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Not going to take it anymore: One agency's fight to appeal unfair survey

Years of effort win right for Indiana agencies to obtain objective review

Surveys can be stressful enough, but how would you react to a complaint-based state survey during which the surveyor never asked for information from the physician or home care nurse involved? What if the erroneous information resulted in a condition-level deficiency report that prevented you from certifying your own home health aides, resulting in tens of thousands of dollars in expense to pay other organizations to perform the competency certification?

"I've been at this agency since 1986, and we've had the same basic administrative staff since the early 1990s," says **Lyn Estell**, RN, administrator of Advantage Health Care, the Muncie, IN, home health agency that experienced that survey. "With this one survey, we went from an agency that had been deficiency-free for seven years to condition-level deficiency with serious restrictions on our ability to function," she says.

Taking a state health board to court to ensure an objective hearing for an appeal is a big step, but Advantage's administration believed that the results of this report and the inaccuracies upon which it is was based were so severe that the agency could not just accept it and move on, Estell says.

"We found out on the Thursday evening before Good Friday that a complaint had been made against one of our nurses for abusing a child," she says. Because the holiday meant a three-day weekend, Estell was unable to conduct her internal investigation until Monday, with the surveyors appearing on Tuesday.

"The complaint came from a foster mother who alleged that the nurse struck a child in the mouth," she says. "She also claimed the nurse did not follow physician orders related to the child's feedings. We found it interesting that Child Protective Services would not investigate the claim of abuse, especially since the agency was the child's legal guardian, but the [Indiana] State Board of Health was willing to conduct an investigation without gathering information from Child Protective Services, the nurse involved, or the physician involved," she says.

Although the original report included information that two people from an organization that places children with foster and adoptive parents

witnessed the incident, a letter from the organization was sent to the board of health one month after the survey, indicating that the organization's employees did not witness any abuse. "We had asked the [Indiana] State Board of Health for working papers related to this complaint and survey, but we never received a copy of this letter," Estell adds.

Once Estell received a copy of the survey report, more than 70 pages, it took her two 70-hour workweeks to complete the plan of correction. "It also took a huge amount of administrative nursing time to implement the plan," she says.

Appeal process less than objective

Advantage did appeal the survey because of many inaccuracies in the report. "In Indiana, our only avenue of appeal was an informal dispute resolution in which we put in writing our reasons for appealing the survey," Estell explains.

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A three-person board that consisted of supervisors and a quality control person who were all involved in the original survey heard the appeal. "We did not believe that anyone took an objective look at the survey, and we decided that we wanted our case heard by an administrative law judge who could be objective," she adds.

"I actually set up the informal dispute resolution process for the home health division when I was counsel for the Indiana State Board of Health," says **Virginia Wright Caudill**, JD, an Indianapolis-based attorney who is representing Advantage in their action against the department.

"Our long-term care division had the process in place, and it made sense that the home health division have the same process. What I didn't realize was that the difference in division staff sizes, with home health division about a third the size of the long-term care division, would mean that the review board would be staffed by people involved in the survey," she says.

"The only way to get an objective review is to go before an administrative law judge, but the Indiana State Board of Health claimed [it was] not subject to the Administrative Order and Procedures Act," Caudill points out. On Aug. 6, 2003, more than two years after the original survey, the Indiana Court of Appeals ruled that Advantage could seek a review with an administrative law judge, opening up an new avenue of appeal and review for all home health agencies, she adds.[1]

Most home health agencies don't pursue appeals and reviews because they do take time and money, she says. "But Advantage really stepped up to the plate when [it] said 'No, this isn't right,' and pushed for an objective review," Caudill says.

In addition to the time and money involved in seeking a review of the one survey report, Advantage experienced six different state audits in the year following the appeal, as compared to the one or two it usually had experienced, Estell says. "I think it's easier for agencies just to accept the report and make the best of it, but we were willing to undergo the extra scrutiny and the extra work because we believed that [our agency] had been wronged," she says.

Nurse leaves home health

The effect of the report also extended to the staff, Estell points out. The nurse who was accused of hitting the child in the mouth and a

nurse who was identified as her supervisor were reported to the Health Professionals Bureau by the board of health.

"The licensure bureau did not pursue any investigation, but we did place the nurse on office duty while we investigated. Even though no evidence of the alleged abuse has ever been presented, the nurse decided to leave nursing because of the stress," she says.

The supervisor who was reported to the licensure board was the incorrect person, even though the original survey report correctly identified the field nurse's supervisor, Estell adds. "This incorrect report to the licensure board meant that a nurse who was never involved spent a great deal of time clearing her own name," she explains.

What about the charge that the nurse did not follow the physician's orders for care? "The nurse had been caring for the child for a period of time, and the physician's orders included feeding instructions that stated a certain amount of food but allowed latitude based upon the child's ability to tolerate the feeding as judged by the nurse and the biological mother," Estell explains.

After the child was hospitalized and discharged to a foster home, the orders from the discharging physician changed slightly. "Unfortunately, the discharging physician's orders specified a certain amount for each feeding without a statement that allowed the nurse to adjust the amount to the child's ability to tolerate," she adds.

The nurse continued to provide the care as it was ordered prior to the hospitalization, but she should have double-checked the new orders and contacted the physician for approval to adjust feeding amounts as needed, Estell points out.

While many agencies may be reluctant to challenge a survey report because of the fear of retribution, it usually doesn't happen as it had in Advantage's case, Caudill says.

Know what your rights are before a survey goes wrong

It's not unusual for a home health agency to have written a plan of correction for something in a surveyor's report that seems ridiculous and unnecessary; but in many cases, it's easier to implement a plan of correction than to appeal the survey.

But what happens if your survey report is full of inaccuracies and crosses the boundary of typical standard-of-care expectations? Are you prepared to appeal?

"Most agencies wait until they receive a condition-level deficiency or a report that they consider unfair before they find out what their rights are," points out **Virginia Wright Caudill**, JD, an Indianapolis-based attorney.

This is too late, she says. "Even if you are gathering information and planning an appeal, you still have a set amount of time in which to file your plan of correction," she adds.

The best time to find out how your state or federal survey organization handles appeals, and what rights you have, is well before any survey takes place, Caudill says.

"If you go to your state's web site and find the agency that regulates home health, you will, in nine out of 10 cases, find a section on your administrative procedure rights that spells out what rights you have to appeal," she says.

Another area in which you need to be knowledgeable is your state's public records statute, Caudill suggests. "Even if you believe your survey report is unfair, you must get access to the surveyor's notes as well as the original complaint to be able to address inaccuracies," she says. If you question some of the findings in your survey, be prepared to write to request all formal and informal notes and documents related to the survey, in addition to the original complaint, she recommends.

