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INSIDE

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Expand your business by partnering with hospitals

Are hospitals courting private duty businesses?

You'd think — given the financial consequences to home care from the 1997 Balanced Budget Act — record numbers of hospitals would be rushing to open private duty home care divisions to offset losses in their Medicare/Medicaid-certified components.

Not so, according to **Anita Porco**, RN, president and CEO of Nurses Today in Dallas. "A lot of hospitals don't have the private duty component. In fact, a hospital in Dallas sold its private duty component after several years because it wasn't making any money for them. Don't ask me why; I never have understood it because a hospital has a built-in referral source."

One reason may be that while all hospitals seem to have the Medicare/Medicaid component, their home care management just may not know how to run a private duty arm. "Their mindset is so totally different," says Porco. "The 'spend as much as you can — don't give anything back to the government' kind of mentality doesn't serve you if you're trying to run a moneymaking organization. Yet you would have thought that there'd be a lot of staff coming out of that Medicare market who would be willing to do private duty, and yet they're not there. Many nursing assistant training programs are folding, so the pool of people we have to work with is lower. I don't know if this is happening throughout the country, but it's certainly happening here."

> ***"The 'spend as much as you can — don't give anything back to the government' kind of mentality doesn't serve you if you're trying to run a moneymaking organization."***

Porco observes that there are a lot of people who know home care, but private duty nursing is really a different animal.

"The traditional model is the per-visit kind of home care in which staff is in the home for a very short period of time to do whatever treatment is

necessary," she says. "Private duty means being with someone for eight hours, possibly 24 hours, a day. Now, you're really getting a much closer look at the client over a longer period of time, and all the social interaction that goes with that. Along with client interactions, there are also interactions with the client's family, attorneys, CPAs, bank trust officers, and other people within the hospital setting if care is being delivered there. The relationships are a lot stronger in private duty care."

Well then, are hospitals recognizing these factors and moving to bring in more revenue by partnering with private duty agencies in some fashion? That doesn't seem to be happening, either. **Lea Wilson**, RN, MBA, executive director of Henry Ford Extended Care in Southfield, MI, says that though the certified care division of the Henry Ford system receives the bulk of its referrals through the system, her private duty arm does not. "I know a lot of our referrals come to us because of the Henry Ford name recognition, but because the private duty arena is predominantly self-pay, the client base comes from all venues."

Wilson, whose private duty case system is Joint Commission-accredited, says private duty care providers in her state receive a lot of support from the private duty forum of the Michigan home health association. The forum, which Wilson chairs, meets monthly to look at issues common to the industry — staffing, numbers, and difficulty in recruitment and retention.

Who's actually succeeding and why?

Yet **Gina Dodson**, administrator for Vanderbilt Home Care Services (VHCS) in Nashville, TN, says her hospital-affiliated private duty home care venture is very successful. "It's making up income for the nonprivate pay division. We do several things that support the hospital's needs in our private duty or extended care side. For example, we do care partner relief, which is certified nurse technician [CNT]-level training. We bring in and train CNTs to be care partners for the hospital. When the hospital is short-staffed and needs some fill-ins, we provide them with that staff. We have been able to tailor our program to the hospital because of our tight affiliation."

Dodson's group actually operates two private duty agencies under the same umbrella. "We have one agency that does traditional Medicare visits that has a private pay extended care division, and we operate a second agency that resulted from a merger with a very small company, and we operate some private pay business out of that."

Hospital-affiliated PDs may acquire others

Perhaps due to its strong affiliation with a large medical center, VHCS has been able to acquire programs that grew out of the hospital and ended up in home care.

For example, Vanderbilt Children's Hospital and the Nashville Junior League manage a respite program for parents of children who are technology-dependent. If their parents want to go out of town for a weekend, a trained private duty nurse goes the home to take care of them.

"When the respite program began, children had to come to the hospital," Dodson says. "But the program directors soon realized that children who don't need to be in the hospital don't want to go there. Also, their families have a lot of equipment and supplies that need to be with the children, and taking it to the hospital wasn't customer-friendly. They have now rolled that program out to home care."

Dodson sees definite benefits to a hospital having its own private care agency, rather than dealing with one in the community. "Vanderbilt Hospital is committed to the continuum of care, so they find value in that home care program along that continuum. The benefit to us is that we provide them a resource; as they do program development and building within the hospital, you can pull in your home care people to help plan for patients."

