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IN THIS ISSUE

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Public to get access to home health quality information thanks to CMS

Review indicators and start preparing now

Nursing homes have been living with public reporting of quality information by the Centers for Medicare & Medicaid Services (CMS) since November. Now, home health agencies will undergo the same type of public scrutiny.

In April 2003, a pilot project testing quality indicators and pubic reporting mechanisms will begin in six states. While those states had not been chosen as of press time, Florida most likely will be at the top of the list, according to CMS.

Other states quite possibly could include Virginia, Missouri, Tennessee, South Carolina, Massachusetts, Oregon, Texas, Iowa, Pennsylvania, or Wisconsin, says **Ann B. Howard**, director of federal policy for the American Association for Homecare in Alexandria, VA. "National implementation is scheduled for October or November of 2003," she says.

While the indicators chosen for nursing home public reports were chosen with no input from the nursing home industry, CMS did include home health representatives on the technical panel that chose the initial quality indicators for home health, Howard says. The 11 indicators **(see box, p. 15)** have created concern for some agencies, but overall, most seem to be pleased with the clinical indictors chosen, she says. The indicators had not been finalized as of press time, but Howard expects all 11, perhaps with minor changes, to be approved.

The biggest concern for many agencies will be the number of indicators that are related to improvement and the public's ability to understand the information, says **Kathy Green**, RN, vice president of product strategy for Healthcare Quality Solutions, a Tampa, FL-based software company that specializes in home health products. "When we look at benchmarking information for our customers, we see that for all outcomes, there is generally improvement in 50% to 58% of all patients," she says. "This means that any home health patient has a 50-50 chance of improving with any agency."

What the public doesn't understand is that the goal of home health is to stabilize and prevent deterioration of a patient's condition in most cases, Green says. "Most often, home health patients improve as much

as possible in the hospital. Once in home health, some patients, such as stroke patients, are expected to show improvement, but a cardiac patient is not likely to improve."

It will be hard for the general public to understand why patients don't improve because the indicators imply that all home health patients should improve, she adds. "What the public won't see with these quality indicators is that we all do a great job stabilizing patients." In fact, Green's company's data show that home health agencies effectively stabilize 80% to 90% of their patients.

Even with this concern, Green says home health agencies have an opportunity to show improvements in all indicators and to greatly improve care to patients. Six of the 11 proposed indicators are related to rehab therapy, she says.

"I think it is exciting that there is an emphasis on rehab therapy because the information from our database shows that patients who receive rehab therapy have better outcomes than patients who don't receive therapy," she says.

In geographic areas where rehabilitation therapists are in short supply, the therapy-related quality indicators will be a problem, says **Phyllis W. Fredland**, RNC, BSN, executive director of Health Personnel Inc., a home health agency based in McKees Rock, PA.

"Most of the complaints I hear from other agencies is how long they have to wait for therapists to see patients and how hard it is to coordinate care with therapists," Fredland says.

For an agency to show improvement in the rehab-related indicators, its manager will have to make sure that care between nurses and therapists is coordinated closely and improvements are documented and reported, she adds.

Another approach to addressing patients' needs for therapy is to incorporate rehab nursing into an agency's services, Green suggests. "I don't believe that most home health agencies think in terms of rehab nursing to address simple therapy needs, but it can be an effective approach."

By training nurses to recognize therapy needs and implement activities to address the needs, home health agencies can help patients who may not qualify for therapy visits, she adds.

Incremental progress not measured

Some home health managers have pointed to the lack of specificity and clear definition of some of the indicators as a problem, Howard says.

"For example, the indicator related to improvement in pain is very general and may not reflect true improvement," she says.

Fredland agrees. "The question related to pain asks if the patient has no pain, pain that does not occur daily, daily pain that is not constant, or constant pain. I might have a patient who experiences pain six times each day initially, but then progresses to experiencing pain only twice each day. The way that the question is asked does not enable me to demonstrate improvement with this patient even though the amount of pain is decreased to one-third of the original pain."

The same problem arises with the indicator related to ambulation, she adds. "Even if my patient improves the ability to walk with a walker from 15 feet to 200 feet, there is no change in his or her condition according to the question which combines all walking with a device in the same category," Fredland says.

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Howard also has heard many agencies express concern that not all indicators are risk-adjusted. "Some managers whose agencies take the sickest patients are worried that their care will seem less effective because they have patients who won't show improvement." Another concern expressed by many agencies is that some home health agencies will be reluctant to accept very frail, old, or sick patients, she adds.

Statistically, agencies that are larger and accept sicker patients also may have the greatest opportunity, Green points out. "The more acute patient has more opportunity to improve than the less acute patient," she says.

