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Improperly trained home health aides result in fraud charges

Medicaid billed for visits performed by aides

A two-year investigation of the home care industry in New York has resulted in the indictment of B&H Health Care Services, also known as Nursing Personnel Homecare, a Brooklyn, NY-based home health agency. According to the indictment, agency management knew that home health aides had not received proper training for the services they provided. That lack of proper training made the aides' services ineligible for the $30 million in Medicaid fees for which the agency billed New York and received payment.

In New York, home health aides must complete a minimum of 75 hours of training from a training program licensed by the Department of Health or the State Education Department. Sixteen of those hours must be supervised practical training conducted by a registered nurse. In addition to the indictment of the home health agency, charges have been filed against two people who helped the agency hire the aides and arranged for them to receive certifications from training schools without the required training.

Although the New York training requirements and the involvement of home health aides training schools may differ from the experience of agencies in other states, the experience in New York is a "harbinger of what is coming," says **Robert W. Markette Jr.**, a home health attorney with Gilliland, Markette & Milligan in Indianapolis. "Home care fraud enforcement is picking up in all states," he says. States are looking carefully at kickbacks, suspicious profit-sharing programs, and false claims, he adds.

The reason that New York is important is that staff training and competence became an issue in the fraud case, says Markette. Although training requirements may differ from state to state, it is important that every agency document aide training and competency tests, he adds. "Every home health agency that bills Medicare must meet the Conditions of Participation requirement that staff members are certified to perform their jobs and that they pass competency tests related to their job responsibilities," he points out.

"In Indiana there are not a lot of training agencies, or schools to train

home health aides, in fact, most home health agencies train their own aides," points out Markette. The only time an agency needs to be careful about accepting a training certification is if the aide is hired from another agency and does not repeat training at the new agency, he adds.

Although New York regulates aide training programs and requires agencies that want to train their own aides to submit a lengthy, comprehensive application that explains curriculum and teaching staff experience, the management at Home Aides of Central New York in Syracuse, NY, chose to provide the training program to the aides hired for the agency. In addition to classroom time, each aide spends two days shadowing an experienced aide, then the first three in-home visits by the aide are supervised by a nurse, explains **Amy Kostyk**, vice president of operations for the agency. Throughout the year, a nurse will supervise aide visits on a random basis, she adds.

The aide training program covers topics such as the patient's bill of rights, Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations, proper body mechanics for transferring patients, procedures to protect against bloodborne pathogens, personal care skills, and nutrition, explains Kostyk. "There is a written exam and every aide must pass a competency assessment that includes demonstration of skills," she adds.

During the training period, the aide is not an employee of the agency, points out Kostyk. "This gives us time to observe the aide's skills as well as his or her interpersonal skills," she explains. "If we see weakness in any area or a disinterest in the job, we ask the person to leave the program," she adds. If an aide requires extra training or additional supervision to master some of the skills, but they appear to be committed and interested in learning the job, they will get an opportunity to retake the tests, she adds.

Competency assessments key to training

A competency assessment is a critical part of evaluating an aide's training, says Markette. Medicare Conditions of Participation require competency assessments, and home health agencies should be documenting each assessment, he says. Competency assessments for aides that have been trained at other agencies also provide protection for agencies, he says. If an aide presents training certification from another source and passes your competency assessment, you can demonstrate that you had no reason to believe that the certification was not legitimate, he explains. "A home health agency is not required to investigate the credentials of a training agency," he adds.

A home health manager should pay attention to trends in competency assessments for aides trained through another organization, suggests Markette. "If you see that several aides with certification from the same organization consistently fail parts of the competency assessment, you should talk with the training organization," he suggests. Let them know what areas of the assessment pose problems for the aides and offer to

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review their curriculum to see if it addresses the areas included in your assessment. "If you have reason to believe that a training program might not be providing the education and you ignore the potential problem, then you could be at risk for hiring aides that are not trained appropriately," he explains.

If you are training your own aides, be sure that their job responsibilities are in line with guidelines set by your state, warns Markette. "There is a question about the limits for home health aides in some states," he says. While an RN can administer medication, home health aides, in most cases, cannot, he says. "But is it administering medication if the pills are counted out and placed in pill boxes and the aide reminds the patient to take the medicine, and may hand them the pills that have been counted out?" he asks.

