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IN THIS ISSUE

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Determine what you want in a nurse before holding the first interview

Plan ahead to identify best traits for nurses who will stick with you

"Fire any manager who invents a new form" was one of the written responses to a survey of nurses conducted by Bernard Hodes Group, a human resources company based in New York City. *(For a copy of the full survey, go to www.hodes.com/hcrecruiting.)*

Unfortunately for home health, it is not the managers creating new forms and additional paperwork that create one of the greatest obstacles to recruiting experienced nurses to home health, say experts interviewed by *Hospital Home Health*.

While there are many positive aspects of home health nursing that help in recruitment, the increasing paperwork required by regulatory and reimbursement organizations is detrimental, says **Coleen Conway-Svec**, RN, MS, MBA, chief operating officer of the Visiting Nurse Association (VNA) of Southeast Michigan in Oak Park.

"Home health agencies have a better product to offer nurses than hospitals because we can offer positions that require independent decision making, flexible schedules, and an opportunity to develop a relationship with a patient. Unfortunately, the amount and detail of the paperwork required chases nurses away," she adds.

"One of our top priorities is to use technology to diminish the paperwork burden on our nurses," says **Don Richardson**, vice president of administration for the VNA of Texas in Dallas.

"We are not automated at this time, but we are looking at automation of all of our forms. We are in a very competitive environment with hospitals being our primary competition for nurses," he says.

Hospitals tend to be Richardson's biggest competitors for experienced nurses because the VNA of Texas pays registered nurses a salary rather than pay based on visits, he states.

"Other home health agencies in the area pay based on visits, so a nurse who wants to go into home health finds our agency's pay policy more attractive," Richardson's says.

"Unfortunately, this also means that the home health agency has to deal with local hospitals' escalating salaries in order to compete," he explains.

Salary and benefits are not an issue for Conway-Svec's agency, but she has had to address other issues to reach her goal of being fully staffed with RNs and even having a few extra on board to handle growth, she says.

"We have addressed the paperwork issue with all full-time field nurses having laptops," she points out. "They are able to complete the OASIS [Outcome and Assessment Information Set] forms and transmit them directly to the office without having to use paper," she explains.

Describe job accurately

The VNA of Southeast Michigan has not always enjoyed a full nursing staff. "Less than two years ago, we typically had a 30% vacancy rate with tenure for new hires averaging six months," Conway-Svec points out.

Even with the use of technology to automate paperwork, one of the most frequently cited reasons for nurses leaving after such a short time was that they didn't realize how much documentation was required, she says.

"We realized that we weren't painting a good picture of the job during the interview and hiring process," she explains.

This realization led to the development of a new way to interview qualified applicants that enables the job applicant to see what is entailed in home health nursing at the same time the agency has a chance to more fully evaluate the applicant's qualifications for home health.

"Our applicant shadowing program allows a job applicant to spend half of a day with a field nurse making visits," Conway-Svec explains. **(See related article, p. 135.)**

"We pay the applicant to spend about four hours with one of our more experienced nurses, riding with the nurse to see patients," she says.

While the job applicant doesn't participate in provision of care, he or she does see the type of care, education, and documentation required during a home health visit, she adds.

Not only does the applicant get an accurate impression of what home health visit is, but the field nurse has time to answer questions that may occur to the applicant after seeing a visit, Conway-Svec says.

"The field nurse also has a chance to form an opinion of how well suited the applicant may be to home health," she adds.

Address feelings of isolation

While use of laptop computers has made the nurse's job more efficient and reduced the driving required to come into the office to pick up visit schedules and turn in paperwork, the technology also has increased the feeling of isolation, another risk to retention of home health nurses, especially new hires, Conway-Svec points out.

Although the independence and autonomy of home health visits appeals to nurses who enjoy decision making and working on their own, the technology that has removed the need to go into the office also has increased the isolation that a field nurse may feel, she says.

"We didn't consider how this isolation would affect the team spirit of our staff when we began using laptops."

To address the lack of face-to-face time, Conway-Svec's agency has developed a more structured continuing education program in

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which nurses must come to monthly courses.

"We build time into each of these programs for networking, visiting with peers or managers, and sharing information or concerns," she adds.