Focus on quality indicators

"The best advice for home health managers is to teach [their staff according] to the test," Howard emphasizes.

"Focus on the quality indicators when the final list is approved because these are the indicators that will focus upon best practices," she says.

In fact, start looking at your outcomes for each of the indicators now, even if you are not located in one of the pilot states, Green suggests. "If you are low in any of the categories, or even average, look at ways to improve," she says.

All home health agencies can expect to see a 5% increase in all scores by the time CMS publicizes the results nationally, she adds. This will be the result of many agencies focusing upon the indicators and addressing ways to improve.

"This means that if you are average now, but do nothing to improve your outcomes, you'll drop below average as everyone else improves," she explains.

Streamlining your systems, care mapping based on outcomes related to these quality indicators rather than just diagnoses, and teaching staff members the basics of outcomes-based quality improvement will help your agency as "scores" are publicized, Green says.

Although this may seem like one more burden to handle along with reimbursement cuts and staffing challenges, it is an opportunity for home health agencies to demonstrate to the public and to potential employees how well they care for patients, Green says. "We all want to provide better quality care, and this is one more tool we can use to help us achieve our goal."

[For more information about CMS' publication of quality indicators, contact:

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CMS' 11 Home Health Quality Indicator Measures

The Center for Medicare & Medicaid Services in Baltimore has proposed 11 quality indicator measures for the pilot phase of the Home Health Quality Indicator Initiative, which involves public reporting of quality improvement indicators as of Jan. 1, 2003.

These indicators may change to some extent after final review expected in mid- to late-January, says **Ann B. Howard**, director of federal policy for the American Association for Homecare in Alexandria, VA. The indicators are:

1. **Acute-care hospitalization** (had to be admitted to the hospital)
2. **Improvement in ambulation/locomotion** (getting better at walking/moving with less equipment)
3. **Improvement in bathing** (getting better at bathing themselves without help)
4. **Improvement in management of oral meds** (getting better at taking medicines without help)
5. **Improvement in transferring** (getting better at getting in and out of bed without help)
6. **Improvement in upper-body dressing** (getting better at dressing themselves without help — upper body)
7. **Improvement in toileting** (getting better at getting to or from the toilet without help)
8. **Improvement in pain interfering with activity** (having less pain when moving around)
9. **Stabilization in bathing** (staying the same at bathing themselves without help)
10. **Improvement in confusion frequency** (confused less often)
11. **Any emergent care provided** (needed emergency medical care)

Communication, activities help dementia patients

Staff training improves satisfaction as well as care

The challenges of caring for a patient with dementia differ from patient to patient because the symptoms vary greatly between patients. There are, however, ways to communicate and methods to employ that enable patients to retain or enhance abilities and experience less agitation.

"First, we need to remember that dementia is a cluster of symptoms, not just one disease," says **Nancy Ledoux**, MDiv, chaplain at Hospice Care in Stoneham, MA.

Dementia is characterized by memory loss, confusion, and impaired judgment, but can be caused by a multitude of illnesses such as Parkinson's disease, multiple strokes, and Huntington's disease, she says. "Of course, the greatest cause of dementia is Alzheimer's disease, which accounts for 75% of all dementias," she adds.

Because certain medications and depression can increase confusion in patients, be sure to evaluate the patient's medications and emotional state before assuming all of the symptoms are attributable to dementia, Ledoux says. Sometimes, minor changes in medication can improve their cognitive function, she adds.

"Although memory deficit is a hallmark of dementia, I don't believe it is the main challenge we face in caring for patients," says **Jan McGillick**, MA, senior director of education and outreach for the Alzheimer's Association of St. Louis. The greatest challenge is learning to communicate in a manner that doesn't upset or further disorient the patient, she says.

Ledoux agrees. "You have to recognize that the patient has lost some of the capacity for reasoning and communicating that we take for granted. We have to figure out how to communicate in a manner that makes sense to them.

"It's important to relate to a dementia patient on an emotional level," she points out. "Approach the patient in a happy manner. Even if you're having a bad day, don't let the patient see that you're worried or distracted." The content of your greeting and conversation is less important than the tone of voice and body language you display, she adds.

For example, move slowly and smile, Ledoux suggests. "Always introduce yourself and schmooze a little before taking out the stethoscope. You can comment on the weather or talk about a photograph on a nearby table," she says.

"Even after you begin taking vital signs, go slowly and explain exactly what is going to happen. I know one nurse who places the stethoscope on her chest first to show the patient what she is going to do," she explains.

"Plan extra time with a dementia patient," says Ledoux. If you can take time to keep the encounter calm and nonthreatening, the patient will benefit throughout the entire day, she says. "Even if the patient cannot remember what you discussed or what you did, the patient will remember the calm, reassuring environment you created.

