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Home health services continue after building lost to hurricane

Staff overcome communications and travel problems to see patients

(Editor's note: The devastation that Florida has experienced this hurricane season is unlike any the state has seen before. This month, Hospital Home Health *relays the experience and lessons learned from one agency caught in the middle of Ivan, one of the more powerful storms. In future issues, stories of other agencies and additional suggestions for home health managers' emergency plans will be shared.)*

Charley, Frances, Ivan, and Jeanne might be the names of friends you invite to your house for dinner. But for people living in Florida, these names represent a trying, traumatic series of hurricanes that kept Floridians and the home health agencies that serve them in a constant state of evacuation, preparation for storm damage, and cleanup after the storms.

Some Floridians still have their houses and offices standing while others, such as Sacred Heart Home Care in Pensacola, are having to relocate and start over because their original spaces were destroyed.

The force of the wind, rain, and storm surge from Ivan collapsed the part of the building that housed Sacred Heart's administration, nursing, clinical, and pharmacy departments, says **Connie Hetterich**, RN, administrator of the agency. "Luckily, a fire wall in the building protected our durable medical equipment offices," she adds.

Records of all active patients were packed up and moved to a safe space at the hospital before the hurricane arrived. However, records of inactive patients that were left in the office were moved to higher locations in case of flooding and covered with plastic.

"The actual medical records are computerized, but we kept paper records of consent forms and supporting documentation," Hetterich explains. "Unfortunately, we no longer have those records or many of the items we had in our desks," she says.

Little things like Hetterich's Rolodex file of important phone numbers and names are missing because no one imagined that the entire office would disappear, she adds.

"We focused on active patient information and employee contact

information so that we could resume care as soon as possible and so we could check on patients and employees," Hetterich points out.

The announcement that Ivan would hit landfall at Pensacola came over a weekend, so Sacred Heart employees started emergency preparations on Monday, says **Nona Wainwright**, RN, director of nurses for the agency.

Getting ready

Nurses spent the day contacting patients to see which patients were leaving the area with family members, which ones were going to a shelter, and which ones were planning to stay, she 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.

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"We had a good idea of patients' plans before we made these calls because, during admission of new patients, we always ask what they will do if there is an evacuation or a threat of a hurricane," Wainwright says.

"All of our supervisors also made sure they talked with each of their employees to find out what their plans were as well," she adds. **(For other tips on preparing employees and patients for emergency situations, see related story, p. 124.)**

Extra meds and oxygen delivered early

"Our pharmacy compounded enough drugs to carry our patients through 72 hours or a week, depending on the medication," Hetterich notes.

Employees then spent Monday and Tuesday making extra deliveries, she adds. "[We] also spent time delivering extra oxygen tanks to patients.

"We were very glad to see that our patients had no problems with oxygen in the aftermath of the storm and that we had correctly planned for their needs," Hetterich continues. "What we didn't anticipate were the number of calls from clients of other vendors who needed oxygen tanks but could not reach their vendors."

While Hetterich's agency helped other vendors' clients as they could, the unexpected calls point out a need for agencies in the area to work together to develop a plan to address patients' needs before, during, and after an emergency, she stresses.

Ivan hit Pensacola at 1:50 a.m. Wednesday. "We were unable to see patients until Saturday because entire areas were flooded, roads were closed, and it was dangerous for anyone to travel," Wainwright says.

"On Saturday, nurses started seeing priority patients, such as wound care patients, as they could," she explains.

Although access to many areas was restricted to prevent looting, home health workers with an identification badge could go into any area to check on patients, Wainwright notes.

"Our employee badge became a very important accessory in the aftermath of Ivan," she says.

While the agency requires employees to wear identification when seeing patients, all employees were reminded to keep their badges with them starting on Monday, rather than leaving them in their desks, she points out.

That was a good idea because after Ivan, many

of those desk items were missing, Wainwright explains.

Home health employees were able to continue working during and after the storm at the hospital where they helped move patients to safer location within the building, delivered meals, supervised children in the "Hurricane Kid Camp" set up for 200 children of hospital and home care employees during and after the storm, and sat with patients to calm them.

"I was surprised to see the number of pregnant women who were at least 36 weeks pregnant, some due in one day or two, who came to the hospital as their shelter," Hetterich says.

"We provided mattresses that the home care agency keeps so that the women would not have to sleep on the hard hospital cots," she adds.

Following the storm, many physicians in the area were unable to provide intravenous therapy in their offices, so their patients came to the hospital for their IV therapy.

"Our home health nurses with IV training were able to supplement the hospital staff so these patients [could receive] their therapy," Hetterich notes.

"Our staff really pitched in to help during the storm; then the hospital employees helped us after the storm," she says.

Gasoline becomes precious commodity

Hospital support for the home care agency included space, help from information systems, maintenance, and administrative departments, as well as supplies such as water, ice, and gasoline.

"We did not have to stand in line for water and ice — the hospital provided it," Wainwright explains.

"Our sister hospitals in Mobile and Jacksonville brought cans full of gasoline so our field staff could make visits, and they also provided employees to help us get back into business," she adds.

The gasoline was critical because there was no electricity in the area, and gasoline pumps don't work without electricity, Wainwright points out. "We did tell employees to make sure their gas tanks were full Tuesday evening, but power wasn't restored for many days in some areas."

In the two days prior to the storm, all field staff made sure OASIS (Organization for the Advancement of Structured Information Standards) records and any information on their laptops were dumped to the server, Hetterich continues.

Coming in December

In the October issue of *Hospital Home Health*, we ran the first part of a two-part article on employee recruitment and retention.

Due to our coverage of the effects of multiple hurricanes on Florida home health agencies and their suggestions that will help all home health managers improve their emergency preparedness, the second part of the article has been moved to our December issue. ■

"We made sure we had backups of the information, and we also exported information to our state CMS [Centers for Medicare & Medicaid Services] intermediary before we took the server off-line," she says.

Even with those precautions, the server did suffer some damage so the agency had to work with paper records for three days; and for some time, they were unable to submit claims electronically, she adds.

Hetterich says she is working with her CMS intermediary to make sure claims are processed properly, and she also is notifying other organizations that OASIS records, medical records, and claims information may appear out of sync due to storm damage and losses.