Because job responsibilities and types of patients may differ from agency to agency, be sure that the training aide that you hire matches the responsibilities that he or she will perform for your patients, suggests Markette. This is another reason to use a standardized competency assessment for your agency and have all new hires assessed before they are hired, he adds. "If a new hire doesn't pass a competency assessment, don't assume the training was inadequate," he says. "Some people don't test well, so be sure you give them a chance to receive additional training and supervision before they re-test," he adds.

Document visits accurately

In addition to making sure that your aides have the skills and training to perform the visits for which you'll bill Medicare or Medicaid, be sure, too, that they understand the importance of accurate documentation of visits, says out Markette. "While the lack of training in New York was part of the fraud, be aware of the potential for aides who claim visits that were never actually made," he says. This fraud risk probably applies to more agencies because not all states have the training requirements that New York has, he explains.

"Unfortunately, this type of fraudulent activity is hard for an agency to catch if families and patients participate in the deception," says Markette. "Aides typically stay with a patient for a longer period of time and see the patient and family members more often than a nurse," he says. The relationship that develops can make families want to protect the aide, even when he or she calls to tell them she can't come by. "I've heard of cases in which the family will call a number and punch a code to say that the aide is at the home and that the aide has left, even when the aide never visited," he says.

"We use a timesheet that the aide and the family sign at each visit," says Kostyk. "We also compare computerized timesheets with the signed timesheets to verify accuracy," she adds.

If there is a conscious decision by the aide to defraud the agency and Medicare, and the family is complicit, it is tough to uncover the fraud, admits Markette. "You can randomly call family members and patients to conduct patient satisfaction surveys and ask about the last time the aide visited," he suggests. In fact, every agency should have a protocol in place to check on all staff members and verify that visits are conducted, he says.

If there is an accusation of fraud, the agency should be able to point to their policy, document agency efforts to verify visits, and demonstrate that employees are told to file visit information correctly, says Markette. "Showing that the agency is not involved in the fraud and that agency staff took every step possible to prevent or uncover fraud is a good defense." ■

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Education and best practices cut infection rates

Make sure caregivers know early symptoms of UTI

[Editor's note: This is the first article of a two-part series on how to reduce the risk of infection for patients with indwelling bladder catheters. This month we take a look at the factors that increase the

risk of infection, patient and staff education, and identification of best practices. Next month, the "sacred cows," or practices that are not based on scientific evidence, will be identified along with the proper practices for catheter care.]

The number of bladder catheter infections per 1,000 device days reported by participants in the Infection Surveillance Project of the Missouri Alliance for Home Care (MAHC) dropped from 3.35 infections in the first quarter of 2005 to 2.68 in the fourth quarter of 2007.

While the decrease in infections is good, it does not present a true picture of what happens at individual agencies, points out **Cyndee Howell**, project manager for MAHC. "Because participating agencies typically drop out of the project when their infection rate reaches 1%, and new agencies typically come into the project with higher rates, we don't see a dramatic decrease in the overall project results," she explains. "We do know that participation in the project increases awareness of the risk of infection and helps agency staff members identify ways to reduce risk through communication with other participants," she adds.

In addition to collecting the surveillance data submitted by the participating agencies, MAHC hosts quarterly conference calls for participants to raise issues for which they need ideas and suggestions, and MAHC produces a participant newsletter that includes peer-to-peer advice, says **Mary Schantz**, executive director of MAHC. "We are trying to improve communications between participants so that we can share the knowledge gained through each agency's efforts to reduce infection," she explains.

When you have a group of people from different agencies talking together, you do get different perspectives, says Howell. "People will think outside the box and come up with ideas they might not have had on their own," she adds. An example of a problem raised in a conference call was one agency nurse who described a patient with sediment in the urine on a constant basis. The suggestion was made that dieticians work with the patient to develop a diet that might prevent infection. "The nurse discovered that the patient was drinking two liters of carbonated cola each day," she says. Once the patient decreased intake of the cola and increased clear fluids, the problem was resolved, she adds.

