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Home health agencies can avoid fraud charges with compliance plans

Medicare law provides some new protections

The Medicare Reform Act passed in 2003 contains a number of new demonstration projects and administrative requirements that affect home health agencies, but the good news is that the myriad new fraud targets the new legislation identifies don't have as much impact on home health as other areas of health care, say experts interviewed by *Hospital Home Health*. **(For more information on the Medicare legislation, see *HHH*, February 2004, p. 17.)**

"The changes included in the legislation are actually good news for home health agencies," says **Marie Infante**, an attorney with Mintz Levin in Washington, DC. "There are more protections for providers who are accused of fraudulent claims," she says. Prior to passage of the 2003 legislation, providers accused of fraudulent claims had to make payments even if they were pursuing an appeal, Infante points out. "We were able to help one client who is filing an appeal to avoid payments until after the appeal is decided." This is one change to fraud and abuse regulations that definitely is welcomed, she adds.

Another aspect of protection for home health agencies is the acknowledgement that information given by representatives of Medicare should be accurate, Infante explains. In other words, if you or another staff member asks a billing question or asks a Medicare representative for instructions on how to handle a particular issue on a claim, and you follow those instructions, you will not be held liable if the information given to you is incorrect, she says. "This law recognizes the fact that you asked for information, and you followed the instructions given."

Even with this protection, an agency staff member must take some extra steps to document the process, Infante adds. "Be sure to maintain logs and put the information in writing," she says. "Send an e-mail or a letter to the person giving you the information and state, 'Per your instructions, I am proceeding in the following manner,'" she adds. Keep a copy of the correspondence and the log that includes name of person, date, and time of conversation, Infante says.

Even though new fraud risks for home health agencies may not be contained in the latest legislation, be sure to stay aware of the most

common risks for home health agencies, says **Kevin McAnaney**, Esq., a Washington, DC, attorney. One of the more common red flags for fraud investigations is a pattern of overpayment of claims, he says.

Although mistakes can be made, home health agencies need to remain diligent in staff education, review of claims prior to submission, and audits of claims paid, McAnaney suggests.

"Be sure your employees understand how to code claims properly and be sure the documentation for the codes is complete." While the Centers for Medicare & Medicaid initially will treat overpayments as mistakes, a trend of overpayments might generate a closer investigation, he adds.

Beware of business arrangements with hospitals that want to set up turnkey subcontractor arrangements, McAnaney warns. Even though most hospital-owned agencies or hospital-affiliated agencies represent legitimate relationships, an agency needs to be wary of some new business opportunities, he says. "There have been cases of hospitals that set up a home health subsidiary, then contracted with an existing agency to provide all home health services."

If the hospital merely is contracting with a home health agency in an effort to capture referrals from the agency when hospitalization is necessary, this is a fraudulent relationship, he adds. Home health agency managers should have an attorney carefully review any contract to ensure that proper protection is in place to minimize the risk of fraud accusations for the agency.

Another area that must be reviewed carefully has to do with home health agency relationships with other organizations in the community, notes McAnaney. Just as a home health manager would want any contracts with hospitals to minimize fraud risks, any agreements with organizations, such as assisted-living facilities, nursing homes, or senior centers, need to be reviewed carefully, he says.

"Be sure the services you provide don't imply an obligation on the part of the other organization to direct home health referrals to your agency," McAnaney says. **(For more information on relationships with assisted-living facilities, see *HHH*, April 2004, p. 37.)**

If you do enter into an agreement that can be construed as a kickback arrangement, the penalties can be high, he points out. The Department of Health and Human Services has been referring more kickback claims to the Office of the Inspector General to pursue as civil cases with monetary penalties, he says.

"The penalty is $50,000 per case of kickback and three times the amount of kickback." Because the charges are heard in an administrative procedure rather than a court of law, it is easier for the government to prove its case, he says. In addition to the monetary penalties, any agency found guilty of accepting kickbacks can be excluded from Medicare, McAnaney explains.

"A home health agency can avoid accusations of kickbacks by making sure your arrangements don't involve lavish gifts to physicians or managers of other organizations, expensive entertainment at meetings, or free services that exceed what you typically provide," he recommends.

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Editor: **Sheryl Jackson**.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Jayne Gaskins**, (404) 262-5406, (jayne.gaskins@thomson.com).
Senior Production Editor: **Ann Duncan**.

