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# Hospital Home Health®

the monthly update for executives and health care professionals

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## IN THIS ISSUE



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# Proactive compliance plan will protect you from fraud charges

*Monitoring and reporting are important components*

One year after being found guilty of conspiring to defraud through a system of kickbacks for patient referrals and the filing of false claims that resulted in overpayments of more than $1 million from Medicare and Medicaid, six co-defendants were sentenced to a combination of almost seven years in federal prison and more than $526,000 in restitution payments.[1]

While the people involved in this case set out intentionally to defraud Medicare and Medicaid, home health managers need to stay alert and be aware of the gray areas of the rules that might put them at risk for allegations of fraud, says **Denise Bonn**, JD, counsel for Schmeltzer, Aptaker & Shepard, a law firm based in Washington, DC, with specialists in home health.

Every home health agency should have a comprehensive compliance plan that not only addresses issues related to fraud issues such as referrals but also to compliance with other federal regulations, she suggests. **(See tips on avoiding fraud with referrals, p. 51.)**

"There are three types of compliance programs that you find in home health," says **Chris Anderson**, vice president of audit services and quality assurance and chief compliance officer for Gentiva Health Services, a Melville, NY-based company, which owns and manages more than 350 home health agencies nationwide.

"You have a mantelpiece program that looks nice but is never used," he says. The second type is found more often in hospital-owned agencies and has all the general elements of a compliance plan but is developed by the hospital and is not home health-specific, he adds. The third type of plan generates a close relationship between quality and compliance activities to promote an attitude of "do it right the first time," he says.

"I'm annoyed by lawyers who say if you have a compliance plan, you can avoid problems," Bonn says. "You need to make sure your plan represents a process that is in place and actively used to identify areas of noncompliance and address the problems," she says. Your plan will not help you avoid problems if it is not actively used, she adds.

Some steps to take to ensure a compliance plan that will work include:

❒ **Include all regulations with which you must comply.**

Medicare and Medicaid fraud is only one risk area for home health agencies, Bonn points out.

"I believe that OASIS [Outcome Assessment Information Set] and HIPAA [Health Insurance Portability and Accountability Act] requirements are more cumbersome and may create more opportunity for compliance problems for the home health clinician than any other area," she says. For this reason, make sure your staff training addresses these issues as well as other areas.

❒ **Train your employees well.**

For your first training session, it is fine to present an overview of the plan and discuss a wide range of issues, but be prepared to offer role- and issue-specific training in follow-up sessions, suggests Anderson. Marketing people need different information than home health clinicians or billing staff, so Gentiva has developed 35 different training sessions that address issues specific to different jobs, he adds.

❒ **Designate a specific resource for compliance information.**

While Gentiva has a designated compliance officer and staff members to oversee compliance issues, not all agencies may have the resources to devote employees to compliance, Anderson admits.

"It is important to designate someone as in charge of compliance issues, and that person needs to be independent of clinical or financial responsibilities," he says.

### *Need a compliance specialist?*

The reason for independence is twofold, he says. "If an employee has a concern about billing practices, how can that employee feel comfortable going to the financial officer to suggest inappropriate activities in his or her department?" Anderson asks. "Also, you don't want the perception of cover-up to occur if the person heading the compliance process is supervising the area in which the concern is raised."

Smaller agencies also might consider using a consultant or attorney to act as an outside compliance officer, he suggests. But be cautious.

It may not be wise to rely upon the same attorney who advises you on day-to-day business practices because the same perception of involvement in the area being questioned might exist, Anderson says.

For this reason, rely upon attorneys who specialize in compliance issues and use them only for oversight of this area, he adds.

❒ **Set up monitoring and auditing systems.**

Self-audits as well as external audits are important, but Anderson also suggests that agencies consider pre-billing audits on a regular basis.

"We have a group of clinicians that look at claims that are ready to submit for payment but have not yet been sent to Medicare," he says.

Sometimes, the group evaluates only one out of 10 claims for some locations, but if there has been a problem with a survey or if the location has not performed well on quarterly self-audits, it will review all claims, Anderson explains. "If we find problems with the claims, we use that information to plan further education for that location's staff."