Managers and supervisors also stay in contact with staff members by voicemail or e-mail so questions can be answered quickly and concerns identified before the nurse is overwhelmed, she explains.

Once you've addressed your agency's paperwork, salary, or isolation issues, it's important to make sure you use the right techniques to attract nurses, Richardson adds.

"We go through cycles when we are shorthanded and need to recruit heavily, and then other times, we are fully staffed," he states.

Depending on the point at which the agency is in their need for staff, he uses a combination of print advertisements in newspapers or periodicals, on-line recruitment, job fairs, direct mail, and referral bonuses for current employees. **(For more, see related article, p. 136.)**

Another key to identifying problems in recruitment or hiring is the exit interview, Richardson points out.

While most agencies do conduct exit interviews, there are some employees that he handles a little differently than the traditional interview.

"Sometimes employees are angry when they are leaving and their emotions may not enable them to give you an accurate explanation of the reasons for their leaving," he says.

For this reason, Richardson waits a month or two, then mails a written survey that asks them to give their opinion of the agency and explain their decision to leave. This cooling-off period results in a truer evaluation of the agency and the opportunities for improvement, he adds.

Watch vacancy rates closely

Perhaps the most important thing an agency can do to make sure your recruitment and interviewing practices are resulting in the best hires is to track your vacancy rates each month, suggests Conway-Svec.

"I came to home health from hospital nursing administration where we always thought in terms of full-time equivalents [FTE] and noted open positions more easily. Because our agency pays on a per-visit basis, there is less emphasis on FTEs," she explains. As long as visits are made, it is hard to see potential problems if there is a shortage of staff, she adds.

To make sure that managers and supervisors stay on top of keeping positions filled, a monthly report that lists vacancies and length of time needed to fill vacancies is run, Conway-Svec says.

"If we can see trends that indicate a problem with our recruitment practices or problems in retaining new hires, we can look for solutions," she adds.

[For more information on nurse recruiting, contact:

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- ***Don Richardson**, Vice President of Administration, Visiting Nurse Association of Texas, 1440 W. Mockingbird Lane, Suite 500, Dallas, TX 75247. Telephone: (214) 689-0003. E-mail: richards@vnatexas.org.]* ■

Recruiting: If they don't understand job, show them

Getting away from the warm body philosophy

It took about 18 months of hard work, but the staff at Visiting Nurse Association (VNA) of Southeast Michigan in Oak Park found the solution to the recruitment and retention problem that made the agency look like a revolving door for registered nurses.

With a vacancy rate of 30% and a new hire tenure of only six months, agency managers and supervisors were constantly recruiting, interviewing, and hiring new nurses, says **Coleen Conway-Svec**, RN, MS, MBA, chief operating officer of the agency.

"It was obvious that we were not hiring the right people for our field nurse positions, so phase one of our plan to address vacancies was to describe who we wanted to hire," she explains.

Nurse managers worked together to develop a profile of a successful hire.

"We looked at the qualities and attributes of our best nurses, added the skills needed for our patient population, and defined the experience that is necessary to work independently to build the profile," Conway-Svec explains.

Along with the profile, a behavioral interview

guide that includes questions that go beyond having the applicant list skills, education, and experience was developed. Behavioral interview questions ask the applicant to describe how he or she would handle certain situations.

It's important to find out if the applicant has the customer service skills and the compatibility with other team members during the interview, points out **Don Richardson**, vice president of administration for the VNA of Texas in Dallas.

"While an individualized training program can address weaknesses in certain skills, it's harder to teach the ability to develop a relationship with a patient, or to work as a team in home health," he explains. **(For more information about interviews, see *Hospital Home Health*, September 2003, p. 104.)**

The shadow knows

After pulling together a profile and interview guide, the second phase of VNA of Southeast Michigan's new hiring program involved development of an "applicant shadow" program in which an applicant spends a half-day in the field with a nurse.

"Our new hires who were leaving within six months were saying that they had no idea how lonely they would be or how much paperwork they would have to complete," explains Conway-Svec.

"We decided the best way to describe their potential job to them was to take applicants we were seriously considering on patient visits," she adds.

With the consent of the patients, the applicant accompanies a "nurse ambassador" on his or her visits. The applicant is paid for four hours to ride with the ambassador, observe the visits, and ask questions of the ambassador during the half-day.

