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Think your agency is prepared? GAO report changes face of state surveys

Surveyors focus on problems, cite more deficiencies

It started out as a normal planned survey at Visiting Nurse Health System (VNHS) in Atlanta. However, during the six weeks between the original survey in June and the resurvey, a complaint came in, changing the focus of the resurvey. The deficiencies cited as a result of the review survey placed the agency in jeopardy of losing its Medicare participation status.

"We were notified on Aug. 8 that we had 21 days to correct all the deficiencies or we would lose our Medicare status," says **Pat Reid**, RN, vice president of development for the home health system, which serves more than 20,000 patients throughout a 26-county area in Georgia.

Although existing patients continued to receive their regular visits, the agency stopped taking new admissions to enable staff members to focus on correcting the deficiencies and implementing a process to communicate with employees on a daily basis so they would know how things were going and could answer questions from patients and families. **(See story on emergency tactics, p. 4.)** The strategy worked, with an Aug. 27 exit interview that generated compliments from surveyors as to the speed and thoroughness with which VNHS responded, she adds.

The best news is that once insurers and other referral sources were notified that the agency was again accepting new patients, all of the business returned, says Reid.

While it's unusual for a home health agency to receive deficiencies that jeopardize its Medicare status, it easily can happen, even to an agency with a good record. The deficiencies for which VNHS were cited mostly were related to documentation and notification of physician, says Reid. **(See story on most often reported deficiencies, p. 3.)** "We never knew who called the state agency to complain about our care of a diabetic patient whose leg had to be amputated when it became gangrenous," she says. "The patient did not file the complaint," she adds.

The state survey environment has changed a lot since the General Accounting Office (GAO) issued a report in summer 2002 that reported inconsistencies and shortcomings in the oversight of home health agencies throughout the country. Specific states, including Georgia, were

identified as not following up on complaints in a timely manner, not reviewing an adequate number of charts, not citing deficiencies properly, and not resurveying in a proper manner. Although state surveyors say the GAO report has not influenced their survey practices, many home health managers contend that it must have had some effect.

"The environment has changed since the GAO report," says Reid. "We get about 12 complaints each year and have never had this experience. The survey is usually no problem, and there has never been any difficulty resolving the complaint," she adds.

With the changing approach of state surveyors as a result of the GAO report and the use of the Outcome and Assessment Information Set (OASIS) data to focus surveys, what can home health agency managers do to prepare for surveys and not be surprised?

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Editorial Questions

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"Check with your state home care association to see if there is a group that either meets with or gathers information from the state survey agency on a regular basis," suggests **Sherry Thomas**, BSN, MPH, senior vice president of the Association for Home & Hospice Care of North Carolina in Raleigh. "Our association produces quarterly reports that show licensure and certification trends, including deficiencies, as well as complaint trends," she explains.

"Our membership uses the information to review their own agency's performance and address issues that show up in surveys," Thomas adds.

Look at state trends

As the GAO report noted, survey practices differ from state to state, so while there are national data available, it's best to look at trends within your own state, suggests Thomas. Although the data are available to compare trends from state to state, that can be misleading, she points out. "Some surveyors may cite a deficiency in one standard, while another state's surveyor may cite the same item as a deficiency in another standard," she says.

Surveyors within the same state may differ as well, says **Brenda Beggs**, RN, CHCE, administrative director, Denton (TX) Home Health Care.

"We are part of a system that has home health agencies in two different survey zones, and when managers compare notes on surveys, we find that what is acceptable to surveyors in one zone is a deficiency to a surveyor in the other zone," she says.

Another way in which state surveys may change is the use of OASIS data to focus surveys, Thomas says. "Surveyors in our state [began] their training on the use of OASIS data in their pre-survey process in December [2002]," she says.

The tool used to analyze OASIS data prompts surveyors to make sure home health agencies have policies and procedures that cover all aspects of receiving, tracking, entering, and transmitting OASIS data, as well as policies that cover how the agency handles OASIS data if another vendor is handling the entry and transmission, she says.

That is important for home health agencies because managers need to make sure they are getting their own OASIS reports and not just relying on the vendor to provide updates or alerts, Thomas adds.