❒ **Make it easy to report concerns.**

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Be sure you not only make it easy for employees to report potential compliance problems, but also make sure your staff understand that there are no repercussions for reporting concerns, Bonn says.

At Gentiva, employees, patients, and family members can contact the compliance department through a toll-free telephone number or by e-mail and maintain their anonymity, Anderson says.

"We assign every call a case number, and that person can use the case number in e-mails or calls to follow up," he says. "We also make a commitment to deal with or resolve every issue brought to our attention within 30 days."

When the hotline was first implemented, about 80% of the calls were related to human resource issues rather than just compliance issues, and most callers chose anonymity, Anderson says.

"It's a sign of our program's maturity that now all calls that come in are strictly compliance-related and that almost all callers give their names and contact information," he adds.

❒ **Check your employees' background carefully.**

In addition to reference and license checks and visiting web sites of the Office of Inspector General (OIG) and the General Services Administration for employees who have been excluded from Medicare program participation upon hiring, Gentiva also runs periodic clearinghouse checks to catch any issues that were posted after hiring, Anderson adds.

"Sometimes, the OIG takes up to a year to post information, so the periodic checks are important," he says.

### *Don't forget to follow through*

❒ **Address problems you identify.**

If you discover that you are routinely billing for 10 physical therapy visits when you don't make the full 10 visits, develop a corrective action plan and implement it, Bonn says.

It may sound obvious that you have to implement the plan, but she says too many agencies go through the exercise of developing a plan and then don't follow through with it. "If a second audit shows that you are still making the same mistake, you cannot plead ignorance or simple mistake," she points out.

❒ **Make sure your independent contractors follow your compliance plan.**

A home health agency can be held accountable for a contractor's actions, Anderson adds.

"We are responsible for managing the patient's care, so we can't have a contractor endanger a patient's safety," he says.

"We are also billing Medicare based upon information from the contractor, so we have to know that the information is accurate," Anderson explains.

For those reasons, Gentiva's contract with independent contractors states that the contractor also is bound by Gentiva's compliance plan.

The most important thing any home health manager can do to avoid noncompliance allegations is to make a compliance plan part of the agency's day-to-day operations, Anderson says.

## Ensure marketing doesn't trigger fraud accusations

All home health managers have heard that they should market to referral sources to build their referral base. How to market without triggering accusations of "buying referrals" is the tricky part, says **Denise Bonn**, JD, counsel for Schmeltzer, Aptaker & Shepard, a Washington, DC, law firm with specialists in home health.

"Basically, you can't pay for referrals," she says. While most home health managers know this, be careful that you don't appear to be paying for these referrals in more subtle ways than handing cash to the referral sources, Bonn points out.

"If you are paying a physician for something such as space rental for one of your locations, make sure you are paying no more than fair-market value for the space. Anything over fair-market value can be construed to be payment for referrals the physician may send your agency," she adds.

While wining and dining good customers or referral sources is standard operating procedure for most industries, it is a no-no for home health, Bonn says. Don't underwrite the hospital discharge planning department's holiday party or pay for a physician's office staff luncheon if you don't want to appear that you're buying referrals, she adds.

Presenting seminars that focus on services, new wound care techniques, or expansion of service areas or hours are appropriate for home health agencies to present to physicians' office staffs or hospital discharge planning staffs as part of their need for continuing education, but don't plan to serve a large meal with the seminar, Bonn suggests.

"Although you might be able to defend your expenditure on the meal, why put yourself in a defensive position?" she asks. ■

"Even a small change in a billing procedure is reviewed by the compliance department," he says. "We want to make sure that the one change the billing department is proposing won't cause problems in other areas."

