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IN THIS ISSUE

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Accusations of theft by HHA employees increase

Proper hiring and supervision reduces risk to agency

"Home health nurse arrested for theft."…. "Family accuses home health nurse of stealing from patient." All home health managers cringe when they see the increasing number of headlines that proclaim home health nurses or aides as guilty of stealing from patients. Are these headlines aberrations, or is there a real, growing trend in the home health industry?

"The risk of theft by employees has always been a problem in home health care," admits **Elizabeth E. Hogue,** Esq., a Burtonsville, MD-based attorney who specializes in the home health industry. The increase in news coverage of this potential problem is a reflection of the increased awareness of the home health industry, she explains. "When I started my law practice 30 years ago, I would tell people I worked with home health agencies and they would ask what a home health agency was," she says. "Now, I mention home health and most people say that their father, mother, or friend had a home health nurse," she adds.

An increased awareness of the industry as well as an increased

EXECUTIVE SUMMARY

The increased publicity of theft by home health employees is more a reflection of the general public's awareness of home health than an increasing number of employees with criminal intent, according to experts interviewed by *Hospital Home Health*. Even so, the problem is real, and agency managers should review the steps they take to reduce the risk of employee theft and preserve their reputation in the community.

- Investigate all allegations of theft immediately and remove the employee from that patient's home.
- Be thorough in reference and background checks during the hiring process.
- Establish guidelines related to accepting gifts from patients or their families.
- Encourage families to file police reports if they feel strongly that a theft occurred.

willingness to press charges are probably more to blame for the headlines than an increasing number of home health employees who steal, suggests Hogue. While some patients might have been reluctant to report home health employees in the past, because they did not want to cause trouble for someone they considered part of the family, others did not report for fear of retribution by the accused employee, she says. Today, family members and patients may not see the same person day after day, and they also realize the agency can stop scheduling the accused employee at their home.

"The first step to take when an allegation of theft is made is to remove the employee from the home," points out Hogue. This is not only done to preserve the trust between the patient and the agency and to protect the agency, but also to protect the employee, she says. "Remember that your employees have rights, and it is important to investigate the allegation fairly," she points out. "In many case, the home health employee is not the only other person coming into the home," she says. Family members, church volunteers, friends, durable medical equipment employees, and even Meals-on-Wheels volunteers may come in and out of the home on a regular basis, she points out.

"Document all of your conversations," she emphasizes. Ask what is missing, when and where it was last seen, and who else has been in the home, she suggests. Talk to as many family members as possible, asking if they have looked for the item or if someone else may have moved it.

If your investigation cannot prove the employee's guilt or innocence, be sure to tell the patient and family that they can file a police report if they wish, stresses Hogue.

Whether they file a report or not, be sure not to send that employee back to the home, even if the family requests the nurse or aide, she says. "People will ask for the nurse again, because they found the item they thought was taken," she says. "You don't want to put your employee back into a situation in which the family didn't trust him or her," she explains.

Be careful, too, about the way your agency gift policy is written, suggests Hogue. "Patients and family members want to give gifts to employees, but other family members may not realize it was given as a gift," she points out. **(See tips on how to set up policy on pg. 135)**

Hire carefully

Of course, the best way to reduce the risk of allegations of theft is to be careful about who you hire, says **Greg Solecki**, vice president of Henry Ford Home Health Care in Detroit. Although interviews do confirm that the potential employee has the skills and experience to work in home health, the majority of time spent in an interview is to discover what type of person the potential employee is, he explains. "We engage the applicant in a conversation and then listen to what we can learn when they are comfortable," he says. Applicants prepare for standard questions

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such as goals and previous work experience, but interviewers can get a real sense of the applicant's opinions, philosophies, and ethics in a conversation, he adds. **(For more about hiring and supervision to reduce risk, see pg. 136)**

Supervision of the employee and communication with the patient also can help reduce complaints about employees, or will let the agency know early if there is a potential problem, says Solecki. "Within the first 24 hours of admission, we make a welcome call to the patient and encourage them to call us if they have any questions or concerns," he says. Another call is made 7 to 10 days into the episode of care to see how the agency staff members are doing and identify any patient needs that are not being met. "The patient feels comfortable talking to us, and this is how we identify problems," he says. While Solecki can count on one hand the number of times that a patient has accused an employee of theft during his 20 years at Henry Ford, other issues such as missed visits can be discovered with these calls. The key is to set up a line of communications outside the employee in the home to reassure the patient that there is someone else with whom he or she can talk, he adds.

