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IN THIS ISSUE

OCTOBER 2003
VOL. 20, NO. 10 • (pages 109-120)

Working in the dark: Recent blackout teaches new crisis-planning lessons

Unreliable communications, no gasoline challenge HHAs

There is nothing like an emergency to test your emergency plan, as agencies in an area east of New York City, north to Toronto, and west to Detroit discovered on Aug. 14 as a rolling blackout affected almost 50 million people.

"We are calling the event Y2K plus three," says **Greg Solecki**, vice president of Henry Ford Home Health Care in Detroit. "Many things that we expected to happen for Y2K happened on Aug. 14," he says. Traffic lights, gasoline pumps, store cash registers, automated teller machines, and water systems didn't work, making everyone's personal lives more complicated, he points out.

From a home health agency perspective, there were other problems that traditional emergency plans did not take into account, he adds. "Although our governor encouraged people not to go into work, my employees were ready to work," he says. The difficulties were communications and finding employees with enough gasoline in their cars to make patient visits, he adds.

"Cell phone coverage was intermittent. My phone worked part of the day, then quit, and other employees' cell phone service would come and go as well," explains Solecki. It took a few hours, but someone discovered that a traditional, land-line phone plugged into the fax line, which is analog rather than digital, would access telephone service, he says. "Prior to making this discovery, we were constantly updating employees at home and at other offices with the cell numbers that were working," he adds.

Even after establishing reliable phone service in the office, Solecki and his staff realized that they were not able to reach employees who had portable phones that relied upon electricity to work. "We've now updated our telephone list to identify which employees have traditional land-line phones," he says.

The staff members at Comprehensive Care Management, the home health service agency for Beth Abraham Health Services in Bronx, NY, also discovered the fax lines, but did not have any telephones they could use, says **Virginia Murray**, RN, BSN, MSN, director of quality

management at the agency. "Now, each of the offices has a princess phone in the closet for this type of emergency," she adds.

The telephone system at Comprehensive Care Management does have a battery backup, but the agency discovered that it lasted only four hours out of the 24 they were without power. "We are talking with our information system people to see how we can beef up the telephone backup," says Murray.

Although her agency's area was out of power for only four to eight hours on Thursday evening, **Susan Schulmerich**, RN, MS, MBA, vice president of community health services for Elant Choice in Newburgh, NY, says that the uselessness of convenient portable phones was quickly recognized by her staff as well.

"We are going to consider adding a question to our initial interview about the type of phone that is available in the house," she says. Most of their patients are older than 55 and less likely to purchase a portable phone, but family members might give them as a gift, Schulmerich explains.

"A portable telephone is fine as long as there is a traditional phone in the house as well," she adds.

"We had no problem getting staff members in to work; in fact, we had no absentees on Friday," Murray points out. Employees reported to the center nearest their homes, she says.

Keep some paper records

Fortunately, priority patients and their contact information are kept on paper lists, but because all of the agency's care plans are computerized, Murray says that they were lucky that one of the on-call nurses' laptop had all of the current care plans.

"We had never thought about the need to access current care plans because we didn't think about areawide power outages that exceeded our backup systems," she says.

Now, each office has one laptop that is updated every day with current care plans and has the battery fully charged, she adds.

Because many people didn't go to work on Friday, family members were with most of the patients, says Murray. Patients who were on oxygen were sent to hospitals, she adds.

Water became a real concern for some people, so nurses delivered water to patients in high-rise buildings who may not have had anything to take with medications, Murray continues.

"We stock some water in our day-care centers and medical clinics, but it went quickly. This is one area her agency is going to study further, she adds.

Another basic piece of equipment that Murray discovered was an AM transistor radio. "It's old-fashioned but everyone in the office has a new respect for my little radio," she says.

"It became an important way to stay on top of the news and keep people informed as to what was happening," she adds. Now, all branch offices have a radio with extra batteries, Murray says.

Branch office managers at Henry Ford had to be creative in terms of managing their staffs, says Solecki.

"Our Lincoln Park office had no phones or power, but the manager's home that is located south of the office had power," he says. "She designated her home as her control center and was

Hospital Home Health® (ISSN# 0884-8998) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Home Health**®, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: customerservice@ahcpub.com. World Wide Web: http://www.ahcpub.com. Hours: 8:30-6 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $479. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $383 per year; 10 to 20 copies, $287 per year. For more than 20 copies, call customer service for special arrangements. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $80 each. (GST registration number R128870672.)

This continuing education offering is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864.

