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the monthly update for executives and health care professionals

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IN THIS ISSUE

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Boost satisfaction scores with key words and quick response

Staff education and involvement are keys to success

One way to make sure discharge planners, physicians, and other referral sources continue to send you new patients is to make sure your patients and their family members are happy with your services.

Ensuring your patient satisfaction program is top-notch takes more than just sending out surveys, according to winners of a national patient satisfaction improvement award offered by Press Ganey Associates in South Bend, IN. **(For other patient satisfaction improvement tips, see *Hospital Home Health*, April 2002, p. 44.)**

"The first step we took was to make sure all of our staff members were familiar with the survey and knew what questions our patients would be asked," says **Tricia Bussell**, RN, manager of Avera McKennan Home Care in Sioux Falls, SD. "While we don't write scripts for our nurses to use, we do point out how the questions are worded and remind them to use the same words when talking with their patients," she says. For example, patients are asked questions on their survey about staff members' concern for safety and privacy, as well as their explanations of medications or medical conditions. Therefore, nurses should use wording such as safety and privacy when explaining things to patients, she explains.

At Baptist Health Home Health in Heber Springs, AR, nurses also use phrases such as, "We're concerned about your privacy," or "We want your family members involved in your care," says **Ann Roberson**, RN, MSN, CNS, director of the agency. "Patients may not receive the survey forms for several weeks after discharge, so we need to make it clear during our visits that we are concerned about their privacy or safety or involvement in the care plan," she explains. The best way to ensure patients remember your concern is not to take for granted that they interpret your actions to indicate concern, she adds.

Because Bussell wants to deal with a complaint immediately rather than a couple of months later when she receives survey forms, she encourages nurses to be aware of patients' or family members' actions that indicate dissatisfaction. "If a nurse believes that the patient is not

happy about something, she reminds the patient that our home health agency wants to make sure we're providing the best possible care, and if there are any concerns, we want to know about them immediately," Bussell explains.

"Nurses handle many of the complaints immediately, but they always let me know if there was a concern expressed by the patient," she says. "This is important for me to know so that I am not caught by surprise if the patient or a family member contacts me about the same thing."

It also is important to look at complaints as a chance to evaluate your agency's service and make improvements, Bussell points out.

"When we do get complaints, they are usually related to scheduling or continuity of staff. We have initiated a performance improvement project that is looking at continuity by evaluating our scheduling practices and geographical location of patients," she explains.

The project should result in a process that increases the likelihood that the same staff person will see a patient over a period of time and should also result in a savings in mileage costs, Bussell adds. "We recognize that it is more beneficial for the same nurse to see patients each time, but we have to balance vacation time, sick leave, and weekend coverage," she says. Even with these challenges, Bussell's goal is to improve continuity of staff for each patient.

Another way her agency addresses complaints about scheduling is to take the patient's schedule into consideration when setting up visits, Bussell says. "We try to work around the family's schedule," she explains. Sometimes, this means avoiding the time slot for the patient's favorite television program, she adds. "While watching 'The Price is Right' is not important to us, it is important to the patient, so we try to respect their schedule."

Roberson's review of complaints or concerns expressed by patients showed patients don't understand their financial responsibilities. "We now have a sheet in each patient information booklet with boxes for the nurse to complete," she says. The forms indicate the expenses for which the patient will be responsible.

"If the patient's visits are covered by Medicare, we indicate that Medicare will pay in full. We leave this information in writing with the patient so that he or she, or any family member will be able to read it whenever they have questions," Roberson adds.

When reviewing results of your patient satisfaction surveys, be aware of the sample size and how that size affects results, she warns.

"We are a very small agency with only nine staff members. We don't have hundreds of patients returning surveys, so when we do have a poor rating from one or two patients, it significantly affects our overall score," she says. In this situation, be aware that it may be only a few poor ratings but also be ready to look at the reason for the complaints, Roberson adds.

"We have also noticed that when our staff members are stressed due to a change in software we use or a staff shortage caused by someone on family medical leave, our patients did complain more," she explains. This means managers must be ready to recognize times of stress for staff and counsel them not to take office-related problems into the

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patients' homes, Roberson adds.

