: (770) 488-1506. Fax: (770) 488-1667. Web site: www.cdc.gov/ncipc. The National Center for Injury Prevention and Control, a division of the Centers for Disease Control and Prevention in Atlanta offers several publications related to falls among the elderly. All publications are free and can be ordered in printed form or found on-line at the web site under "publications." Documents related to falls include:* U.S. Fall Prevention Programs for Seniors, *a description of selected programs using home assessment and modification;* A Tool Kit to Prevent Senior Falls, *which includes fact sheets, graphs, and brochures;* Check for Safety: A Home Fall Prevention Checklist, *a patient brochure that is also available in Spanish; and* What You Can Do to Prevent Falls, *a patient brochure that also is available in Spanish.]*

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You worked how long? Tracking hourly wages

Tips for verifying overtime

With all of the paperwork and record keeping handled in a home health agency, none is more important to employees and more frustrating to managers than keeping track of time worked for hourly employees.

The January 2002 decision by the U.S. District Court for the Northern District of Ohio at Cleveland that ruled against a home health agency that paid a nurse a combination of per-visit fees and hourly wages has caused many home health agencies to review their pay practices.[1] As different approaches to paying staff are evaluated, managers who opt to pay hourly wages with overtime for work more than 40 hours per week are looking for the best way to document and verify time worked. **(See *Hospital Home Health,* April 2002, p. 39.)**

First of all, overtime for home health is defined as any time greater than 40 hours in a seven-day pay period, says **Liz Pearson**, Esq., president of Pearson and Bernard, a law firm in Covington, KY, that represents home health agencies. "Your pay period doesn't have to run Sunday through Saturday," Pearson explains. "You can define it as Monday through Sunday, if that works best for your business." This differs from many hospitals that have two-week pay periods and 80 hours worked, she adds.

Making sure your field staff understand when the day begins and ends also is important, says Pearson. The workday begins upon arrival at the first patient's home or the office, if the clinician starts the day there, she explains. From that first visit or stop at the office, all travel time to the next visit counts as work time, she adds.

The workday ends at the completion of the last patient visit or a stop by the office, if required, Pearson says. "The workday does not include the travel time from the employee's home to the first visit or the time from the last visit to the employee's home.

"Within the workday, a specified amount of unpaid time, usually one hour, must be allowed for the employee's mealtime, she adds.

It is important to make sure employees understand that overtime is hours worked and has nothing to do with productivity levels, explains **Renee Korb**, CPA, a home health consultant in Indianapolis. If a clinician is very productive and able to make more visits in a workday than other clinicians, that is rewarded with bonuses or salary increases, she adds.

When employees are responsible for tracking their own time, there may be questions raised about the accuracy of hours reported, says Korb. One way to verify hours and locations of work is a telephony system, she suggests. The telephony vendor can provide the home health agency with an 800-number for clinicians to call when they arrive at the patient's home and when they depart the home. **(See list of resources at the end of this article.)**

The telephony system can identify the number from which the call is made and match it to the patient's telephone number that is programmed into the system, Korb explains. Because the clinician's schedule is also entered in the system, a follow-up report that lists the clinician's schedule, time of arrival, and time of departure can be used to compare to the employee's report of hours worked, she says.

Many agencies also are using telephony systems to collect information on activities performed during the visit at the same time the clinician makes the departure call, Korb says. **(See *HHH*, July 2001, p. 73.)**

"Three years ago, we implemented a telephony system for our aides, and we are planning to expand it to our nurses and other staff members," says **Sharon Chilcoate**, MSW, LCSW, director of

home health services for Reid Hospital and Healthcare Services in Richmond, IN. "Our aides call upon arrival and upon completion of the visit," she says. The aides use the telephone to key in the tasks that were completed when they make the departure call, she says.

Chilcoate's agency tries to avoid overtime by scheduling field staff carefully. "Standard productivity for our nurses is six visits per day and we do schedule geographically to make it easy for them to get from one patient home to another," explains Chilcoate. "We also offer patients the option of visits on the weekend, and we have nurses who work weekends only," she adds. This does decrease the number of visits that Monday-through-Friday nurses may need to squeeze in, she says.