The time frame for receiving these documents varies, with worst case usually 30 days following the receipt of the request, but you need to know what the statute requires, so you can plan your actions to respond to the survey.

Because you may have to wait for the public records you've requested, you still need to work on your plan of correction. "In most states, you can request an extension to the 10 days you are normally given for the plan of correction, but make sure you know what your options are within your state," Caudill says.

Even if you have to submit a plan of correction prior to receiving the information you've requested, you can place a statement at the beginning of your plan of correction that indicates you do not agree with the findings of the surveyor, but you have prepared the best reply to the alleged deficiencies with the information you currently have, she suggests.

Once you have gathered more information or you have initiated an informal dispute resolution or appeal, you can submit an amended plan of correction that includes the statement, "I have received additional information that has enabled me to more knowledgeably address the issues in the report, and I have amended the plan to better serve my patients." ■

"The real problems occur when you don't have an opportunity to challenge a survey because there has to be a system of checks and balances," she says.

"The significance of this court decision is that it gives agencies a chance to challenge an unfair report and that is important because if you allow government agencies to step over boundaries, the problems won't go away, they'll just get worse," Caudill adds.

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Reference

1. *Advantage Home Health Care, Inc. v. Indiana State Department of Health and Indiana State Health Commissioner*, No. 18A02-0211-CV-928, Court of Appeals of Indiana (Aug. 6, 2003). ■

Telemedicine offers regular patient monitoring

Education, proper technology needed for success

(Editor's note: This is the first of a two-part series that looks at telemedicine in home health. In this article, representatives from two agencies describe their programs and specific issues related to choosing technology and patients who are appropriate for telemedicine. In next month's article, some of the financial aspects of telemedicine will be presented, including tips on funding programs.)

Telehealth is not a new concept to the home health patients of the Visiting Nurse Association (VNA) of Houston. Some form of telehealth has been in place for many years to help patients monitor themselves. But as technology has changed, so has the VNA Houston program.

"We started our program with videophone hookups but switched to a link that did not utilize video a little more than two years ago," says **Sandy McNeely**, RN, MSN, telemonitoring program manager for the agency.

While the video hookup seemed attractive to many clinicians who believed they needed the eye-to-eye contact to assess their patients' conditions, many patients were not comfortable being on screen and were timid as they talked with the nurse, she explains.

"Financially, it did not create a great savings in time or dollars because we still had to have a nurse talking with the patient throughout the visit," says McNeely.

While the time and expense of travel to patients' homes was eliminated, the reluctance of patients to allow a videophone hookup in their home reduced the effectiveness of the program, she adds.

In 2001, the agency switched to the HomMed Sentry Observer, an alarm-clock-sized monitor that can be plugged into peripheral equipment that measures blood pressure, O_2 saturation, weight, glucose, temperature, and heart rate.

Telemedicine Resources

- **American Telemedicine Association**, 910 17th St., N.W., Suite 314, Washington, DC 20006. Telephone: (202) 223-3333. Fax: (202) 223-2787. Web site: www.americantelemed.org. The organization's web site contains a library of guidelines and resource material related to telemedicine as well as links to related sites.
- **Wantagh,** 2014 Ford Road, Unit G, Bristol, PA 19007. Telephone: (215) 826-9998. Fax: (215) 826-8102. Web site: www.wantagh-inc.com. Company produces monitor that can be used by home care patients to measure cardiac impedance.

The following companies offer telemedicine products and services to the home health industry:

- **AMD Telemedicine**, 67 Middle St., Lowell, MA 01852. Telephone: (800) 742-1674 or (978) 937-9021. Fax: (978) 937-5249. Web site: www.amdtelemedicine.com.
- **American TeleCare**, 7640 Golden Triangle Drive, Eden Prairie, MN 55344. Telephone: (800) 323-6667 or (952) 897-0000. Fax: (952) 944-2247. Web site: www.americantelecare.com.
- **HealthCare Vision**, 2601 Scott Ave., Suite 600, Fort Worth, TX 76103. Telephone: (888) 836-7428 or (817) 531-8992. Fax: (817) 531-2360. Web site: www.healthcare-vision.com.
- **Health Hero Network**, 2570 W. El Camino Real, Suite 111, Mountain View, CA 94040. Telephone: (650) 559-1000. Fax: (650) 559-1050. Web site: www.healthhero.com.
- **HomMed**, 19275 W. Capitol Drive, Suite 200, Brookfield, WI. Telephone: (888) 353-5440 or (262) 783-5440. Web site: hommed.com.

"Although we have not needed the capability, the equipment does offer the option of a digital camera hookup to monitor daily wound care," says McNeely. Although her agency chose HomMed in Brookfield, WI, as its supplier, there are many vendors that offer telemedicine technology, she says. **(See resource box, p. 124.)**

"Be sure you take a close look at your own patient population before evaluating telemedicine equipment to make sure that you choose technology that meets your needs," she suggests.

Because her agency has a large population of cardiac patients, McNeely's telemonitoring program primarily captures information of most interest to them, such as blood pressure and weight, she points out. "We do have some diabetic patients for whom we monitor glucose levels every four hours."

McNeely's monitors will notify the patient with an alarm when it is time to take a reading. The patient hooks up the appropriate leads or the blood pressure cuff, takes the reading, and transmits the information. The only time the patient's telephone line is used by the monitor is during transmission, she explains.

"This ensures that the patient doesn't need a special telephone line or an extra line for the monitor," she says.

Teach disease self-management

After the data are transmitted, the reading stays on the monitor's display for about five minutes to enable patients to record the information in a log that McNeely requires that they keep.

"Our goal is to help the patients self-manage their disease, so it is important that they stay aware of their own readings and what a fluctuation in weight might mean," she explains.

Helping patients learn how to manage their conditions is a weak area in many telemedicine programs, says **Ann K. Frantz**, RN, BSN, director of cardiac program development for Advanced Professional Home Care in Pontiac, MI. "We've been doing tele-electrocardiogram monitoring since 1990," she says.

"Since we started telemonitoring, the technology has advanced, and we are capable of remotely monitoring many more vital signs. But is it appropriate in all cases?" Frantz asks.

"I think it is important that home health agencies take a good look at their patients and their needs and base their choice of technology on what is right for them rather than what the technology companies say is important," she states.

"Because cardiac problems represent the condition for which telemonitoring is most frequently used, it's important to make sure you are measuring vital signs that give you a chance to identify early exacerbation of the condition," Frantz says.

While weight is the most common objective measurement to identify problems, the patient already is suffering from pulmonary edema when the weight gain is noticed, she adds.

"We try to ask the patient if he or she is experiencing a bloated feeling, lack of hunger, or trouble sleeping to identify problems before the weight gain, but patients don't always recognize these symptoms," she adds.