"If you are part of a hospital system, be aware that the patient's experiences within the hospital may affect their perception of your service as well," she notes. That is why it is important to keep your staff members attuned to identifying and handling patient complaints quickly so you know which complaints are truly home care-related and which relate to previous care, Roberson says.

One way to improve staff members' recognition of the importance of a patient satisfaction program and increase their efforts to address patient satisfaction is to share the survey results with them, Bussell says. "We hold a unit meeting once each month to discuss a variety of issues, but patient satisfaction is always on the agenda. I review the results and point out areas in which we've improved or declined." She encourages group input for ideas to address weaknesses.

"When I can identify the specific clinician in a patient's complaint or compliment, I share that on a one-to-one basis with the clinician," Bussell says. "This feedback is important so that clinicians understand how patients perceive them."

Whether you contract with an outside firm to conduct your surveys or you handle them in-house, Roberson suggests you look carefully at the survey tool. "Make sure the tool fits your client base. If the form is too lengthy, hard to read, and contains repetitive questions, an older patient will get frustrated and not even complete it," she notes.

Although her agency has won Press Ganey's award for improvement of patient satisfaction scores twice in the past four years, Roberson points out that the real benefit of working to improve your patient satisfaction results isn't an award.

"We know that we provide excellent care, but the survey results prove to us and to other people throughout the hospital system that our patients also believe we provide excellent care," she stresses.

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Data can be helpful, but frustrating as well

Prioritize analysis to focus on problems

If information is power, and data are information, then home health managers may be the most powerful people in the world. Or should we say, home health managers are the most overwhelmed people in the world?

One way to transform yourself from overwhelmed to powerful is to understand the data available to you and prioritize the information you need to evaluate and successfully manage your agency, according to experts interviewed by *Hospital Home Health*.

"There are several core, key indicators from a home health Medicare perspective," says **Mark Sharp**, CPA, senior managing consultant at BKD, a Springfield, MO-based accounting and consulting firm. By focusing on these key indicators, a manager can identify opportunities for improvement, he adds.

"The first key indicator is the case-mix weight," says **Pamela Teenier**, RN, BSN, MBA, CHCE, director of Medicare operations for Gentiva Health System in Corpus Christi, TX. Because the case-mix weight is composed of 23 different elements, it is important to look at each element to see if your agency falls above or below the average, she says.

Getting down to the element is important because you can't just tell your staff members they need to improve the case-mix weight, Teenier says. For example, if your agency is below the benchmark for vision, be sure the vision assessment question is filled out appropriately, she explains.

Another reason to look at specific elements is the fact that a case-mix weight for therapy might be high for your agency due to the type of patients you have, says Teenier. A high therapy

score might make your overall case-mix weight appear to be on target, but the one high score masks low scores in other areas, she explains.

"It's also important to look at your reimbursement per episode," Sharp points out. While cost per visit is the standard unit of service used by most agencies, it is more important to look at the whole episode. Although you need to know the cost per visit to estimate the cost per episode at the start of care, care plans are designed to cover entire episodes, he adds.

If you evaluate your profit-or-loss margin on an episodic basis, you can better identify case management practices that will improve productivity of your staff, Sharp says. For example, between visits, a therapist can call patients to remind them to do the prescribed exercises each day, he suggests. "This reminder may speed up the patients' recovery and get them discharged earlier."

Teenier also advocates a close look at utilization management. If your agency's number of visits per episode exceeds the benchmark level, there are several steps to take, she suggests.

"Evaluate telemedicine as one way to decrease visits without compromising outcomes," she says. **(For more information about telemedicine, see *Hospital Home Health*, November 2003, pp. 124-126.)** Another tactic to monitoring utilization management is to put an internal authorization process into place, Teenier recommends.

This approach requires a field staff member to get authorization from a supervisor to add extra visits to the number of visits identified in the initial care plan, she explains. While extra visits will be approved if necessary, the need to get authorization and provide an explanation of the need usually makes nurses evaluate case management methods up front, Teenier adds.

Are your adjustments high?