Although employee theft may be rare in your agency, be aware that it does happen, says Hogue. While your investigation may not uncover any wrongdoing, and the patient may decide that he or she just misplaced the item, theft by home health employees does happen. The employees are not always smart about hiding their theft, either. She says, "My favorite story is of the home health employee who worked for a family that repeatedly reported missing items, but the agency and the family could never substantiate the allegations. About a year later, the employee held a garage sale to prepare for a move, and the items she was accused of taking were included in the sale!" ■

SOURCES

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Require disclosure to avoid misunderstandings

HHA employees should never accept cash

Home health nurses, aides, and therapists do a wonderful job caring for their patients, so it is natural that the patients and families want to thank them with gifts. Unfortunately, the size and type of gift can put the employee and agency in the uncomfortable position of being accused of theft if strict guidelines are not developed and followed.

"I believe that the best policy is that no employee can accept a gift worth more than $25," says **Elizabeth E. Hogue,** Esq., a Burtonsville, MD-based attorney who specializes in the home health industry. Even with the dollar limit, make sure that employees immediately report the gift to their supervisor and document when it was given, she suggests. By insisting on full disclosure by the employee and placing limits on the value of the gift, both the agency and the employee are protected, she says.

There are times when a patient may give away an item that another family member believes should stay in the family, because it is an heirloom or part of the family history. Other times, family members just don't realize the patient gave the item away, says Hogue. In either case, once a family member contacts the agency about the "missing" item, offer to return it, she says. "You can say that you knew the gift had been given and that the employee reported the gift immediately, but you understand that the patient may have given away something the family wanted to keep," she says. In most cases, once the family realizes that the item was given as a gift, they no longer ask for its return, she adds.

Cash is also not appropriate, says Hogue. "Policies need to state that employees can never accept cash," she says. Although grateful families may want to give cash bonuses at holidays or at the end of service, employees should make it clear that they appreciate the gesture, but agency policy does not allow them to accept it, she says.

To make sure that all employees are familiar with the policy, be sure that you have them sign a

document that they've received and understand the agency gifts policy, says Hogue. "This ensures that employees do know the policy and cannot claim otherwise." ■

Background checks, references important

Look for ways to gather info

Checking a potential employee's background is harder than ever, with previous employers reluctant to give much information about the employee beyond the dates they worked at the organization.

"Even when a former employer indicates whether or not the employee would be rehired, the information is not definitive," says **Elizabeth E. Hogue,** Esq., a Burtonsville, MD-based attorney who specializes in the home health industry. While background checks with local police might identify some problems, the only reliable check is a national check through the FBI, and that takes months, she adds.

The next best way to evaluate potential employees is to put the onus on the applicant, points out **Greg Solecki**, vice president of Henry Ford Home Health Care in Detroit. "We ask for the name of a supervisor or manager who would be willing to talk with us, and we ask them to bring in copies of past performance evaluations," he says.

When his staff talks with previous employers, they explain that they have a consent form from the applicant that gives the former employer permission to release information, explains Solecki. "Even with this consent, we have many employers who say they can only confirm dates of employment," he admits. The next step is to "read between the lines," he says. "We explain that they can never get into trouble for releasing positive information, especially with a consent form," he says. If the previous employer says they understand, but they are still not able to say anything, you can make an assumption that there may be something negative about the employee. In these cases, check other sources carefully, he suggests.

Also, trust your gut instinct, says Hogue. "A lot of home health managers and supervisors have been doing this a long time, and there are times that their radar tells them something is wrong," she says. "Trust these feelings, and if the person is already hired, add extra, unannounced supervisory visits," she suggests.

