Coding guidelines rarely stick around long enough for staff to learn them before the government implements a new set of rules. Allowing V and E codes on the Outcome and Assessment Information Set (OASIS) is the latest modification to the ever-changing home health coding system.

Effective October 1, 2003, for the first time since the Centers for Medicare & Medicaid Services (CMS) implemented PPS in home care, home health agencies (HHAs) can use V codes in the primary diagnosis field and E codes in the secondary diagnosis field on the OASIS.

In addition, CMS added item M0245 to determine case mix and reimbursement for cases with V codes as the primary diagnosis.

Although the main goal of the home health quality initiative is to provide consumers with information about home health agencies (HHAs)—based on 11 quality indicators derived from Outcome and Assessment Information Set (OASIS) questions—the initiative will clearly affect your agency’s quality improvement (QI) efforts.

CMS believes the initiative will also provide consumers assistance in making educated decisions about home care services.

“This is the centerpiece of this initiative and it’s the philosophy that is going to drive quality improvement. We believe consumers deserve this information. We believe that consumers, clinicians, and caregivers will use this information for decision-making. We’ve seen and believe that this information, in the public domain, is an incredible stimulus to improve care,” adds Paul.

CMS modeled the home health quality initiative by establishing new standards and enforcing current ones, offering doctors and providers technical assistance, and promoting and creating partnerships among home health organizations, Barbara Paul, MD, quality expert and quality coordinator for CMS, said during a recent Open Door Forum on the initiative.

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Coding regulations

M0230 replaces a case-mix diagnosis code, HHAs can fill out M0245 with the code they would have reported under the original OASIS instructions.

Changes to meet HIPAA requirements

Before the switch to Prospective Payment System (PPS), HHAs could use V codes as primary diagnoses. But with the implementation of OASIS, V codes were deemed too general and prohibited for M0230 (primary diagnoses). CMS also said V codes did not “foster and monitor improved home health care outcomes,” one of its main objectives in creating the form.

“We couldn’t use [the V codes] because they were too broad. For instance, you have a V code for attention to a neoplasm. But that doesn’t tell you where the neoplasm was. It doesn’t tell you whether it was malignant or benign. Consequently, the V codes didn’t do a good job determining case mix for PPS and were prohibited,” says Prinny Rose Abraham, RHIT, CHPQ, of HIQM Consulting in Minneapolis, MN.

Although the V codes alone are still not specific enough to provide meaningful quality improvement (QI) data, they meet the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions and code sets rule. “The transaction standard says that every health care provider who bills electronically has to use five defined data sets in a standardized manner. The ICD-9 is one of those data sets. In order to meet both [OASIS and federal HIPAA] regulations, something had to give,” says Abraham.

Using V codes for primary diagnosis and another code in M0245 for payment and QI purposes offers the best of both worlds. The V codes present the most accurate portrayal of the patient diagnosis, while the code in M0245 provides the details of the diagnosis. “When the OASIS first came out and they couldn’t use the V codes, people were a little upset. Now I think they’ll be a lot more comfortable with the primary diagnoses,” says Carol Conrad, RN, BSN, MEd, of Simione Consultants, LLC.

E codes also have HIPAA implications. Used in addition to a primary diagnosis code, E codes explain circumstances and causes of wounds. Cases where an E code would be appropriate are generally the interesting cases clinicians might want to talk about with people other than caregivers. But they can’t because of the privacy regulations, says Abraham. “They’re the gun shot wounds and the falls from ladders, those kinds of things.”

Challenging transitions for HHAs

Adjusting to the new codes will be difficult, especially since many HHAs find limited education opportunities in this area. “We’ve been searching and trying to find written information. We haven’t received anything in the mail. There’s very little information out there,” says Fanchon Snelling, patient account representative at Lake Regional Home Health in Osage Beach, MO.

“I think the changes are necessary because instead of putting everyone into one classification, they break it all down a little more,” says Snelling. “In the long run, it will help explain the reasons for the care of each patient. But right now, it’s an education challenge.”

The questions of how and when to teach staff present the biggest obstacles. “I think for the clinicians, they’re going to need training on how to use the codes and what exactly this [change] means. I know they used the codes pre-OASIS, but coding has changed so much since then. It’s so much more specific now,” says Conrad.

