Wound care is particularly important when helping home-bound patients recover and resume normal activities. For home health care agencies, however, the cost for treating wounds has been very high. As of 2000, the Centers for Medicare and Medicaid Services (CMS) changed from a system of fee for service to a prospective pay system (PPS), reportedly for two reasons: to control runaway costs and to consolidate Medicare Part A home health benefits into a single payment for the agency.

Under this current system, OASIS (Outcome and Assessment Information Set) data is used to assess the needs of home health patients and measure their outcomes over time. Data is collected by the admitting nurse or therapist using the OASIS standardized set of questions at the start of home health care, at the resumption of care and at discharge—this assessment is the basis of the home health plan of care (HCFA Form 485).

All reimbursements are based on the OASIS assessment, which is transmitted electronically to CMS. Payment covers two months of service, regardless of the number of visits or the types of supplies provided. As such, reimbursements can vary significantly, depending on the patient’s condition, their ability to perform daily activities and their need for therapy. (And though home health care for patients with private insurance is organized differently, Medicare regulations are generally considered the “standard of care” for all home health care interactions.)

For wound care in the home, wounds are to be diagnosed using an objective wound assessment, documented to measure progress and guide visits and reevaluated as necessary. Twenty-two OASIS questions affect reimbursements and four of these are based on wound assessment. The data collected has also been used to inform the public about quality of care issues and to guide state and federal surveys, making it particularly important for providers to answer the questions accurately and consistently.

Another wrinkle in the system particular to wounds, additional points can be added to the initial clinical score generated by OASIS. For example, if a patient has trauma or burns and a wound, 21 points are added to the score. For the most problematic surgical wound, seven points can be added. This is significant for home health providers, in that this system allows the agency to receive more appropriate reimbursements for those patients who require more extensive wound care.
M0230 and M0240 are the primary and secondary diagnoses codes for wounds. Diagnoses in five categories affect reimbursement: neurologic, orthopedic, diabetic, traumatic and burns (if associated with a wound). Added to the diagnosis is the severity rating, given on a scale of 0 to 4.

**Severity Rating**

0 — Asymptomatic, no treatment needed  
1 — Symptoms are well controlled with current therapy  
2 — Symptoms are controlled with difficulty, affecting daily functioning, ongoing therapy needed  
3 — Symptoms poorly controlled, patient needs frequent assessment in treatment and dose monitoring  
4 — Symptoms poorly controlled, history of re-hospitalizations

Since this new PPS system was initiated, however, providers found the OASIS questions on wound status difficult to answer, because the classifications used to define wounds were not universal. Providers were especially concerned that they were not interpreting these terms correctly: “non-healing,” “partially granulating” and “fully granulating.” The Wound, Ostomy and Continence Nurses Society (WOCN) then developed a set of guidelines to help classify wounds, and CMS has accepted these classifications as appropriate.

To access the WOCN Society OASIS Guidance Document, visit the WOCN Web site at www.wocn.org and click on the WOCN Library tab and the Fact Sheets tab, or go to www.homecareFLA.org and access the Resources library.
Currently, over 270,000 patients receive in-home services from Florida’s 838 Medicare-certified home health agencies. Late in 2001, the U.S. Department of Health and Human Services and its agency, the Centers for Medicare and Medicaid Services (CMS) launched the Quality Initiative, a program designed to help ensure quality healthcare for all Americans. This initiative aimed to “empower consumers with quality-of-care information to make more informed decisions about their healthcare” and to “stimulate and support providers and clinicians to improve the quality of healthcare.” The first phase of the initiative was implemented in 2002 with nursing homes and the second in 2003 with home health care agencies.

