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IN THIS ISSUE

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Massage, music, and meditation become extra tools for HHA staff

Recognition of complementary therapy benefits grows

The use of integrative medicine therapies continues to grow, with hospitals opening integrative medicine centers and health care providers offering massage therapy and acupuncture. Recent articles point out the use of complementary therapies by cancer patients with needs that are not met by traditional medicine[1] and the use of reflexology to reduce the stress and pain of nursing home residents.[2]

Integrative or complementary therapies also are beneficial to home care patients, says **Gayle Hasledalen**, MSW, social worker at Lakeview Hospital Homecare and Hospice in Stillwater, MN. "We are working with our hospital to develop a group of home care nurses who receive healing touch training," she says.

Currently, the agency offers therapeutic massage to patients with a group of massage therapists who volunteer their time. "Most of the patients who have asked for massages are younger, in their 40s, and have had massages before," says Hasledalen.

Age is not always a predictor of a patient's willingness to try a

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Complementary therapies are becoming more popular as ways to reduce pain, stress, high blood pressure, and depression. Home health managers are finding ways to incorporate complementary therapy into home care services to enhance patient care.

- Massage of the hands or feet as well as gentle back rubs can reduce pain and stress.
- Meditation and self-hypnosis can help patients with anxiety and depression.
- Staff members need focused training on how to use therapies with frail, elderly, or chronic pain patients.
- Home health agencies can partner with licensed massage therapists or acupuncturists to provide services that require certification and licensure.

complementary medicine approach, says **Kathleen M. Wesa**, MD, an internist and specialist in integrative medicine at Memorial Sloan-Kettering Cancer Center in New York.

"Acceptance of an alternative therapy depends more on the personality of the patient than the age," she explains. If the patient doesn't like needles, acupuncture is not a good therapy to consider, she points out. "Other patients might not [like] sitting still to meditate, while others are not comfortable with massage," she points out. The key to successful use of complementary therapies is to match the technique to the patient. **(See p. 123 for list of most common complementary therapies.)**

Complementary therapies can be used to manage pain, stress, nausea, anxiety and a range of other symptoms patients might have, says Wesa. While only well trained, licensed professionals should do some therapies, such as acupuncture and hypnosis, there are several therapies that nurses and home health aides can learn and perform in the home, she adds.

Even though most health care professionals know the importance of touch, it is important that staff members learn the proper technique, says **Melissa Gulick**, RN, patient care supervisor for Community Hospice in Pittsburg, KS. Once staff members learn how to properly give hand or foot massages, they can teach family members, she says. "In hospice, many family members will withdraw from the patient because they are afraid of hurting them when they are fragile or increasing their pain," she explains. When taught how to give hand, back, or foot rubs gently, family members can reconnect with the patient and meet the emotional needs of both family and patient, she adds.

Family members are receptive to learning simple massage techniques, says Gulick. "They have been so busy meeting the medical and physical needs of the patient that sometimes they don't think they have time to give a back rub," she says.

Gulick's staff underwent therapeutic touch, and now clinicians and aides report positive results. "One aide happily told us about her patient who always became agitated at bath time," says Gulick. The patient had dementia and was unable to communicate, she says. The aide had been quietly singing to the patient to calm her, but after attending the therapeutic touch session, she tried rubbing her arms as they got ready for the bath. "The patient became so relaxed that she slept during the bath," she adds.

Physical therapists and nurses also can use yoga to help increase range of motion and fitness for bed-bound or homebound patients, says Wesa. "Gentle exercises that work on balance and strength are helpful for patients in many different ways," she points out. "Any time that you focus on an activity, such as exercise, you alter your brain waves," she says. Concentrating on performing an exercise can reduce stress and decrease pain because the patient is focusing on something other than the stress or pain, she adds.