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Editor: **Sheryl Jackson**.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles Mckagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Christopher Delporte**, (404) 262-5545, (christopher.delporte@thomson.com).
Senior Production Editor: **Ann Duncan**.

Editorial Questions
For questions or comments, call **Christopher Delporte** at (404) 262-5545.

able to receive faxes from referral sources with power and use her phone to stay in touch with staff," he explains.

"Our Southfield office managers had to work out of their cars in the parking lot of the office building in which they are located because the building uses electronic card access and had no backup system for entry," Solecki points out.

"This was no problem for the other tenants, who are not health care organizations and had no employees reporting to work on Friday, but it pointed out an area that we need to address in future leases," he says.

Long hours and going the extra mile

At the main office, intake staff members went back and forth to the three main hospital referral sources to hand carry paperwork for admissions, Solecki says.

In fact, one employee worked a 12-hour shift, walking eight blocks between the hospital and the office the whole day, he adds.

Hospitals were trying to clear beds so patients requiring oxygen or other support that could be provided by the hospital generators could be admitted, and it was important that the home health agency be able to evaluate and admit patients, he points out.

Although the agency admitted new patients, it wasn't a smooth process, Solecki adds.

"Unfortunately, we were admitting patients who were sent home without supplies they needed and our nurses didn't have admission packets and paperwork they would have had if they could have come by the office first," he says.

"We also learned that it's not a good idea to eliminate all paper records," Solecki says. Laptops, office-based computers, and even the electronic discharge program between home health and hospital referral sources were useless.

"We were handwriting referral and admission information in duplicate," he points out. "We all started wishing that we kept a supply of carbon paper on hand and even wondered if carbon paper is still available," he jokes.

Although all of the agency's Priority 1 patients were seen or contacted by telephone to ensure their safety, scheduling visits required more than just calling a nurse, Solecki says.

"Because gasoline pumps were not working, we not only had to find out where the employee was located but also how much gasoline was in the car," he says.

The agency's Y2K plan recommended that employees not let their gas tanks go below the half a tank mark, and Solecki says that they, once again, are recommending that to employees.

"Since 9/11, New York agencies have been very aggressive in developing extensive emergency plans," Schulmerich adds. Even with the glitches in plans that were discovered during the power outage, the result of the planning was evident, she says. "No one panicked, and everyone approached their jobs in a professional manner," she points out.

Solecki agrees and adds that even after the power was restored, the agency continued in an emergency mode because computers would go on- and off-line erratically, and data needed to be backed up more frequently.

The event also pointed out the need to continually review emergency plans. Solecki says. "We've reconvened our disaster planning task force to evaluate this event and look at all variations of disasters. The lessons we learned from this emergency will only strengthen our plan."

[For more information on disaster preparation, contact:

- ***Greg Solecki**, Vice President, Henry Ford Home Health Care, One Ford Place, 4C, Detroit, MI 48202. Telephone: (313) 874-6500. E-mail: gsoleck1@hfhs.org.*
- ***Susan Schulmerich**, RN, MS, MBA, Vice President Community Health Services, Elant Choice, 31 Cerone Place, Newburgh, NY 12550. Telephone: (845) 291-3700. E-mail: sschulmerich@elant.org.*
- ***Virginia Murray**, RN, BSN, MSN, Director of Quality Management, Comprehensive Care Management, Beth Abraham Health Services, 668 Allentown Ave., Bronx, NY 10467. Telephone: (718) 519-5483. E-mail: vmurray@bethabe.org.]* ■

Your quality info to be made public soon

National rollout of CMS web site in October

The effect of Home Health Compare, the Centers for Medicare & Medicaid Services (CMS) web site that publicizes results of 11 home health quality indicators, has been minimal for agencies located in the eight pilot test states.

Home Health Compare's pilot test began in

May 2003 and includes outcomes data such as improvement in ambulation, improvement in bathing, acute-care hospitalization, and improvement in toileting. **(For full list of indicators and more information on the program, see *Hospital Home Health*, February 2003, p. 15.)**

The national rollout of the program to include all 50 states is set for mid- to late October, according to a CMS spokeswoman. *(Editors note: The exact date had not yet been announced at press time.)* All 11 indicators that were used in the pilot test will be continued, she adds.

Early response and education

"We've had a few families tell us that they contacted us after viewing the CMS web site, but it has not been significant," says **Joanne Smith**, RN, director of Florida Hospital Memorial Home Health in Ormond Beach, FL.