For this reason, Frantz is monitoring patients' pulmonary status with a device manufactured by Wantagh in Bristol, PA.

"The monitor is about the size of a videotape, and the patient attaches two electrodes to take the reading," she says. The equipment measures electrical impedance changes throughout the thorax as aortic blood volume increases and decreases in response to the beating of the heart. The patient

Evaluate patients before starting telemonitoring

Not the right prescription for some patients

Even if you have a strong telemedicine program with enthusiastic staff members and physicians, a good inventory of equipment, and a thorough patient education program, not all home health patients will qualify for the program, says **Sandy McNeely**, RN, MSN, telemonitoring program manager for the Visiting Nurse Association of Houston.

Basic guidelines used by McNeely include:

- ✔ Caregiver or patient must demonstrate the proper use of telemonitoring equipment.
- ✔ Caregiver or patient must be willing and able to consent and agree to daily monitoring.
- ✔ Environment is safe for equipment. For example, the home is safe from threat of theft, weather damage, extreme dust or dirt, or other environmental factors that will affect the equipment's operation.

It is important to make sure that patients are well-educated about the use of the equipment and that you are able to keep the equipment in working order, says **Elizabeth E. Hogue,** Esq., an attorney in Burtonsville, MD. **(See *Hospital Home Health*, July 2003, p. 80, and August 2003, p. 93.)** ■

then writes the reading into his or her logbook and reports the reading when the nurse calls.

"We base the number of times the nurse calls each week on the patient," Frantz adds.

"We call every day during the first week the patient is on the monitor, then reduce the calls to a point at which the nurse and the patient are comfortable." Because the patients are so tuned into their readings, they will call the nurse if they notice a slight increase, she says.

Patient education essential

Along with teaching the patient how to use the monitor, the nurse gives extensive education on what can cause pulmonary edema, Frantz says. Patients who experience an increase in thoracic impedance are asked about their diet on the previous day to determine what might have caused the fluid retention.

"Our patients are quick to realize that the extra pickles they ate at the birthday cookout for their family member might be the reason for the increase." The benefit to catching the fluid retention before it causes weight gain is that simple treatments such as a serving of asparagus, a natural diuretic, or an extra dose of a diuretic such as furosemide, she points out.

Because her monitoring program relies upon the patient to take readings and report them to the nurse over the phone, education is important, Frantz says.

"We want the patients to be active participants in their care so we make sure that we teach them at the beginning of care and throughout the monitoring in conversations and visits with the nurse," she says.

The key benefit to using telemonitoring, especially for cardiac patients, is that you can reduce the number of hospitalizations and better care for the patient, McNeely points out.

"It was important for us to show our physicians how our program could provide trend data that give an accurate picture of their patients' health and how early intervention will keep their patients from experiencing an acute episode that requires hospitalization or a visit to the emergency room," she adds.

While not all patients are appropriate for telemonitoring, the ones who are put on a telemonitoring program will appreciate the service, says McNeely. **(See how to set guidelines for choosing patients, p. 125.)** "The ability to monitor themselves and understand what the data mean gives the patient and family members confidence in their ability to self-manage the disease."

[For more information on telemedicine in home health, contact:

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Put yourself in MD's shoes before asking for referrals

Develop concise message to describe your services

Will that new supply of coffee mugs, calendars, note pads, and pens engraved with your agency's name and phone number make physicians or their nurses refer to your agency? Probably not, according to experts interviewed by *Hospital Home Health*.

"I don't need another coffee mug; I need a home health agency that will be a partner in my success and save me time and make me money," says **M. Tray Dunaway**, MD, FACS, CSP, a physician and author of *Doctors are from Jupiter and Compliance is from a Galaxy Far ... Far ... Away*, and *Pocket Guide to Clinical Coding*.

"Most home health marketing people are health care people, and they don't always look at what they are selling from the buyer's perspective," Dunaway says.

When you are trying to establish a relationship with a physician, it is the physician who is the customer, so it is important to focus upon the issues that are important to the physician and the physician's practice, he adds. "Saving time and making money are important," he reiterates.

Make communication easy

If your agency has a mechanism that makes referrals simple and getting orders signed easy for the physician, then you are saving time for the physician, Dunaway adds.

He does point out that agencies that send orders for signature through the mail with postage-paid return envelopes actually have been a financial boon for him as he collects all of the orders, returns them in one envelope, and saves the stamps from every other envelope. It is OK, and preferable, to include more than one order for signature in an envelope, he explains.

The staff at Community Home Health & Hospice in Longview, WA, still mail orders to physicians, but have been able to greatly improve response time and have made it easier for the physician to read the orders, says **Terry Skrentny**, BSW, RN, clinical information systems and medical records director at the agency.

"We used to have 40% of orders take 30 or more days for signature. Now, we receive 85% to 90% of the orders within two weeks," she says.

Skrentny's agency automated with a software system that gives field nurses laptops on which they enter the visit information and transmit the data to the office. Orders and 485s are automatically printed in the office for staff members to mail to physicians.

"Prior to automation, we would hand write the orders and often had physicians say that they couldn't read what was written," she explains "With automation, the orders are legible, and the physician doesn't have to spend time trying to decipher handwriting," Skrentny adds.

Some of Skrentny's physicians prefer to have orders faxed to them for signature, and her software has that capability, she says.

"We still mail 90% of the orders." Although her agency is not yet using the capability to send and receive electronic signatures, it is a possibility for the future if enough physicians will benefit, Skrentny adds.

Give physician billing info

While home health agencies cannot bill for physician oversight of a home health patient for the physician, provide resources that can be used to make sure the physician is reimbursed for time, Dunaway says. **(For more information about coding in the physician's office, see *Hospital Home Health*, September 2002, p. 103.)**

Providing booklets that explain billing codes or referring physicians to web sites that offer guidance will demonstrate that you understand the financial implications as they relate to a physician's office, he says. **(For resources, see box, above right.)**

Communication Resources

These companies provide a variety of Internet-based communications programs, including an application that coordinates and tracks plans of care, verbal orders, and other documents, and makes these documents available to physicians. Physicians can review documents, request further information from the agencies, and provide approval by electronic signature. Other applications provide billing services for physicians.

- **Ancillary Care Management**, 725 S. Figueroa, Suite 2150, Los Angeles, CA 90017. Telephone: (888) 627-1515 or (213) 213-2400. Fax: (213) 213-2435. Web site: www.acmcentral.com.
- **eClickMD**, 3001 Bee Caves Road, Suite 250, Austin, TX 78746. Telephone: (888) 660-5465 or (512) 439-3900. Fax: (512) 439-3901. Web site: www.eclickmd.com.