Hospitals that would derive the most benefits from a private duty component or partnership are the larger, possibly research-allied institutions that have the capacity for a number of different

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SOURCES

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arms. "There are lots of different niches where you can pull home care into your strategic plan," Dodson says. "I think for smaller hospitals, there are probably still some strategic issues, such as the need for post-acute care. It may be a little harder to get at the issue in a smaller hospital. You really have to look at each hospital system individually."

Dodson recommends that hospital managers who are contemplating creating a private duty component or partnering in some fashion with an outside agency begin by developing strategic plans for their facilities. This process can also be used by private duty agencies looking to partner with hospitals. "Given the current volatility of all of health care, it's a great time to look at what you're going to do with a health care system," Dodson says.

Research target facility, make a strategic plan

Either way, accurate research is imperative. If you run a private duty agency and want to expand and partner with your local hospital, you should:

• **Assess where private duty home care might fit in to the hospital's plan.** Reviewing the Joint Commission's standards for private duty home care accreditation is a good place to begin. Private duty might benefit your target hospital greatly by making enough money in the private duty sector to offset its losses in the Medicare sector.

• **Look at all markets for private duty care.** Dodson's group provides a large number of sitters for Vanderbilt Hospital, suicide precaution, child abuse cases, and families who want someone in the room with their ill relative all the time. You can also do some work in senior high-rise communities. It gives you a chance to do something beyond traditional care.

• **Remember that each hospital has its own policies, procedures, and standards of care.** Patient bases differ greatly from hospital to hospital.

• **Present your partnering proposal as helping the hospital to build a moneymaking infrastructure.** Get hospital administrators out of the mindset of the traditional Medicare home care business and show them private duty can be prosperous.

Any information you get from inside the hospital will help to give you an idea of what you're getting into, but the key will be to have someone on your team who thoroughly understands the private duty business getting together with someone on their team who understands the hospital.

• **Create a strong network between your agency and the hospital's peer group.** Make connections to organizations with which the hospital is affiliated. State and regional hospital associations often have home care alliances. Even on an informal basis, it's great to have people in the same business in the same geographical area with whom you can share information.

Rural areas have harder time with private duty

Dodson observes that while many of the hospitals in large urban areas have successfully done private duty home care, hospital-based programs in rural areas have a much harder row to hoe. "Staffing has become such a difficult thing," Dodson says, "and rural areas have a smaller population from which to draw. You have to have a much larger pool to staff a small number of cases, because you're looking at 24 hours a day, seven days a week. I staff on a full-time basis for 500 to 600 patients per month in the visiting division. I probably have between 70 and 80 caregiving staff in full-time positions. Our temporary business may have a caseload of 60 patients per month, and we run a temp roster of probably 250. People choose temp work for flexibility — it takes many more people to staff a case than in a visiting job."

"Hospitals have traditionally wanted their home care to be known as hospital-based, so that they would be able to allocate hospital overhead to the cost of the home health agency. If the management goes to someone else, it's going to be hard to keep your home care as hospital-based, and you may not get the financial break. There are certainly still hospital-based agencies that contract out for management, but it's slowing down dramatically," says

Covington, KY, attorney **John Gilliland**. He says that hospitals wanting to get out of home care would probably be happy to sell their home care arms, but not many people are interested in buying certified agencies these days. He points out that some hospitals like to keep their home care anyway because they find it easier to bid on managed care contracts if they have it in-house.

"Everybody's different," Gilliland says. "I find that in working with clients, they'll want to start by asking if they should form another corporation. I'll say, 'That's the end of our meeting. Let's talk about what you want to do. Don't talk corporations, don't talk where it is; tell me what your goals are. At the end of that, I and your accountants and other professional advisers will come back with a structure or options that will accomplish your goals. Change your goals — the structure's going to change.'" ■

SC decision: New options for disabled students

PD providers can seek school-nursing assignments

According to **William A. Dombi**, vice president for law at the National Association for Home Care in Washington, DC, a recent Supreme Court decision may open new opportunities for private duty care in schools across the country. "In the case of the *Cedar Rapids Community School District v. Garret F.*, No. 96-1793, U.S. Supreme Court (March 3, 1999), the court found that under the Individuals with Disabilities Education Act (IDEA) the school districts have a responsibility to provide nursing services to students who require them as a way of facilitating an integration of those students into the mainstream of education," he says. Since those students may be so technology-dependent as to require a full-time care attendant, school nurses will not be able to meet their needs.