"We did not promote the web site to our patients or referral sources, but local newspapers did run articles," she says.

A statewide newspaper in West Virginia also ran an article on the web site and listed comparisons of the bathing improvement indicator among agencies but neither the article or the web site has resulted in families or referral sources choosing or staying away from Braxton County Memorial Hospital TLC Home Health Care, says **Lisa Ware**, RN, nurse manager of the agency.

"Even if people in our area checked the web site, we are in a rural area, and we are the only home health agency serving the area," she adds. "We still rely upon word of mouth and our usual referral sources," she says.

Although North Kansas City (MO) Hospital Home Health Services has not received any comments, telephone calls, or other feedback regarding the web site, **Rebecca Murrell**, RN, BSN, supervisor of the agency says that everyone was prepared.

"We started educating our staff a year before the web site went on-line," she says.

"Because we started before the final 11 indicators were chosen, we shared outcome information for all 41 indicators with staff members," Murrell explains.

The focus of the educational effort was to increase accuracy of the initial patient assessments so that outcomes would not appear to be negative, Murrell says.

"We divided the staff into small groups of four to five people and had each group evaluate each question," she continues.

The definitions, guidelines, and suggestions on what should be included in answers were suggested by the small groups and shared with the entire staff, she explains.

"We wanted to make sure that everyone was assessing the patient accurately and that everyone was consistent in how they documented and reported each item," she explains.

Denise McConnell, RN, clinical manager for Roper-St. Francis Home Health in Charleston, SC, contends that very few patients or families understand the quality information and they don't know how to apply it to their situation.

"I also wish that indicators that measured stabilization were included as well as improvement indicators," she adds.

"For many home health patients, stabilization is the ultimate goal and is just as important as improvement might be for other patients," says McConnell.

Staff need to have the answers

Even if patients and their families, or even some of your referral sources don't understand the data, be sure your staff members are all aware of the web site, suggests Murrell.

"Your staff members should be able to answer any questions a patient might have, or at least know about the web site and offer to get the answers for the patient. This reassures the patient that you are comfortable with your quality information being made public and you are proud of your agency's record," she says.

[For more information on Home Health Compare, contact:

- ***Joanne Smith**, RN, Director, Florida Hospital Memorial Home Health, 785 W. Granada Blvd., Ormond Beach, FL 32174. Telephone: (386) 673-3121.*
- ***Lisa Ware**, RN, Nurse Manager, Braxton County Memorial Hospital TLC Home Health Care, 100 Hoylman Drive, Gassaway, WV 26624. Telephone: (304) 364-1063.*
- ***Rebecca Murrell**, RN, BSN, Supervisor, North Kansas City Hospital Home Health Services, 2900 Clay Edwards Drive, North Kansas City, MO 64116. Telephone: (816) 691-1358.*
- ***Denise McConnell**, RN, Clinical Manager, Roper-St. Francis Home Health, 1483 Tobias Gadson Blvd, Suite 208A, Charleston, SC 29407. Telephone: (843) 402-7000.]* ■

With adverse events, don't stick your head in the sand

Adverse event reports can strengthen QI

The phrase "adverse event outcome reports" might make you want to run and hide, but these reports can be a wealth of information and require constant attention by all home health agencies, according to experts interviewed by *Hospital Home Health*.

"Adverse event reports help us monitor the quality of our care and assess the validity of our OASIS [Outcomes and Assessment Information Set] assessments," says **Jeannie Snyder**, RN, BSN, CQI coordinator for Sacred Heart Home Health Services in Eugene, OR.

"By reviewing them on a regular basis, we also have a chance to address issues raised by the reports before a surveyor brings them to our attention," she adds.

The most common reason for an adverse event report for her agency has been falls, Snyder adds. "We have a large number of weak, elderly, debilitated patients and no matter how much information the nurse provides to avoid falls, the patients do get up in the middle of the night and fall," she continues.

After monitoring the adverse event information related to falls, Snyder's nurses changed the focus of their teaching from preventing falls to learning how to fall safely, she says.

"We teach patients to grab onto a bar or table to slow their fall so their landing won't be so hard," she explains. "We also recommend hip protectors or pads under and around the bed to soften the fall and prevent fractures."

Efforts from this change have been positive, Snyder points out. "In 2000, we had 63 patients access the emergency department [ED] following a fall, and 42 of the patients had fractures," she says.

These numbers steadily have dropped. In 2001, 49 patients went to the ED, and 19 had fractures. In 2002, 56 patients went to the ED, but only 15 had fractures. In the first six months of 2003, 19 went to the ED, and six had fractures.