Trusting instinct during the hiring process is important, says Solecki. "As an agency, we've made the decision that we'd rather work without a full staff rather than fill positions with warm bodies. We want to make sure that the employees we send to patients' homes are the right employees for our agency." ■

Face-to-face meetings improve communications

Keep meetings meaningful and short

Case conferences can be an excellent way to improve communications between staff members and ensure that the plan of care is up to date. The challenge presented by case conferences for hospice and home health agencies is the staff's perception that time spent in meetings is not time well spent for patient care.

"We call our weekly meetings multidisciplinary team meetings, but they are case conferences during which each team discusses plans of care for patients who are cared for by team members," says **Patricia Burke**, RN, director of clinical services and operations for Caritas Home Care in Norwood, MA. "We limit the meeting to one hour, and each case is presented by the admitting clinician or the primary clinician," she says. There are nine clinical teams, each with a heavy caseload, so the presentations are limited to new admissions, recertifications, and medically complex patients who require extra attention.

Because weekly team meetings represent a change in practice for the agency, there was some resistance, admits Burke. "Everyone uses a point-of-care system, so staff members do not regularly come into the office," she says. The biggest concern of most staff members was that the meetings would be a waste of their time, Burke says. To alleviate that concern, the one-hour limit was established, and housekeeping items such as announcements of training opportunities or other administrative items is limited to no more than 10 minutes at the beginning of the meeting.

"We also built in a 10-minute period at the end of the meeting to allow staff members to bring up

any issues that they want to discuss," Burke says. Those 10 minutes might be used to ask for suggestions that could help the clinician with a patient not discussed in the case conference or to ask about other clinician's experience with certain equipment or patients, she explains.

In addition to the team meetings, Caritas Home Care staff members meet individually with their case manager on a weekly basis. "This gives staff members a chance to review all of their patients," she explains. Case managers also use that time to review documentation requirements with staff members and point out ways that the clinician can improve his or her documentation. "These meetings are also kept to a minimum time so that the clinician has time to see patients," she adds.

Attendance at meetings and participation in case conferences now are part of each clinician's job description, but there is little resistance these days, says Burke. "New clinicians find both the team meetings and the weekly meeting with the case manager a great learning experience," she says.

Communications have improved because team members get a chance to talk face to face each week and get questions answered quickly, points out Burke. Even though experienced staff members initially viewed the meetings as a waste of time, one employee recently told Burke, "I didn't think I'd like these meetings, but I never realized how much time they really save me." ■

The Joint Commission places standards online

The Joint Commission's revised standards, rationales, and elements of performance for 2009 for home care, which includes hospice, now are available online at www.jointcommission.org/Standards/SII/default.htm. The standards will take effect Jan. 1, 2009, and have been placed online to give organizations time to become familiar with the new language, ordering, and numbering.

The changes are part of the Standards Improvement Initiative (SII), launched in 2006 as part of The Joint Commission's ongoing quality improvement efforts. SII focuses on clarifying standards language, ensuring that standards are program-specific, deleting redundant and nonessential standards, and consolidating similar standards. While no new requirements were added, chapter overviews, standards, introductions, rationales, and elements of performance were designed for ease of use. In the standards reorganization, requirements were split or consolidated. Standards have been renumbered and reordered to allow electronic sorting and to allow the addition of new requirements in the future.

Other aspects of SII include:

- Changes in the scoring and decision process will take place Jan. 1, 2009, for all accreditation and certification programs.
- Single-user license electronic E-ditions of the manuals will be provided for the first time.
- Color-coded tabs in print manuals distinguish standards and requirements from accreditation policies and procedures.
- Accreditation program-specific language is used in all manuals. ■

Chronic care program helps diabetics manage

One-stop clinics, community health workers key

A chronic care program for diabetics at St. Elizabeth Health Center in Tucson, AZ, provides recommended care at a reduced cost and copay, helps them develop self-management goals, and supports them when they go back into their communities.