"You need to stop what you're doing if you notice the patient becoming agitated. Tell the patient that you're sorry and didn't mean to upset anyone, and then say that we'll just do this another time," she suggests.

Montessori activities improve interaction

Home health aides have an opportunity to make a big difference in a dementia patient's condition, says **Kathy Kaiser**, RN, BSN, administrator of Menorah Park Home Health Care Services in Beachwood, OH.

A research program that has studied the effect of Montessori-based activities on nursing home patients with memory loss was expanded into the home health arena last year. **(See description of Montessori teaching methods, p. 17.)**

The research is conducted by the Beachwood, OH-based Myers Research Institute, with a grant from the Wolf Family Foundation in London, Ontario, with Menorah Park home health aides and patients.

"We found a 10% increase in a patient's pleasure and a 20% increase in constructive engagement when Montessori-based activities are used during an aide's time with the patient," Kaiser says.

At the same time, there was a 3% decrease in patient anxiety. The decrease in anxiety is attributable both to the patient's involvement in an activity and the ability of the aide to cope better with dementia patients as a result of the training aides receive in the program, she adds.

Because the Montessori method is based on teaching skills in a sequential manner with each component of the activity practiced one component at a time, the activity can be as simple or as

Hands-on projects may stimulate conversation

Increased motor skills help across the board

Montessori-based programming is based upon the work of Maria Montessori, an Italian physician who, in the early 1900s, introduced the concept of enabling children to learn at their own pace with manipulatives and tools that help them understand concrete ideas before moving on to abstract ideas.

"The use of Montessori activities in home health is designed to help dementia patients maintain or improve skills they need in their daily lives," says **Kathy Kaiser**, RN, BSN, administrator of Menorah Park Home Health Care Services in Beachwood, OH. Although each patient's ability to improve a skill varies according to the stage of the disease, the greatest achievement is a sense of accomplishment and a social connection with the home health aide who is spending time with the patient, she adds.

It's important to pick an activity to which a patient can relate, suggests **Jan McGillick**, MA, senior director of education and outreach for the Alzheimer's Association of St. Louis. For example, an aide with a patient who had enjoyed traveling collects inexpensive postcards from different places and puts them in a basket that she brings on her visits to the patient, she says.

"The aide makes a cup of tea for herself and the patient, and they sit down to look at the cards and talk about the different places. Not only is this an enjoyable conversation for the patient, but she is using fine motor skills to remove the cards from the basket and mental skills to focus on the cards and discuss the different locations," she adds.

Other activities that can be introduced include:

SORTING/MATCHING

By sorting pieces of cloth, cardboard shapes, or even pictures from magazines, the patient stimulates mental skills, McGillick says. The sorting or matching activity can focus on shapes, colors, and similar categories.

Whenever possible, make the activity relate to the patient's experience or interest, suggests Kaiser. For example, if the patient was an interior designer, use scraps of carpet or wallpaper in the sorting activity. Not only will this stimulate the patient's mental and sensory skills as each item is handled, but it may also prompt conversation about the patient's former occupation, she adds.

MOTOR SKILLS

Place golf balls into a muffin pan and ask the patient to use an ice cream scoop to remove them and place them in a basket, Kaiser suggests. The objects are large enough for patients to handle easily, but activity stimulates and strengthens the same motor skills used for self-feeding, she adds.

Other fine motor skill activities are stringing beads and cutting activities, McGillick says. Cutting paper is more meaningful if you have the patient cut coupons that can be used by family members, she says.

COOKING

If your patients enjoyed cooking, bring a box of muffin mix and cook together, McGillick says. The mixes are not complicated, and your patients will enjoy the sense of accomplishment when they can offer the treats to their families, she adds. The stirring, measuring, and pouring involved in preparing the muffins also are good motor skill activities, she adds.

GARDENING

Patients who used to garden as a hobby enjoy activities that involve identification of plants or repotting plants, McGillick says. The aide can look through gardening books or magazines with the patients to encourage conversation about their hobby.

PERSONAL GROOMING

"If your patient is someone who always has been concerned about hair, makeup, or nails, be sure to recognize the concern and offer to paint fingernails or fix makeup," McGillick says. For someone who always spent time on appearance, personal grooming meant more than just brushing teeth and being clean, she adds. By doing something as simple as painting fingernails, you can improve the patient's self-esteem, she explains. ■

complex as the patient can handle, Kaiser says.

All of the activities are designed to improve the patient's ability to handle normal activities of daily living, even if at first glance, the activities don't seem to relate to actions such as buttoning shirts, says **Gregg Gorzelle**, research analyst and project manager for the Montessori program. For example, activities such as stringing beads, lacing, and cutting paper promote use of fine motor skills that can translate to buttoning a blouse.

