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IN THIS ISSUE

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Your agency can become the local home health care employer of choice

Corporate culture, clear expectations, and recognition prove successful

(Editor's note: This is the first of a two-part series covering strategies home health agencies can use to successfully recruit and retain qualified employees. This month, we look at how a home health agency can establish itself as the employer of choice within its community. Next month, we will examine how hiring the right supervisor or manager can greatly help with successful retention of employees.)

Name brand recognition is the key to success for product manufacturers. It doesn't matter if the manufacturer makes soap or soup. The goal is to make the package memorable, the name familiar, or the benefits so attractive consumers automatically think of just one brand when they go to purchase that item.

Home health agencies that are successful employers also brand themselves, but not in the same way that product manufacturers brand their products, says **D. Mark Hornung**, senior vice president of Bernard Hodes Group in Redwood City, CA. "Home health agencies brand themselves as the employer of choice for their community by developing a strong relationship with current, former, and potential employees."

While this relationship can be described in advertisements and brochures, the home health agency management has to go beyond using words to describe a strong employer-employee relationship. The management staff members must "walk the walk," he adds.

A successful employer-branding program involves commitment from all levels of agency management and staff, Hornung explains. The program needs to include a true focus on helping employees do the best job they can by providing them with resources they need and recognition they deserve.

"Most home health agencies are aware of salary and benefits offered by other agencies in their community; so in most cases, these items are comparable from agency to agency," he says. The differences among agencies show up in areas such as scheduling, continuing education opportunities, respect for employees' skills and efforts, and general work environment, Hornung adds.

At Henry Ford Health Care in Detroit, employees don't have to guess about their employer's commitment to them. "We have printed our mission, vision, credo, and values on a wallet-size card for all employees," says **Greg Solecki**, vice president.

"We make it clear that we put patients first by caring for them as we would a family member, and that we have a work environment where employees respect each other and work as a team. Then, we work to create this environment every day," he adds. By making these promises and working to keep them, his agency has proven that management takes the relationship with all employees seriously, Solecki explains.

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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.

Any relationship with an employee starts with recruitment, Hornung notes. "A nurse or aide who is thinking about changing jobs looks at the local newspaper or a trade publication that is filled with advertisements for jobs.

"The challenge for any home health agency is to make sure its ad stands out from the rest of the ads," he points out. If your recruitment ads are the typical, small, job-opening ads that every other agency runs, the job seekers may never see them, he explains.

At Henry Ford Home Health, the ads don't just describe a position that is open — they describe the type of person who is needed for the job, adds Solecki.

"We don't want just any home health nurse to want to work for us. We want nurses who look at this as a profession, and we want nurses who understand this is a hard job," he says.

Recruitment advertisements for his home health agency describe the nurse who works at Henry Ford Home Health as "wanting to make a difference, wanting to care for the sickest home health patients, and wanting to be true to a mission of caring," Solecki points out.

"When we first showed our ads to our human resource personnel, they told us that no one would read them and that we wouldn't get any response," he admits.

"We've proved them wrong by not only getting applications for job positions, but by getting applications from a different caliber of nurse," Solecki says.

Nurses who respond to their ads generally are more committed to home health than applicants for traditional ads, he notes. "They understand that home health is hard work, but they also understand that there are rewards in home health that don't exist in other areas of nursing," Solecki adds.

Job applicants at Henry Ford Home Health get a sense from the start that this employer is different, he says. "We have a policy [of getting] back to the applicant the same day that the resume is received." Solecki's organization is so quick to respond and to schedule the interview that some job applicants have said that they've already accepted positions at Henry Ford before other home health agencies even acknowledge receipt of their application, he says.

A successful recruitment program shows current employees that you are providing resources they need to do their own jobs, Hornung adds.

"The nursing shortage means that when someone leaves, other employees have to cover the

extra caseload until a new nurse is hired. With a successful, ongoing recruitment program that creates a pool of qualified applicants that can be contacted immediately, you show your staff that you understand the pressure of taking on extra patients, and you don't want them handling extra work for a length of time," he explains.

Just hiring someone doesn't mean you are meeting the needs of your organization, Solecki says.

"We are very upfront about our expectations of employees in terms of how we all treat each other as well as our clients. We are also very honest about how home health is not an easy job. "We want to make sure we hire the right person in terms of clinical skills as well as [addressing] likelihood [that person will] stay with us," he points out.