Don't forget the value of meditation, suggests Wesa. Meditation can take many forms, from a

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• **Beth Israel Center for Health and Healing**, 245 Fifth Ave., Second Floor, New York, NY 10016. Telephone: (646) 935-2220. Fax: (646) 935-2272. Web site: www.healthandhealingny.org. The web site includes a library of related web sites, books, audiotapes, and other educational material related to a variety of complementary therapies.
• **National Center for Complementary and Alternative Medicine** (NCCAM), P.O. Box 7923, Gaithersburg, MD 20898. Telephone: (888) 644-6226 or (301) 519-3153. Fax: (866) 464-3616. Web site: www.nccam.nih.gov. Part of the National Institutes of Health, the center was established to research and evaluate complementary/alternative therapies in order to determine their effectiveness and safety and to communicate this information to the public and the health care community. The web site contains information about complementary/alternative medicine (CAM), news and events, FAQs, classification of CAM practices, fact sheets, consensus reports, clearinghouse, clinical trial awards data, and clinical trial opportunities.

centering prayer to guided imagery to breath awareness, she says. The key is to find a technique that enables the patient to completely focus on the meditation activity in order to relax. "There are great psychological benefits of meditation. It has been shown to decrease heart rate, reduce blood pressure and lessen the patient's stress response," she says.

Whichever complementary therapy nurses choose to incorporate into home care, remember that complementary therapies are not a substitute for ongoing assessments and traditional care, says Gulick. "Massage, music, and healing touch are beneficial tools that enhance our ability to meet patient needs."

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Complementary therapies offer new options

Different techniques benefit patient needs

Complementary. Integrative. Alternative. These three words often have been used interchangeably to describe non-traditional therapies to relieve pain or stress and reduce anxiety and heart rates. Before including these therapies in your home health services, be sure to know how to describe them, suggests **Kathleen M. Wesa**, MD, an internist and specialist in integrative medicine at Memorial Sloan-Kettering Cancer Center in New York.

"An alternative therapy is an unproven treatment that is used in the place of proven, traditional medical treatment," explains Wesa. The therapies that home health agencies are most likely to implement can be called integrative or complementary, she says. "This means that they are used in addition to medications and traditional care to enhance care," she explains.

The most effective therapies for home health, according to Wesa, include:

• **Self-hypnosis**

"This therapy is helpful in reducing anxiety or panic attacks," says Wesa. While it is a safe therapy, it must be taught by a staff member who is trained and certified to teach hypnosis, she points out. "This ensures that the therapy is effective for the patient," she adds.

• **Acupuncture**

Although acupuncture is typically performed in a clinic setting, it is very effective in reducing pain, says Wesa. "Patients with chronic pain who undergo acupuncture can reduce the dose of pain medication over time," she says. Be sure that the acupuncturist is licensed, well trained, and experienced, she adds.

• **Physical fitness**

Yoga and tai chi can be taught by homecare nurses to help bed-bound and homebound patients improve strength and balance along with their emotional outlook, says Wesa. "Focusing on the exercise can help patients reduce pain, anxiety, and nausea," she says. Be sure that the exercise is appropriate for the patient's age and condition, she adds.

• **Massage**

"Gentle massage is appropriate for all patients, even frail patients, when done correctly," says Wesa. While most nurses or home health aides may not feel comfortable giving full body massages, they can easily be trained for foot and hand massages, she says. Not only does massage reduce pain and depression at the time of the massage, but the effects of a 20-minute massage can last at least 48 hours, she points out.

• **Meditation**

Not all home health patients are comfortable with meditation, but there are a number of techniques that can be used to relax patients, reduce stress, and decrease heart rate and blood pressure, says Wesa. Meditation with a centering prayer and guided imagery can greatly improve a patient's emotional well-being, she says. "If the patient is not visual the patient can focus on breath awareness instead of visual images," she points out.

• **Music Therapy**

Although some home health agencies do use certified music therapists in their program, nurses and home health aides can use music to calm an anxious patient or prompt conversations. "If music was a part of the patient's life prior to illness, it can be a very moving therapy," says Wesa.

Be aware of state licensing requirements for different complementary therapists, suggests Wesa. "Licensing and credentialing requirements differ from state to state," she warns. If you choose to partner with a community-based therapist for acupuncture, massage, or music therapy, be sure that, in addition to the proper training, they have experience with ill, homebound, frail, or elderly patients, she suggests. ■

Hurricane Ike tests HH emergency plans

Pleased with response but need improvements

Winds that exceeded 80 miles per hour, storm surges that covered major streets, and power outages that lasted more than a week for many people were just a few of the effects of Hurricane Ike. The good news for Texas hospice and home health organizations is that their emergency plans worked well.

"Our patients were in the areas that were under evacuation orders," says **Wyona Freysteinson**, RN, MS, director of home health and hospice at Memorial Hermann Hospital in

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Even the best emergency preparedness plan can be improved upon, but some of these improvements are not identified until an emergency situation occurs. Hospice and homecare agencies in Texas and throughout the Midwest and Southeastern United States had a chance to test their plans following Hurricanes Gustav and Ike.

