Payment methods vary by size and location of agency

Nurses, therapists, and aides are the backbone of the home care operation. Since money is tight in most home care organizations, increasing pay may not be a realistic approach for recruiting and retaining staff. However, restructuring the way you pay may accomplish the same goal without breaking the bank.

The most effective payment system depends on a number of factors, from the size of your staff and your patient census, to your location. Not every method works for every agency. Hospital-based agencies usually have to work within the limits of the parent organization’s system. Rural agencies need to take into account travel distances between patients.

By using a fee-per-visit system, a rural agency would likely lose the majority of its nurses because they can’t make much money if they’re not paid for travel time. The key is finding a system that suits both the needs of your agency and the needs of your staff.

Large agency combines methods

The Visiting Nurses Association (VNA) of Greater Cincinnati and Northern Kentucky, which runs a daily census of 700 home

Solve potential pulse oximetry problems with a policy

Although pulse oximetry seems straightforward enough, home health agencies (HHAs) and home medical equipment agencies (HMEs) have trouble meeting the requirements and understanding the rules for this type of procedure. Some HMEs inadvertently cross into an area with a whole different set of regulations when they provide pulse oximetry after delivering oxygen.

Victor Plavcan, general manager of Berkes Medical Equipment in Reading, PA, knows all too well the negative impact of misinterpreting the rules for in-home procedures like this. During its most recent survey, Berkes received a Type I recommendation because one clinician performed one clinical respiratory procedure under their HME label.

The first time—and it only takes one time—an HME performs a procedure like pulse oximetry, the agency moves into the realm of clinical respiratory services. When the HME returns to that same home for a second visit, it is now
Pulse oximetry

responsible for completing the other tests needed to carry out the patient’s plan of care, says Plavcan.

“We became clinical because we did testing one time,” he says. “Then if we had to go back to the patient, we were clinical with all these other bullet points to address. We had to assess pain management, we had to assess drugs, we had to assess respiratory diseases, things like that. It’s just a big plan of care that you have to do for these patients, which takes up time,” he says.

HME companies may not want to take on that additional responsibility, and that means being extremely careful about only providing equipment and not performing any oxygen-conserving procedures, says Marcia Bowers, RN, MSN, CPHQ, home care accreditation consultant.

“If I drop off the equipment and just drop it off, that’s equipment management. But if I drop it off and then do a pulse ox, the doctor could use my assessment to better treat a patient and then that’s no longer just equipment management. That’s clinical. That’s the big issue with HMEs,” she says. “Some companies overstep equipment management and become clinical without really knowing it.”

Pulse oximetry testing did not always pose a problem for HMEs, but the rules for performing this test have changed. Years ago, labs performed the oxygen saturation tests for doctors in the patient’s home. But Medicare would not reimburse them for the pulse ox, so most labs moved away from the testing and left the burden on clinical HMEs and HHAs.

Adding to the challenging process, HMEs and all home care organizations need a physician’s order to perform the procedure.

An all-around tricky situation
Creating a clear, comprehensive policy about pulse oximetry provides an easy way to put everyone at your agency on the same page. Bowers says your policy should state the following:

- What the purpose of the test is
- When it is necessary to administer oxygen
- How much oxygen to give
- When to give the oxygen
- What the nurses should be looking for
- What the nurses should do with the final results
- Which nurses have permission to perform pulse ox
- How the agency determines which nurses can perform the test

“The agency needs to have a policy saying how it deems its nurses competent and that the nurses know what to do with the results. You should make sure you have an inservice to train the staff,” Bowers says. “Watch them apply and read the pulse ox correctly before they are deemed ready to go out and give these tests.”

Include in your policy details about the medical equipment used to perform the pulse ox. “Most pulse ox devices do not have calibration guidelines. The home health agency’s policy needs to follow the guidelines of the manufacturer,” says Bowers. “The JCAHO gets particular about recalibrating equipment. Your policy needs to state that you’ll follow the manufacturer’s guidelines and recalibrate the equipment. As long as you actually do it, you’ll be fine.”

As soon as you understand the regulations and have a policy in place, your agency can perform the pulse oximetry procedure—as long as you have a prescription from a physician. All home care organizations need a physician’s order to perform pulse oximetry.