“The change doesn’t take place until October and it really means turning on a dime on October 1. However, you still have to figure out when to do the training and develop the training material. You also have to modify your forms or your screens depending on whether you’re paper- or computer-based,” Abraham says. She suggests starting with Attachment D to Chapter 8 in the OASIS User Manual within the next three months. (See sidebar on p. 3 for details about training your staff.)
New codes worth the struggle
Most agree that the new codes will be beneficial because they'll give a more accurate picture of reasons for treatment. “The V codes provide specific information as to why the patient is receiving care. Any time we code anything, we want to paint as accurate a picture as we can about why the patient is in our care. The V codes just do a better job of that,” says David McCann, director of coding services at HP3, Inc.

Once they understand the new codes, home health workers should feel relief about the new process. “Once all this is over and once everybody codes and bills the same way, it’s going to be so much easier. It’s just getting from point A to point B that’s the problem,” says Snelling.

Solve coding woes by educating staff
We asked coding experts Prinny Rose Abraham, RHIT, CPHQ, of HIQM Consulting; Dave McCann, director of coding services at HP3 Inc.; and Carol Conrad, RN, BSN, MEd, of Simione Consultants, LLC, how home health agencies (HHAs) should prepare to use codes. Their answer? EDUCATION.

Follow their advice on teaching your staff how to use the new codes, effective October 1, 2003.

1. Start early. October may seem far away, but the earlier you start training staff on the coding changes, the easier the transition will be. “I would recommend they start now by looking at ways to implement the changes and ways to train the clinical and billing staff. Bring people up to speed now,” says Conrad.

You don’t need to complete all training right away. Start now and do a little at a time to keep your staff calm and to ease the pressure that will arrive once October rolls around, she adds.

2. Use the resources provided by CMS. Attachment D to Chapter 8 in the OASIS User Manual, which can be found both in print and online at the Centers for Medicare & Medicaid Services’ Web site, describes the new changes in detail. (See this month’s insert, “Home health coding 101,” for all the coding changes.)

“That alone is a good teaching document,” says Abraham. Walking your staff through the case studies and putting explanations of the new applications of code assignments on the Outcome and Assessment Information Set and the 485 can help, she adds.

3. Bring in experts to train your staff. “Consulting companies do this kind of training all the time,” says McCann. Bringing in an outside expert also takes pressure off administrators because they don’t have to understand the rules immediately. They can learn along with the rest of the staff.

4. Provide ongoing training to boost staff confidence. Constant changes make it difficult for staff to have confidence when choosing codes. Provide opportunities for continuing education for staff who feel they need it but might be afraid to ask.

“There’s a lot of insecurity about whether they’re picking the right diagnosis code. In facilities and hospitals, they have people who do only coding. They are trained for it. In home health agencies, you don’t find that kind of person often because the agencies don’t have the resources,” Conrad says.

5. Leave room for error, particularly in the beginning. In the beginning, implement a process for double-checking where two people look at each diagnosis code. Although it will take extra time, it may help you catch early errors.

“Initially it’s going to make things more complicated until the people doing this get some training and education,” says McCann. “Once they understand and know what codes are available to them, it will make it easier.”
Write clear policies and monitor DME contracts for safe management of medical equipment

Staff at home health agencies (HHAs) and hospices may think their only dealings with medical equipment are their contracts with home medical equipment (HME) companies. But they handle equipment all the time. Even small machines such as pulse oximeters are considered medical equipment, and almost all accrediting bodies require HHAs and hospices to have policies for managing it. Policies help the staff understand and use the equipment safely, which in turn prevents harm to patients. “In the end, [they] improve the quality of care that patient gets,” says Maria Bishop, BBA, RRT, PL, home care accreditation consultant in Grand Rapids, MI.

Standards EC.7 and EC.7.1 in the Joint Commission’s Comprehensive Accreditation Manual for Home Care state that home care organizations must create and implement a plan for medical equipment used by staff when providing patient care or services. The plan must include processes for choosing, acquiring, maintaining, storing, and monitoring equipment, as well as adhering to hazard notices and recalls, and reporting any incidents in which equipment is connected to injury or death.