The four-pronged initiative seeks to improve quality by:

- Regulating and enforcing through state survey agencies and CMS
- Improving consumer information about the quality of care provided by home health agencies
- Providing continual, community-based quality improvement programs for home health agencies
- Establishing partnership to leverage knowledge and resources

CMS’ role starts by collecting the information home health agencies enter into OASIS (Outcome and Assessment Information Set), the electronic database that CMS reviews for all patients receiving Medicare-funded home care services. From 41 OASIS measures, technical experts and CMS staff identified the ones, now up to 12, that provide information about patients’ physical and mental health, and whether their ability to perform daily activities improved. This data is then provided to consumers, in user-friendly language, through CMS’ Home Health Compare tool, where they can not only get information about agencies in their area and the services they provide but also compare the performance of home health agencies on the quality measures.

The 12 quality measures are:

**Three measures related to improvement in getting around**
- Percentage of patients who get better at walking or moving around
- Percentage of patients who get better at getting in and out of bed
- Percentage of patients who have less pain when moving around

**Four measures related to meeting the patient’s activities of daily living**
- Percentage of patients whose bladder control improves
- Percentage of patients who get better at bathing
- Percentage of patients who get better at taking their medicines correctly (by mouth)
- Percentage of patients who are short of breath less often
Two measures about how home health care ends

- Percentage of patients who stay at home after an episode of home health care ends
- Percentage of patients whose wounds improved or healed after an operation

Three measures related to patient medical emergencies

- Percentage of patients who had to be admitted to the acute care in a hospital (ACH)
- Percentage of patients who need urgent, unplanned medical care
- Percentage of patients who need unplanned medical care related to a wound that is new, worse or become infected

The quality measures have been “risk-adjusted” to allow for a fair comparison between agencies, for example to reduce the likelihood a particular agency would compare unfavorably to others because they serve a sicker, more frail population.

Currently, Florida home health agencies meet or exceed the national average results on 8 of the 12 quality measures: ACH, ambulation, oral medications, pain interfering with activity, discharge to community, bathing, status of surgical wounds, and emergent care. As far as the other four, Florida is within a percentage point of the national average. Our state has every right to be very proud of this record.

Quality Improvement Organizations have been established to provide help to those agencies that want to improve their performance on the quality measures. In Florida, the QIO is FMQAI. For more information on the Quality Initiative, the Home Health Compare tool and QIOs, visit www.medicare.gov. For more information about FMQAI, www.fmqai.com.

THIS INFORMATION BROUGHT TO YOU BY:
Medicare home health agencies (HHAs) are paid under a prospective payment system (PPS). This means a HHA is paid in advance of the time the care is actually rendered to the patient.

While the process is simple in design, it is very complex in execution. Here are the most important steps:

1. The patient is referred to a HHA for care and a registered nurse or physical therapist is sent to the home, under orders from the patient’s attending physician, to do a comprehensive assessment.

2. This assessment includes collecting data in a set format, referred to as OASIS (Outcome and Assessment Information Set). The OASIS information is designed to establish the patient’s acuity level – how ill or impaired the patient is.

3. The OASIS data are then input into a software program that translates the patient’s condition into a formula that determines how many resources will be needed to care for this patient over the next 60 days.

4. The amount of resources needed to care for this patient is then correlated with a financial code which dictates how much money the HHA will receive to provide all of the home care services and supplies the patient will need over the next 60 days – a period of time called an episode of care.

5. If a patient continues to need home care services as the end of the episode approaches, the HHA will re-certify the patient for another episode. This recertification process includes administering another OASIS and another calculation for the money needed to care for the patient in the second episode.

6. While this process of recertification can be repeated, the Medicare home health benefit is designed to provide part-time, intermittent care and only a low percentage of patients qualify for additional episodes.

7. When an episode ends, the HHA submits a final claim to Medicare for payment. These claims are subject to various computer edits and to an audit review if there are any questions about the accuracy of the claim.

At the end of each fiscal year, every HHA files a cost report which summarizes all the services provided and payments received from Medicare. These cost reports are subjected to audit procedures and any questionable items are reviewed by Medicare and, if the HHA cannot substantiate why the expense claimed is a legitimate Medicare expense, the money is returned to Medicare.

