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Use technology to improve your patients' health and your agency

Telehealth positively affects outcomes, retention, and efficiency

(Editor's note: The Association of Telehealth Service Providers defines telehealth — also known as telemedicine — as follows: "Telemedicine is the use of electronic communication and information technologies to provide health care when distance separates the medical professional from the patient. It also includes educational and administrative uses of these technologies in the support of health care, such as distance learning and administrative videoconferencing. . . . Telemedicine typically involves physicians using interactive video and/or store-and-forward consultations to treat patients.")

Home health managers constantly are looking for ways to improve efficiency without compromising patient care. At the same time, they want to improve retention of good nurses so they are not always in a hire-and-train mode.

A study conducted by the Pennsylvania Homecare Association in Lemoyne and Penn State University in University Park, which was published this year, shows the use of telehealth can increase efficiency as well as improve retention of nurses.

The data show agencies using telehealth have an average RN to patient ratio of 1-to-15, while nontelehealth agencies have a ratio of 1-to-11. Thirty-four Pennsylvania home health agencies are participating in the study. Twenty-three agencies use telehealth, and 11 agencies do not.

"We decided to participate in the study when it began three years ago because we saw an opportunity to improve patient outcomes," says **Kim Kranz**, RN, MSN, vice president of operations for Home Nursing Agency in Altoona, PA. "We did not have telehealth prior to the study," she says. "We have seen improved outcomes because the information that we now receive daily through the telehealth system enables us to make decisions to intervene in a more timely manner," she explains. Not only has her agency seen a decrease in the number of rehospitalizations of congestive heart failure (CHF) patients, but Kranz and her staff have noticed additional benefits.

"Our relationship with our patients' physicians has improved

because we can call them with hard data about changes in their patients' condition," Kranz explains. "Physicians like data, and when we can provide readings from several days in a row to show trends, they are more responsive," she adds.

Kranz also expects telehealth to help when recruiting new nurses. "When younger nurses are ready to leave the hospital and look at home health as an option, they see telehealth as an important tool," she explains.

Unlike current home health nurses who may not be familiar or comfortable with new technology, younger nurses have grown up with technology, Kranz continues.

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"These nurses are techno-savvy, and they expect to have this technology available," she adds.

Even with existing staff, the use of telehealth is a positive, says **Linda E. Bettinazzi**, RN, BSN, president and chief executive officer of Visiting Nurse Association (VNA) of Indiana County in Indiana, PA.

"Our nurses are proud that our agency is progressive and looks for ways to help them do their jobs and better care for patients," she says.

"Our retention rates are high anyway, but telehealth is one more way to improve job satisfaction," Bettinazzi adds. **(For more on the relationship between employee satisfaction and telehealth, see article on telehealth, p. 51.)**

VNA of Indiana County has offered a telehealth service since 1999 and currently has 83 monitors that serve 90 patients. Some of their monitors can handle multiple patients who use an electronic card with their personal health information to access the monitor and send information.

"This is very helpful in an assisted-living facility where you can place the monitor in one central easy-to-reach location as opposed to providing multiple units in one location, Bettinazzi says.

"When we first began researching the technology, the video component was not very good, so we opted for a monitoring unit that collects vital signs through a unit in the patient's home that sends the information via a phone line to a central station in the home health agency's office.

"We can also program specific questions for the patient to answer, such as, 'How do you feel today?' to gather more information," she explains.

The patient's case manager reviews the data each day, Bettinazzi says. "These data aren't used to replace nursing visits; instead, they are used to determine when the patient most needs a visit.

"The nurse can visit the patient if there are readings that indicate a problem," she says.

This differs from the traditional system of scheduling a visit to a specific patient on Tuesday and Thursday of each week, Bettinazzi notes. "It is more effective because the patient might be fine on Tuesday but might have a crisis on Wednesday."

Plan time for installation and removals

Bettinazzi's agency has a dedicated group of four nurses to handle all 90 telehealth patients.

"Their caseload is higher than nontelehealth nurses' caseload, but they are not visiting their patients as many times," she points out. "We've found that our CHF patients on the telehealth

service receive an average of 10 visits as compared to CHF patients on traditional service who receive an average of 17 visits," she says. "Our telehealth patients are also rehospitalized fewer times," she adds.