To use adverse event reports most effectively, you must have a process in place to regularly review the reports, audit the charts involved, and determine the reason the adverse event occurred, Snyder says.

"We download our reports monthly, then our continuous quality improvement (CQI) staff review the report and have medical records pull the appropriate charts," she explains.

"The charts are placed in a staff auditing area next to CQI, and letters are sent to the appropriate case managers along with the audit forms for the specific adverse event," she says.

The staff are so tuned into the process that sometimes staff members will ask for an audit form as soon as they've completed a transfer or a discharge OASIS and know that it will generate an adverse event, says Snyder.

"They say it is easier to complete the form and document the care while it is fresh in their mind rather than one month later," she adds.

Having the case managers and the nurses involved in the audits is an important teaching component of the process, says Snyder.

"No matter how much you teach OASIS, there are still many items that require subjective judgment, and the audits demonstrate how an inaccurate assessment can result in an adverse event," she says.

By seeing real-life examples of different situations, nurses more easily can identify the same situation in another patient, she adds.

Use a team approach

At Home Health Care of Washington County Hospital in Hagerstown, MD, staff members review the adverse event information quarterly and evaluate the information in multidisciplinary teams, says **Barbara Leatherman**, RN, performance improvement coordinator for the agency.

The teams are responsible for presenting the information to staff meetings and developing recommendations for improvement. Different staff members serve on the task forces each quarter so everyone has an opportunity to learn more about OASIS, adverse events, and performance improvement, she says.

"A recent surveyor was very impressed with our task force approach," she adds.

Whether you use individual nurses or a task force to audit the charts, the audit will produce one of four results, Snyder explains.

1. Data entry error

The staff checked the correct box, but the data entry staff coded it wrong on submission. "We still have a problem with this occasionally because we do all of our OASIS on paper," she says.

2. OASIS error

Staff had incorrect information or checked the wrong box. "This sometimes happens when different clinicians handle the start of care and the discharge OASIS," explains Snyder.

When your audits do show OASIS errors as the reason for the adverse event, use the information to improve your educational focus, suggests Leatherman.

"Over the past year, we have looked at all OASIS questions and given staff members additional information and definitions for them to use to improve their accuracy," she says.

3. Unpreventable adverse event

"Some events, such as falls, occur even when all appropriate care and teaching was provided and documented," says Snyder. If you see trends in certain unpreventable adverse events, use the information as a way to evaluate your teaching, but be aware that some adverse events are going to occur in spite of your best efforts, she adds.

4. Quality concern

Sometime a chart audit will show a true quality concern such as wounds that are not properly measured, assessed, or documented at each visit, says Snyder. These finding should prompt action within the agency to further educate the staff, she adds.

Surveyors are using adverse event reports to focus their surveys, says Leatherman. "Our surveyor showed up with her report in her hand and asked me what I thought of our most recent report," she says. "Because we work with the information on a regular basis, I was able to show that I understood the information and that our agency used the information in a constructive way," she adds.

"I like using the reports because it enables us to benchmark against other agencies and track results over time," says Leatherman. "More importantly, they enable us to identify quality of care concerns that are relevant to our agency and our patient population."

[For more information on learning from adverse events, contact:

- ***Barbara Leatherman**, RN, Performance Improvement Coordinator, Home Health Care of Washington County Hospital, 1799 Howell Road, Hagerstown, MD 21740. Telephone: (301) 766-7815. E-mail: bleather@wchsys.org.*
- ***Jeannie Snyder**, RN, BSN, CQI Coordinator, Sacred Heart Home Health Services, 1121 Fairfield Drive, Eugene, OR 97402. Telephone: (541) 607-8157. E-mail: jesnyder@peacehealth.org.]* ■

Losing staff to burnout? Recognize the symptoms

Fatigue, sloppiness, complaints signal burnout

"I'm tired of the paperwork. I don't enjoy seeing so many patients in one day. I'm not satisfied with my work. I just feel burned out."

Burnout is a hard state of mind to define, but many times it is one reason that good employees leave, says **John Henry Pfifferling**, PhD, director of the Center for Well-Being in Durham, NC.

"Although there are no studies or data that correlate job burnout with retention, there are many anecdotal examples," he says.

A home health manager can improve retention of good employees by understanding the factors that increase job stress that leads to burnout, and by recognizing the symptoms of burnout early on, so the manager and employee have a chance to address the problem before the employee decides to leave.