One of the most beneficial aspects of incorporating these activities into an aide's interaction with the patient is the social aspect of the aide's time with the patient, Kaiser says. "Our research shows that the patient is more engaged and less agitated when the aide spends time interacting with the patient," she adds.

The interaction needs to be nonthreatening, and

geared toward the patient's abilities, McGillick points out. You also should speak precisely, she adds.

"Don't use pronouns or abstract words. [For example, say], 'Your husband gets home at 4 p.m.,' rather than 'He gets home later,'" she says.

Avoid asking questions that make the patient feel as if he or she must make a decision, McGillick suggests. "Rather than asking the patient if he or she thinks it's a good day to take a walk, just state that it is a good day to take a walk," she says.

Scrapbooks or coffee-table books with big pictures can be good conversation stimulators, she says. Memory books in which the aide helps the patient create a scrapbook of his or her life also is helpful. "Ask the family for basic information to get started and then add to the story with the help of the patient."

By talking with the patient about memories of parents, childhood events, spouse, and children, the aide can engage the patient in a pleasant activity that keeps the patient engaged, McGillick adds.

Questions asked during this conversation should be phrased to elicit more than yes or no answers, she points out. For example, ask, "How did you meet your husband?" rather than, "Did you meet your husband at a friend's house?"

At Menorah Park Home Health Care, aides who are chosen for the program attend four one-hour training sessions where they learn about basic dementia-care topics, coping skills, Montessori methods, and hands-on applications, Gorzelle says. Aides with the special dementia-care training do receive additional pay as part of their advancement on their career ladder, he says.

Although the financial incentive is appreciated, the aides are most satisfied with the additional knowledge they gain and their increased confidence that they can provide good care, he adds. Because it's hard to find and keep good home health aides, this program is one more way to improve retention and attract good employees, he points out.

"I would hand-pick the aides to go into this program," Kaiser says. The criteria should include maturity, caring attitude, initiative, few discipline problems, and longevity with the agency, she says.

Kaiser includes longevity as program criteria, because the agency is investing time and money to train the aide and wants to make sure the aide stays for a while.

At this time, Menorah Park is offering the program only to private-duty patients, and there is no charge, Kaiser says. "We are looking at a charge structure that might be $1 to $3 more per hour," she says.

Family members also are very pleased with the program, she says. "They see the aide doing something with the patient, and they notice the patient's decreased agitation."

One family that especially is pleased is a son and his second wife who live across the street from the patient, Kaiser says. "Instead of recognizing the second wife as a wife, the patient referred to her as 'that hussy,'" she says. "After using the memory book to look at pictures of the wedding and talk about the daughter-in-law, the aide was able to help the patient recognize and accept the woman as her son's wife."

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- ***Myers Research Institute**, 27100 Cedar Road, Beachwood, OH 33122. Telephone: (212) 360-8212. Web site: www.myersresearch.org. The institute publishes* Montessori-based Activities for Persons with Dementia, *a guide to implementing a program within a nursing home. Although the book is geared toward nursing home patients, the many activities described in the program can easily be adapted to home health.]* ■

Home health should prepare for smallpox

Though not frontline, some areas are involved

Although the recently announced smallpox vaccination plan doesn't identify home health workers as members of first response teams to receive possible smallpox patients, the home health industry stills needs to pay attention to the

(Continued on page 20)

Smallpox vaccination is a simple procedure

Although there are few health care workers today who administered smallpox vaccines in the earlier eradication effort, the process of administering the vaccine is simple, says **Steven Christianson**, DO, MM, medical director of the Visiting Nurse Service of New York in New York City. There are, however, some differences in skin preparation and care of the vaccination site. This vaccination information is found on the Centers for Disease Control and Prevention smallpox web site (*www.bt.cdc.gov/agent/smallpox/index.asp)*:

MULTIPLE PUNCTURE VACCINATION

During the global smallpox eradication effort, the bifurcated needle was used along with a technique called multiple puncture vaccination. Today, this still is the recommended method for administering smallpox vaccine. Each bifurcated needle is sterile and individually wrapped. The bifurcated needle is for one-time use only and should be discarded in an appropriate biohazard container immediately after vaccinating each patient.