The PPS reimbursement rates for HHA are barely keeping pace with inflation. Each year HHAs have to go to Congress to fight for an increase in these rates.
This increase is called a market basket increase because it is tied to the nation’s inflation rate. All the various health care providers want annual increases and HHAs have to compete with hospitals, physicians, nursing homes and other various provider groups. It is a difficult battle for HHAs since they are not as politically powerful as some of the other provider groups.

Moreover, this annual increase is more important to HHAs than many of the other providers because HHAs have a much higher percentage of their expenses tied to personnel costs. Approximately 76.5% of a HHAs expense goes to pay staff. We all know that to keep good employees, a company must give an annual pay increase. But for a Medicare HHA to do this it needs an increase in Medicare’s reimbursement rates – hence, the need for the annual market basket increase in payment rates.

The PPS process was created in 2000 and has undergone one major over-haul since then. This substantial revision went into effect on January 1, 2008. The intent of the revised PPS is to more closely align patient care needs with the money needed to meet these needs.

Since medicine is still as much art as science, it is very difficult to predict exactly how much home care a patient will need over the period of 60 days. There will be some patients who need a lot more care than the PPS predicted and the HHA will lose money on these patients. There will be patients who need less care than originally predicted. Thus, HHAs will lose money on some patients and make money on others. It is hoped that, over time, these cases will average themselves out so the HHA ends each year with a reasonable amount of financial reserves and is able to continue in business.

So far, in the seven years the PPS has been in existence for HHAs, it has worked out all right. We hope that it will continue to do so as time goes on.

For more information, refer to:

- Code of Federal Regulations, 42 CFR - Sections 409.43(b) and 484.18(a);
- CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Chapter 7, Section 30.2.2;
- CMS Manual System, Pub 100-08, Medical Program Integrity Manual, Exhibit 29; and

THIS INFORMATION BROUGHT TO YOU BY:
In-home infusion therapy has advanced significantly in recent years and has several advantages over the same therapy delivered in a traditional, inpatient setting. It is cost-effective, it reduces the risk of nosocomial infections (those caught while a patient is in a hospital) and antibiotic resistance and it can help patients more quickly resume their normal daily activities. Prescribed doses of antibiotics, chemotherapy or chemical food substitutes can be delivered from a sterile bag or bottle through a catheter into the bloodstream, under the skin or into the membranes surrounding the spinal cord.

Drug therapies commonly administered by infusion include antibiotics, chemotherapy, pain management, parenteral nutrition and immune globulin. The major home IV therapy remains IV antibiotics, prescribed primarily for such diagnoses as cellulitis (infection and inflammation of the tissues beneath the skin), sepsis (caused by microorganisms or their toxins in the tissue or the bloodstream), and osteomyelitis (inflammation of bone and marrow caused by infection). Urinary tract infections, pneumonia, sexually transmitted diseases and sinusitis (inflammation of the membrane lining a sinus) may also require IV antibiotics. Other treatments commonly delivered by infusion include those for resistant infections, cancer and cancer-related pain, gastrointestinal diseases and disorders that prevent normal functioning of the GI system, congestive heart failure, immune disorders and growth hormone deficiencies, among others.

A qualified physician overseeing the care of the patient must prescribe infusion therapy, and the provider of infusion must be a licensed pharmacy or work in conjunction with a licensed pharmacy. Home health care services are required to provide proper patient education and training and to monitor the care of the patient at home.

For Medicare patients, the home care services associated with the therapy are covered; but drug coverage for infusion therapy has caused some concern. Drugs not covered by either Part A or Part B are covered under the new Part D benefit. Under Part D, however, while charges for IV medications and their dispensing fees are covered, the associated supplies are not.