Prevent burnout before it strikes your staff

Obviously, the best time to address staff burnout is to prevent it in the first place, says Pfifferling. While there is no guaranteed method of preventing burnout, organizations that experience low burnout among employees have similar characteristics, he says.

Organizations that communicate honestly with employees, offer specific, timely feedback on employee input, and address the issues that can create stress and exhaustion are the organizations with lowest burnout, says Pfifferling.

"It's also important to address excess workloads and personal issues that add to job stress," he adds.

Because home health employees deal with emotional issues such as the illnesses or deaths of their patients as well as illnesses or deaths in their personal lives, it's important to put a process in place to help people through tough times, says **Mary Dyck**, RN, BSN, MHA, director of home care services for Riverways Home Care Services of Ozarks Medical Center in Westplains, MO.

"When an employee has an illness or crisis in their personal life, it can create extra work and tension for other employees if you don't have a program that plans for the unexpected," she explains.

Dyck's agency has set up a care team network that goes into action when any employee has a crisis in his or her personal life. **(See description of program, p. 116.)**

The network is designed to help employees with meals, personal errands, transportation to the doctor or clinic for treatments, housework, or anything they need to help them get through the crisis. "Other employees appreciate the network because it gives them a way to help that is meaningful but doesn't overwhelm them," she explains.

Dealing with personal crises

By having a process that helps the employee deal with his or her crisis and helps co-workers deal with the uncertainty of an ill or absent employee, everyone benefits, Dyck says.

"We've found that this program has retained our good employees because it clearly demonstrates that we look at each of our employees as family members and we don't want them to feel left out or burdened," she says.

Burnout is a process that differs from person to person but there are typical symptoms that can help a manager identify an employee who is approaching burnout, Pfifferling says.

"All of these symptoms can be symptoms of any number of problems, but if a manager notices a pattern or trend in behavior that includes these symptoms, he or she should explore the cause with the employee," he suggests.

The symptoms include:

- **Fatigue and health complaints**

"The employee complains of aches, gastrointestinal problems, tiredness, and is also more irritable than usual," Pfifferling says. Sometimes, the employees blame their mood on their inability to fall asleep or stay asleep, he adds.

- **Depersonalization of clients**

The patient is no longer "Pat" but "that old lady," says Pfifferling. "It's important for managers to listen to the words used by the employee," he says.

An employee who is burning out will refer to patients as the diabetic or the heart patient, or even as the third patient seen on Tuesday, Pfifferling explains. Relationships with patients no longer are personal, just part of the job, he adds.

- **Negativity, cynicism, bitterness**

A highly stressed employee notices only the bad, points out Pfifferling. For example, rather than viewing the use of a laptop for charting, the employee sees it as yet another thing to learn. The employee always expects the worst and focuses on what has gone wrong in the past, he adds.

- **Lack of creativity**

"An employee who feels burned out is not motivated to find a new way to provide care or engage a patient in conversation," Pfifferling continues.

The employee will do the job, but because of his or her fatigue and lack of interest in the job, there won't be any extra effort made, he adds.

- **Talk about quitting work**

While we all experience days that make us wish for another job, the burned out employee actually tells co-workers, patients, or friends that he or she wants to find another job, Pfifferling says.

The employee may not be looking actively for something else, but talking about it may be a tactic to convince him- or herself that it is the right thing to do, he adds. A manager also will notice an increase in tardiness, inattention to details, and sloppiness, he says.

Talking with employees who are exhibiting potential symptoms of burnout is important, Pfifferling says. "A burned out individual is contagious. That person's tardiness, criticism, or sloppy work affects all other workers, increasing their stress and their risk of burnout."

The first step is to know what you are going to do when you identify an employee who seems to be burning out, Pfifferling suggests.

"Talk with the employee privately or if a manager has a supervisor who knows the employee better, have the supervisor talk with the person," he says.

Keep the conversation nonthreatening and express concern. If the employee makes a statement such as "I don't feel like I fit in anymore," ask what can be done to make it a better fit, he suggests.

As you evaluate your staff and yourself for signs of burnout, remember that health-related caregivers are very susceptible to the emotional depletion that can contribute to burnout, says Pfifferling. Giving people a chance to get together at inservices or social settings to talk about what they like is important. "Don't forget to talk about the energizers in your jobs, the things that make the job more special than other types of jobs, and don't forget to give people a chance to talk with each other about the good things about home care."

