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IN THIS ISSUE

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Set your agency apart with specialty programs and disease management

Choose specialties you already may serve

"We do a great job. Everyone loves our nurses, and our outcomes are great."

You may feel this way about your agency, and it may be true. But is it enough to make your agency stand out from the dozens or hundreds of agencies with which you compete?

The challenge in marketing a home health agency is that every agency sounds the same, says **Alison Cherney**, a marketing consultant with Cherney and Associates in Brentwood, TN.

"Everyone offers the same basic service 24 hours each day, seven days each week," she says. "A home health manager needs to find a way to differentiate his or her agency by providing the service in a way that is better and different from competitors," she says.

"Nordstrom is a retail store like many other retail stores, but people choose to shop at Nordstrom because the customer service is better," Cherney explains.

"Just as Nordstrom offers personal shoppers and friendly employees, a home health agency can offer an intake process that is easier and more efficient, an assessment process that is more thorough and includes better communications, and a discharge process that results in patients who are better prepared to manage their conditions on their own," she points out.

Another way to differentiate your agency from other agencies is to develop a disease management program, or to promote a special expertise your agency has, Cherney suggests.

One way to succeed in today's health care market is to specialize, she says. "Many agencies may already have a specialty, but it isn't packaged and promoted as a specialty," she says.

For example, a home health agency may provide services for a large number of diabetic or wound care patients by using employees with extra training to handle these patients, Cherney notes.

"If you already provide the care, you just need to take a few steps to make sure you are meeting the needs of the special population, and

then promote yourself as an expert," she says.

An advisory board that includes physicians and other experts related to the disease management program can give you some good ideas about features that are important for a successful program, Cherney says.

"Package your service by medical specialty, such as respiratory or heart, or by disease such as diabetes," she adds.

To find the right service for your agency, look at your current patient population, says **Amor Bango**, RN, BSN, director of clinical operations at Visiting Nurse Association of Central New York (VNA) in Syracuse, NY.

Two years ago, Bango and other managers noticed that more than 20% of their new admissions were for cardiac-related reasons and about 33% of all of their patients had cardiac disease even if it wasn't the reason for admission to home health. Congestive heart failure is the strongest reason for readmission to the hospital for VNA's home health patients.

Therefore, the agency management developed a team to focus on heart patients and improve monitoring and education for this group, Bango says. The program was launched in February 2003.

"We developed a cardiac team and named the program Heart Smart, says **Diane Nanno**, RN, BSN, clinical nurse manager for VNA. But the agency did more than just create a name.

"We chose nurses for the team that either have a strong interest in cardiac care or a background in cardiac care," she says. All of the nurses are also experienced home health nurses, she adds.

The Heart Smart nurses, who were chosen from existing staff members, underwent intensive training to learn more about cardiac disease, diagnosis, and medications used to treat cardiac disease, Nanno explains.

The education continues on a monthly basis as Heart Smart team members meet to discuss the program, patients, and new articles or research that relate to their patients' condition, she adds. "We also look for inservice opportunities using outside experts that can increase our knowledge," she says.

In addition to equipment such as pulse oximeters and scales, the agency developed a teaching guide that serves as a written record of the patient's daily status as well as a reference guide to support patients when the nurse is not in the home, Nanno continues. There was no need for a large financial investment to develop the program because it did not require anything that they weren't already doing, except the specialized education for the nurses, she says.

The benefits to the agency include a more positive relationship with referring physicians and a new relationship with a local hospital that has set up a program for patients with advanced heart failure, Bango says. **(For more details about the Heart Smart program, see box, p. 75.)**

Sometimes, the specialty doesn't relate to clinical issues, as discovered by the staff at Wellspring Personal Care in Chicago. "When I joined this agency, I was struck by the number of our clients

(Continued on page 76)

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Cardiac program helps patients and agency's image

Heart Smart program brings positive results

What do you do when you find that more than 20% of your new admissions are for cardiac-related reasons and about 33% of your patients have cardiac disease, even if it isn't the reason for admission to home health?

If you are the staff at Visiting Nurse Association of Central New York (VNA) in Syracuse, you put together a special team of employees who work only with cardiac care patients and call it Heart Smart.