Participants in the surveillance project not only have the opportunity to identify best practices, but they also have the opportunity to discover practices that are based on myth and "we've always done it this way" thinking rather than scientific evidence, says Schantz. As the nurses in the project learn more from other agencies, they go back to their own agencies to educate staff, physicians, and patients, she adds.

"I have been able to change some of the long-term habits of nurses because I can present data and experience from the surveillance project and other participants," says **Rita Sansoucie**, RN, BSN, staff development director of Phelps Regional Homecare in Rolla, MO. While Sansoucie's agency has seen a decrease in the infection rate for patients with bladder catheters, she believes that participation in the surveillance project and ongoing discussion in staff education and team meetings about the agency's results and lessons learned from others has had the most positive effect on the infection rate. "I think when people are thinking about a specific issue, they pay close attention to activities that can affect an infection rate," she explains.

In addition to ongoing education, Sansoucie's agency also has made bladder catheter care a part of the employee evaluation process. "We've incorporated it into our competency assessments," she says.

Symptoms can be patient-specific

Because the goal of a home health agency is to help the patient be as independent as possible, patient and family education about the care of an indwelling catheter is critical, says **Gayle Lovato**, RN, MS, infection control practitioner at Inova Loudoun Hospital in Leesburg, VA, and a member of the Association of Infection Control Professional's communications committee. Make sure that patients know the symptoms of an infection, she suggests. A burning sensation; a change in the appearance or smell of the urine; redness, swelling, or drainage at the insertion site; increased confusion; pain in the flank; or nausea or vomiting are all potential symptoms. "Fever is also a symptom, but not all patients have a fever," she explains.

Because symptoms can vary from patient to patient, it is important to determine the pattern of symptoms for each patient, suggests **Lisa Gorski** MS, APRN, BC, CRNI, FAAN, clinical nurse specialist at Wheaton Franciscan Home Health & Hospice in Milwaukee, WI. "Teach nurses to look back in the chart to see what symptoms led to treatment of a previous urinary tract infection," she recommends. Then use that pattern of symptoms to

teach the family how to recognize the early stages of an infection, she says. This gives the family members a chance to contact the nurse at a point where the patient won't require a trip to the hospital and can be treated at home, she adds. Stress the importance of calling immediately, she says. "Some patients and families are reluctant to call the home health nurse and believe it is easier to go to the emergency room," she explains.

Keep patient and family education simple and emphasize good hygiene, recommends Lovato. "Make sure they use soap and water only to clean the area twice a day and pat dry with a towel after cleaning," she says. "The bag should be changed when it becomes one-half to two-thirds full," she says. Have family members wear gloves if they change the bag in case there is splash, she adds.

In addition to stressing the importance of washing hands before catheter care, be sure to tell family members and patients that they must wash hands afterwards, even if they wore gloves, says Lovato. "We have healthcare personnel who believe that gloves eliminate the need for handwashing, so we have to make sure we teach everyone to wash hands regardless of the use of gloves," she adds.

When teaching, the nurse must watch a return demonstration by the patient or family caregiver, points out Lovato. "Don't rely upon verbalization or a repetition of the information," she says.

"There's a lot of information about bladder catheter care, so there's no need to reinvent the wheel when developing protocols," says Schantz. "Home care is a unique health care setting, so it's important to look to other home health agencies for ideas and tools." ■

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Software improves, saves time for case managers

Documentation, reports, letters completed in real-time

Not long ago, case managers for Medical Management International lugged huge cases of patient files with them when they visited clients and often worked into the night, entering documentation and patient notes into the computer.

Now, thanks to a productivity software system, the case managers need only a notebook computer and can enter their documentation, access patient files, and send out reports and letters while they are talking with their patients or waiting in an office.

"I know a lot of case managers who go around with a stack of files and a lockbox, and that is what our case managers had to do in the past. Now, we each have a 12-inch tablet PC with an air card," says **Suzanne Tambasco**, RN, BSN, Med, CCM, CBMS, CRRN, COHNS/CM, LNCC, NCLCP, CEO of the suburban Atlanta-based company and a practicing case manager.

Medical Management International (MMI) contracts with insurance companies to manage workers' compensation claims, legal liability, short-term and long-term disability, and legal nurse consulting.