Editorial Questions

For questions or comments, call **Jayne Gaskins** at (404) 262-5406.

"Also, if you do offer services in an assisted-living facility and you rent a room in which you provide the services, be sure the rent you pay is in line with fair market value in the area," adds McAnaney. Billing for unnecessary or undelivered services is another hot spot for home health agencies, he says. "This is the classic fraudulent claim in which the agency simply bills for services that were never delivered."

"Documentation is key to protecting yourself from charges of fraud," Infante adds. "Nurses know when their patients need additional services, but without the physician's order authorizing those services, you will have compliance problems," she says.

The best protection for any home health agency is an effective compliance plan that all employees know and understand, McAnaney stresses. "It's not enough just to write a plan. Make sure your staff are well-trained in their job responsibilities, and that you have appropriate employees monitoring chart audits, claims processing, and employee evaluations."

[For more information, contact:

- ***Marie Infante**, Attorney, Mintz Levin, 701 Pennsylvania Ave. N.W., Washington, DC 20004. Phone: (202) 434-7489. Fax: (202) 434-7400. E-mail: MCInfante@mintz.com*
- ***Kevin McAnaney**, Esq., Law Offices of Kevin McAnaney, 1800 K St. N.W., Suite 720, Washington, DC 2006-2202. Phone: (202) 457-0494. Fax: (202) 457-6636. E-mail: Kevin@mcaneylaw.com]* ■

Be proactive: Improve patients' quality of life

Extra help for frail elderly, chronically ill

(Editor's note: This is the second of a two-part series that looks at innovative approaches to patient care and expansion of services by home health agencies. Last month's article examined partnerships with other community organizations. This month's article looks at the approach of two agencies that have found a way to offer a more holistic approach to patient care.)

As outcomes are emphasized more in the home health industry with Home Health Compare **(for more information, see *Hospital Home Health*, December 2003, p. 143)**, home health managers are looking for ways to be proactive with their patients and make sure that the best outcomes possible are achieved.

"The switch to the prospective payment system did give home health agencies flexibility and did emphasize outcomes," points out **Robert L. Heineman**, LPT, MS, MBA, director of rehabilitation for Holy Redeemer Home Health and Hospice Services in Philadelphia. "Collection of OASIS [Outcome and Assessment Information Set] data have also helped us identify exactly who our patients are and where we need to enhance services in order to improve outcomes," he adds.

Holy Redeemer's approach to enhancing services was to develop a disease-management program that focused upon the frail elderly. The program, Life Assess, enabled the agency to become the first health care organization in the country to be certified for a frail elderly program by the Joint Commission on the Accreditation of Healthcare Organizations.

Life Assess addresses the needs of patients 85 and older who are admitted to Holy Redeemer's service for an acute episode, Heineman explains. "We know that we will see the patients only for an acute episode, but we also know that frailty is a comorbidity that increases the need for services for reasons other than the reason for referral to home health," he says.

"Our philosophy is that frailty is not an end-of-life issue; it is a period of life that requires additional support in order to stay at home," notes Heineman. "Our program is not designed to do more for the patients, but to identify what their extra needs may be and help them find the resources they require to address those needs to improve their quality of life at home," he says.

It does not matter what the reason for referral to home health is, all patients ages 85 and older automatically are screened for depression, dementia, falls risk, and urinary continence problems, Heineman adds.

All field staff members are given screening tools to use when they visit Life Assess patients, he says. "We may have a patient who is being seen by a physical therapist following a stroke. In the past, the therapist would do his or her job by working with the patient to strengthen balance and reduce the risk of falls, but the therapist might not recognize signs of other problems."

The Life Assess screening tool is a simple mechanism that, along with staff education, can help any field staff member identify other areas of need for the patient, he adds.

"I had one physical therapist who suspected depression in her 89-year-old patient after conducting the screening. The therapist pointed out that the patient seemed sad, but the patient declined the therapist's offer to pursue a referral to someone who could help," Heineman says.

"Seven months later, the therapist saw the patient out in public, and the patient came up to her and said that the therapist had changed her life," he adds.

"The patient stated that no one had ever asked her how she felt and after the therapy ended, the patient did seek help from her doctor. Just because the therapist recognized a potential problem and brought it into the open, the patient felt comfortable seeking help," Heineman explains.