IDEA is a federal law that applies to any school district that gets federal funding and part of a family of laws that deal with the disabled. One of the issues that has been in controversy was the degree to which a school system had to provide for nursing care. Some school districts interpreted the law as meaning that they didn't have to provide a physician, but did have to provide nursing services when needed. Other school districts decided that providing care for a single individual who required full-time care was beyond the scope of their responsibilities.

The court effectively held that it is the schools' obligation to do so. The Garret F. case has triggered some additional analysis of how the school districts' obligations interface with the Medicaid program, which has often been the financing source for those services because IDEA does not bring any significant funding to schools to handle the cost of private duty nursing.

Districts must comply with court decision

According to Dombi, Medicaid, under the Early Periodic Screening, Diagnosis, and Testing (EPSDT) program, that all Medicaid programs are obligated to have in place, would provide for private duty nursing.

"EPSDT is written to say that for children under 18 — if the state can put private duty in as an item in its Medicaid program — it must be made available to EPSDT clients. Anyone under age 18 enrolled in Medicaid would qualify," Dombi explains. "Private duty nursing, which was an optional Medicaid benefit, now becomes a mandatory benefit under the EPSDT program for that class of Medicaid recipients."

Each school district will now have to analyze whether they are complying with the Supreme Court's decision. If they are not compliant, they could voluntarily bring themselves into compliance, or someone who is adversely affected by the non-compliance can challenge them. "The court's action doesn't mean that everybody will suddenly comply, but it does mean that they can be forced to do so. We expect that most school districts will analyze their compliance status to determine whether or not they have exposed themselves to some challenges," Dombi says.

Garret F. was tube-fed and ventilator-dependent. His parents asked the school system to pay for the private duty nursing the child needed when he was about to be mainstreamed into school. The school system initially refused, but Garret's parents were successful in an administrative appeal. The school system appealed the administrative appeal, lost again, and continued through the courts until the case reached the Supreme Court.

Dombi says that one of the things that has apparently been decided by the Health Care Financing Administration (HCFA) is that it is acceptable for state Medicaid programs to be the foundation for payment of in-school private duty

care. "One of the questions HCFA is looking at is whether the billing for those services will come from the school system or from the health care provider delivering the care. The school system has its options on how it approaches this issue, but the state Medicaid program has its limitations on who are eligible providers of services, too," Dombi says. "In some states, the only way you get private duty nursing financed under Medicaid is through delivery of services by a home health agency. In other states, they will go so far as to pay the individual who is delivering the care."

Whether the states will have to adjust who is an eligible provider of services to facilitate an arrangement between a school system and the Medicaid program will have to be analyzed specific to that location.

Do your homework, then take the initiative

"What we've put out from the National Home Care Association is an opportunity for entities that provide private duty nursing to approach this as another line of business, to turn to the school systems and say, 'We're available. We'd like to be your provider of choice on these services under a contract with the school system,'" Dombi adds.

Dombi says that private duty contractors can do this in two ways. "The first is to ask the child's parents to advocate for your services. The second is to approach the school board armed with both the understanding of what the school system's obligations are and with whatever would be best to sell your services to the school system."

Dombi points out that the Medicaid recipient has a right to choose any qualified provider of service. "That raises the question of who the provider is. Is the school system, the home health agency or an individual? If the school system and the state connect and decide that the school system will be the provider, and they will contract to fulfill that responsibility, then the choice is going to be very limited. If the patient chooses to go to that school system, then they therefore have automatically chosen who the provider of care is, as distinct from a school system that allows the individual to choose his or her own provider of nursing. There's nothing in the Supreme Court decision that addresses this whole Medicaid issue, and I think there's plenty in the law that allows the flexibility for the school systems to take different routes. They can either being the direct provider, or the party that arranges for the service, or being the party who facilitates the opportunity to bring that service into the school setting." If your school district chooses one of the last two, you have a possible new venue for your services.