The Heart Smart program increased the agency's exposure as an expert in home care for heart patients and also decreased hospital readmissions for congestive heart failure patients, says **Mary P. Hussain**, RN, MSRN, CNS, clinical nurse specialist for Heart Smart.

Staff members on the Heart Smart team undergo intensive training related to cardiac disease to help them become experts on their patients care, she says.

Comprehensive patient education is used to teach patients to recognize signs that indicate changes in their condition and take steps to improve their condition, Hussain explains.

Heart Smart patients see the same staff members each visit except in cases of staff vacation or illness, she says.

"This continuity improves the effectiveness of patient teaching because the nurse knows what has been taught," Hussain points out. The continuity also strengthens the relationship between the nurses and the patients and family members, she says. If a staff member is unavailable, another nurse who is member of the cardiac team makes the visit, Hussain notes.

The strong relationship improves a patients' desire to follow instructions on daily weight monitoring and other activities to control and monitor their conditions. It also results in the patients' being less likely to go to the physicians' offices or emergency departments for changes that might be controlled at home, Hussain adds.

"Our patients are comfortable calling us to report changes in their condition," she explains. For example, each patient monitors weight on a daily basis and is given parameters for weight control, Hussain says. If a patient's weight exceeds those parameters, the patient knows to call the nurse, she adds.

This call gives the home health nurse a chance to talk with the patient to determine what might have caused the weight gain and to make a home visit to assess the patient. "Our immediate intervention can usually prevent a hospital admission," Hussain adds.

The Heart Smart program focuses upon patient education to keep patients at home and out of the hospital. "We follow a clinical path that includes skilled nursing, physical therapy, and nutritional evaluations as our approach to improving the patient's quality of life," says **Diane Nanno**, RN, BSN, clinical nurse manager for VNA.

"We've also developed a teaching manual that not only explains how to monitor with pulse oximetry and daily weight, but also gives the patients and nurses a place to write the information, including vital signs taken at visits, as it is obtained," she says. This informal medical record serves as an excellent method of communication for a nurse or therapist who might fill in for a staff member on vacation as well as for family members, she adds.

A nurse visits a new Heart Smart patient three times in the first week of admission. The nurse next makes two visits for two weeks, and then weekly visits up to six weeks, says Hussain. "Between visits, we check on patients by telephone, and we add visits as needed," she says.

Because the program relies heavily on education, a patient must be teachable or must have a teachable in-home caregiver to be eligible for Heart Smart, according to Hussain.

Although the program is about one year old, there have been some positive results in terms of recognition for the agency, says **Amor Bango,** RN, BSN, director of clinical operations. "In February 2004, we were asked to provide the home care component for patients of a local hospital that developed a clinic for heart patients receiving nesiritide, an intravenous medication to treat symptoms of patients suffering advanced heart failure," she says.

The patients receive the infusion at the hospital clinic, then Bango's staff is responsible for patient education, monitoring any side effects, and assessing the patient's condition, she explains.

"We would never have been contacted if we had not developed the reputation as an agency that specialized in care of cardiac patients," she adds.

"I've also noticed that communications between cardiologists and our nurses are greatly improved because there is a new level of respect for these nurses who have become experts on heart patients," says Hussain. And the fact that there is one nurse who knows the patient very well is another advantage for the physician, she adds.

The best thing about the program is the fact that focusing on this group of patients was relatively easy, Hussain says.

"We were already providing excellent care. This program just enhances that care and gives the nurses a chance to increase their knowledge and expertise," she notes. ■

who came to us after exploitation by a family member or other in-home caregiver," says **Gwen W. Watkins**, MSW, LSW, director of marketing for the agency.

In addition to the medical issues of the patient, Wellspring staff members were dealing with emotional issues related to the patient's experience following financial exploitation by people they previously trusted, she says.

The agency's reputation and record of responsiveness had created a group of attorneys and bank trust officers that would call upon the agency when a case of exploitation was discovered or suspected, Watkins says.

Although the agency didn't purposely choose to specialize in this type of case, she realized that it was important to define the process to make sure the patient was protected.