"Our nurse ambassadors are hand-picked, experienced nurses who receive about eight hours of training for the program," Conway-Svec continues. Their training includes review of the agency's mission, values, programs, and services. "They also spend time learning how to handle tough questions from applicants in a positive manner."

This approach to hiring has a number of benefits that were not expected, she admits. "Bringing field nurses in as ambassadors has created a new group of staff members beyond supervisors and managers, who have a sense of ownership and a stake in the success of our hiring program.

"We also have an opportunity, through the ambassadors, to observe the applicant in a typical home health setting and judge whether or not the applicant will be a good fit," Conway-Svec adds.

In addition to the results of interviews with supervisors and managers, the ambassadors' feedback is taken into account when evaluating an applicant.

"Many times the ambassadors will intuitively know whether or not the person will make a good home health nurse and we trust their judgment," she explains.

Goal reached in nine months

Within nine months of implementing the new interview process and the applicant shadow program, all positions were filled and the agency enjoys a low turnover rate, Conway-Svec says.

"Our turnover rate for new hires within the first six months is only 4%," she says proudly.

The reason for VNA of Southeast Michigan's success is that the agency has moved toward a process of finding the right person for the job, Conway-Svec says.

"We no longer have a warm body philosophy in which we just hire anyone. We make sure the job is the right fit for both the agency and the applicant," she adds. ■

Vary recruitment efforts to improve hiring process

There is no magic formula for attracting the best applicants to your agency, but using a combination of marketing tools to reach nurses with news of job openings will help you find the people you want, according to **Don Richardson**, vice president of administration for the Visiting Nurse Association of Texas in Dallas.

His agency uses a combination of newspaper and periodical advertising, job fairs, referral bonuses, on-line recruitment, and direct mail to reach potential employees.

Keep the approach fresh

"It's important to vary your recruitment efforts so that your approach stays fresh and so that you can evaluate which method works," Richardson points out.

The referral bonus, for example, always is run

as a short, usually 60-day program during which employees get a cash bonus for referring a candidate who is hired, he says.

"The referral program is not a huge success that always results in a lot of job applicants, but it is another tool for us to use, and the applicants we get through referrals from other employees are always appropriate in terms of experience and skills," he says.

Your print advertising also should be evaluated on a continuing basis, says **Coleen Conway-Svec**, RN, MS, MBA, chief operating officer of the Visiting Nurse Association of Southeast Michigan in Oak Park.

Although she isn't spending any more money on advertising than she did two years ago, her ads are more effective after a redesign in which more white space and graphics were added to make the add stand out among other help-wanted ads, she says.

"The new ads get more attention, and we get plenty of qualified applicants when we run them," Conway-Svec says.

Once someone responds to the advertisement, be sure you present the right message, Richardson adds.

"You must make the job applicant feel like you really want them. When a job applicant comes into our office, we roll out the red carpet and make sure they know that we think they are important," he explains.

"We greet them as soon as they come in to the office, we don't leave them sitting in the waiting area for a long time, and we show them that we respect their time and their interest in our agency." These efforts do pay off, he says.

"This is the way we want our nurses to treat our patients, so we need to treat them in the same manner when we first meet them as applicants," Richardson points out. ■

Telemedicine funds: Know where to look for grants?

Focus on new approaches, serving more patients

(Editor's note: This is the second installment of a two-part series that looks at telemedicine in home health. In the last issue, representatives from two agencies described their programs and specific issues related to choosing technology and patients who are appropriate for telemedicine. This month, tips on funding telemedicine programs are presented.)

The opportunities for telemedicine in home health are exciting in both the clinical area and the funding area, according to **Robert Waters**, a health care attorney who specializes in telemedicine issues with Arent Fox in Washington DC.

"It is becoming clear that telemedicine is one way to improve home care monitoring and avoid hospital admissions," Waters says. "Home health agencies that serve high-risk patient populations can use telemedicine to increase the number of contacts with patients without increasing the number of actual visits," he explains.

Because the initial investment in telemedicine technology is a stumbling block for many home health agencies, **Sandy McNeely**, RN, MSN, telemonitoring project manager for the Visiting Nurse Association of Houston, suggests agencies seek grants to fund demonstration projects that will enable them to purchase the equipment.