If you decide to pursue this venue, here's a possible plan of action for you:

- **Do some research to find out how many children in the school districts your agency serves could use your services.**
- **If you determine that there are sufficient number to warrant putting your time and effort into capturing the market, don't wait until you see a notice in the newspaper that the school district has decided to hire private duty care.**
- **Be aware that school districts are heavily influenced by school boards, which are usually comprised of private citizens with a fairly conservative political bent.** Research and network. Find out who your school board members are, and see if you can find out their positions on private duty care in schools. Check the archives of your local paper for coverage of past board actions and profiles of board members.
- **Call the school board office and ask for a copy of the board's meeting calendar.**
- **Think about why your agency would be the best choice the board could make.** Prepare a presentation package on your services for each school board member. Make sure it's to the point, easy to read, and sells your positive points. Imagine you are in the board members' position. Ask yourself what your agency has to offer. The answer to this can be anything from quality to price. Include a price range and examples of pricing for specific services. As the children you are seeking to care for will almost certainly be highly technology-dependent, you should be prepared to provide references from former and present clients with similar or at least analogous problems.
- **Lobby those who hand out the contracts.** Make an appointment to meet with each of the school board members, the district head individually. Once you have met with them, lobby members of the governing body (usually a board of county commissioners) that budgets school funding. As these people will be elected representatives, it helps to take one of their constituents with you to these meetings — preferably a constituent who voted for that commissioner.
- **Expect to do a certain amount of educating during these meetings.** (This is where being armed with an understanding of the law and Medicaid regulations comes in.) If you know the person with whom you are meeting has resisted

SOURCE

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private duty care in the past, expect to do some pleasant persuading as well.

• **Once you've accomplished all this, ask to be placed on the agenda to make a brief presentation at the next school board meeting.**

• **Find out which reporters cover the school board and county commission "beats."** Take an information packet for each of them, too, and make yourself available to answer their questions.

• **Keep your cool no matter how heated the discussion becomes.** ■

Y2K: Prepare for the worst, expect the best

Both providers and patients will benefit

Unless you have a more than sufficient number of staff — or a less than sufficient number of clients — you won't be able to assign a staff member to sit with every patient on New Year's Eve. Few home care clients are so technology-dependent that a power failure could create a life-threatening crisis; however, home care agencies should do everything possible to forestall year 2000 (Y2K) difficulties and allay clients' fears of a worst case scenario.

Sheila Robida, manager for the Connecticut Hospital Association's (CHA) Y2K project, says the two most important things home care providers can do are:

• **Have a contingency plan in place in case problems do arise.**

• **Ascertain the Y2K-compliant status of computerized medical equipment use in their patients' homes.**

"Home care providers should work with clients to create a contingency plan in place so that if the power does go out or the phones go dead, care can continue with as little interruption as possible," says Robida. "If the worst happens. having a plan in place means there's a logical next step to take."

All agency management and staff, clients, and their families should fully understand what that plan is, so that nobody panics and everyone knows what to do. "The biggest issue is no surprises. You want to make sure that everyone understands what everyone else is doing so that if there is a problem, it is handled correctly and smoothly," Robida says. She also stresses that every home care agency should assess the needs of its client base and communicate its findings to hospitals and other community institutions that might be called upon should clients require institutional care. Hospitals need to know what patients might need admission, and transport should be arranged for in advance.

Are your clients' medical devices Y2K-ready?

"Most people who are on home medical equipment rent the equipment," Robida says. "But if they have purchased it, they should query the manufacturer on Y2K-compliant status and find out if they need to have any upgrades to the equipment." Medical care devices with computer chips won't necessarily quit working on Jan. 1, 2000, because their functions aren't tied to time and date the way that airline reservations and bank accounts are. Robida says many medical devices manufacturers have told the FDA that most of their devices will be unaffected by Y2K problems; those devices that might malfunction should have had possible Y2K problems before the end of the year.

However, Robida points out that anything with a computer chip, from a magnetic resonance imaging system to a patient monitor, has a potential for failure. "It may be a pretty low potential, but the device should be checked out." The American Hospital Association (AHA) suggests that health care providers test biomedical systems and devices themselves. The Food and Drug Administration (FDA) has an on-line national clearinghouse that lists voluntary responses to the agency's requests for medical device Y2K compliant status. The FDA clearinghouse can be accessed at **www.fda.gov/cdrh/yr2000/year2000.html**.