Allowing victims to stay at home

"When an older adult falls victim to exploitation, a nursing home often is considered the best place to protect them from further exploitation," Watkins says.

"We wanted to provide a service that enables the person to stay in the home," she points out.

The program includes a "SWAT" team that sees the client within 24 hours of a referral from an attorney, bank trust officer, physician, or even another family member who suspects abuse. "We go into the home to evaluate the patient's health and assess the home environment."

Because staff members are trained to recognize signs of both physical and emotional abuse, they are able to recognize and document any indication that there may be something going on, Watkins adds. **(For more information on the Wellspring elder abuse program, see story, p. 77.)**

Marketing of the program includes educational articles related to elder abuse as well as presentations to groups that might come in contact with victims, such as bank trust officers and attorneys, says Watkins.

The signs of financial exploitation can be as obvious as a request to change a will or a power of attorney to someone not known to the family or to a family member who has not been involved in the care of the senior. Or it can be as subtle as a caregiver isolating the senior from contact with others, she explains.

Both Wellspring and the VNA programs were willing to change traditional approaches to meet the needs of the clients. "A willingness to change processes or organizational structure is important to create an effective disease management or special expertise program," Cherney points out.

"Nothing is worse than saying you have a program specially designed for one group, [and] then providing a service that does not differ from every other service you offer," she says.

Also, make sure your intake, billing, and other administrative areas of your agency are doing their jobs well, Cherney notes.

"Even if your clinical program is excellent, if referral sources can't get through to send you patients, you won't succeed," she explains.

Now that the Heart Smart program is established, staff members at VNA are looking at other groups of patients that might benefit from a disease management program, says Bango.

"We are developing a wound care resource team, and we're evaluating the use of telemedicine to enhance the cardiac program as well as support other patients," she says.

While development of a disease management program or a special focus may give you a marketing edge over your competitors, Bango says it is also a natural move for home health agencies today.

"I've been in home care for over 30 years, and for most of that time, you had to know a little bit about everything," she says.

"Today, home care patients are more ill, their care is more complicated, and they have less family support, so home health nurses need to know more about specific conditions, Bango adds. "Nurses appreciate the opportunity to become experts, and they are rewarded by seeing the impact they have when they can focus on one type of patient."

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Agency offers protection for victims of elder abuse

Safe environment, predictable routine lead to recovery

More than 12% of the substantiated elder abuse cases reported involve financial or material exploitation, according to statistics compiled by the National Center on Elder Abuse. Caring for victims of exploitation after the abuser is removed requires more than just meeting their medical and daily living needs, says **Gwen W. Watkins**, MSW, LSW, director of marketing for Wellspring Personal Care in Chicago.

"These patients have been traumatized by a family member or other person who they trusted, and we have to create a sense of order and safety for them before they can begin to recover," she points out.

Wellspring's team for elder abuse consists of nurses, aides, and social workers trained to recognize signs of abuse, including physical, emotional, and financial, and to work with the patient to develop a trusting relationship, she says.

Once the agency receives a referral from a bank trust officer, attorney, or family member who suspects abuse, a team responds within 24 hours to assess the patient's medical condition as well as the home environment.

If there are signs of abuse, they are reported to the referral source or to the appropriate authorities, Watkins explains.

Signs of neglect can be little or no food in the refrigerator or pantry, dirty bed linens or clothing, unkempt appearance of the patient, and lack of necessary medical supplies. Signs of emotional abuse are more subtle, she adds.

"Abuse victims look and act like victims of war. They are fearful, anxious, fatigued, and reliant on another person to answer questions or make decisions," Watkins says. **(For more information about spotting signs of elder abuse, see *Hospital Home Health*, August 2002, p. 88.)**

Techniques used to exploit and manipulate an older person include destruction of the routine of normal life and creation of turmoil, she says.

That turmoil makes the person feel unsafe and dependent upon the abuser, she says. "Our role is to come into the person's home to restore order and create a safe environment," Watkins adds.

"We use the same nurses and aides for as long as it takes to stabilize the patient so that he or she is not seeing new faces every day," she says.