At this time, the four telehealth nurses are responsible for both the installation and removal of the telehealth equipment, Bettinazzi says.

"I have suggested that we could train someone else to handle these tasks to free the nurses' time to be with patients, but the nurses want to continue the installation," she says.

"They believe it is an important teaching opportunity as they get to know the patients and their family members," Bettinazzi explains.

She is considering setting up an employee to handle the removal of the equipment upon discharge, she adds.

At VNA of Wyoming Valley in Edwardsville, PA, home health aides install and remove the equipment, says **Nancy P. Barnard**, RN, BSN, MHA, director of home health at the agency, an affiliate of Wyoming Valley Health Care System.

"The nurse is in the home immediately after, or at least on the same day as, the installation to teach the patients, but we've found that using the aides to install the equipment shortens the nurse's visit and makes better use of the nurse's time," she says.

One of the unexpected challenges with managing telehealth equipment is tracking all of the equipment and accessories, Barnard notes.

"You always remember to pick up the monitoring unit and items such as the blood pressure cuff, but little things like ground wires and telephone jacks often got left behind when we first started," she says.

"We now have a checklist that lists all of the items used to install the equipment, and the aide uses that checklist to make sure all of the items are picked up at discharge," Barnard adds.

"You can design your checklist to be taped to the monitor so that you don't have to search for the list when it's time for the aide to remove the equipment," she suggests.

All of the nurses in Barnard's agency work with telehealth patients. "We have an LPN who monitors the daily readings at the central station," she says.

The LPN checks with the scheduler to see if a patient whose readings are abnormal is scheduled for a visit that day, and together they will rearrange the schedule to make sure the patient is seen.

"We also talk with the patients by telephone to see how they are feeling and to see if their vital sign reading might have been affected by diet, medication, or other activity," she says.

Telehealth can affect staff retention and job satisfaction

The three-year study conducted by the Pennsylvania Homecare Association and Penn State University is designed to evaluate how telehealth affects not only patient care, but also home health's ability to continue providing care during the nursing shortage. In addition to looking at agency workloads, this study assessed home health nurses' attitudes towards their jobs and their response to telehealth. A total of 1,241 surveys were distributed to home health agencies participating in the study with a total of 629 surveys returned. Respondents were asked to score their responses on a scale of 1 (low) to 5 (high).

Results included:

- **Job satisfaction was high, with an average score of 4.18.**
- **Nurses' involvement in telehealth activities is low, with an average score of 1.9.**
  The majority of nurses report they perform telehealth activities less than once per week. This can be attributed to the fact that many agencies use a small core group of nurses to perform telehealth activities.
- **The average score for perceived usefulness of telehealth is 3.57.**
  The longer the home health agency has been using telehealth, the more useful the nurses perceive it to be.
- **Overall, nurses indicate organizational support for telehealth is in the midrange with an average score of 3.76.**
  Study coordinators also looked at the relationship between telehealth and nurse retention rates. A measurement of the annual turnover rate for each of the 34 participating home health agencies was taken.

Data show the following:

- **Voluntary turnover rates for RNs in this sample of home health decreased from 17% in the first year of the study to 13.4% in the second year.**
- **The lowest turnover rates were found in home health agencies that have implemented telehealth — estimated at 11% as compared to 19% for agencies without telehealth.**

Source: Pennsylvania Homecare Association, Lemoyne, PA; December 2004.

The combination of telehealth and telephone contact with patients enables Barnard's nurses to see patients when they most need to be seen, she explains.

Therapists find data helpful

Most agencies are targeting patients with certain diagnoses such as CHF, diabetes, prenatal, coronary artery disease, or stroke for telehealth, but it can be helpful for non-nursing cases as well, Barnard notes. "We may discharge a stroke patient from our nursing service before the therapy services are complete, but we don't immediately pull the monitor from the home," she says.

"We found that our therapists were very interested in the data that showed a patient's vital signs when at rest, immediately before therapy, and immediately after therapy," Barnard says. "We started leaving the monitors in the home when therapists expressed disappointment that we were taking them as soon as the patient was discharged from nursing care," she adds.