Solecki's approach seems to work. Even though he admits that his agency loses 50%

The deadline for new ICD-9 codes is Oct. 1

Review RAPs, final claims to ensure correct coding

There is no grace period for the new ICD-9 codes that go into effect Oct. 1, 2004, so home health managers and coders need to make sure they understand the effect of some of the new codes.

"The coding changes that most affect home health were made to increase specificity of the diagnosis," says **Prinny Rose Abraham**, CPHQ, RHIT, a coding consultant with HIQM Consulting in Minneapolis.

"A more specific code is actually a good thing for the home health agency because it [more accurately] demonstrates skills needed and helps nurses prepare a more specific care plan," she says.

The greatest code change for home health will be the set of codes that are used for decubitis ulcer, says Abraham. "The code we've used [in the past is] 707.0 for decubitus ulcer with unspecified site.

"The new five-digit codes specify sites and in reality, no home health nurse should have a patient with an unspecified site. We do have to know where it is to treat it," she points out.

The new codes for decubitis ulcer are:

- 707.00 — unspecified site
- 707.01 — elbow
- 707.02 — upper back
- 707.03 — lower back/sacrum
- 707.04 — hip
- 707.05 — buttocks
- 707.06 — ankle
- 707.07 — heel
- 707.09 — other site, including head

Because home health agencies use this code so frequently, and because agencies bill by 60-day episode, Abraham points out that billing and coding personnel need to be aware that the Request for Anticipated Payment (RAP) might have used the four-digit code that was in place at the time service was provided.

"This means that a final claim must be corrected to include the five-digit code if the final claim is submitted on or after Oct. 1," she explains. Agencies also have the option of running a report Oct. 1 to determine which RAPs included the old codes, and submit a corrected RAP, Abraham says.

Other code changes include:

- **Venous embolism and thrombosis**

The old code of 453.4 did not specify a site, she explains. Now, you use 453.41 to designate proximal lower extremity and 453.42 to designate distal lower extremity, Abraham adds.

- **Obstructive chronic bronchitis**

In 2003, this code was subdivided to 491.20 for obstructive chronic bronchitis without exacerbation and 491.21 for obstructive chronic bronchitis with exacerbation, she says. "We now have 491.22 for obstructive chronic bronchitis with acute bronchitis to better describe the patient's condition," notes Abraham.

- **Diabetes**

"Insulin-dependent and noninsulin-dependent were removed from the 250 category," Abraham points out. The words "adult onset" also was removed from the description because people were coding all children as Type I and all adults as Type II, regardless of the actual type of diabetes, she says. The change is designed to produce a more accurate description of the patient's condition, she adds.

Abraham suggests that home health staff members get to know all of the codes that might apply to their patients because the more accurate claims are today, the more accurate reimbursement will be in the future. "The diagnosis data that we submit today will be used to create reimbursement policy. The more accurate the data, the more accurate the reimbursement will be."

[For more information about coding, contact:

- ***Prinny Rose Abraham**, CPHQ, RHIT, Health Information Consultant, HIQM Consulting, 5748 Russell Ave., Minneapolis, MN 55410. Phone: (612) 927-9813. Fax: (612) 926-0342. E-mail: prinny@hiqm.com*

To see changes in the ICD-9 codes, go to www.cms.hhs.gov/medlearn/icd9code.asp] ■

of new nursing hires within the first six months, with one-half of those leaving during the orientation period, the average tenure of his nurses is 9½ years. "If we can keep them during the first six months, we have them with us for a long time," he adds.

At HomeReach HomeCare in Worthington, OH, the "Get it right from the start" program is a systematic way to interview, select, welcome, and support new employees.

"All managers receive training and a binder that contains information to help them make sure they hire the right people," says **Lisa Lerdon**, employment specialist for HomeReach. This support tool has helped managers better evaluate people they interview and identify the people who will be successful in home care, she adds.

One of every new employee's key concerns is not knowing anyone, Lerdon points out. To address this issue, all new employees wear a lapel pin that lets other employees know that they are new, she says.

"They wear the pin for 90 days — the length of their orientation — and all other employees know to stop and introduce themselves, ask if the new employee has any questions, or offer to help them if they need assistance."At the end of their 90-day orientation, the group of new employees celebrates with a breakfast and a graduation gift from the agency, she adds.