- Make sure you know exactly how your area 211 plan is designed. Does it provide transportation directly from the patient's home or from a central pick-up point?
- Be prepared for damage from a storm and power outages even if you are a great distance from the point at which the hurricane reaches landfall.
- Know how a hurricane can affect delivery of items such as gasoline to your area and prepare for shortages.
- Celebrate the staff's efforts and recognize that they, too, had to undergo evacuations and fear for their families' safety.

Houston. In addition to working with patients to be sure the hospice knows where they are going and how to contact them, Freysteinson's staff calls hospices in the destination area to arrange for care while they are evacuated. "This is a key component of our evacuation plan," she says. "There are other hospices in the Houston area that told their patients who were evacuating to go to the hospital in their destination area if they needed care," she says.

As soon as the reports showed that Ike would be a bad storm, hospice staff began calling patients and verified that they all had seven to 10 days of medication, says Freysteinson. "Prior to the storm we made sure that any patients who needed transportation during an emergency were included on the county's 211 list to make sure they would be evacuated," she says.

Staff members at Lakes Area Hospice in Jasper, TX, also made sure that patients were included on the county's 211 list, but they discovered that their understanding of the 211 service differed from reality. "We got to test the system when Hurricane Gustav threatened our area," says **Paula Moore**, volunteer coordinator of the agency. Although Gustav's path veered away from Jasper, Moore learned that the 211 system was set up to transport people from central pick-up locations rather than pick people up from their homes. "The county did not have the budget to pay for transportation to all 300 homes of home health and hospice patients on the 211 system and had decided to have people meet at the local high school or other central location," she explains. Unfortunately, people registered with 211 because they had no driver's license, no car, and no other caregiver who could drive them, she says. "We only had one week between Gustav and Ike, so the county had to improvise," she says.

"I'm in awe of the county workers who used their vehicles to go to all 300 homes to pick up patients," says Moore. "This was not the most efficient use of their time because they had other evacuation-related responsibilities, but they put the safety of patients first," she says. Review of the 211 plan and ideas to improve it are under way, she says.

Moore believes that her agency was able to implement its plans quickly because she was in touch with county emergency management as a result of her involvement in the monthly emergency management meetings. "There have been many months when I wondered why I was spending my time at these meetings, but the information I received, the contacts I made, and ideas I heard, all helped my hospice be better prepared," she says. **(For specific tips on preparing for emergencies, see pg. 126.)**

Hurricanes cause crises in many areas

Even hospices and home health agency staff members who were away from the coast and outside Texas found themselves facing emergencies related to Ike. "We have an emergency plan in place, but the damage from the winds that were a result of Hurricane Ike were completely unexpected," says **Dorean Levenberg**, RN, administrator of Deaconess Home Care in Cincinnati. Power outages were the biggest problem caused by the wind as trees fell on power lines throughout the area, she says. "We had one person who had gone in to the office on Sunday to finish up some paperwork, and she called to tell me that there was no power at the office," she says. "I never would have known that we had a problem if she had not called," she admits.

Because Levenberg had the warning that there were power outages that could affect her agency, she and other managers showed up early at the office to start calling employees. "We found that our power had been restored overnight, but there were many staff members and patients without power," she says. Staff members without power at their homes came into the office to charge cell phones and laptops, and all staff members who had power at their homes operated as usual. **(For other tips on dealing with power outages, see pg. 127).**

Power wasn't a problem in the Southeast, but staff members at Visiting Nurse Health Service in Atlanta had to deal with a different effect of Hurricane Ike. Because Georgia and several other Southeastern states receive gasoline through pipelines from the Texas coast, gasoline supplies in some areas were reduced as a result of pipeline shutdowns. "We heard from a staff member who called the office to report that she had a hard time finding a gas station with gasoline before the Atlanta media began reporting the problem," says **Mary Zagajeski**, RN, MS, COS-C, vice president of home health operations for the agency. Communication with staff members was the key to making sure that clinicians were able to visit all patients, she adds. **(For specific actions taken, see p. 128.)**

Whatever emergency your agency experiences, be sure to recognize staff efforts once everything