Adjustments, such as low utilization payment adjustments (LUPA), should be monitored carefully, Teenier explains. If a published benchmark for LUPAs is 10% and your agency has more than 10%, you are providing care in fewer visits than other agencies. "If this is the case, you might claim to have a stellar staff, but you need to consider other reasons as well," she says.

Another area that causes a significant adjustment is when a patient meets the high therapy threshold, which is 10 or more physical, occupational, or speech therapy visits, and for various reasons, 10 or move visits were not provided, Teenier says. Avoid therapy downcoding by making sure you do not predict more visits than needed at the beginning of the episode, she suggests.

Even if your agency has few LUPAs, be sure the episodes that include only five or six visits are legitimate, Teenier warns. With the LUPA threshold at four visits, the Centers for Medicare & Medicaid Services will look at episodes with only one or two visits over the LUPA threshold. "Make sure that those visits are not added just to avoid a LUPA," she adds.

Software and national benchmark companies can provide the benchmark information you can use to evaluate your data, says Sharp. You can also use Medicare's annual cost report to gather benchmark data.

"You can find benchmark information in a number of publications, at conferences and seminars or through state associations," says Teenier. Even if you are a small agency without the budget to subscribe to ongoing benchmarking services, it is important to evaluate your information regularly against some industry benchmarks, she adds.

If you use the annual Medicare cost report to provide your benchmarks, don't evaluate your information only once each year, points out Sharp. By the time the annual cost report is produced, the information included may be as old as 18 months, he explains. "Looking at information once each year, using old data, is not timely enough to make changes that are effective." For this reason, evaluate your data at least monthly or quarterly, he suggests.

Smaller agencies may not accumulate enough data to produce accurate results on a monthly basis, but quarterly reviews of the data are essential for any size agency, Teenier notes.

Whatever time frame you use to perform your evaluation, be sure to prioritize the data you analyze, says Sharp. "Start at the highest level of data, focusing on the few key indicators that can affect performance, then dig further when those indicators are out of whack." By focusing on indicators that don't meet benchmark parameters, you can use your time more effectively, he adds.

Teenier also points out that home health managers need to realize that the volumes of data reports won't identify the solutions but will identify the areas in which opportunities for improvement exist.

She admits data can be frustrating because "data don't provide answers; they just raise more questions."

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Health workers need influenza immunization

APIC calls for increase in low rates

In response to the unacceptably low influenza immunization rates among health care workers, the Association for Professionals in Infection Control and Epidemiology (APIC) issued specific recommendations to health care facilities to develop and implement comprehensive influenza vaccination programs for employees.

APIC is a nonprofit professional association composed of more than 10,000 members whose responsibility is the prevention and control of infections and related adverse outcomes in patients and health care workers. APIC's new recommendations were published in the May issue of the *American Journal of Injection Control*. **(To see the highlights of the recommendations, see box, at right.)**

Only 36% of health care workers receive an annual influenza vaccination despite long-standing recommendations by the Centers for Disease Control and Prevention (CDC) and other organizations. Health care workers are at high risk for acquiring influenza infection due to their exposure to ill patients as well as their exposure in the community. Health care workers are defined here as all personnel who have contact with patients, both medical and nonmedical, because when these staff are infected with influenza, they can spread the virus to patients in their care.

Research, in fact, suggests health care workers can be a key source of institutional outbreaks, contributing to increased morbidity and mortality among vulnerable patients.

"Greater emphasis needs to be placed on improving influenza immunization rates among health care workers to help ensure patient safety and protection — especially for patients at increased risk of influenza-related complications," said **Jeanne A. Pfeiffer**, RN, MPH, CIC, APIC president.

"Immunization also provides personal protection for health care workers and minimizes work force absenteeism during the influenza season," she explained.

Health care workers encounter patients throughout the influenza season in a variety of settings, including medical practices, general hospitals, specialty hospitals, pediatric hospitals, long-term care facilities, emergency departments, ambulatory care settings, rehabilitation facilities and home care sites.

Studies show health care workers are more likely to work through illness and return to work sooner when they are ill, thus increasing the likelihood of virus transmission to patients in their care and co-workers.