Sometimes, the problems that are identified are fairly simple to address, he points out. "If incontinence is a problem, it may be a matter of the bathroom being too far away, and we suggest equipment or tools to help."

The Life Assess tool provides a pathway for clinicians to follow as they evaluate a patient's needs. "All of our tools are evidence-based and rely upon an interdisciplinary approach to patient care," Heineman adds.

Because the initial assessment visit usually is jam-packed with questions and forms to complete, the Life Assess evaluation usually is not performed until after the first or second regular visit, he explains. "Patients in this age group are not usually comfortable talking about depression or dementia with someone they don't know, so a visit or two is necessary for the staff member and the patient to feel comfortable discussing something other than the initial reason for home health," Heineman says.

One reason Life Assess has a positive effect on patients' quality of life is the agreement of different disciplines of care to work together on committees to plan, develop, and oversee the progress of the program, he says. Although Holy Redeemer staff members do not follow patients beyond the acute episode of care, Heineman says his agency is pursuing grant funds to set up some sort of follow-up.

Students provide care

Visiting Nurse Association (VNA) of Connecticut patients who are part of the CareLink program do receive follow-up care once they are discharged from the acute episode care provided by VNA. The CareLink program was developed by the VNA and the University of Connecticut in New Britain.

"The partnership addresses two needs," says **Karen Reid**, RN, BSN, director of public health services for the agency. "The program provides real-life training for nursing students, and it also provides free, on-going care for patients with chronic conditions once they no longer have a need for acute home health care," she explains.

Patients admitted to the CareLink program are between ages 60 and 90, with the average age being 75, says Reid. "The only other criteria for admission is that they have a chronic condition such as diabetes or cardiovascular disease, and that they are willing to learn how to control their condition," she says.

Patients with dementia or mental health issues are not eligible for the program because a key part of the student nurses' training is patient education. Therefore, the students need to work with patients capable of learning, she explains.

Once a patient is discharged from VNA into the CareLink program, student nurses take over patient care. Supervised by the nursing school with the VNA available for additional resources, the student performs health assessments, health teaching, monitoring of chronic illnesses, referrals to other resources, and telephone support. The students follow their patients throughout the semester, and they usually see between two and four patients per semester, says Reid.

"By seeing the patients for a period of time, the students have an opportunity to see the effects of their intervention," she adds. About 200 patients are enrolled in the CareLink program.

An added benefit of this program is the availability of graduate students to perform research regarding outcomes and to develop additional interventions to help patients. Pet therapy is one additional service added to CareLink as a result of data collected in the program.

Although patients are no longer under VNA care once discharged to CareLink, VNA stays involved through ongoing communication with the school of nursing, says Reid.

"The coordinator of the program is employed by both the VNA and the university, so we are able to provide resources the students may need," she says. The agency does absorb the cost of supplies such as glucometer strips, gloves, soap, and towels, but the expense is not great.

"The student nurses are not providing direct services such as wound care, so the supply cost is minimal," she says.

Patients appreciate the program because it

gives them extra support as they learn to manage chronic conditions and it also provides a sense of security, Reid points out.

"Because the student nurses are constantly assessing the patient's condition, any change or exacerbation of their condition is noticed. This has resulted in a number of patients being referred back to us for acute care in a timely manner," she explains.

[For more information on these home health programs, contact:

- ***Robert L. Heineman**, LPT, MS, MBA, Director of Rehabilitation, Holy Redeemer Home Health and Hospice Services, 12265 Townsend Road, Philadelphia, PA 19154. Phone: (215) 698-5586. E-mail: bheineman@holyredeemer.com*
- ***Karen Reid**, RN, BSN, Director of Public Health Services, Visiting Nurse Association of Central Connecticut, 205 W. Main St., New Britain, CT 06052. Phone: (860) 826-6313. E-mail: Karen@vnacc.com]*

Suggested reading

1. Bernal H, Shellman J, Reid, K. Essential concepts in developing community-university partnerships. *Public Health Nurs* 2004; 21:32-40. ■

HIPAA Q & A

[Editor's note: This 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, *Thomson American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsmjackson@cs.com]*

Question: If a covered entity is purchasing new computers to replace hardware that has been used to store and create electronic protected health information (EPHI), what actions must the organization take before disposing of the old computers?

