Taking care of premature babies earns this agency a Codman Award
How one NC home health agency found success

The numbers don’t lie
To find out just how much improvement it took for a North Carolina medical center to win the Ernest A. Codman Award, see p. 2.

Assess your pain
Here’s a sample pain assessment form that you can use on your home visits. Turn to p. 6.

The end of ORYX
The JCAHO may modify its controversial initiative requirements. Find out more on p. 7.

Survey monitor
A mid-Atlantic pharmacy faces the music of multiple Type I recommendations. See how officials responded to the survey on p. 8.

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The mission is simple: Get premature babies out of the neonatal intensive care unit and into their homes as soon as possible.

Accomplishing this objective earned Carolinas Medical Center of Charlotte, NC, the fifth annual Ernest A. Codman Award from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in the home care category.

Under its program, the hospital sends home premature babies, who usually stay in the hospital up to two months after birth, a couple of weeks early on average if the parents agree to place their child under the care of a home health nurse after discharge.

In the three-plus years since its inception, more than 200 infants have gone through the program, making it quite the success story.

You’re not in Kansas anymore
It isn’t the magical Oz, but the program, “There’s No Place Like Home,” now allows Carolinas to send low birth-weight babies home an average of 15 days sooner than when it was first established.

Make your pain assessments a pain-free experience

Assessing pain is arguably one of the most difficult challenges for nurses completing the Outcome and Assessment Information Set (OASIS). Many patients will not admit they have pain and those who admit it may not be able to describe it.

Pain assessments help agencies determine the resources that will help the patient manage his or her pain. Although your agency won’t lose as much reimbursement from incorrectly answering M0420 as it would from projecting therapy incorrectly or mis-staging wounds, it could still cost you the chance to improve a patient’s quality of life.

Patients may not help
Even though reducing a patient’s pain can be rewarding, assessing it is no easy task.

Some of the difficulty comes because patients may not be
“We were so successful because we used neonatal intensive care nurses and cross-trained them in home care so they could do home visits,” says Martha Whitecotton, Carolinas vice president and chief nurse executive. “They had to learn how to meet all of the regulations required for home care [in the 2001–2002 Comprehensive Accreditation Manual for Home Care].” The program is a collaborative effort between Carolinas Medical Center and Carolinas Home Care.

The training program to indoctrinate hospital-based intensive care nurses into the home care agency lasts about three or four weeks. Home health nurses train their neonatal counterparts how to fill out required paperwork, recognize infection control issues in the home, obtain physician orders, and much more.

“They already had basic expertise in clinical care, but we’re teaching them to recognize the differences of treating patients in their homes. There are complexities of caring for a patient in intensive care v. being at home,” Whitecotton says, adding that nurses take care of babies in intensive care while parents take care of babies at home.

What led to the program
After examining how other facilities discharged premature babies earlier than usual, Carolinas started looking in 1997 at implementing a similar program. Because most premature babies bring with them expensive hospital stays, programs such as this save money, says Whitecotton.

This type of program also helps children develop faster by allowing them a chance to interact more frequently with their parents. “Our whole goal is to integrate these babies into the community. It’s where they will live. If you keep them in the hospital, it delays their transition,” Whitecotton says.

A different approach
Carolinas babies remain under the care of the hospital pediatrician, as they did before implementing the program, but the babies also get home care visits from the neonatal intensive care nurses in addition to their pediatrics. This is a big positive to parents,” Whitecotton says.

Here are some statistics, courtesy of Martha Whitecotton, Carolinas Medical Center vice president and chief nurse executive, that show the improvement babies in the “There’s No Place Like Home” program made compared to their hospital counterparts:

- Premature babies in the program gained 1.1 oz to 1.3 oz per day. Premature babies in the hospital gained an average of 0.7 oz each day.

- Babies in the program go home 15 days earlier than those who do not.

- The average readmission rate nationwide for neonatal intensive care babies is anywhere from 4% to 9%. In the hospital’s neonatal intensive care program, the rate is less than 1%. In the

“There’s No Place Like Home” program, the rate drops to 0.74%.

With the home management nurses visiting the babies, pediatricians tell parents not to bring the babies in for visits. “We were able to coordinate the treatment of all the specialists, which is a big positive to parents,” Whitecotton says.

Going one step further, because many of the discharged babies require specially formulated medications, Carolinas found that many families could not fill those prescriptions at their local pharmacist. To remedy the situation, Carolinas pharmacists developed instructions to combine different medications so parents could get the prescriptions filled at their local drugstore.
visits to the pediatrician. “There’s No Place Like Home” allows the nurses trained in home care to make skilled visits to the infant in the home setting.