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### Reference

1. *United States v. DuPont,* No. 00-05-009-01-15-CR-SW-3, United States District Court, Western District of Missouri (June 20, 2002). ■

# Innovative programs help caregivers cope

*Alert systems, community nursing fill gaps*

*(Editor's note: This is the second of a two-part series that looks at family caregiver issues such as education, stress, burnout, and support. Last month, experts talked about the educational needs of family caregivers and how a home health nurse can recognize caregiver burnout. In this month's article, different programs to support caregivers and different approaches to offering care to home health patients are discussed.)*

The spouse used to be so calm with the patient. The caregiver isn't purchasing the patient's medications on a regular basis. The wife doesn't help the patient out of bed to use the toilet. Does any of this sound familiar?

Caregivers experience burnout for a number of reasons ranging from emotional to financial and physical stresses, say experts interviewed by *Hospital Home Health.*

One of the first steps a home health nurse should take when there are signs of caregiver burnout is to find community resources that can provide needed support, says **Nancy Stallings**, MAM, program manager for caregiver support for Salt Lake County Aging Services in Salt Lake City. **(For assessment tips, see "Is your caregiver starting to experience burnout?" *Hospital Home Health,* April 2003, p. 42.)**

One of the best resources is your local area agency on aging, says Stallings. "We offer federally funded caregiver support by providing classes on coping with stress and dealing with issues related to caregiving, and we offer short-term respite for family caregivers," she explains.

The area agencies on aging also will fund moderate home modifications that are needed for older adults with mobility or stability problems, she adds.

Because the financial aspect of caring for a homebound person can mount quickly, it's also important to offer counseling and advice about bills, claims, and financial resources, Stallings says.

"There are programs that offer either discounts or underwrite the cost of certain medications." she adds. **(For information on finding drug assistance programs, see resource box, p. 54.)**

Even if a home health nurse or aide brings in a social worker to offer referrals to community resources, the nurse or aide should know about the resources so the caregiver can be reassured that there is help, she explains.

Other good resources for caregivers are local churches, says Stallings. "Many churches have programs that may provide someone to sit with the patient for a short time while the caregiver goes shopping, to a hair appointment, or to his or her own doctor's appointment.

"Even a brief period of time for themselves gives caregivers a much needed break," she points out.

### Alert systems can provide peace of mind

Another service that provides peace of mind to family members who are concerned about elderly homebound patients and elderly spouses who are caregivers are alert systems that enable patients and caregivers to quickly summon help.

"We've been using a personal alert system for many of our patients since the late 1980s," says **Carol Ortiz**, intake coordinator for Fishkill Home Care in Beacon, NY.

"Most of our patients are elderly with elderly spouses as caregivers, or they live alone," she

says. "Because we are in a rural area, it's important that the patients be able to easily and quickly call for help," she adds.

Personal alert systems are designed to automatically call a monitoring center that will send an ambulance when the patient pushes a button that is either on the unit, a necklace, or wristband. Telephone service is necessary for the unit's operation, and all units come with battery backup in the case of a power outage.

Although Medicaid patients' personal alert systems are covered, Medicare patients and private-pay patients must pay for their own systems, Ortiz says.

Most often, other family members who don't live with the patient and caregiver will choose to pay for the system for the peace of mind it offers, she adds. **(For information on costs of medical alert systems, see resource box, p. 54.)**

If you are considering offering personal alert systems as an added service, Ortiz has the following suggestions:

- **Plan to keep between four and 10 units in your agency to send out on the admission visit.**

"It's best to have the units available on the first visit so the nurse or another staff member doesn't have to make a second trip," she says. "It also gives the patient a sense of more security because they do have a way to call for help if needed," she explains.

- **Prepare your nurses to handle installation.**

"The installation is simple, but be sure the company that provides your personal alert systems is available to educate your staff initially and be available if a nurse encounters a difficult installation," says Ortiz.

- **Insist monitoring is 24 hours, seven days a week.**

"In addition to full-time monitoring, make sure the company updates information about emergency assistance in the patient's area on a regular basis," Ortiz suggests.

- **Choose a unit with which your patients are comfortable.**

"A couple of years ago, we tried a really neat unit that talked to patients to remind them to take medications, check blood sugar, or other actions," says Ortiz.

"All of our staff thought it was a great idea but our patients said it drove them crazy. We learned that sometimes more sophisticated technology makes our older patients uncomfortable," she adds.