Answer: "The security rule requires home health agencies to implement procedures for handling EPHI on old computer hardware and other electronic media that the entity will no longer be using," says **Robert W. Markette Jr.**, an Indianapolis attorney. "Because of the flexibility of the rule, home health agencies are not told specifically what they need to do. An agency's disposal procedures need to reflect reasonably anticipated threats to information on computers and other storage media that the entity is removing or replacing," he adds.

The risk comes from the way computers handle information that is deleted, Markette explains.

"When you drag a file to the trash or recycle bin and empty it, the information is not removed from the computer's hard drive," he points out. "Instead, the computer simply removes the file's address from its address book. Essentially, the computer still contains the information, but does not know where it keeps the information," he says. Someone else can use an "unerase" utility to simply scan the hard drive and determine the location of files, he explains.

The only way to truly erase a file is to write new information over the same location on the hard drive, Markette notes. If a home health agency staff member uses a wipe utility, the program will go to the location of the file to be deleted and write random information over it, he adds.

This means an entity needs to decide if placing information in the trash is sufficient or if more thorough efforts need to be taken, points out Markette.

"This decision depends upon what the agency perceives the threat to be," he explains. If the only threat is that somebody will turn on the computer and simply find files that contain EPHI, the trash may be a reasonable precaution, he says.

"If, however, you are concerned that somebody will actually attempt to recover deleted files, then a wipe utility may be appropriate," Markette suggests. "A point to remember in all of this is that no precaution is perfect," he adds.

"Even with a wipe utility, a dedicated hacker may still be able to recover something. One information technology professional tells me that the only way to ensure that no data are recovered from a discarded hard drive was to physically destroy the hard drive," he says.

"With that in mind, I would recommend that any home health agency be reasonable when implementing security rule precautions and be aware of the information that may be contained on hardware that is scheduled for replacement," Markette adds.

[For more information on the HIPAA security rule, contact:

- ***Robert W. Markette Jr.**, Attorney at Law, Gilliland & Caudill, LLP, 3905 Vincennes Road, Suite 204, Indianapolis, IN 46268. Phone: (317) 704-2400 or (800) 894-1243. Fax: (317) 704-2410. E-mail: rwm@gilliland.com]* ■

LegalEase

Understanding Laws, Rules, Regulations

New Phase II Stark rules affect provider payments

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

As many providers already know, the Stark law prohibits physicians from making referrals to providers who render "designated health services" (DHS) if the referring physicians have an ownership or investment interest in, or compensation arrangement with, the provider.

DHS generally include home health, home medical equipment, and infusion services. Likewise, providers of DHS generally cannot bill for services provided to patients referred by physicians who have ownership or investment interests in their operations, or compensations arrangements that violate the Stark law.

Exceptions to these general rules were published in the form of final regulations on Jan. 4, 2001, and are known as Phase I Stark rules. On March 26, 2004, Phase II Stark regulations were published as interim final rules in the *Federal Register*. These Phase II regulations further clarify exceptions to the statute described above.

Here are some of the provisions of the Phase II regulations:

1. **Many providers utilize the services of referring physicians as consulting physicians to their organizations.**

These consulting physicians perform a wide variety of appropriate services to providers. There is an exception for personal service arrangements that may include payments to referring physicians for consulting services. To meet the requirements of this exception, providers must ensure:

- ❒ They have a written agreement with physicians signed by providers and physicians that specifies the services covered by the arrangement.
- ❒ The arrangement covers all services to be furnished by referring physicians to providers.

This requirement is met if all separate arrangements between providers and physicians and between providers and any family members of physicians incorporate each other by reference. If they cross-reference a master list of contracts that is maintained and updated centrally, it must be available for review by the secretary of the Department of Health and Human Services upon request.

- ❒ Aggregate services provided do not exceed those that are reasonable and necessary for the legitimate business purposes of providers.
- ❒ The term of each arrangement is for at least one year.

To meet this requirement, if an arrangement is terminated during the term, with or without cause, the parties may not enter into the same or substantially the same arrangement during the remainder of the first year of the original term of the agreement.

- ❒ Compensation paid over the term of the agreement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.
- ❒ The services to be furnished under each arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal laws.

2. **Compensation paid to referring physicians who have compensation arrangements with providers must be set in advance, based upon a unit of time, such as per-hour or unit-of-service rates.**

The formula providers choose must be included in the written agreement described above, and providers must be able to verify that services actually were rendered. In addition, the formula may not be changed or modified during the term of the agreement in any manner that reflects the volume or value of referrals or other business generated by referring physicians.