[Editor's note: A burnout risk appraisal can be viewed at the Center for Professional Well-Being web site. Go to www.cpwb.org and click on News, then click on Burnout Survey at the top of the page.

For more information on combating burnout, contact:

- ***John Henry Pfifferling** PhD, Director, Center for Professional Well-Being, 21 W. Colony Place, #250, Durham, NC 27705. Telephone: (919) 489-9167. Fax: (919) 419-0011. Web site: www.cpwb.org.*
- ***Mary Dyck** RN, BSN, MHA, Director, Riverways Home Care Services of Ozarks Medical Center, 114 E. Main, Westplains, MO 65775. Telephone: (417) 256-3133. Fax: (417) 256-5961. E-mail: riverways@ozarksmedicalcenter.com.]* ■

Care network addresses employees' needs

All benefit as they help co-workers

Helping employees deal with problems, illness, and even death in their own families is one tactic used by Riverways Home Care Services of Ozarks Medical Center in Westplains, MO, to retain employees.

Because the relationship among the staff is similar to that of a family, anything that happens to one employee affects the others in some way, says **Mary Dyck** RN, BSN, MHA, director of the agency.

"We saw that people wanted to help when someone was ill or had a death in the family but they didn't know what to do," she says.

Not knowing how best to help a co-worker made some people uncomfortable and raised the stress level for everyone, Dyck adds.

Now, when an employee becomes ill or has a crisis in his or her personal life, the agency's care team network goes into action.

"First, we find a facilitator — preferably someone close to the employee and someone with whom the employee feels comfortable discussing their personal situation," Dyck continues.

The facilitator is responsible for talking with the employee, determining what is needed, and acting as the single point of communication. "The facilitator makes it possible for us to stay in touch without the ill employee receiving a lot of telephone calls from many different people," she explains.

Once the facilitator determines what the employee needs, a schedule is developed for meal preparation, baby-sitting, housework assistance, transportation, grocery shopping, or other day-to-day needs.

"This schedule enables people to sign up for activities with which they feel comfortable and still help the co-worker," says Dyck.

For example, a social worker might not want to change beds but is willing to grocery shop, she says. "This organized schedule relieves a lot of guilt among co-workers who want to help but don't know what to do," she says.

It's important to have administration buy in to any care network developed because it may be productive to let employees help their co-worker during the workday, says Dyck.

For example, a co-worker underwent surgery then needed to undergo dialysis several times a week, but was unable to drive herself, she explains.

The facilitator put up a sign-up sheet for employees who would be in the area of either the employee's home at the time she needed to go the clinic or of the dialysis clinic at the time the employee needed to return home.

"Nurses who were seeing patients in the area would pick up the employee. If no nurse was available, office staff were permitted to transport the co-worker," she says.

An important part of this process is that the employee with the personal crisis still feels connected to his or her co-workers.

Another benefit is that co-workers who are assigned the absent employee's workload are not resentful because they understand what is happening and they see it as part of helping out, Dyck says.

"When you assign extra responsibilities to others, be sure to spread them out over several people so one person doesn't assume the whole burden," she suggests. "Also, be prepared for employee filling in not to do the job as well as the original employee."

Whenever a co-worker experiences a serious illness or a death in his or her family, it can cause stress and distraction among other staff members, Dyck points out.

Unfortunately, the patients and physicians of the home-care agency still expect business to go on as usual, she says.

The benefit of a care network is that it brings structure to the madness and uncertainty that surrounds a crisis and helps everyone focus on day-to-day activities." ■

LegalEase

Understanding Laws, Rules, Regulations

Market services carefully to avoid legal pitfalls

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

Home-care providers face a variety of significant legal issues. During initial implementation of the Medicare prospective payment system (PPS), many agencies faced a number of challenges that made it difficult to devote resources to key legal issues.

Since many providers are functioning effectively under existing reimbursement systems, now is the time for agencies to focus on legal issues of particular importance at this juncture in the continuing development of the home care industry.

One key area upon which agencies should focus is marketing. Specific issues include:

- marketing home care services without violating applicable fraud and abuse prohibitions and Stark rules;
- assuring a steady stream of referrals without violating patients' right to freedom of choice of providers and without engaging in impermissible kickbacks and rebates in the form of free services;
- establishing relationships with physicians who will advocate on behalf of agencies with other physicians.

First, it is important to note that these issues should be of concern to almost all home care providers, even those that do not provide services to Medicare patients and/or are not Medicare-certified.