Another way to support caregivers and patients is to provide a service that continues after the Medicare episode is over, according to **Lisa M. Zerull**, RN, MS, program director at Valley Health System in Winchester, VA.

"Our community nursing program grew out of a need by our acute care hospital to find a way to help patients manage chronic conditions after they no longer qualify for Medicare home health coverage," she says.

A community nursing program that enables RNs to continue visiting patients who are no longer homebound to ensure that they comply with medication schedules, blood sugar monitoring, or other recommendations for managing their disease was the answer, she says. **(For a full description of the program, see article, p. 54.)**

## *Cutting hospital admissions*

By offering patients an option for follow-up beyond a Medicare home health admission, Valley Health System has cut hospital admissions, emergency department visits, and critical care days, she says.

"We looked at the hospital use of patients in our program and saw that pre-community nursing, they had 499 hospital admissions, 70 emergency department visits, and 67 critical care days," she explains.

"After they were enrolled in the community nursing program, the number of hospital admissions dropped to 219, emergency visits dropped to 48, and critical care days dropped to 20," she adds.

At this time, Valley Health does not charge patients for community nursing care, but a fee structure is being evaluated, says Zerull. "The health system determined that the cost avoidance that results from a longer period of follow-up to ensure compliance with things like medication schedules was worth the expense of creating a community nursing program," she says.

The department has three full-time RNs and one part-time director. The RNs' salaries and other costs total $65,000 per nurse, but each nurse has a caseload of approximately 35 patients, Zerull says.

"When we took a look at what our patients typically cost the hospital in terms of admissions or emergency department visits, we found that potential cost avoidance to the hospital ranged from $350,000 to $1 million per year as a result of community nursing," she adds.

No matter which way a home health agency chooses to help caregivers find the support they need or bridge the gap in coverage by Medicare or insurance, Ortiz points out that it is important to find a way to offer reassurance to patients and caregivers that they are not alone.

"We have to find nonclinical ways to make sure our patients are getting the assistance they need, even when the nurse is not with them," she says.

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## RESOURCES FOR CAREGIVERS

For information about services for older adults, go to: www.aoa.gov/directory/default.htm. This directory was compiled by the Administration on Aging and the National Institute on Aging and contains a comprehensive list of all community-based programs and organizations that offer services to older Americans. Contact information, locations, and links to individual web sites are included.

For information about prescription drug assistance programs, go to: www.needymeds.com. The web site offers a description of all assistance programs offered by drug manufacturers and other groups. The listings are available by manufacturer and by specific drugs.

For information on personal alert systems, contact:

- **LifeFone Personal Response Services**, 16 Yellowstone Ave., White Plains, NY 10607. Telephone: (800) 882-2280. Web site: www.lifefone.com. Costs for LifeFone are $75 for the initial programming fee and $26 to $29 per month.
- **Lifeline Services**, 111 Lawrence St., Framingham, MA 01702. Telephone: (800) 543-3546. Web site: www.lifelinesys.com. Initial programming fees range from $50 to $100, and monthly fees range from $35 to $45.

# System joins community nursing and home health

*Coordinate intake and resources for success*

Although Valley Health System in Winchester, VA, originally set up the community nurse case management program as a separate department that operated independently of home health, people soon realized that the two areas needed to coordinate their activities, says **Lisa M. Zerull**, RN, MS, program director of the community nurse case management program.

"Physicians were confused with two departments offering care in the homes, and we would accept patients who would have qualified for home health and vice versa," she says.

"We also found that physicians would refer their patients to community nurse management because there are fewer requirements in terms of written orders, signatures, and oversight," says **Patricia Klinefelter**, RNC, BSN, home health director for Valley Health.

To address these problems, home health's intake department now screens all patients referred for home care and determines which level of care is best for the patient, she explains.

Basically, a home health admission is a patient who has experienced an acute episode, is coming out of a hospital admission, and needs skilled nursing services such as wound care, Foley catheter care, or intravenous medications, Klinefelter says.

Community nurse management patients are chronic patients, often with congestive heart failure, diabetes, chronic obstructive pulmonary disease, behavioral health, or other heart conditions, she adds.