“There’s No Place Like Home” allows the nurses trained in home care to make skilled visits to the infant in the home setting.

“The nurses’] selling point to the pediatricians was this, ‘We’re going to provide expert care.’ This reassured the pediatricians and got the buy-in we so desperately needed to get the program going,” Whitecotton says. “Now, pediatricians are more comfortable that the babies get the expert care of the hospital in the home care setting.”

Maturing program becomes a successful one
After 18 months of studying the problem, Carolinas sent its first neonatal patient home through the program in July 1998. Three-and-a-half years later, the program usually handles 15 to 20 infants at one time.

What is the Codman Award?
The JCAHO awards the Codman Award to the organization that demonstrates “the effective use of performance measurement, thereby enhancing knowledge and encouraging the use of performance measurement to improve the quality of health care,” according to a JCAHO press release.

“The Joint Commission salutes Carolinas Medical Center for [its] superb efforts in enhancing the quality of care for patients. The accomplishments of Carolinas Medical Center underscore the productive innovations that can be achieved in productivity by measuring and using outcomes to improve patient care processes,” said JCAHO president Dennis S. O’Leary, MD, in a press release.

Dear reader,
You may have noticed a new look to this month’s issue of your newsletter.

Maybe you saw the new title, Home Health Accreditation & Reimbursement Report, and thought, “This doesn’t look like my accreditation newsletter” or, “Where’s my PPS newsletter that I get every month?”

Before we answer that question, some of you may recall us asking via e-mail a few weeks ago what you wanted in your home health newsletter. Did you want more accreditation news? More reimbursement news? Both?

Well, we listened to your answers and proudly introduce what we believe to be the most comprehensive home health newsletter on the market today: Home Health Accreditation & Reimbursement Report.

In place of those newsletters you are used to seeing—Briefings on JCAHO: Home Health, Hospice, and HME and PPS Alert for Home Health—you’ll now find in Home Health Accreditation & Reimbursement Report the latest accreditation news and compliance advice along with tips to help complete your OASIS and much, much more.

We’re still working out some of the kinks on just what HHARR is going to look like, and if you have any thoughts, please feel free to e-mail me at ehannan@hcpro.com, or give me a call at 781/639-1872, ext. 3220. I’d love to hear from you.

In the meantime, enjoy the first issue of Home Health Accreditation & Reimbursement Report.

Sincerely,
Ed Hannan
Managing Editor
Home Health Accreditation & Reimbursement Report
Pain assessments

in pain during their visit with you, which makes the pain difficult to characterize. Also, they may not understand the language used to describe pain, says Linda Stock, RN, BSN, CHCE, a senior consultant with LarsonAllen Health Care Group in Charlotte, NC.

In addition, people tolerate different levels of pain, says Stock. “The only way to get a good measurement is by consistently measuring that person’s pain in relationship to the same scale.”

Some patients will not even admit they are having pain, either because their family or ethnic background does not encourage it, says Stephanie Mello-Gaskell, MS, MBA, RN, vice president of clinical services for the Visiting Nurses Association (VNA) of Southeastern Massachusetts in Fall River.

“I think to a certain extent that when patients admit to having pain they are giving up something.”

Don’t ignore the signs
If a patient says he or she is not experiencing pain, the nurse must look for signs that the patient is in pain, such as guarding certain body parts. (For a sample pain assessment you can use in your facility, turn to p. 6.)

“Patients will say they have no pain, but as the nurse continues the assessment, the patient exhibits that he or she is in pain,” says Gaskell.

Ask patients to demonstrate their ability to dress themselves and their ability to get off their chair and walk, says Gaskell. Watching how comfortable they are performing these activities can also help predict therapy utilization.

Pay attention to how patients look during these activities. If they grimace, find out why. If they’re hesitant to move from one place to another or they can’t get things themselves, moving may be too painful, says Stock.

“Be careful not to overlook seemingly unimportant activities such as the patient saying he or she sits in the chair all day and puts off going to the bathroom because it hurts too much to get up from the chair or

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Frequently asked questions about pain assessments

The following questions are excerpted from the Opus Communications book, Twenty-five Common Questions and Answers to the Pain Management Standards. To order a copy, call 800/650-6787.

Q. Can assessment be as simple as asking to a patient, “Are you having pain or discomfort now?” or does the assessment need to also ask about recent pain?

A. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards don’t specify. Some people follow up with a second question: “Have you had pain or discomfort in the recent past?”

Q. How often does the Joint Commission require pain to be reassessed?

A. The JCAHO does not give a designated frequency for reassessment. Instead, it expects you to establish your own frequency for reassessment and to follow your policy.

When you reassess, remember to always include a combination of “time triggers” (e.g., every shift, every third visit, etc.) and event triggers (e.g., following any intervention to relieve pain).
to walk,” advises the OASIS Implementation Manual.

Also, remember that patients can have pain in more than one area of the body, so ask about all sites of pain. They may be recovering from surgery, but if they’ve always had arthritis or headaches that does not just go away.

Education is key
All nurses at the VNA of Southeastern Massachusetts train on a self-learning module during orientation to become familiar with pain management and assessments. The module covers the definition of pain, the cultural issues surrounding pain, and different drugs to manage pain.

The module also discusses nurse-physician resistance, since their beliefs can affect pain management. Some physicians have a “grin and bear it” attitude, while others work to treat pain, says Gaskell.

The agency also assesses its problem areas by having managers and staff complete the OASIS at the same time, says Gaskell.

Stock encourages nurses to practice assessments on each other. “If someone has pain right now, have them quantify it to see how difficult it is for the patient.”

Check the list
When reviewing a patient’s medications, look for medications for pain or joint disease. This allows you to explore the presence of pain, to see when pain is most severe, which activities pain interferes with, and to determine how frequently pain interferes with activity or movement, says the OASIS Implementation Manual.

Consider the patient’s treatment for pain when evaluating whether the pain interferes with activity or movement, says the manual. Pain that is well controlled with treatment may not interfere with activity or movement at all.

Also, find out whether the patient is actually taking his or her medication regularly, says Stock. People may avoid taking it because they don’t like one of the side affects.

Document consistently
Each nurse at your agency should use the same pain scale. “That way it wouldn’t matter if you had seven different nurses assessing the patient because they would all be using the same language for pain,” says Stock. “You would be able to categorize pain among your patients.”

The VNA of Southeastern Massachusetts is also examining whether the patient’s homebound status and M0420 are consistent. Sometimes nurses will not mark that a patient has pain on his or her assessment, but the nurse will describe the patient’s pain in the visit notes and use pain as the reason the patient is homebound.

“If the pain is causing the patient to be homebound, then you would expect to see it on their OASIS documentation,” says Gaskell. “That’s where I see problems—people don’t consistently document around pain.”
### Pain Assessment

**Y N** Are you currently experiencing any pain or discomfort? If **Y**, continue pain assessment. Describe your pain: **Sharp**, **Stabbing**, **Burning**, **Aching**, **Pressure**, **Other**. Location of the pain: **Mark site(s)** on diagram below.

**How long have you had this pain?**

**Y N** Does this pain radiate? Where? **Mark area(s)** of radiation on body diagram below. Using one of the following scales, indicate patient’s present level of pain.

**Pain Level**

**Scale used**

*Use this scale for subsequent reassessment*

**Pain Assessment Scales**

<table>
<thead>
<tr>
<th>Scale A</th>
<th>Scale A2</th>
<th>Scale B</th>
<th>Scale C Wong-Baker</th>
<th>Scale D (&lt;3 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Sleeping</td>
<td>Grimacing</td>
<td>Moaning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>calm/relaxed</td>
<td>with Movement</td>
<td>with Movement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not agitated</td>
<td>(=3-4, Scale A)</td>
<td>(= 5-6, Scale A)</td>
</tr>
</tbody>
</table>

**Y N** Have you had treatment for this pain in the past? Describe.

**Y N** Is there anything that relieves or lessens the pain? If so, please describe.

**Y N** Is there anything that makes the pain worse? If so, please describe.

What level of pain can you tolerate?

What impact does the pain have on your life and daily functioning?

What is your desire regarding the management of your pain?

**Mark site(s) on body diagram**

Indicate specific location(s) of pain with “P”, and with “→” indicate area(s) of radiation. If more than 1 pain site, identity as “P1”, “P2” etc.

Source: Twenty-five Common Questions and Answers to the Pain Management Standards, Opus Communications.
Is ORYX on its way out?  
JCAHO may modify its controversial initiative requirements

Oh, the times they are a-changing.