One recommendation that Bettinazzi has for managers implementing a telehealth program is to have standing orders for interventional activities in place. "There are things our nurses can do in the home to prevent a trip to the hospital, but some of our physicians are hesitant to allow us to intervene at home when we call to tell them their patients are experiencing difficulties," she says.

"They tend to send the patients to the hospital," Bettinazzi explains. If, at the start of a telehealth service, you can set up some standing orders specific to CHF or other conditions, it will further decrease visits to the emergency department and rehospitalization, she says.

"As nurses age and we have to care for patients with fewer nurses due to the nursing shortage, it becomes more important to have data from telehealth to determine which patients need to be seen on each day," Bettinazzi says.

By making sure a nurse's time will be used effectively, you can provide quality care without overextending your staff and risking staff burnout, she adds.

Kranz contends telehealth is an important tool for home health and says, "With the emphasis on reducing rehospitalizations and improving home health outcomes, and the pay-for-performance approach to home health reimbursement that is around the corner, telehealth is not going to be just a nice addition to our services; it is going to be essential to our agency's success."

[For more information about telehealth services, contact:

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For more information about results of the Pennsylvania Homecare Association study, go to www.pahomecareresource.org and choose "research" on the left navigational bar. Under the heading "Telehealth Research," there are three reports that provide information collected during the first two years of the three-year project.] ■

Lymphedema program attracts new patients

Certification for therapists is a must

One way to set your agency apart from other agencies is to offer a service not offered by others in your market. A Florida hospital home health care facility established a successful lymphedema program that resulted in an increase in referrals and a reputation as an expert in specialized care among physicians.

"I was working in the outpatient services department of the hospital before I transferred to home care, and I saw how use of the new lymphedema treatments could prevent hospitalization for patients if they were administered before the patient reached an acute stage," says **Susan Allen**, OTR/L, CLT/LANA, staff occupational therapist and lymphedema specialist at Florida Hospital Homecare in Orlando.

"By treating the lymphedema in a timely manner, we can help improve wound care because improved circulation helps wounds heal more quickly," she explains.

The typical patient in Florida Homecare's

program is an average age of 69 and on Medicare, says **Craig Moore**, MSPT, rehabilitation supervisor at Florida Hospital Homecare.

Female patients comprise 67% of lymphedema patients, with cancer treatments and surgical procedures causing the lymphedema. Thirty-three percent of patients are male with venous problem contributing to their lymphedema, he says.

Because many of his agency's lymphedema patients also require wound care, it is important for therapists and nurses to work together, Moore explains.

"We usually schedule back-to-back visits for the nurses and therapists so that a therapist comes to the patient at the end of the nurse's visit, he says. This enables the nurse to provide the wound care before the therapist provides the lymphedema treatment.

Cost-effective program

Developing a program specifically for lymphedema treatment is cost-effective, Moore points out. "These patients have a chronic condition that can result in infections and other complications that require hospitalization if the lymphedema is not treated or monitored," he says.

"By setting up a home care visit, we can see patients before these complications occur," he adds.

Not only does reimbursement cover the costs of the therapist and supplies for lymphedema treatment, but also, by treating the lymphedema, the patient's wounds heal faster and signs of infection are more likely to be discovered before they require hospitalization, Moore explains.

"Plan on seeing these patients for a while; 90% of our lymphedema patients require more than 10 therapy visits," he continues.

Advances in treatment of lymphedema make home care of the condition much more effective, Allen points out.

"In the past, we were limited to the use of pumps, diuretics, and elevation to reduce the swelling, but we now know that manual drainage, or massage, as well as compression bandages and patient education can improve patients' conditions and reduce the risk of complications," she continues.

An important part of patient education is making sure the patient knows the signs of infectious cellulitis, a complication of lymphedema, Allen notes.

"When infections are caught early, they are more easily treated," she continues.

While home care nurses can be taught how to massage a patient and put compression bandages in place, it is important that you have lymphedema specialists on staff, Allen suggests.

"Five of our therapists have undergone the 140-hour training course to become certified as lymphedema specialists so we do have the expertise to set up a treatment plan that is most effective for each patient," she explains.

"Because the number of lymphedema patients waxes and wanes, these therapists also see other patients," Moore explains.