HHAs and hospices that have contracts with HMEs should monitor them because the agencies are responsible for the actions of the HMEs, even if not for the equipment itself. “If a hospice or HHA is going through its accreditation survey, and the surveyor goes to visit an HME that they’re contracted with, and something isn’t right, the penalty will be against the hospice or HHA, not the HME,” says Bishop. “Once you’ve contracted with someone—whether they’re doing business with your patients or they’re providing services for your patients—they are an extension of you. So it’s the responsibility of the hospice or HHA to know that [the HME] is maintaining its practice as required by the standards.”

A medical equipment success story
Lorraine Waters, CSN, CHCE, director of Southern Home Care in Jeffersonville, IN, integrated her medical equipment policy into the policy she created to meet the new patient safety goals. (For a sample medical equipment policy, see p. 5.) “I think safety is a big issue, especially with the new [standards and goals] that have just come out. Two of them directly relate to equipment,” she says.

The staff now have a heightened awareness of safety, Waters says. “I think it’s a good thing that they are becoming more aware of the importance of understanding the equipment we handle. The Joint Commission is not going to point out these things unless there’s a reason for it. And the reason is because there have been instances of harm to patients.”

Southern Home Care staff use several different pieces of equipment, including pulse oximeters, portable electrocardiogram (EKG) machines, and ultrasounds. In addition, their patients use equipment provided by several different HMEs. Although not every nurse and clinician regularly deals with equipment—only two thirds of the staff use it on a daily basis—all staff at Southern Home Care must know the equipment policy and most must go through training.

Southern Home Care trains its staff on each piece of equipment. “We use the manufacturer’s database as a beginning and then actually have the [manufacturer] come in to demonstrate correct procedure,” says Waters. “The staff that use the EKGs go through EKG training at the hospital.”

Waters also expects her nurses and clinicians to learn about the role of the HMEs the agency works with to avoid problems that could arise due to lack of understanding or miscommunication.

“I think that communication probably trips people up the most. Some home care nurses don’t know the limitations on HMEs as far as what they can do in the home. That may be an issue as well,” she says.

Waters’ staff have had relatively few problems follow-
ing the agency policy for handling medical equipment and dealing with HMEs. “We do find occasionally that the patients don’t know as much about their equipment as we wish they did and that could be for one of two reasons. Either they just couldn’t absorb the information, which is often the case, or it wasn’t given to them. Then it’s our obligation to make sure the patient is using the equipment safely,” says Waters.

Since most HHAs and hospices deal with a limited amount of medical equipment, training shouldn’t be difficult. Follow these simple guidelines for dealing with medical equipment safely:

1. **Communicate with staff.** Make sure your staff know about your medical equipment policy, understand it, and follow it. Post the policy around your agency to keep it in the front of their minds, and offer help or suggestions if staff don’t understand.

2. **Know what your HMEs are doing.** “Pay a visit to them on a regular basis, even quarterly, to see whether they are maintaining their practices up to the standards [you] would want [your] own practices to be,” says Bishop.

“We’re always monitoring service,” adds Waters. “That’s where people run into more trouble than anywhere else. [HMEs] say they’ll be out and then don’t come until a few days later. That would be an HME we would not use again and I’d report it.”

3. **Be sensible.** Following the standards for patient safety and medical equipment shouldn’t make treating patients more difficult because they are common practices, says Waters. “I think it’s just common sense. In fact, we recently went to a Joint Commission workshop and that’s basically what we were told. Just use common sense.”

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**Sample maintenance/cleaning of patient care equipment policy**

**POLICY:** The agency maintains a limited supply of equipment used for patient care and/or teaching/training.

Information regarding manufacturer, model, serial numbers, and date of last preventive maintenance (PM) calibration of equipment is kept in an equipment inventory book located in the supply room. Maintenance and calibration of biomedical equipment used in provision of home health services is the responsibility of the clinical engineering department of the agency or hospital system.

Supply room staff are responsible for maintaining the equipment records and notifying clinical engineering when PMs need to be done. Clinical staff are responsible for checking current PM dates on all equipment used in the care of the patient, and for taking equipment out of service or notifying suppliers if the PM is past due.

Clinical staff are responsible for wiping down equipment taken into patient homes with germicidal wipes prior to returning them to the supply room. Infection control should be consulted for cleaning instructions if patients have obvious drainage/documentated infections.

Maintenance of records of PM and repair of home health equipment is the responsibility of clinical engineering and these records are maintained and housed at the clinical engineering department at the agency or hospital system.