The program includes proactive care through planned visits and group visits, as well as education and follow-up by promotoras, or community health advisors. The clinic is able to offer the reduced costs by using local health taxes for safety net programs and accessing pharmacy assistance programs.

The clinic provides a wide range of medical, dental, and community services to more than 19,000 new patients each year and a total of 60,000 patient visits a year, according to **Sr. Janet Sue Smith**, ACS, RN, MAPS, director of community outreach, St. Elizabeth Health Center.

Patients who are eligible for treatment at the clinic are uninsured or underinsured. About 80% are Hispanic.

"We work to identify people with diabetes who are not getting consistent care and get them into the system. Our patient load changes frequently, because the Medicaid contracts change and people find themselves without coverage," Smith says.

The clinic is staffed by two physicians, two nurse practitioners, a dentist, and 150 volunteer providers.

To develop the chronic care program, the clinic worked closely with the Carondelet Health System and became a satellite center for that organization's group diabetes classes, according to **Donna Zazworsky**, RN, MS, CCM, FAAN, director of network diabetes care, faith community nursing and telemedicine for Carondelet Health Network also in Tucson, AZ.

The clinic staff tapped into the local YWCA's promotora program and trained the promotoras to work with diabetes patients.

A key component of the program is diabetes group visits, a one-stop monthly clinic during which patients see an ophthalmologist, podiatrist, and dietician as well as a primary care provider. They receive all the recommended tests and procedures for diabetes and receive diabetes supplies.

"Diabetics are referred to at least one diabetes group visit a year to ensure that they get foot checks, eye checks, and other tests. We encourage them to come to the clinic regularly to see a primary care practitioner," Smith says.

During the group visit, patients receive annual podiatry and retinopathy exams, recommended laboratory tests such as cholesterol and hemoglobin A1c tests, a pharmacy review, and a review by a primary care provider. They attend a group class and work with a promotora to set self-management goals.

Patients pay considerably less for a diabetes visit than for a typical fee-for-service visit for the same services. Funding sources that allow St. Elizabeth to offer the low rates include grants and donations.

The clinic also provides glucometers and glucometer strips at no charge or at a reduced cost. Insulin and syringes and oral medications are provided while patients are being coordinated into a pharmacy assistance program.

A year after the chronic care program began, the percentage of patients with a hemoglobin A1c of less than seven had increased from 18% to 38%. The target is 70%. The percentage of patients with an LDL cholesterol of less than 100 rose from 40% to 74%, exceeding the goal of 70%. The percentage of patients who develop self-management goals have increased from 78% to 98%.

"The key to success is an aggressive multidimensional approach through reminder calls, newsletters, and clinical flow sheets," Zazworsky says.

When patients are enrolled in St. Elizabeth's diabetes program, they receive a diabetes risk assessment that stratifies them as to their risk for diabetes.

The clinic provides care that fits with the patients' cultural backgrounds and in ways that they can understand, Zazworsky says.

All individuals with diabetes and pre-diabetes received a quarterly newsletter in English and Spanish and reminders of the diabetes days.

Patients who have diabetes come for quarterly visits with a primary care provider who refers them to a nurse and a dietician. The physicians also refer patients to diabetes self-management classes and diabetes group visit clinics.

Promotoras follow up with the patients either face to face, on the telephone, or in the home and help them work on their self-management goals.

"Communication is an important component. The patients need outreach between visits to help support them in meeting their goals," she says.

The clinic created a "Passport to Better Health" that shows the patient's actual and targeted hemoglobin A1c levels, blood pressure, cholesterol, and weight along with boxes to be checked off when the patient receives his or her pneumonia and flu shots.

The passports, available in English and Spanish, also include key target laboratory values for people living with diabetes along with advice such as getting regular exercise, seeing their provider every three months, taking medication as directed, and checking their feet daily.

"The passports are patients' report cards that provide consistent messages. They assess where the patients are in their disease process and help them learn what they need to do to control their disease," Zazworsky says.