"I was able to obtain grant funding from a local organization to enroll an additional 50 patients to our program to monitor cardiac care patients," McNeely says. This represents 50 more patients for the program with a minimum of investment from her agency, she adds.

Because grants are designed to meet the needs of underserved populations or to add to the knowledge telemedicine effectiveness, it is important to write your grant proposal in such a way to show how your project will meet these goals, Waters suggests.

"A proposal should demonstrate a new approach, investigate the effect on a particular patient population's outcomes, enhance services already offered, or accumulate data that will add to our knowledge of telemedicine," he says.

You also need to define the significant effect your project will have on the health of people in your local area, or nationally, if your project has national significance, he adds.

As you pursue grant monies, be sure to keep a few things in mind, Waters recommends. **(For other tips on garnering grant funds, see *Hospital Home Health*, June 2003, p. 65.)**

- **Make sure your agency is committed to the project.**

Commitment and support need to run throughout the entire organization, Waters says.

Make sure that all areas of the agency — clinical, business office, and administration — understand

the project's goals and the reporting requirements that are a part of the grant, he adds.

- **Designate a project manager.**

You need one person who is passionate about the project and will oversee the details of the program and reports back to the grant organizations, says Waters.

A project manager will ensure that good fiscal controls are in place and that all members of the team know what is happening, he explains.

- **Know how you will handle the program after the grant expires.**

The length of grant awards varies according to the original grant, the funding organization, and the results of your program, Waters points out.

If this is a service you intend to continue, think about how you will fund it after the grant-support years, he says.

Although initial investment in equipment and training will be supported in the original program, be sure you evaluate how ongoing education, equipment maintenance, and expense reimbursement can be absorbed by the agency, Waters suggests.

It is better to address these issues well before the funding ends, he adds.

There are a variety of funding sources that home health agency should investigate, says McNeely.

Check out resources

"The Office for the Advancement of Telemedicine in the Department of Health and Human Services, is an excellent resource, as are local organizations," she suggests.

"Don't forget your own hospital foundation, either," McNeely points out.

"Remember that the hospital has a vested interest in reducing readmissions, so support of a telemedicine project is a win-win situation," she adds. **(For more suggestions of funding organizations and contact information, see resource box, at right.)**

"Don't forget managed care and private payers when you consider financial support of telemedicine," McNeely says.

"Because telemedicine can greatly reduce the cost of caring for some patients by avoiding readmissions to hospitals, be sure you negotiate reimbursement for telemedicine into your contracts," she explains.

Another way to make sure your reimbursement for telemedicine services is accurate and

Telemedicine Funding Resources

Some of the organizations that offer grants to fund home health telemedicine projects include:

- ✔ **Office for the Advancement of Telehealth,** 5600 Fishers Lane, Room 7C-22, Rockville, MD 20857. Telephone: (301) 443-0447. Fax: (301) 443-1330. Web: http://telehealth.hrsa.gov/index.htm. The site contains general information about telemedicine as well as description of grants and the grant application process.
- ✔ **Telemedicine Information Exchange**, 2121 S.W. Broadway, Suite 130, Portland, OR 97201. Telephone: (503) 221-1620. Fax: (503) 223-7581. Web: www.tie.telemed.org. The organization maintains a funding database that describes funding opportunities and links to funding organizations.
- ✔ **Robert Wood Johnson Foundation**, P.O. Box 2316, College Road East and Route 1, Princeton, NJ 08543. Telephone: (888) 631-9989. Web: www.rwjf.org. The organization offers health care grant opportunities. Go to the quick links section on the right side of the home page to investigate grant opportunities, grant application procedure, and existing grant programs.
- ✔ **U.S. Department of Agriculture (USDA)**, Distance Learning and Telemedicine Program, USDA-RUS, STOP 1590, 1400 Independence Ave., S.W., Room 4056, Washington, DC 20250-1590. Web: www.usda.gov/rus/telecom/ dlt/dlt.htm. In October 2003, the USDA announced almost $44 million in grants to develop telemedicine programs, distance-learning programs, and broadband Internet access in rural areas. The web site includes a description of grants and application procedures as well as local and regional contacts for USDA staff members.