More than the line from a classic Bob Dylan song, it reflects the Joint Commission on Accreditation of Healthcare Organization’s (JCAHO) sentiments toward its ORYX initiative for home health.

In August 2001, when rumors began swirling in the field that the accreditor would soon discontinue the program, a JCAHO spokesperson told Briefings on JCAHO: Home Health, Hospice, and HME that ORYX remained intact.

As months passed, readers told us that they heard directly from their JCAHO surveyor that the accreditor had already decided to dump ORYX. However, we had no official to support the speculation.

Yet, in January, JCAHO spokesperson Mark Forstneger told Home Health Accreditation & Reimbursement Report, “The Joint Commission is taking a very serious look at the ORYX requirements for home care organizations. We conducted an opinion survey on our Web site within the past month regarding [agencies’] experiences with ORYX, and we proposed several options for organizations to consider. We’re listening to customers about the issues and then, from all of this feedback, we will review the ORYX requirements for possible modifications.”

The survey asked providers whether they would rather submit performance measurement data through the Outcome and Assessment Information Set (OASIS), a single core vendor, or via one of the contracted ORYX vendors. It also asked them whether they wanted to continue with the ORYX program.

Should Forstneger’s comments mark the beginning of the end of ORYX, it won’t be a moment too soon for some readers who describe the initiative as “useless” and “a waste of time.”

Different strokes for smaller folks?

Take, for instance, Kathy Beck, RNC, the regional director of nursing with ATS Health Services in Jacksonville, FL. ATS consists of seven home health agencies, but only Beck’s agency in Jacksonville is JCAHO accredited and, therefore, must comply with ORYX.

Beck can’t find the required six measures to fulfill the ORYX mandate at her agency, which sees 45 patients each year. “For such a small agency, it’s just a waste of my time. It’s really useless,” she says.

For smaller agencies, Beck believes that the state Medicare survey process should be the only accreditation requirement. “If I had 300 patients and three divisions, I could see the need for ORYX, but not here. It’s not improving the care of my patients,” she says.

Beck chose easy-to-track ORYX measures:

• Cleanliness of service
• Same caregiver assigned to a patient
• Timeliness of an admission
• Timeliness of initiating the start of home care service
• Documentation of changes in the health status of a client
• The number of witnessed and unwitnessed falls
• The number of times the agency rebills a patient for an incorrect bill

Meanwhile, the director of one Midwestern home care agency says that if the JCAHO drops ORYX, “I would be pleased. I get no value from the $2,500 it costs me to collect the data. The OASIS information is much more useful.”
Survey monitor
Mid-Atlantic pharmacy hit with multiple Type I’s in JCAHO survey

Although an exhaustive three-day Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey of this mid-Atlantic pharmacy produced four Type I recommendations, officials voiced little concern about whether they would receive accreditation.

In fact, the pharmacy director says his superiors do not hand down any directives requiring the company to get a specific score on the survey.

“There’s no pressure on us to get certain scores of any type. We try to make a company-wide effort to pass the survey. We want to look good. Obviously, some areas need work,” he says.

During the two-and-a-half day visit, the JCAHO surveyor found several areas that demand attention, including the company’s performance improvement (PI) program, its incomplete pain assessments, deficient patient medication profiles, and a missing performance evaluation.

Let’s take these sore spots—each of which received a Type I recommendation in the surveyor’s preliminary report—and look at how the surveyor came to that conclusion.

PI needs improvement
Essentially, the surveyor found that the company did not go far enough in its PI program to demonstrate that it had, in fact, improved performance.

With too much volume left in the pharmacy’s infusion pump bags, the company tried to fix the problem by first examining the pumps, then bringing in the sales representatives who sold the company the pumps. The company eventually corrected the problem: a faulty upstream occlusion alarm, a device that, when working properly, safeguards against inaccurate medication flow.

“The incident reports did illustrate we had a problem, and we went through the process of fixing it,” the director says, adding that the efforts did not appease the surveyor, who wanted to see more of a general performance improvement project rather than a pharmacy-specific one.

Customer satisfaction surveys also lacked enough evidence to convince the surveyor that the pharmacy had implemented a successful PI program.

“They wanted us to find a problem, figure out a solution, and accumulate data to show the problem went away,” the director says. “Although we had programs running, we did not [aggregate] the data to show a problem [existed] and if the changes we made had any impact. There’s no way of knowing if the changes had successfully reduced the problem.”

Make PI a job for more than Magnum
The director suggests that companies make sure they have at least one person dedicated solely to PI work.