The clinic's clinical information protocol form has built-in guidelines that trigger physicians when gaps in care occur.

During the diabetes group visit, the patients meet with promotoras who help choose goals to work on, such as walking three times a week or eating smaller portions.

The promotoras have been trained in motivational interviewing and help the patients develop goals that they are willing to meet.

They use a tool that helps patients measure their readiness to change on a scale of one to 10. For instance, they might ask "How ready are you to start working on portion control on a scale of one to 10."

If the patient rates him or herself at an eight, the promotora knows he or she is ready. If it's a five or less, ask what it would take to get the patient to an eight and maybe suggest trying portion control just for breakfast.

The promotoras make follow-up calls to support the patients in meeting their goals, she says.

"The follow-up calls by the promotoras are very important because they coach the patients and problem solve with them to help them continue to work on their goals. They relay any information they discover in the follow-up calls to the providers so they'll know what's going on with the patient. The promotoras help facilitate the whole process," she says. ■

Patients receive all their interventions in one place

Three-hour group visit improves adherence to plan

Monthly diabetes group visits, where patients receive all their recommended tests and examinations in one place, are an effective and cost-efficient way to help diabetics keep their disease under control, but they take a lot of organization, says **Donna Zazworsky**, RN, MS, CCM, FAAN, manager of network diabetes care, faith community nursing and telemedicine for Carondelet Health Network in Tucson, AZ.

At St. Elizabeth Health Center, the primary care providers refer their patients for the group visits. The group visits are on the same day each month, so the physicians know when it will be and can refer their patients.

A different group of patients attends the clinic for the group visits each month and receives all the services and laboratory tests in two to three hours.

The team compiles a list of patients eligible for group visits and notifies the providers to make sure they can be on hand when their patients arrive.

"It's a lot of work up-front. We work off the telephone list from our registry and health plan registries and send letters out to eligible patients. In some cases, we have to get prior authorization from the health plan for the patient to attend," she says.

On the day of the group visit, the team designates one person to handle traffic flow.

When the patients first come in, the laboratory staff come down and draw the blood. Then the patients use the patient flow sheets to track their visits to all the stations.

Roughly half of the patients who come to the clinic attend a group class, while the others are receiving their eye and foot checks and provider visits. Then the other group repeats the process.

After the group meeting is over, the promotoras, or community health advisor, show a seven-minute video on the basics of diabetes and talk to the group about self-management, says **Sr. Janet Sue Smith**, ACS, RN, MAPS, director of community outreach, St. Elizabeth Health Center.

A contract is passed off that sets out self-management goals and helps patients identify their needs and set goals to address them.

The promotoras call the patients a week later to check on their progress in meeting their goal and work with them on any problems or issues. They continue calling regularly until the problem is solved, Smith says.

The cost for the group visit is about $600 for three hours or $50 to $60 a patient. Patients pay between $10 and $20 each, depending on their income. The rest of the cost is provided by grants and donations.

The aim of the Diabetes Day clinics is to help patients adhere to their treatment plan and receive the recommended tests and procedures by having it all in one place — and to eliminate barriers to care, Zazworksy says.

For instance, when St. Elizabeth Health Center began its chronic care model for diabetes, the team analyzed the patient records and found that although a sizeable percentage of patients failed to receive hemoglobin A1c tests each year, it wasn't because the doctors weren't prescribing the tests.

"The patients weren't getting the tests because they couldn't afford the cost. We obtained a machine so we can analyze the blood right here in the clinic at a cost of just $6.50 to the patients," she says.

The team tackled other barriers to receiving care.

For instance, the uninsured have high no-show rates, which improve if they receive calls three days before the appointment as well as a reminder call the day before.

Even with discounts the clinic provides, the cost of care and self-management can be prohibitive, Zazworsky points out.

When the promotoras make the reminder calls,

they ask if there will be a problem with payment and can waive the fees. If the patient is having problems finding a ride, they can help with transportation.