To help health care providers ascertain the Y2K compliant status of their equipment, CHA has formed Security Third Millennium (SIIIM). SCT's staff has developed a database on Y2K compliant status by querying manufacturers of medical equipment. Owners and managers of private duty agencies with a large number of clients on computer chip-dependent equipment may want

SOURCES

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- **Alan Jackson**, Computer Specialist, Curative Health Services, 150 Motor Parkway, Hauppauge, NY 11788. Telephone: (516) 689-7000.

to consider subscribing to a service provided by SIIIM to be able to give their clients accurate information on the Y2K status of the devices they are using. The information is offered to health care providers by subscription. They can either subscribe to SIIIM's service or search its data base for information on their particular devices and equipment, or send in their biomedical device inventory for review. In each case, the care provider receives a report relaying what the manufacturers have stated has been done for Y2K compliance. Care providers other than hospitals may obtain query service on a case-by-case basis, the cost of which depends on the size of their inventories.

"We are able to tell pretty quickly where you stand with Y2K compliance," Robida says. "We need a manufacturer's name, device model number, and serial number, if available. If the manufacturer is not yet contained in our database, we'll contact them and get the information."

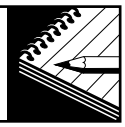
Subscription costs vary, depending on the institution type and expenses.

Also, check your accounting system

Home care professionals should also double-check the status of their computerized accounting systems, but they probably won't have any Y2K compliance problems. According to **Alan Jackson**, computer specialist with Curative Health Services in Hauppauge, NY, most companies that do medical billing re-evaluate their systems every few years due to the rapidity of changes within the information technology industry. "Just through recent computer system purchases, many Y2K issues would have been resolved," Jackson says, "and a self-contained, small office that prints its own bills could probably continue to do so. One product we have found very useful in identifying Y2K problems both at the hardware and shrink-wrap software levels is the program Norton 2000.

On the hardware side, it will identify whether the hardware is certifiable and can even fix some hardware problems." Suggested retail price for Norton 2000 is $49.95. ■

GUEST COLUMN



To help client with advance directives, know thyself

By **Sharon Newton**, MS, RN, CDMS
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Most regulatory bodies require medical and home care agencies to provide information on advance directives to their clients. This stems from the federal Patient Self-Determination Act passed in 1992. There are several advance directives common among all the states; there are some specific to certain states. It's important for you, as manager, to know what is pertinent to your state so you can help your staff implement these rules. It is also important for you to be able to cope with death so you can support your staff when a beloved client is at the end stage of life.

• **Advance directives**

Essentially, a competent individual can express his or her choice(s) for life-sustaining medical treatment before s/he becomes incapacitated and unable to do so. Additionally, a client may make a Declaration for Mental Health Treatment in some locations such as Texas.

The common choices a client may make include the directive to physicians (living will), the durable power of attorney for health care and the do-not-resuscitate (DNR) order. Some states, California and Texas for example, have added the out-of-hospital do-not-resuscitate order and the declaration for mental health treatment.

The witnesses who sign these forms usually must not be related to or caring for the client; nor can they benefit from the client's will.

• **Directive to physicians (living will)**

This choice directs the individual's physician to withhold procedures that would prolong life in the event of a terminal illness. The document is signed

in front of witnesses and the original provided to the physician. It is a good idea for the individual to discuss the decision with family members in order to avoid the initiation of procedures the client did not want. Usually two physicians have to certify that the client is terminally ill.

The procedures to be withheld may include cardiopulmonary resuscitation (CPR), intubation, and artificial feedings.

• **Durable power of attorney for health care**

In this choice, the client designates someone to make health care decisions for him or her if s/he becomes incapacitated and is unable to do so. It applies only to health care, not finances.

• **Do-not-resuscitate order (DNR)**

The competent client can tell the physician that a DNR order should be placed on the chart in the event of admission to a hospital, nursing facility, or hospice. The client does not have to have a terminal condition. The order would go into effect in the institution should the client stop breathing or not have a heartbeat.

• **Out-of-hospital do-not-resuscitate order**

It is now possible for a client to have a DNR order in place while s/he is at home. This advance directive would usually apply specifically to emergency medical service (EMS) or other health care personnel.

• **Declaration for mental health treatment**

A competent adult may choose certain mental health treatments to be used in the event of incapacitation. These include psychoactive medications, electroconvulsive treatment, emergency medical care, and other preferences. Two witnesses must sign the form.