Many so-called private-duty agencies care for patients under state Medicaid programs and/or Medicaid waiver programs. This means that applicable statutes and regulations described in this article also apply to private-duty agencies.

Under cost-based Medicare reimbursement, many Medicare-certified agencies could not afford to engage in marketing activities. Such activities were unallowable costs; and when community awareness activities were re-characterized as marketing activities by auditors, agencies often incurred large overpayments.

Under PPS, the allowable cost rules have not changed and still are in effect. But since payments under the PPS system to agencies are considered to be payment in full, unallowable costs do not result in overpayments to agencies. To the extent that unallowable costs are included on agencies' cost reports, however, they may result in reductions of rates.

So, many agencies concluded that the road now was clear for them to engage in marketing activities. Since agency staff members were unaccustomed to engaging in these activities, they likely were unfamiliar with applicable prohibitions, especially those involving possible violations of the federal statute governing illegal remuneration and Stark rules.

Questions to ask

Here are some questions about marketing activities that agencies may ask:

- **Can staff take food to physicians' offices?**

Yes, generally speaking, agency staff members can take food to physicians' offices so long as the value of these items does not exceed $300 per year consistent with applicable Stark rules.

- **Can staff leave mugs, notepads, pens, etc., with referral sources of all types on a routine basis?**

Yes, staff can leave items of nominal value with referral sources without engaging in kickbacks and rebates.

- **Can agency staff members walk the halls of referral sources looking for patients who may be appropriate for home care services?**

No, agency staff members must first receive a referral of a patient. Referrals do not have to come from physicians. They may come from patients, patients' family members, and discharge planners/case managers. Agency staff must document the date and time of the referral, and the name of the person who made the referral.

- **Can agency staff members take referral sources to sports and entertainment events?**

If physicians are involved, the limit of $300 per year cannot be exceeded consistent with Stark rules. If other referral sources are involved, the amount of money spent cannot be significant enough to induce referrals. From a practical point of view, it may, therefore, be wise to apply the limits included in Stark to all referral sources.

Since patients generally now receive fewer services, a steady stream of referrals is crucial to success in home care. But providers must be wary of potential violations of patients' rights to freedom of choice of providers and a federal statute that prohibits illegal remuneration.

Some general guidelines that agencies should follow with regard to these potential violations are as follows:

- All patients, regardless of payer source, have the right to freedom of choice of providers. Agency staff members must be careful not to create barriers to the exercise of choice by patients such as knowingly or unknowingly misrepresenting the types of services that agencies provide or refusing to provide physicians' orders for home care services if particular agencies will be caring for patients.
- Physicians have the right to designate the agency that will provide home care services so long as their designation is based upon quality of care only.
- Agencies should not provide free visits or other services to patients, including services provided after hours by visiting staff on their own time.
- According to the Balanced Budget Act of 1997, hospitals must create a list of Medicare-certified home-care services that provide care in the area where patients reside and who ask to be on the list. Hospital discharge planners and case managers must scrupulously avoid applying other criteria to agencies that ask to be on the list. Hospitals may include agencies on the list in which the hospitals have financial interests, but this fact must be included on the list. This list must be presented to patients as part of the discharge planning process.
- Agencies may provide coordination and liaison of home-care services only after they have received a referral of patients as described above. Therefore, it generally is inappropriate, for agency staff to attend discharge planning meetings at which patients are discussed for whom agencies have not received referrals. Otherwise, agencies may be providing free discharge planning services in exchange for referrals.

Establish relationships carefully

Agencies need physicians who they know can advocate on behalf of agencies to perform the following types of functions:

- consult with agency staff members regarding patients with complex clinical conditions and the development and maintenance of specialty care programs;
- attend meetings of the professional advisory board and similar boards and committees;
- work with referring physicians to resolve issues such as inappropriate orders, failure to return needed signed plans of care and other orders on a timely basis, and lack or responses on a timely basis to reports from staff members about significant changes in patients' signs and symptoms.

Provider agreements

Since physicians who already make referrals to agencies most likely are able to fulfill these functions, agencies must comply with applicable requirements of exceptions or safe harbors of both the illegal remuneration statute and the Stark rules. These criteria generally require agencies and physicians to enter into written agreements for a term of at least one year that meet the following criteria:

- Compensation is set in advance at fair market value and is not tied to either the volume or value of referrals made by consulting physicians.
- Consulting physicians who also refer patients to agencies provide services that are reasonable and necessary.
- Regulators can verify that physicians actually provided the services for which they were paid.