These organizations offer resources to keep you up to date on changes in regulations, reimbursement requirements, and issues affecting telemedicine:

- ✔ **Center for Telemedicine Law**, 1050 Connecticut Ave., N.W., Washington, DC 20036-5339. Telephone: (202) 775-5722. Web: www.ctl.org. The site includes publications regarding reimbursement laws at state and federal levels.
- ✔ **Arent Fox**, 1050 Connecticut Ave., N.W., Washington, DC 20036-5339. Telephone: (202) 857-6000. Fax: (202) 857-6395. Web: www.arentfox.com. The web site contains information and links specific to telemedicine. Go to home page, choose "health care" under the "special focus" heading on the left navigational bar, then go to "e-health and telemedicine" to find state, federal, and funding information.

up to date, is to stay on top of changes in state and federal regulations regarding telemedicine, Waters suggests.

"Organizations such as the American Telemedicine Association, the Center for Telemedicine Law, and law firms with a specialty in telemedicine do a good job of keeping current and passing the news on to home health agencies," he says.

Reducing isolation, maintaining contact

It is ironic that the modern technology that enables us to utilize telemedicine actually will enable home health agencies to provide the type of personal, old-fashioned care that people expected from physicians who made house calls, Waters says.

"The ability to maintain contact via telemonitoring and the telephone will make rural homebound patients feel less isolated and less anxious, and will enable nurses to maintain contact with more patients throughout the day," he adds.

[For more information on acquiring telemonitoring resources, contact:

- ***Sandy McNeely**, RN, MSN, Telemonitoring Project Manager, Visiting Nurse Association Houston, 2905 Sackett Road, Houston, TX 77098. Telephone: (713) 630-5579. E-mail: smcneely@tmh.tmc.edu.*
- ***Robert Waters**, Attorney, Arent Fox, 1050 Connecticut Ave., N.W., Washington, DC 20036-5339. Telephone: (202) 857-6398. Fax: (202) 857-6395. E-mail: watersr@arentfox.com.]* ■

Do sacred cows still graze in your agency?

Evaluate rituals with eye to profitability

They still graze in and around your agency, but an increasing number of home health managers are starting to look critically at "sacred cows" that need to be put out to pasture.

Sacred cows are rituals, beliefs, or guidelines that are routinely followed without anyone really questioning the origin or even the appropriateness of the belief.

"The home health industry is even more reluctant to let go of some practices than other homecare-related industries, such as infusion or durable medical equipment," says **Dexter Braff**, MBA, MS, president of The Braff Group, a health care mergers and acquisitions firm based in Pittsburgh.

"The fundamental difference between home health and the other two industries is that home health grew under a cost-based reimbursement plan," he says.

"Home health managers and staff members developed a way of doing business that fostered an attitude that is still hard to shake," Braff explains.

The first and most obvious sacred cow for home health is the belief that profit is a dirty word, Braff says.

"As an industry, home health representatives are embarrassed to talk about profits, as if making a profit equates to giving less-than-quality service," Braff says.

In fact, under the cost-based reimbursed system, many extra costs were generated in the name of quality when the reality was that extra services did not always translate to extra quality, he adds.

"Today, people are still receiving quality care, even though agencies are having to find innovative ways to become more efficient," he explains.

"Even if you are a not-for-profit agency, you still need to generate profits to continue providing services and have a reason to be in business," Braff points out.

Managers who are uncomfortable with the idea of generating profits can think of the profit as a surplus that can be used to provide other patients services, he suggests.

The best way to overcome the idea that profit is a dirty word is to run monthly financial statements in which you can see the earnings you generate, your contribution to the organization's bottom line, and the surplus you provide to support not-for-profit or free services to underserved patients, Braff recommends.

"If your agency is not making money, you are not operating efficiently and need to evaluate changes that will improve your efficiency," he says.

Private duty always the answer?

"We can protect ourselves from the risk of decreasing Medicare reimbursement by going into private duty is another belief that may or may not be right for your agency," Braff says.

"While private duty is a good business strategy for some, it is very difficult to succeed when

you offer both Medicare and private-duty services," he says.

Although the initial response is that resources can be used for both sides of the business, this is not accurate, Braff points out.