Although new employees spend six weeks in the classroom and the rest of the orientation period working with a preceptor, Lerdon says managers emphasize the fact that it can take as long as a full year for a nurse to feel completely comfortable as a home health nurse. "We want to make sure that everyone feels comfortable asking for advice, even after the orientation period."

This approach has helped many new employees avoid feeling discouraged when they realize that they still have a lot of questions after the initial 90 days, she explains.

After establishing an environment in which people want to work, advertising your agency as a great place to work, and hiring the right people, it is important to recognize people in ways that make them want to stay, Hornung says.

"We base an annual bonus to employees on the achievement of home health agency goals," says **Jean R. DeLong**, RN, MSN, director of clinical services for HomeReach.

Every employee gets a copy of the balanced scorecard that shows how meeting goals in each of the categories (quality of work life, patient satisfaction, financial status, and clinical outcomes) contributes to success throughout the agency, she says.

"We make it clear that we can't meet our patient satisfaction goal of 90% of patients saying they are very satisfied unless we are also scoring high in our employee satisfaction surveys and meeting our clinical and financial goals," DeLong adds.

"We all know the goals at the beginning of the year, and we review progress toward those goals in staff meetings throughout the year," she says. This keeps employees up to date and reminds them that their day-to-day actions contribute toward meeting the goals, she explains.

Keys to Success also are used to recognize staff members' efforts throughout the year, DeLong notes. "Any praise for an employee is written on the Key to Success form and must identify what the employee did and which service standard their action met," she says.

Keys are collected, and when employees receive certain numbers of keys, they can choose different levels of awards, she adds. The awards range from restaurant gift certificates to a day off with pay, DeLong explains.

It is important to evaluate how employees perceive you, Solecki continues. "We conduct an annual employee survey; and this past year, 89% of employees responded, with the great majority of the responses overwhelmingly positive. People wrote that they got a personal sense of satisfaction from their job and that they enjoyed working here," he adds.

Making sure your employees are speaking well of you as an employer pays off in recruitment efforts, Lerdon notes. "I am constantly told by applicants that they chose to interview with HomeReach because their friend or neighbor has told them that this is the best place to work."

[For information about employer branding, contact:

- ***Jean R. DeLong**, RN, MSN, Director of Clinical Services, HomeReach HomeCare, 404 E. Wilson Bridge Road, Suite D, Worthington, OH 43085. Phone: (614) 566-0888. E-mail: jdelong@ohio health.com*
- ***D. Mark Hornung**, Senior Vice President, Bernard Hodes Group, 333 Twin Dolphin St., Suite 400, Redwood, CA 94065. Phone: (650) 264-1134. E-mail: mhornung@pa.hodes.com*
- ***Greg Solecki**, Vice President, Henry Ford Home Health Care, One Ford Place, 4C, Detroit, MI 48202. Phone: (313) 874-6500. E-mail: gsoleck1@ hfhs.org]* ■

JCAHO list on look-alike/ sound-alike drugs released

Drugs must be added to agencies' lists to comply

Home health agencies must choose at least 10 of the look-alike and sound-alike drug names to place on their watch list of medications that can be easily confused to meet the 2005 National Patient Safety Goal that focuses upon reducing medication errors. **(For more information on the 2005 goals, see *Hospital Home Health*, September 2004, p. 99.)**

The list, which was recently released from the Joint Commission on the Accreditation of Healthcare Organizations, identifies the medications in two tables that address different types of organizations.

In addition to the organization-specific tables, there is an additional table that lists supplemental pairings of look-alike, sound-alike drug names.

Some of the problematic drug names include:

- ✔ **Amaryl and Reminyl.** Handwritten orders for these two brand-name drugs can look similar according to the Joint Commission. Amaryl is used for type II diabetes and Reminyl is used for Alzheimer's disease. If a patient receives Amaryl in error, he or she would not be provided with blood glucose monitoring, which could lead to a serious error.

- ✔ **Avandia and Coumadin.** Poorly handwritten orders for Avandia, which is used for type II diabetes, and Coumadin, which is used to prevent blood clot formation, have been misread and have resulted in potentially serious adverse events.

- ✔ **Celebrex, Celexa, and Cerebyx.** Patients affected by a mix-up between these three drugs can experience a decline in mental status, lack of pain or seizure control, or other serious adverse events.