In addition, institutional influenza outbreaks can have serious implications for both the patient and health care provider. These events can put patients at risk, result in or exacerbate existing staff shortages, curtail admissions, and increase health care costs.

Vaccination is the primary means of reducing

Recommendations for Health Facilities' Immunizations

APIC recommends that all health care facilities develop and implement comprehensive influenza vaccination programs for employees. Highlights of APIC's new recommendations include:

- Prepare a written policy stressing the need and importance of annual influenza vaccination annually for health care workers.
- Implement influenza immunization programs annually, including health care worker education on influenza vaccination.
- Monitor annual immunization rates and providing feedback regarding program success.
- Increase access to vaccination by removing associated costs and making vaccine easily accessible.
- Facilitate administration of vaccination to health care workers in all settings.

Source: Association for Professionals in Infection Control and Epidemiology, Washington, DC.

influenza transmission and preventing infection from the influenza virus. Each year, the infection causes an average of 36,000 deaths and 114,000 hospitalizations in the United States.

"Health care facilities have an important role to play in maximizing influenza vaccination rates in health care workers," Pfeiffer said. "Every facility should develop and implement comprehensive influenza vaccination programs for employees."

APIC initiated a multifaceted initiative in January 2004 aimed at increasing influenza immunization rates among health care workers. As a result, APIC is completing a membership survey to assess the state of employee influenza immunization programs at members' institutions across the country.

In addition, APIC is developing new resources for infection control professionals and other health care providers that will help encourage institutions to implement formal influenza control policies.

APIC's initiative, including the survey results and new professional resources, will be highlighted at its 31st Annual Educational Conference in Phoenix, June 9, 2004.

[More information on APIC's position statement on health care worker influenza immunization can be found on-line at www.apic.org

For the most current CDC Advisory Committee on Immunization Practice recommendations for influenza immunization, go to www.cdc.gov/mmwr/preview/mmwrhtml/rr53e430a1.htm] ■

Report links nursing care to patient safety

Overworked staff can affect patient safety

Do nurses at your agency complain they are overworked and understaffed? If so, you may have a bigger problem than retention on your hands — compelling new evidence suggests poor nursing conditions put patients in danger.

Patients may be harmed due to fatigued nurses coping with inefficient work processes, intimidating and unsupportive leaders, and an organizational culture of blame, according to *Keeping Patients Safe: Transforming the Work Environment of Nurses,* recently released by the Washington, DC-based Institutes of Medicine (IOM).

"Quality managers should pay close attention," urges **Lillee Gelinas**, RN, MSN, vice president and chief nursing officer for VHA Inc. and co-chair of a National Quality Forum (NQF) committee that reported on core measures assessing nursing care. "This is not just another report coming out of Washington — it is enormously important and is taking the industry by storm. It has shocked a lot of people."

In addition, the NQF has endorsed a set of 15 Nursing-Sensitive Performance Measures to provide a framework for evaluating the quality of nursing care. "These are 15 measures that hospitals need to be accumulating data around and reporting," Gelinas says. (For information, go to www.qualityforum.org and click on "Nursing Care Measures Project.")

This is the first set of voluntary consensus standards to look at nursing care specifically, explains **Kenneth W. Kizer**, MD, MPH, president and CEO of NQF. "Some health systems may have measured this internally, but this is the first attempt to put national measures in place," he notes.

What's more, the emphasis on nursing will continue to increase in the quality world, Kizer predicts, adding that there is no question that nursing is closely linked to quality and patient outcomes. "Now that we can view nursing care though the objective lens of performance measures, this will become increasingly recognized."

There are no current plans to report the data publicly, but that could change, he says. "It is reasonable to assume that at some point, it will be made public, because that is the direction we're going in."

Kizer points to widespread coverage of the nursing home measures endorsed by NQF in 2003. "These are reported in newspapers across the country routinely. While the hospital measures are being made available on web sites, they are not necessarily reported in newspapers. But that is just a matter of time."

When this occurs, he adds, patients will be better informed about health care quality than ever. "As consumers get more knowledgeable, they will be looking for this information, just as people now look at reports comparing automobiles, washers, and toasters and everything else."

Since these 15 measures may end up being publicly reported in the future, it gives you an added incentive to improve, Gelinas advises.