"You use different types of caregivers and different billing systems, so you can't blend all services," he says.

"It's the same with agencies that believe the same staff can be used to provide hospice, pediatric, and private duty services," Braff adds. "You have specialized nursing for hospice, geriatric, and pediatric patients, so you aren't saving on staff costs because you still need the specialists."

Another cow that needs to be pastured is the idea that home health agencies can reap the benefits of economy of scale as they add new patients, he says.

"The economy-of-scale theory works well in many industries but not in home health because there are virtually no fixed costs in home health," Braff says.

"Agency managers misidentify costs by assuming that administration, billing, and nurse supervisors are fixed costs," he says. "In reality, they are step-variable costs, which means that I don't need to add another billing clerk or another nurse supervisor for one new patient, but I will for 100 new patients," he explains.

For this reason, managers need to know exactly where they will need to increase resources to add new patients so that they can accurately predict costs and profits, Braff says.

"This is especially critical for agencies that negotiate managed care contracts," he adds. "If a new contract might mean 100 new patients, be sure that you know exactly how much you will have to spend to care for those patients before you sign the contract and agree to a price that leaves you no margin for profit," he says.

Reluctance to invest in tech

"Another leftover belief from the days of cost-based reimbursement is that some home health managers are reluctant to invest in technology for which the government doesn't pay," Braff says.

While many agency managers get the concept of the need for technology, they are not ready to make the leap, he adds.

The most effective technology for agency managers to consider is anything that cuts down on processing information, automates OASIS (Outcome Assessment and Information Set), or decreases the amount of time to get the initial request for anticipated payment (RAP), he says.

"We cut our administrative costs by 30% because we didn't have to input the data from paper forms, we reduced the mileage reimbursement for our nurses because they didn't have to return to the office each day, and our cash flow improved because we cut 15 days off the time it took to receive our RAP," says **Mark O'Brien**, owner of Texas Senior Care of Dallas. He's describing the results of automating his agency with hand-held computers for all of his field nurses.

Hand-held computers one agency's choice

"We chose hand-held computers rather than laptops because they are very inexpensive and don't require a staff person to maintain them," O'Brien says.

"They are much easier for nurses to carry, especially when climbing stairs and carrying other supplies," he adds.

"Not only are the forms legible, but the software doesn't allow conflicting information to be entered on the OASIS form," O'Brien continues.

"For example, if a nurse indicates that the patient can be taught to perform certain care activities, then later describes the patient as having dementia, the software does not enable the nurse to proceed until the inconsistency is resolved," he says.

This inconsistency is a mistake that would delay payment while the mistake was identified and resolved with paper forms, O'Brien says.

While home health employees tend to be more motivated by caring for people rather than making money, there is a shift in home health with more business-oriented people taking management positions, Braff adds.

"We now look at home health not as a clinical service, but as a business that provides clinical service," he says.

[For more information, contact:

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LegalEase

Understanding Laws, Rules, Regulations

Avoid negligence charges with adequate supervision

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

Home care is different from institutional care in a number of ways. One crucial difference is field staff members essentially are working without direct supervision on a routine basis.

The cost of providing direct supervision for staff as they provide services to home-care patients clearly is prohibitive. Consequently, providers are vulnerable to claims that they failed to adequately supervise staff.

These claims may include allegations of negligence and fraud and abuse.

Perhaps the greatest risk involves staff members who say they made visits that they really did not make. When visits are missed, changes in patients' conditions may not be addressed. Visits that are claimed but turn out not to have been made after all also are a common basis for allegations of fraud and abuse.

However, in view of inherent limitations on agencies to directly supervise field staff, what is the applicable standard of care that must be met?

Generally speaking, appropriate supervision means that agencies must make reasonable efforts to ensure that field staff meet applicable standards of care.

Reasonable efforts to ensure adequate supervision may include the following:

- New employees may be required to make several visits with experienced employees with proven track records so that any deficiencies in abilities or practices of new staff can be determined as quickly as possible. The results of these visits, of course, must be documented.
- Agencies should develop and implement a policy and procedure that requires random supervisory visits. Thereafter, managers should make "unannounced" supervisory visits to patients' residences at all hours of the day and night so that employees understand that they may be directly supervised at any time without notice.
- Managers also may wish to investigate systems that are available commercially to track the arrival and departure of field staff members at each patient's home. These systems may require staff to place a telephone call that registers in a computer when they arrive at patients' homes and again when they depart.