“Pulse ox measures oxygen saturation, in other words, how much oxygen is being pumped through the vessel. They can’t perform the test without a physician’s order,” says Bowers.

“I’m sure there are a lot of companies out there that don’t get prescriptions for conservers. They just throw them on the patient,” says Plavcan. “But we’re not like that. I guess for us, doing it the right way, we became clinical and actually didn’t really know it. We’re learning to live with it.”
Prepare your agency for HIPAA

With the Health Insurance Portability and Accountability Act of 1996 (HIPAA) deadline around the corner, your agency has to take appropriate steps to meet the privacy rule.

“Getting ready to comply requires a logical process. If your agency hasn’t started yet, you need to begin now and make it a high priority. You need to develop your compliance program as fast as you can,” says Bill Roach, a principal in the law firm of Gardner, Carton & Douglas. Follow Roach’s advice to make your agency HIPAA-compliant by April 14, 2003.

Understand the law and regulations of HIPAA. Many home health agencies (HHAs)—and most other health care organizations for that matter—do not recognize the magnitude of HIPAA and misunderstand the regulations. The first step is to gain an understanding of the rules that affect your agency. For example, one of the biggest areas of confusion deals with which patients need to receive a notice of privacy practices under the new rule and when that notification must take place.

“The requirement is that the individual receive the notice at the first point of treatment after April 14,” says Roach. “It doesn’t mean that you’re prohibited from giving notice ahead of time, but you are required to make a reasonable effort to get acknowledgement of receipt of that notice, which is easier done face-to-face than through the mail.”

Look at the uses and disclosures of protected health information (PHI) at your agency. Once you understand the HIPAA regulations, determine how they apply to your agency. Start by looking closely at the details of your patient PHI. Without examining that information, you’ll have difficulty determining whether you need to change your procedures.

 “[Agencies] need to determine what PHI is in the agency and where it comes from,” says Roach. “They also need to figure out how they use the PHI and to whom they disclose it. If they determine that current uses are not consistent with HIPAA rules, they then need to decide what steps to take to make themselves compliant. This is also the step when they determine whether their agency is a “covered entity” subject to HIPAA.”

Make changes to meet compliance regulations and train your staff. As soon as you determine that certain current practices do not comply with the privacy rule, implement changes within your agency and train your staff on them. Some agencies still do not realize that all parts of HIPAA apply to them, or they just put off changing their policies and procedures because they think they have more time than they really do, says Roach. “They know it’s coming, but other problems take priority and HIPAA gets ignored.”

Spend extra time on confusing or complicated aspects of the rule. Creating the notice of privacy practice, the business associate agreement, and appropriate authorization forms are complex tasks.

Agencies can use a layered notice—a short summary of their HIPAA policies and procedures on top of the entire lengthy notice. (See p. 4 for a sample layered notice.) Patients can sign the summary as an acknowledgement of receipt of the entire notice. The shortened version of the notice not only highlights the important points of the agency’s privacy practice and makes it easier for patients to understand, but it also makes for less paper in the medical record.

Just remember that a summary cannot replace the actual notice of privacy practices. You must also provide the full notice. “Some covered entities have two-page summaries on top of the more detailed HIPAA notice. But the summary won’t completely cut it because it only gives the reader a snapshot of the actual HIPAA notice,” he says.

The focus of HIPAA compliance will be different for each agency because not every organization starts at the same point. Some HHAs already meet the majority of regulations and don’t even know it. If you haven’t already, now is the time to figure out your agency’s compliance level.
Sample layered notice of privacy practice

Patient rights under the Final Privacy Standards:

1. **Right to Notice.** All customers have the right to be provided this written “Notice of Protected Health Information Practices.”

2. **Right to Request Restriction.** All customers have the right to restrict the use and disclosure of their Protected Health Information (PHI) by providing a written, signed, and dated “Restriction Notice” with specific instructions to the Supplier.

3. **Right to Access.** All customers have the right to access, inspect, and copy their own PHI within 30 days of their request.

4. **Right to Amend.** All customers have the right to amend their PHI with legitimate information that is corroborated by their treating physician.