These organizations offer books that provide information for physicians to use when coding home health-related activities:

- **American Academy of Home Care Physicians**, P.O. Box 1037, Edgewood, MD 21040-1037. Telephone: (410) 676-7966. Fax: (410) 676-7980. Web site: www.aahcp.org. Publishes *Making Home Care Work in Your Practice: A Brief Guide to Reimbursement and Regulations.* Price of booklet is $10 for members and $12 for nonmembers, plus shipping and handling charges. Orders can be placed by telephone or on-line.
- **Rebel Records**, 1413 Mill St., Suite B, Camden, SC 29020-2934. Telephone: (803) 425-8555. Fax: (803) 713-8690. Web site: www.healthcarevalueinc.com. Publishes *Pocket Guide to Clinical Coding.* The book includes a chapter specific to home health-related activities. Price of book is $15.75 for up to 49 copies and $14.75 for more than 50 copies, plus a $4.95 shipping and handling charge for orders totaling less than $100.

Not only does a physician expect you to provide quality care to his or her patients, but a home health agency representative also should be able to describe services that differentiate the agency from others in the area, Dunaway says.

"If you tell me that you are better than other agencies, I immediately doubt it," he says.

"Instead, tell me about your cardiac rehab program, your cutting-edge wound-care program, or your specialized staff for diabetes care. If I see that your agency is able to handle the tough

patients, I will know that you can handle routine patients," Dunaway adds.

A home health agency is an extension of the physician's practice in the patient's home, he explains. Not only does the physician want to be assured that the home health staff are comprised of quality nurses, but he or she also wants to know that the nurses will support the physician in front of the patient, he says.

"For example, if the nurse notices an error in the medication order, instead of saying that it appears the doctor made a mistake, the nurse should say that with all new, cutting-edge medications we have available, he or she just wants to double-check the dose," Dunaway suggests.

"Then, the nurse can call me and point out that one of the new medications may interact with another, and I have a chance to prescribe another medication, or change the dose. In this instance, the nurse enabled me to fix my mistake without compromising my patient's trust in me," he adds.

Focus on top referral sources

"Everyone likes closing a sale, but what does it mean if you visit 100 doctors and only 10 of them are likely to refer patients to your agency?" asks Dunaway.

"Know your buyer; know exactly who is sending you patients," he says. This not only means knowing who your top referral sources might be, such as specific physician practices or hospitals, but also knowing the specific people in those organizations, he explains.

Be sure you focus your efforts on the people most likely to send you business, Dunaway says.

Skrentny agrees. "We have 3,000 physicians in our database for the geographic area we serve, but 75% of our referrals come from 300 of those physicians."

As you focus on your top referral sources, remember that you only get about two minutes to sell the physician on developing a relationship with your agency, Dunaway points out.

"Have your positioning statement ready and explain how your services will save the physician time, provide excellent care, and make his or her life less stressful," he suggests.

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LegalEase

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HHAs take note: OIG looks at joint ventures

By **Elizabeth E. Hogue**, Esq.
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The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services issued a *Special Advisory Bulletin* on contractual joint ventures on April 30, 2003.

This bulletin addresses contractual arrangements for the provision of items and services that the OIG previously identified as suspect in a *Special Fraud Alert* on joint venture arrangements in 1989.

Specifically, the OIG is aware of a proliferation of arrangements between those in a position to refer patients, such as physicians and hospitals and those providing certain types of items or services, including home care. Sometimes, these arrangements are called joint ventures.

Such ventures may take a variety of forms, including contractual arrangements between two or more parties, or may involve the establishment of new legal entities such as corporations or partnerships. For purposes of the bulletin, the OIG defines a joint venture as "any common enterprise with mutual economic benefit."

The bulletin focuses on joint ventures in the form of contractual arrangements in which a provider in one line of business expands into a related health care business by contracting with an existing provider of a related item or service to provide a new item or service to existing patients.

In other words, a referring provider with an existing base of patients contracts out the entire operation of the related line of business to a managing party that is otherwise a potential competitor and receives profits of the business in return.

Arrangements between some physicians and hospitals and home health agencies may be included in these types of arrangements.

These problematic arrangements typically are established as follows:

- The referring provider expands into a related line of business, which is dependent on referrals from or other business generated by the provider's existing business. The new business primarily serves the provider's existing patient base.
- The provider does not operate the new business or commit substantial financial, capital, or human resources to the venture. Instead, it contracts out substantially all of the operations of the new business. The other party to the venture typically agrees to provide management services, but also a range of other services such as inventory, personnel, and billing services. The referring provider's actual business risk often is minimal because of the provider's ability to influence substantial referrals to the new business.
- The other party or managing party to the arrangement is an established provider of the same services as the referring provider's new line of business and might otherwise be a competitor.
- Both parties share in the economic benefit of the new business. The managing party takes its share in the form of payments under the various contracts with the referring provider; the referring provider receives its share in the form of profits from the new business.
- Aggregate payments to the managing party typically vary with the value or volume of business generated for the new business by the referring provider.

The OIG further explains that the protection of safe harbors or exceptions to the federal statutes that prohibit illegal remuneration are unlikely to apply to these types of arrangements.

The illegal remuneration, kickback, or rebate in these arrangements often is the difference between the money paid by the referring provider to the managing party and the reimbursement received from federal and state health care programs. The opportunity to generate a fee and profits is itself remuneration that may violate the federal anti-kickback statute.

To help suppliers identify ventures that may violate fraud and abuse prohibitions, the OIG lists criteria that may indicate a prohibited arrangement:

- **New line of business**

The referring provider typically seeks to expand into a health care service that can be provided to the referring provider's existing patients.

- **Captive referral base**

The new business predominantly or exclusively serves the referring provider's existing patient base or patients under the control or influence of the referring provider.

- **Little or no bona fide business risk**

The referring provider's primary contribution to the venture is referrals; it makes little or no financial or other investment in the business, often delegating the entire operation to the managing party while retaining profits generated by the new business.

- **Status of the managing party**

The managing party would be a competitor of the referring provider's new line of business and normally would compete for the referring provider's patients. The managing party has the capacity to provide virtually identical services in its own right and bill insurers and patients for them in its own name.

- **Scope of services provided by the managing party**

The managing party provides all or many of the following key services:

— day-to-day management;
— billing services;
— equipment and supplies;
— personnel and related services;
— office space;
— training;
— health care services.

Generally speaking, the greater the scope of services provided by the managing party, the greater the likelihood that the arrangement will not pass muster with the OIG.

- **Remuneration**

The practical effect of the arrangement is to provide the referring provider with the opportunity to bill insurers and patients for business otherwise provided by the managing party.

- **Exclusivity**

The parties may enter into a noncompete agreement that bars the referring provider from rendering similar services to patients other than those that it refers to the arrangement and bars the managing party from providing services in its own right to patients of the referring provider.