When there are a high number of lymphedema patients, home care nurses who have been taught the basic massage and bandaging techniques can see some patients between therapist visits, he says.

Referrals to the lymphedema service come from hospital case managers and physicians, Moore says.

Although the home care agency did provide inservice education to local hospital discharge planners and case managers, the service has grown primarily because of good outcomes, he explains. "We have seen a 97% improvement in activities of daily living for patients on this service."

"Word-of-mouth promotion from physicians who have told us that they are pleased with the dramatic results they've seen in their patients have generated the most referrals," Moore adds.

The best way to ensure a successful lymphedema program is to invest in training some therapists as specialists, Allen notes.

"Therapists can attend a three- to four-day conference and learn some skills, but they won't be prepared for all types of lymphedema," she says.

"The two-week certification course is the best way to make sure that your therapists have all of the skills needed to positively affect outcomes and reduce emergency department visits and rehospitalizations," Allen explains. **(For more on the courses, see contact information at the end of this article.)**

While lymphedema is a chronic condition, home care provides the best chance for patients to regain a better level of independence and handle their condition on a long-term basis, Moore says.

"The one-on-one education gives patients a better understanding of lymphedema and gives them more confidence that they can manage it after home care ends," he adds.

[For more information about setting up a lymphedema home care program, contact:

- ***Craig Moore**, MSPT, Rehabilitation Supervisor, Florida Hospital Home Care Services, 600 Courtland St., Suite 300, Orlando, FL 32804. Phone: (407) 691-8205, ext. 4346.*

For information on certification as well as links to other lymphedema organizations, contact:

- ***The Lymphology Association of North America**, 1901 N. Roselle Road, Suite 800, Schaumburg, IL 60195. E-mail: lana@telusys.net. Web site: www.clt-lana.org.]* ■

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Understanding Laws, Rules, Regulations

Fraud alert issued for home health providers

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

Home health agency staff may benefit from a reminder that the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services issued a Special Fraud Alert that specifically addresses the issue of fraud in the home health industry. (Go to www.oig.hhs.gov and search for Special Fraud Alert.) That alert specifically addresses false or fraudulent claims relating to the provision of home health services, claims for home health visits that were never made and for visits to ineligible beneficiaries, fraud in annual cost report claims, paying or receiving kickbacks in exchange for Medicare or Medicaid referrals, and marketing uncovered or unnecessary home care services to beneficiaries. A number of these areas are especially problematic for home care providers:

Claims for visits to ineligible beneficiaries

The OIG reminds home care agencies that Medicare will pay for home health services when beneficiaries' physicians certify that they are:

- homebound, i.e., confined to the home except for infrequent or short absences or trips for medical care;
- in need of one or more of the following qualifying services: physical therapy, speech-language pathology, or intermittent skilled nursing services.

Agency staff members, however, are all too familiar with situations in which physicians certify patients for Medicare home care services who do not meet these criteria.

One of the key reasons for inappropriate certifications is that physicians do not understand the requirements for eligibility for Medicare home care services described.

In most instances, physicians have not been initiated into the specifics of eligibility for Medicare home care services. In addition, agency staff members often interpret and apply these criteria in different ways, which tends to further confuse physicians about who can be certified.

Finally, physicians often are subjected and vulnerable to pleas from family members to certify or recertify patients because the caregivers feel an acute need for assistance regardless of the eligibility requirements.

The OIG also makes it clear, however, that both physicians and home care staff have a responsibility to resist the provision of home care services to patients who are ineligible.

Specifically, the basis on which any claim is submitted is that the services provided were necessary and appropriate. When services are provided to ineligible patients, the services fail to meet these criteria because they were not necessary and/or appropriate. Thus, claims submitted for patients who do not meet the criteria for services are false claims.

Both physicians and agency staff members have a responsibility to police the provision of inappropriate or unnecessary services according to the OIG.

Specifically, physicians who order unnecessary home health care services may be liable for causing false claims to be submitted by the home health agency, even though physicians do not submit the claims themselves.

Furthermore, if agency personnel believe services ordered by physicians are excessive or otherwise inappropriate, the agency cannot avoid liability for filing improper claims simply because a physician has ordered the services.