Step-by-step instructions

1. **Review patient history for contraindications**
2. **Choose the site for vaccination**
   The deltoid area on the upper arm is preferred.
3. **Skin preparation**
   No skin preparation is required. Under no circumstances should alcohol be applied to the skin prior to vaccination as it has been shown to inactivate the vaccine virus.
4. **Dip needle**
   The needle is dipped into the vaccine vial and withdrawn. The needle is designed to hold a tiny drop of vaccine of sufficient size and strength to ensure a take if properly administered. The same needle should never be dipped into the vaccine vial more than once, to avoid contamination of the vaccine vial.
5. **Make perpendicular insertions within a 5 mm diameter area**
   The needle is held perpendicular to the site of insertion. The wrist of the vaccinator should be maintained in a firm position by resting on the arm of the vaccinee or another firm support. A number of perpendicular insertions are made in rapid order in an area approximately 5 mm in diameter. Refer to the package insert for the exact number of insertions. Strokes should be vigorous enough to evoke a trace of blood at the site after 15-30 seconds. The bifurcated needle is for one-time use only and should be discarded in an appropriate biohazard container immediately after vaccinating each patient.
6. **Absorb excess vaccine**
   After vaccination, excess vaccine should be absorbed with sterile gauze. Discard the gauze in a safe manner (usually in an infection control receptacle) to avoid contaminating the site or infecting others who may come in contact with it.
7. **Cover vaccination site**
   It is important that the vaccination site be covered to prevent dissemination of virus. Recommended coverings include the following:

- Sterile gauze should be loosely secured by tape (taking care to obtain history of tape sensitivity).
- Health care workers involved in direct patient care should keep their vaccination site covered with gauze or a similar absorbent material. This dressing should, in turn, be covered with a semipermeable dressing. Products combining an absorbent base with an overlying semipermeable layer also can be used to cover the vaccination site. Health care workers do not need to be placed on leave after receiving a smallpox vaccination.
- Vaccinees in settings where close personal contact is likely (such as parents of infants and young children) should cover the vaccination site with gauze or a similar absorbent material, wear a shirt or other clothing that would cover the vaccination site, and also make sure to practice good hand hygiene. Perforated plastic bubbles also have been used to cover the vaccination site.

Note: *The use of semipermeable dressing alone could cause maceration of the vaccination site and increased, prolonged irritation and itching at the site, thereby increasing touching, scratching, and contamination of the hands. Thus, only those who are health care workers involved in direct patient care should use semipermeable dressings (over gauze or a similar absorbent material as described above).*

8. **Educate vaccinee**
   To avoid contact transmission of the virus, vaccinees must be cautioned to do the following:

- Do not rub or scratch vaccination site.
- Keep site covered and change dressing every one to two days or if wet.
- Discard gauze carefully in plastic bags.
- Wash hands thoroughly after touching vaccine site or handling gauze.
- Report any problems to the healthcare provider who administered the vaccine.
- Return seven days after vaccination for a “take” check (to see if the vaccination was successful).
- Record the vaccination.
- Record the following information in the patient record history form:
  — Vaccine used
  — Diluent used
  — Lot number
  — Any adverse reactions

Source: Centers for Disease Control and Prevention, Atlanta.

issue and prepare to serve a role if needed, says **Steven Christianson**, DO, MM, medical director of the Visiting Nurse Service of New York in New York City.

The current draft of the plan calls for febrile contacts to be initially monitored in a facility then discharged to home for further monitoring, he points out. Although the plan allows for telephone monitoring, the guide states that if resources are available, closer monitoring such as daily visits would be good, Christianson says. Because the public health system could be overloaded if it attempted this type of monitoring with a significant outbreak, it makes sense that home health could help, he adds.

"I still believe that in a serious outbreak, people with mild cases of smallpox may be cared for in their homes, especially if the entire community is quarantined," Christianson says. Home health agencies and public health agencies should be working together to make plans for this scenario, he adds.

Home health agencies also may play a part in the vaccination program, he says. "We will be helping the New York Department of Health vaccinate health care workers and first responders."

While teaching nurses the 15-prick vaccination process is simple, it's also important to make sure nurses know how to handle the vaccine, he says. "The vials need to be stored in a temperature between 0 and 4 degrees Celsius, and each vial contains 100 doses," he says.

Discarding empty vials must be a controlled process to avoid exposure of the live virus to unvaccinated people; normal precautions taken for other biohazard materials are appropriate, Christianson says. Nurses also need to know to tell people they vaccinate to keep vaccination site covered to prevent spread of the live virus, he adds. **(See vaccination procedure, p. 19.)**

In addition to helping with vaccination efforts, home health agencies that are located close to hospitals that are designated as treatment facilities must have a rapid admissions process that can be implemented in the case of a large outbreak, Christianson suggests. "A hospital will be trying to discharge as many patients as possible to make room for smallpox victims, and a number of these patients may require home health care," he says.