Unforgettable experience

Wainwright plans to incorporate before and after pictures of the agency's office into her employee education on emergency preparation.

"When you live in Florida, you develop a tendency to become complacent when a hurricane is predicted because we often prepare for a storm that doesn't come. I want to make sure that we don't forget what happens when it does hit, to make sure we all take emergency preparations seriously," she adds.

"I just never imagined that we would literally lose our building," Hetterich explains. If she had anticipated the loss, she would have taken items such as her Rolodex file with her.

"My staff have always said that if anything happened to me they would be fine because they would have my Rolodex file," Hetterich points out.

When asked if her staff are more protective of

her now that the Rolodex file is gone, she laughs and says, "Actually, the thing that concerns me is that they are still looking for the Rolodex file."

[For more information about Sacred Heart Home Care's experience, contact:

- ***Connie Hetterich**, RN, Administrator, Sacred Heart Home Care, 213 E. Wright St., Pensacola, FL 32501. Phone: (850) 416-2578. Fax: (850) 416-4984.*
- ***Nona Wainwright**, RN, Director of Nurses, Sacred Heart Home Care, Pensacola. E-mail: nwainwri@shhpens.org]* ■

What to do before and after an emergency

Communication is critical

The most critical issue before, during, and after any emergency is communications, say the Florida home health managers who have faced multiple hurricanes during the 2004 hurricane season.

"We had no electricity after the hurricane, so we had no phone system for the home health agency," says **Sheila Carlson**, director of Lee Memorial Home Health in Fort Myers, FL. **(For a description of other effects of no electricity, see *Hospital Home Health*, October 2003, p. 109.)**

Don't count on your cell phones

"Cell phones were not always effective because the cell phone system was so stressed with the volume of calls people were making," she adds.

"Our field staff have wireless laptops so they were able to communicate with each other, but our managers don't have them, so it was a challenge to keep in touch with all of our staff," notes Carlson.

Her agency also discovered that the hospital's telephone system continued working, thanks to backup generators and a more sophisticated system.

"We will use the hospital's voice-mail system next time," Carlson explains. "We can leave messages for staff members who can call in for updates and information."

"We are considering two-way radios for our emergency communications," says **Bobbie D'Angola**, administrator of United Home Care Services in Miami.

"Our employees see patients in their own geographical area so, once travel is possible, they can check on patients; but with no telephone or sporadic cell phone service, we can't always communicate with them," she notes.

Prior to all of the hurricanes' arrivals, home health staff members throughout the state were on the telephone to all clients and staff members to verify their plans for evacuation.

Although this season has been unusually active, Floridians are very aware of the possibility of evacuation in case of weather emergencies, says **Karen Rutledge**, RN, director of nursing for Omni Home Health in Homosassa Springs, FL.

Evacuation is a reality for many of her patients because they live in mobile homes near the Gulf of Mexico, she adds.

"All new patient admissions include the completion of an emergency medical service contact form that includes a description of the patient's needs and the patient's plans or needs in case of evacuation," Rutledge says.

At the beginning of each hurricane season (June 1 through Nov. 30), staff members contact each patient to update the forms, she explains.

Copies of the forms are forwarded to the county emergency medical service (EMS) so EMS personnel know which patients need assistance for evacuation.

As weather worsens, or the threat of severe weather increases, home health nurses contact patients to check on them to see if they need further help, Rutledge adds.

Following the hurricane, staff members contact patients who planned to stay alone in their homes during the storm, she says. "If we can't reach them by telephone, we go to them if we are able to travel to the area, or we ask EMS personnel to check on them."

Prepare patients for evacuation

Admission information for Homosassa Springs' patients also includes a checklist for items to include in an evacuation kit.

"We make sure patients have all of their medications, a copy of their medical history with names and phone numbers of physicians or health care providers, a list of allergies, a copy of their living will, if they have one, and any other information that will help them continue receiving care in the area to which they evacuate," Rutledge says.

Because United Home Care also provides community-based services to patients other than Medicare-certified patients, staff help prepare their patients for the hurricane by stocking pantries with three to five days of meals that don't require electricity to store or prepare, and water, D'Angola adds.

"We've been lucky this season because our personal care attendants have been able to continue seeing patients with no more than a one-day delay," she says.

Because Miami residents, especially the older people, still have horrible memories of the devastation of Hurricane Andrew in 1992, the aides and nurses often are responsible for reassuring patients and reducing their anxiety, D'Angola notes.

"We make sure our employees know to stay upbeat and calm during threats of hurricanes so that we are able to prepare our patients for the weather and possible evacuation without scaring them," she says.

"If we do have a patient who is extremely anxious, and the aide cannot reassure [that person], our licensed clinical social worker will visit the patient to counsel him or her," D'Angola adds.

Most home health agencies are providing counseling services to patients and employees, and it is a needed service, Rutledge explains. The emotional toll on staff and patients from this year's busy hurricane season concerns her.

"I noticed that, with each hurricane watch or warning, people were more laid back, less alert," she says. "I know that continuous warnings of a storm that doesn't always arrive creates a wait and see attitude that can be dangerous," Rutledge admits. She says she plans to continue educating staff and patients that each warning should be taken seriously.

One of the more depressing aspects of a hurricane is that even when the threat is taken seriously, plans can backfire. Rutledge explains,

"One of our nurses decided that she would leave our area when Jeanne was approaching. She left the night before to head to Jacksonville, only to discover the next day that the storm changed direction and Jacksonville was right in the middle of its path," she adds.

[For more information on home health preparation for emergency situations, contact:

- ***Sheila Carlson**, Director, Lee Memorial Home Health, P.O. Box 2218, Fort Myers, FL 33902. Phone: (239) 332-6440.*
- ***Bobbie D'Angola**, Administrator, United Home Care Services, 5255 N.W. 87th Ave., Suite 301, Miami, FL 33178. Phone: (305) 716-0765. Fax: (305) 716-0288.*
- ***Karen Rutledge**, RN, Director of Nursing, Omni Home Health, 4363 S. Suncoast Blvd., Suite A, Homosassa Springs, FL 34447. Phone: (352) 628-4900. Fax: (352) 628-6770. E-mail: krutledge@omnihha.com]* ■

Financial and regulatory issues after an emergency

Although the safety of employees and patients as well as the resumption of care to patients is a priority for a home health agency following an emergency, don't forget to address financial and regulatory issues that affect your agency's operation, says **Connie Hetterich**, RN, administrator of Sacred Heart Home Care in Pensacola, FL.