- ✔ **Zyprexa and Zyrtec.** Name similarity has resulted in mix-ups between Zyrtec, an antihistamine, and Zyprexa, an antipsychotic. Patients receiving Zyprexa in error have reported dizziness that sometimes results in injuries related to falls. Patients on Zyprexa who receive Zyrtec in error have relapsed.

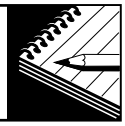
Along with the list of names, the Joint Commission lists recommendations for prevention of mix-ups.

Recommendations differ for various medication names but include suggestions such as using brand names rather than generic names, educating staff members, including the purpose of the medication (many look-alike/sound-alike medications are used for different purposes), and accepting verbal or telephone orders only when necessary.

Home health agencies accredited by the Joint Commission must have a look-alike/sound-alike drug name list in place and educate staff members as to the potential dangers of these drug mix-ups no later than Jan. 1, 2005, to be in compliance with the patient safety goals.

To see a complete list of the medication names and recommendations, go to www.jcaho.org and choose "see look-alike, sound-alike drug list," under Headline news on the right navigational bar. ■

GUEST COLUMN



Follow your own rules for staff background checks

Check suitability for unsupervised care in home

By **Jan J. Gorrie**, Esq.,
Blake Delaney
Buchanan Ingersoll Professional Corp.
Tampa, FL

In July 1995, a baby boy was born with esophageal reflux, causing him to vomit day and night. The child's condition prevented the mother and father from sleeping through the night.

In addition, the mother suffered from postpartum depression. Seeking relief four months later, the couple's insurance company retained a home health agency to provide overnight in-home child care for 12 nights.

When selecting the particular nurse's aide for the job, the agency failed to comply with its prehiring screening policies — neither the agency nor the parents knew that the nurse's aide was addicted to Vicodin (hydrocodone), a narcotic

pain reliever. As with all narcotics, Vicodin has been known to impair a person's mental and/or physical abilities by causing hallucinations, mental clouding, and severe confusion.

The couple also did not know that the nurse's aide allegedly had stolen a credit card from a previous client of the home health agency.

Nevertheless, the aide was given the 12-night assignment in November, and she provided adequate care for the baby during that time.

When the couple's insurance benefits ran out in December 1995, the agency discontinued its overnight child care in the parents' home. Later that same month, the mother began treatment for severe depression and panic disorder at an outpatient psychiatric clinic.

Consequently, the couple offered to hire the nurse's aide to moonlight at their home. Despite a clause in the aide's contract with the home health agency prohibiting such unofficial services, the aide agreed to the couple's offer in late December.

On Dec. 29, the nurse's aide baby-sat overnight without incident. The aide next baby-sat during the early hours of Jan. 3, when the parents asked her to watch the boy for the last six hours of the night.

The following morning, the aide saw the baby was unresponsive and called the father, who attempted to resuscitate the child while waiting for the paramedics to arrive. The baby was pronounced dead as a result of blunt trauma and shaken baby syndrome. The most noticeable injuries were brain and eye hemorrhages.

An Illinois state court convicted the nurse's aide of murder. In her appeal, the aide argued that because so many people had access to the baby that night, including the mother and father, it was improper for a jury to have found her guilty beyond a reasonable doubt.[1]

After spending several years in prison, the Illinois Second District Appellate Court reversed the aide's conviction in May 2000. At that time, she pleaded guilty to attempting to obtain prescription drugs without a prescription and to theft of a credit card.

Following the reversal of the aide's criminal conviction, the parents sued the nurse's aide for willful and wanton conduct. The couple also sued the home health agency for negligence, claiming the agency's failure to comply with its screening policies caused the baby's death.

The parents alleged that the agency's screening policies would have led to discovery of the Vicodin addiction, and the plaintiff's expert argued that the Vicodin addiction led directly to the killing of the baby.

The defendants first argued that the injuries happened before the nurse's aide arrived at the couple's home on the morning of Jan. 3.

Defense experts testified that the injuries could have occurred any time during the 24 hours before the baby boy's death and the fact that the aide was only present during the last six hours of the night created enough doubt about whether the aide was responsible.

Furthermore, the defense argued that either the father or the paramedics were responsible for the eye and brain hemorrhages, given that the father observed none of those injuries when he was first called by the aide to attend to the unresponsive baby.