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is back to normal, says Freysteinson. "We've held parties at each office, luncheons at some and breakfasts at others depending on what fits their normal schedule for meetings," she says. Awards such as a crossword puzzle book for the staff member who sat the longest in the gas line, three rubber ducks for the staff member whose home was flooded the most, and a flashlight for the staff member who was without power the longest were awarded at each office. She explains, "This was a scary experience with winds and trees crashing into homes. It is important to set aside time to say that we're glad to be alive." ■

Hurricane: Lessons learned improve preparedness

Generators, extra oxygen, and walkie talkies

There is nothing like a real emergency to test and evaluate your hospice emergency preparedness plan. Although hospices and home care agency managers interviewed by *Hospital Home Health* came through Hurricanes Gustav and Ike with flying colors, they all identified additions that will enhance their plans.

• Keep communications systems operating.

Although most of her staff stayed in the area, even after evacuating their own families, **Wyona Freysteinson**, RN, MS, director of home health and hospice at Memorial Hermann Hospital in Houston, points out that communication is difficult. "Many staff members and our office was without power, so we could not rely upon e-mail communications, because we didn't know if employees could keep their laptops charged or find a wireless connection," she says. Cell phones were not reliable due to the number of cell phone towers damaged, and even text messages did not transmit in a timely manner, she adds. "We will rent … walkie-talkie phones prior to the next storm," she says. Although there is always the possibility that they won't cover all areas, they seemed to be a more reliable form of communication during Ike, she adds.

• Make sure staff members know their role in an emergency.

Staff members at Memorial Hermann Home Health and Hospice did not evacuate, even when they made sure their families left the areas targeted by Hurricane Ike, and even if they couldn't contact the office, they knew their role as first responders, says **Wyona Freysteinson**, RN, MS, director of home health and hospice at Memorial Hermann Hospital in Houston. "We told everyone that if you can safely get to your patients' homes, do so," she says. Staff members knew which patients were evacuating and which ones were not, so as soon as it was safe to travel, they visited patients, taking ice and water when needed, she says. "Our nurses took water and ice or other supplies to patients' homes without being told to do so," she says. "Reimbursement of these items had not been planned in the emergency plan, but it is now included," she adds.

• Have backup oxygen tanks for patients.

"Many of our patients have switched from oxygen tanks to oxygen concentrators because they are easier to use, and you don't have to worry about replacing tanks," says **Dorean Levenberg,** RN, administrator of Deaconess Home Care in Cincinnati, OH. The problem with concentrators occurs when there is a power outage. "The concentrators require electricity, and although they have battery backup, if the power

outage lasts as long as some of ours did, the battery runs out and the concentrator does not work," she says. "We will now start to make sure that patients have a portable oxygen tank in their home just in case of a power outage," she adds.

• Identify partnerships for emergency use.

Although staff members never found themselves stranded with no gasoline, there was time spent finding gasoline and sitting in long lines when Visiting Nurse clinicians found themselves in the midst of a gasoline shortage following Ike, says **Mary Zagajeski,** RN, MS, COS-C, vice president of home health operations for Visiting Nurse Health System (VNHS) in Atlanta. While there is no need for the agency to install its own gasoline tank, she does say that they are going to talk to different suppliers to see if they can develop a plan that will make it easier for VNHS staff members to obtain gasoline during a crisis.

• Stay involved in the county/city emergency management team.

The meetings throughout the year may seem to be a waste of time, but **Paula Moore**, volunteer coordinator at Lakes Area Hospice in Jasper, TX, says that her involvement and attendance at local emergency management meetings gave her an opportunity to prepare ahead of time for the hurricane. Because her area was evacuated, hospice staff needed passes and ID badges to enter areas in which their homes not located. "Prior to the storm I was able to obtain passes that enabled all of staff, clinical, clerical, and durable medical equipment, to cross barriers to get to patients or to get to the office to coordinate clinicians," she says. There was no delay in seeing patients, because Moore knew what was needed and how to get it before the emergency occurred, she adds. ■

Electronic records are great except during power outages

Keep good supply of paper forms at all times

Laptops and other point-of-care documentation systems have greatly increased the efficiency of hospice clinicians. They no longer have to travel to a central office to pick up schedules, patient information, or updates from the agency, and they can upload their day's work from their homes. The only warning related to electronic records and laptops from hospices affected by Hurricane Ike is "don't get rid of your paper forms."