“Most companies have a PI director. We used to have one, but through reorganization in the company, we assigned PI to each department manager and it slipped through our fingers. Managers and individuals don’t want to sit down and collect the data. It’s
time-consuming and it takes you away from running the department," the director says.

"If you had someone overseeing the whole process, in touch with managers on a regular basis and pushing to collect data, PI will work. If you can pass the data on to the dedicated [quality improvement] manager, that's an ideal situation."

Pain assessments prove painful
Although the admission package given to new patients explains their right to a pain assessment, the company failed to follow through on that statement, according to the surveyor. "We did not have an adequate program for [assessing pain]," the director says.

Since the survey, however, the pharmacy put together an assessment that calls for physician involvement if the pain indicators reach a certain level, the director says.

When good medication profiles go bad
The pharmacy demonstrated that it completed medication profiles for each of its patients, but the surveyor still found inaccuracies after visiting patients' homes.

For instance, some patients took medications not indicated on the profile, primarily the over-the-counter medications.

"Sometimes, patients are reluctant to [tell you about] all their medications," the director says, specifically referring to over-the-counter medicines like Tylenol, as well as herbal remedies.

However, to convince the patients of the importance of keeping the profiles accurate, the pharmacy could tell patients the information will remain private, and that the information must remain accurate for the pharmacy to provide proper care, the surveyor told the pharmacists.

The surveyor also stressed the importance of asking about medications each time the pharmacist talks to the patient. "If there's no change, make a note of it," the director says the surveyor suggested.

"Medication profiles are the most difficult problem we face," the director says.

Down, but not out (of business)
Although Home Health Clinical Services has not received its final score, the director says the surveyor told him the pharmacy should expect to pass its survey. The director says he's content with the survey results.

"I expected some of these hits but, all in all, the surveyor left pleased with the company. He was satisfied [that] these few Type I's would be corrected appropriately. He thought the company was in good shape. He loved the employees and thought they were a dedicated group focused on patient care. Everything is easily correctable. Patient care is always there. That's the important thing."
Foot care policy eliminated, then reinstated
Regional home health intermediaries eliminated routine foot care as a skilled nursing service as of January 1, 2002.

Then, at the behest of the Centers for Medicare & Medicaid Services, they continued the coverage until further discussion occurs among national policymakers.

Therefore, until further notice, the routine foot care benefit remains in effect, and intermediaries will pay skilled nurse visits to provide foot care when agencies meet the criteria of this benefit.

To find out more about the foot care policy, visit www.iamedicare.com/provider/meda1.htm.

Intermediary overpaid HHA, OIG says
An Office of Inspector General (OIG) audit report investigation found that a Mutual of Omaha fiscal intermediary overpaid two home health agencies by $179,018.

The overpayments occurred because Mutual used incorrect provider statistical and reimbursement data, according to the report. Additionally, Mutual incorrectly determined periodic interim payments at the final settlement, increasing the overpayment to $316,949.

The Medicare Payment Advisory Commission in January unanimously recommended the elimination of the 15% reduction in payments to hospital-based home health facilities scheduled to take place on October 1.

The committee also recommended the extension of the 10% add-on for rural home health agencies through April 1, 2005, to allow more time to study the effect of the additional payments.

A government body, MedPAC provides guidance to Congress on Medicare payment issues. Congress will take up the 15% cut later this spring.

CMS not enrolling providers ineligible for Medicare, report says
The report stemmed from a review of a sample of the home health agencies, owners, or managers enrolled in Medicare between October 1, 1997, and September 30, 2000.

None of the agencies, owners, or managers had been excluded from Medicare participation before CMS enrolled them to provide home health care. None of the owners or managers had a felony record when CMS approved them. And all of the sampled agencies had met minimum capitalization requirements before Medicare contractors approved them for reimbursement.

To view the report, visit http://oig.hhs.gov/oei/reports/oei-04-00-00550.pdf.

JCAHO accepting Codman Award applications
Applications for the Joint Commission on Accreditation of Healthcare Organization’s (JCAHO) 2002 Ernest A. Codman Award Program have been posted on the JCAHO Web site, www.jcaho.org, and are available by calling 630/792-5800.

The Web site also features a summary of the 2001 Codman Award winning initiatives, including the “There’s No Place Like Home” program featured in this month’s issue of HHARR.

The JCAHO presents the Ernest A. Codman Award to health care organizations for achievement in the use of process and outcomes measures to improve organization performance and, ultimately, the quality of care provided to the public.