"When you're living in chaos, health care is not a priority. Our outreach workers problem solve with the patients to resolve issues the day before the appointments," she says. ■

CMs help seniors understand treatment plans

Medicare project increases quality, cuts costs

When selected Medicare beneficiaries being treated at University of Michigan Health System facilities are discharged from the hospital medical unit or treated and released from the emergency department, case managers at the University of Michigan Faculty Group Practice Medical Management Center call them to make sure they have follow-up appointments and that they understand their treatment plan.

The initiative is part of the University of Michigan Health System's efforts to provide quality care at a reduced cost through the Centers for Medicare & Medicaid Services' Group Practice Demonstration Project, which rewards physicians for providing high-quality care.

"Case management is just one piece of the project," points out **Donna Fox,** RN, health services manager and case manager for the Medical Management Center at the University of Michigan Health System.

The program targets about 20,000 traditional Medicare beneficiaries who receive nearly all their care at University of Michigan facilities. Medicare Advantage members or those who receive only limited care from the health system are not included.

The practice, part of the University of Michigan medical school, includes all 1,500 faculty physicians who care for patients at three hospitals and 40 health centers operated by the University of Michigan.

The purpose of the follow-up calls is to prevent patients from being readmitted to the hospital or visiting the emergency department by eliminating the gaps in care that often occur between the time patients are discharged from the acute care hospital and when they make follow-up visits to their primary care provider.

"One of our goals is to make sure patients are not at home and getting sicker because they are confused about their medication or their treatment plan," Fox says,

Case managers attempt to get in touch by telephone with all patients on the medical units who have been hospitalized for non-elective episodes of care, as well as patients who have received vascular procedures, such as catheterization and stents.

The case management team receives a list of patients being discharged from the hospital each day.

"We review the cases and eliminate those who are discharged to a skilled facility or those with diseases such as end-stage renal disease or those who have a cancer diagnosis with a treatment plan. We know they are already being case managed by others," Fox says.

The demonstration project targets patients who receive the bulk of their care from the University of Michigan Health System. Most live within an eight-county area, but if patients who live further away get most of their care from the health system, the case managers call them as well.

If the patients are seeing a primary care physician who practices outside the health system and the medical record indicates they need a quick follow-up visit, the case managers ask the patients for permission to call their doctor and make him or her aware that the patient has been hospitalized and needs a follow-up appointment in the next few days.

The case managers typically make follow-up calls to about 70 patients a day. Mondays are the busiest because they are calling patients who were discharged from the hospital or visited the emergency department on Friday, Saturday, and Sunday.

If the patients have been hospitalized, the case managers go over the discharge summary with them and explain the treatment plan. They make sure the patients understand their medications and how to take them.

"When patients are discharged from the hospital, they often have numerous bottles of pills they were taking before admission as well as new prescriptions. We go over the medications and help them understand what to take and what not to take. Medication reconciliation is a huge piece of what we do," Fox says.

If patients are confused about their treatment plan, the case managers can call the attending physician or the discharging physician if

appropriate for clarification.

"I always tell the patients to take all their medications with them to their next doctor's visit and to ask the doctor to go through them and determine which ones they should be taking," Fox says.

The case managers talk to the patients about the importance of getting their prescriptions filled and make sure that they are able to afford to get them filled.

The case managers access the health system's electronic health record to determine what upcoming appointments the patient has and discuss them with the patient. If patients have not scheduled an appointment or can't go to the one scheduled, the case managers assist them in scheduling or rescheduling an appointment.

"We can set up a conference call with the doctor's office while the patients are still on the phone. This works best because we can take care of transportation issues and scheduling right on the spot," she says.

When Medicare patients targeted in the demonstration project have visited the emergency department, the case managers contact them to make sure they have rapid follow-up with their primary care physicians.

"Sometimes patients end up in the emergency department because their condition got worse during the hours when they couldn't make an office visit to see the doctor. We make sure they get in a cycle of seeing their physician regularly and avoiding an exacerbation that sends them to the emergency room," she says.