Historically, agency staff members have sometimes stated they know patients are appropriate for home health services because physicians have certified them for care. That Special Fraud Alert forces home care providers to look behind the

certification to make an independent evaluation about appropriateness. Agencies have an independent obligation to make sure ineligible patients do not receive services, even if physicians certify them for home care services.

When staff identify instances of improper certifications, an appropriate course of action may be to involve the agency's medical director. The best communication with physicians is still doctor-to-doctor. The medical director should, therefore, personally contact physicians who certify inappropriately to talk with them regarding Medicare eligibility and to explain why patients will not receive services after all.

It also may be helpful for agencies to initiate efforts to provide education for physicians regarding Medicare criteria for home health services. An ounce of prevention sometimes is worth a pound of cure, in the sense that it is far better to assist doctors to reach appropriate conclusions about eligibility for home care services than to confront them repeatedly regarding specific patients.

Kickbacks for Medicare or Medicaid referrals

This area of the Special Fraud Alert is especially problematic for hospital-based agencies because the OIG specifically indicated that providing hospitals with discharge planners, home care coordinators, or home care liaisons to induce referrals is a kickback or rebate.

The prohibition against the provision of hospital discharge planners has been clear for some time. The additional twist in the alert is that the OIG now prohibits use of home care providers or home care liaisons by agencies in hospitals as well.

Hospitals are obligated to provide discharge-planning services to patients according to the Joint Commission on Accreditation of Healthcare Organizations and other applicable requirements.

To the extent that home care agencies provide discharge planning services that the hospitals are obligated to provide, hospitals save money.

The OIG characterizes those savings as kickbacks or rebates if agencies that provide discharge-planning services also receive referrals of patients, and the provision of discharge planning services by agency personnel does not fall within one of the exceptions or "safe harbors."

But the OIG's language about prohibitions on home care coordinators or liaisons in hospitals is difficult to interpret and apply.

Part of the difficulty lies in the fact that there is a genuine need for coordination of home care services between hospital discharge planners, family members, and home care staff while patients are still in the hospital *after the discharge planning process is complete.* That is, after the discharge planning staff have developed a discharge plan that includes home health services, it may be appropriate for home care staff to begin the process of coordination of services while the patient is still in the hospital.

The key to compliance is that the discharge planning staff must make a decision, *independent of assistance from home care staff*, that the patient may be appropriate for home care services even if a home health agency later determines that the patient is not appropriate for home care services after all.

Since the decision to refer patients is made by the discharge planners, the subsequent coordination or liaison work of agency staff does not supplant the work of discharge planners that hospitals are required to provide and, therefore, may not constitute a kickback or rebate.

Specifically, agency staff members should not:

1. **Regularly attend discharge planning meetings for all patients being discharged to home care until a referral has been made first.** Although agencies are used to thinking of a referral as something that must come from a physician, referrals can come from a variety of sources, including physicians, discharge planners, patients, patients' family members, etc. They may be verbal or in writing.
2. **Engage in so-called "case finding."** Agency staff members should not roam hospital floors reviewing charts of patients who are going to be discharged in search of patients who may be appropriate for home health services.

The key distinction on this issue may be whether the activities of home care coordinators and liaisons involve activities that induce referrals. To the extent that the activities of agency staff members amount to no more than routine coordination that is done for many patients who are referred to the agency, it is doubtful that the agency has acted to induce referrals. But, to the extent that agency personnel become intimately involved in assisting hospital discharge planners to do their jobs, the OIG may reach a different conclusion.

The Special Fraud Alert is by no means the final word on this issue for home care providers. Agency staff members must closely monitor

developments in this area to make certain their conduct does not run afoul of the law.

[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.] ■

Help your elderly patients prevent falls

Tips to prevent serious injuries caused by falls

Elderly patients pose special challenges when it comes to falls, so your prevention strategy must take into account the factors unique to this population. This summary is offered by Roberta A. Newton, PhD, professor of physical therapy at Temple University in Philadelphia:

Vision

Visual acuity decreases with age. Therefore, periodic eye exams or checkups are recommended. Be aware that either old prescriptions or new prescriptions can alter the visual field and cause falls. Also, clean glasses daily.

Changes in contrast sensitivity occur. This is related to the ability to detect and discriminate objects in the environment. One way to accommodate this is to increase the lighting, such as using higher wattage bulbs.