**A quick snapshot of eligible infusion services for Medicare payment:**

**Medicare Part A Home Health**
- Patient is homebound and in need of part-time or intermittent skilled nursing or therapy services
- Professional fees are covered
- Home health therapy is responsible for providing hydration fluid and IV supplies if infusion is provided via gravity feed method
- Drugs and biologicals are specifically excluded, except those that are considered supplies for durable medical equipment (DME) and certain osteoporosis drugs
Medicare Part B Durable Medical Equipment (DME)

- It is medically necessary for drugs to be administered through an infusion pump
- Professional fees are not covered
- Equipment and supplies are covered
- Drug dispensing fee and drug ingredient fee are covered

Medicare Part D

- Drugs that are not currently covered under Parts A and B
- Professional fees are not covered
- Equipment and supplies are not covered
- Drug dispensing fee and drug ingredient fee are covered

The fully detailed grid and a Home Infusion Coordination Decision Tree can be found online at: www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/HomeInfusionReminder_03.10.06.pdf or on the AHHIF Web site, www.homecareFLA.org.

THIS INFORMATION BROUGHT TO YOU BY:
Home care’s future is bright. Ask any patient if he would prefer to receive his health care at home, or in some facility, and virtually everyone will choose his own home. Now, thanks to medical advances and technological developments, many more treatment modalities are available in the home setting.

As the ability of modern medicine continues to increase the amount of health care that can be delivered at home, another phenomenon, which will contribute to the unprecedented growth home care is about to experience, is coming upon us at breakneck speed. The so-called “baby boomers” (born between the years 1946 and 1964) are starting to retire.

This demographic tsunami means the number of people aged 65 and older is going to double between 2008 and 2028 – at which time they will number 78 million. This baby boomer patient will drive our health care delivery system for the next generation because:

- Their numbers far exceed any preceding retiring population segment.
- They are significantly more wealthy than any previous generation.
- They are demanding individuals who are not afraid to complain and a MD name tag will not insulate the bearer from serious inquiries and criticism.
- They will expect quality services and products for their money and they will be willing to pay for it.
- They will be more obese and used to less physical exercise than any preceding generation.
- They will want, and expect, their health services delivered in the setting most convenient for them – their own places of residence.

This all means the demand for home care services is going to increase exponentially over the next 20 years. Baby boomers will need more health care due to their poor health habits and they will not let the medical establishment push them around.

Is there any cloud on the horizon for home care? Yes, and it is a big one, especially in states like Florida where the population is already weighted towards the elderly. Today, we are already having difficulty finding enough caregivers to meet the need for home care in some areas in our state. What are we to do when the demand for home care starts accelerating out of sight and our caregiver supply remains constant, as the US Department of Labor projects it will?

There are two strategies we can employ to help alleviate this coming problem, but they are not easy. They involve money and turf, always a tough combination to beat.

**1. Increase Use of Telehealth.** Our society must recognize the value of telehealth. This means we must be willing to pay for the costs associated with purchasing the equipment needed by home health agencies (HHAs) to effectively deploy this technology to their patients homes. Currently, Medicare does not recognize either the capital expense to purchase, or the on-going expenses incurred in the maintenance and continual monitoring, required by an effective telehealth program.
This must change, for the benefits far exceed the costs:

- A telehealth program allows HHAs to reduce on-site nursing visits by 20% or more. This means this program effectively increases our available nursing personnel resource by that amount.
- A telehealth program allows HHA staff to monitor patients closely and provides warning signals when a nursing or medical intervention is necessary in order to treat the patient at the most effective stage of an illness – the beginning.