"You want to make sure they're good data being publicly reported and not halfway good

data. Can you imagine if your failure-to-rescue data are not the cleanest, so they show a high failure to rescue rate, and that gets published? You don't want that for your organization." If and when the new measures are publicly reported, patients may begin asking their physicians questions such as, "What is the nursing turnover rate for the [agency]?" she points out. "It's not something patients would normally ask. But we know that has an impact on how good your nursing care will be and whether you'll be put at risk or not."

It's possible that you already are collecting the data you'll need for the new nursing care measures, such as smoking cessation counseling for pneumonia patients. "Quality managers may well be collecting this information already," Kizer says.

Regardless, your data collection burdens are unlikely to decrease anytime soon, so you'll need to develop ways to streamline the process. "There will be more and more performance measurement and reporting down the road," he adds.

"We are just at the beginning of the era of making health care much more transparent and accountable. This is just the latest development in performance measurement and reporting. Stay tuned: There are others to follow," Kizer continues.

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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*, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsm jackson@cs.com]*

Question: Do the security regulations address wireless security? How does an organization make sure any of its wireless devices are in compliance with HIPAA regulations?

Answer: "The security rule does not distinguish between wireless and wired electronic transmissions," points out **Robert Markette Jr.**, an Indianapolis-based attorney.

"You need to assess the risks associated with your wireless network in the same manner that you would assess the risks to your wired network. Obviously, the mode of attack on a wireless network can be different than an attack on a wired network," he says.

"With a wireless network, a hacker can usually sit outside of your office, such as in a parking lot, and intercept transmissions. Because the wireless transmissions are encrypted between the computer and the wireless router, a hacker needs to intercept packets of information to attempt to decrypt the transmissions," Markette explains.

"This means that the first thing you should evaluate is whether you can access your wireless network from outside of your office," he says.

"This can be done quite easily, Markette notes. "Simply take a laptop that is equipped for wireless networking and walk the exterior perimeter of your office," he says.

"Start in a place where people can be outside for a period of time without be detected such as a parking lot," Markette suggests.

Another wireless security issue to consider is employees who travel with laptops accessing electronic personal health information (EPHI) using public wireless hot spots, he points out. This is a situation in which EPHI may be transmitted in fashion with which the home health agency may not be comfortable, due to the potential for eavesdropping, Markette says.

For this reason, a home health agency may not want employees using their wireless-enabled laptops from public places or, in some cases, their homes unless the agency has tested the security of those locations.

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LegalEase

Understanding Laws, Rules, Regulations

Changes for Medicare termination notices

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

A recent ruling in *Healey v. Thompson* may mean that home health agencies (HHAs) will be required to provide notice to Medicare patients whenever services are reduced or discontinued for any reason.

That lawsuit was filed in 1998 just after implementation of the interim payment system. The goal of the lawsuit was to force HHAs to provide greater procedural protections before reducing or terminating services to Medicare beneficiaries.

There have been two previous court decisions in this case. In *Healey* I, the judge ruled that Medicare beneficiaries have a legal right to receive written notice from an HHA before services are reduced or terminated because the patient no longer meets the eligibility requirements of the Medicare home health benefit.

Recent multiple revisions to Advanced Beneficiary Notices (ABNs) were, at least in part, a result of this court decision.

In *Healey* II, the court declined to extend the notice requirement required by *Healey* I to reductions or termination of services for reasons other than failure to meet the eligibility criteria of the Medicare home care benefit, including physicians' failure to certify plans of care for patients. Consequently, agencies currently are not required to provide ABNs to patients if physicians do not provide orders for services.

The case was appealed to the U.S. Court of Appeals for the Second Circuit, which reached a decision Feb. 26, 2004.

Specifically, the court decided:

1. The Medicare statute requires notice to beneficiaries whenever an HHA reduces or terminates home health services regardless of whether the reason for that change is a Medicare coverage determination, lack of physician certification, an agency's unwillingness to provide services for business reasons unrelated to coverage or "sheer caprice."
2. Although notice prior to reductions or termination of services may be required, no review of such decisions (i.e., pre-deprivation review) is required.