"Surveyors want to see that home health agencies are reviewing and using OASIS data

Avoid citations: Learn to spot common traps

Some deficiencies cited more than others

Although frequently cited deficiencies vary from state to state, there are a few that experts interviewed by *Hospital Home Health* point to as commonly recurring problems for home health agencies throughout all states:

✔ **Written plan of care**

For the third quarter of 2002, 24.65% of all agencies surveyed nationally were cited for not following a written plan of care. "This is one standard that surveyors are watching carefully, says **Sherry Thomas**, BSN, MPH, senior vice president of the Association for Home & Hospice Care of North Carolina in Raleigh.

"In North Carolina, we noticed that the number of deficiencies in this area jumped from five to 14 in one quarter," she says. To avoid this deficiency, make sure your nurses are following a written plan of care and documenting their care in the same words and manner in which the plan of care was written.

✔ **Incorrect initial assessments**

"Outcomes can be negatively affected when the admission nurse does not document a full assessment," says **Carolyn Duck**, RN, supervisor of Medicare Other Unit for the Alabama Department of Public Health in Montgomery. "We have been seeing cases of nurses who neglect to document evidence of mental problems such as disorientation or confusion at the patient's assessment," she says.

"Later, when the patient is discharged, the primary reason for home health care, such as a wound, may have healed, but the patient's outcome is not considered good because of disorientation or confusion that appears to have occurred while in home health care," she explains. It is important to document all aspects of a patient's condition, even if it is not related to the reason for home health care, she adds.

✔ **Failure to follow physician's orders**

This is one area in which home health nurses have no leeway, points out **Pat Reid,** RN, vice president of development for Visiting Nurse Health System in Atlanta. "If the orders call for a nurse to irrigate a Foley catheter with 50 cc of normal saline, the nurse cannot irrigate with an extra 30 cc even if she noticed some sediment and wanted to make sure the extra fluid ran clear," she says.

The extra 30 cc constitutes not following orders, she points out. According to Medicare regulations, the nurse should call the physician and ask for a verbal order to run extra fluid through the catheter, she says. Although physicians have told Reid that they don't see calls such as these as practical or in most cases, even necessary, Reid says that surveyors will cite you for not following physician orders, even when the extra action was necessary and safe for the patient. "We've even had physicians offer to write orders with a range rather than a specific number to enable our nurses to use their judgment but Medicare doesn't allow a range in an order," she adds. The only thing that can be done in a case like that is for the physician to indicate in the original order that an additional amount of fluid can be used if sediment is noticed.

✔ **Failure to report a significant change in patient's condition to physician**

While any home health nurse would report a significant change to the patient's physician, a surveyor's interpretation of "change" may not match the agency's, Reid says. "When one of our nurses arrived at a diabetic patient's home, the blood sugar level was 70. While the nurse was there, the patient ate breakfast," she says.

"Before leaving the home, the nurse took another reading and found it to be 130," she says. Although the rise in blood sugar was normal and due to the patient's food intake while the nurse was there, the surveyor stated that the nurse should have notified the physician since the blood sugar level jumped from 70 to 130, Reid points out. ■

to monitor their performance," she explains.

Surveyors also will ask home health agency managers to print out a final validation report for four to six records showing at least one assessment sent to the state. "This means that agency personnel have to be familiar with OASIS and be able to provide the validation reports when asked," Thomas points out.

Surveyors in Alabama have been using OASIS data to focus their surveys for several months, says **Carolyn Duck**, RN, supervisor of Medicare Other Unit for the Alabama Department of Public Health in Montgomery. "Our surveys are more focused, and we're able to concentrate on areas that appear to be potential problems for agencies," she explains.

Although Duck says that the GAO reports did not affect the way her surveyors approached agencies, she does say that they are seeing more condition of participation-level deficiencies than they have in previous years. "Most of the deficiencies are related to documentation issues," she says. For example, a surveyor may not see any notes in the chart related to a wound assessment before treatment, she explains. Although the nurse most likely performed the assessment, if it is not written in the

record, the surveyor has to assume the assessment didn't occur, Duck says.

The type of deficiency raises questions as to whether the nurse was too rushed to do his or her paperwork because of workload, or in some cases, the nurse may be unfamiliar with the computerized charting system, causing him or her to chart incorrectly, she suggests.

Even when cited for deficiencies, a home health agency has to look at surveys as a chance to improve, Reid says. "We now have teams composed of six nurses and two social workers, and each team manager is paired with a quality-improvement person to review charts and educate team members on a regular basis," she says. "Our medical director is also more involved and meets on a weekly basis with the clinical personnel to discuss our sickest patients."