2. Increased Use of Nursing Delegation. Our state must enact laws that encourage nurses to delegate prescriptive tasks to home health aides on a regular basis. There is virtually no delegation occurring now because our home health licensure rule prohibits many activities that other states allow a nurse to delegate to an unlicensed person. This is true even though our nurses regularly delegate many tasks to elderly spouses or frail neighbors that they cannot delegate, by law, to a trained home health aide with 20 years experience. The advantages of delegation are many:

- It frees the licensed nurse to maximize his or her training and experience by giving him or her time to spend working time on assessment and analysis while delegating simple, but important tasks to home health aides.
- It gives home health aides more meaningful work to perform. Currently, they are limited to the activities of daily living (ADLs) which consist of assistance with dressing, eating, toileting, bathing and the like. With a proper legal structure which allows reasonable delegation, the aide, for example, could perform simple wound care, including changing sterile dressings, irrigating body cavities such as giving an enema, irrigating a colostomy or wound, injecting stable diabetics who cannot self inject, administering specified medications, applying heat, and caring for a tracheotomy tube.
- The end result of the delegation process, properly and fully implemented, is that the impact of our approaching caregiver shortage is substantially reduced. Our nurses will operate at maximum efficiency and our home health aides have meaningful work that allows us to create a career ladder for them. In this way, many more job seekers will consider a career as a home health aide than would otherwise be the case.

The expansion of telehealth will be greatly influenced by the willingness of the public payers – Medicare and Medicaid – to pay for the capital costs incurred by a HHA that wants to expand its service delivery system to include telehealth equipment and training. The expansion of delegation depends on the attitude of the professional nursing community and its regulators. Will they see it, not as a threat to their job security, but as an empowerment of nurses to free themselves of the time-consuming burden of performing so many prescriptive tasks so they can oversee the care of more patients than is possible under our current delegation limitations? The future of expansive, effective home care depends, to a significant degree, on how we, as a society, decide to fund telehealth in the home setting and how nurses decide the basic policy issue of delegation authority.

THIS INFORMATION BROUGHT TO YOU BY:
Being cared for at home is a goal for many patients, but their complex care needs can prove time-consuming for physicians and non-physician practitioners (NPPs, which include nurse practitioners, clinical nurse specialists and physician assistants). These services, known as care plan oversight, or CPO, are reimbursable for Medicare home health and hospice patients. Medicare allows this reimbursement to encourage more physicians to oversee services for at-home patients.

Understanding the requirements and documenting the services correctly are key to filing medicare claims successfully. Patients are eligible to receive CPO services if they require complex treatment, are being cared for by multidisciplinary teams and are under the care of a Medicare-approved home health agency or hospice.

Requirements:

- The physician or NPP must have had a face-to-face encounter with the patient in the six months before the first billing for CPO services is made. An NPP must have a collaborative relationship with the physician who signed the initial plan of care.
- Only one physician or NPP can bill per patient per calendar month for CPO services.
- The CPO services must take at least 30 minutes in a calendar month to be billable. The services do not need to be provided on the same day, but the total services over the course of a month must add up to at least 30 minutes.

Reimbursable CPO services include:

- Reviewing charts, reports and treatment plans
- Reviewing diagnostic studies if the review is not part of an evaluation and management (E/M) service
- Talking on the phone with other healthcare professionals who are not employees of the practice and who are not part of the patient’s care
- Conducting team conferences
- Discussing non-routine drug treatment and interactions with a pharmacist
- Coordinating care if physician or NPP time is required
- Making and implementing changes to the treatment plan

Services that are not covered under CPO include:

- Renewing prescriptions
- Talking with fellow employees of the practice
- Traveling
- Preparing or submitting claims
- Talking to the patient’s family, even to discuss treatment plan changes
- Holding informal conferences with physicians who are not treating the patient
Working on discharge services
Interpreting test results

To bill for CPO services, the physician or NPP must personally document the date, the time spent and a brief description of the activities provided in the patient’s record. The claim form should only have CPO services documented on it (use another form for other reimbursements) and submit the claim after the end of the month in which the services were provided.

The example shown documents CPO services that cover two calendar months.

The From Date is the date on which the reimbursable CPO service was performed by the physician or NPP, while the Tot Date is the date during the calendar month on which the physician or NPP provided the last CPO service countable toward the required 30 minutes. The codes used to bill CPO are: G0181 for home health agency care and G0182 for hospice care.

The claim should be filed as soon as, but not before, the provider accumulated 30 minutes of countable CPO services. The number of services reported should be one (1).