5. **Right to Accounting.** All customers have the right to an accounting of all company disclosures that are not related to Treatment, Payment, or Operations within 60 days of their request.

Administrative Requirements for Covered Entities

6. The Company has designated ______________________ as its Privacy Officer who will oversee compliance of Company rules and procedures regarding PHI.

7. All company employees are trained and updated on Company privacy policies, rules, and procedures.

8. The Privacy Officer will accurately document and promptly investigate all customer complaints regarding the use and disclosure of PHI.

9. The Privacy Officer will provide the complainant with a detailed report of the results of the investigation, and explain the actions taken to resolve the problem and prevent its recurrence.

10. Employees who fail to comply with Company privacy policies and procedures are promptly sanctioned in accordance with the Company Disciplinary Policy.

11. The Company retains all privacy policies and procedures for six years from the date of their creation.

12. The Company must obtain a one-time “Authorization to Use and Disclose PHI” from all Customers before it can use and disclose their PHI for any treatment, payment, and operations related to that Customer.

13. On each separate occasion that the Company intends to disclose a Customer's PHI to a Business Associate, the Company must first obtain an additional “Authorization to Disclose PHI” from that Customer. Business Associates are defined as Accountants, Attorneys, Consultants, or Auditors. The authorization must include a statement explaining the specific reason for disclosure and limiting its use by the Business Associate.

Company Privacy Policy and Procedure

14. The Company ensures that the software utilized to electronically transmit PHI has been tested and approved by Medicare and it provides reports that accurately reflect its use and disclosure.

15. The Company has placed “firewall” and “anti-virus” software in its Internet-based computers possessing PHI.

16. The Company maintains all PHI in a secure location.
17. Company personnel will sign out only the minimum necessary PHI to perform the specific job.

18. A dated sign-out log is utilized by the Company requiring all authorized personnel to enter the description of the specific PHI used, the reason for its use, the time it is taken, and the time it is promptly returned upon completion of the specific job.

19. Company personnel are required to diligently protect all PHI from unauthorized use or disclosure while it is in their possession. It must be kept from the plain view of customers, visitors, and other unauthorized persons. It must not be spoken of in the presence of customers, visitors, and other unauthorized persons.

20. The Company employee who last signed out a Customer’s PHI from the file room is held responsible for its total protection, safeguard from unauthorized persons, and prompt return.

21. No Company employee is allowed to speak about a Customer’s PHI outside of or in conflict with his or her professional responsibility (i.e., with family, friends, for personal benefit, or with malicious intent).

22. All Company personnel are instructed to remain alert for any abuse of these privacy policies and procedures, and to immediately correct, prevent, and report such abuses to the Privacy Officer in accordance with Company Communication Policy.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

<table>
<thead>
<tr>
<th>Customer</th>
<th>Date</th>
<th>Authorized Representative/Witness</th>
<th>Date</th>
</tr>
</thead>
</table>

Source: Adapted from Randy Sease and Associates, Columbia, SC. Reprinted with permission.

What you need to know about business agreements

Surveyors will look at your business associate agreement (BAA) to find out how people outside your organization use your agency’s protected health information (PHI). The definition of a business associate and other rules regarding the agreement tend to confuse home health agencies (HHAs), so we asked Bill Roach, a principal at the law firm Gardner, Carton & Douglas, to clarify some misconceptions.

Who is a business associate? HIPAA defines a business associate as “a person to whom the covered entity discloses protected health information so that the person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the covered entity.”

This even includes companies and individuals that only see a list of patient names and addresses, rather than entire records. Any individual or organization that has access to PHI is a business associate. “If you’re sharing PHI with outside contractors, you need to determine whether they are business associates,” says Roach.

What should you include in the business associate agreement? The regulations specify what provisions the BAA must include. “In the agreement, [business associates] must agree to apply safeguards to protect the privacy of PHI while it’s in their hands.”

When do you need to comply? Any new business associate must sign the agreement and follow all HIPAA rules regarding business associates and patient privacy starting April 14, 2003.