"We notified our CMS intermediary that we would be submitting paper claims immediately after the emergency due to lack of electricity and damage to our server," she explains.

Fortunately, the Centers for Medicare & Medicaid Services (CMS) had approved paper claims for agencies affected by the hurricane.

"We also notified the state licensure agency and our accreditation agency that we had experienced a significant loss of documentation due to the destruction of our building," Hetterich says. **(See cover story.)**

This notification is important so that Sacred Heart is not penalized for missing documentation for this time period, she says.

Home health agencies in Florida are experiencing real challenges that have not been addressed by CMS because many of the issues only have developed recently as a result of multiple massive storms, says **Gene Tischer**, executive director of the Associated Home Health Industries of Florida, the state association for home health agencies in Florida.

Tischer's state association, along with the National Association of Home Care and Hospice in Washington, DC, has been working with CMS to address issues such as financial penalties suffered by agencies when patients evacuated to other areas, claims processing, and OASIS (Organization for the Advancement of Structured

Information Standards) time frames.

"We have agencies that have missed OASIS collection points and reporting deadlines so we have asked CMS to provide relief; but until that is given in writing, Florida agencies must do the best they can to meet OASIS mandates," Tischer notes.

Using a holding pattern during emergency

Another policy revision that will help home health agencies that experience major disasters and disruption of service is the development of some type of holding pattern for patients who are forced to evacuate the service area, he says.

"A time frame of up to 30 days could be established during which another home health agency can provide service to the agency and get paid for services performed during the patient's evacuation, while the initial home health agency can pick up care where it left off before the evacuation," Tischer suggests.

That type of rule would help home health agencies avoid lost revenue created by patients leaving their service before completion of episodes of service or before enough therapy visits had been made to meet prospective payment system (PPS) requirements, he adds.

Another issue the state association is addressing is the development of a process that enables home health agencies to use out-of-state home care nurses to supplement their staff, especially if agency staff are unavailable due to their own personal situations or due to evacuation, he says.

"Out-of-state health workers were allowed to assist Florida agencies, but they had to volunteer their time and work through the Red Cross," Tischer explains.

"We need to find a way to allow them to work for pay under the auspices of a Florida provider in the future," he notes.

Until emergency rules are put into place, it is important to stay in touch with CMS intermediaries and other regulatory agencies to alert them to problems that your agency may experience in meeting deadlines, Tischer advises.

[For more information about emergency regulatory issues, contact:

- ***Gene Tischer**, Executive Director, Associated Home Health Industries of Florida, 512 N. Calhoun St., Tallahassee, FL 32301-2600. Phone: (850) 222-8967. Fax: (850) 222-9251. E-mail: gtisher@ahhif.org]* ■

Telehealth improves care, coordination, satisfaction

VA telehealth model opening nationwide

Experts predict a larger role for telehealth in the health care industry as model programs demonstrate high patient/caregiver satisfaction and improved staff efficiency and quality of care.

Home health agencies and hospices increasingly are using a variety of telehealth services, says **William A. Dombi**, JD, vice president for law at the National Association for Home Care and Hospice in Washington, DC.

"The types vary from vital-sign checks to monitors that offer high-resolution pictures of a patient that allow monitoring of everything from wound sites to skin tone," he says.

Hospice agencies are the latest to explore the advantages of telemedicine, experts say.

"I've been involved in doing research in telemedicine since the early 1990s, and one of the areas that has emerged over time as being an important area is hospice and palliative care services," says **Pamela Whitten**, PhD, associate professor at Michigan State University in East Lansing. "Telemedicine has huge ramifications for hospice and palliative care," Whitten adds.

The Veterans Health Administration (VHA) in Bay Pines, FL, launched a telemedicine care coordination service in 2000 as a way to provide home services while keeping patients connected to the health care system, says **Patricia Ryan**, RN, MS, director of the Veterans Integrated Service Network 8 (VISN-8) and acting associate chief consultant to the VHA Office of Care Coordination in Bay Pines.

VISN-8 recently added hospice and palliative care services to the program, and there are plans to roll out the telehealth program in other states, she says.

"We're not taking over any other of the health care programs we have in the VA system, but this is a complex system," Ryan explains. "So what we wanted to do was make sure that those patients who were very sick and clinically complex could participate in their own care at home, and if they needed hospice care, we were there for them."

The Michigan telehealth program was limited to home health for the purposes of research, says Whitten.

"We decided to determine what type of

technology could be brought into the home in a realistic manner, and we decided to use video phones that use analog phone lines," she adds.

"We wanted to look at areas where there was a potential challenge in access, and so we provided telehealth services to rural areas and an urban area," Whitten notes.

The rural areas were located in Northeastern Michigan, where severe winter weather sometimes makes it difficult, if not impossible, for home health professionals to visit patients, Whitten explains.

The urban area selected was in parts of Detroit, where one challenge is to provide evening home health services to some low-income patients because of safety issues, she adds.

The Bay Pines VHA's telemedicine project is divided into 21 programs across the state of Florida and in Puerto Rico, and each program serves a different population, Ryan says.

For example, one program at the San Juan, Puerto Rico, VA serves only diabetes patients, and another serves wound care patients. In northern Florida, there is a palliative care program, and another program serves most chronically ill medical patients, she explains.

Program targets clinically complex patients

The hospice/palliative care program has a chaplain who serves as care coordinator. While that was the first formal telehealth program, many of the other programs also will help patients stay at home at the end of their lives, Ryan adds.

"Not everyone in the VA system is enrolled in these programs," she notes. "We look at those who use the system the most — the most clinically complex patients."

Dombi, Whitten, and Ryan describe some of the features of telehealth programs and how they may fit in with existing home health services.