Agencies also may wish to enter into preferred provider agreements with physicians in which they agree to order home care services from a particular agency. So long as such orders are based on quality of care concerns only and no payments or free services are provided by agencies to physicians, it is likely that they will pass muster with regulators.

It must seem like there is always something to worry about in home care. Try as they may, agency managers cannot eliminate all risks. However, they can minimize the risks associated with marketing by being aware of the rules and making sure that staff members and physicians adhere to them.

[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.] ■

NEWS BRIEFS

JCAHO announces new quality reports for 2004

The Joint Commission on the Accreditation of Healthcare Organizations plans to release quality reports on all Joint Commission-accredited facilities starting in 2004.

The reports, which will replace current organization-specific performance reports, will include the date of each organization's accreditation, a list of accredited services it provides, any special awards granted to the agency, and compliance measures implemented by each agency to meet the National Patient Safety Goals.

The Joint Commission held a series of focus groups to get feedback from consumers on what they feel is essential accreditation information, and based the new reports on what was learned from those sessions.

For more information, go to: www.jcaho.org and click on "accredited organizations." Next, select "home care" then "Home Care Bulletin." Click on "March/April 2003." ▼

OIG reports on transaction and code set compliance

Ninety-four percent of Medicare Part B providers expect to be in compliance with the Health Insurance Portability and Accountability Act's (HIPAA) transactions and code sets standards by the Oct. 16 compliance date, according to a recent report from the Office of the Inspector General (OIG).

The report, *HIPAA Readiness: Administrative Simplification for Medicare Part B Providers*, is based on the results of a mail survey sent to a random group of providers that submitted claims between July 1, 2001, and June 30, 2002.

One hundred twenty eight providers, including physicians, durable medical equipment suppliers, and independently practicing therapists, responded.

Of the respondents, 90% say they either have or intend to develop testing strategies that include internal and external data interfaces.

Approximately half of the respondents are developing contingency plans in the event their system is not in compliance by Oct. 16. Forty-seven percent say that vendors and trading partners might affect their ability to meet the deadline.

For the full report, go to the OIG's web site: http://oig.hhs.gov/oei/reports/oei-09-02-00422.pdf. ▼

Free caregiver resource available on-line

The National Alliance for Caregiving in Bethesda, MD, and Friends and Relatives of Institutionalized Aged (FRIA) in New York City have created a family caregiver's resource on palliative care.

The publication defines palliative care and explains the planning process necessary to ensure the best care for the patient. A list of questions that the family caregiver should consider is included to help the family member make decisions.

The booklet can be downloaded at no cost from FRIA's web site at www.fria.org. Just click on "publications," then choose "Palliative Care: Complete Care Everyone Deserves." ■

COMING IN FUTURE MONTHS

- Results of *Hospital Home Health* salary survey
- Leader vs. manager: Which is best for your agency?
- Is your agency budget working or gathering dust?
- How to measure the competency of your patients' parents
- What new challenges will you face in 2004?

CE *questions*

For more information about the CE program, contact customer service at (800) 688-2421.

1. What is one change that Greg Solecki, vice president of Henry Ford Home Health Care in Detroit, plans to make in future lease agreements following his agency's experience with the blackout in August?
   A. He will ask for multiple keys to office doors.
   B. Extra space will be leased to handle employees from other offices.
   C. Alternate method of entry will be provided if electronic key cards normally are used.

2. What steps did North Kansas City (MO) Hospital Home Health Services take prior to the agency's involvement in the pilot test of the Centers for Medicare & Medicaid Services public access to home health quality information to ensure accurate outcome data?
   A. Staff members worked in small groups to evaluate OASIS questions and clearly define the appropriate guidelines for answering each one.
   B. Staff members were reminded to turn paperwork in on a timely basis.
   C. One person was assigned the responsibility of completing the OASIS forms.
   D. Reporters were invited to cover staff meetings.

3. What is a possible result of a chart audit following an adverse event report, according to Jeannie Snyder, RN, BSN, CQI coordinator for Sacred Heart Home Health Services in Eugene, OR?
   A. data entry error
   B. OASIS error
   C. unpreventable adverse event
   D. all of the above

4. Which of the following might indicate burnout in one of your employees, according to John Henry Pfifferling, PhD, director of the Center for Well-Being in Durham, NC?
   A. a desire to spend more time talking with patients
   B. continuous requests for overtime
   C. depersonalization of clients
   D. recommending friends for job openings

Answer Key: 1. C; 2. A; 3. D; 4. C

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. ■