One thing VNHS staff discovered is that they often were taking patients that were too sick for home health care, says Reid. "It's much easier for our medical director to talk to the hospital or referring physician and convince them that the patient may not yet be ready for home health care than a nurse," she says.

The medical director's involvement has made it possible for the patient to get care in the best setting and when the patient does enter home health care, the medical director stays involved in the case, Reid adds.

As the memories of a hectic three weeks of seven-day workweeks fade, Reid does admit that it was a good learning experience for both VNHS and the state survey agency.

"Although the deficiencies threatened our Medicare status, the experience has made us a better organization," she says.

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Constant communication vital for resurvey success

Agency stayed in touch and improved the process

While most home health agencies think of emergency preparedness plans to address business operations during a natural disaster or terrorist attack, the Visiting Nurse Health System (VNHS) in Atlanta discovered that a good emergency plan also is needed when a state survey results in condition of participation-level deficiencies that jeopardized the agency's participation in Medicare. **(See *Hospital Home Health,* November 2002, p. 212.)**

Because the agency was given 21 days to correct the deficiencies, it was important to have as many staff members available to work on developing and implementing needed changes, says **Pat Reid**, RN, vice president of development for the home health system. To meet the deadline, which required correction, not just a plan of action, VNHS stopped taking voluntary admissions from all insurers, hospitals, and other providers.

"I dreaded making those telephone calls, but it turned into an uplifting experience as everyone offered their support and expressed their belief in the quality of our service," she says.

While stopping new admissions seems extreme, VNHS chose to do so to enable staff members to focus completely on the corrections needed and to show the state survey agency that the home health firm took the citations seriously, Reid says.

"We also stayed in close contact with our employees during the three-week period," she explains. While communicating with employees who are in the field is a challenge, VNHS made use of its voicemail system to broadcast messages from the agency president. "The president would leave messages at least once a day updating employees on the progress we were making," she says.

This was important because some of the media coverage implied problems that would result in patients finding themselves with no home health care. "We wanted to make sure that our employees had up-to-date information so they could answer questions from patients and their families," she adds.

Nurses have told Reid that they would check their voice mail up to 10 times each day and that they appreciated how openly the agency communicated with them. ■

CDC's hand-hygiene rules work for home health

Hand washing, staff education cut infection rates

Your employees face different challenges than hospital-based personnel face, so they can't be expected to follow every guideline and process used in a hospital, right? Wrong, say infection control experts interviewed by *Hospital Home Health.*

Guidelines, that were developed by the Centers for Disease Control and Prevention's (CDC) Healthcare Infection Control Practices Advisory Committee (HICPAC) have been used within acute-care settings for years but they can be used in home care settings with the same effect of reducing infection, says **Michele L. Pearson**, MD, medical epidemiologist for the CDC's Division of Healthcare Quality Promotion in Atlanta.

"The first, most important activity to prevent spread of infection is hand washing," she says. "Home care personnel have been on the leading edge of facing obstacles to hand washing as they've faced home situations with no running water or unclean washing areas," Pearson points out.

For that reason, HICPAC's recently released hand-hygiene guidelines that encourage the use of alcohol-based hand rubs as a way to save time and encourage more frequent hand cleaning are guidelines that home care personnel can easily use in their day-to-day practice, she says. **(See CDC guidelines, at right.)**

Alcohol hand rubs big switch for CDC

The endorsement of alcohol-based hand rubs rather than soap and water, in many cases, is quite a departure for the CDC, she admits. "We now have enough research to demonstrate that in most cases a hand rub not only saves nursing personnel time and causes less irritation of the skin, but hand rubs also are readily accessible, so hand hygiene is improved," Pearson says.

Another factor research reviewed by HICPAC confirmed is that hand rubs do decrease bacterial counts enough to reduce the spread of infection, she adds. **(For more on hand hygiene, see *Hospital Home Health,* March 2002, p. 27.)**

A good flu and pneumonia immunization program also is important for a home health agency, Pearson says. **(See *Hospital Home Health,* December 2002, p. 136.)** Recent changes in Medicare policy related to standing orders may make it easier for home health agencies to implement a program. ■

Hand-washing guidelines allow alcohol-based rubs

New rules is a departure for the CDC

The biggest change in the Centers for Disease Control and Prevention's (CDC) recently approved hand-washing guidelines is the approval of alcohol-based hand rubs as an accepted method of cleaning hands between patients.