• **The manager's role**

As a manager, you must be familiar with the rules and regulations concerning end-of-life issues in your state. You must be familiar with your feelings toward these issues. You must be able to support your nurses and staff and be able to comfortably discuss your agency's expectations and then allow the nurses time to become comfortable with their own death so they, in turn, can support the clients during the decision making process.

Over and above your feelings toward these end-of-life issues, however, is the client's autonomy to choose what is best for him/her based on his/her culture, religious beliefs, and his/her own acceptance or avoidance of these topics. Empower your nurses and staff to be client advocates.

• **The nurse's role**

The nurse usually is the agency's representative who gives the client the written information about the advance directives designated in that state. The nurse must be familiar with the advance directives and must be able to explain them to the client in easily understandable terms. Some agencies do not routinely provide the specific forms unless the client requests them. Since people often are uncomfortable discussing matters related to incapacitation and death, the nurse must be sensitive to the client's needs when making these explanations.

• **Nurses' attitudes**

In order to discuss adequately these end-of-life issues with the client, the nurse must face his/her own incapacitation and/or death. Take time now to assess your feelings. A shared emotion is fear of death. What are you afraid of as you ponder the fact you will die? Nothingness? Abandoning loved ones? Unfinished business? Losing control? As you come to grips with the answers, you will be better able to be empathetic in discussing death and advance directives with your client.

• **Caregivers' attitudes**

In the home setting, you often encounter family members and friends who care for and about the client. With the client's permission, include them in your teaching, too. In the event of an out-of-hospital DNR, family understanding and cooperation is vital. Be prepared to know how you will handle the situation if the client who has this in place ceases to breathe while you are in the home and the family member wants you to call EMS. What are you ethically bound to do? To whom or what is your responsibility now? If you have included the caregiver and other significant people, the client's wishes can be honored with dignity and assurance.

• **Conclusion**

According to regulations, clients must be given information about advance directives. The agency manager and nurse must know and understand the advance directives required in his/her state in order to educate the client adequately. The manager should know his/her own feelings toward death in order to be sensitive to the needs and sensitivities of the nurses and staff who will be working closely with the client and caregivers. The nurse should also know his/her own feelings toward death in order to be aware of the needs and sensitivities of the client and caregivers. The nurse, operating from an ethical standpoint, is in an enhanced position to aid the client in this period of end-of-life transition. ■

Appropriateness for home care services

By **Elizabeth Hogue**, attorney
Burtonsville, MD

The private duty home care industry is appropriately focused on "the bottom line" — i.e., operating a profitable business. In order to help ensure profitability, agencies must make certain that patients are not admitted who are not generally appropriate for home care services. Patients who are admitted for home care who are not generally appropriate for such services gobble up the agency's resources with an ultimate adverse effect on the bottom line. In addition, admission and continuation of services to patients who are inappropriate for home care enhances the likelihood of legal liability in this litigious society.

Consequently, private duty home care agencies must evaluate every patient for general appropriateness for home care before they are admitted and for general appropriateness for home care after they are admitted. Patients who fail to meet even one of these criteria prior to admission should not be admitted, services should be discontinued to patients who met these criteria upon admission, but later do not meet them any longer:

- **The patient's clinical needs can be met at home.**
- **The patient can either self-care, or there is a paid or voluntary reliable primary caregiver to meet the needs of patients when staffing cannot be provided or between home visits.**
- **The patient's home environment supports home care services.**

The ability of home care providers to care for medically complex patients has been greatly enhanced in recent years. Consequently, it is relatively rare that the clinical needs of patients cannot be met at home. These rare instances may involve, for example, patients who are prematurely discharged from an institutional setting.

In addition, patients must be able to self-care, or there must be a paid or voluntary reliable primary caregiver prepared to meet the needs of patients when home care staff members are not present. Private duty home care providers may encounter very significant difficulties with these criteria as follows:

- **When staff evaluate patients for admission, they will certainly identify a primary caregiver.** But, realistically speaking, about all they can tell about primary caregivers upon admission is that they are vertical and breathing. The competence and reliability of primary caregivers can only be assessed over time.
- **Staff members are often also working uphill against the expectations of patients and their families.** Specifically, discharge planners in institutional settings are under so much pressure to move patients out of the institution that they rarely explain to patients and their families what their role in home care must be. Consequently, patients often are referred to home care with the expectation that nurses will take care of everything, just as they did in the institution. This expectation is further enhanced by the general lack of understanding by many patients and their families about home care. In addition, in the face of illness, it is only human for vulnerable patients and families to want agencies to simply step in and take care of everything.
- **In addition, some of the tasks that primary caregivers may be expected to perform are repugnant to them.** The "big three" tasks are wound care, changing diapers, and giving injections. When these tasks are involved, the reliability of primary caregivers may be sorely tested.