These systems are, of course, not foolproof. Instances in which staff members paid patients and/or family members to call in for them as though the worker arrived and departed patients' homes already have been reported.

But to the extent that the use of such systems makes it clear that agencies are using reasonable means to help verify that services actually were rendered, even if the system is circumvented, helps to ensure that agencies adequately have managed risks associated with visits that are not made as scheduled.

- Agencies also should develop and implement policies and procedures that require patients and/or someone else present in patients' homes when visits are made to sign a document verifying that services were provided. If the patient cannot sign and no one else is present to sign, staff should be required to provide a detailed explanation for missing signatures.
- Quality assurance staff should conduct retrospective audits to make certain that signatures from patients and/or family members verifying services are obtained routinely. When there are a number of instances when specific staff members failed to obtain signatures as required despite the presence of a written explanation, further investigation must be conducted to determine why signatures are missing on multiple occasions.
- Agencies should continue to use patient satisfaction surveys to assist them to satisfy their obligation to monitor workers. Agency staff members sometimes observe correctly that most of the surveys returned by patients fall into a category that can best be described as "We love our nurse." Nonetheless, valuable information occasionally can be gleaned from surveys.

For example, a patient of an agency responded to a survey by saying that he was very pleased with the care provided, but wished that the agency would not send a different nurse every day.

The staff initially were quite puzzled by this response since their records showed that the

same nurse had visited the patient each day. Following further investigation, however, staff were astounded to learn that the agency worker was subcontracting the care of the patient to members of an extended family so that, indeed, the patient was being cared for by a different "nurse" each visit.

It is impossible for agencies to duplicate the supervision provided by institutional providers. Nonetheless, every reasonable effort that agencies can demonstrate to show that they provided adequate supervision of field staff will work in their favor when workers' performances are scrutinized.

[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.] ■

HIPAA Q & A

[Editor's note: This periodic column addresses specific questions related to Health Insurance Portability and Accountability Act (HIPAA) implementation. If you have questions, please send them to Sheryl Jackson, Hospital Home Health*, American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsmjackson@cs.com.]*

Question: How should a home health agency proceed if a patient agrees with only portions of the privacy notice?

Answer: "A patient does not agree or disagree with the notice of privacy practices," points out **John C. Gilliland II**, an Indianapolis-based health care attorney.

"It is a notice of the provider's privacy practices, not something to which a patient must agree," he explains. The provider must give a copy of its notice of privacy practices to the patient and attempt to obtain the patient's written acknowledgment that he or she received it, he says.

If the written acknowledgment cannot be obtained, the provider must document the efforts it made to obtain the patient's acknowledgment and why the acknowledgement was not obtained, he adds. The form that the patient is asked to sign is an acknowledgment of receipt of the privacy notice, not of agreement or understanding, says Gilliland.

Question: When a patient asks a home health agency to restrict the disclosure of information beyond that provided in the agency's privacy notice, does the agency have to comply?

Answer: "No, the provider does not have to comply," Gilliland says. "An individual has the right to request restriction on the use and disclosure of his or her protected health information."

However, the provider does not have to comply if the patient's request goes beyond the provider's normal disclosure restriction, he adds.

Question: Can a home health agency post thank-you letters from patients on a bulletin board that can be seen by staff and other patients?

Answer: "In my opinion, they cannot post the letters unless the letters are de-identified so they no longer constitute protected health information," Gilliland says.

"De-identification" is a process under the privacy rule by which health information is made to no longer be individually identifiable. "Typically, it requires removing all of 18 identifiers stated in the privacy rule including names, geographic subdivisions smaller than a state, most zip codes, telephone numbers, and medical record numbers," he says.

[For more information on the nuances of HIPAA privacy regulations, contact:

- ***John C. Gilliland II**, Gilliland & Caudill, LLP, 6650 Telecom Drive, Suite 100, Indianapolis, IN 46278. Telephone and fax: (317) 616-3647. E-mail: jcg@gilliland.com. Gilliland is the author of* HIPAA Privacy Compliance Resource Manual*. For more information about the manual, go to www.gilliland.com.]* ■

COMING IN FUTURE MONTHS

- Predictions of new challenges for home health
- Wound care update: New treatments improve outcomes
- What do new laws, regulations mean for your agency?
- Make sure your education programs are effective
- How do family translators affect care, education?