**PERSONNEL:** All home health clinical staff.

**DESIRED OUTCOME:** Equipment used for patients will be kept in good order and will be clean.

**APPROVAL:**

Home health administrator Date

Source: Adapted from GHS Home Health and Hospice, Greenville, SC. Reprinted with permission.
Quality initiative

Health initiative after the nursing home quality initiative launched in the fall of 2002. “CMS wanted to provide the public with more information about what they consider quality care in nursing homes,” says Julia Hopp, vice president of patient accounting at Paramount Healthcare Company in San Antonio, TX. “The intended results were to ensure the highest quality care in the nursing homes and also to give the public more information so they could more easily decide which nursing home to place family members in.”

Planning for the initiative

Nursing homes went to great lengths preparing for the quality initiative, says Hopp. “One of the most important things they did was to make sure their minimum data set (MDS)—the nursing home version of OASIS—was correct. In doing so, they made sure that the person completing the MDS really knew how to code accurately and understood what she was coding and the importance of its accuracy. They also informed family members that this data was being published and where they could find it,” she says.

HHAs now face similar challenges in preparing for their own quality initiative. Hopp suggests

- checking for errors or inconsistencies in your OASIS forms
- making sure clinicians feel confident about filling out the forms and understand the rules
- telling the families of your current patients what to expect from the new initiative

How does ‘Home Health Compare’ compare?

Home Health Compare reviews quality measures of home health agencies (HHAs) by state. Consumers can go to www.medicare.gov to find information on the initiative. Cindy Wark, director of the division of Web site management for the Centers for Medicare & Medicaid Services (CMS), and David Biddle from the University of Colorado Health Services Center, describe the particulars.

“The Web site was built to make all the pieces fit together,” says Wark. “For the HHAs that are not in a phase I state, some information will still be available through the Web site. Quality measures will be available for phase I states only, and we will put information on the site to explain what is a phase I state.”

In addition, CMS will only provide information on Medicare-certified agencies during phase I. “Medicaid-only agencies do not have the same reporting requirements that the Medicare-certified agencies do. Therefore, you will not see them,” she says.

The outcome information on the Web site will look slightly different than Outcome Based Quality Improvement (OBQI) reports have looked in the past, says Biddle. “However, the measures entered on Home Health Compare are drawn from those measures included in the OBQI reports,” he adds.

“You’ll be observing a risk-adjusted outcome rate, which is going to be your agency’s observed rate plus the difference between the national predicted outcome rate and the agency predicted outcome rate,” says Biddle. “We’re giving you what you would’ve experienced had your agency had the same case mix as the rest of the nation.”

The Web site will also include the following:

- Geography-based search pages
- Results pages with agency-specific information
- Instructions on how to make data corrections
- Links to home health publications
- Links to state Web sites where available
- A listserv with updates
- A downloadable database

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“Be sure that the people completing the OASIS assessment really know exactly what they’re doing because if they aren’t confident and if they don’t know how to code accurately, then your data will be completely useless,” says Hopp. Since the quality indicators of the home health initiative are based on the OASIS form, consumers will get an inaccurate picture of your agency if your OASIS information is wrong.

“Secondly, inform the public, families, and residents about the information that will be coming out,” Hopp suggests. Nursing homes had particular difficulty explaining the initiative to families because despite the “consumer language” included, many could not understand the percentages they saw, how those percentages were obtained, and what they meant. To overcome this obstacle, the nursing homes held family counseling sessions to explain the initiative in detail and to allow the family members to ask questions in a comfortable, private setting.

**What to expect when the initiative arrives**

Nursing homes have overcome the initial hurdles of their initiative, but HHAs have just begun their journey. CMS plans to report the information in newspaper ads, online at the Medicare Web site in a special section entitled “Home Health Compare,” and through promotion by the quality improvement organizations. “If you’re looking for a timeline, we would announce one day, the ads would run in the papers the next day, and more than likely the preponderance of stories that will also come out on the initiative will run the next day,” says Rob Sweezy, the home health, hospice, and durable medical equipment Open Door Forum Washington, DC, cochair.

CMS may implement the initiative across the country by this fall. But HHAs shouldn’t worry too much about the program yet. It will probably have more of an impact inside your agency than on outside consumers right now, says Hopp.