Patients who can't get in to see their primary care physicians can be seen at the Turner Geriatric Clinic's transitional care clinic, designed for patients who are post-discharge.

"It's best if they can see their primary care physician because that doctor knows them best. If not, we get them into the transitional care clinic to make sure they see someone," she says.

The transitional care visits typically are longer than regular physician visits and may involve a social work assessment.

"It's a great visit for patients coming out of the hospital. They aren't rushed. The providers review all the medications and talk to the family to make sure the patient has everything he or she needs to follow the treatment plan and stay healthy at home," she adds.

When they talk to Medicare beneficiaries on the telephone, the case managers assess their psychosocial and socioeconomic needs and their support system at home in the community.

"We ask who helps them at home, if they are able to get their own meals, and if they need assistance getting their prescriptions filled. Community support is a big issue for seniors, because they want to be independent and live in their own home. If they have problems, we talk to them about accessing community resources that can help meet their needs," she says.

The case managers often ask the seniors for permission to speak to family members if they feel there is a problem and follow up with the family to make sure they are aware of all the issues facing their loved ones.

"Sometimes the seniors are too proud to admit that they need help with everyday tasks or that they don't have the money to pay for food and medication. We make the families more aware of their needs and work with them to find community resources that can help," she says.

The case managers make referrals to the visiting nurse agency if they feel the patient is unsafe at home or that something has been missed.

"Sometimes we'll assess a patient on the phone, and they are so confused about their medication and other parts of their treatment plan that we ask for a visiting nurse to visit and the doctor signs off on the referral. Our goal is to keep these patients from going back to the emergency department," she says. ■

Hospital discharges to post-acute care on rise

The annual number of patients discharged from U.S. community hospitals to home health care rose 53% between 1997 and 2006, while the number discharged to long-term care and other facilities rose 30%, according to a new report from the Agency for Healthcare Research and Quality. According to AHRQ, the increases in part reflect the rising number of hospital patients who are acutely ill. Total annual discharges from community hospitals rose 14% over the period,

while Medicaid discharges grew 36%, uninsured discharges 34% and Medicare discharges 17%. The data is from the 2006 Nationwide Inpatient Sample, part of AHRQ's Healthcare Cost and Utilization Project.

To see a copy of the report go to http://www.hcup-us.ahrq.gov/reports/factsandfigures/HAR_2006.pdf. ■

CMS issues HHPPS notice

The Centers for Medicare & Medicaid Services (CMS) issued a notice to update the Home Health Prospective Payment System (HH PPS) for calendar year 2009. Medicare payments to home health agencies will increase by an estimated additional $30 million next year as a result of a 2.9% increase in the annual market basket calculation of the cost of goods and services included in providing services under the HH PPS. The update also accounts for a 2.75% reduction to the HH PPS rates (the second year of a 4-year phased in reduction) to account for the changes in case-mix that are unrelated to patients' health status, and an updated 2009 wage index.

A copy of the notice (CMS-1555-N) is available on the CMS website at: http://www.cms.hhs.gov/center/hha.asp. ■

Alliance to sponsor home health education and research

A group of home health organizations have formed the Alliance for Home Health Quality and Innovation (AHHQI) to support education and research, and to demonstrate the value of home-based care to patients, their families and policymakers.

The group is dedicated to improving the nation's health care system through solutions that include high quality, cost-effective home-based care models. This initiative comes at a time when policymakers are grappling with a changing health care landscape in the face of rising costs and patient demands for high quality, innovative health care approaches.