Here are their observations and advice regarding starting a telehealth program:

- **Understand the licensing and legal issues.**

While a telehealth program doesn't need a special license, there are circumstances when its use could be in violation of state licensing laws, Dombi says.

For instance, if a physician is licensed in New Jersey and is providing health care services to a New York resident via telemedicine, then this could be a violation of licensing laws because the doctor is not licensed to practice medicine in New York. It's also important to understand the special liability and malpractice concerns that affect telehealth programs, he says.

"There are some issues that arise regarding practice acts for nurses," Dombi points out.

Nurses must comply with state nurse practice acts. States commonly only give nurses limited authority to act without a physician order; and in most states, nurses usually can only provide care consistent with a physician's order, he explains.

So the question arises: "Do they need an order to use telehealth service in the fashion they are using it?" Dombi asks.

"We've long recommended having specific physician orders for telehealth, for both liability and licensing issues," he adds.

"The liability concern relates to someone who has the responsibility to the patient, and then something goes wrong and leads to injury; if the nurse is acting consistently with the physician's order, then you're at least sharing risk with the physician," Dombi says.

- **Select the telehealth model that works best for your clientele and staff.**

The telehealth study conducted in Michigan found that patients uniformly liked the service, and many even wanted to use it more frequently, Whitten says.

Challenge came from providers' resistance

"Some providers loved it from Day One, and some providers resisted it," she says. "The challenge was not with the patients accepting telehealth and liking it; the challenge was with the providers."

This project used videophones and video monitors plugged into existing telephone lines. All patients would have to do is push a button for a video connection, making it a very simple process, Whitten explains.

The staff would conduct home visits via the video phones in the same way they would conduct a visit in person, with each visit tailored to the particular patient, she says.

"Some might need a pain assessment and to talk about issues with pain, and others might need counseling of some type," Whitten adds.

"Sometimes, the providers would just call in to check on their comfort and check on bed sores or wounds." At other times, hospice providers might provide support services to family members or caregivers, she adds.

- **Care coordinators direct telehealth services.**

The VA telehealth program provides a nurse practitioner and chaplain for palliative care services, and also provides easy access to physicians, an interdisciplinary team, and anyone else who is needed, Ryan says.

Selecting the appropriate technology

The first step is to assign the patient a care coordinator who selects the technology that will be used to provide the telehealth services, she points out.

Typically, the technology is a 365-day messaging unit, about twice the size of a caller ID box, that is connected to the patient's telephone.

Each morning, the unit will beep until the patient responds to 10 to 15 questions that require four simple button presses to answer.

Based on these answers, the care coordinator labels each person as "green" for OK and "yellow" if the patient needs to be watched, Ryan explains.

The patient's answers to the questions are sent to a computer, where the care coordinator can evaluate all the patients' results to determine who needs to be called that day, she adds.

- **System tailors education to patient.**

The system then automatically delivers education to the patient based on how the patient answered questions, Ryan says.

"Instead of giving patients a 3-inch notebook with information, you give them education based on their answers and on their behaviors," she notes.

For patients who are unable to use that technology, a videophone also is available, Ryan adds. Either way, patients are monitored by the technology, but they always have someone they can call in case of an emergency or if they have additional questions.

- **Provide initial home visits, emergency care, and follow-up support.**

It typically takes one home visit to set up the messaging device if patients need assistance, she says of the VA's telehealth system.

"Everyone who receives a telemonitor will receive a home visit, but there are some patients you wouldn't visit at home at all," Ryan says.

"We screen everyone to see if they need a home visit, and for the palliative care population, we make at least one or two visits to their home," she adds.

For palliative care patients, the care coordinator will establish routine communication with the caregiver to assess the caregiver's burden, notes Ryan.

"A lot is done by the phone, but as more of a scheduled activity to relieve the caregiver's stress," she explains.

"Also, for palliative care patients, we'll arrange for respite care if it's needed, because a lot of time, there's access to a lot more community services," Ryan continues.

The program provides some patients with added support through the use of a videophone that the patient can use to speak with another family member who is too ill to visit the patient, she adds.

The chaplain will keep in touch with the patient and family by telephone and may schedule regular appointments for spiritual counseling.

The chaplain, like other care coordinators, also serves as a conduit to the primary care physician and other providers, so if a patient needs access to some service, the chaplain will arrange it for the patient, Ryan says.

Patients who need help outside of scheduled calls and visits can call a 24-hour nurse during off-hours, she adds.

So far, the system has helped reduce unnecessary emergency department visits and hospitalizations, Ryan notes.

Hospice nurses, physicians, and other clinicians know that the care coordinator is keeping a close eye on the patient, so if the care coordinator calls to request that someone see the patient, the visit is scheduled immediately, she says.

Sometimes, patients in the Michigan program will call in for assistance via the videophones, but usually their telehealth visits are scheduled, Whitten notes.

There have been occasions when the telehealth service has saved nurses hours of commuting time when an emergency has occurred, she notes.

For example, one patient's caregiver in northern Michigan called to say the patient was having some abdominal discomfort, and the caregiver didn't know what the problem was.

The nurse asked the caregiver to move the videophone camera down the patient's body so she could look at the patient, and she discovered a kink in the Foley catheter.

Once the caregiver unkinked it, following the nurse's instructions, the patient's discomfort eased, Whitten recalls.

"That would have been a 60-mile visit out and back in the middle of the night for the nurse," she says. ■

LegalEase

Understanding Laws, Rules, Regulations

Fraud and abuse in free discharge planning

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

Hospitals are required to provide discharge planning services. Case managers who provide these types of services and agencies that receive referrals from hospitals must be aware of a possible type of fraud and abuse in the form of free discharge planning services.

Anti-kickback and rebate statute

Specifically, there is a federal statute that governs illegal remuneration in the Medicare, Medicaid, and other federal and state health care programs.

The statute is often called the "anti-kickback and rebate statute." It basically says that anyone who either offers to give or actually gives anything to anyone to induce a referral has engaged in criminal conduct.

Possible penalties for violation of this statute include imprisonment, fines, suspension and exclusion from participation in the Medicare, Medicaid, and other state and federal health care programs and civil money penalties. So the stakes are extremely high.

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services is the primary enforcer of fraud and abuse prohibitions.