Agencies should be concerned about what happens next. First, either party to the lawsuit may decide to appeal the court's most recent ruling. If either side appeals, agencies must wait for further court decisions.

But if neither side appeals, the case will be returned to a lower court to work out the details of providing notice to beneficiaries in the event of reductions or terminations of services for any reason.

What should agencies do now?

1. Agencies should NOT change their current practices with regard to provision of ABNs to patients. Patients should receive a home health agency ABN when they no longer meet the eligibility criteria of the Medicare home health benefit and there are physicians' orders for care.
2. Whether on appeal or as the details of additional notice are worked out, the realities of the provision of home health services must be considered. For example, it does not appear that the plaintiffs and the court have considered that services often are reduced or discontinued because patients have met the goals of their plans of care. Does the court really mean to require agencies to provide notice of termination/reduction of services under these circumstances? If so, will such notice be required in the form of an ABN with all of the current requirements for delivery, patients' signatures, etc? If so, agencies may have to expend considerable time and resources in meeting such requirements. Agencies should work with their trade associations to be heard with regard to these and other issues that do not yet appear to have been considered.
3. With regard to termination of services for other reasons such as noncompliance, violence, or threatened violence, agencies already should provide both verbal and written notice prior to discontinuation of services. But if the court decides that such notices must be given in the form of an ABN with current requirements for delivery, agencies may have an additional burden to meet. They should, therefore, closely

monitor developments in this case.

The *Healey* case has been pending since 1998. It may continue for many years to come. Stay tuned!

To obtain a complete set of policies and procedures governing termination of services to patients under a variety of circumstances, send a check for $105 (includes shipping and handling) made out to Elizabeth E. Hogue, Esq. at the address below.

[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) 421-1699. E-mail: ehogue5@Comcast.net] ■

Target marketing to baby boomers

Aim to reach the decision makers

Educating physicians about the cost-effective, high-quality care provided by your agency is only half of the marketing equation. Patients are the other half; and in many ways, they're a tougher nut to crack.

While most home health care patients are older Medicare beneficiaries, they can be a diverse lot, especially if you account for the fact that their middle-aged children may be the decision makers for medical care.

As the nation's population grows older, baby boomers — the proverbial cow making its way down the python's gullet of U.S. health care — will be faced not only with their parents' mortality, but their own as well.

An influential group

Boomers have been characterized as a group that is accustomed to being in control. It was the boomer-aged women who prompted hospitals to rethink their approach to labor and delivery. They demanded more choices and greater power in the process and changed an industry as a result.

Baby boomers are poised to change the home health care industry in much the same way. They will watch their parents go through the dying process, and that experience will provide the basis for their own choices regarding home health care. Home health agencies have every reason to make that experience as good as possible.

According to **Kristen Wolf**, president of Spitfire Strategies, a Washington, DC-based communications consulting firm that helps organizations effect social change, targeting marketing efforts toward health care decision makers within a family and those who have influence on family decisions can go a long way.

The traditional home health care marketing approach can be summed up simply: "Get the word out." That usually entails producing brochures and videos explaining the agency's philosophy.

At its best, that approach is a rational way of increasing awareness, but it's less effective as a way to reach a middle-aged daughter confronted with the declining health of a parent.

"These are emotional times," Wolf adds. "Your marketing cannot be rational."

In other words, brochures or nurses explaining home health care may not be enough. In a time of crisis, the home health message will be lost if it is not delivered by a figure of trust.

You have to target marketing to those who have an emotional connection to the patient or family. For example, clergy can have a tremendous influence on families in times of crisis.

A targeted marketing approach begins with understanding exactly who you are trying to reach. Look for the gatekeepers, Wolf says. These are the people who are advisors to patients and their families.

Once you determine who your target is — women in their 40s, for example, because they are the primary medical decision makers for elderly parents — ask yourself this question: What motivates this population to seek home health for a family member? There may be a number of answers, such as guilt, fear of watching loved ones suffer, or dissatisfaction with current medical care.

Targeted marketing is nothing new. It's omnipresent. Just look at the wide variety of television ads. Fast-food companies aim their messages at a variety of different audiences. Cereal boxes are designed to appeal to children because producers know children can affect the buying habits of their parents.