"We also work with our medical director to make sure medical conditions are addressed, and may suggest medications to help the patients sleep until they feel safe enough to fall asleep on their own," Watkins adds.

Agency staff members try to re-establish daily routines. "We have one client who loved to have her hair done at a certain salon before her exploitation. She is unable to go to the salon now, but the stylist does come to her home," Watkins adds.

While stabilizing the patient, Watkins' agency looks for ways to keep the patients out of a nursing home and either in their own home or in the home of a nonabusive family member.

"These patients want to stay independent as long as possible, and when they have financial resources to support care in their homes, we suggest ways to accomplish this," she says.

Adult day care programs and home health aides can help a person stay independent. "The goal is to make sure that the patient isn't placed in a position where he or she is at risk of exploitation again," she says.

Elder Abuse Resources

- **National Center on Elder Abuse**, 1201 15th St., N.W., Suite 350, Washington, DC 20005-2800. Telephone: (202) 898-2586. Fax: (202) 898-2583. E-mail: NCEA@nasua.org Web site: www.elderabusecenter.org/ The site contains fact sheets, publications, caregiver resources, state statutes, research, and links to other resources on elder abuse.
- **National Committee for the Prevention of Elder Abuse**, 1612 K St., N.W., Washington, DC 20006 (c/o Bob Blancato). Telephone: (202) 682-4140. Fax: (202) 223-2099. E-mail: ncpea@verizon.net Web site: www.preventelderabuse.org/ The organization offers a variety of publications and research materials related to elder abuse.
- **Clearinghouse on Abuse and Neglect of the Elderly (CANE)**. This is the nation's largest archive of published research, training resources, government documents, and other sources on elder abuse. The CANE collection is fully computerized. Web site for database: www.elderabusecenter.org/ Click on Clearinghouse on Abuse and Neglect of the Elderly on the right navigational bar.

If your agency takes on victims of financial exploitation, make sure you don't put yourself in a position where you can be accused of exploitation as well, Watkins suggests.

"We do purchase groceries, medical supplies such as incontinence [supplies], or clothing that they need, if necessary. But we pay for it, submit a receipt, and are reimbursed by an agent of authority who pays us from a trust," she adds.

One of the major components of a program to help victims of abuse must be strong case management, Watkins continues.

"A nurse must plan to be on-site frequently during the first few weeks to help the aide or other caregiver establish a trusting relationship," she says. ■

Advanced planning eases care for aging

Seniors, close relatives should prepare for aging

Planning is something Americans do on a regular basis. They plan their vacations. They plan for the birth of a new baby. They plan for retirement. And they even plan for death. Yet few plan for the aging process.

"It is good for people to start to think ahead," says **Marilyn Rantz**, PhD, RN, director of the Center of Excellence in Aging and a professor at the school of nursing at the University of Missouri in Columbia.

Families need to consider the various scenarios that could take place as people age such as not being able to drive or maintain a house. Then they should research the services and options available within their community, and work with close family members to develop a plan.

Rantz has talked to seniors and family members who volunteered at nursing homes, assisted living, or senior centers to help them become familiar with the services available to seniors in their community.

"That saved so much stress in those families who were proactive and took the time to understand what services there were in their community," Rantz notes.

Michael Doran, CSW, coordinator of Caregiver Services at Health Outreach, New York Presbyterian Hospital in New York City, often meets caregivers who are overwhelmed with the responsibilities of caring for an elderly loved one while trying to meet work and family obligations.

"Quite often when people present for help, they feel things are out of control," he says.

To help families prepare for the care of aging relatives, patient education coordinators can provide information on what types of resources might be needed by seniors and their family members, how to determine when it is time to make use of such services, and how to find services that meet budget constraints and family requirements.

A list of community outreach centers would be very useful to families looking for help with the care of aging family members, says **Collette Schelmety**, RN, assistant nurse manager on the Acute Care for the Elderly (ACE) unit at New York Presbyterian-Cornell Hospital in New York City.

These centers have access to the resources that families may eventually need for an aging relative, Schelmety says. For example, some have social workers who can help explain which services Medicare might cover, or they might offer home safety evaluations.