Agencies need to have plans to handle a large volume of admissions in a short amount of time, he adds. **(For more information on other emergency issues to consider, see *Hospital Home Health,* November 2002, p. 121.)**

Home health nurses should also be educated on other issues that are related to smallpox as well, Christianson suggests.

"Wound care, signs of infection, quarantine requirements, and infection control should all be addressed," he says. "There are still a lot of post-event issues for which we need to plan but now we can make sure we know how to take care of the patients."

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For information about the smallpox vaccination plan, the vaccine, identification of smallpox, and other clinical information, as well as patient education materials in English and Spanish, contact:

- ***Centers for Disease Control and Prevention**, Atlanta. Smallpox home page: www.bt.cdc.gov/agent/smallpox/index.asp.]* ■

[Editor's note: This is a periodic columns that addresses specific questions related to the 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: Does the signed acknowledgement of notification of privacy rights have to be a separate form?

Answer: "Home health agencies are extremely concerned about the amount of paperwork that patients must review, and in some cases, sign, especially during the initial or admission visit. Agency staff members are acutely aware that patients and/or their family members often are ill, tired, in pain, afraid, and worried during the initial visit," says **Elizabeth E. Hogue**, Esq., a home health attorney in Burtonsville, MD. This means that reviewing and signing multiple forms is quite burdensome to many patients, she adds.

The revisions to the final privacy regulations of HIPAA generally require patients to sign an acknowledgement that they have received an agency's notice of privacy rights at the first service delivery, Hogue points out. Because this is yet another form that patients must sign upon admission, many agency managers would like to include the acknowledgement along with other consent forms so that patients only have to sign once, she says. As long as your process is consistent with the final privacy regulations, you may include the acknowledgement required by HIPAA in a form along with other items, she says.

Here is what the revisions to final regulations published in the *Federal Register* Aug. 14, 2002, say on this subject:

"The department also agreed with commenters that the notice acknowledgement process must be flexible and provide covered entities with discretion in order to be workable. . . . The rule requires only that the acknowledgement be in writing and does not prescribe other details such as the form that the acknowledgment must take or the process for obtaining the acknowledgment.

"For example, the final rule does not require an individual's signature to be on the notice. Instead, a covered health provider is permitted, for example, to have the individual sign a separate sheet or list, or to simply initial a cover sheet of the notice to be retained by the provider. . . . In addition, those covered health care providers that choose to obtain consent from an individual may design one form that includes both a consent and the acknowledgement of receipt of the notice.

"Covered health care providers are provided discretion to design the acknowledgement process best suited to their practices." ■

Ensure proper referrals from hospital owners

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Home care providers have a duty to assess patients for appropriateness for home care prior to admitting them for treatment. Current standards of care require an evaluation of several factors prior to admission. Just because patients meet the eligibility criteria of their payer source, such as the Medicare program, does not mean they are appropriate for home-care services.

When agencies fail to evaluate patients prior to admission or make inappropriate admission decisions, they violate applicable standards of care and may be legally liable for their decisions. They also may jeopardize their financial success.

Home-care agencies owned by hospitals often are under great pressure to accept inappropriate referrals since their primary referral source has authority over the decisions that are made. In fact, it often is fair to say that hospital home-care providers are tempted to use home-care agencies as a "provider of last resort," or perhaps even a "dumping ground," to limit their financial losses under DRGs and capitation payments. Hospital home-care providers must work to open the lines of communication with hospital management so that they are not forced to take patients who are

inappropriate for home care and, therefore, subject agencies and their staff members to unnecessary risks of legal liability.

Applicable standards of care require home-care providers to evaluate a number of factors. Some of the most important factors that agencies should assess as they try to determine whether to admit patients are the patient's clinical condition, the availability of a reliable primary caregiver, and the environment in which patients reside.

The types of care rendered in patients' homes have changed dramatically so that care that previously was provided only in institutional settings, such as intravenous therapy and parenteral and enteral nutrition support, now are provided in patients' homes. There still are certain clinical conditions that cannot be treated at home. Patients with systemic infections, for example, often cannot be managed in the home. Applicable standards of care require home-care providers to assess patients' conditions before initiating care in order to determine appropriateness from a clinical point of view.

The limitations of home care from a clinical point of view are often unclear to hospital personnel or ignored by them. Hospital staff members tend to take the attitude that hospital home-care providers should take any patient referred to them by hospitals, regardless of clinical condition, to limit financial losses to hospitals under prospective payment and capitation systems.

Inappropriate patients increase liability

On the contrary, the standards of care in this regard are the same for freestanding as well as hospital-based providers. Regardless of ownership, home-care agencies are required to appropriately assess patients and refuse to admit those who cannot receive appropriate care in the home-care setting. When agencies fail to do this, they are attempting to care for patients who require a more intensive level of care. Needless to say, general principles of risk dictate that caring for patients at inappropriate levels of care greatly increases the risk of care rendered.