"Our office had no power for six days, and many of our staff members had no power at their homes to use computers or to charge the laptops' batteries," says **Wyona Freysteinson**, RN, MS, director of the home health and hospice at Memorial Hermann Hospital in Houston. "Everyone loaded up on paper forms as we prepared," she says. Staff members were told to use laptops if they had electricity and to use paper forms if they did not, she says.

"We were able to use an office at the hospital until our office power was restored so we could continue scheduling and communicating with patients and staff members," says Freysteinson. "Next time we are threatened by a hurricane, I will rent a small generator to make sure we can stay in our office," she adds.

Because gasoline pumps rely upon electricity to work, Freysteinson told staff members to top off their gas tanks prior to the storm. "Our hospital has a tank that we can use if needed during emergencies, so we knew if staff members had trouble finding gas after the storm, we had a way to get fuel," she adds.

The staff at Deaconess Home Care in Cincinnati always keep paper forms in their car, but luckily most employees had access to power at their homes or at the central office, says **Dorean Levenberg**, RN, administrator of the hospice and home health agency. Because the agency has a backup server in another state, they did not run the risk of the server going down due to loss of power, so there was no disruption in documentation or billing, she says.

"Luckily, the power in our office was out for less than 24 hours, but we do address extended power outages in the office in our emergency plan," says Levenberg. "My house is the first alternate site, with other staff members' homes designated as backup sites in case I have no electricity at my home," she explains.

Hurricane-force winds are not a common occurrence in Ohio, says Levenberg. "These winds and damage caught us by surprise because our weather emergencies are usually related to tornadoes," she says.

"Fortunately, everyone knew how to react because they understand our plan and no one panicked." ■

Long lines at gas pumps not limited to coastal areas

Staff alerts managers to beginning of crisis

Hospice staff members in areas directly affected by Hurricanes Gustav and Ike knew to prepare for gasoline shortages or the inability to access gasoline due to power outages, but when you are 800 miles away from the hurricane's landfall, your emergency plans typically don't plan for gasoline shortages.

Hospice managers in several Southeastern states scrambled to help staff members find and conserve gasoline when pipelines from Texas refineries were shut down as a result of Hurricane Ike. A random phone call from a nurse who reported that she kept passing gasoline stations with no gas and long lines at stations with gas alerted managers at Visiting Nurse Health System (VNHS) in Atlanta that a problem existed before media began reporting the problem, says **Mary Zagajeski**, RN, MS, COS-C, vice president of home health operations for the agency.

The first step taken by VNHS was to review coverage areas carefully to make sure that clinicians were seeing patients near where they lived and not making trips outside their coverage area. "We typically schedule clinicians so that they drive the least distance possible, but sometimes when we need extra coverage in an area, we'll call nurses that are willing to drive to another area, even if it's not close," she says. "Now we look in the next closest area to find extra coverage," she adds.

VNHS human resource staff members spent their days searching media web sites that listed gasoline availability in different areas of Atlanta, as well as calling corporate headquarters of gasoline distributors to identify areas most likely to receive deliveries. "We sent emails to each clinician's laptop with updated information, and we also left voicemail messages if the information was urgent," she says. In addition to reminding employees to conserve gasoline, Zagajeski and her managers directed employees not to let their tanks get less than half full. "We also learned from gasoline stations that early morning was the most likely time to find gas, since stations that did receive deliveries got them around midnight," she adds.

Along with shortages, gasoline prices in Atlanta fluctuated week to week, with some prices reaching $4.50 or more per gallon. To make sure that employees are reimbursed fairly, VNHS has been reimbursing with a floating rate based on information from web sites that calculate the average cost of gas in the city rather than a set rate that is not adjusted for price changes, says Zagajeski. "The rate changes with each pay period every two weeks so that reimbursement is fair to employees," she says.

The rising price of gasoline made VNHS employees aware of conservation, but the latest crisis has caused everyone to look more closely at ways to save gas, says Zagajeski. "We have always used technology to enable our employees to access schedules and patient information from their homes so they don't have to go into an office," she says. Laptops with wireless cards mean that all documentation and notes from the day can be uploaded from any location and careful scheduling prevents unnecessary driving. She adds, "Now, more employees use our system's mapping tool to find the most efficient sequence and route to travel between patients' homes." ■

Use Internet to speed referral process

Two-way communication ability is best

In today's fast food society, a speedy response often determines which home health agency gets the referral. By taking advantage of the speed of the Internet to secure and process referrals, Swedish Home Care in Seattle was able to boost referrals by 80% and slash referral processing time by 75%.