The OIG stated in a *Special Fraud Alert* published in June 1995, that the activities of coordinators and liaisons supplied by providers who want referrals cannot supplant the services of discharge planners.

When coordinators and liaisons perform services that discharge planners are supposed to perform, it is a kickback or rebate to referral sources in the form of free discharge planning services.

Recently, discharge planners/case managers at hospitals and long-term care facilities seem to have increased interest in entering into written agreements with post-acute providers such as home care agencies, home medical equipment, and hospices to provide coordinators and liaisons.

Although written agreements for the provision of coordinators/liaisons are not required, they may be acceptable if appropriately drafted.

Specifically, these agreements must be drafted very carefully to avoid possible kickbacks and rebates.

Here are some of the potential pitfalls of such agreements that should be avoided:

1. Agreements should not require administrators to keep a coordinator/liaison in the facility on a full-time basis unless the number of referrals clearly justifies the commitment of an employee for this amount of time. Otherwise, this requirement may reinforce the likelihood that this arrangement will be viewed by the OIG as an impermissible kickback or rebate. If the liaisons/ coordinators are not providing discharge planning services, there is no need for them to be on the premises on a full-time basis. Rather, an agreement for legitimate coordinator/liaison activities would require them to be available to receive referrals on an as-needed basis only. If providers supply liaisons and coordinators under the proposed agreements on a full-time basis, but do not receive enough referrals to justify assignment of personnel on a full-time basis, it reinforces a conclusion that liaisons and coordinators actually are supplying discharge planning services in exchange for referrals.

2. Agreement for the provision of coordinators/ liaisons should not require them to develop and/or implement an appropriate discharge plan or to document these activities in patients' charts. Medicare Conditions of Participation for hospitals make it quite clear that it is the job of discharge planners to develop and implement appropriate discharge plans.

3. Agreement for liaisons and coordinators should not include a requirement that they must be RNs. It is common practice in post-acute care industries to utilize coordinators and liaisons who are not licensed professionals who perform very effectively in these positions. A reasonable interpretation of this requirement is,

therefore, that liaisons and coordinators must be RNs because they will, in essence, be providing discharge planning services.

4. Discharge planners/case managers should not propose agreements for use of coordinators and liaisons that include indemnification provisions. If no free discharge planning services are being provided, there is no need for indemnification.

5. Hospitals that elect to have written agreements with providers who supply coordinators and liaisons also must be careful to handle compliance with Health Insurance Portability and Accountability Act privacy requirements appropriately. Specifically, providers who supply coordinators and liaisons should not be required to sign business associate agreements. The Standards of Privacy of Individually Identifiable Health Information generally define a business associate as an entity that performs a services on behalf of a covered entity. The OIG is likely to conclude that the services performed by providers as business associates on behalf of hospitals are discharge planning services.

The standards and related materials also make it clear that providers who receive referrals from other providers are not business associates of referring providers.

Such referrals, including information shared to make referrals, is part of treatment, payment, and health care operations of covered entities that does not require consent of patients to disclose.

Agencies are in the proverbial hot seat as the marketing activities of post-acute providers and enforcement activities by the OIG heat up.

They must be careful to keep up to date on these issues.

[For a complete list of publications, contact:

- ***Elizabeth E. Hogue**, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Phone: (301) 421-0143. Fax (301) 421-1699. E-mail: ehogue5@ Comcast.net*
- *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 above.*
- *To obtain a copy of* Wound Care: Legal Issues, *send a check for $35 (includes shipping and handling) to Elizabeth E. Hogue.]* ■

Florida's urgent call for nursing help is answered

Florida has received an overwhelming response from hospitals offering the names of nurses willing to temporarily travel to the state to help relieve hurricane-weary nursing staff or assist with public health needs resulting from the four hurricanes that ravaged the state.

Volunteer help has been offered from several states: "Virginia, South Carolina, California, North Carolina, Tennessee, and Colorado; and we already have 16-member teams in place from Iowa and Oklahoma," says **Monica Rutkowski**, a member of the Florida Department of Health's (DOH) Public Health Nursing Team.

The American Hospital Association, working with the American Organization of Nurse Executives and many state hospitals in the Southeast, asked hospitals for help in identifying nurses willing to assist in Florida's hardest-hit areas.

The Florida State Board of Nursing is granting temporary licenses to the out-of-state nurses, so they can be assigned to hospitals, health clinics, and special-needs shelters, Rutkowski explains.

COMING IN FUTURE MONTHS

- ■ Improve quality of life with memory training
- ■ Are you e-mail savvy? Communicate effectively
- ■ New labor laws: How do they affect HHAs?
- ■ Tips to find free HIPAA resources
- ■ How to help your patients manage rising drug costs

The Florida DOH, which organized the nurse volunteer effort with the Florida Hospital Association, will continue to contact nurse volunteers as specific needs are determined. ▼

JCAHO announces 2005 survey fee increase

The Joint Commission on Accreditation of Healthcare Organizations' survey fees will increase for 2005.

The fee increases, only the second in the last decade, will vary by program and, within programs, will vary by the types and volumes of services provided.

The Joint Commission also announced plans to institute a subscription billing model in 2006 that will allow accredited organizations to begin to spread their survey fees over the three-year accreditation cycle.

The Joint Commission has changed the survey process significantly in the past two years and added a variety of new services that have increased the costs of conducting surveys, according to **Dennis S. O'Leary**, MD, president of the Joint Commission.

The final fee schedule had not been set as of publication date, but the estimated average increase for home care is $880. For specific pricing, contact the Joint Commission Pricing Unit at (630) 792-5115 or by e-mail to pricingunit@jcaho.org ▼

CMS reimbursement for flu vaccine rises

The Centers for Medicare & Medicaid Services (CMS) has announced an increase in the Medicare Part B payment allowance for this year's influenza vaccine.

Reimbursement for the influenza vaccine is $10.10 per adult dose, an increase of $0.15 from last year's price of $9.95. This year's pneumococcal vaccine payment allowance is $23.28, also up from last year's price of $18.62.