What staff can do to improve the odds

What can agency staff members do to increase the likelihood that they can identify and support primary caregivers in ways that will enhance the likelihood of reliability?

During the admission visit, staff should be very direct with primary caregivers about the role they must play. They must further make it clear that if primary caregivers fail to fulfill their role, patients simply cannot remain in home care. For example, staff may say to potential primary caregivers: "In order for the patient to be admitted to home care, you must be willing to dress the patient's wound twice a day, change the patient's diaper many times each day, and inject the patient three times each day. Are you willing to perform these functions?" In addition, the staff should be very direct about the fact that the agency will use reasonable efforts to provide staffing, but cannot guarantee it. In instances when the agency cannot provide staffing, the primary caregiver must be prepared to care for the patient's needs based on education and teaching previously provided by the staff. This very direct discussion and the potential caregiver's agreement or refusal to perform these tasks

must be documented.

If it appears that there is a reliable caregiver and the patient is admitted, staff must continue to monitor for reliability. Staff must specifically document every instance of noncompliance by primary caregivers. It is not sufficient to document that the caregiver is non-compliant. Rather, staff must indicate that they changed the patient's diaper at 2 p.m. and place a red mark on the tab at 2 p.m. When staff returned the next day, the patient was lying in excrement and urine and still wore the labeled diaper. Then staff must re-teach primary caregivers, and if appropriate, get a return demonstration which, of course, must be documented. This process should encourage reliability by caregivers.

Finally, the patient's home environment must support home care services. Documentation related to this issue is often provided in the form of safety in the patient's home. This term is very vague and can mean everything from too many scatter rugs on the floor to rats gnawing on intravenous tubing. So staff members should be careful to document that the patient's home environment will not support home care services for specific reasons.

(To obtain additional information about the risk of legal liability discussed above included in a book, Legal Liability, *send $25.00 including shipping and handling to Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. To obtain a complete set of policies and procedures related to termination of services when patients are no longer appropriate, send $105.00 to the above address.)* ■

Getting on-line services to streamline your billing

e-MedSoft.com gets a new client

Home Medical of America (HMA), the largest privately held provider of home health care services in the United States, has contracted with e-MedSoft.com of Jacksonville, FL, to improve communication and billing practices for its125 locations and 14,000 employees. According to **Ron Wing**, vice president of marketing, e-MedSoft is a health care product available through the Internet that provides connectivity solutions to home health providers, physicians, and payers through its application sets. "Essentially what we do is provide a new vehicle for these groups to connect and do business on a transaction basis using the Internet," says Wing. "We provide the application and all the services it takes to get into our environment."

SOURCE

- **Ron Wing**, Vice President, e-MedSoft.com, 1300 Marsh Landing Parkway, Suite 106, Jacksonville, FL 32250. Telephone: (800) 627-2642. Web site: www.mdtk.com.

Wing says e-MedSoft significantly reduces the amount of time health care firms spend on book work. "When a nurse or technician is at the (care delivery) site, there are a lot of forms to fill out. They are usually working on a work order prescribed by a physician, and they're trying to capture data as well as fill out reports for the managed care service. We can provide that electronically, so they can do that within the home with a palmtop or laptop computer. Users can then plug the data into their desktop computers and into the e-Medsoft application. "Our eventual goal is to be able to do that on a wireless remote basis, but right now there are technical credibility (transmission interference) problems if you're not connected to a dedicated wireless line."

The e-MedSoft core system has the traditional patient registration, transfer discharge features, plus claims submission and processing. System users mouse-click on an icon to request electronically transmitted data from the patient's records. "We have a back-end claims processing service," says Wing. "You go on the Internet with a browser, mouse, and keyboard. You're prompted to enter data for a claim. You see the same screen every time, but the edits around that claim will differ between payers. We take care of that editing in combination with the electronic transporter, which is sent back to the payer. So all our clients do is enter data into a simple screen. The back-end processing is all done for them and submitted to the payer for reimbursement."