The case managers all work in the field, working out of their cars and often spending eight to nine hours a day on the road or seeing clients. Then they have to complete their documentation, send out reports and letters, and document their time for billing purposes.

In the past, the case managers often had a backlog of reports and documentation for billing purposes because of the manual operation. They didn't always document their time correctly because they simply couldn't remember everything they did once they started the documentation process.

Billing up to date now

Since the firm started using the software system, the case managers are able to handle 60%

more business, and the reports and billings are up to date, Tambasco says.

"Case managers in the field are paid on billable hours and we have to document it well in order to get paid. Health care is a business and you have to focus on getting paid as well as taking care of clients. Instead of jotting down notes and entering time for billing later, this system allows the case managers to document it in real-time," Tambasco points out.

The system has decreased the cost of office supplies — such as paper, ink, faxing, and storage — and increased productivity, allowing MMI to eliminate two part-time administrative positions.

Tambasco configured her own case management software system using document management software that was easy for her to customize to fit the needs of her company.

Taking control of work flow

The system includes a work flow process that guides the case managers from the time they open the first report on a patient through the entire management process until the case is complete.

When a case is open, the system generates a task list and sends regular reminders to the case managers of tasks waiting to be completed.

Tambasco and her case managers have created a cache of custom standardized letters that are automatically generated to update therapists, employers, attorneys, or insurance companies, including the data necessary for each recipient.

"A therapist needs to know the diagnostic information from the visit but the adjuster doesn't need that information. The attorney wants information on the objective issues. Everybody wants to know work status. The software generates the letters for each and adds the pertinent information," she says.

When MMI case managers are assigned a new case, they immediately contact the individual, physician, the employer, the therapist, and the attorney if one is involved.

"This could be the patient's first day in the hospital or a two-year old case," Tambasco says.

The case manager enters the name of the patient, a description of the injury, the name of the treating physician, and other pertinent information into the computer system. If the firm has worked with a physician, a therapist, or an attorney in the past; the case manager has to enter only the name and the rest of the data are automatically loaded into the patient file.

"Once the information is entered, it goes into the database, and it never has to be entered again," she says.

If the company receives the patient's electronic medical record, it is automatically entered into the system.

When the case manager goes to the appointment module and enters an appointment with the physician, the software generates a confirmation letter to the patient.

When the patient completes an appointment, the case manager adds the outcomes information and notes and sends a report to the interested parties.

"Case managers don't treat patients. We communicate what is going on with the patient and if we don't do that quickly, there's no purpose for it. This allows us to get reports and letters out in a timely manner. We just fill out the screen with data and send it out. Instead of writing several individual letters, we can enter the data just one time and send it to whomever we choose," she says.

The system contains a prompting mechanism that alerts the case managers when they need to check on something.

For instance, if the case manager orders a wheelchair for the patient for an estimated 30 days, the case manager will prompt the patient to check to see if the wheelchair is still needed when the 30-day rental period is about to end.

"A lot of rentals are for 30 days and if you go over that you're stuck for another 30-days' rent. The system helps us remember so we don't waste the client's money," she says.

"The software sets a diary and an action plan for us. It automatically shows us all the documentation fields we need for our meetings, whether it's with a doctor or a therapist," she says.

The system allows the case managers to have the patient's entire medical record with them when they accompany the patient to appointments.

Tambasco tells of accompanying a patient to visit a physician who had not yet gotten the results of the patient's CT scan.

"I was able to go into my computer, download the report, and fax it to him on his office fax machine while I was still in his office with the patient," she says.

"This system allows us to input all our patient records, do a data search and get what we need. It's all on a secure server that meets HIPAA medical record-keeping standards. We can multi-task and take care of sending letters and reports while we are waiting for the next appointment," she says.

The system allows case managers to share cases if they are busy or looking for a different perspective on a case. Each case manager's "diary," or to-do list, is on a "notice board and the schedules are available to all case managers.

"If I have appointments on opposite ends of town, I can have my colleague cover mine and me hers. If someone gets a call or has some free time, they can access my work and help me out or answer a question and bill for that.