The second defense offered by the home health agency was that the aide's private contract with the parents released the agency from any liability. In response to this, the parents contended they relied on the agency's background check in making their decision to hire the nurse's aide.

At the conclusion of the trial, the jury was not convinced that the nurse's aide was responsible for shaking the baby and returned a defense verdict in her favor.

The jury then found that the home health agency was negligent in conducting its screening process. It found that the agency's negligence exposed the family to danger, even though the danger never materialized into any real damages.

As a result, although arguably inconsistent, the jury's verdicts released the aide from all liability, yet awarded the parents $75,000 in damages from the agency.

What this means to you

Because a home health care provider, by its very nature, has no control over the environment in which its employees will deliver the health care services, such providers universally establish procedures for screening prospective employees during the hiring process.

"This case presents a classic illustration of why it is absolutely imperative that an organization follow the rules, especially when it was the organization itself that wrote the rules," states **Ellen Barton**, JD, CPCU, a risk management consultant in Phoenix, MD.

All screening procedures undoubtedly ensure an applicant's satisfaction of licensing and other

technical qualifications required for providing medical care.

However, part of the rules also should include reviewing a prospective employee's suitability for the unsupervised nature of home health care service.

"The very core of a home health agency's operations is the delivery of care in a client's home. Thus, the agency not only needs to assure itself that the prospective staff are clinically competent, but also that the prospective staff can be trusted to deliver care in a safe and effective manner," Barton says.

During the screening process, a home health care provider should evaluate several aspects of an employee's background relevant to providing medical care while in a patient's home.

"First, no one would disagree that it is prudent for an organization in the home health business to conduct screening procedures that include criminal background checks on all applicants," Barton states.

Criminal history will signal problems

A criminal history can signify an employee's general disregard for following rules and, depending on the specific nature of the criminal record, may indicate particular problems that are likely to arise in a home health care situation.

A second relevant aspect of a prospective applicant's background is the employee's lifestyle, including any illegal or destructive habits, such as alcoholism and other drug addictions. In this case, although the aide's Vicodin addiction would not have surfaced during a routine criminal background check, such information is nevertheless relevant to the quality of care that the home health care agency should expect from her.

As the plaintiff's expert opined in this case, the narcotics habit may have impaired the mental and physical abilities of the nurse's aide to the point of causing the death of the baby.

Thus, while a home health care agency has no control over the environment in which the care will be delivered, it does have some control over the staff that it hires to provide services.

Such control not only will lead to a higher level of patient satisfaction, but it also will reduce liability in a field that depends upon unsupervised individuals providing care in the most intimate of settings: the patient's home.

"If the agency had followed its own screening procedures and conducted an appropriate background check, it is unlikely that the nurse's aide would have been hired. Even if the agency had not discovered the aide's drug addiction and criminal background, but had followed its own screening procedures, it is unlikely that the agency would have been held responsible for exposing the family to danger," Barton notes.

This is because it would be difficult for a jury to find that a home health care agency acted negligently if the agency could show that it acted reasonably according to the relevant standard of care.

"On the other hand," Barton says, "what if the home health agency had conducted a background check, discovered the red flags in the prospective employee's background, and chosen to ignore them because of what it perceived as a business need to hire staff?

"It's likely that under those circumstances, the agency could have exposed itself to both civil and criminal liability," she adds.

"The lesson from this case is simple: Follow the rules!" Barton concludes.

Reference

1. DuPage County (IL) Circuit Court, Case No. 97L-1403. ■

Case managers can be physician's eyes in home

Case mangers provide care, coordinate services

At Integrated Home Care, nurse case managers provide hands-on care as well as handling the traditional case management duties, such as evaluating patients, developing a customized plan of care, coordinating with other members of the health care team, and arranging services such as social work or dietitian services.

In most cases, the Integrated Home Care case managers do skill assessments and assess patients for medication adherence as well, says **Denise R. Edgett**, PHN, manager of the agency, which is a division of Bloomington, MN-based HealthPartners Inc.

"They are very much responsible for the overall implementation and coordination of the client's home care services," she adds.

Every patient who receives home health services is assigned a case manager. The agency has both nurse case managers and physical therapy case managers.