This is a departure for the CDC's previous recommendations because there now is enough scientific evidence to support alcohol-based products, says **Michele L. Pearson**, MD, medical epidemiologist for the Division of Healthcare Quality Promotion in Atlanta.

Other highlights of the hand-washing guidelines include:

- The use of alcohol-based hand rubs by health care personnel for patient care will address some of the obstacles faced when taking care of patients.
- Hand washing with soap and water remains a sensible strategy for hand hygiene in nonhealth care settings.
- When health care workers' hands are visibly soiled, they should wash with soap and water.
- The use of gloves does not eliminate the need for hand hygiene, nor does the use of hand hygiene eliminate the need for gloves. Gloves reduce hand contamination by 70% to 80%, prevent cross-contamination, and protect patients and health care personnel from infections. Hand rubs should be used before and after each patient, just as gloves should be changed before and after each patient.
- When using an alcohol-based hand rub, apply the product to palm of one hand and rub hands together, covering all surfaces of hands and fingers until hands are dry. Note that the volume needed to reduce the number of bacteria on hands varies by product.
- When evaluating hand-hygiene products for potential use, managers or product-selection

committees should consider the relative efficacy of antiseptic agents against various pathogens and the acceptability of products by personnel. Characteristics that can affect acceptability and, therefore, usage include smell, consistency, color, and the effect of dryness on hands.

(Editor's note: To see full text of hand-hygiene guidelines, go to: www.cdc.gov/handhygiene/.) ■

Catheter strategy sticks it to infection rates

Guidelines also stress proper staff education

Because intravenous therapy is handled by home care personnel, Healthcare Infection Control Practices Advisory Committee (HICPAC) guidelines on prevention of intravenous catheter infections especially is applicable to home care, suggests **Michele L. Pearson**, MD, medical epidemiologist for the CDC's Division of Healthcare Quality Promotion in Atlanta.

"[These are] some very specific recommendations, including the use of a 2% aqueous chlorhexidine gluconate solution to prepare catheter insertion sites," she says.[1]

Products containing chlorhexidine have been available in the United States only since July 2002 when the Food and Drug Administration approved the 2% solution for skin antisepsis, she adds.

The catheter guidelines **(see resource box, at right)** also stress the importance of educating staff as to the proper procedure for hand hygiene, skin antisepsis, and insertion of catheters, Pearson points out.

"Our findings show that even short educational programs have reduced catheter-related infections by 30%," she says. Although the data studied by the guidelines' authors were gathered from acute-care settings, the findings and recommendations are not exclusive to hospital settings, Pearson adds.

Sometimes, finding out what your infection rate is can be a challenge, but staff at Northwest Community Home Care in Arlington Heights, IL, have developed a process to identify patients at risk and follow up on infections that appear.

"Our admissions nurse fills out a form that lists possible risk factors for development of infections, then as nurses visit the patient, they look for symptoms of potential infections," explains **Shannon Quaritsch**, RN, BA, quality improvement specialist for Northwest Community Home Care.

Symptoms for which a nurse would look include fever, new antibiotic order, purulent drainage from a wound, change in odor or color of urine, or change in color or consistency of sputum. Once a potential infection is identified, the infection control supervisor evaluates the patient and contacts the physician.

The key to tracking infection rates and identifying ways to reduce infections was to have nurses turn in their intake reports as well as weekly infection control reports from regular visits, Quaritsch says.

Although employees are typically reluctant to report infections because they believe that an infection reflects badly on the care they are providing, she says that once the nurses saw how gathering the information actually helped them reduce infections, they asked for voice mail messages reminding them to send in the reports.

"As we've gathered data, we find that oftentimes we have to re-educate the family caregiver and even make the process of changing wound dressings easier so that they will perform the

Infection Control Resources

For information about setting up infection control programs in home care:

- ***Infection Control in Home Care*** by Emily Rhinehart. A special issue of the *Morbidity and Mortality Weekly Report* published by the Centers for Disease Control and Prevention. The issue is available on-line at: www.cdc.gov/ncidod/eid/vol17no2/rhinehart.htm.