"At the end of the day, [the system] gives us more time at home because we don't have to document or write reports in the evening and it makes our families happier, too," she says. ■

Nurse practitioner model improves care for elderly

Proactive approach keeps patients out of the hospital

A nurse practitioner-led care management model has resulted in lower costs, better care, and high patient satisfaction ratings for frail elderly nursing home patients being managed by Inspiris, a Brentwood, TN-based health care management firm.

Inspiris and Mercy Care Plan of Arizona's nurse practitioner care management model was named the best practices award winner in URAC's first Best Practices Consumer Empowerment and Protection Awards program in March.

Medicare managed care plans contract with Inspiris to manage the care of their members in nursing homes. The nurse practitioners visit the patient in person in the nursing home and collaborate with the nursing home staff, the attending physician, and the family.

Patients in the program typically have 300 to 350 hospital admissions per 1,000 compared to a typical Medicare rate of 1,200 to 1,400 admissions per 1,000, says **Sarah White**, NP, vice president of clinical operations for Inspiris.

In a recent study of the New York market, an analysis of Medicare claims data indicated that the Inspiris CarePlus plan reduced emergency room use by 46% and hospitalizations by 74%.

In Phoenix, one health plan that contracted for the program assigned half of its members and facilities to the Inspiris nurse practitioner care management model and half to the physician-only model.

Over the first eight months of the Phoenix pilot study, acute inpatient hospital admissions for the patients whose care was managed by a nurse practitioner dropped 63% per 1,000 as compared to the control group, White reports. The results were so compelling that the pilot study was dropped and all the patients in the plan were enrolled in the Inspiris program, she adds.

One-on-one care

The program is different from traditional case management and disease management models because the nurse practitioners see their patients in person, rather than relying on telephone calls to manage care

"Telephonic care management doesn't work with patients who are cognitively or functionally impaired or those in a nursing home. Our model represents a major shift in the way health care is being delivered in the long-term care setting," she adds.

The frail elderly population is among the biggest drivers in health care costs, particularly during the last 18 months of their lives, White points out.

"Most health care is delivered in the nursing home through a physician-reactive model. Under fee-for-service Medicare, physicians see the patients only if it's a visit required by Medicare regulations or if it is deemed medically necessary. We see the patients frequently and pick up problems early, revise treatment plans, and deliver care in a timely manner," she says.

The nurse practitioner serves as a case manager and the primary care provider, working with the physician and the nursing home staff.

"The nurse practitioner sees the patients an average of once a week, sometimes with the physician and sometimes alone," White says.

Even subtle changes, such as not eating or sleeping well, can be a sign of failing health in an elderly person, White points out.

"The physicians visit so infrequently that the nurses may forget to tell them about problems. But when the nurse practitioners visit, they specifically ask the nurses about subtle changes and can take proactive steps," she says.

The nurse practitioners usually cover two to three nursing homes, depending on the volume of patients. Their typical caseload is between 80 and 100 patients. They spend their time at the nursing home or in transit and document their findings on a laptop computer.

Patients are enrolled in the Inspiris program through their health plan contract with Inspiris.

Practitioners use an assessment tool that helps them stratify the patients as high, medium, or low risk, based on factors that include the severity of their chronic medical conditions and past medical utilization. The tool includes a cognitive function assessment, fall risk assessment, depression screening, and skin assessment. The nurse practitioner also performs a comprehensive history and physical examination.

The nurse practitioner uses all of the information from the assessment tool and his or her clinical judgment to set the risk level of each patient.

"The nurse practitioner is seeing the patient in person and may pick up something that the tool didn't. The tool is a good indicator of risk, but it doesn't replace the nurse practitioner's professional judgment," White says.

The nurse practitioners meet the family member who is the legal representative for the patient, review the medical record, and talk to the family member about the patient. They talk to the family frequently, sometimes over the telephone and sometimes in person.

"During the introductory visit, the nurse practitioner begins to establish a relationship with the family. A lot of our work involves communication, and when patients can't make decisions for themselves, it's essential to have a good relationship with the family," she says.

The nurse practitioners educate the family members on medical issues, where the loved one is in their disease process, and what their prognosis is.