Use of a formula for payment that is based upon units of service allows providers to pay a flat fee for actual participation in each of a variety of meetings, such as professional advisory board

meetings, team meetings, case conferences, interdisciplinary team meetings, and ethics committee meetings.

3. Providers must pay for services from consulting physicians at fair market value.

Many providers have asked how they should go about determining fair market value. The new Phase II Stark rules make it clear that fees paid to referring physicians for their services will be considered to be at fair market value if an hourly payment is established using either of the following two methodologies:

- ❒ The hourly rate is less than, or equal to, the average hourly rate for emergency department physician services in the relevant physician market, provided there are at least three hospitals providing emergency department services in the market.

Workbook helps prevent needlestick injuries

The Centers for Disease Control and Prevention (CDC), which has been criticized for not being more directive and aggressive on preventing needlestick injuries, has posted an impressive, interactive workbook on the issue. The document is on the web site of the CDC's Division of Healthcare Quality Promotion (www.cdc.gov/ncidod/hip).

"This workbook contains a practical plan to help health care organizations prevent sharps injuries," the CDC stated. "Once implemented, the program will help improve workplace safety for health care personnel. At the same time, it may help health care facilities meet the worker safety requirements for accrediting organizations [and] federal and state regulatory standards."

Noting that the injuries are "often preventable," the CDC estimates that 385,000 needlesticks — some 1,000 every day — are sustained by hospital-based health care personnel annually. Similar injuries occur in other health care settings, such as nursing homes, clinics, emergency care services, and private homes. Sharps injuries primarily are associated with occupational transmission of hepatitis B virus, hepatitis C virus, and HIV, but include the transmission of more than 20 other pathogens, the CDC stated.

"The true magnitude of the problem is difficult to assess because information has not been gathered on the frequency of injuries among health care personnel working in other settings [e.g., long-term care, home health care, private offices]," the CDC warned. ". . . In addition, surveys of health care personnel indicate that 50% or more do not report their occupational percutaneous injuries."

An effective sharps injury-prevention program includes several components that must work in concert to prevent health care personnel from suffering needlesticks and other sharps-related injuries. The CDC plan is designed to integrate into existing performance improvement, infection control, and safety programs. It is based on a model of continuous quality improvement, an approach that successful health care organizations increasingly are adopting. The main concept is a systematic, organizationwide approach for continually improving all processes involved in the delivery of quality products and services. The program plan also draws on concepts from the industrial hygiene profession, in which prevention interventions are prioritized based on a hierarchy of control strategies.

The workbook includes several sections that describe each of the organizational steps and operational processes. A toolkit of forms and worksheets is included to help guide program development and implementation. The workbook also contains

- Comprehensive overview of the literature on the risks and prevention of sharps injuries in health care personnel
- Description of devices with sharps injury prevention features, and factors to consider when selecting such devices
- Internet links to web sites with relevant information on sharps injury prevention
- The Joint Commission on Accreditation of Healthcare Organizations standards for surveillance of infection, environment of care, and product evaluation
- Centers for Medicare & Medicaid Services compliance with the Conditions for Medicare and Medicaid Participation
- Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard (29 CFR 1910.1030) and its related field directive, *Inspection Procedures for the Occupational Exposure to Bloodborne Pathogens Standard* (CPL 2-2.44, Nov. 5, 1999) requiring use of engineered sharps injury-prevention devices as a primary prevention strategy (www.osha.gov/SLTC/bloodbornepathogens/index.html)
- State OSHA plans that equal or exceed federal OSHA standards for preventing transmission of bloodborne pathogens to health care personnel
- State-specific legislation that also requires the use of devices with engineered sharps injury-prevention features and, in some cases, specific sharps injury reporting requirements (www.cdc.gov/niosh/ndl-law.html)
- Federal Needlestick Safety and Prevention Act (PL 106-430), (Nov. 6, 2000) ■

As a practical matter, that means providers must obtain the rates that at least three local hospitals pay physicians who staff their EDs. This information must be documented in writing and maintained by providers to demonstrate compliance. Providers should update this information periodically, and these updates also should be documented in writing.