The RN case managers are responsible for supervising care by other providers such as LPNs or home health aides. If a patient needs physical therapy but not nursing care, the physical therapist assumes the role of case management, coordinating the patient's care, collaborating with physicians, and supervising the therapy assistants or home health aides.

Educating patients

Many of the patients who need skilled care and meet the criteria for home care have chronic conditions and comorbidities, such as congestive heart failure and chronic obstructive pulmonary disease.

The nurses perform hands-on wound care, handle the infusion therapy and other medications, change catheters, and do a lot of disease management teaching. They may teach caregivers or the patients themselves about self-care or educate them about their medications. If patients need help with bathing, dressing, or other activities of daily living, they are assigned a home health aide, often a certified nursing assistant.

"Our agency has always had a model where case managers are never exclusively on the telephone. They have hands-on contact with the patient and often know the patient better than the physician, acting as the physician's eyes in the home," Edgett says.

Whenever possible, the case manager who will handle the patient's home health care makes the first visit and conducts the assessment.

The agency does have admission clinicians who do the first visit when the case manager can't. The case manager who is going to handle the patient's care does the admission visit about half of the time.

The case managers are responsible for scheduling the services the patient needs and either providing the care themselves or working with an LPN partner and delegating the care.

All of the case managers have laptops that allow them to work remotely as well as in the office. About half of their time in an eight-hour day is in direct care. During the rest of the day, they perform administrative functions such as coordination of care, documentation, and travel.

A full-time RN case manager typically handles a caseload of 27-36 patients with mixed acuity. Typically, they see a few patients only once a month and may see others several times a week or even daily.

The case managers are assigned primarily by geographic area. "Our work is to serve patients in their homes. Case managers average about 12 miles each visit and generally are in the home 30-40 minutes," Edgett says.

The case managers' laptops give them a complete medical record when they visit the home and the ability to do most of their documentation on the spot.

"Our most successful case managers are people with excellent organizational and time-management skills. They work their documentation into the rhythm of the visit and don't leave a large list of things to do at the end of the day. Otherwise, they'll have a very long day," Edgett adds.

Generally, the nurses see five or six patients a day while the therapists see about five patients a day.

Most of the patients handled by Integrated Home Care need skilled care intermittently and receive services on a short-term basis. For instance, a patient may have been hospitalized with an exacerbation of congestive heart failure and may need home care for a short time to ensure he or she is medically stable and knowledgeable enough to adhere to his or her medication and diet.

Another patient may be home from the hospital after hip or knee replacement surgery and need short-term rehabilitation therapy. Others with long-term chronic conditions may need assistance with funding sources, such as community waiver programs, to receive ongoing help with their activities of daily living.

"As our population ages, there are more patients who need home care and qualify for home care under their insurance," Edgett explains.

However, she points out, if a patient can come into the outpatient setting, the insurance won't cover home care.

Limited telehealth services also available

Integrated also has a small telehealth program focusing on congestive heart failure and chronic obstructive pulmonary disease patients to provide help above and beyond the face-to-face visits.

Case managers conduct telehealth visits with some patients, using a unit that looks like a

computer monitor with a camera and transmits via a telephone line.

Nurses in the office can connect with patients, see how they look, and measure vital signs such as blood pressure, heart and lung sounds, and weight. They talk with the patient and do assessments and teaching through the telehealth visit.

"At this point, there is only one payer in Minnesota that reimburses us for telehealth. We don't consider reimbursement when evaluating eligibility for the program, but obviously the patient has to have the cognitive skills and dexterity to operate the unit. With some patients, the telephone line can be a barrier if the phone is frequently disconnected," she says. ■

LegalEase

Understanding Laws, Rules, Regulations

Managing pressure ulcer risks in the terminally ill

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

Calculation of damages in malpractice cases involving negligence often includes the life expectancy of injured patients as a key component. Therefore, agencies should, at least in theory, have some added protection against large monetary awards.

It now appears, however, that courts and juries may have a great deal of sympathy for patients with limited life expectancies, so providers must devote increasing attention to risk management issues when caring for terminally ill patients.

Agencies generally are familiar with liability based upon substandard wound care. Based upon the possibility that terminally ill patients may develop a type of pressure ulcer called a "Kennedy Terminal Ulcer," providers must take steps to minimize claims of substandard wound care.