"We try to give them the big picture and educate them about the trajectories that are part of the aging and disease process," she says.

They work with the family on end-of-life planning and help them make decisions about hospice or palliative care as the patient's condition worsens.

The nurse practitioners visit their patients on a regular basis and work on preventive measures, such as immunization, fall prevention, and pressure ulcer prevention. They work with the nursing home staff to manage multiple chronic and acute conditions.

The company has developed protocols for managing the care of elderly patients with chronic diseases.

"The goal is to be proactive and to create a treatment plan that is appropriate for each patient. We talk to the family and patient to get their input about treatment decisions. We might not treat conditions in this age group as aggressively as we would in a younger population," she says.

With an older patient, palliative care to keep him or her comfortable may be more appropriate than aggressively treating a disease to prevent negative outcomes, White says.

"We examine each treatment decision independently and work with the patient or surrogate to make informed decisions that guide the rest of the protocol," she says.

"The nurse practitioners are in the facility frequently and get to know the staff who are providing care for the patient. They work with a multidisciplinary team that may include nurses, dieticians, social workers, and a consulting pharmacist," she says.

Since they are in the facility regularly, the nurse practitioners can pick up on subtle changes in a patient's condition early on. Often, the facility staff mentions a change to them.

"The facility nurses develop a relationship with the nurse practitioner and will mention that Mr. Smith isn't eating or sleeping well. This is a red flag to the nurse practitioner to begin an in-depth assessment and manage the problem safely in the nursing facility if possible," she says.

The process pays off, even during flu season when the hospitals are often packed with patients, White says.

This year's flu season was particularly rough, and one nurse practitioner with 50 patients in one facility saw many who developed the flu or other respiratory symptoms although only one was admitted to the hospital.

"She managed the rest successfully in the nursing home. She was able to identify the problems early and take steps before the patients got so sick they had to be hospitalized," she says.

If a patient has to go to the hospital, the nurse practitioner calls the hospital or the emergency department and gives them a quick patient history.

"The nurse practitioner reminds the hospital staff that the patient is in a nursing facility that can handle many things like IV antibiotics, therapy, or wound care. This awareness results in a shorter hospital stay," she says.

"We give the family an update at least quarterly and more frequently if there is a change in the patient's condition," she says.

The nurse practitioners follow the patients through the continuum of care, from the nursing home to the hospital and back again.

"Over time, the nurse practitioner gets to know

the patient and family really well, and a trusting relationship develops," she says.

The nurse practitioners establish a good working relationship with the health plan case managers, so they can collaborate if issues arise.

For instance, in the case of high-risk, complex patients, since the nurse practitioners see the patients in person, they can give the health plan case managers additional information to take to the plan's medical director when issues of coverage arise.

If a patient is discharged from the nursing home to the community or to a group home or assisted living center, the nurse practitioner coordinates the transfer with the health plan case manager. ■

Study shows gaps in availability of hospice care

Education, wealth, and age predict locations of hospice

An estimated 1.3 million patients received hospice services in 2006, a 162% increase in 10 years, and approximately 36% of all deaths in the United States in 2006 were under the care of a hospice program.[1] Unfortunately, even with the growth in hospice access as a result of the Medicare Hospice Benefit enacted in 1982, a new study shows significant gaps in access due to locations of hospice agencies.

The hospice benefit was designed to improve access to hospice and to eliminate health disparities among different groups of people, says **Maria J. Silveira**, MD, MPH, assistant professor of internal medicine at the University of Michigan in Ann Arbor, and author of the study that examines the availability of hospice throughout the United States.

"We know that there are disparities in the utilization of hospice throughout the country, and this study was initiated to identify the underserved areas," she says. Using a combination of Medicare data on hospices and federal county-level 2000 census data, Silveira developed a "picture" of the gaps in hospice service. The main office address of the hospice and a 60-mile radius service area were compared to the population in the home county as well as surrounding counties into which the service area extended, she explains.

The map that shows concentrations of hospice agencies looks like a patchwork quilt with the areas of highest hospice availability in the Northeast, upper Midwest, and most of California. There is less availability in states along the Mississippi and in the Rocky Mountain states and the Southwest. Lower-than-average availability of hospice is found in much of the South, Texas, Florida, and the Plains states.