A sample claim for May 12 – May 31, 2007:

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>CPT</th>
<th>Number of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>05122007</td>
<td>05312007</td>
<td>G0181</td>
<td>1</td>
</tr>
</tbody>
</table>

The wrong way to submit a claim:

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>CPT</th>
<th>Number of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>05122007</td>
<td>06152007</td>
<td>G0181</td>
<td>2</td>
</tr>
</tbody>
</table>

A monthly routine can be a big help when tracking CPO services. One way to approach this effort is to create a log for each patient for whom CPO is provided each month. Keep a CPO log in each patient chart and document the date, total time and a brief description of the services each time they are provided. Be sure to sign this documentation. Collect the logs from the patients’ charts at the end of the month and bill CPO for those patients with more than 30 minutes of CPO during that month.

THIS INFORMATION BROUGHT TO YOU BY:
Each year in our country, insurance companies process more than five billion claims for payment. In our computerized world, standardized codes are used to enter and track a wealth of information about patients and their concerns.

For providers, though, these systems can seem like alphabet soup. Fortunately, resources are readily available to help sort through the various coding systems. Three primary systems are the most pertinent for home health care providers.

1. The Healthcare Common Procedure Coding System, or HCPCS, is used by the Centers for Medicare and Medicaid Services (CMS) to identify medical procedures, services, products and supplies.

2. The ICD-9 is the National Center for Health Statistics’ Internal Classification of Diseases.

3. And finally, specifically for home health agencies, CMS provides the Home Health Prospective Payment System, or HH PPS, which also has its own codes for billing and reimbursement.

HCPCS

This code set is divided into two categories, Level I and Level II. Level I codes come from the CPT codes (Current Procedural Terminology), which is the numerical system maintained by the American Medical Association (AMA). This system consists of descriptive terms and associated codes that identify medical services and procedures given by physicians and other healthcare professionals. These providers use the CPT to identify services and procedures for which they bill public and private health insurance programs. The CPT codes are republished and updated every year by the AMA.

Similarly, Level II of the HCPCS is a standardized coding system, but one used primarily to identify the products, supplies and services not included in the CPT codes. This system includes such things as ambulance services and durable medical equipment (DME), prosthetics, orthotics and supplies used outside a physician’s office. Because Medicare and other insurers cover a variety of services, supplies and equipment that are not identified by CPT codes, Level II HCPCS codes were established for submitting claims for these items. Level II codes are alpha-numeric, because they consist of a single alphabetical letter followed by four numeric digits, while CPT codes are identified using five numeric digits.

For everything about HCPCS codes, visit www.cms.hhs.gov. Click on the Medicare tab, then Coding. With questions, e-mail hcpcs@cms.hhs.gov.
ICD-9

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization’s Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital stays. The ICD-9 is also used to code and classify mortality data from death certificates.

Three measures related to patient medical emergencies:
- a tabular list containing a numerical list of the disease code numbers
- an alphabetical index to the disease entries
- a classification system for surgical, diagnostic and therapeutic procedures (alphabetic index and tabular list).

The National Center for Health Statistics (NCHS) and CMS are the agencies responsible for overseeing all changes and modifications to the ICD-9-CM. The updated ICD-10 is process.

For everything about ICD-9, visit www.cms.hhs.gov. Click on the Medicare tab, then Coding.

HH PPS

In 2000, CMS implemented the prospective payment system (PPS) for home health agencies as part of the Balanced Budget Act of 1997. Under the PPS system, Medicare pays home health agencies a predetermined base payment, which is adjusted according to several factors, including the health condition and care needs of the patient, with higher adjustments for very ill patients, and the geographic differences in wages for home health agencies. These adjustments are known as the case-mix adjustment. The home health PPS provides home health agencies with payments for each 60-day episode of care for each patient. After the first period ends, a second can begin—there are no limits to the number of 60-day periods patients can receive, as long as they remain eligible for home health benefits.