Decline in depth perception occurs as a decreased ability to judge distances and relationships among objects in the visual field. Stairs, carpets with patterns, and curbs are risk factors for individuals with such declines in depth perception. The person may have difficulty estimating the height of the step and therefore misplace the foot. Or the person may think that the carpet is uneven and alter balance and walking to accommodate the misperception.

The ability to recover from a sudden exposure to a bright light or glare decreases. When moving from a dimly lit to a brightly lit environment or the reverse, the person should pause a second to allow the eyes to accommodate to the change in light.

Hearing

Periodic hearing checkups are recommended. Because we rely on sound for orientation in the environment, a person may not be as quickly aware of a potentially hazardous situation when hearing is decreased.

Feet and shoes

More than 75% of older adults have foot pain. Foot pain is caused by, but not limited to, thin heel pads, corns, bunions, dry and cracked skin, ingrown or overgrown toenails, and sores. Foot pain can cause a change in the biomechanics or alignment of the body, thereby increasing the risk for falls.

Another potential risk factor for falls is the decreased sensation in the feet. This is more noticeable in the person with diabetes, but gradually occurs with the aging process. Sensation can be tested on the person using a Q-tip or something soft and brushing it on the sole of the foot.

Caregivers also may consider a daily foot inspection for red areas, sores, condition of toenails; application of cream; avoidance of abrasive substances such as pumice stone or acid to reduce calluses or corns; and shoe inspection for worn areas.

Also noteworthy is the condition of the person's currently worn shoes and slippers. Ill-fitting or badly worn footwear can lead to tripping and falling or sprains and strains. This problem is especially hazardous when combined with ill-fitting clothing that drags on the floor.

Medications

Four or more medications constitute an automatic risk factor for falls. Single or multiple medications (polypharmacy) can cause side effects such as dizziness, drowsiness, or low blood pressure. Prescription medicines and regularly taken over-the-counter medications should be checked by the physician or pharmacist.

Balance and gait

A gradual decline in balance abilities and speed of gait occurs with age. These two are linked with activity level. One cause of tripping and stumbling is the anterior tibialis muscle, which dorsiflexes the ankle and toes to clear the toes during walking. With age, it becomes a little out of sync in its timing with other muscles in the leg. As a result, the timing of toe clearance is a little off and the toe may catch on the floor. During walking, toe clearance is approximately 1 cm.

Gait speed also decreases, and the person may not have sufficient time to get out of the way or

may have to hurry to perform various activities.

To have to walk faster, particularly when it is associated with anxiety, can cause a fall. Remaining active and participating in leisure and social activities helps maintain balance and gait.

Blood pressure

Both high and low blood pressure can cause a person to become unsteady. When moving from one position to another, such as either from the bed to sitting or from a chair to standing, the person should pause for a couple of moments to let the blood pressure adjust and to orient to the new position.

(Editor's note: For more advice on preventing falls among the elderly, go to www.temple.edu/older_adult/fppmanual.html.) ■

Holistic approach helps special-needs patients

Patient care and social work go hand-in-hand

Since Horizon NJ Health plan started its Care Coordination Unit (CCU), a comprehensive, holistic program for Medicaid beneficiaries with special needs in 2000, costs of care for special-needs members have dropped in many cases.

"Our goal is to provide quality care for these members and to manage them in order to keep them out of the hospital," says **Karen Szerlik**, RN, CMCN, team leader of the CCU.

The CCU case managers work with populations of all ages with mental and physical disabilities and complex medical conditions.

Members in the program range in age from infants to the elderly, and many have multiple comorbid conditions, including mental health problems.

Some of the members have specific disabling conditions such as quadriplegia, paraplegia, cerebral palsy, spina bifida, Down syndrome, and autism. Others have complex chronic conditions such as HIV/AIDS, sickle cell disease, and end-stage renal disease, while others may be waiting on an organ transplant or undergoing cancer treatment.

The CCU case managers take a holistic approach to coordinating care and often work with the plan's social work case managers to help with members' nonmedical needs, including housing, food, transportation, and utilities.