"We monitor overtime carefully, and if one person seems to report more overtime than is typical, we take a look at the schedule and ask the person to come in to talk with us," Chilcoate says.

Part of counseling an employee who routinely reports overtime might be to go with the employee on several visits, Korb says. "If one person is taking a significantly longer time to do the same job as other people, it might mean the employee needs additional training related to specific activities," she says.

Other reasons may include unusually heavy traffic at the time of day the employee is traveling a certain route, or even a temporary detour due to road construction, she adds. When you discover an overtime variance, the key is not to jump the gun, she says. Following counseling and re-training if necessary, monitor the time to see if there is an improvement. "If there is no improvement, you have an employee who can't do the job and should be fired," Korb adds.

If you don't choose to use telephony to track employees, be sure to have the paper or electronic documentation to verify hours worked, Pearson suggests.

"Document travel time separately from patient visit time, and document all time the clinician completed paperwork, even if the paperwork is completed at the nurse's home," she says.

Pearson does point out that clinicians taking paperwork home may be a practice that needs to be reviewed in light of the Health Insurance Portability and Accountability Act. **(See *Hospital Home Health*, June 2002, p. 61.)**

You can verify visits and activities performed during a visit by making a telephone call to the patient following the scheduled time for the visit, Korb suggests. "This can be part of your quality improvement initiative, gather patient satisfaction information at the same time you verify the visit," she says.

If you do plan to make telephony a part of your home health agency's effort to collect accurate data on time worked as well as visits made, be sure to inform your patients, Chilcoate suggests. "We were concerned at first that patients would be uncomfortable with our employees using their telephones," she admits.

That did not present a problem once the system was explained to patients, she adds. "We now include an explanation of the system in all of our admission packets."

Prepare for unusual circumstances in which a telephone may not be available in a patient's home, Chilcoate says. "We just ask employees to call as soon as they get to a working phone and let us know why the call could not be made from the patient's home."

"I am convinced that telephony is the way to go," Korb points out. "With vendors offering systems that interface with scheduling, billing, and payroll, life for home health managers can be simplified."

[For more information about tracking and verifying overtime, contact:

- ***Sharon Chilcoate**, MSW, LCSW, Director of Home Health Services, Reid Hospital and Healthcare Services, 1401 Chester Blvd., Richmond, IN 47374. Telephone: (765) 983-3157. E-mail: chilcos@reidhosp.com.*
- ***Renee Korb**, CPA, Consultant, 627 N. Pennsylvania St., Indianapolis, IN 46204. Telephone: (317) 387-7375. E-mail: reneekorb@ameritech.net.*
- ***Liz Pearson**, Esq., President, Pearson and Bernard, 1224 Highway Ave., Covington, KY 41011. Telephone: (859) 655-3700. E-mail: lizlegal@msn.com.*

The following vendors offer telephony systems for home health:

- ***Santrax**, 26 Harbor Park Drive, Port Washington, NY 11050. Telephone: (800) 544-7263; (516) 484-4400; or (718) 628-2277. Fax: (516) 484-6084. Web site: www.santrax.com.*
- ***CareWatch**, 5555 Oakbrook Parkway, Suite 330, Norcross, GA 30093. Telephone: (866) 869-4953 or (770) 409-9084. Web site: www.carewatch.com.*
- ***LoginSoft**, 4510 Daly Drive, Suite 300, Chantilly, VA 20151. Telephone: (703) 788-4900. Web site: www.loginsoft.com.]*

Reference

1. *Wendy Elwell v. University Hospital Home Health Care Services*, No.-98-02472, U.S. Court of Appeals for the Sixth Circuit (Jan. 11, 2002). ■

Coding education makes MD relationship stronger

Physicians don't always file for oversight

As your agency struggles to develop and maintain strong, lasting relationships with referring physicians, don't forget that your expertise and experience in dealing with Medicare claims might be just what the doctor needs.

"Physicians are comfortable with familiar paperwork, and most physicians are not familiar with the paperwork required to document home care claims," says **Peter A. Boling**, MD, professor of medicine at Virginia Commonwealth University in Richmond, past-president of the American Academy of Home Care Physicians (AAHCP) in Edgewood, MD.