Now is the time for agencies, which are owned or affiliated with hospitals to review the arrangements in which they provide services. Existing

relationships that meet some or all of the criteria described above may require restructuring. Now that providers specifically have been warned about potential violations inherent in some types of joint ventures, it would be unwise to consider establishing such arrangements in the future.

[A complete list of Elizabeth Hogue's publications is available by contacting: Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Telephone: (301) 421-0143. Fax: (301) 421-1699. E-mail: ehogue5@comcast.net.] ■

CMS starts plan to boost compliant claims

The Centers for Medicare & Medicaid Services (CMS) has implemented a contingency plan to accept noncompliant electronic transactions. This plan will ensure continued processing of claims from thousands of providers who were not able to meet the deadline and otherwise would have had their Medicare claims rejected, CMS said.

"Implementing this contingency plan moves us toward the dual goals of achieving HIPAA [Health Insurance Portability and Accountability Act] compliance while not disrupting providers' cash flow and operations, so that beneficiaries can continue to get the health care services they need," said CMS Administrator **Tom Scully**. CMS made the decision to implement its contingency plan after reviewing statistics showing unacceptably low numbers of compliant claims being submitted.

"Medicare is able to process HIPAA-compliant transactions," said **Tom Grissom**, director of CMS' Center for Medicare Management, "but we need to work with our trading partners to increase the percentage of claims in production."

The contingency plan permits CMS to continue to accept and process claims in the electronic formats now in use, giving providers additional time to complete the testing process. A CMS spokesperson points out that implementation of this contingency plan does not affect the transactions and code sets requirement that all claims be submitted electronically. Institutional providers with 25 or fewer employees and noninstitutional providers with 10 or fewer employees are the only providers that still will be able to bill Medicare on paper after Oct. 16. ▼

Study: More than half of HHAs not ready for HIPAA

As of May 2003, only 43% of home health agencies responding to the Alexandria, VA-based American Association for Homecare's (AAHomecare) 2003 Financial Performance Survey Report indicated that they were in compliance for the Health Insurance Portability and Accountability Act (HIPAA) October deadline for electronic transactions. Home health companies spent an average of $5,700 on Information technology (IT) compliance with 25% of respondents spending more than $17,000.

The annual survey of financial and management practices of home-care companies is based on data from the previous year's operations. This is the 14th Survey Report released by AAHomecare and features new sections on HIPAA IT compliance and delivery and clinical personnel efficiencies.

"This report is the leading industry benchmark for the financial and operational management of home-care providers. It provides an opportunity for our diverse membership to see how they measure up against industry averages with companies of similar size and market segment," said **Kay Cox**, AAHomecare president and CEO.

"The comparative information in this survey is an essential tool for management teams within the homecare industry," she stated.

Key findings in the survey this year include:

- Hospital ownership of firms was 28% in 2002. In past surveys, the proportion of hospital ownership has ranged anywhere from 25% to 35%, putting this year's results at the lower end of the range.
- In 2002, overall accounts receivable days outstanding averaged 83 days, which is down by 2% over the prior year. The percentage of receivables for a period of 120 days remained high at 24%.
- The 8% of participating companies that reported making an acquisition experienced an overall growth rate of 22% (up from 16% in 2001). However, their average growth rate for continuing business was 9%, closer to the industry average.

The entire study, including additional profit statistics and a wide range of additional industry financial data, can be purchased by visiting the AAHomecare web site (www.aahomecare.org) or by calling Allison Barton-Kramer at (703) 535-1883. The cost is $250 for AAHomecare members, $500 for nonmembers. ▼

CMS begins effort to stop wheelchair benefit abuse

The Centers for Medicare & Medicaid Services (CMS) announced an initiative to substantially curb abuse of the Medicare program by unscrupulous providers of power wheelchairs and other power mobility products who prey on Medicare beneficiaries.

At the same time, the Department of Health and Human Services Office of Inspector General (OIG) said it is investigating the proliferation of durable medical equipment (DME) fraud cases involving inflated billings to Medicare, charges for equipment and supplies not delivered, and the falsification of documents to qualify beneficiaries for wheelchairs and other equipment that they often did not need.

"Spending on power wheelchairs has increased nearly 450% over the last four years, an unprecedented growth in this benefit," said **Tom Scully** CMS administrator.

"While many of these wheelchairs are provided by ethical suppliers and go to beneficiaries in need, we know that a great number of unscrupulous suppliers are promising free wheelchairs to

CE *questions*

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

- Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
- Describe how those issues affect nurses, patients, and the home care industry in general.
- Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices.

5. According to Lyn Estell, RN, administrator of Advantage Health Care in Muncie, IN, why did her agency resort to legal action against the Indiana State Board of Health?
   A. Survey report was based upon inaccuracies.
   B. Survey report resulted in penalties and restrictions that affected agency operations.
   C. It was the only way they could hire new staff.
   D. A and B

6. What physiological factor that can be monitored in the home does Ann K. Frantz, RN, BSN, director of cardiac program development for Advanced Professional Home Care in Pontiac, MI, believe is the best predictor of exacerbation of a congestive heart failure patient's condition?
   A. blood pressure
   B. thoracic impedance
   C. temperature
   D. weight gain

7. What benefit from automating documentation by field nurses did Terry Skrentny, BSW, RN, clinical information systems and medical records director at Community Home Health & Hospice in Longview, WA, enjoy?
   A. Legible orders meant quicker physician signatures.
   B. Cost of postage was reduced.
   C. Nurses saw more patients.
   D. Travel time was cut.

8. How can a home health agency differentiate itself and make an impression on a physician, according to M. Tray Dunaway, MD, FACS, CSP, a physician and author of *Doctors are from Jupiter and Compliance is from a Galaxy Far ... Far ... Away*?
   A. List phone numbers on a coffee mug.
   B. Have the marketing person state that the agency is better than others.
   C. List all of the physicians who refer to the agency.
   D. Describe the programs you offer to handle the tough patients.

Answer Key: 5. D; 6. B; 7. A; 8. D

United States Postal Service

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	(3)	Other Classes Mailed Through the USPS	0	0
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5. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

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PS Form **3526**, September 1999 *(Reverse)*

beneficiaries who don't need them. We are taking immediate action to stop these scams," he added.

Acting Principal Deputy Inspector General **Dara Corrigan** warned Medicare beneficiaries to be suspicious of offers of "free" scooters and other enticements from unscrupulous suppliers.

"DME fraud is a major and increasingly serious problem that costs taxpayers billions in lost and wasted dollars and deprives vulnerable beneficiaries of the care and support they need. The perpetrators of these fraudulent schemes face serious consequences, including fines, jail time, and exclusion from doing business with Medicare and other federal health programs." she said.