However, you have leeway with contracts that already exist because the government recently granted a compliance extension for BAAs. “If you already have an agreement with a BA, even if it does not meet all regulations, you can continue to operate under that agreement until April 14, 2004, or until the date you amend the agreement,” he says.
Payment method

Home care patients, uses several different payment methods. Home care aides who provide hourly visits or work in private duty are paid hourly. They’re paid for travel time and mileage between clients. Home health nurses receive a salary and the opportunity to earn additional productivity pay, says Angi Johnson, RN, executive vice president for clinical services.

“We have put into place recognition for people who go above and beyond and, based on that, we have weighted certain activities,” says Johnson.

The agency created a point scale based on its statistics for the average amount of time it takes clinicians to perform each type of visit effectively. Due to restrictions of the computer program, a visit equals four units rather than just one. An admission is eight units (or the equivalent of two standard visits), and a resumption of care or anything that requires a follow-up Outcomes and Assessment Information Set (OASIS) is six units (one and one-half visits). A discharge is four units.

“In our computer system, we have codes for each of these activities, for each one of the professions. I can pull out a report that tells me how many regular admissions the nurse or therapist did, how many service admissions the nurse or the therapist did, how many ‘not home/not founds’ they did. Then that’s tabulated to come up with a point system,” explains Johnson. “Let’s say you have 10 days. I would expect out of a nurse 60 visits for 10 days. After we adjust everything for those 10 days, she made 65 visits. Five of those visits will be paid at a bonus rate.”

Johnson felt the bonus system made up for the increased time spent on the OASIS during admission. “If you’re getting hit with more of the OASIS, you need to be recognized in a financial manner,” she says. “If they’re spending an hour and a half in the home doing all the pieces they have to do, it’s not fair to expect them to make the same number of visits as someone who does not have to do that. So it’s right, and we did it for morale.”

Johnson hopes that recognizing the extra effort the staff make will prevent them from rushing through the OASIS during admission, ensuring accurate, thorough forms.

Although the system has only been in place for two months, Johnson says the agency has already felt the impact. Johnson now has less trouble scheduling patients and follow-ups, and notices fewer complaints from her staff.

“We’re having less grumbling. What we’ve received more than anything that I think will be to our benefit is the nurses saying, ‘Finally. Thank you. You’re recognizing what we’re doing.’”

—Angi Johnson, RN

Medium agency offers choice

Like the VNA, Mount Sinai Home Health in Chicago also uses several different payment systems, but the agency allows each staff member to choose his or her own payment method. “We use a combination. We have some salaried staff and we have some fee-per-visit staff,” says Donna Escallier, RN, BSN, home health manager for Mount Sinai.

Despite the difference in options offered at her agency, Escallier does not see a large discrepancy in the amount of money the two groups make. “Actually, it can come out the same because for our salaried people, we include an incentive,” she says.

“They base is 35 visits a week because we’re an urban agency and travel distance is not an issue. So it’s 35 visits a week and anything they do...”
Angi Johnson, RN, vice president of clinical services for the Visiting Nurses Association (VNA) of Greater Cincinnati and Northern Kentucky; Donna Escallier, RN, BSN, home health manager for Mount Sinai Home Health in Chicago; and Karen Lethbridge-Cadinha, director of home health at Trinity Home Health Services in northern California, offer advice on choosing the payment system that fits your agency.

1. Research the payment methods of home care organizations around you and talk to your staff. “Do a survey of the agencies in your area and see exactly how the people are paying,” says Johnson. Determine whether a different system will give you an advantage. “If no one else is doing it, the advantage [your system] may have is it may be attractive to other nurses,” she adds.

The more input your staff have, the more they’ll feel in control of their careers. Escallier says her staff appreciate the schedule flexibility her agency’s payment system allows. “I think that they tend to see more [patients] and some of that is financial, but some of that, from what they’ve said to me, is just that feeling of being in control.”

“One of the biggest mistakes we in management make is we sit here and try to decide what would make them happy,” adds Johnson. “I think it’s really important to talk to them.”

2. Make sure your payment system reflects the size and location of your agency. Methods used by small, rural agencies will usually not work for large, urban agencies and vice versa.

“We’re so rural that if [our staff] were only paid per visit and had to travel long distances, they wouldn’t do it,” says Lethbridge-Cadinha. “I can see in bigger agencies it would be different, where you have a lot of staff and patients are close enough that you can get there without having to drive over mountains in the snow like we do, but [per-hour pay] works really well for us.”