"Because they do not learn home care during their education and because there have been publicized cases of fraud with physician claims for home care oversight, many physicians are reluctant to file or don't want to take the time to document," he says. "Home care certification and re-certification is the easiest money any physician can make," Boling says. The codes are simple and uncomplicated, he says. **(See physician payment codes for home health, below.)** One thing that physicians must file correctly is the home health agency's six-digit Medicare provider number.

Care plan oversight is not as simple, Boling admits. "Care plan oversight pays twice the amount of certification, but it does require more documentation," he says.

Because Medicare rules state that a patient requires 30 minutes or more of physician involvement during a month, only 10% to 20% of a physician's home health patients will meet this requirement, he explains. For this reason, many physicians don't document any activities that might be eligible for care plan oversight because they believe it is too time-consuming, he adds.

When physicians comment that documenting care plan oversight cases is too complicated, **Albert deMartino**, MD, medical director for the Visiting Nurse Services of Westchester in White Plains, NY, recommends that they take some time to develop documentation forms and make sure office staff members understand the coding for home health reimbursement.

"Each year I go through the list of our referring physicians and send a copy of the AAHCP's *Making Home Care Work in Your Practice* booklet to

Specific activities qualify for care plan oversight

Medicare regulations enable physicians to bill for activities related to certification or re-certification of home health patients and for care plan oversight, but physicians must document carefully for care plan oversight claims, according to **Peter A. Boling**, MD, professor of medicine at Virginia Commonwealth University in Richmond.

Home care claims require the use of the Centers for Medicare & Medicaid Services Common Procedure Coding System rather than Current Procedural Terminology codes.

The code for initial certification is G0180 and applies to new orders only. The code for re-certification is G0179 and occurs every 60 days unless there is a significant change in condition that requires new orders.

The care plan oversight code is G0181 and can be used if the patient is receiving Medicare skilled home care and if the physician spends 30 minutes or more on care plan work defined as countable by Medicare, Boling says. Activities that can count as time spend on care plan oversight are:

- Speaking with agency professionals.
- Coordinating specialty or urgent care.
- Reviewing physician chart for issues related to home care.
- Reviewing care plans and related forms.
- Reviewing lab data.
- Completing medical equipment forms.
- Reviewing home care agency correspondence.

Time spent speaking with family or other nonprofessional caregivers does not count toward care plan oversight and neither does work performed by a physician's office staff, Boling explains.

A physician's claim for care plan oversight will be denied if there is no documentation of these activities in the chart, he adds.

A complex home health patient can generate an additional $130 per 30-day period, Boling points out. "If the physician is already doing the work to oversee the patient's care plan, then he or she should bill for it," he says. ■

physicians who refer more than 10 patients to our agency," deMartino says. **(For ordering information, see list of resources at the end of this article.)** "The booklet contains descriptions of the codes and a sample documentation form that can be placed in a home health patient's chart," he explains.

"It is a simple, easy-to-read guide for physicians who certify or oversee home health patients, order durable medical equipment for their patients' use, or make home visits," he adds.

While the home health agency cannot file the physician's Medicare claim, deMartino points out that the agency can offer to educate the office staff and recommend processes that can make documentation simpler.

Whether you use a booklet or simply make the offer in a face-to-face conversation with the physician, offering to help the physician collect payment for services that are rendered is a positive step in an agency-physician relationship, deMartino says.

[For more information about physician coding and documentation for home care services, contact:

- ***Peter A. Boling**, MD, Professor of Medicine, Virginia Commonwealth University, P.O. Box 980102, Richmond, VA 23298. Telephone: (804) 828-5323. E-mail: pboling@hsc.vcu.edu.*
- ***Albert deMartino**, MD, Medical Director, Visiting Nurse Services of Westchester, 360 Mamaroneck Ave., White Plains, NY 10605. Telephone: (914) 682-1480. Fax: (914) 682-1477.*

To order a copy of Making Home Care Work In Your Practice: A Brief Guide to Reimbursement and Regulations, *contact:*

- ***American Academy of Home Care Physicians**, P.O. Box 1037, Edgewood, MD 21040-1037. Telephone: (410) 676-7966. Fax: (410) 676-7980. Web site: www.aahcp.org. Price of the booklet is $10 for members and $12 for nonmembers plus shipping and handling charges. Payment may be made by Visa or MasterCard. Orders can be placed by telephone or on-line.]* ■

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Admission agreements establish relationships

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

Legal liability comes with every relationship between agencies and patients. Unfortunately, the home health model of care precludes the use of criteria such as a patient's entry into a health care institution to determine when the provider-patient relationship is created.