"If you want to grow your customer base, you'll have to target your marketing," Wolf concludes. ■

NEWS BRIEFS

CMS to slow payments of noncompliant claims

Beginning July 1, 2004, the Centers for Medicare & Medicaid Services (CMS) will pay claims no earlier than 27 days after receipt of the claim instead of the current 14 days, if the claim is not compliant with the Health Insurance Portability and Accountability Act (HIPAA) transactions standard.

While CMS calls the operational change an incentive to meet HIPAA standards and a "measured step toward ending the contingency plan for payment of electronic claims," others claim that it unfairly penalizes some organizations. **Lawrence Hughes**, regulatory counsel for the American Hospital Association points out that "slowing down payments burdens and penalizes only the provider when the problem may be a trading partner who is not ready to use, transmit, or accept the standardized transactions. It doesn't create an incentive for other critical partners involved in the transactions process, such as vendors, clearinghouses, or carriers, to cooperate and work diligently with providers in moving compliance forward." ▼

10 most common health care mistakes by seniors

Based upon information gathered for educational courses and books, the Institute for Healthcare Advancement (IHA) in La Habra, CA, has identified the 10 most common health care mistakes made by seniors.

"Seniors are enjoying themselves and remaining active much later in life," says **Gloria Mayer**, RN, EdD, president and chief executive officer of IHA. "But they must also take charge of their health care," she adds.

By identifying key areas in which seniors make mistakes, the institute hopes to further education of seniors as well as family members. The most common mistakes identified by IHA are:

- Driving when it's no longer safe
- Fighting the aging process and its appearance by refusing to wear eyeglasses, hearing aids, or dentures as well as refusing to use walking aids
- Reluctance to discuss intimate health problems such as urinary difficulties with a doctor or health care provider
- Not understanding what the doctor has told them about their health problem or medical condition and not asking for further explanations
- Disregarding the serious potential for a fall by keeping scatter rugs and poor lighting in their homes
- Failure to have a system or plan, such as pillboxes, written daily schedule, or check-off record, for managing medications
- Not having a single primary care physician who looks at an overall medical plan for treatment to avoid multiple medical regimens that might cause adverse reactions
- Not seeking medical attention when early possible warning signs occur
- Failure to participate in preventive programs
- Not asking loved ones for help for reasons such as stubborn personalities, a desire for independence, or early signs of dementia

An easy-to-read, easy-to-understand self-help book for senior citizens — *What to Do for Senior Health* — has been published by IHA. For information or to order the book, call (800) 434-4633 or go to www.iha4health.org and click on "Bookstore" link. The cost of the book is $12.95. ▼

Self-disclosure reduces penalties

A hospital in Greenville, SC, will pay nearly $9.5 million to resolve Medicare billing improprieties from 1997 through 1999 in its home health, hospice, and durable medical equipment programs, the Office of Inspector General (OIG) announced recently. The settlement is the largest reached in such cases. **Dara Corrigan**, acting principal deputy inspector general, announced the settlement with St. Francis Hospital, which self-disclosed the improper billing.

When purchasing St. Francis in 2000, Bon Secours Health System discovered billing and documentation problems at the hospital. Bon Secours then launched an internal investigation

that revealed "significant error rates and systematic documentation lapses" in St. Francis' Medicare billings, Corrigan said. The hospital brought its findings to OIG under the Self-Disclosure Protocol, which encourages providers to approach the government voluntarily when they uncover evidence of potential fraud and compliance problems in their organizations.

Under the Self-Disclosure Protocol, OIG outlines how providers should investigate and audit compliance problems and how OIG will work with disclosing providers to resolve the situation. Corrigan said St. Francis was subject to much higher penalties than the settlement amount, but because the organization self-disclosed and quickly took corrective steps to remedy the problems, OIG took a cooperative approach to remediation. ▼

Improving outcomes in pain management

Kathleen Rose, RN, MSHSA, president and CEO of Vineyard Nursing Association, and Sandi Corr-Dolby, RN, clinical director of Vineyard Nursing, will present "How to Integrate Pain Standards and Palliative Care Principles into a Home Care Agency: A Case Study" at the 22nd Annual Meeting and Exhibition of the Visiting Nurse Associations of America. The educational conference will be held April 21-23, 2004, at the Hyatt Regency in New Orleans.