Local, state, and national agencies provide resources for older adults, says **Jennifer S. Browning**, MS, RN, CS, gerontology clinical nurse specialist at The Ohio State University Medical Center in Columbus. Senior centers within communities also are an important resource. They often have classes for older adults as well as social activities and meals.

Associations and organizations are good resources for disease-specific information. For example, the local chapter of the Alzheimer's Association based in Chicago provides services for caregivers of elderly relatives diagnosed with this disease.

Preparing for potential problems

As relatives age, it is important for family members to foster their independence, but the family also should stay involved and supportive as needed, Browning explains.

For example, social isolation could become a problem if an elderly person cannot drive or is not physically able to get out much.

"They need frequent contact, even if it is just a phone call," she says. Relatives also can encourage visitors. Interaction with other people and the stimulation of talking about current events and

things of interest is important, she says.

Caregivers need to be aware of the mental and physical changes that take place as people age so they know when to intercede, Schelmety notes. For example, some forgetfulness is common as people age. Therefore, it would be wise to take steps to prevent potential problems by putting a list of emergency numbers next to the telephone.

It's also important for caregivers to encourage elderly relatives to participate in activities that stimulate their minds. "Seniors can improve their memory by continuing to be active in such recreational activities as Scrabble or cards," adds Schelmety.

Caregivers should note that signs of dementia include consistent loss of memory that affects activities of daily living and a person's ability to participate in social events, and to take care of him or herself, Browning says. In this case, an elderly relative would need more assistance and may need to be moved to an assisted living facility.

Older adults also are at risk of depression, which is underdiagnosed and undertreated, Browning explains. It is important for caregivers to know the signs of depression in the elderly.

"Older adults present differently. Their only complaint may be physical symptoms such as fatigue," Schelmety says.

As people age, there is a decrease in strength and balance and bones become less dense, so they are more susceptible to fractures, she adds.

Therefore, home modifications may be required to improve safety. For example, better lighting might be installed and throw rugs removed.

"One out of three persons age 65 and older fall each year, and fractures are the most serious consequences of the falls. Many of the injuries can be prevented," Schelmety explains. People can obtain environmental safety checklists to evaluate their homes. **(For a list of Internet resources for educating caregivers and seniors about the changing needs of aging adults, see box below.)**

Medications can cause confusion as well as falls. Caregivers should review all medications an

Try these Internet sites for elder care resources

Find agencies, printed handouts, and services

Families with aging parents and other relatives need resources to help them address problems that arise as family members take on the role of caregiver.

A source of support and information is important, says **Michael Doran**, CSW, coordinator of Caregiver Services at Health Outreach at New York Presbyterian Hospital in New York City. In his position, he gets calls from families looking for advice on legal issues, home safety, how to set in place advance directives, and other issues.

Following is a list of on-line resources to help patient education coordinators assimilate a source of support and information for the families that utilize their health care facilities.

- **Administration on Aging: www.aoa.gov**
  200 Independence Ave., S.W., Washington DC 20201.

  The Administration on Aging is a division of U.S. Health and Human Services. The web site on aging has an Alzheimer's Resource section and a Caregiver's Resource section. Information for caregivers includes how to find help, how to cope with the role of caregiver, and how to find support groups. It also has a resource directory of names, addresses, phone numbers, and fax numbers of organizations that provide information and resources on the needs of older adults.

- **Alzheimer's Association: www.alz.org**
  225 N. Michigan Ave., Fl 17, Chicago, IL 60601. Telephone: (800) 272-3900.

  The Alzheimer's Association National Office maintains a web site that provides information on Alzheimer's including the risk factors and warning signs, as well as connections to local chapters, resources, and services.

- **Best Caregiver Information: www.bestcaregiverinfo.com** Telephone: (561) 212-5297.

  This web site contains articles, connections to organizations and associations that provide help, and information on standards of excellence. Articles on the Web site include tips on identifying depression in older adults, home modification and repair for safety, and how to find transportation services.