Home care providers must, therefore, develop other mechanisms for controlling both the beginning and end of relationships with patients. When agencies fail to control the start and finish of the provider-patient relationship, the potential for legal liability is greatly enhanced.

So providers must ask and answer some crucial questions, including: When should the provider-patient relationship begin? Are agencies responsible for patients from the moment they receive referrals? Are staff responsible, for example, for patients who are referred via fax at 4:00 p.m. on Friday afternoon?

Clearly, the most appropriate answer to these questions is that home care providers should establish relationships with patients only after they have an opportunity to assess patients' appropriateness for home care. Otherwise, home health agencies will assume liability for patients whom they have never seen and over whom they have no control — a very risky proposition.

Of course, many patients' and referral sources' expectations are exactly the opposite. That is, they anticipate that home care providers have agreed to provide services upon receipt of referrals and will take care of everything even before staff have a chance to evaluate patients.

These expectations were reinforced by cost-based reimbursement when home care agencies were rewarded for admitting as many patients as possible and providing as many visits as possible to them.

Staff directly must confront these expectations. Visiting staff should tell patients and their families upon arrival for the first time at the patients' home that they have not agreed to provide care for the patient.

Rather, the staff member has come to assess the patient for appropriateness for home health services. If the assessment reveals that the patient is appropriate for home health care, the patient will

be admitted. But if the evaluation shows that the patient is not appropriate for home care, the patient will not be admitted, and agency staff will not provide services.

Staff should then assess patients. Patients should *not* be asked to sign any documents such as a consent to treat or acknowledgement of the Patients' Bill of Rights until the assessment is complete.

This practice is contrary to the procedures advocated by many surveyors. But surveyors' insistence on a particular practice that cannot be supported by Conditions of Participation has the effect of subjecting agencies to increased liability because it forces agencies to establish the provider-patient relationship before proper assessment is completed.

The rationale given by many surveyors for this is that consent is required before staff "lay hands on" patients.

The law does not support such reasoning. In fact, the law regarding consent to treatment clearly indicates that no informed consent is required for routine types of treatment, including physical assessment. In addition, consent is implied when staff are admitted to patients' residences and patients follow instructions to complete evaluations.

Assessments performed by staff should be global and include:

- the patients' clinical condition;
- the patient's ability to self-care or the availability of a reliable primary caregiver to meet the needs of patients in between visits by agency staff;
- the patient's home environment, and if it will support home care services.

If this comprehensive evaluation indicates that patients are appropriate for home care services, patients should be asked to sign an admission agreement.

"Admission agreement" may be an ominous term for providers in the sense that they may envision a long, complex document. On the contrary, admission agreements usually include a combination of the various forms agencies use upon admission, including the agreement to pay, consent to treatment, release of medical information, acknowledgement of the Patients' Bill of Rights, etc. All of these forms should be combined into one document that is called the admission agreement.

Some providers are tempted to call this agreement something else. Calling it something else should be avoided at all costs because the point of the agreement is to serve as evidence that the provider-patient relationship has been established.

The use of admission agreements should be accompanied by an agency policy and procedure that makes it clear that only patients who have signed agreements are the responsibility of agency staff.

If, however, staff members determine that patients are not appropriate for home care, then no agreement should be signed. Patients should be told that they are not appropriate for home care and that agency staff will not return to provide services. The fact that this information was conveyed to patient must be documented.

Field staff also should:

- Notify referral sources and attending physicians that patients are not appropriate for home care services and document that they have made these notifications.
- Call 911 and ask for transport of patients in need of immediate care to the emergency room. Patients who decline transport likely are to have assumed the risk of any injury they may suffer.

Historically, agency staff members sometimes have acted from the point of view that something in the way of health care services is better than nothing. This tendency must be resisted. When home health agencies undertake care that basically is inappropriate, the risk of legal liability increases substantially.