- ❒ Providers also may choose the following method, especially if there are fewer than three hospitals providing ED services in their geographic area. They may pay physicians at an hourly rate determined by averaging the 50th percentile national compensation level for physicians with the same physician specialty or, if the specialty is not identified in the survey, for general practice in at least four of the following surveys divided by 2,000 hours:
  - Sullivan, Cotter and Associates Inc. — Physician Compensation and Productivity Survey
  - Hay Group — Physicians Compensation Survey
  - Hospital and Healthcare Compensation Services — Physician Salary Survey Report
  - Medical Group Management Association — Physician Compensation and Productivity Survey
  - ECS Watson Wyatt — Hospital and Health Care Management Compensation Report
  - William M. Mercer — Integrated Health Networks Compensation Survey

4. **The Phase II Stark rules include an exception for compliance training, which allows organizations to provide a variety of training and education from providers from whom they receive referrals.**

Under the exception, providers may offer such training to physicians, their immediate family members, and office staff who practice in the provider's local community or service area if the training is held in that area. This exception does not, however, include medical education.

"Compliance training" means

- ❒ Training regarding the basic elements of a compliance program, such as establishing policies and procedures, training of staff, internal monitoring, or reporting.
- ❒ Specific training regarding the requirements of federal and state health care programs, such as billing, coding, reasonable and necessary services, documentation, and unlawful referral arrangements.
- ❒ Training regarding other federal, state, or local laws; regulations; or rules governing the conduct of the party for whom the training is provided.

5. **Finally, all providers furnishing services for which payment may be made under the Medicare program will be required to submit information about financial relationships covered by the Stark law and regulations to the Centers for Medicare & Medicaid Services or to the Office of the Inspector General.**

Providers should promptly review their financial arrangements with referring physicians and make any modifications needed to comply with the Stark laws and regulations.

[A complete list of Elizabeth Hogue's publications is available by contacting Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Phone: (301) 421-0143. Fax: 301) 412-1699. E-mail: ehogue5 @comcast.net] ■

Avoid PCA errors with education

Don't let family members administer medication

Medication errors associated with patient-controlled analgesia (PCA) pumps most often are caused by inadequate patient and staff education, misuse by well-intentioned family members, and improper patient selection, according to results of a recent survey by the Institute for Safe Medication Practices in Huntingdon Valley, PA.

"Although our survey was informal, the health care practitioners who responded identified a number of reasons for PCA errors," says **Hedy Cohen**, RN, BSN, MS, vice president of the nonprofit organization that reviews and provides education on medication errors and adverse events to the health care industry.

One of the most frequently cited practice-related problems is incorrect programming of the PCA pump, she says. Staff may misplace a decimal point, misread a prescription, or neglect to double-check settings before beginning infusion, Cohen reports. "It is essential that staff members not only receive initial training on the pump, but that they also be retested on the pump's use frequently."

Because different brands of pumps require

PCA Resources

- A copy of the report on patient-controlled analgesia can be viewed at no cost on-line (www.ismp.org). Choose "Medication Safety Alerts" from the top navigational bar, then choose "Archives." The report is in two parts and appears in the July 10, 2003, and July 24, 2003, issues. For more about the *ISMP Medication Safety Alert* that reviews safety issues with patient-controlled analgesia, contact: The Institute for Safe Medication Practices, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006. Phone: (215) 947-7797. Fax: (215) 914-1492.
- For a free review of patient-controlled analgesia pumps conducted by ECRI, a nonprofit health research organization in Plymouth Meeting, PA, go to www.ecri.org and click on the "Patient Safety" button on the right side of the home page. Scroll down the left navigational bar to "Health Devices Alerts Special Reports," and choose JCAHO's *2003 National Patient Safety Goal for Infusion Pump Free-Flow Protection: Assessing General-Purpose and Patient-Controlled Analgesic Pumps.*

staff members to learn a variety of programming steps, it is best to choose one pump for the entire facility, Cohen adds. "It is not only more efficient, but also more effective if your nurse has to learn how to program and how to teach the patient to operate only one pump," she says.

Another frequent reason for misuse of PCA pumps is a well-meaning family member, Cohen points out. One of a PCA pump's safety features to prevent an overdose of medication is a lockout interval that prevents a patient from administering a dose within a certain time period, she continues. "Patients are supposed to evaluate their own pain level and administer medication when they feel the need. This means that a drowsy, sedated patient won't push the button for more medication."