- **Consumers' Guide to Quality Care:** www.nursinghomehelp.org

  The Consumers' Guide to Quality Care was produced by the school of nursing at the University of Missouri in Columbia. It offers advice for families searching for quality nursing home care and includes suggestions about what to look for inside nursing facilities, how to identify quality nursing staff, and links to other resources on the Internet. ■

elderly relative is taking and learn the side effects of each as well as the proper dosage and method of taking them. Medication containers need to be clearly marked for older adults, Schelmety notes.

Vaccinations are a must for older adults

Certain immunizations and screenings are required for good health as people age; therefore, it is a good idea for people age 65 and older to begin seeing a physician who specializes in geriatrics, she says.

Older adults should be vaccinated against pneumococcal pneumonia and influenza because these illnesses are in the top 10 leading cause of death for this age group.

While good health practices are vital at any age, there are many things the elderly can do to improve the aging process. For example, to increase strength, flexibility, and balance, they need to make exercise a part of their daily routine. Good nutrition and hydration is important as well, Schelmety explains.

Communication between the aging adult and his or her caregiver is very important as long as interaction is possible. Good health practices, living situations, and care should be discussed and advance directives should also be set in place.

"Caregivers should find out what the older adult wants — they shouldn't assume anything. [Caregivers] need to communicate well with their loved one," Browning advises.

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Use health education as a marketing tool

Agencies can increase services via partnerships

As the population ages and the needs of seniors change, home health managers are looking for ways to make their services more applicable to today's senior population.

One way to expand services and increase the visibility of your home health agency is to form partnerships or relationships with other organizations in the community.

It's much easier for private-duty agencies to establish partnerships with assisted-living facilities because rules related to anti-kickback statutes don't apply, says **Karon Austin**, MPA, RN, CHCE, a home care consultant and owner of Healthcare Concepts in Avon, CO.

"During my 21 years as an owner of a private duty home care company, I was able to establish several relationships with assisted-living facilities," she says.

Her arrangements actually specified her agency as the preferred provider when the assisted-living facility needed to refer to a home care agency.

While Medicare-certified agencies are unable to establish the same type of formal agreement, there are a number of ways that all home care agencies can establish relationships, she explains.

"One of the services we provided to our assisted-living facility partners was a monthly educational program in which we provided speakers on a variety of topics of interest to the facility's clients," Austin continues.

"We would present topics on health issues such as osteoporosis and Medicare coverage topics, such as benefits for wheelchairs, canes, or other durable medical equipment," she says. "We also provided cholesterol screenings and coordinated annual health fairs."

Speakers for the educational programs and the health fairs can be a mix of agency nurses with expertise in certain areas, representatives from vendors such as durable medical equipment providers, and medical personnel such as podiatrists or dentists from the local area.

"We never charged the clients for the seminars, and we never paid fees to any of the speakers," Austin says.

There was, however, never a lack of willing volunteers to speak, especially when local health

care providers and physicians learned about the program and saw it as an excellent way to establish a connection with an audience that would most likely need their services at some point, she adds.

Before finalizing any agreement to provide health fairs or educational programs at an assisted-living facility, be sure to have an attorney review the agreement for violations of state and federal anti-kickback regulations, suggests **John Gilliland**, an Indianapolis-based attorney.

Basically, a home health agency cannot promise a free service such as an educational program in exchange for a promise of referrals, he explains.

The laws differ from state to state, with some state regulations being even tougher than federal regulations, so each agency needs to have its agreements evaluated, Gilliland says.

It also is important to make sure the assisted-living facility has a policy that gives preference to patient choice when choosing a home care agency, and that the facility follows its policy.

This gives a Medicare-certified home health agency an extra measure of protection against charges of kickback violations, he says.

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Understanding Laws, Rules, Regulations

Using nonsolicitation, noncompete agreements

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Competition among home health agencies for referrals can be fierce. Agency managers are increasingly concerned about employees and independent contractors who leave agencies and take patients with them.

Agencies have used a variety of strategies to combat the loss of patients to other agencies when former employees or contractors take patients with them including nonsolicitation agreements and noncompete agreements.