“The only impact that we’ve seen [from the nursing home initiative] is that now this is published data that the public can see. But really, we haven’t even seen comments from family members regarding the information they saw, either in the newspaper or on the Web site,” she adds. ■

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**The five ‘Ws’ of the home health quality initiative**

**Who:** Home health agencies (HHAs) in eight pilot states (Florida, Massachusetts, Missouri, New Mexico, Oregon, South Carolina, Wisconsin, and West Virginia) will test the new initiative.

**What:** The Centers for Medicare & Medicaid Services (CMS) will publish information about HHAs based on quality indicators derived from the Outcome and Assessment Information Set data set, including the following:
- Dressing
- Bathing
- Getting to and from the toilet
- Walking and or moving around
- Getting in and out of bed
- Taking oral medications correctly
- Confusion
- Pain when moving around
- Admissions to the hospital
- Urgent, unplanned medical care

**When:** CMS launched the initiative in the pilot states at the end of April. The agency hopes to roll out the program to the rest of the country by this fall.

**Where:** The information on the quality indicators will be published in at least two newspaper ads in each of the pilot states. Larger states will have more ads. The information will also be available online at www.medicare.gov on the Home Health Compare Web site. (See p. 6 for the specifics of the Web site.)

**Why:** CMS wants to provide consumers with information on HHAs to assist them in choosing the right facility to meet their needs. CMS also hopes to prompt quality improvement efforts at HHAs. ■
Although they try to avoid it, most agencies are scrambling the week or two before the surveyor is scheduled to arrive. But Home Care Providers, a hospital-based home health agency (HHA) in Burlington, NC, did not wait until the last minute to prepare. Instead, the agency integrated Joint Commission on Accreditation of Healthcare Organization (JCAHO) standard changes into its daily practices as soon as they happened and received a score that reflects that hard work.

“I’m proactive and constantly looking at the changes during the year. Any time changes in standards or regulations happen, including Medicare or JCAHO changes, I try to address those at the present time,” says Dorothy Moseley, RN, MPHA, director of Home Care Providers. “I really felt like we had everything in place [before the surveyor arrived].”

Home Care Providers received a score of 94 with one possible Type I recommendation for use of pulse oximeters. “The staff was using [pulse ox], but it wasn’t always showing up in their plan of care. It may come out as a supplemental, but it will probably be a Type I,” says Moseley. In the future, the agency plans to enforce regulations about documenting pulse ox more strictly.

A little tweaking here and there
Despite updating policies and practices as standards changed, Moseley still had to do some pre-survey preparation. In a series of five hour-and-a-half sessions, she went over problem areas with her staff. “I started with the patients we have admitted to the agency. Then I showed the staff what we have in place to meet the standards for each patient. I did it in reverse,” she says.

Moseley focused on the standards related to her staff’s specific practices. “If you’re doing orientation with your staff, try to take your processes and relate them back to the standards rather than taking the JCAHO standards back to your processes.”

She also found the sample questions in the Joint Commission’s manual helpful, asking staff questions she thought the surveyor might ask. “For instance, I would say, ‘How would we handle a patient complaint? What is our process here?’ And then the staff could tell me what we’ve done.” Moseley listened for her nurses and clinicians to answer by relaying the practices back to the standards, and she offered constructive criticism when their answers lacked depth. “I thought they did really well,” she adds.

Moseley also tried to work the national patient safety goals into her preparation. “We were pretty much aware that the national safety standards were going to be an issue this year. The safety standards are really not in the JCAHO manual, but we had been doing this because our hospital dealt with them and it’s really all integrated.”

A pleasant surprise
The surveyor arrived at the beginning of April and stayed for three days. Moseley, a 17-year veteran of the North Carolina agency, immediately noticed a difference in this survey from those her agency had undergone in the past. The surveyor put the staff at ease right away, making the experience like a consultation with a score rather than a test. She didn’t try to trick them with hard questions, says Moseley.

“I think before, the surveyors tried to stick too much to directing [surveys] toward verbalizing the standards and that made the staff very nervous. The staff were nervous this time, but they were also relaxed because the surveyor really put them at ease,” she says.

The surveyor toured the facility, completed a policy and procedures review, and made a total of six home visits, reviewing the patients’ records before
the visits. The surveyor asked the patients whether they had contact information for the agency during and after hours, and about their care, rights, and financial responsibilities.

“Then she observed the staff during care. She looked to see whether they used good infection control techniques, if they washed their hands, how they handled their equipment,” says Moseley. “Infection control was a big issue when she went on visits.”