New for 2002 is a multiple organization team award category that recognizes performance improvement achievements of multiple JCAHO-accredited health care organizations that work collaboratively on a single performance improvement initiative. Other award
categories are: ambulatory care, assisted living, behavioral health care, home care, hospitals, laboratories, long-term care, and networks.

Send all applications to the JCAHO by April 8, 2002. In October, the JCAHO will notify award winners, who will receive a specially designed award at the Joint Commission Resources national conference in December.

Equipment supplier settles in overbilling case
A medical equipment supplier in St. Petersburg, FL, agreed to pay $690,000 to settle allegations that it overbilled Medicare, according to the Tampa Tribune.

Priority Oxygen and Medical Equipment, Inc., and its owner Dennis McEleny, allegedly delivered scooters to Medicare beneficiaries in 1998, but billed the agency for more expensive motorized wheelchairs, the newspaper reported.

Priority and McEleny filed false claims for more than 100 motorized wheelchairs, billing Medicare $5,000 per wheelchair on several occasions, according to the U.S. Attorney's office. The parties involved are waiting for approval of the settlement from a federal judge.

Woman steals from senior residence
A woman posing as a home health aide got past the locked front door of a senior apartment complex and stole money from two of its residents, according to the Sarasota Herald-Tribune.

The intruder allegedly told a female resident at the J.H. Floyd Sunshine Village that she was there to help her take a bath and then asked for a glass of water. When the resident left the room to get the water, the intruder took her purse and ran.

The intruder then offered to do the laundry of a male resident at the facility. When the resident gave the intruder his clothes, she took $10, the basket of clothes, and disappeared, the newspaper reported.

Submitting false notes gets nurse probation
A Massachusetts home health nurse was sentenced to four years' probation, participation in a mental health program, and 500 hours of community service for Medicare fraud.

On 75 occasions between 1997 and 1999, Patricia Texeira submitted false skilled nursing notes for visits that she had not made to patients, according to the U.S. Attorney's office. Texeira worked as a registered nurse responsible for providing psychiatric visits to the homes of Medicare patients.

Texeira's employer used the fraudulent nursing notes, which detailed the supposed mental health of patients, to submit claims to Medicare for reimbursements. Medicare paid an average of $72.40 for each fraudulent claim. The home health agency, which did not know of the fraud, repaid Medicare the money it received as a result of Texeira's false claims, according to the U.S. Attorney's office.

Missouri home health executive settles charges
The owner of a Missouri home health agency and private nursing company has settled with the U.S. government over false claims in the company's medical reports.

Larry T. James, former president of LAB Home Health Inc., LAB Professionals, Inc., and Gateway Homecare, Inc., pleaded guilty to felony charges of making false statements when he knowingly submitted altered documentation to the Medicare representative, Wellmark. He feared that Wellmark might disallow some of the costs claimed in one of the cost reports that he submitted on behalf of the company.

James will pay more than $370,000 as part of the civil settlement. He cannot participate in any future federal health care program and will serve four months of home detention and 30 months' probation.

Two national home care associations to merge
The American Home Care Association (AHCA) voted to cease operations and join the American Association for Homecare (AAHomecare).

AHCA Legislative Director Ann Howard and Director of Special Programs Carmen Johnston will assume the same duties for AAHomecare. Other high-ranking staff from AHCA will assume similar duties and board positions with AAHomecare.
And despite winning the award, Whitecotton says there is more work to be done.

“We’re always looking for ways to improve. Because we want a stable home environment, we have a very select group of people who participate,” Whitecotton says, adding that the average age of the mothers in the program is 29. The average age of mothers treated only in the hospital is 26. But working under the belief that younger parents would benefit more, Whitecotton says making the program accessible to that age group remains a challenge.

Carolinas also tries to address the top criticism of families in the program—increasing the number of home visits covered by insurance. Currently, the average is four visits per baby, although Whitecotton says some patients receive up to eight home visits.

Award brings many benefits
During its triennial survey in 2000, the JCAHO surveyor who visited Carolinas told the agency to apply for the Codman Award.

“We were thrilled,” Whitecotton says of her reaction to finding out Carolinas had won. “It has improved the visibility of the program. We’ve gotten a lot of requests from competing hospitals to set up a similar program in their facility.”

Although Whitecotton estimates that no more than a handful of similar programs exist across the country, she doesn’t see hers as special.

“I don’t know that we’re much better than any other home health program. We were just willing to tell the JCAHO we did it.” —