"The home health industry offers a well-developed delivery system of high quality, lower cost health care services — one of the most efficient and effective systems that exists in health care today," said Bill Borne, Founding Member of AHHQI and chief executive officer of Amedisys. "The Alliance will demonstrate the readiness of the home health care industry to offer this delivery system as a key component in implementing new and innovative initiatives to meet the health care needs of our nation, particularly for America's seniors." To learn more about AHHQI, go to www.ahhqi.org. ■

Palliative care access varies widely

Although more than half of the 50-bed or larger hospitals in the United States offer palliative care services to ease pain and suffering for seriously ill patients and their families, the availability of these services varies widely across geographic regions, according to a recent study.[1]

Whereas in 2000, only a few hospitals in the United States provided palliative care services, this report documents a steady overall increase in adoption of palliative care, with 52.8% of hospitals surveyed offering services aimed at alleviating pain and suffering. The number of large hospitals (more than 249 beds) with palliative care programs has increased to 72.2%, while fewer small hospitals (fewer than 50 beds) reported offering those services. Growth in palliative care has occurred primarily in not-for-profit hospitals and has been most notable in the midwestern and western regions of the United States.

COMING IN FUTURE MONTHS

- "Superbugs" spread to community settings
- Stroke program expands patient base
- A new tool for employee retention
- How to develop the best managers for your HHA

"This paper documents the success and applicability of this new field of medicine in American health care," says **Charles F. von Gunten**, MD, PhD, editor-in-chief of the *Journal of Palliative Medicine* and provost, Institute for Palliative Medicine at San Diego Hospice. "I hope it leads to the patient expectation that the expert relief of suffering will be as routine in hospitals as cardiology or surgery."

Reference

1. Goldsmith B, Dietrich J, Du Q, et al. Variability in access to hospital palliative care in the United States. *J Palliative Med* 2008; 11:953-1,060. ■

Hospice, home health drive more than UPS

NAHC study evaluates amount of home care travel

Nurses, therapists, home care aides, and others who serve elderly and disabled patients in their own homes drive nearly 5 billion miles each year. Caring for nearly 12 million patients annually with 428 million visits, the providers of home care and hospice services are health care's version of "road warriors," according to a study produced by the National Association of Home Care's (NAHC) Foundation for Hospice and Homecare.

The study shows that the number of miles driven by hospice and home care workers reached 4.8 billion miles in 2006. With the expansion in the use of lower-cost home care services as the average age of the U.S. population rises, the estimated miles driven for 2008 should well exceed 5 billion, according to the report.

Putting the miles driven in perspective highlights the magnitude of the undertaking in home care. The annual miles driven by the nurses, therapists, aides, and others is the equivalent of 1,386,458 trips across the United States at its widest latitude, 192, 920 times around the Earth, 10,017 round trips to the moon, and 52 trips to the sun. UPS, an international delivery service, drives just more than 2 billion miles every year globally, according to the report.

The data were calculated from more than 4,200 Medicare cost reports, as well as through an online survey of 1,200 home care providers. ■

CNE *questions*

5. What is the first step to take when an employee is accused of theft by a patient, according to Elizabeth E. Hogue Esq., a Burtonsville, MD-based attorney who specializes in the home health industry?
   A. File a police report
   B. Transfer the patient's care to another agency
   C. Remove the employee from the patient's home
   D. Help the patient look for the missing item

6. What is a reasonable value limit for a gift that an employee can receive from a patient, according to Elizabeth E. Hogue Esq., a Burtonsville, MD-based attorney who specializes in the home health industry?
   A. $10
   B. $25
   C. $40
   D. $55

7. What do supervisors and managers ask job applicants at Henry Ford Home Health Care in Detroit, MI to provide to help evaluate the applicant, according to Greg Solecki, vice president of the agency?
   A. References from previous patients
   B. A list of work-related goals
   C. A copy of previous criminal background checks
   D. Copies of past performance evaluations

8. What can a home health agency do to increase the likelihood that a patient will tell someone about concerns related to theft or, even, missed visits, according to Greg Solecki, vice president of Henry Ford Home Health Care in Detroit, MI?
   A. Supervised visits for first week or two of episode
   B. Patient satisfaction surveys in the admission packet
   C. Switching home health nurses and aides every two weeks
   D. Series of telephone calls from a supervisor throughout episode of care

Answer Key: 5. C; 6. B; 7. D; 8. D.

On-line bonus book for *HHH* subscribers

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*.

The report examines salary trends and other compensation in the hospital, outpatient, and home health industries.

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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** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

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