The surveyor also interviewed staff from several departments at the agency. She spoke with the clinical staff to learn about the types of educational programs the agency offers and she talked to the clerical staff—the intake employee, the scheduler, and the account representative. Moseley had never seen that during any of her other surveys. “She wanted to see our process. Particularly, she wanted to see how we let patients know their financial responsibilities.”

**Heavy duty focus areas**
The surveyor concentrated on infection control, emergency preparedness, sentinel events, and patient safety, almost overlooking performance improvement (PI) measures altogether. “One of the interesting things she discussed a lot was the emergency preparedness, because of all the terrorism. The surveyor stated that within the next year or two, they’re going to be looking to see if an agency has participated in a mock drill testing the emergency preparedness plan,” says Moseley. (For more on developing an emergency preparedness plan, see p. 10.)

Moseley expected more focus on PI. The surveyor asked some simple questions about aggregation of data and the progress of PI measures, but then she quickly moved on, she says.

Like most home care directors, Moseley hoped for a score of 100, but was satisfied with the agency’s almost-perfect score, cutting herself and her staff some slack because of recent changes that disrupted the smooth flow at the agency, including preparation to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

“We were having an upgrade of our computer system, to have HIPAA programs put into our software,” says Moseley. “It was a very difficult time for us since January and we had to adjust. To come out and have a good survey was rewarding for the staff.”

**Advice**
Integrating preparation for accreditation surveys into practices on a routine basis is key because it makes the staff feel comfortable and that confidence comes through during the survey.

“I think you’ve got to try to have it part of your daily operations. If you just try to meet the standards and you don’t integrate them into your daily practices, you lose the benefit of performing at a high level of quality.”

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**Survey at a glance**

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<thead>
<tr>
<th>Name of agency:</th>
<th>Home Care Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
<td>Burlington, NC</td>
</tr>
<tr>
<td>Size:</td>
<td>Patient census of 350</td>
</tr>
<tr>
<td>Hot spots:</td>
<td>Patient safety, infection control, and emergency preparedness</td>
</tr>
<tr>
<td>Type I’s:</td>
<td>Possible Type I recommendation for pulse oximetry. The staff used the procedure, but did not always record it in the plan of care. Home Care Providers is still waiting for the final word on whether this was a Type I or supplemental recommendation.</td>
</tr>
</tbody>
</table>

**Quote of note:** “I think before, surveyors tried to stick too much to directing [surveys] toward verbalizing the standards and that made the staff very nervous. The staff were nervous this time but they were able to relax because she put them at ease.”
An effective plan and an educated staff can help prepare your agency for a terrorist attack

With Operation Iraqi Freedom as a constant backdrop and the memories of September 11 still fresh, home care organizations need to be prepared in the event of a future terrorist attack.

Colonel Maria Morgan, RN, deputy adjutant general for New Jersey in the Department of Military and Veterans Affairs, provides advice on preparing staff and patients:

Create an emergency plan. If you don’t currently have an emergency plan, create one. Do it quickly, but don’t compromise the depth of your plan to save time, says Morgan. The Joint Commission’s Environmental Safety and Equipment Management (EC) standards require home care organizations to establish and implement emergency plans and to test those plans on a regular basis. But more important, an emergency plan will protect staff and patients.

“We always need to be prepared for the worst-case scenario. We don’t want another September 11, but we’re preparing for the contingency that there might be. We haven’t detracted from that at all,” says Morgan.

Educate your staff. After creating a plan, educate your staff on the basics. “First and foremost, all the providers need to get educated on biological agents, signs, symptoms, and treatment. That also applies to chemical and radiological agents, and any weapons of mass destruction,” says Morgan. “All staff providing direct care, including nurse assistants and therapists need this education,” she adds.

Morgan suggests attending educational seminars. “There are programs being offered by a myriad of organizations, from the federal government down to the local level. They have, for the most part, targeted physicians and nurses. However, more are now being offered to the general health community.” In many states, the state health care organization has taken the lead in the educational process, she adds.

Educate your patients. Teaching your patients and their families how to continue treatment and stay calm during an emergency is as important as educating your staff. Reassure patients that you’ll still provide care during extreme circumstances, but inform them of the importance of being educated themselves. “The patients need to know how to protect themselves. The nurses and nursing assistants are not in there 24 hours a day, so families also need to get educated,” Morgan says.