[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.] ■

A look at home health usage state by state

How does your state compare?

According to data recently released by the General Accounting Office in Washington, DC, Louisiana leads all other states with the greatest number of home health users per 1,000 beneficiaries at 61, and with the greatest number of visits per user at 42.

(Continued from cover)

The first hurdle to overcome in developing a pain management strategy is the misconception that effective pain management is not a problem within your facility or does not need to be a high priority. The audio conference **Complying with JCAHO Pain Management Standards: Is Your Facility at Risk?** is scheduled Oct. 8, from 2:30-3:30 p.m., ET. Conference speakers **Patrice L. Spath**, RHIT, and **Michelle H. Pelling**, MBA, RN, will teach participants how to:

- Comply with the new Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards relating to pain medication range orders and titration.
- Integrate the Joint Commission's "Speak Up" campaign into a patient education initiatives. The groundbreaking program encourages patients to become active, involved, and informed participants on the health care team.
- Develop a performance measurement system to evaluate the effectiveness of pain management and continually monitor and improve outcomes.
- Avoid documentation deficiencies and staff complacency that can derail a pain management program.

"Hospitals must have a systemwide standard of care for pain management that will reduce patient suffering from preventable pain," Spath says. "Failure to meet this standard of care can result in a Type I recommendation from JCAHO. But more important, inadequate pain management will undermine patients' confidence in the quality of care provided by your health care facility."

A Type I recommendation would require your health care organization to resolve insufficient or unsatisfactory pain management standards compliance in a specified amount of time to maintain your accreditation.

Federal regulators are turning up the heat on needle safety compliance, increasing inspections and issuing more than a million dollars in fines in less than a year.

The Occupational Safety and Health Administration (OSHA) dramatically has stepped up enforcement of needle safety provisions. Between July 2001 and May 2002, OSHA issued 1,876 citations for those who still haven't gotten the message that needle safety is now the law of the land.

These facilities were slapped with $1.3 million in fines, and only about 20% of the inspections were prompted by an employee complaint.

With random visits a possibility, you need to know the latest regulatory information to ensure you can pass muster with OSHA while protecting your employees and patients. **Sharps Safety Compliance: How to Avoid OSHA Citations and Costly Fines** is slated for Wednesday, Oct. 23, 2:30-3:30 p.m., ET. Our program will feature practical handouts and guidance along with the answers to some of your most pressing questions. OSHA expert **Katherine West**, BSN, MSEd, CIC, veteran infection control consultant at Infection Control/Emerging Concepts in Manassas, VA, will review the latest OSHA requirements and give you the inside tips necessary to pass any future inspection with flying colors.

Bruce E. Cunha, RN, MS, COHN, manager of health and safety at Marshfield (WI) Clinic, has 24 years working experience on the front lines of occupational health and safety. He will provide vital insight on what practitioners can do to ensure safety for clinical procedures for which there are currently no safety needles available.

Educational programs for hospital staff at all levels can ensure that sound pain management and sharps safety standards are understood and put into practice. To sign up for either conference, call (800) 688-2421 and mention effort code **62751** for pain management and **62761** for sharps safety.

The facility fee for each program is $299, which includes free CE for pain management and free CE or CME for sharps safety. Also included with each conference package are program handouts and additional reading, a convenient 48-hour replay, and a conference CD. If you sign up for both audio conferences, your cost is only $500. That's a $100 discount. Don't miss out. Educate your entire facility for one low fee. ■

A state-by-state comparison of home health utilization from January to June 2001 breaks down the number of users, the number of visits per user, the number of visits per episode, the number of users with one episode, and the number of users with multiple episodes. **(See chart, inserted in this issue.)**

Data from Medicare provider claims and beneficiary files for the 2001 calendar year, which was available as of Jan. 24, 2002, were used to produce the chart. Episodes were defined as periods of care that comprise four or fewer visits for which the home health agency received a low utilization payment adjustment.

To determine the share of home health users with multiple episodes, claims data was used to identify all beneficiaries who had an episode that ended in the first three months of the year and then received additional episodes of care during the first six months of 2001. ■

NEWS BRIEFS

CMS plans to reduce OASIS paperwork

In a proposal submitted to Health and Human Services Secretary Tommy G. Thompson's Advisory Committee on Regulatory Reform, the Centers for Medicare & Medicaid Services (CMS) plans to reduce the paperwork burden on home health agencies by streamlining Outcome and Assessment Information Set (OASIS) assessments.