Other differences in the two programs are that home health requires a physician order, provides medical care, and can provide visits multiple times during a day, week, or month, says Zerull.

"Community nursing does not require a physician order, unless we are asked to fill medication boxes or take pulse oximetry readings. We focus on nursing care, patient education, and assessment of the patients' understanding of their condition and their responsibilities," she adds.

"We also visit the patients only once per week," she says.

Because there only are three nurses in the community nursing program, Zerull has chosen to

hire only RNs. "We want to make sure the nurse is able to assess the physical and medical condition of the patients to make sure they are stable and not in need of other medical care," she explains.

Although physician orders are not necessary for community nursing, Zerull says that they do contact the patient's physician with a letter that lets the physician know a nurse is seeing the patient, and periodic reports are faxed to the physician.

With the nursing shortage making it difficult for home health agencies to find qualified nurses, Zerull was careful not to "raid" the home health agency.

"My three nurses were all employed in the hospital in the rehabilitation, pulmonary, and emergency departments. They required some training and attend inservices with the home health staff, but they made the transition to community nursing very easily," she explains.

The community nurse's main responsibility is to enhance patient education and help patients comply with the activities they need in order to stay stable or improve their condition, explains Zerull.

"The nurses develop a close, long-term relationship that is more like a friendship with the patients because they see them for almost three months in most cases," she says.

"We've had many patients who want to please their nurse, so they make sure they check and log their blood sugar levels or whatever task the nurse will check," Zerull adds.

Patients are discharged from community nursing when they:

- meet intake criteria for home health, hospice, or other community agency;
- are able to manage self-care with little or no support;
- move out of the region or receive health care from another hospital or health system;
- choose not to work toward improved self-care;
- are not at home three times for scheduled visits;
- engage in drinking, drug abuse, or other activity that makes the environment unsafe for the nurse;

The key to a successful community-nursing program is to coordinate care between home health and community nursing, Klinefelter points out.

"We want to make sure that no nurse is asked to perform a duty outside the scope of his or her service," she says. "We also wanted to streamline the process so referral sources or patients could make one phone call and be admitted to the best service for their needs."

Another reason to have the two programs work closely together is accreditation, Zerull adds. "Community nursing is surveyed under the same standards as home health, so we did borrow the home health policies and procedures to set up our own.

"We recently underwent an accreditation survey by the Joint Commission on the Accreditation of Healthcare Organizations and received a score of 99 for home health and community nursing," she says. "Surveyors commented on how the coordination of the programs reduced duplication of services and assured good patient care. ■

# Cut claims and liability risk with careful planning

*Spot danger ahead; teach good risk management*

Forget the lottery as your way to riches. According to *Judge Judy*, *The Practice*, and countless other television legal shows, you can easily recoup real and imagined losses by suing someone.

Even though popular television shows demonstrate the benefits of lawsuits, a home health agency manager can reduce the risk of being sued by being aware of risks, resolving problems quickly, and communicating with patients and their families, says **Tracy Mabry**, a health care attorney with Dean, Mead, Egerton, Bloodworth, Capouano & Bozarth in Orlando, FL.

"A malpractice lawsuit against a home health agency is expensive, so it is only in the most serious cases of an unexpected patient death that a family is likely to file a malpractice suit," he says.

A home health manager should be proactive to prevent less serious incidents from becoming major claims, he adds.

The most common areas of risk in home health are slips and falls, burns as a result of overheated bath water, medication errors, and some physical abuse, says **Bill Thompson**, CIC, senior vice president and partner at Smith, Bell & Thompson, a Burlington, VT-based insurance agency specializing in coverage for health-related organizations.

While a good risk management plan doesn't always equate to upfront savings, it is important

to prevent claims and reduce risk in the future," says Thompson. **(See tips for savings, p. 57.)**

"The most important part of a risk management program is a proactive approach," he says. Make sure your staff education classes emphasize the need to respond quickly to any complaint or to incidents that occur in the patient's home, he suggests.