The price is effective starting Sept. 1 and is good until Dec. 31. Because the total vaccination Part B reimbursement includes the Medicare allowance price plus administration costs, and those costs vary according to administration area, each agency's payment will differ, according to CMS officials. ■

CE *questions*

5. Following Hurricane Ivan, which area of service indicated the need for home health agencies to address some emergency preparedness issues as a group, according to Connie Hetterich, RN, administrator of Sacred Heart Home Care in Pensacola, FL?
   A. fewer available staff due to evacuations
   B. claims processing during power outages
   C. communications between staff and patients
   D. requests for extra oxygen tanks from other agencies' clients

6. Name one service that home health agencies should be prepared to offer employees and patients following a lengthy emergency situation, according to Karen Rutledge, RN, director of nursing for Omni Home Health in Homosassa Springs, FL.
   A. extra pay or discounted services
   B. time off for employees
   C. counseling
   D. assistance in filing claims

7. Which of the following do Dombi, Whitten, and Ryan of the Veterans Integrated Service Network 8 recommend regarding starting a telehealth program?
   A. Understand the licensing and legal issues.
   B. Select the telehealth model that works best for your clientele and staff.
   C. Use a care coordinator to direct telehealth services.
   D. all of the above

8. According to Elizabeth E. Hogue, Esq., in her article on fraud and abuse in free discharge planning services, the anti-kickback and rebate statute basically says that anyone who either offers to give or actually gives anything to anyone to induce a referral has engaged in criminal conduct.
   A. true
   B. false

Answer Key: 5. D; 6. C; 7. D; 8. B

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	(4) Other Classes Mailed Through the USPS	12	10
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*		130	111
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1) Outside-County as Stated on Form 3541	20	21
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	(3) Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*		25	25
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6. Item 17 must be signed.

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PS Form **3526**, September 1999 *(Reverse)*

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. ■

2004 SALARY SURVEY RESULTS

Hospital Home Health®

the monthly update for executives and health care professionals

Rising salaries increase importance of retention

Nonmonetary efforts attract and keep employees on the job

The good news for respondents to the 2004 *Hospital Home Health* Salary Survey is that 85% of survey respondents saw their salary increase between 1% and 6% in 2004. Even better news for 10% of respondents was the 11% to the more than 21% increase they received. **(See chart, below.)**

What's the bad news?

The bad news is that home health managers are having to face increasing salaries at the same time they try to attract new employees and deal with shrinking reimbursement.

Experts interviewed by *Hospital Home Health* point out that there are ways to recruit and retain employees without resorting to salary wars.

Judith Walden, BSN, CHCE, director of Castle Home Care in Kaneohe, HI, admits that she is fortunate in many ways. "We have little turnover and we are continuing to grow," she says.

"We do not offer financial incentives to attract new employees, but we do pay at the same level as the hospital, and we offer flexible hours and good benefits," Walden explains.

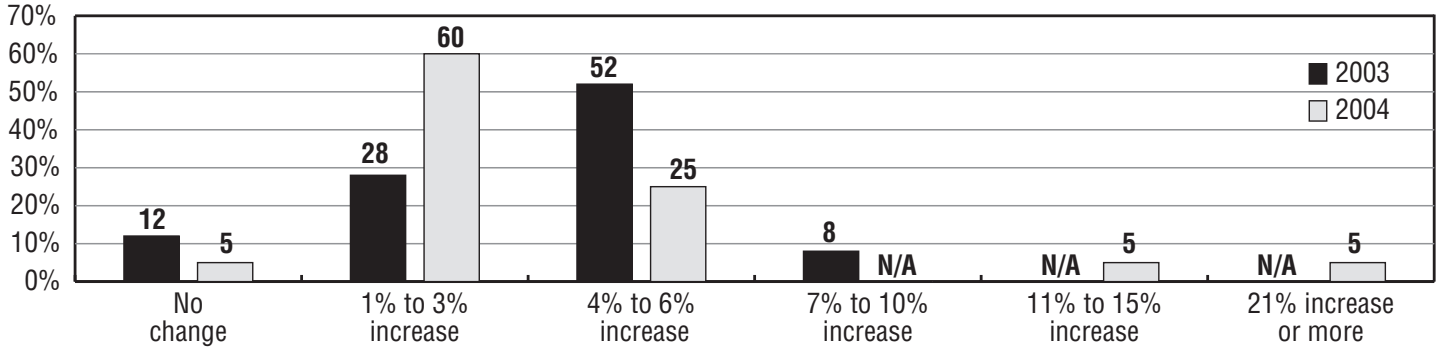
These benefits, along with little competition in her area, have made it easy to fill positions as her staff size increases, she adds.

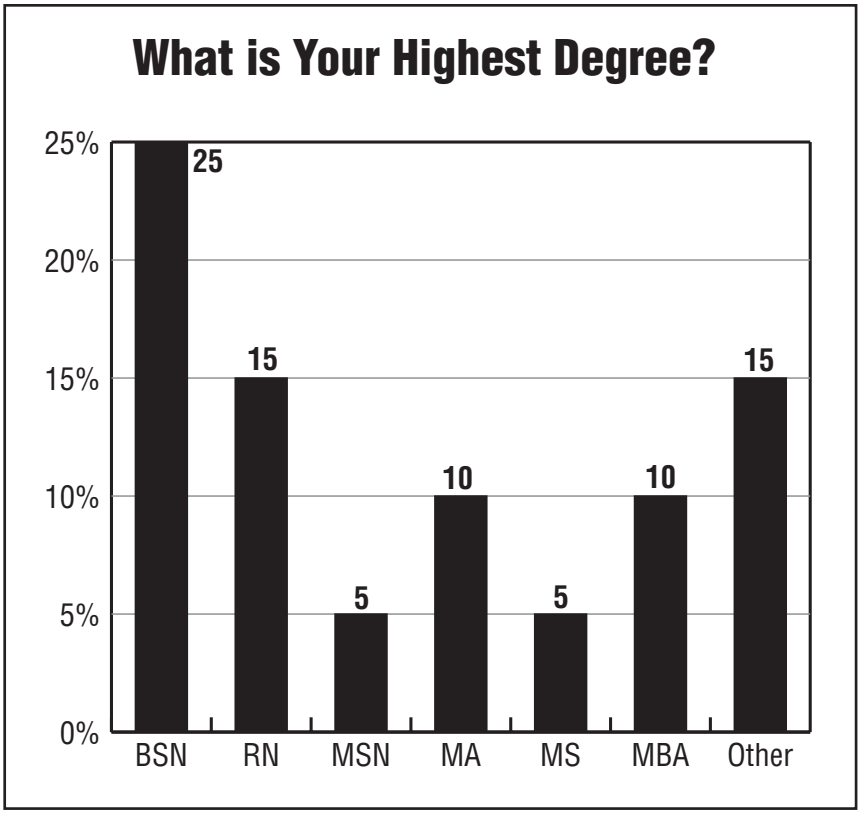
Does hospital affiliation help?