- **Association for Professionals in Infection Control and Epidemiology,** 1275 K St., N.W., Suite 1000, Washington, DC 20005-4006. Telephone: (202) 789-1890. Fax: (202) 789-1899. Web site: www.apic.org. The association offers *Guidelines for the Prevention of Intravascular Catheter-Related Infections* and *Draft Definitions for Surveillance of Infections in Home Health Care* on its web site. APIC also offers *Home Care Handbook of Infection Control*, a home-care-specific quick reference guide for infection control. The handbook is available for $29 for APIC members and $38 for nonmembers.

dressing changes on a regular basis," she says.

One month, a rise in the number of pressure ulcers in patients caused Quaritsch to look closely at the patients to determine the cause of the ulcers. "We discovered that all of the patients came from one particular nursing home, so we offered to conduct an inservice at the nursing home," she says.

The staff at Northwest Community also works with the hospital's infection control department to identify the cause of infections as hospital-acquired or community-acquired, Quaritsch explains. By knowing where the infection began, treatment and prevention usually are more effective, she adds.

Infection control must be a continuous effort, Quaritsch points out. "We not only started our program with clear, well-defined guidelines based on scientific evidence, but we gathered baseline data prior to implementing our infection control program so we could evaluate its effectiveness."

Another key to success is to communicate results, she says. "Our infection control statistics are reported at all quarterly meetings, and I meet one on one with field nurses to go over the data."

Quaritsch also recommends setting priorities for the surveillance program by evaluating the patient population and focusing on the most typical infections. "In home care, we tend to see more pressure or other types of ulcers as well as post-op wound infections, but you also must look for urinary tract infections, bloodstream, and gastrointestinal infections. Also, involve an infectious disease specialist or infection control nurse in the development of your plan to add credibility."

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Reference

1. O'Grady NP, Alexander M, Dellinger EP, et al. Guidelines for the Prevention of Intravascular Catheter-Related Infections. *MMWR* 2002; 51(RR10):1-26. ■

HIPAA Q & A

[Editor's note: This is the first in a series of periodic columns that will address specific questions related to Health Insurance Portability and Accountability Act (HIPAA) implementation. If you have questions, please send them to Sheryl Jackson, Hospital Home Health, *American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsmjackson@cs.com.]*

Question: What information can discharge planners give home health agencies without a patient's permission?

Answer: Because gathering complete and accurate information upon home health admission is important, many home health managers are concerned that HIPAA regulations will restrict the type and amount of information that can be given upon patient referral.

Not so, according to **Elizabeth E. Hogue**, Esq., a Burtonsville, MD-based attorney who specializes in home health.

"Home care providers should not expect any change in the ability of discharge planners, social workers, or case managers at referral sources to share information with agencies about patients they want to refer once the HIPAA privacy regulations in effect on April 14, 2003," says Hogue.

"First, this is because revisions to the final regulations allow providers to share information for treatment, payment, and health care operations without patients' consent or authorization," she says.

Since hospitals and long-term care facilities, for example, are required by Medicare conditions of participation to provide discharge planning services, sharing information to comply with this requirement may fall within this exception to the need for consent or authorization, she adds.

This same exception allows providers to share information with other providers for treatment and payment purposes, points out Hogue. This portion of the exception also may serve as the basis for sharing such information since the information is necessary in order for other providers to render services to patients, she adds.

Staff responsible for discharge planning may be concerned, however, about referrals to entities that their employers own or in which

they have a financial interest, Hogue says.

Concerns may be based on the section of the revised final HIPAA privacy regulations that state that patients' authorization is needed for marketing purposes, she says.

"Because discharge planners are making referrals to other entities owned by their hospitals, they may be concerned that such referrals constitute marketing services that require authorization from patients," she explains. On the contrary, the revised final HIPAA privacy regulations make it clear that such activities constitute case coordination, not marketing, for which patients' authorizations are not needed, she adds.

"Anecdotally, we are already hearing reports of discharge planners who misunderstand the HIPAA privacy requirements," Hogue says. What should agencies do when the discharge planners in their hospitals misunderstand the above requirements?

"The best course of action may be to go to the designated privacy official within the organization to ask for clarification and communication with discharge planners," she suggests. ■

Turn one-time gifts into long-term pledges

Planned fundraising campaigns add support

Your budget is shrinking. Reimbursement is dropping. Expenses are rising. How can you meet the growing need for funds?