"The best way to reduce your risk as a home health manager is to make sure you have well-trained nurses, strong quality-assurance programs, and up-to-date licensing of all appropriate personnel," says Mabry.

Another factor that often exacerbates a situation and may cause the patient or family to file a claim, is a perception that the home health personnel are insensitive to the family's situation, he says.

"We don't see significant claims, even when there is an incident, when the home health nurse and other personnel have a good relationship with the patient and family members," Mabry says.

"If the home health personnel are demonstrating concern for the patient and family members while working out a problem, the family is less likely to file a claim or seek a higher judgment," he adds.

When asked why they pursued claims against home health agencies, various plaintiffs told their attorneys that the agency manager and staff seemed, "inattentive, insensitive, and failed to acknowledge that there was problem," Mabry says.

## Follow up on incident reports

In addition to making sure your employees are well-trained for their jobs and making sure you have a process to receive complaints and incident reports and follow up on them quickly, take a good look at your hiring practices, says Mabry.

"Allegations of theft and abuse occur more in home health than other areas of health care because it is a unique setting in which the home health employee is working unsupervised in the patient's home."

Be sure to screen employees carefully, and always run criminal history checks, he says. "Call the agencies for which the employee previously worked." If the person has a pattern of moving from agency to agency, inquire more closely about specific work habits and reasons for leaving, Mabry says.

Make sure your hiring policies spell out the process you undertake to ensure that employees are trained, free of criminal charges, and dependable people, he adds. Then, follow the policy. "Your agency is at risk if you don't exercise due diligence in hiring and if you don't follow your policy," he says.

## Risk management issues

Also, watch your infection control practices and train employees on infection surveillance and diagnosis. "Infection issues can create serious complications such as high medical costs, amputations, and death," Mabry points out.

As with any aspect of patient care, be sure your nurses are documenting every observation and action taken. "Infections can move quickly, and you have to prove that you observed the infection and took steps immediately to address it," he adds.

Appointing a person within the agency as a risk manager also is a good step to take, says Mabry. "It's less common for a smaller agency to have one staff position as risk manager, but there should be someone with risk management responsibility assigned to him or her."

Even if the person also handles quality assurance, you can make sure that there is a resource within the agency that is constantly looking for areas of risk for the agency, he adds.

While home health agencies do not have the deep pockets of other health care providers involved with the patient, Mabry points out that family members have different expectations of home health than they have for other health care providers.

"No one expects a home health patient to become sicker or die. Because the person is at home, the family expects him or her to improve, so it's a shock if there is an adverse event," he says.

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# Don't gamble with your malpractice insurance

With major insurance carriers moving out of the malpractice area, it is harder to find insurance coverage, and it can be expensive, says **Bill Thompson**, CIC, senior vice president and partner at Smith, Bell & Thompson, a Burlington, VT, insurance agency specializing in coverage for health-related organizations.

"Unfortunately, some home health agencies that are smaller, independent agencies, may be taking a chance by having no coverage," he says.

"This is a real gamble because as our society becomes more litigious and jury awards rise, a home health manager runs the risk of losing the business to one claim," he adds.

To control costs, a home health manager can retain more of the risk by having a higher deductible, says Thompson. "By maintaining a deductible of $5,000 and higher, you can keep premiums lower," he explains.

You can also look at a "claims-made" policy rather than an occurrence form of insurance, says Thompson.

The difference is that the occurrence type of insurance is good for the one year that you buy it while the claims-made insurance is continuous but only covers claims for the year or years for which you buy it, he says. "Claims-made" policies are less expensive, he adds.

Statute of limitations might differ from location to location and depend on the type of claim, but more than 95% of all claims made will happen within four to five years of the incident, says Thompson.

To keep the cost of your workers' compensation insurance down, be sure to use good hiring practices and check out former employees for any workers' compensation claims that potential employees might have filed, says Thompson.

"If you notice a job hopper applying for a position, be sure to check [the applicant] carefully. Job hopping is sometimes an indication of a workers' compensation abuser," he advises.

Also, keep in mind that part-time employees vs. full-time employees file more workers' compensation claims, says Thompson.