3. Take small steps first. Making changes—even in an effort to please staff—can be daunting, but you don’t have to overhaul the system all at once. “Maybe if [agencies are] doing nothing, they should look at first weighting their admissions, look where that takes them, and then go from there,” says Johnson.

4. Cover all your bases. Keep in mind that a nurse’s job does not end when she leaves a patient’s home. The nurse completes paperwork and projects outside the patient visits and deserves compensation for that extra time. If you use a fee-per-visit method, Escallier advises setting up an hourly rate or a task rate for the extra time.

“With the fee per visit people, it gets tricky about how you pay them for the time they’re in the office,” she says. “Look at all the other things you ask your nurses to do, that when they’re not hourly, they should be compensated for.”

5. Remain flexible and ready to make changes. You may have to strike out a few times before you hit a homerun. Johnson’s agency did just that. Before the VNA could benefit from the new payment method, it had to lower its goals. “We did something that was a little different in that we reduced our productivity expectations,” says Johnson. Although lower productivity expectations decreased profit for that time period, it made the bonus level more attainable for the nurses.

“We had a bonus structure set up long before I came, but people couldn’t reach it. That’s kind of demoralizing to know that you’ve got an apple out there and no one can get it. So we came up with a new system. Pay for our nurses we left at six [visits per day], which we thought was reasonable. But we adjusted what it would take for them to get to the six, so now it makes the apple reachable.”
Payment method

after that gets paid at a per-visit rate.”

Escallier’s agency has not changed its payment system in five years because the administration likes having a devoted group of clinicians, and because the staff like the system. “We felt like we needed to have that dedicated base of salaried people. We’re lucky in that we have a lot of long-term staff, like 10 years or more, and some of them want and need the salary and the benefits. None of the fee-per-visit people can get benefits in our structure. I know in some places you can, but in our structure, you’re either salary with benefits or fee-per-visit with no benefits.”

The payment system at Mount Sinai gives the nurses control and flexibility with their schedules and the opportunity to make extra money. “Some weeks they can maybe see [fewer patients] if they have things going on. Other times they can see more and still benefit financially. It certainly helps the salaried people because without that little incentive, it’s discouraging to work all week and not really have any way to make more money,” she adds.

Escallier worries that the current system could affect patient care if nurses rush through visits. To make sure the nurses do not take on more than they can handle just to gain the monetary benefit, the agency’s administration pays close attention to the numbers of patients the nurses see.

Having a base salaried staff decreases Mount Sinai’s risk of losing nurses and eases the worry of the administration at a time when finding nurses is hard, but keeping them is even harder, says Escallier. “It’s nice to have that solid base of salaried. The fee-for-visit helps you control cost because if your visits drop, you don’t have the steady cost of that amount of employees. It also helps with scheduling and staffing because we can reward them for doing something extra, not only in a week, but on a particular day.”

Small agency pays by the hour

Compared to the VNA and Mount Sinai Home Health, Trinity Home Health Services is tiny, serving a census of only 25 patients per week. But its location in rural Weaverville, CA, accounts for the size. Trinity has only seven staff members, with just two working full-time. That’s why its payment system differs greatly from the other two.

“Two of us are salaried. I’m salaried and the person who does the billing and the secretarial work is salaried. The nurses are hourly. Home health aides are hourly. Physical therapy is hourly,” says Karen Lethbridge-Cadinha, director of home health.

Trinity has used this type of payment for as long as Lethbridge-Cadinha has been with the agency. The administration has never considered changing it, mainly because of the location.

“We’re so rural. If we had to pay per visit, sometimes they go over 100 miles for one visit and it just wouldn’t be worth it for them,” she says. Staff also receive hourly pay for time spent on travel, classes, projects, and meetings, making additional work well worth their while.

The staff love the payment method. Since most health care organizations in the area have difficulty recruiting and keeping staff, Trinity works hard to please the staff it already has. So far the effort has worked, evident by the excellent retention rate in the home care department.

“I think they absolutely love it. We did a productivity study about a month or two ago. When they have down time, we have a list of projects that they work on here, and they’re a very productive group,” says Lethbridge-Cadinha.