CMS plans to start its nationwide cleanup campaign in Texas, where recent reports from the CMS Dallas Regional Office and a Houston newspaper have highlighted a growing and very serious financial threat that improper spending on wheelchairs poses to the Medicare program.

In Harris County, TX, alone, Medicare paid for more than 31,000 power wheelchairs in 2002, compared to a little more than 3,000 power wheelchairs in 2001. HHS agencies will work with the Department of Justice in attacking the problem. ■

2003 SALARY SURVEY RESULTS

Hospital Home Health®

the monthly update for executives and health care professionals

Good managers are secret to retaining experienced nurses

Being supportive, approachable, and fair are vital traits

Home health agency managers have looked at every aspect of their new employee recruitment programs to identify how to best attract good nurses.

Competitive salaries, ongoing educational opportunities, and a strong benefits package are a few ways to attract new nurses, but how do you keep them satisfied with the job and happy with you as an employer?

Staff are too hard to replace

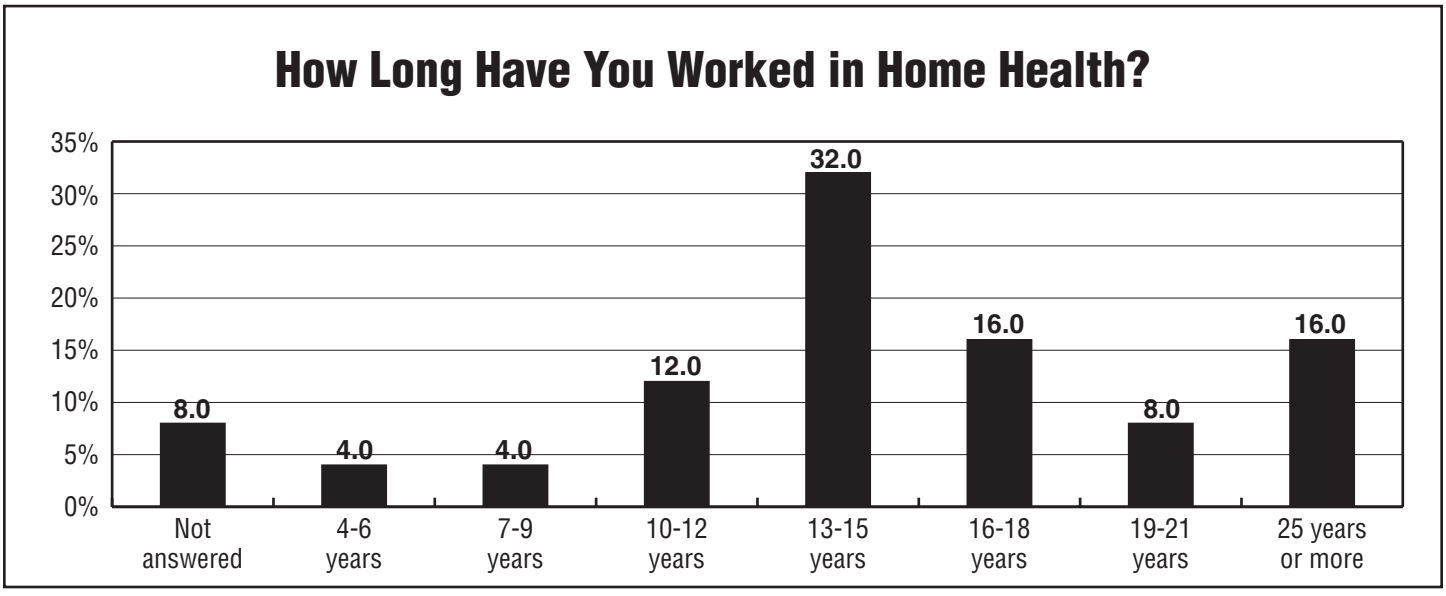
As home health programs get busier, it is more important than ever to be able to keep good employees because it is too hard to replace them, says **Karen A. Hart**, RN, BSN, senior vice president of the health care division of the Bernard Hodes Group, a human resource communications company in New York City.

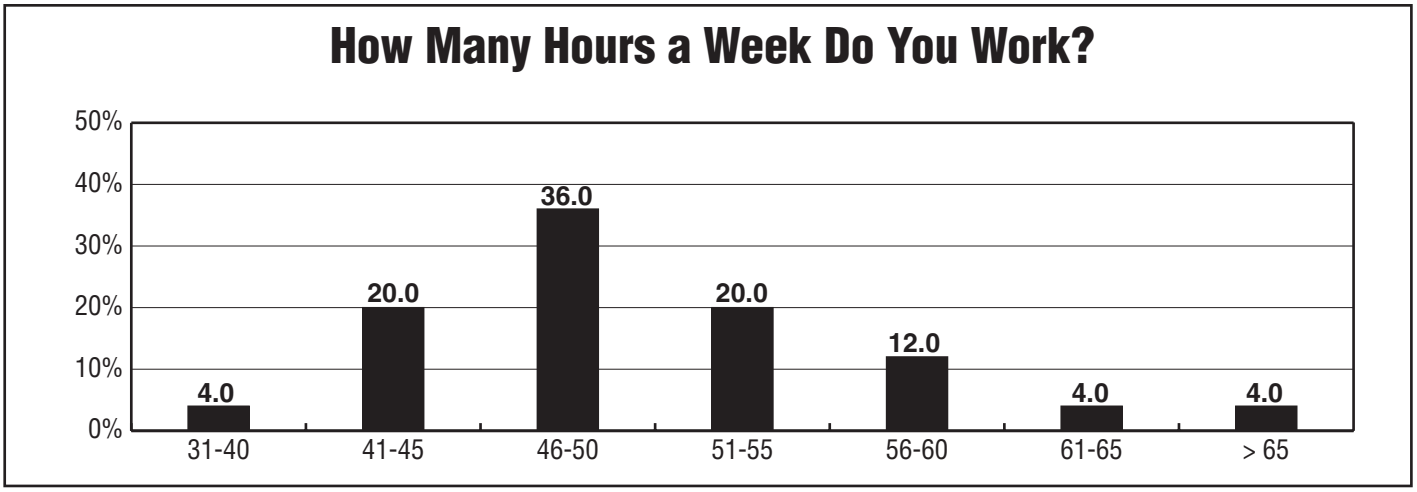
While salaries and benefits are important to recruitment of new nurses, they are not key reasons that nurses leave their employers, according to a survey recently conducted by Bernard Hodes Group, Hart says. **(For a copy of the survey report, go to www.hodes.com/hcrecruiting.)**

Staff need to feel valued, respected

The reasons nurses leave include not feeling valued (39%), lack of growth potential (33%), lack of confidence in management (31%), and lack of professional respect (30%), she adds.