Plans call for elimination of two of the 10 current OASIS assessments, which should result in a 27% overall reduction in paperwork time. The two assessments identified by the proposal for elimination are the second and 10th assessments.

CMS also plans to cut the number of questions on other OASIS assessments, including the recertification assessment.

The proposal calls for a decrease from 92 to 25 items in the recertification assessment. ▼

More bureaucracy via competitive bidding?

Implementing a national Medicare competitive bidding program for medical equipment, services, and technology will require a 35% increase in the Centers for Medicare & Medicaid Services (CMS) work force, according to a report from Multinational Business Services, a Washington DC-based research firm.

The report states that a national competitive bidding program, such as the one passed in H.R. 4954, would require CMS to hire 1,626 additional full-time employees to manage the program. CMS' current work force is approximately 4,630.

CMS Administrator Thomas Scully said at a June 12 congressional hearing on competitive bidding, "The reality is, it's going to be extremely expensive to do . . . that if you want us to do more things and competitive bidding to save money for the trust funds, we just don't have the capability to do it right now."

The report was commissioned by the Coalition for Access to Medical Services, Equipment and Technology (CAMSET), an Alexandria, VA-based organization with 22 consumer advocacy organizations and trade associations, which are concerned that the expansion of competitive bidding from two demonstration projects to national policy is premature. CAMSET members say that competitive bidding would undermine quality of care, restrict patients' choice of suppliers and service providers, stifle the development of new technology, and drive suppliers out of operation.

A copy of the full report can be found at the coalition's web site: www.protectaccess.org. Click on "reports," then scroll down to the report, *Regulatory Mandates Imposed Under the New Medicare Competitive Bidding Program — Section 511 of the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954).* ■

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THOMSON
AMERICAN HEALTH CONSULTANTS

Clinical trials harmed by lack of informed consent

The mention of clinical trials often triggers a silence between physician and patient, usually because neither one knows much about the subject. Nearly 80% of physicians admit they would like to know more about clinical trials so they can help their patients make an informed decision before volunteering to participate.

"Most subjects enrolled in clinical studies have a meager understanding of what they have gotten into," says **Alan Sugar**, MD, chairman, New England Institutional Review Board and professor of medicine at Boston University School of Medicine. "Informed consent has largely focused around the signed form and has not practically become the continuous process that it needs to be. As a result, a subject's misunderstandings largely go unchallenged."

Properly informing patients is not only ethically necessary, say clinical trials experts, but it also ensures better trials and data. Last year, more than 17 million people thought seriously about participating, but only a few million actually completed their trials. And even among them, many gave their consent without a thorough knowledge of the facts. Indeed, patients can be so daunted by questions and lack of information that they simply decide not to volunteer.

"There's a simple ethical mandate that you don't ordinarily do dangerous things to people without their knowledge and consent," says **Dale E. Hammerschmidt**, MD, FACP, associate professor of medicine and director of Education in Human Subjects' Protection for the University of Minnesota Medical School in Minneapolis. "From a more pragmatic perspective, a well-informed subject is likely to cooperate better with the trial and is more likely to report potential problems. The quality of the data and the safety of the trial are both enhanced when the subjects really know what's going on."

A new resource, written for doctors and clinical trial participants, can help answer some of these tough questions. Boston-based CenterWatch, the leading publisher of clinical trial news and information, now offers *Informed Consent,* a guide to the risks and benefits of volunteering for clinical trials.

Informed Consent, a step-by-step guide with a history of the clinical trials industry, explores the drug development process and how a new drug makes its way to the marketplace. It also details why people decide to participate, how to find clinical trials, how to research clinical trials and evaluate their risks, how to ensure proper informed consent, what the vulnerable populations are, and what to do when things go wrong. Cost is $16.95, and can be ordered from CenterWatch at (800) 765-9647, or by faxing (617) 856-5901. It also can be ordered through www.centerwatch.com; www.amazon.com; and www.barnesandnoble.com. ■

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. ■