Hospital affiliation can be a plus when it comes to offering benefits, as 40% of survey respondents who report hospital affiliation can attest. The other 60% of survey respondents report that they work in freestanding agencies.

Ownership or control of home health agencies

In the Past Year, How Has Your Salary Changed?





represented in the survey ranged from 5% owned by colleges or universities; 10% controlled by state, county, or city government authorities; 35% owned by a for-profit entity; to 50% operated by a nonprofit corporation.

The greatest percentage of respondents, 45%, are located in the Midwest, and 30% are located in the West.

"We offer a traditional benefit package for full-time employees that includes health, dental, life, and disability insurance along with a 401K plan," points out **Lawrence M. Leahy**, MHA, CHCE, vice president of business development for Foundation Management Services, a Denton, TX-based company that owns and manages home health and hospice agencies.

"We have seen a reduction in our home care staff and our administrative staff, but our hospice business is growing. Turnover throughout our agencies is moderate but more prevalent within the home care agencies," Leahy adds.

Why do staff members leave?

The major reason for employees leaving their agencies is movement out of the area, according to Walden and Leahy. This is an issue rural agencies deal with on a regular basis.

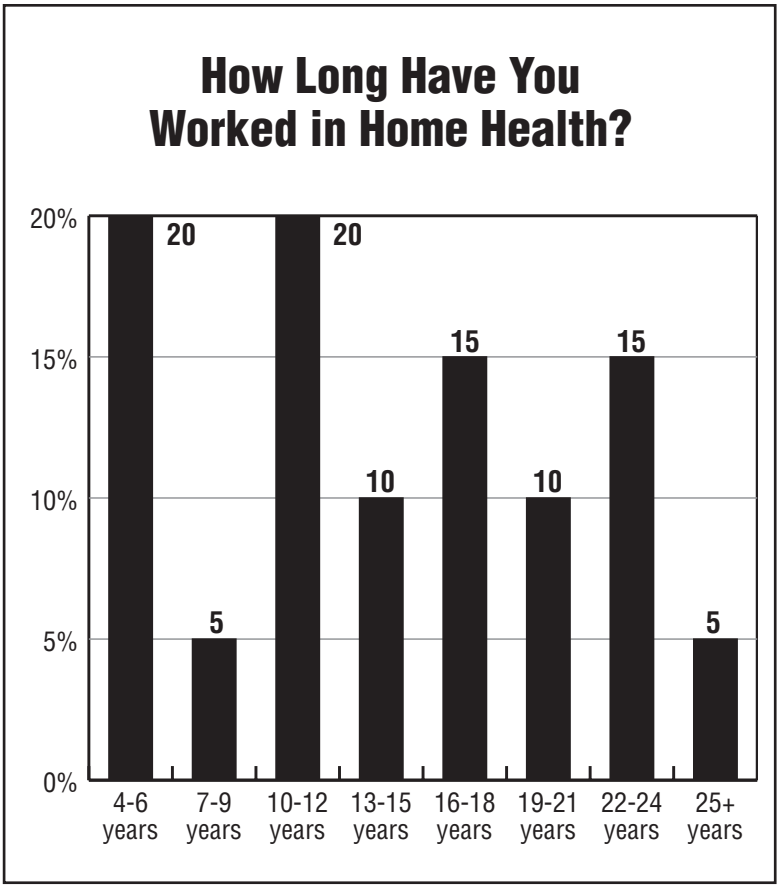
Only 15% of survey respondents are located in rural areas, with 10% located in urban, 25% in suburban, and 45% in medium-sized cities.

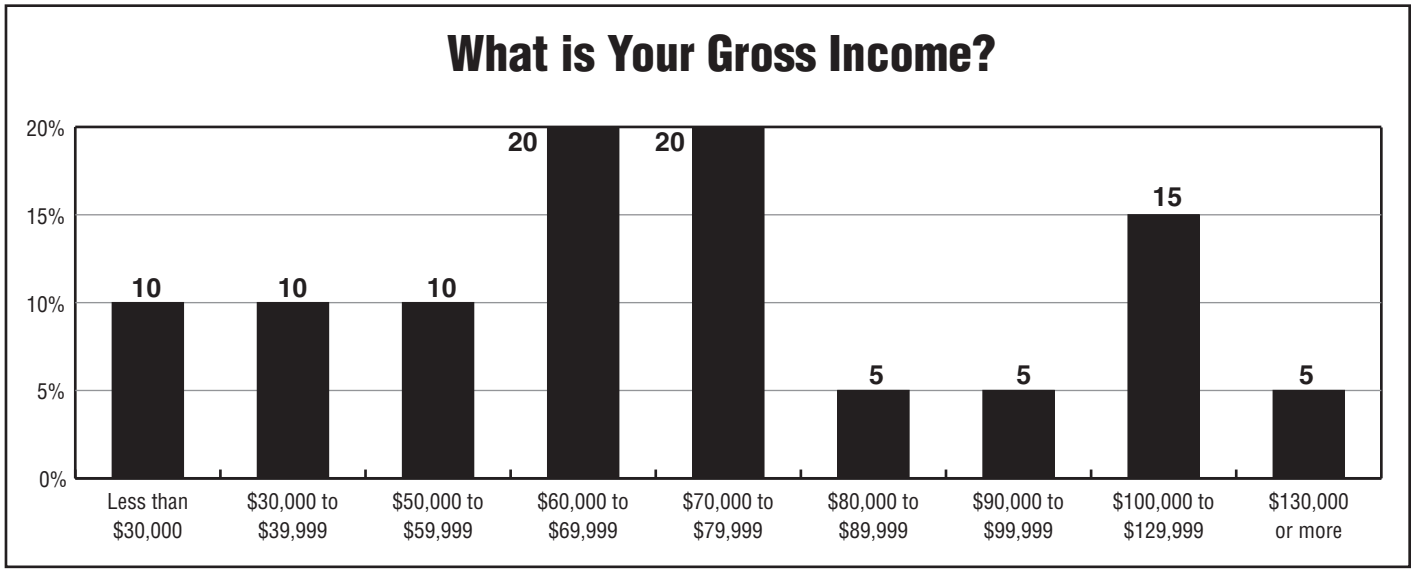
Neither Walden nor Leahy report any problems finding new employees because their agencies have excellent reputations as employers within their communities. **(For more about the importance of agency reputation and recruitment see "Your agency can become the local home health care employer of choice"** ***Hospital Home Health*****, October 2004, p. 109.)**