Home-care providers also must evaluate the capabilities of primary caregivers prior to admission in order to determine appropriateness for home care. In some case, patients may be able to care for themselves. But in many instances, home-care patients require assistance from third-party caregivers. Prior to admission, home health agencies must determine that third-party caregivers are capable of assisting with patients' care and available and reliable to provide needed care. Patients who live alone, therefore, may be inappropriate for home care because of the lack of availability of a primary caregiver. Likewise, patients who reside with family members who are employed full time outside the home may be inappropriate for home-care services.

Legal and ethical imperatives require home-care staff to correctly assess this factor and to make decisions to admit patients based on their assessments whether or not they are freestanding or hospital-owned. Again, applicable standards for primary caregivers often are misunderstood by hospital management.

The environment in which patients reside also is a key consideration for admission. Home-care providers may encounter unheated residences or homes that are heated in unsafe ways — given the fact that patients are receiving oxygen. Home-care providers have reported that they see rats gnawing on the intravenous tubes of patients residing in environments that are not conducive to home care.

Despite the lack of understanding by some hospital personnel, however, the standards of care for hospital-based home-care providers are the same as for freestanding agencies with regard to conditions in patients' homes. Home-care providers are required initially to evaluate patients' homes for appropriateness and continuously monitor the environment to ensure that patients in home care will be adequately supported.

Thus, there clearly are defined standards that govern admission of patients to home care and the availability of care on a continuing basis. These standards do not vary depending on ownership of home-care agencies; they are the same regardless of affiliation. Hospitals that put pressure on agencies to ignore applicable standards subject both the hospital and the agency to significant risk of legal liability.

Educate hospital referral sources

What strategies can hospital-based providers use to encourage hospitals to recognize inherent limitations placed upon home-care staff regarding appropriate patient admissions? Ongoing programs of education and continuous communication may help reduce pressures on hospital-based agencies.

Educational programs should be initiated before another situation arises in which hospitals put tremendous pressure on agency personnel.

Consideration of the issues apart from emotional

confrontation over particular patients is most useful. These programs should be directed at discharge planners, physicians who have privileges at the hospital, and top management of hospitals, at a minimum. They may include inservice programs, presentations at quarterly medical staff meetings, and retrospective review of case examples at management meetings.

One-on-one communication is another important key to the process of limiting risk through avoidance of admission of patients inappropriately. The home health model of care radically is different from institutional care in terms of the degree of control over patients and their environments that can be exercised.

Hospitals have maximum control while home health agencies often have little or no control. It often is difficult for hospital personnel to bridge the gap between the two kinds of care in this regard. It never occurs to them that patients may reside in environments that simply will not support the provision of adequate care.

The process of assisting them to acknowledge some of the limitations of home care may be long and arduous. Share a copy of this article with key players in the hospital. Keep them abreast of particular problems encountered by agency staff. Invite them to make home visits with staff to experience what home care is all about on a firsthand basis.

Hospital home health agencies often find themselves between a rock and a hard place when it comes to admission decisions. Some hospital staff members do not understand that basic support must be available to provide home-care services. The process of education and communication needed to close the knowledge gap between home care providers and hospitals is just beginning. The message must be sent loud and clear that agencies cannot legally and ethically serve as providers of last resort for patients hospitals want to discharge.

[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.] ■

CE *questions*

17. What is one way to improve outcomes for the CMS quality indicators related to therapy, according to Kathy Green, RN, vice president of product strategy for Healthcare Quality Solutions?
    A. Only accept patients who qualify for rehabilitation therapy visits.
    B. Refer all patients to therapist.
    C. Focus improvement efforts only on indicators related to therapy.
    D. Evaluate the feasibility of rehab nursing education for staff.

18. How much did dementia patients' constructive engagement time improve as a result of the Montessori-based activities introduced by Menorah Park home health aides?
    A. 5%
    B. 13%
    C. 20%
    D. 28%