Nonsolicitation agreements

Nonsolicitation agreements frequently require employees and independent contractors to agree not to solicit patients who currently receive services from the agency at the time the relationship terminates.

They also may prohibit former employees and independent contractors from soliciting employees and independent contractors of agencies to work elsewhere at the time relationships end.

Of course, the difficulty with nonsolicitation agreements is that it may be difficult to prove that solicitation occurred.

Former employees and independent contractors may claim, for example, that patients who switched agencies did so on their own without any encouragement from them, much less solicitation. Nonetheless, it may be helpful to ask employees and independent contractors to sign nonsolicitation agreements because it may deter them from engaging in attempts to get patients and staff to change agencies.

Noncompete agreements

In view of the potential limitations of nonsolicitation agreements, agencies also have utilized noncompete agreements.

Those agreements may, for example, prohibit employees and independent contractors from working for other providers of similar services within a specific geographic area for a specified period of time. Or they may prohibit them from providing services to patients that they cared for at the agency for a specified period of time after the relationship with the agency ends.

Many agencies recognize that the terms of noncompete agreements must be reasonable.

However, what is reasonable is likely to be determined by a mediator, arbitrator, or a judge in a courtroom.

But generally speaking, if the terms of noncompete agreements amount to deprivation of the ability to earn a living, they will be considered unreasonable.

With regard to noncompete agreements, it also is important for agencies to be meticulous about getting these agreements signed *before* they hire employees as opposed to after they already have been employed.

It is important to get noncompete agreements signed before staff members are employed because the courts in some areas of the country have ruled that noncompete agreements with existing employees are unenforceable.

The crucial issue for many courts is whether employees receive consideration in exchange for signing a noncompete agreement. With regard to employees who sign agreements before they are hired, the consideration is clearly getting the job.

Employees who were asked to sign noncompete agreements after they already are employed have successfully argued in court that there was no consideration for the agreement so they are unenforceable.

Of course, employees asked to sign noncompetes always can quit their jobs, but some former employees have claimed that they could not realistically do so. Since signing a noncompete agreement did not guarantee continued employment, it was unfair, without consideration, and therefore, unenforceable.

On the contrary, other courts have concluded that, when existing employees sign noncompete agreements and continue to be employed, their continued employment was consideration for signing noncompete agreements. After all, employers could have fired them if they refused to sign the noncompete agreements.

What should agencies do in response to the different conclusions reached by courts in various jurisdictions about these issues?

1. Ask employees to sign noncompete agreements as a prerequisite to hiring. This may increase the likelihood that noncompete agreements will be enforced.
2. Agencies should ask current employees to sign noncompete agreements before potential problems with a continued employment relationship are encountered or the agency contemplates layoffs. To the extent that employment continues after employees signed noncompete agreements, they are more likely to be enforced.
3. Enforcement of noncompete agreements is a rapidly changing area of the law. Agency managers should review their agreements periodically and any applicable state statutes and regulations and make amendments to them as needed to help ensure enforcement.

Competition among home health care agencies is increasing. Agencies cannot afford to lose patients to others when staff members leave to work elsewhere.

All reasonable steps must be taken to ensure patients are not lost, including the use of nonsolicitation and noncompete agreements.

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NEWS BRIEF

Medicare project: Greater freedom for homebound

Department of Health and Human Services (HHS) Secretary, **Tommy G. Thompson**, recently announced the three states where Medicare will conduct a demonstration project involving a new definition for homebound that would allow Medicare beneficiaries receiving

home health benefits to leave their homes more frequently and for longer periods without risking the loss of those benefits.

The demonstration in Missouri, Colorado, and Massachusetts will mark an important step in identifying strategies to promote greater freedom and independence for people with disabilities who require daily assistance.

Medicare redefines 'homebound'

As part of the three-state demonstration, which was authorized by the Medicare modernization legislation enacted last year, Medicare will use a more liberalized definition of homebound to allow greater mobility to those receiving home-based services.

"This demonstration will give those with chronically disabling conditions a chance to live full lives and contribute to their communities while still receiving services in their homes," Thompson said.