Use the Internet to find information about homeland security. “In New Jersey we have a Web site, which is www.njhomelandsecurity.com. We also have materials that have been produced by the New Jersey Domestic Security Preparedness Task Force. I don’t know all the details of what other states are doing, but I do know that most of them have similar organizations and references,” she explains.

Understand your community’s role during an emergency. Community resources can help during a terrorist attack, but only if staff know where to look, says Morgan. “If it’s a biological event, you’re going to have everybody involved including the CDC, the FBI, the state health department, the county public health officials. Response to an incident usually starts at the local level and works its way up to a state and federal level. All the nurses and providers working in a home health agency need to understand what those systems are and be able to tap into them.”

Learn about your county and state homeland security efforts. Part of education on terrorism includes knowing how your county and state are preparing for the possibility of an attack. Discovering this information should be simple, says Morgan.

“Start out with your governor’s office and ask who your state homeland security guru is,” she says. “That should lead you to all the levels of your state government providing services. Then, for the county that you live in, call your county office of emergency management and they can tell you how they relate to the state office.”
**News briefs**

**JCAHO to switch to all unannounced surveys**
The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) intends to make all accreditation surveys unannounced by January 2006, it announced April 2. “The new accreditation process creates the expectation that each accredited organization be in compliance with 100% of the Joint Commission’s standards 100% of the time,” says Dennis O’Leary, president of Joint Commission.

The accrediting body will test the new survey process in volunteer health care organizations over the next two years, starting with hospitals in 2004 and moving to all health care organizations in 2005. The JCAHO will continue its random unannounced surveys through 2005. Go to www.jcaho.org/newsroom and click on “JCAHO news releases” for more information.

**SSP committee approves new home care standards**
The Standards and Survey Procedures (SSP) committee of the JCAHO approved health care error reduction and patient safety standards for home care that will go into effect January 1, 2004. The standards will fall under five categories in the Home Care Accreditation Manual: rights and ethics, improving organization performance, leadership, human resources, and environmental safety. The specifics of the new standards are still unknown.

**Duke study shows positive impact of home care on heart disease patients**
A survey by Duke University Medical Center, funded by the Agency for Healthcare Quality Research, found that heart disease patients who received home health care after discharge from the hospital reported better quality of life than those who had no home health visits. The study covered 1,300 patients recently hospitalized for heart problems. They were contacted nine months after discharge and asked to fill out a survey on how they perceived their quality of life since hospitalization.

Researchers broke up the patients into four groups according to the reason for their hospital stay: unstable angina, heart attack, angioplasty, or coronary artery bypass surgery. More than a third of the heart attack patients (34%) and almost half of the bypass patients (49%) who received home care reported they felt “much better” after discharge compared to 19% and 45% respectively, for those who did not receive home care. The researchers hope the study results will provide strategies for improving outcomes for heart disease patients.

**OASIS accuracy assurance project underway**
In an effort to reduce the number of errors on OASIS forms, 3M Health Systems, the National Association of Home Care (NAHC), and Fazzi Associates have joined forces on “The National 3M OASIS Integrity Project—Ensuring the Accuracy of...”

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OASIS Assessments.” The aim of the project is to identify strategies and protocol for producing accurate answers on the Outcome and Assessment Information Set (OASIS).

The project is expected to take at least nine months. Participants will generate recommendations for improving the overall process, ensuring accuracy, and fixing problematic areas. They will also submit proposals to the Centers for Medicare & Medicaid Services for modification or removal of difficult or unnecessary items from the OASIS. At NAHC’s annual meeting in October 2003, the organizations hope to present a final report of their findings.


2004 National Patient Safety Goals

The Sentinel Event Alert Advisory Committee met earlier this month to discuss possible focus areas for the 2004 National Patient Safety Goals, which could include preventing surgical fires, eliminating kernicterus (a disorder found in children caused from untreated jaundice), and reducing the risk of nosocomial infections. The members also considered whether any of the existing goals should be pushed through to next year.

The Committee hopes to announce the 2004 goals and recommendations in July 2003, following approval from the Board of Commissioners.

Watch the Joint Commission’s web site at www.jcabo.org for details on the new goals and go to www.jcabo.org/about+us/advisory+groups/sea.htm for more information on the Committee.

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Home Health Accreditation & Reimbursement Report

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