NEWS BRIEFS

CMS rolls out its quality initiative

Nov. 3, 2003, marked the first day that Home Health Compare, the Centers for Medicare & Medicaid Services' (CMS) national quality initiative for home health agencies became active.

Home Health Compare's pilot test began in May 2003, and includes outcomes data on items 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. For information on how the pilot test affected agencies, see *HHH*, October 2003, p. 111.)**

To see the advertisements that CMS is placing nationally, go to: www.cms.hhs.gov/quality/hhqi. You also can choose the link to the Home Health Compare web site to see how consumers will view your agency's scores as compared to local and national benchmarks. ▼

FDA approves new Alzheimer's drug

The Food and Drug Administration has approved memantine, a drug sold in Germany for many years, and the first treatment designed specifically for late stages of Alzheimer's disease.

U.S. marketer Forest Laboratories will sell memantine here under the brand name Namenda, for patients with moderate to severe Alzheimer's symptoms.

A Forest spokesperson says the drug should be available in January 2004.

While some patients given memantine experience improvement in memory and thinking skills, the majority of Alzheimer's patients will experience a slower pace of deterioration, letting patients maintain certain functions a little longer. For example, the drug helped some patients maintain the ability to go to the bathroom independently for six more months, according to studies, a benefit caregivers consider important.

Memantine is the first option for advanced stages of Alzheimer's. The nation's four other Alzheimer's medications — Aricept, Exelon, Reminyl, and Cognex — work in early stages of the disease.

About 4 million Americans have Alzheimer's, and a million of them are believed to suffer severe symptoms. ▼

Study shows caregivers often overestimate pain

A study conducted by the College of Nursing at the University of South Florida in Tampa, shows that caregivers often believe their family member is in greater pain that the patient feels.[1]

As health care increasingly moves out of hospitals, the care of patients with cancer is provided in the community with the help of family caregivers. In many cases, nurses depend on family caregivers to provide assessment data about patients. This makes the accuracy and dependability of the data given by caregivers particularly important.

The study included 264 newly admitted adult patients with advanced cancer in hospice home care and their primary caregivers.

Patients and caregivers completed questionnaires that included numeric rating scales for pain, dyspnea, and the Constipation Assessment Scale.

All of the scales were designed to describe the patient's symptom intensity. The results indicated that caregivers significantly overestimated symptom intensity for all three symptoms.

Results of the study indicate that hospice and home health nurses need to train family caregivers in conducting systematic assessments of pain instead of assuming that they understand the patient's symptoms. Until then, nurses need to be wary of relying upon family caregiver reports of pain.

Reference

1. McMillan SC, Moody LE. Hospice patient and caregiver congruence in reporting patients' symptom intensity. *Cancer Nurs* 2003; 26(2):113-118. ■

CE *questions*

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

9. According to Coleen Conway-Svec, RN, MS, MBA, chief operating officer of the Visiting Nurse Association of Southeast Michigan, why did so many of her newly hired nurses leave after only six months on the job?
   A. paperwork
   B. isolation
   C. salary
   D. A and B

10. Don Richardson, vice president of administration for the VNA of Texas in Dallas, believes that one way to attract quality nurses is to:
   A. make them feel welcome as soon as they arrive for an interview
   B. run advertisements in nursing publications only
   C. rely solely on referrals from current employees
   D. pay signing bonuses

11. Sandy McNeely, RN, MSN, telemonitoring project manager for the VNA of Houston suggests what funding source as a win-win situation for the home health agency and the hospital?
   A. hospital foundation
   B. local health departments
   C. international organizations
   D. nursing associations

12. What created many of today's home health sacred cows, according to Dexter Braff MBA, MS, president of The Braff Group, a health care merger and acquisition firm based in Pittsburgh?
   A. managed care
   B. technological advances in health care
   C. the old cost-based reimbursement system
   D. the nursing shortage

Answer Key: 9. D; 10. A; 11. A; 12. 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. ■

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