"We occasionally use newspaper advertisements, but our reputation means that word-of-mouth advertisement about openings works best," Leahy notes.

Because her agency offers competitive benefits and salary, Walden also points to word of mouth as the best way to attract new employees.

"Our best recruiters are our current

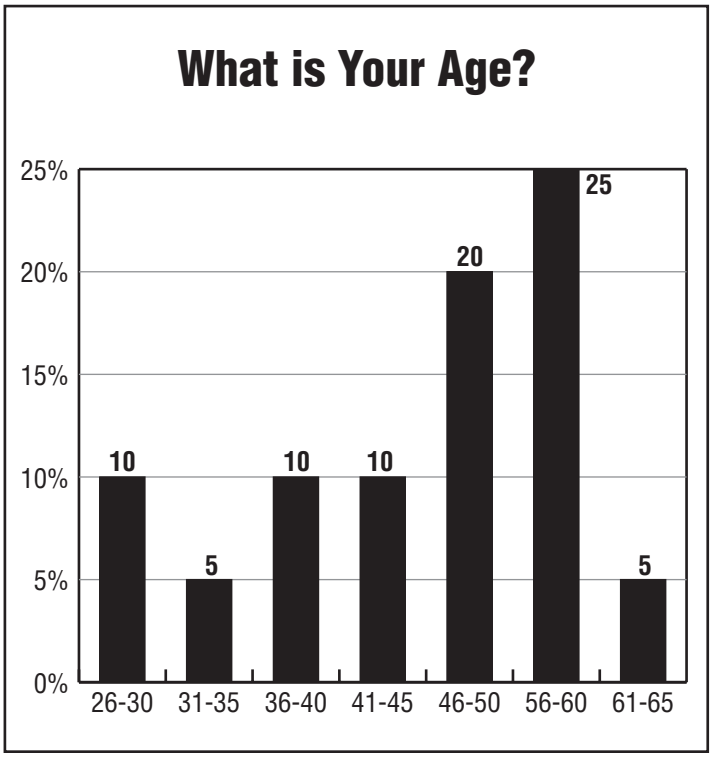




staff members who have friends in other home health agencies."

Employees who can handle their jobs

Even when it is easy to fill positions, it is important to make sure you are getting employees who have the experience and skills to handle the job. Salary survey respondents carry impressive credentials with 25% holding RN licensure and 20% holding graduate-level degrees. **(See chart, p. 2.)**



Years of experience also are present in survey respondents with 20% reporting between 10 and 12 years of experience in home health and another 25% reporting between 13 and 18 years of experience. **(See chart, p. 2.)**

When asked how long they have worked in health care, 45% of survey respondents report more than 25 years, and 30% report between 13 and 21 years of health care experience.

Even if your agency isn't experiencing high turnover rates, look carefully at your staff members' ages to predict future turnover.

Only 10% of survey respondents report their age as younger than 30, while 20% report their age as between 36 and 40. **(See chart, at left.)**

The most significant response to the question asking age was the 45% of respondents who indicated that their age was between 46 and 50.

Income levels follow age and experience with 50% of survey respondents reporting incomes of $70,000 per year up to $130,000 or more annually. **(See chart, above.)**

Thirty-five percent of respondents reporting income higher than $70,000 carry the title of vice president/executive.

Offer your staff opportunities to advance

One of the keys to retention of good employees is offering them a chance to advance in responsibility, education, or professional certification, according to Leahy.

"We offer internal continuing education unit programs, career ladders for all staff members, opportunities for staff members to develop new

"I am involved in a start-up hospice in rural Texas and have not had to advertise for any positions," he notes.

"For example, while negotiating a contract for inpatient services, I found out that the administrator's wife had tried to volunteer numerous times [for] our major competitor.

"I had lunch with her and found out that she had not only been a hospice volunteer but had also been a volunteer coordinator for a large hospice in Central Texas," he explains.

"Needless to say, she is now our volunteer coordinator," Leahy concludes.

[For more information, contact:

- ***Judith Walden**, BSN, CHCE, Director, Castle Home Care, 46-001 Kamehameha Highway, Suite 212, Kaneohe, HI 96744. Phone: (808) 247-2828. Fax: (808) 236-1337. E-mail: waldenjp@ah.org*
- ***Lawrence M. Leahy**, MHA, CHCE, Vice President, Business Development, Foundation Management Services, 1330 Teasley Lane, Suite 101, Denton, TX 76205. Phone: (361) 293-9099. E-mail: leahyl@fms-regional.com]* ■

programs, and support of professional certification," he notes.

No one promotes home health as an easy job if they want the new employee to begin work with realistic expectations.

In fact, only 30% of survey respondents report working 40 hours or less each week. **(See chart, at right.)**

The majority of respondents, 60%, report working between 41 and 60 hours per week, while 10% report working more than 65 hours each week.

Leahy's agency is up front with new employees. "We describe our culture which includes hard work, but we also offer fun and a management team that promotes friendship," he states.

Perhaps the most important aspect of working with Leahy's company is that employees do participate in decisions that affect them, he points out.

"Our company is supportive of the individual, and we have developed a team approach to accomplishing our goals," he says.

Leahy also points out that sometimes you have to keep your eyes and ears open to find good employees.