The Kennedy Terminal Ulcer was first identified by Karen Kennedy. Her web site (www.kennedyterminalulcer.com) says that a Kennedy Terminal Ulcer is a pressure ulcer that some patients develop as they get closer to death.

These types of ulcers, which often are shaped like a pear in the sacral area, are red, yellow, and black in color and have irregular borders.

Kennedy Terminal Ulcers often have an extremely sudden onset. They usually start out as blisters or Stage II pressure ulcers and rapidly progress to Stage III or IV.

They tend to start out larger than other types of pressure ulcers, and usually are more superficial initially but increase very rapidly in size and depth.

The causes of these ulcers are unclear. Kennedy suggests on her web site that they may be caused by a blood profusion problem exacerbated by the dying process. They also may be a symptom of multiorgan failure toward the end of life.

When Kennedy Terminal Ulcers progress to Stages III or IV, they may look terrible to patients and their families who do not know very much about pressure ulcers.

It may be hard for them to understand that such awful-looking wounds developed even though care rendered was within applicable standards of care.

It may be equally difficult for judges and juries to comprehend how such terrible wounds could develop unless hospice providers were negligent in some way.

How to minimize risk

The following are some practical steps home health agencies can take to minimize risks associated with claims of substandard would care.

1. Educate all staff providing direct patient care about the signs that a Kennedy Terminal Ulcer may be developing. Specifically, staff members need to know that these types of ulcers often begin as little black spots. Providers may think it is a speck of dirt or dried bowel movement and try to wash it away only to find that it is under the skin, not on the surface of the skin. In a matter of hours, the spot may look like a small black blood blister or like someone colored it with a permanent marker. The patient's skin may be intact in the morning; but by the same afternoon, providers may observe the above.
2. Develop a policy and procedure for routine observation of all patients for development of pressure ulcers, including the Kennedy Terminal Ulcer. The policy and procedure

should, of course, include routine documentation of compliance with the protocol.

3. As soon as staff members identify a possible onset of a Kennedy Terminal Ulcer, they should begin treatment. Applicable standards of care indicate that these types of ulcers should be treated just like other pressure ulcers.
4. Educate patients and their caregivers about the possibility of rapid onset of Kennedy Terminal Ulcers. Staff may even want to show patients and their caregivers pictures of these types of ulcers in various stages so that they are alert for possible development of them. Staff who provide this education should emphasize to patients and their caregivers that these types of ulcers often develop in terminally ill patients and do not necessarily mean that caregivers, both professional and nonprofessional, failed to provide appropriate care. In other words, appropriate expectations about these types of ulcers may prevent caregivers and families from reaching erroneous conclusions about the quality of care provided by agencies.
5. As soon as there are signs of the development of Kennedy Terminal Ulcers, visiting staff should take pictures of the wound. In view of the rapid onset of these ulcers, staff initially may want to take pictures during each visit. The name of the patient and the date on which the picture was taken must appear *in* the picture as opposed to writing it *on* the picture. Patients must also, of course, give written permission for the taking of photographs. Agencies are well-advised to obtain general consent for the taking of pictures upon admission.

Home care providers generally care very deeply for patients and their families and have very positive relationships with them.

Allegations of substandard wound care based on the development of Kennedy Terminal Ulcers should not adversely affect an otherwise excellent relationship if agencies take proper precautions to manage risks associated with these types of pressure ulcers.

[To obtain more information about negligence and risk management related to wound care in a book — Legal Liability *— send a check for $30 (includes shipping and handling) to Elizabeth E. Hogue at the address below.*

To obtain a copy of Wound Care: Legal Issues, *send a check for $35 (includes shipping and handling) to Elizabeth E. Hogue.*

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] ■

NEWS BRIEFS

Medicare payment is too low for inhalation drugs

A study of inhalation drug therapy services provided to Medicare beneficiaries in their homes finds the new 2005 Medicare reimbursement formula paid on average sales price (ASP) would underreimburse the actual cost of providing two key drug therapies by $68.10 per monthly supply.

The American Association for Homecare study includes responses from 109 pharmacies that represent 2,448 branch locations providing inhalation drug therapy services to 337,348 Medicare beneficiaries per month, or 615 of all Medicare inhalation drug therapy patients.

In a notice of proposed rulemaking for the 2005 Medicare physician fee schedule issued last month, the Centers for Medicare & Medicaid Services proposed 89% reimbursement cuts based on the ASP formula for albuterol sulfate and ipratropium bromide.