"It represents another step forward in President Bush's New Freedom Initiative, which is breaking down barriers to community living for people with disabilities and addressing the needs of persons with disabilities. "They should not fear that they will lose home-based services that they depend on just because they try their best to have lives outside the home," he added.

Current rules used to determine who qualifies for Medicare payment of services at home require that any time away from home must be "infrequent or of short duration."

Congress and the Centers for Medicare & Medicaid Services (CMS) have refined this definition in recent years, by clarifying that leaving home for adult day care or religious services is allowed.

The demonstration project removes a limitation based on actual time spent away from home, eliminating the concern among many homebound persons that they will lose their home-based care if they attempt to take advantage of activities outside the home.

"This evaluation of a less restrictive definition of homebound for Medicare coverage is an important step toward achieving our goal of greater freedom and independence for people with disabilities," said **Mark B. McClellan**, MD, PhD, administrator of CMS, the agency that oversees the program.

"By eliminating current restrictions, this group of persons who require substantial daily assistance will have access to more normal lives in their own communities," he explained.

Up to 15,000 beneficiaries will be eligible to enroll in the two-year demonstration, which will begin in the fall of 2004.

To qualify for the demonstration, Medicare beneficiaries must have a permanent, severe disability that is not expected to improve.

In addition, the individual must meet each of the following needs-based criteria:

- Needs permanent help with three of five activities of daily living (ADLs) such as bathing, dressing, eating, toileting, and transferring
- Needs permanent skilled nursing care, and daily attendant visits to monitor, treat, or provide ADL assistance
- Requires assistance to leave home
- Is not working outside the home

The goal of the demonstration is to determine the cost impact on the demonstration for patients with chronic illnesses — a population that otherwise may be at risk for costly institutional care.

Open Door Forum planned

As part of the process of addressing this question, CMS plans to host an Open Door Forum June 25 specifically to solicit input from interested groups to discuss the major features of the demonstration.

"As we move forward on implementing this important demonstration program, we will work with home health professionals and advocates for disabled beneficiaries to make sure we do so effectively," McClellan said.

"We need to find the best, least costly ways to provide more freedom for beneficiaries with severe disabilities," he explained.

HHS has played a critical role in advancing the New Freedom Initiative since its launch Feb. 1, 2001.

To date, about 60,000 people with disabilities now have Medicaid health coverage through the Ticket to Work and Work Incentive Improvement Act Medicaid Buy-in Program.

HHS also has approved waivers for nine states that give about 22,000 individuals with disabilities the option to direct their own health care.

In addition, the HHS fiscal year 2005 budget plan would authorize more than $2.2 billion in new spending over the next five years to build on and expand the New Freedom Initiative to promote greater independence for Americans of all ages with a disability or long-term illness. ■

CE *questions*

13. What is the first step to take when you are trying to decide what disease management program is best to develop for your agency, according to Amor Bango, RN, BSN, director of clinical operations at Visiting Nurse Association of Central New York in Syracuse?
    A. Review current research to determine the diseases that are predicted to increase in the next few years.
    B. Study home health publications to see what agencies in other areas of the country are doing.
    C. Look at your own agency population to see if you already serve a large group of similar patients.
    D. Check Medicare reimbursement schedules to see which disease management program has the highest reimbursement.

14. What is one of the key benefits of the teaching manual developed for the Heart Smart program offered by the Visiting Nurse Association of Central New York, according to Diane Nanno, RN, BSN, clinical nurse manager for the agency?
    A. It guides inexperienced nurses through the teaching process.
    B. It serves as a marketing tool.
    C. It replaces the medical record.
    D. It serves as a communications tool between home health personnel, patients, and family members.

15. What are some of the signs of emotional abuse or exploitation of a patient, according to Gwen W. Watkins, MSW, LSW, director of marketing for Wellspring Personal Care in Chicago?
    A. Patient is anxious.
    B. Patient is fatigued.
    C. Patient looks to someone else to make decisions or answer questions.
    D. all of the above

16. According to Elizabeth Hogue, many courts rule that a noncompete agreement is valid only if the employee received consideration in exchange for signing.
    A. true
    B. false

Answer Key: 13. C; 14. D; 15. D; 16. 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. ■