"In order to promote good medical outcomes, we address the member in a holistic way, including providing support to the caregivers of an adult or the parent of a child. If psychosocial support is not provided for patients with special needs and their caregivers, the outcome is likely to be very poor," Szerlik adds.

The CCU case managers look at the needs of the members they work with and seek to meet them, whatever those needs are. For example, if a member is wheelchairbound and needs transportation to the physician or clinic, the case managers authorize for the member to receive transportation assistance.

The CCU case managers collaborate with the health plan's social case managers to provide the members with linkages to community agencies that can help with their care, adds **Cathy Kelly**, RN, BA, CMCN, manager of clinical operations.

For instance, if a member has cerebral palsy, the case managers help them get access to a cerebral palsy clinic and also help the caregiver get involved with a support group.

"With chronic diseases such as cystic fibrosis, cerebral palsy, muscular dystrophy, and sickle cell disease, care can be enhanced with social support. Because many of our members have been in other Medicaid programs that don't offer or even have this kind of social support, they do not know how to access community resources," she adds.

The CCU case managers coordinate with the social case managers and durable medical equipment providers to ensure the members have everything they need after discharge. The case managers make sure the durable medical equipment company does a home evaluation before any equipment is provided.

"If you provide a $20,000 electric wheelchair to somebody who lives on the [third] floor of a building with no elevator, you're doing them a disservice. We check the home out before the member receives the service," Szerlik notes.

On occasion, the CCU case managers will visit their clients in the home if they feel a personal visit is necessary to review the situation and the members' needs.

"If we feel that our eyes in the community or our community contacts and linkages are missing something that could impact the health and welfare of the member — or we have a concern that something isn't what it might appear to be on the

surface — we send our nurse case managers or the social case managers out to the house so that we can provide the best services possible for each case and each member's needs," Szerlik says.

For instance, one patient was having problems with the bedrails breaking constantly when she was turned over for wound management. The case manager talked to both the home health nurse and the member's husband and discussed the problem with the equipment company.

When Szerlik visited the home, the case manager discovered that the bed was so small that the woman had very little room in which to maneuver. She only had five inches in which to turn around. Szerlik arranged for a larger bed and solved the problem.

"Mental health is a very big issue, whether it's a need for counseling for behavioral issues or difficulty in coping or helping relieve the stress a caregiver experiences when taking care of a special-needs patient," Szerlik reports.

The case managers are able to give social support and help families tap into resources that will provide respite care. It means a lot to family members to know they have someone to talk with when they have problems or just need a shoulder to cry on, Kelly explains.

"Some families have two or three special-needs children. It's hard to imagine the demands put on these caregivers," she adds.

The health plan coordinates care for all members, but the special-needs members often need a lot of coordination, Szerlik says. For instance, some members with complex medical needs may be going to as many as five different hospitals for care. The case managers set them up for care at a tertiary care center with various specialists so they can receive care in one place.

In the case of newborns with special needs, the case managers help the mother understand what their infants require, help them coordinate visits to specialists, and assist them in connecting to services in the community that they need.

When a member joins Horizon NY Health, the outreach staff begin an aggressive program to get in touch with the member so they can conduct a screening to see which programs would best benefit him or her. "We make numerous attempts to get to the member by telephone, send out letters if there is no phone number available, and work with the primary care physician to locate the member," Kelly says.

The prescreening questionnaire contains triggers that indicate if the member needs a more extensive risk assessment to determine if he or she qualifies for the special-needs program. Primary care physicians, internal staff, and self-referral also make referrals to the program from members.

The case managers receive the referrals and conduct a risk assessment to determine if the member has complex needs.

The risk assessment stratifies members into three categories, each with different levels of contact. Members on Level 1 receive at least one outreach attempt annually. Case managers are in touch with Level 2 members on a monthly basis and those on Level 3 twice a month.

During the initial contact, they begin educating the member on the services that Horizon NJ Health will provide. "Most of the members are accustomed to straight Medicaid fee for service. We discuss and explain the services we provide and help them navigate through the system," Kelly says.

The health plan also sends the members a formal letter introducing them to their case manager with a telephone number they can call if they have questions or problems. Any case that is referred to the CCU stays open as long as the member is in the plan. Members' levels can change, depending on their needs at the time, and the type of support they need may change over time.