Fundraising campaigns are one way, but home health agencies typically don't run capital campaigns for one-time needs, says **Charles R. Hillary**, president of Hillary Lyons Associates, a fundraising consulting firm in Dimondale, MI.

"Home health and hospice agencies need to focus on long-term fundraising efforts that are designed to support all services of the agency, not just one immediate need," he suggests.

Hillary recommends that home health and hospice organizations take a look at how they can convert their periodic memorial gift givers into ongoing contributors. "People who make memorial contributions based on their good feelings about your agency and how you treated their family member are an excellent way to build a donor base," he says.

The funds can be significant for agencies that take the time and effort to build a fundraising program, says **Anne E. Koepsell**, MHA, executive director of the Hospice of Spokane (WA).

"Between the years 1985 and 1997, we usually received around $300,000 in donations," she says.

Following her efforts to establish a formal program for fundraising, her agency has seen growth in donations rise to $544,000 in 2000 and $937,000 in 2001. "Part of the money we raised in 2001 are funds designated for use to build a hospice house, but the undesignated funds are at least $600,000," she says.

Undesignated funds are used to underwrite programs such as bereavement classes, new services, and staff salaries, Koepsell explains.

Hospital affiliates have extra challenge

Koepsell's agency is not affiliated with a hospital, so it was easy for her to gain approval to actively solicit funds.

"Hospital-affiliated hospice and home health agencies may have to get permission to conduct their own fundraising activities, but it can be done," Hillary says.

He suggests that agency managers offer to get staff and themselves involved in the hospital's fundraising effort and offer community-service activities such as seminars on health-related issues or bereavement issues as a way to help the hospital foundation's community efforts.

"The more educated donors and your own hospital fundraisers are about your services, the more likely you can participate in raising or helping distribute funds received," Hillary says.

"We are not allowed to solicit our own funds, and whatever donations we do receive from patients or the community go directly to the hospital foundation," says **Judy Hannah**, RN, director of home health care and hospice for Hamilton Medical Center in Dalton, GA.

"All of our employees do participate in the hospital's fundraising campaign through payroll deduction, and we often do request financial assistance for some of our patients through the foundation," she says.

"Almost all of our requests are for hospice patients who need financial assistance to pay for medications, add a room air conditioner during the summer months, or pay essential bills such as rent or telephone," Hannah says. Although most home health patients don't require the same type of assistance, it is available if needed, she adds.

Hannah does point out that if funds are designated for use in hospice or home health, they

must be used in those areas. "We have one hospice benefactor who donated a substantial amount of money and designated it for the hospice's use," she says. The funds were used to refurbish and refurnish the hospice agency's offices to make them more efficient, she adds.

If you can solicit your own funds, be sure to think long term, says Hillary. Design your program to ask first for donations from two groups that are already believers in your good service, he says. "Solicit funds from employees and from people who have already contributed," he says.

Not only are these two groups readily available, but also it is important to show that your employees support your efforts before you go to community donors, he adds.

Rely on community leaders

The most successful long-term fundraising programs are based on a system of committees composed of community volunteers, Hillary says. "We set up committees such as annual support, planned giving, and major gifts. The leaders of these committees as well as key community leaders make up the volunteer governing board," he says.

Each committee chair is responsible for recruiting committee volunteers and developing a plan for soliciting donors, he explains. Employees volunteer to serve on the employee giving committee and set their goals and objectives, he adds.

Be sure to recognize your donors with letters, preferably handwritten, never e-mailed, Hillary says. "I also recommend telephone calls and will often suggest a board meeting at which half of the time is spent calling donors to say thank you," he says.

While technology has made mailing, receiving, and tracking pledges much easier, it's important to remember that fundraising is an effort that requires a personal touch, he adds. Also, don't forget public displays such as a wall of honor that displays donors' names in a lobby or area that others will see, he suggests.

Setting up a fundraising program doesn't require the use of a consultant, but Koepsell chose to hire a consultant when she realized that her staff did not have the expertise or experience to keep everyone focused on the task during the formation of the committees and kickoff of the program.

If you choose to use a consultant, look for one that offers assistance in the specific type of program in which you are interested, suggests Hillary. "Some consultants specialize in long-term fundraising, capital campaigns, or planned giving," he says.