On average, the study found that counties have 2.1 hospice main offices within their borders, but the actual number for each county ranges from none to 125 hospice agencies, says Silveira. When the 60-mile-service area is considered, an average of 52 hospices served each county, but once again, the actual number ranged from none to 280, she adds.

"This study was a pilot study to see if it is possible to correlate the data from Medicare and the census," Silveira says. The fact that a hospice's main office location rather than the main office and all branch offices were used in the initial data may increase the number of hospices serving some counties, she says. "This study presents a big picture rather than many details, so that we can identify other studies needed to determine hospice availability," Silveira explains.

Education, wealth, and age affect availability

After examining the population density of the county compared to hospice availability, Silveira looked at other factors' correlation to use of hospice.

"The three most influential factors related to use of hospice were education, wealth, and age," she explains.

Areas with the higher numbers of people with high school degrees had higher numbers of hospices, says Silveira. "Also, for every 5% increase in the population making more than $100,000 per household, the number of hospices doubled," she adds.

Age also is a strong indication for availability of hospice, says Silveira. "Counties with the lowest availability of hospice averaged 16.2% of the population over the age of 65, and counties with highest availability averaged 14.2% of the population over the age of 65," she says. This finding does jibe with other research that shows elderly people choose hospice less often than they choose nursing homes and home health, she explains.

"We also know that African-Americans and Hispanics traditionally choose nursing homes or home health over hospice, and this study confirms that areas with higher African-American or Hispanic populations have less availability of hospice," Silveira says.

Because her initial study did not look at the availability of nursing home or home health care in comparison to hospice, Silveira plans to include this comparison in her next study. "The data from this study does not account for the availability of these services, so we don't know if people in these areas have access to them in place of hospice," she says.

While nursing homes and home health can provide care, the concern about the lack of hospice availability is the difference in the quality of end-of-life care provided by each organization, she adds.

Rural areas underserved

Although population density was not a key indicator of hospice availability, most hospices are located in areas with larger populations, says Silveira. Another correlation highlighted by the data is that counties that are larger than 1,000 square miles have 7% less hospice availability than counties smaller than 1,000 square miles. Because larger counties are typical of more rural areas, this statistic points out the challenge to hospices that serve rural areas, she points out.

Time and distance are two key challenges for hospices serving rural areas, but some organizations are turning to technology for help, says **George Demiris**, PhD, associate professor of behavioral nursing and health systems at the University of Washington School of Medicine in Seattle and researcher with the Missouri Telehospice Project. The Telehospice Project is a group of four hospices that are using videophones to test the outcomes and develop best practices for the use of telehospice, he explains. Telehospice is a tool that can potentially be very useful for hospices serving rural areas, he adds.

One of the research projects focused on the use of videophones to include the patient and family caregivers, explains Demiris. "Most agencies invited family caregivers and the patients to their interdisciplinary team meetings, but they rarely attended due to the distance of travel or the frailty of the patient," he explains. By installing a videophone at the patient's home and in the hospice conference or meeting room, patients and their family caregivers can participate, he points out.

The study utilized two groups, one with the videophones and one without videophones. "The patients with videophones were able to direct their questions to members of the team they don't normally meet, such as the medical director," Demiris says. Issues related to pain control or symptom management were brought up by the patient or caregiver and addressed immediately by the nurses or medical director, he explains.

Issues related to pain control or symptom management were less likely to be addressed in as timely a manner in the control group, Demiris says. "Because patients and caregivers might not tell nurses about all of their concerns, nurses did not always know to bring up issues at the team meetings, so they would have to follow up with physicians or other team members after visiting the family," he says.

Staff members and patients using the videophones reported higher satisfaction with outcomes and the process than members of the control group, says Demiris. "The videophone allows patients to participate more effectively in decisions about their care, even when distance is a problem," he adds.