A system like this has success in a small, rural organization like Trinity because the agency has relatively few people to keep happy. With a staff of fewer than 10 and a census below 30, Trinity can pay hourly without a problem.

See the tips on p. 7 for more advice on evaluating your agency’s payment system.
Survey monitor: Switching to CHAP raised confidence and quality of care at Indiana agency

When accompanied by praise, criticism during a survey doesn’t seem so bad. Just ask staff at Hancock Memorial Hospital, Home Care, and Hospice in Greenfield, IN, who recently completed their Community Health Accreditation Program (CHAP) survey.

Although the organization received required actions, it also got praise for the areas in which they performed well.

“We had a commendation for our quality improvement study on pain management. The required actions meant that we just had to change our policies or our practices. Our [required actions] were minor enough that they just said, ‘Change the policies by the next survey,’ which is triennial,” says Valerie Wender, RN, quality improvement coordinator at Hancock.

Wender’s agency decided to switch accreditation organizations when its Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation expired in the middle of 2002. “We did that because we had heard that CHAP was educational and collegial rather than punitive, and we also did it for the financial benefit,” she says. In November 2002, two CHAP surveyors stayed with Wender’s agency for five days.

The survey began with an opening interview where the surveyors spoke with staff and decided which patients to visit. At the end of their visit, the surveyors also gave a closing interview, during which they presented the agency with commendations, recommendations, and required actions.

“At that time, they gave us their recommendations and were also able to tell us that we passed with no follow-ups needed and that we did have full accreditation,” says Wender. “It was all pass/fail based on hundreds of standards.”

No time to spare
As soon as the agency decided to switch to CHAP, Wender and other administrators at Hancock began preparing for the survey. The agency’s JCAHO accreditation expiration date was fast approaching, and they hoped for CHAP accreditation as soon after that date as possible. They had no time to waste.

Wender started by making sure her agency’s policies and procedures were up to date. Next, the agency held inservices to inform staff on policy changes and clear up any misunderstandings.

But the inservices and the policy reforms felt almost trivial compared to the CHAP-required self-study, which was by far the most difficult and time-consuming part of the agency’s preparation. “It is daunting. It is enormous to go through. It took us every bit of the time we had,” Wender says. The self-study asks questions about structure and function, quality, resources, and long-term viability.

“The self-study really makes you look at your organization. You can tell where your weak points are and work on them from there,” she says. The core self-study applies to the entire organization, but there are also separate components for home care and hospice.

The hard work on the self-study paid off. Wender and the rest of the clinicians at Hancock knew the surveyors’ focus areas before they even stepped foot in the agency.

Ready or not, here they come
During their time with the agency, the CHAP surveyors visited 10 patients and asked them a series of questions.

“They wanted to know if the patients knew their rights and responsibilities. They also wanted to know if they knew how to contact people after hours and if they ever had to do it, how it went. They asked those two questions of every patient, even the Alzheimer’s patient they visited,” says Wender.

None of the patients had trouble answering...
the surveyors, not even the Alzheimer's patient.

“He pointed to our telephone number he had posted on his refrigerator and said, ‘This is the way I would [get in touch with them after hours]. I know my rights because I have my blue folder in the hall.’ He knew everything. I was just floored,” she says.

After the patient visits came the chart reviews and administration interviews. The surveyors looked at the charts of the patients they visited, along with 20 other charts. “They did a really thorough chart review. They must have done a percentage of our active census. It might have been 10% or so,” says Wender.

The surveyors spoke with the clinical supervisor, the administrator, and the quality coordinator, asking about areas they were monitoring and any major projects for 2002. “They were interested in our philosophy of quality improvement and our projects.” The surveyors emphasized quality of care, continuity of care, and communication. If they found an incident in a chart, they looked to make sure the information was distributed correctly and that the agency called a doctor or one of the other disciplines, says Wender.