Because respondents to *Hospital Home Health's* 2003 salary survey represent a range of different types of locations, rural to urban **(see chart, p. 3)**, they often find themselves facing different problems or needing different solutions, but Hart points out that the importance of a manager's relationship





with employees does not differ with location.

"We find that a manager or supervisor is the key to retention of a quality nursing staff," says Hart.

"There are people who are natural managers, and you can see it immediately as they talk with staff members and walk around their departments," she says.

"Other people may need training because they don't instinctively know what is necessary to manage people," Hart adds.

Communication challenges

Ongoing communications with staff members in a home health agency is more difficult because you have field staff who do not come into one central area every day, says **Frances A. Johnson**, RN, BSN, manager of clinical services for Duke Health Community Care in Durham, NC.

"This makes it necessary for managers to find ways to communicate at staff meetings, e-mail notes, and voicemail messages," she says.

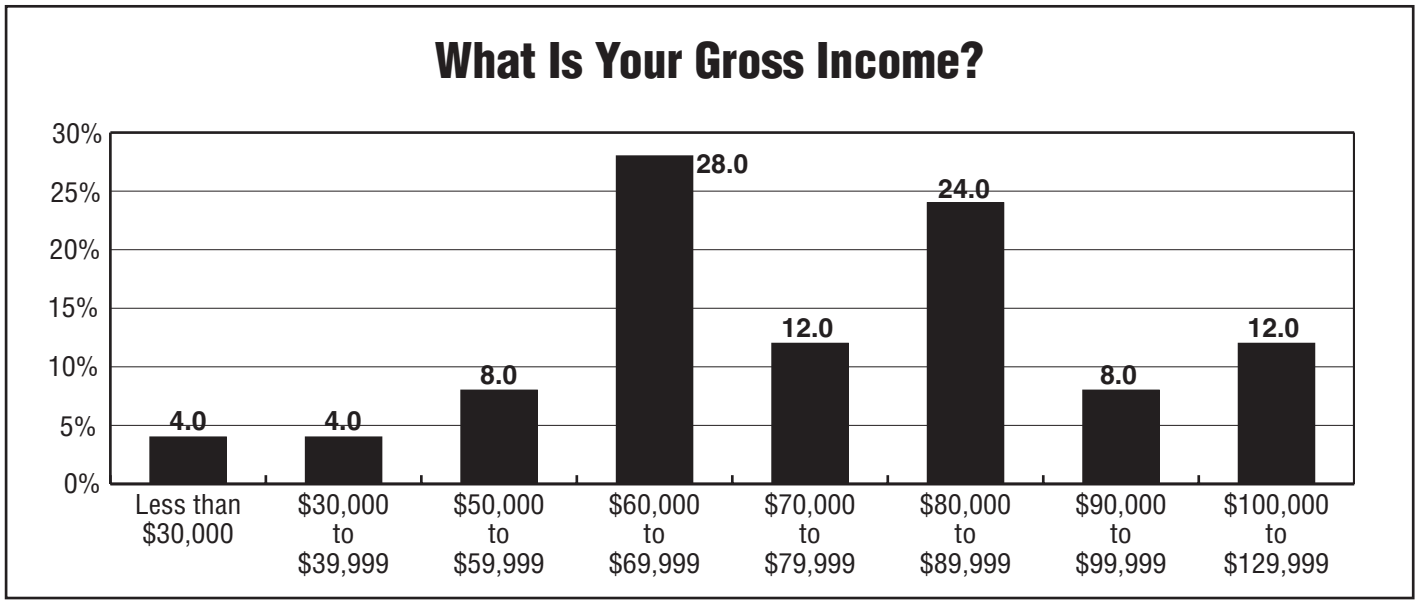
Manager traits that are important to employees can differ according to generational differences, says **Ann Warner**, RN, MS, CCRN, assistant professor, College of Nursing at McNeese State University in Lake Charles, LA.

Are you a team player?

"In a study that we conducted to compare the traits nursing students considered important to manager traits that experienced nurses considered important, we found a number of interesting differences," she says.[1]

"Of the top three traits identified by both groups, only 'team player' and 'receptive to people and ideas' are mentioned as a top-10 trait by both groups," Warner says.

Even with these two traits, the groups ranked them differently, she points out.



"Experienced nurses identified 'receptive to people and ideas' as third most important while students rank it ninth. 'Team player' is ranked first by students, while experienced nurses rank it ninth. Clearly, these two groups value different traits," she adds.

Generational differences

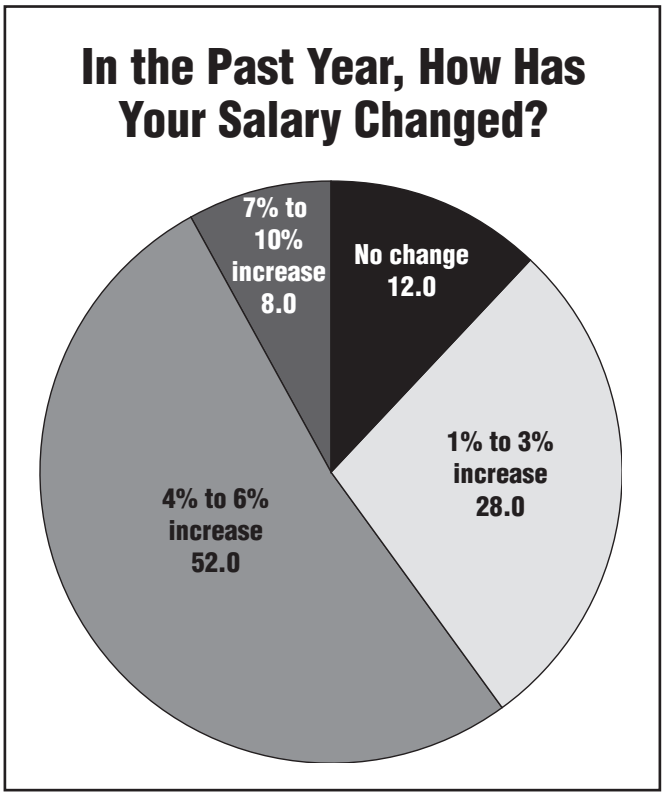
The differences in traits valued in a manager are generational, says Warner.