Unfortunately, well-meaning family members or nurses may push the button and think that they are helping the patient avoid pain, when, in fact, they may be oversedating the patient, she says.

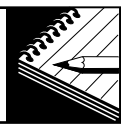
While PCA pumps are designed to prevent overmedication, this safety feature works effectively only when the patient is pushing the button, Cohen explains. If a patient already is drowsy or sedated, the patient won't push the button for more medication because he or she feels comfortable, she adds. If, however, a family member decides to push the button to help the patient avoid pain, the pump may administer the medication because the request for medication falls within proper time frames and doses, she says.

"This extra medication has resulted in oversedation, respiratory depression, and even death," Cohen adds. One way to avoid "PCA by proxy" is to hang a sign on every PCA pump that clearly states that the patient is the only person who should push the button, she suggests. "It's also important to emphasize this fact to nurses in their own education and to family members during patient education."

Proper patient selection also is critical when determining who will use a PCA pump, adds Cohen. "The patient must be mentally alert and capable of managing his or her own pain in order to be issued a PCA pump." When an infant, small child, or cognitively impaired elderly patient is assigned PCA, the staff are relying upon PCA by proxy, and that process often has errors associated with it, she adds. **(For a list of PCA resources, see box, at left.)**

PCA is an effective, safe way to control pain, Cohen explains. "The only problem is that we've become complacent because 99% of the time, there are no problems. We need to make sure we stay alert to the errors that can occur infrequently." ■

GUEST COLUMN



Managing the patient care continuum

Assess and improve continuum linkages

By **Patrice Spath**, RHIT
Brown-Spath & Associates
Forest Grove, OR

Health care delivery has grown more sophisticated and complex in response to changing patient needs and emerging technologies.

Regardless of length and breadth of the patient care continuum, the goal should be to deliver seamless, patient-centered care. However, with few exceptions, that goal has not been realized.

That concern was substantiated in the 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*, published by the Institute of Medicine. According to the report's

authors, the health care delivery system is highly fragmented and, for the most part, lacks even rudimentary information-sharing capabilities.

Case managers, nurses, and other health care support staff serve as links between physician groups, hospitals, and other health care organizations that often operate as silos. The report's authors maintain that safer, higher quality care will occur only through redesigned systems of care. The ideal health care system is, unfortunately, many years away. That is why it is so important today for health care professionals to be vigilant in assisting patients during the transition from one caregiver to another or from one level of care to another.

To effectively manage the patient care continuum, caregivers must control the transitions or handoffs in the process of care. These transitions may be between caregivers within the same setting, between services or departments within the same setting, or between caregivers in different settings.

Continuity of patient care is affected when

- Two or more components of the heath care delivery system interact during the provision of care for a patient
- There's a change in the patient's condition
- A patient moves from service to service
- A patient moves from setting to setting

Nurses, case management services, and other caregivers must facilitate the effectiveness of these transitions. High-quality patient care involves more than the excellent provision of discrete health services over a defined time period.

Everyone must help to ensure coordination between primary and specialty medical care, support services, and rehabilitation services, or follow-up care. Effective care coordination also should promote optimal personal autonomy, human dignity, and quality of life for patients.

Continuity of patient care is multidimensional. Interventions are needed to coordinate a great variety of relationships between patients, families, and health care services. Continuity of care has many facets, such as availability of information, availability or constancy of a caregiver, and follow-up services. The goal of effective management of continuity of care is to provide seamless patient transitions from one setting to another.

Of all facets of continuity, efficient flow of patient information is essential. Practitioners in every setting where the patient may receive care must have knowledge of or ready access to relevant facts about the patient. Health care organizations must help to make sure that complete and relevant information is available to all caregivers.

Effective information sharing must occur among the practitioners caring for a patient, whether in the same institution, between institutions, or between care settings.

Information continuity depends on data being up-to-date, accurate, retrievable, understood, and used. In transitions between settings of care, information is at risk of not being transferred, of being transferred but not read, of being read but misunderstood, or of being understood but discounted. ■

Nursing organization adopts 2004 platforms

The American Organization of Nurse Executives (AONE) in Washington, DC, a subsidiary of the American Hospital Association, has unveiled its policy platforms. The major policies are

- **Foreign Nurse Recruitment**

AONE supports the lawful entry of nurses from foreign countries to work in the United States and its territories provided they meet all federal qualifications for entry and practice.