COMING IN FUTURE MONTHS

- How to identify retention-savvy managers
- Results of the 2004 *Hospital Home Health* Salary Survey
- Are you getting all the therapy reimbursements you are due?
- Patients and home remedies: Do you know what they use?
- Prepare yourself before the subpoena arrives

These drugs commonly are prescribed to treat diseases such a chronic obstructive pulmonary disease.

Survey respondents report that because of patient-management, pharmacy, compounding, delivery, and administrative costs, these drug therapies cannot be provided to Medicare patients at the ASP mandated formula without a substantial service or dispensing fee. ▼

Laws hinder adoption of health IT, study says

Legal barriers posed by certain fraud and abuse, antitrust, federal income tax, intellectual property, malpractice, and state licensing laws hinder providers' adoption of health information technology (IT), the Government Accountability Office (GAO) concluded in a recent report.

"Because the laws frequently do not address health information technology arrangements directly, health care providers are uncertain about what would constitute violations of the laws or create a risk of litigation," the report said.

Such "uncertainties and ambiguity in predicting legal consequences" make providers reluctant to invest significantly in IT.

The Physician Self-Referral or "Stark" Law and anti-kickback law, for example, make providers wary of establishing arrangements between providers that could promote adoption of health IT, the report continued.

The GAO stated that, while the Department of Health and Human Services, which is charged with fostering broader adoption of health IT, has attempted to address some of those barriers, the agency's efforts have not been sufficient to overcome providers' concerns.

The report is available at www.gao.gov ▼

Report shows value of telemonitoring

Remote physiological monitoring can help reduce hospital visits, length of stay, and health care costs for heart failure patients while improving patients' quality of life, according to a study by the New England Healthcare Institute.

The study found that using remote monitoring for heart failure patients lowers re-hospitalization rates by 32% and can produce net cost savings of 25% when compared to standard care.

Because the prevalence of heart failure has grown by 500% over the past 30 years, and because the baby boomer generation continues to age, the authors predicted the cost of providing standard care to heart failure patients could become catastrophic over the next decade.

The report also discussed barriers to use of telemonitoring. Lack of Medicare payment to cover the purchase of telemonitoring devices and to cover the time spent by clinicians monitoring and responding to the data are two reasons some providers are slow to adopt telemonitoring.

Other barriers include clinician concerns about a lack of outcome data to support telemonitoring's benefits and a lack of patient awareness of the technology.

To see the full report, *Remote Physiological Monitoring: Innovation in the Management of Heart Failure,* go to www.nehi.net, choose "Research & Publications," on the top navigational bar, then choose "NEHI Publications" on the left navigational bar. ■

CE *questions*

1. What is one way Henry Ford Health Care management makes sure employees know and understand the mission, vision, and values of the agency, according to Greg Solecki, vice president of the agency?
   A. They rely upon word of mouth from other employees
   B. Supervisors are asked to mention it occasionally in staff meetings.
   C. A wallet card outlining the philosophy and beliefs is given to all employees.
   D. Employees must repeat the information to patients.

2. Why are the new codes, in general, a good thing for home health agencies, according to Prinny Rose Abraham, CPHQ, RHIT, a coding consultant with HIQM Consulting in Minneapolis?
   A. Reimbursement levels will rise with the new codes.
   B. The grace period will allow three months for full implementation.
   C. Old requests for anticipated payments will not have to be resubmitted.
   D. The specificity provides better data for care plans and future reimbursement actions.

3. According to the Joint Commission, when do home health agencies need to have a list of look-alike/sound-alike medications and education for their staff on the list?
   A. Oct. 1, 2004
   B. Jan. 1, 2005
   C. March 1, 2005
   D. July 1, 2005

4. In the article by Elizabeth Hogue, Esq., which of the following are listed as practical steps home health agencies can take to minimize risks associated with claims of substandard would care resulting from Kennedy Terminal Ulcer?
   A. Educate staff about the signs that a Kennedy Terminal Ulcer may be developing.
   B. Develop a policy and procedure for routine observation of all patients for development of pressure ulcers.
   C. Educate patients and their caregivers about the possibility of rapid onset of Kennedy Terminal Ulcers.
   D. all of the above

Answer Key: 1. C; 2. D; 3. A; 4. D

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. ■