One good source of information is the Association of Healthcare Philanthropy in Falls Church, VA, and colleagues in other agencies that have conducted campaigns, he suggests.

While long-term fundraising foundations or programs don't have the specific amount of money to raise or a brick-and-mortar project to describe to potential donors, it still is important to be specific about how the money is used, says Hillary. "In all of your reports, describe how much you raised and how the funds were used," he says. If you add a music therapy program, a special camp for children who have lost a parent, new equipment, or extra staff that enable you to provide a service for which you previously had to rely upon outside contractors, describe how it benefits your patients, he explains.

Be careful with fundraising expenses

You also need to watch how much you spend to raise funds, adds Hillary. In the first two years of a fundraising program, plan to break even at best, he says. But in the third through fifth years, plan on spending less than 20 cents to 25 cents to raise each dollar, he suggests.

Koepsell's agency spent a little more than 13 cents per dollar raised in 2001. "We do have a total of two full-time equivalents allocated to support the fundraising effort," she explains. The staff people coordinate the volunteer meetings, handle paperwork such as minutes, receive and track donations, and generate reports for the governing board.

"We started by assigning two staff people to handle support of the fundraising effort as well as community education, but it was too much," Koepsell says.

Now, the director of fundraising spends about half her time on community education, and another employee also splits time between fundraising and community education, she explains.

You can keep fundraising costs down by selectively recruiting some volunteers, Koepsell points out. "We have a printer on one of our committees, and he printed our brochures at a very low cost," she says.

"We encourage 'in-kind' donations from our donors because it is an easy way for them to

donate and it keeps our costs down," she adds.

Brochures don't have to be glitzy, but they do have to present a professional image for your organization, Koepsell says. "I don't want people thinking that the money they've donated was used for a fancy brochure, but I do want them to understand the high professional standards we have for our agency, and the goals and objectives of our fundraising efforts."

[For more information about fundraising, contact:

- ***Charles R. Hillary**, President, Hillary Lyons Associates, P.O. Box 99, Dimondale, MI 48821. Telephone: (517) 646-2096. E-mail: hillarylyons@att.net.*
- ***Anne E. Koepsell**, MHA, Executive Director, Hospice of Spokane, P.O. Box 2215, Spokane, WA 99210-2215. Telephone: (509) 456-0438. E-mail: akoepsell@hospiceofspokane.org.*
- ***Judy Hannah**, RN, Director of Home Health Care and Hospice, Hamilton Medical Center, 1103 Memorial Drive, Dalton, GA 30720. Telephone: (706) 226-2848.*
- ***Association of Healthcare Philanthropy**, 313 Park Ave., Suite 400, Falls Church, VA 22046. Telephone: (703) 532-6243. Fax: (703) 532-7170. Web site: www.ahp.org. The organization offers a variety of publications about fundraising and fundraising consultants.]* ■

LegalEase
Understanding Laws, Rules, Regulations

Get pre-authorizations from MCOs with OIG's help

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

Home care providers still are struggling to obtain authorizations from managed care organizations (MCOs) for medically necessary and appropriate care.

MCOs may bear the risk of any legal liability associated with failure to provide medically necessary and appropriate care, especially when providers protest such adverse payment decisions.

Now, there is an additional avenue for staff to pursue to obtain authorizations for medically necessary and appropriate care. Specifically, the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, the primary enforcer of fraud and abuse prohibitions, has indicated that it will pursue MCOs more aggressively for violations of the False Claims Act when they fail to provide needed care or provide substandard care for patients.

The False Claims Act is a federal statute, so it applies to MCOs all over the country that provide services to Medicare and Medicaid patients. It also applies to MCOs that provide services to patients of other state and federal health care programs.

Defining fraudulent billing

Generally, the act says that anyone who writes down something on a piece of paper that is not true and sends it to the federal government to get paid has engaged in fraud.

The OIG also has indicated that when providers submit claims for care rendered to patients to the government, providers promise that the care was reasonable and necessary. If the government subsequently determines that the care does not meet these standards, it is a false claim even though everything written on the claim form is true.

For example, such a claim occurs when providers are ordered by physicians to put betadine on patients' pressure ulcers. Treatment of pressure ulcers with Betadine is no longer considered to be within applicable standards of care for wound care.

Consequently, claims that indicate staff applied Betadine to patients' pressure ulcers are false claims, even though everything written on the claim form is true.