It is incumbent upon institutions that recruit foreign nurses to foster an environment that is culturally sensitive and supportive as these nurses are assimilated into the American health care system.

COMING IN FUTURE MONTHS

- Overtime pay still an issue for some agencies
- Tips to improve diabetes education
- Asthma programs address minorities
- Retain good employees by training managers
- How to make sense of and use the data you collect

- **Mandatory Overtime**

It is the view of AONE that mandatory overtime is the staffing vehicle of last resort, limited to crisis situations that would put patients in danger of not receiving the basic requirements of the safe care that they require.

- **Mandated Staffing Ratios**

AONE does not support mandated nurse-staffing ratios. Mandatory nurse staffing ratios will only serve to increase stress on a health care system that is overburdened by an escalating national and international shortage of registered professional nurses and has the potential to create a greater risk to public safety.

The AONE policy statement can be found on its web site (www.hospitalconnect.com). ▼

OSHA and CDC establish hand hygiene policies

To improve hand hygiene among health care workers, the Centers for Disease Control and Prevention (CDC) recommends the use of alcohol-based hand sanitizers. Health care workers only need to use traditional soap and water if their hands are visibly soiled, according to the CDC.

The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogen Standard adds a caveat, however. OSHA requires employees to wash their hands with soap and water if they have had "occupational exposure to blood or other potentially infectious materials."

"OSHA interprets this to mean that when an employee is removing gloves and has had contact, meaning occupational exposure to blood or other potentially infectious materials [OPIM], hands must be washed with an appropriate soap and running water," wrote **Richard E. Fairfax**, director of the Directorate of Enforcement Programs, in an interpretation letter. "If a sink is not readily accessible (e.g., in the field) for instances where there has been occupational exposure, hands may be decontaminated with a hand cleanser or towelette, but must be washed with soap and running water as soon as feasible. If there has been no occupational exposure to blood or OPIM, antiseptic hand cleansers may be used as an appropriate handwashing practice," he added.

Gloves are not impervious, according to an OSHA industrial hygienist. Even if no contamination is visible after removing the gloves, soap and water still should be used, Fairfax stated. ▼

CMS tightens claims processing requirements

The Centers for Medicare & Medicaid Services (CMS) has produced an educational article explaining the changes to the Health Insurance Portability and Accountability Act (HIPAA) claims processing requirements that will take effect July 6, 2004. The changes affect all health care providers who bill Medicare Fiscal Intermediaries. Medicare now will require certain data elements that are not needed for payment of Medicare claims but are required by HIPAA. Data that Medicare previously allowed, but is not permitted by HIPAA, will result in claims rejection. Also, data that Medicare now edits only for syntax will be edited for content and will result in claims rejections if data are not valid.

Examples of changes that can result in claims rejections after July 6 include:

- For all home health claims, all line items must contain a date or dates of service for each revenue code or it will be rejected.
- Any claims that are not inpatient claims containing covered days (QTY Segment) will be rejected.

To view the article and for links to more technical documents related to the change, go to the CMS web site (www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3031.pdf). ■

CE *questions*

5. According to Marie Infante, an attorney with Mintz Levin, what steps should you take when seeking advice from a Medicare representative?
   A. Ask three different people to see if they all suggest the same thing.
   B. Rely upon your internal billing experts for your final decision on how to proceed.
   C. Follow whatever advice you are given in a telephone call.
   D. Confirm in writing that you received specific advice and are proceeding in a certain manner according to that advice.
6. Which of the following is *not* included in the Life Assess screening tool used by Holy Redeemer Home Health and Hospice Services in Philadelphia?
   A. Diabetes
   B. Risk of falling
   C. Dementia
   D. Incontinence
7. According to Robert W. Markette Jr., does HIPAA specify how an HHA must dispose of computer equipment and other storage media that might contain EPHI?
   A. Yes
   B. No
8. Which of the following are included in the new Phase II Stark regulations?
   A. There is an exception for personal service arrangements that may include payments to referring physicians for consulting services.
   B. Compensation to referring physicians must be "set in advance," based upon a unit of time, such as per-hour or unit-of-service.
   C. Providers must pay for services from consulting physicians at fair market value.
   D. The Phase II Stark rules include an exception for compliance training.
   E. All of the above

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

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. ■