Wing says e-MedSoft offers eligibility determination on-line and has referral management capability. If a primary care physician is working within the context of a PPO and has to refer a patient to a specialist, there are referral parameters within the plan. The context of the application and the connectivity of the plan will do that for you."

Wing says one of the things HMA wants to do is streamline their processing systems. "Because of the way the company came together, it has multiple processing systems for bill generation, service requests, inventory — all the components of their

service cycle. What we're going to do is integrate all the different offices and connect them into a back end with our system so that they can manage their own inventory, billing, [and] asset management. They can do scheduling out to the sites so they know when they need to send a truck with equipment and when a nurse needs to be there."

E-MedSoft charges a monthly subscription fee for the right to use the application. Fees are based on the number of users, access to applications, and customization required. ■

AGORA: The private duty marketplace

Judith Clinco, RN, BSN, CHHE, president and CEO of Catalina In-Home Services in Tucson, is also now our new consulting editor for *Private Duty Homecare.* During recent discussions with her, we asked for her thoughts on how *PDH* can best fulfill the informational needs of its readership.

Clinco suggested that because home care standards and regulations vary so greatly across the country, a positive step in serving the *PDH* readership would be to open a forum on how to bring about uniform standards for private duty home care nationwide. These would include educational and other standards for caregivers, standards for practice and licensing, and whatever other standards readers wanted to consider.

These are her thoughts on that subject: "There are a lot of things we could consider using to increase the standard of care that's provided to the client and the community, and the kind of support, education,and acknowledgement that the home care sides get for the great job they're doing. It really is being of service to another. It's hard work. We don't pay people a livable wage, and we don't provide benefits, and we also don't provide acknowledgement and recognition from

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the agencies or the community for the kind of work they're doing. We don't recognize family caregivers either. They're just behind closed doors doing their work and not getting any pay.

With regard to the home care aides, I think our biggest challenge is how are we going to be able to recruit a qualified labor force if we don't take the risks and pay excellent wages. We have to provide a livable wage to our employees, or in this labor market we are not going to be able to recruit good people and retain them long-term. And if we don't retain them long-term, there's nothing that goes to the bottom line. I have suggested in print that maybe we should go ahead as a country and subsidize the industry.

I'm charging $16.80 an hour. I provide health insurance to people who work with me 30 hours or more a week, and then I do a percentage of the health insurance on a yearly basis. By the time my staff have been with me for five years, I'm paying 50% of their health insurance premiums. But I can't provide everyone's health insurance for all my employees. I also give everyone a week's paid vacation.

I would love to have some subsidy for my 150-hour training course. My training courses cost me a lot of money, and if people don't stay with me, they don't put anything to my agency's bottom line. It's another contribution to the community — but it would be nice if I could be subsidized.

I know that changing the verbiage in that law is an undertaking. That's something that we in the industry would have to stand up for.

In hospitals, nursing homes, and health care clinics, employees are able to work 80 hours within the two-week pay period. They can't work for more than eight hours a day, but they could work for 10 consecutive days and then have four days off within that two-week period. The way I'm boxed in now, my staff can't work more than 40 hours in any given week.

When you read the fair labor law, it says that if you are a health care provider, and you are taking care of elders or the mentally ill, that you fall under this particular guideline, but you have to be a facility. It doesn't even mention home care providers because when the law was written we weren't providing home care the way we are today. This is a federal labor law. All they need to do is rewrite the law to say a health care institution is defined as a facility or an agency that is providing care to people in their homes.

What are your thoughts about these issues? Would you like to participate in a nationwide movement to raise and unify private duty home care standards, for the benefit of all concerned? How do you think it could best begin, and what can *PDH* — as an apolitical facilitator — do to help you? Write to us, e-mail or snail mail. Addresses are in the back of this newsletter. Phone numbers are, too. ■

CE objectives

After reading this issue of *Private Duty Homecare,* CE participants will be able to:

1. Understand and describe the correct criteria for admission of appropriate patients to home care services.
2. Draft a plan for selling home care services to school boards.
3. List advance directives for death and dying.
4. Write a Y2K contingency plan for continuation of client services. ■