Make sure that your part-time employees are receiving the same safety and body mechanics training that your full-time employees receive, he adds. ■

HIPAA Q & A

# When is it safe to share patients' information?

*[Editor's note: This is a periodic column 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:** Can home health staff members share information with patients' family members or caregivers?

**Answer:** Yes, agency staff members may disclose information that is directly relevant to patients' involvement with patients' care or payment for care to family members, other relatives, close personal friends, and other persons identified by patients, says **Elizabeth E. Hogue**, Esq., a home health attorney in Burtonsville, MD.

"When patients are present during the disclosure or otherwise available prior to the disclosure and have the capacity to make health care decisions, the agency may disclose protected health information if the agency staff member obtains patients' agreement, provides patients with an opportunity to object to the disclosure, and patients do not express an objection," she points out.

"Staff members may also disclose information when they reasonably infer from the circumstances, based on the exercise of professional judgment, that patients do not object to the disclosure," Hogue explains. When patients are not present during disclosures or the opportunity to agree or object to the disclosure cannot practicably be provided because of patients' incapacity or an emergency circumstance, the agency staff members may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of patients, she adds.

If so, the agency may disclose only the protected health information that is directly relevant to that person's involvement with patients' health care, she explains.

**Question:** If requests for information are received from family members or caregivers via telephone, what obligation, if any, do staff members have to verify that the callers are who they say they are?

**Answer:** Agency staff members should use sound judgment with regard to verification that individuals who telephone the agency asking for information about patients are who they say they are, Hogue says. "At a minimum, staff should document the full name of the individual to whom information was given and the date and time the staff member provided information."

On Feb. 13, the Department of Health and Human Services adopted final security standards that protect patient information that is maintained or transmitted electronically.

The rule requires covered entities to implement administrative, physical, and technical safeguards to protect electronic protected health information in their care. The security standards were published as a final rule in the Feb. 20 issue of the *Federal Register* with an effective date of April 21, 2003.

The rules require organizations to provide security awareness training to all employees, to conduct risk analyses to identify security vulnerabilities, to establish policies that allow access to protected health information on a need-to-know basis, to limit physical access to information, to establish audit controls, and to enforce sanctions.

The regulations will become enforceable for most covered entities on April 21, 2005. ■

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# Don't get caught: Client requests can discriminate

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

An RN recently sued a home health agency in Pittsburgh based upon case management practices. Specifically, the RN received copies of case management forms for a specific patient on two separate occasions. Both case management forms included a section in which the special needs of patients could be noted.

Both forms indicated in this section that "no black RNs" were to care for the patient. The nurse who received the forms and was asked to provide care to the patient is African-American. The RN made one visit to the patient but was never assigned to the patient again. She subsequently sued the provider for discrimination based upon race.

As many providers know, patient preferences for certain types of caregivers are common.

Experienced home health managers have been asked by patients not to provide caregivers who are foreign, for example. The question is whether such requests should be honored.

Generally, such requests should be rejected, especially when they involve discrimination based upon race, religion, or any other basis commonly used to treat groups of people differently. Legally and ethically, providers should not engage in such practices.

There is one exception to this general rule that occurs when patients ask for caregivers of the same sex as the patient based upon concerns about bodily privacy.

Then it is acceptable to assign only same-sex caregivers to patients who have made such requests.

## *Match skills to needs*

In addition to concerns about discrimination, providers also must be concerned about risk management when they honor such requests. Especially in view of increasing shortages of staff, limitations on available caregivers may mean that patients' needs cannot be met by staff members who are acceptable to patients.

In view of staffing shortages, the fewer caregivers who are permitted to care for certain patients, the more likely it is that patient needs will go unmet. Unmet patient needs are, in turn, likely to significantly enhance the risk associated with providing care to such patients.

Perhaps, the pressure to honor patients' requests is at its greatest when patients receive home-care services. Patients who will accept any caregiver assigned to them in institutional settings somehow feel that they have the right to decide who may provide services in their homes.

On the contrary, with the exception noted above,

assignments of staff should be made without regard to client preference in home care just as assignments are made in institutional settings.