Moving to a web-based system for the home health agency has been a multistep process, says **Debby Ramundo**, RN, BSN, MSIT, senior project manager for the home care division of Swedish Medical Center. "Our first version of an electronic referral system relied upon faxed referrals and follow-ups," she says. The next version was a simple system accessed through a web page on which the name and contact information was captured in a spreadsheet. "The significant increase in referrals appeared when we developed an in-house program that enabled two-way communication so that we could better coordinate care," she says.

While the home care agency was developing its own in-house referral system, the hospital system was developing a system as well, says **Terri Wallin,** BSN, MHA, executive director of Swedish Home Care Services. The hospital system program utilizes Extended Care Information Network (ECIN) [Allscripts, Chicago] software and enables communication between all hospitals and departments throughout the system, she explains. The ECIN system includes information on home health, skilled nursing facilities, durable medical equipment providers, transportation, and more, she explains. Now that the hospital system is up and running, home care is moving to the ECIN system, she adds.

"We are ratcheting down our use of our homemade service, and I'll admit that it lasted longer than I ever thought it would last," says Ramundo. Referrals are now coming primarily through the hospital system's ECIN program, and only a few referrals from providers outside the hospital system come through the home care web-based system, she says.

When moving to a web-based referral system, be careful about "who owns the referral," points out Wallin. With the first versions of the home care system, once a discharge planner, physician or social worker sent the referral to the home care agency, they considered themselves finished with the case, she points out. "Even if the referral wasn't appropriate for home care, it took time to track the referral source and get them to handle the patient," she says. "With the hospital-based system, it is clear that it is the hospital's patient until home health has accepted the patient," she adds.

As part of developing each of the referral systems, Wallin and Ramundo talked with discharge planners, physicians, and social workers to identify what makes a home care agency stand apart from others. In addition to responsiveness and good communication, one orthopedic surgeon asked a very good question, says Ramundo. "He asked why he could schedule a surgical procedure 12 weeks in advance but had to wait to the day of discharge to request home care for his patients," she says. Because orthopedic surgery recovery periods are predictable for most patients, she worked with home care staff to develop a process for "preferrals" that are scheduled at the same time as surgery.

The cost of implementing a web-based referral system doesn't have to be enormous, says Ramundo. "Our first version cost about $10,000 for development and testing, and we used existing computers," she says. "The second version cost about $29,000 for development and testing and did not require new hardware." The ECIN system costs the hospital system a fee based on number of users but includes software development and updates as well as ongoing support.

"The important thing to remember is that there is an option for almost any budget," says Ramundo. The investment is an important way to differentiate yourself from your competitors, she says.

When asked if there is anything she would have changed about the development or implementation of the electronic referral system, Wallin says, "I wish we would have included home care in the ECIN system from day one. Having to disassemble and transition to a new system can be done, it's just not the easiest way to go." ■

SOURCE

For more information about electronic referral systems, contact:

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NEWS BRIEFS

AHRQ says telehealth can improve home care

Implementation challenges identified in report

Patient safety and quality of care are improved with the use of telehealth, according to a recent report by the Agency for Health Care Research and Quality (AHRQ). Although the

benefits and experiences of many telehealth patients in the 10 states awarded telehealth grants by AHRQ were positive, information collected from agencies identifies several challenges and obstacles that can reduce the effectiveness of telehealth.

AHRQ-funded projects are in primarily low-income, rural areas in which telehealth can extend care of chronic illnesses. Several project participants reported success in preventing medication errors and reducing unnecessary visits to the emergency room.

Technical challenges related to telehealth implementation can affect effectiveness, according to the report.

• Vendor-supplied home monitoring devices failed to work on a regular basis for one project, so approximately one-third of patients stopped using the devices out of frustration.

• Video cameras used to transmit video and still images did not have high enough resolution to accurately see small pills and patient wound areas.

• Technical support was not always available around the clock. Small companies that provided the equipment were closed on weekends and evenings.

For other reports and resources for telehealth and information technology tools in healthcare go to http://healthit.ahrq.gov. ■

CMS takes steps to fight fraud

RACs to look at DME claims

The Centers for Medicare & Medicaid Services (CMS) is consolidating its fraud detection efforts; strengthening its oversight of medical equipment suppliers and home health agencies; and launching the national recovery audit contractor (RAC) program.