Home health staff members should not hesitate to point out to the representatives of MCOs that provision of substandard or inappropriate care for patients may be fraudulent. Perhaps, the clearest example occurs when providers are caring for fee-for-service Medicare patients who elect to join a Medicare MCO. Patients may be receiving a variety of types of supplies and equipment.

The company has been routinely paid for these services. Although there are no changes in the patient's clinical condition, the MCO denies authorization for further supplies and equipment and/or drastically reduces them. This is a relatively clear-cut example of substandard care.

Agencies should not hesitate to make the argument that inappropriate services and substandard care are violations of the False Claims Act. MCOs worth their salt will sit up and take such observations from providers seriously.

[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.] ■

Medicare tests program for smoking cessation

Medicare beneficiaries living in seven states chosen to pilot a Medicare stop-smoking program will have access to smoking-cessation strategies not normally covered by Medicare.

Beneficiaries who are older than 65 and living in Alabama, Florida, Missouri, Nebraska, Ohio, Oklahoma, and Wyoming will receive free therapy that may include counseling in person or over the telephone, nicotine patches, a prescription smoking-cessation drug, and educational materials.

Strategies that will work for older smokers

Those strategies will be tested in various combinations to determine which strategies are most effective for older smokers. Once enrolled, beneficiaries will be assigned to one of the study options and will have access to the services for one year. Results of the study will be available in 2005.

To enroll, Medicare beneficiaries who are older than 65, living in one of the seven pilot program states, and enrolled in fee-for-service Medicare Part B, can call (866) 652-3446 for more information about the study and to find out if they are eligible to participate. ▼

CMS proposes tracking hospital referrals to HHAs

The Centers for Medicare & Medicaid Services has issued a proposed rule to collect information on hospital referrals to home health agencies and other entities with which the hospital has a financial interest.

Once collected, the information will be made available to the public.

The purpose of the rule is to ensure that patients have an opportunity to make an informed choice of home health agency to which they are referred.

Hospitals are required to show a list of Medicare-certified agencies that serve the patient's geographic area.

Hospitals must indicate the agencies with which there is a financial interest and hospital personnel are not permitted to specify a agency that must provide services.

One result of the proposed rule might be a change in hospital-referral patterns, affecting some home health agencies' new admissions.

To read the full text of the proposed rule, "Nondiscrimination in Post-hospital Referral to Home Health Agencies and Other Entities," go to: www.access.gpo.gov/su_docs/aces/aces140.html. List title in search terms and enter 11/22/2002 as the date.

Comments on the proposed rule will be accepted until 5 p.m., Jan. 21, 2003.

Mail written comments (one original and two copies) to: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1224-P, P.O. Box 8014, Baltimore, MD 21244-8014. Refer to file code CMS-1224-P within your comments. ■

COMING IN FUTURE MONTHS

- HHA public quality reports: What do they mean to you?
- Understanding and choosing external benchmarks
- Don't cross this line when soliciting referrals
- Answers to your HIPAA questions
- What should you do with those sacred cows?

CE *questions*

13. What did Visiting Nurse Health System of Atlanta do to make sure a deadline for correcting deficiencies that jeopardized their Medicare status could be met?
    A. appealed the surveyor's findings
    B. stopped taking new admissions to enable staff to focus on corrections
    C. communicated daily with office and field staff
    D. B and C

14. What percentage of home health agencies surveyed nationally by their state organizations were cited for failure to follow a written plan of care?
    A. 15.75%
    B. 17.65%
    C. 24.65%
    D. 32.75%

15. What is recommendation of the Healthcare Infection Control Practices Advisory Committee's guidelines on catheter care that can reduce infections, according to Michele L. Pearson, MD, medical epidemiologist for the Division of Healthcare Quality Promotion?
    A. Schedule regular staff education on catheter insertions.
    B. Change catheter more frequently.
    C. Use 2% aqueous chlorhexidine gluconate solution to prepare catheter insertion sites.
    D. A and C

16. What is a key component of any fundraising campaign, according to Charles R. Hillary, president of Hillary Lyons Associates, a fundraising consulting firm?
    A. well-designed brochures with color photographs
    B. a nationally known spokesperson
    C. personal and public recognition of donors
    D. "bricks and mortar" project that people can see

Answers: 13. C; 14. D; 15. C; 16. D

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. ■