So how should managers respond when patients tell them not to assign any foreign nurses to them? First, they should explain that the agency does not discriminate against its employees and that to avoid assignments based on cultural or ethnic background may constitute unlawful discrimination. Then staff should explain that if limitations on caregivers were acceptable, the provider might be unable to render services to the patient at all because they may not have enough staff.

The bottom line is that staff will be assigned without regard to patient preference in order to prevent discrimination and to help ensure quality of care.

Needless to say, patients' requests and managers' responses specifically must be documented in patients' charts. Documentation that says patients expressed preferences for certain caregivers or rejected certain types of caregivers is too general. Specific requests and responses of staff must be documented.

After patients have expressed what may amount to prejudice against certain groups of caregivers, managers must follow up and monitor for inappropriate behavior by patients directed at caregivers who are not preferred.

Managers should be alert to the potential for this problem and should follow up with patients and caregivers to help ensure that caregivers are receiving the respect they deserve. Follow-up activities and ongoing monitoring also should be specifically documented.

Professional caregivers are becoming a scarce commodity. Agencies cannot afford to lose or alienate a single caregiver based upon discrimination or inappropriate behavior by patients.

*[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.]* ■


## CMS reminds providers about hospice care

The Centers for Medicare & Medicaid Services highlighted the benefits of hospice care and reminded physicians and health care professionals at skilled nursing facilities and hospitals that hospice is a viable option for Medicare beneficiaries in a March 28, 2003, program memorandum.

The memo included these points:

- Physicians can encourage patients to use hospice care, or patients can elect the care themselves.
- Hospice care is intended primarily for patients whose prognoses are terminal, with six months or less of life expectancy.
- Medicare covers hospice care for two 90-day election periods, followed by an unlimited number of 60-day election periods.

The program memorandum can be found at http://cms.hhs.gov/manuals/pm_trans/AB03040.pdf. ▼

## Unannounced JCAHO surveys start in 2006

The Joint Commission on Accreditation of Healthcare Organizations announced its intent to begin conducting all regular accreditation surveys on an unannounced basis beginning in January 2006.

The organization plans to introduce a substantially new accreditation process beginning in January 2004 that creates the expectation that Joint Commission-accredited organizations will be in compliance with commission standards

### *COMING IN FUTURE MONTHS*

- Investigate adverse events to improve quality
- Tips for meeting Joint Commission patient safety standards
- Retain employees with creative programs
- Make OASIS changes possible
- Pain management: home health specific research results

100% of the time, says **Dennis S. O'Leary**, MD, president of Joint Commission. The next logical step is the introduction of unannounced surveys.

During 2004, up to 100 hospitals will participate in the pilot test of the unannounced survey process, and in 2005, the Joint Commission will conduct voluntary unannounced surveys on a limited basis to all types of accredited organizations, including home health. ■

## CE *questions*

5. What regulations do a good compliance plan address, according to Denise Bonn, JD?
   A. OASIS
   B. Medicare billing
   C. HIPAA
   D. all regulations that apply to home health
6. According to Lisa M. Zerull, RN, MS, program director at Valley Health System, why does community nurse management result in better patient self-care and compliance?
   A. The nurse sees the patient several times each week.
   B. The patient was ready to take care of himself or herself anyway.
   C. The strong relationship between nurse and patient makes the patient want to please the nurse.
   D. Patients want to do well because they are paying for each visit.
7. What causes many family members or patients to file claims against home health agencies, according to Tracy Mabry, a health care attorney?
   A. lack of understanding about home health's role in patient care
   B. the "deep pockets" of home health agencies
   C. a belief that home health personnel didn't take the incident seriously
   D. a desire to recoup expenses of home health care
8. What is one request by a patient that a home health agency is obligated to refuse, according to Elizabeth E. Hogue?
   A. a caregiver preference that discriminates against a staff member's race, religion, or cultural background
   B. time and day of visits
   C. request for same-sex caregiver
   D. request that family members not be given information

**Answer Key:** 5. D; 6. C; 7. C; 8. A





## 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. ■