"It's one thing to understand what a little baby needs. As a person with cerebral palsy or muscular dystrophy grows older, the caregivers also need someone to talk to about the evolving needs," Kelly adds.

Staff at Horizon NJ Health have biweekly multidisciplinary meetings to discuss the needs of the members. Staff attending include the medical

director, pharmacist, social case manager, regulatory affairs, and legal services if needed.

The case managers bring up specific cases with unresolved issues, and the team collaborates on how to resolve the problems.

"In a holistic approach, the case manager needs to address counseling support. For instance, if we have a member in a pain management program, it's critical for them to develop a coping mechanism," she says.

The case managers coordinate dental care for special-needs patients through Horizon Dental's special-needs program for dental services. Many of the children are wheelchairbound and have behavioral issues that make it difficult for them to receive dental care from a dentist who is not skilled in working with special-needs patients.

"These children can't express that they're in pain, but they may exhibit behavior outbreaks. In any case, they still need routine dental care. Our nurse case managers work with Horizon Dental to make sure they get special-needs dentistry," she says. ■

NEWS BRIEF

3 free HIPAA resources available on the Internet

Three resources that address the security rule of the Health Insurance Portability and Accountability Act (HIPAA) are available on the Internet.

1. The National Institute of Standards and Technology (NIST) has released a special publication that gives examples of how organizations can meet the requirements of the security rule. The paper, "An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act Security Rule," explains some of the key concepts of HIPAA security, including administrative, technical, and physical controls, as well as general administrative and organizational requirements. The NIST paper is available at www.csrc.nist.gov. It is listed as Special Publication 800-66.
2. The Centers for Medicare & Medicaid Services has published the third white paper in its HIPAA security series. The paper addresses physical safeguards required by HIPAA, and it can be found at www.cms.hhs.gov/hipaa/hipaa2/education/.

   The objectives of the white paper include the following:
   - to review each physical safeguard and implementation specification listed in the security rule
   - to discuss physical vulnerabilities and provide examples of physical controls that a covered entity (CE) could implement
   - to provide sample questions CEs may want to consider when implementing physical safeguards

   The next paper in the series will cover technical safeguards under the security rule.
3. A third HIPAA resource addresses transaction and code set requirements and questions. A web site (www.x12n.org/portal) sponsored by the Washington DC-based American National Standards Institute's Accredited Standards Committee X12 and the Alexandria, VA-based Data Interchange Standards Association puts providers in touch with expert volunteers who answer questions about interpretations and inconsistencies of implementation guides for HIPAA's code set and transaction rules.

   A searchable database can give visitors answers to frequently or previously asked questions. The site can help providers negotiate or resolve disputes with business associates, partners, clearinghouses, and other entities by providing clear definitions and interpretations. To search the database, click on "search" on top navigational bar. ■

CE *questions*

For more information on the CE program, call customer service at (800) 688-2421.

5. What is one of the unexpected challenges discovered by Nancy P. Barnard, RN, BSN, MHA, director of home health at Visiting Nurse Association of Wyoming Valley in Edwardsville, PA, when managing a telehealth service?
   A. finding employees interested in learning about the equipment
   B. convincing patients to use the equipment
   C. documenting results of program
   D. making sure all equipment and related wires and connecting pieces are recovered during removal of the equipment at discharge

6. According to results of the telehealth study conducted by the Pennsylvania Home Care Association and Penn State University, what is the turnover ratio of home health agencies with telehealth as compared to home health agencies without telehealth?
   A. 8% to 15%
   B. 11% to 19%
   C. 14% to 21%
   D. 16% to 23%

7. What outcome have patients experienced since his agency set up a specialty program focused on the care of lymph edema patients, according to Craig Moore, MSPT, rehabilitation supervisor at Florida Hospital Homecare in Orlando?
   A. 58% improvement in activities of daily living (ADL)
   B. 65% improvement in ADL
   C. 85% improvement in ADL
   D. 97% improvement in ADL

8. According to Elizabeth Hogue, if home health agency personnel believe Medicaid services ordered by physicians are excessive or otherwise inappropriate, the agency cannot be held liable for filing improper claims because the services were ordered by the physician.
   A. true
   B. false

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

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. ■

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the September issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■