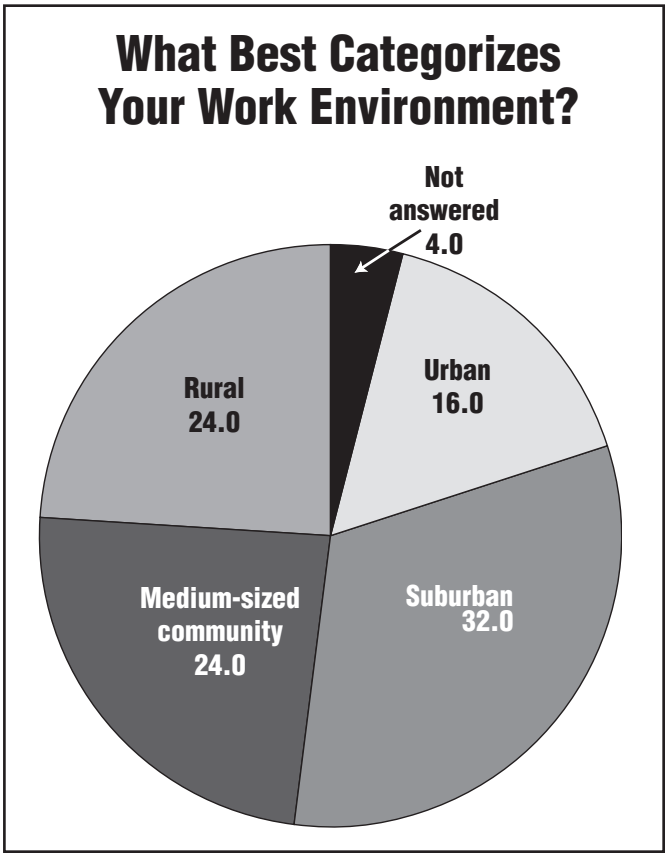
"This is important to understand because many managers, and many entrenched nurses, are members of the baby boomer generation who are having to learn how to supervise members of Generation X," she explains. **(For more information on the differences between generations, see "Beyond baby boomers: Managing various ages," *Hospital Home Health,* December 2002, p. 139.)**

All are hard workers

Respondents to the 2003 *Hospital Home Health* salary survey are representative of the baby boomer generation, with 48% of respondents born between 1946 and 1961. Generation X, ages 26 to 40, is represented by only 8% of survey respondents. **(See chart, p. 4.)**

The majority of respondents, 60%, have worked in home health between 10 and 18 years. **(See chart, p. 1.)**





"Nurses tend to be workaholics, but there are generational differences so managers need to understand that while baby-boomers will put in long hours, Generation X nurses want to finish the task, then move on to their personal life," Hart says.

Salary survey respondents also point out that home health managers are workaholics as well, with slightly more than 76% of the respondents working more than 46 hours each week. **(See chart, p. 2.)**

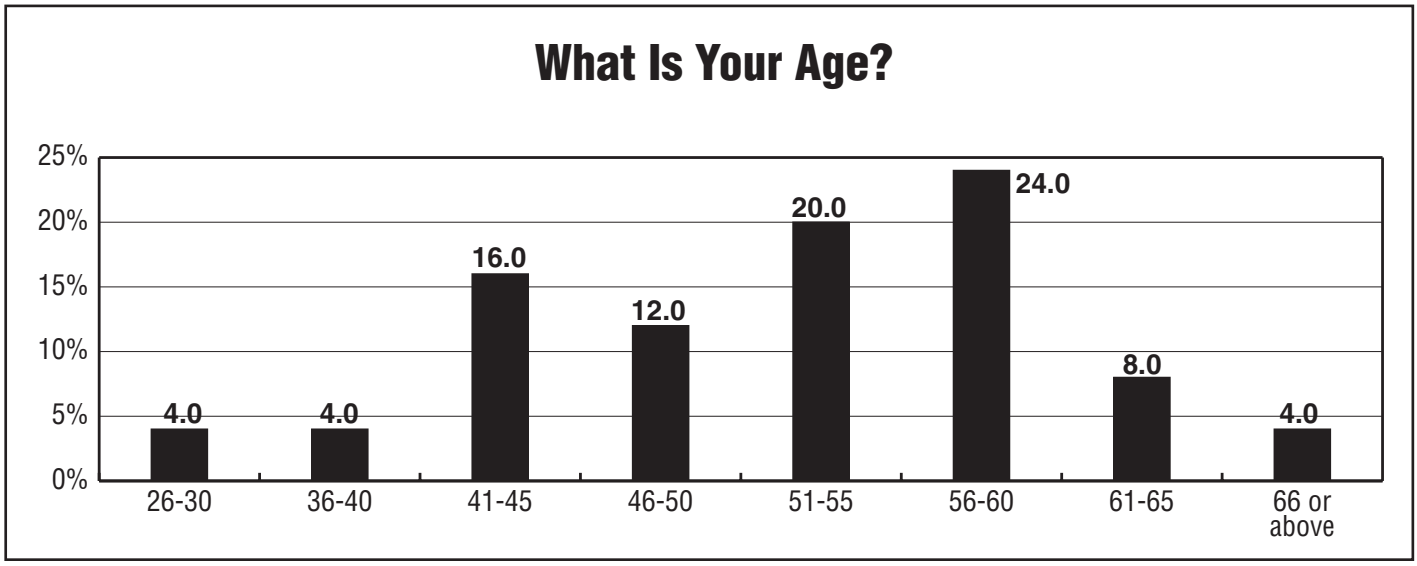
With the extra work hours, the good news for survey respondents is that although 12% experienced no pay increase in 2003, almost 80% experienced an increase that ranged between 1% and 6%. **(See chart, at left.)**

Sixty-four percent of survey respondents earn between $60,000 and $89,999 annually. **(See chart, p. 2.)**

Prioritizing staff's workload is important

With increasing workloads for managers, it is more important than ever that managers be able to prioritize their work, Hart points out.

"Being able to prioritize your staff's work



also is an important trait for a manager because employees want to know that the manager has them doing the most important work when time is limited," she adds.

In addition to addressing generational differences, it is essential that managers understand the difference between management and leadership, Johnson says.

Create a vision for your agency

"A leader creates a vision for the agency and develops an atmosphere that makes change possible. A manager makes the vision a reality and can see what needs to be done on a day-to-day basis to create the vision," she explains.

"The ideal manager knows that it is necessary to be a leader sometimes, and a manager other times," Johnson adds.

Experience is the best teacher

While you can teach management and leadership skills in a classroom, the best way to learn is the school of hard knocks, she says.

"I like to see supervisors and managers get a chance to learn while they are doing, and at the same time, have a mentor to whom they can go to with questions or problems," Johnson explains.

"I always tell my staff that they can make mistakes as long as they learn from them," she stresses.

If you want to evaluate your own management style, Hart suggests that you think back to all the years of your work experience.

"I always tell managers that it is helpful to think about the manager who made the biggest difference in their careers. What qualities possessed by that manager can you emulate?" she asks.

"When you encounter a difficult situation, ask yourself what that manager would have said or done," Johnson advises.

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Reference

1. Thompson J, Wieck L, Warner A. What perioperative and emerging workforce nurses want in a manager. *AORN J* 2001; 78 246-261. ■