"Because Medicare pays for medical services and items without looking behind every claim, the potential for waste, fraud and abuse is high," said CMS Acting Administrator **Kerry Weems**. "By enhancing our oversight efforts, we can better ensure that Medicare dollars are being used to pay for equipment or services that beneficiaries actually received, while protecting them and the Medicare trust fund from unscrupulous providers and suppliers."

As part of these enhanced efforts, CMS is also shifting its traditional approach of reviewing claim history to fight fraud by working directly with beneficiaries to ensure that they received the durable medical equipment or home health services for which Medicare was billed.

CMS will be taking additional steps to fight fraud and abuse in home health agencies in Florida and suppliers of durable medical equipment, prosthetics and orthotics (DMEPOS) in Florida, California, Texas, Illinois, Michigan, North Carolina and New York. Those additional steps include:

• conducting more stringent reviews of new DMEPOS suppliers' applications, including background checks to ensure that a principal, owner, or managing owner has not been suspended by Medicare;

• making unannounced site visits to double-check that suppliers and home health agencies are actually in business;

• implementing extensive pre- and post-payment review of claims submitted by suppliers, home health agencies and ordering or referring physicians;

• validating claims submitted by physicians who order a high number of certain items or services by sending follow-up letters to these physicians;

• verifying the relationship between physicians who order a large volume of DMEPOS equipment or supplies or home health visits and the beneficiaries for whom they ordered these services;

• identifying and visiting high-risk beneficiaries to ensure they are appropriately receiving the items and services for which Medicare is being billed.

For those claims not reviewed before payment is made, CMS is implementing further medical

COMING IN FUTURE MONTHS

■ Study looks at community-based care options

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■ Coding mistakes to avoid

review of submitted DMEPOS claims by one of the new recovery audit contractors (RAC). The three-year RAC demonstration program in California, Florida, New York, Massachusetts, South Carolina and Arizona collected over $900 million in overpayments and nearly $38 million in underpayments returned to health care providers. **(For more information about RACs, see "Prepare now to reduce risk and consequences of RAC audit," Hospital Home Health, May 2008, p. 48)**. ■

Palliative care saves money, study says

A palliative care program can save hospitals an average of at least $279 per day, up to $374 per day, according to a study of eight hospitals by the Center to Advance Palliative Care and the National Palliative Care Research Center.[1]

The two-year study analyzed administrative data to evaluate the cost of providing care to patients who received palliative care compared to patients who did not receive palliative care.

Palliative care patients who were discharged alive had an adjusted net savings of $279 per day compared to patients who received usual care and palliative care patients who died had an adjusted net saving of $374 in direct costs per day. Significant cost reductions in pharmacy, laboratory, and intensive care unit costs were seen with palliative care patients, according to the authors. The authors conclude that "Hospital palliative care consultation teams are associated with significant hospital cost savings." ■

CNE *questions*

1. What is one symptom that several complementary therapies affect, according to Kathleen M. Wesa MD, an internist and specialist in integrative medicine at Memorial Sloan-Kettering Cancer Center in New York?
   A. Breathing difficulties
   B. Diabetes
   C. Wounds
   D. Pain

2. What is one complementary therapy that all nurses and aides can use to help patients?
   A. Hypnosis
   B. Massage
   C. Acupuncture
   D. Meditation

3. What is one of the reasons a home health agency should invest in an electronic referral system, according to Debby Ramundo RN, BSN, MSIT, senior project manager for the home care division of Swedish Medical Center in Seattle, WA?
   A. Improved billing
   B. Better documentation
   C. Differentiates your agency from other agencies
   D. More efficient use of clinical staff

4. What is one step that the Centers for Medicare & Medicaid Services (CMS) is taking to ensure that home health services and durable medical equipment claims are accurate that has not been done before?
   A. Reviewing all claims within a certain period of time
   B. Holding all payments until claims are verified
   C. Looking for original physician signature
   D. Contacting beneficiaries to verify receipt of services or equipment

Answer Key: 1. D; 2. B; 3. C; 4. D.

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Readers of *Hospital Health Management* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2008 Healthcare Salary Survey & Career Guide*.

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CNE 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. ■

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **March 2009** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■