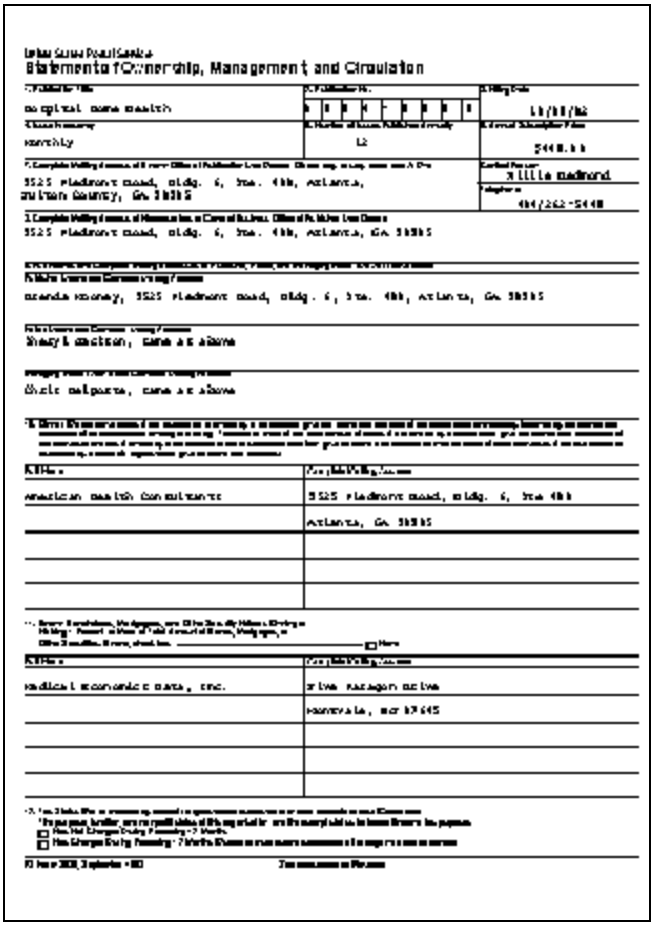
19. What is one way home health agencies may be involved in a smallpox response plan, according to Steven Christianson, DO, MM, medical director of the Visiting Nurse Service of New York?
    A. Include home health staff in vaccination programs for first responders.
    B. Educate public on smallpox response plan.
    C. File insurance claims for vaccinations.
    D. Maintain supplies of vaccine for emergency use if needed.

20. According to Elizabeth E. Hogue, hospital-affiliated agencies must consider what issues before accepting a referral, even if the hospital-owner of the agency insists the patient be accepted?
    A. likelihood of improvement in different quality categories
    B. percentage of payment expected from insurer and patient's ability to cover shortfall
    C. patient's clinical condition, presence of family caregiver, and safe environment
    D. relationship with hospital and patient's physician

Answers: 17. D; 18. C; 19. A; 20. C

COMING IN FUTURE MONTHS

- Do your nurses assess cognitive problems?
- Motivating and retaining home health aides: Ideas that work
- Best practices from the home health industry
- Reduce your liability risks: Tips from experts
- Rehab nursing: Benefits for staff, patients, and the bottom line



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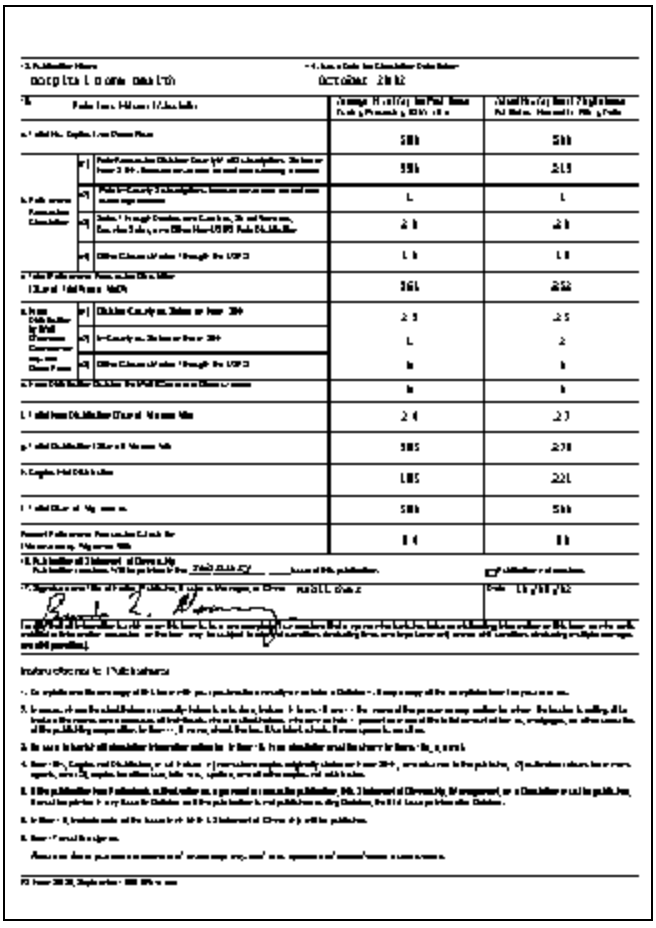

CE objectives

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. ■