Making the grade
Hancock’s home health staff came away from the survey with one commendation, a few recommendations, and several required actions. The required actions included the following:

- Changing their professional advisory board meetings from yearly to quarterly.
- Documenting more information in the on-call log for its nurses.
- Putting the grievance resolution policy in the client’s rights and responsibilities notice. Hancock already had a policy containing similar information, but the surveyors asked the agency to include more detail.
- Adding a statement to any patient survey that explains patient rights and asks whether the patient agrees to discharge.
- Instituting monthly supervisory visits and annual performance evaluations of all clinicians.

“We had, of course, what we thought was adequate supervision, but we did not include monthly shared visits for clinicians in that,” says Wender.

She knew about the monthly visit standard, but the agency did not have time to implement a new policy ahead of time. CHAP generally looks at one full year from the survey date, and Hancock applied for accreditation from CHAP only six months before its survey.
News briefs

GAO recommends tougher surveys in home care
The General Accounting Office (GAO) is recommending that the Department of Health and Human Services (HHS) conduct stricter surveys for home health agencies (HHAs) and nursing homes. In a report released in January, the GAO highlighted several areas it wants HHS to focus on this year. The GAO has recommended similar action in the past, but said increased attention to improving oversight of nursing homes caused inadequate monitoring of HHAs.

A review of nursing homes and HHAs revealed continuing problems with the filing and timeliness of complaint investigations, particularly regarding complaint hotlines and priority of investigations, according to the GAO.

The GAO suggests that problems with HHAs can be attributed to the survey process, since HHA surveys occur less frequently and are less detailed than those in other health care fields. If HHS follows the advice outlined in the report, HHAs can look forward to more scrutiny in future surveys. Go to www.gao.gov/pas/2003/d03101.pdf to read the full report.

Survey provides insight into health care priorities
At the National Conference of State Legislatures, the Health Policy Tracking Service surveyed top state health officials about their health care priorities for 2003, finding that controlling the Medicaid budget, reducing the cost of pharmaceuticals, and providing access to health care and insurance were all near the top of the list. In 2003, 44 states will consider freezing or reducing eligibility, reimbursement rates, and other optional services to control the cost of Medicaid, and 38 states will likely take action to reduce the cost of pharmaceuticals, the survey showed. In the search for less-expensive quality care, 28 states will consider less costly alternatives to nursing homes such as family care, home care, and assisted living. Go to www.hpts.org/HPT97/home.nsf to read the “2003 State Health Care Priorities Report.”

Final HIPAA security standards ready to go
HHS published the long-awaited Health Insurance Portability and Accountability Act of 1996 (HIPAA) security standards in the February 20 Federal Register. The regulations are designed to safeguard protected health information (PHI) that is maintained or transmitted in electronic form.

Most home care and hospice agencies are “covered entities,” meaning that they transmit patient information electronically in conjunction with at least one of several specified transactions. All HIPAA covered entities must comply with the new rule.

HHS accomplished its goal to integrate the security rule with HIPAA’s privacy rule, which becomes enforceable in April, says John Christiansen, JD, attorney with Preston, Gates & Ellis, LLP in Seattle. The security regulations will become enforceable for most covered entities on April 21, 2005. Small health plans will have an additional year to comply.
Wender felt encouraged by the survey, as it panned out almost exactly as she imagined. “They were very educational in their survey. It wasn’t just checking things off and going on. Both surveyors were open to opinions. We could argue our point and they took that into consideration. Sometimes we won, sometimes we lost, but they were very open to opinions,” she says.

Wender appreciated that the focus of the survey was quality of care, not a score. “I think there’s an advantage to [the CHAP survey] because you’re not so hung up on a score,” says Wender. “It’s a commendation, a recommendation, or a required action on every single standard or nothing.

They take into consideration the entire survey and the number of recommendations and required actions and what they’re related to.”

“It was hard, but we were relatively certain we would pass. We were very pleased with our first survey not to have to write any plans of correction or have a follow-up survey. That was our goal, and we met it,” she says.

To other agencies trying to meet their own CHAP survey goals, Wender offers some advice.

“As soon as the decision is made, [the self-study] needs to be attended to because it really takes a lot of time and it will help on the survey. If you can answer all the self-study questions satisfactorily, you’re going to do fine on the survey,” she says.

“Just like having policies. You can have beautiful policies, but if you don’t follow them, you’re out of compliance. They do the same thing with the self-study.”