While technology can be used to improve a hospice's ability to serve rural areas, it does not address a significant reason that hospices have difficulty serving rural areas, says Silveira. One of the ways that hospices traditionally had made ends meet financially is to rely upon charity and volunteers, she points out. This need for a strong financial base may be one reason that hospices are located in areas that are more urban with residents who have higher financial resources and educational backgrounds, she says. One solution that would enable more hospice service in underserved areas would be an increase in the Medicare Hospice Benefit, she suggests. "If the Medicare Hospice Benefit was designed to cover the costs of providing hospice care, hospices would not have to rely upon charity and volunteers to cover costs, Silveira says. "This would enable more hospices to provide services in communities that may not have the population, education, or wealth to provide the extra support."

COMING IN FUTURE MONTHS

- "Sacred cows" of infection control
- How to take care of your agency caregivers
- When should you close a branch office?
- Personal health records-what will they mean for HHAs?

Reference

1. National Hospice and Palliative Care Organization. *NHPCO's Fact and Figures on Hospice.* Alexandria, VA; 2007. Web: www.nhpco.org/files/public/Statistics_Research/NHPCO_facts-and-figures_Nov2007.pdf. ■

NEWS BRIEF

Baby boomers may not have specialists needed at age 65

When 78 million baby boomers reach age 65 in 2011 they will depend upon a health care workforce that is too small and unprepared to meet their needs, according to a new report from the Institute of Medicine.

The report, *Retooling for an Aging America: Building the Health Care Workforce*, identifies a number of bold initiatives that should begin immediately to train all health care providers in the basics of geriatric care and to train families how to care for aging friends or family members.

Several reports show an overall shortage of health care workers in all fields, but the situation is worse in geriatric care because it attracts fewer specialists than other disciplines and experiences high turnover rates among direct-care workers — nurse aides, home health aides, and personal care aides. For example, there are just over 7,100 physicians certified in geriatrics in the United States today — one per every 2,500 older Americans. Turnover among nurse aides averages 71% annually, and up to 90% of home health aides leave their jobs within the first two years.

Older adults as a group are healthier and live longer today than previous generations, the report notes. Even so, individuals over 65 tend to have more complex conditions and health care needs than younger patients. The average 75-year-old American has three chronic conditions, such as diabetes or hypertension, and uses four or more prescription medications, the committee found. Dementia, osteoporosis, sensory impairment, and other age-related conditions present health care providers with challenges they do not

CNE *questions*

13. What step does **Robert W. Markette Jr**., a home health attorney with Gilliland, Markette & Milligan in Indianapolis recommend that home health agencies take to protect themselves from fraud charges related to inadequate aide training?
    A. Investigate all organizations from which you receive training certifications
    B. Administer competency assessments to all new employees
    C. Obtain references from previous employers
    D. Ask employee what they learned in training course

14. Why does **Gayle Lovato**, RN, MS, infection control practitioner at Inova Loudoun Hospital in Leesburg, VA, suggest that nurses review the chart related to bladder catheter patients' previous infections?
    A. To make sure proper medication was administered
    B. To doublecheck format for documentation
    C. To identify person who treated previous infection
    D. To incorporate patient-specific symptoms into catheter care teaching

15. Since Medical Management International started using its new software system, it has been able to handle 40% more business.
    A. True
    B. False

16. The number of patients receiving hospice services in 2006 showed an increase of 162% over 10 years.
    A. True
    B. False

Answer Key: 13. B; 14. D; 15. B; 16. A.

often encounter when tending to younger patients.

While the number of older patients is rapidly increasing, the number of certified geriatric specialists is declining. Medicare, Medicaid, and other health plans need to pay more for the services of geriatric specialists and direct-care workers to attract more health professionals to geriatric careers and to stanch turnover among care aides, many of whom earn wages below the poverty level.

Although a comprehensive examination of Medicare was not the focus of this study, the committee noted several ways that the program hinders the provision of quality care to older adults, including Medicare's low reimbursement rates, its focus on treating short-term health problems rather than managing chronic conditions or age-related syndromes, and its lack of coverage for preventive services or for health care providers' time spent collaborating with a patient's other providers.

Copies of *Retooling for an Aging America: Building the Health Care Workforce* are available from the National Academies Press at 202-334-3313 or 800-624-6242 or on the Internet at http://www.nap.edu. Additional information on the report can be found at http://www.iom.edu/agingAmerica. ■

CNE 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. ■

CNE 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 credit letter. ■