In their 90 minute program, Rose and Corr-Dolby will demonstrate how Vineyard Nursing, a full-service home care agency located on Martha's Vineyard Island 25 miles south of Cape Cod, MA, has achieved measurable improvement in its chronic pain management program since implementing new administrative and clinical procedures developed by Pain Resources Network (PRN) of Melrose, MA.

PRN president Cathy Schutt, RN, MS, ANP, will join Rose and Corr-Dolby in discussing how systemwide changes and interactive clinical tools have helped Vineyard Nursing meet or exceed the standards recommended for pain and palliative care by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other regulatory agencies.

"We knew our staff members were highly skilled in traditional curative care practices, but the long-term nature of illness experienced by a large percentage of our client population made us realize that we needed to improve the quality of the palliative care we delivered as well," Rose explains. "To do this, we needed to address our chronically ill patients' very subjective pain and symptom management needs more consistently and effectively. We wanted to adopt a comprehensive, interdisciplinary approach to patient care that would view pain as the fifth vital sign. We wanted to integrate the diagnosis and treatment of pain and its related symptoms into our daily clinical routine."

Pain Resources Network worked with Vineyard Nursing to assess the situation, establish goals and objectives, redesign administrative and clinical practices and procedures to accommodate the implementation of recommended pain standards, and train the entire interdisciplinary team in effective pain management and palliative care.

PRN also developed hands-on clinical tools that would help each member of the health care team assess pain more accurately, carry out appropriate interventions more confidently, and communicate more consistently with patients, families, and each other.

"We at Vineyard Nursing are now very confident when dealing with our patients' chronic pain symptoms," Rose says. "The ways in which our staff interacts with patients, families, MDs, and colleagues are measurably more consistent and effective. Our pain and palliative care outcomes have achieved the standards of care set forth by JCAHO, and we have significantly improved the quality of life for those patients who are not heading toward a cure. We are very committed to continuing this program and to training others with whom we work as well."

The pain management and palliative care program being used by Vineyard Nursing is available to all health care providers in the form of an

COMING IN FUTURE MONTHS

- Are your eating policies culturally savvy?
- Tips to help your wound care patients heal
- Design productivity measurements with your staff in mind
- Is a disease management program right for your agency?
- How one agency became a community advocate for its patients

implementation and training system called *Integrating JCAHO Pain Standards: Strategies and Tools for Non-Acute Settings*, published by Pain Resources Network.

For information, go to www.painstandards.com or call Kris Gravina at (781) 620-1919. ■

CE *questions*

9. How did Baptist Health Home Health address the problem identified by patient complaints related to misunderstandings of financial obligations, according to Ann Roberson, RN, MSN, CNS, director of the agency?
   A. Set up a telephone hotline for patients and family members.
   B. Nurses talked about financial responsibilities at each visit.
   C. Referred the family to the proper insurance company or Medicare.
   D. Created a form for the patient information booklet upon which nurses can write the information for the patient to keep.
10. What is the best use of a home health manager's time when evaluating data to determine the state of the agency's financial performance, according to Mark Sharp, CPA, senior managing consultant at BKD, a Springfield, MO-based accounting and consulting firm?
    A. Assign the job to several different people.
    B. Hire outside consultants to perform the task.
    C. Prioritize the data and indicators that are to be evaluated.
    D. Perform the analysis only once each year
11. Which of the following reasons does the Association for Professionals in Infection control and Epidemiology give for strongly recommending that health care workers get an annual influenza immunization?
    A. Prevent spreading the virus to their patients.
    B. Protect themselves from getting influenza.
    C. Minimize work force absenteeism during the influenza season.
    D. all of the above
12. According to Elizabeth Hogue, patients should receive a home health agency ABN when they no longer meet the eligibility criteria of the Medicare home health benefit and there are physicians' orders for care.
    A. true
    B. false

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

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. ■