For everything about HH PPS, visit www.cms.hhs.gov. Click on the Medicare tab and click on Prospective Payment System under Medicare Fee-for-Service Payment. The Home Care Association of Florida also provides the latest information on coding and billing issues. Visit www.homecareFLA.org.

THIS INFORMATION BROUGHT TO YOU BY:
With the number of people aged 65 and older expected to increase by more than 50 percent over 20 years—from 35 million in 2000 to 54 million in 2020—the unique needs of older people will move to the forefront of healthcare issues. People today can expect to live 30 years longer than their grandparents, and current research suggests that the quality of aging is determined as much by lifestyle as it is by genetics. With help from healthcare providers, people expect to live longer, healthier and more independent lives.

The American Academy of Family Physicians offers guidance to healthcare providers as they look for ways to assist older patients. Simple screenings can identify issues before they become problems, and help care become pro-active and preventive.

**Areas to assess include:**

**Safety Factors**
- Are safety belts, bike helmets and the like being used?
- Are smoke detectors installed appropriately in the home?
- Has the temperature of the water been lowered (below 120 degrees)?

**Mobility Issues**
- A simple medical exam can identify changes in balance, strength and coordination.
- Has the home been updated with better lighting, no-step entries and thresholds, non-slip surfaces and mobility aids like grab bars and handrails?
- Look for medications that may increase the risk of falls.

**Vision and Hearing**
- Has the patient had recent exams to detect vision problems or disease?
- Has the patient had recent exams to detect hearing loss?

**Nutrition**
- Is the person willing and able to eat?
- Have regular dental exams, brushing and flossing been continued?

**Immunizations**
- Have updated vaccinations been given?
- Have the flu vaccine and the pneumococcal vaccine been given?

**Sexuality**
- Problems with the ability to have and enjoy sexual activity are not part of the normal aging process, and concerns should be raised with the primary care physician.
- Sexually transmitted diseases (STDs), including HIV, are on the rise with older people.
Continence
- Though common, incontinence is not a normal part of aging and is frequently reversible, and concerns should be raised with the primary care physician.

Cognitive Issues
- Dementia and depression are issues for older people, and concerns should be raised with the primary care physician.

Social Issues
- Is there a support system in place?
- Do caregivers have options, such as adult day care, to help avoid burnout?
- Have legal and financial matters been addressed?

Another issue faced by all healthcare providers, and home health providers in particular, is non-compliant patients or caregivers. Though patients need services, overlooking chronic non-compliance puts both the patient and the provider at risk. The patient risks injury or damage and the provider risks legal action. When providers continue to render services to non-compliant patients, their risk of legal liability is greatly enhanced—it is extremely difficult to separate substandard care from non-compliance by patients and caregivers. The legal issue will be: if practitioners knew that patients or their primary caregivers were non-compliant, why did they continue services?

To avoid problems with non-compliance:
- Document every issue of non-compliance, whether from the patient or the caregiver, regardless of how seemingly minor the issue is.
- Be very specific when documenting the issue.
- Counsel the patient and caregiver on the problem, and document that conversation.
- Provide additional teaching, if necessary, and document that.

How long this process goes on should be related to the consequences of the non-compliance—if the patient is at great risk for injury, but continues with chronic non-compliance, additional steps must be taken, from developing a written contract with the patient and caregiver to involving protective service agencies.

THIS INFORMATION BROUGHT TO YOU BY:
Technology has revolutionized our lives in a myriad of ways. Access to information is an area of particularly profound change. Using technology to provide information to every patient is the goal of telehealth, an umbrella term that simply means taking advantage of telecommunications technology to improve patient care. The closely related telemedicine refers to remote healthcare that involves actual clinical services.

Telehealth practices are being conducted all around us: when a radiologist interprets medical images from a number of different clinics located near and far; when a surgeon operates on a patient hundreds of miles away; when a nurse takes a patient’s blood pressure, but she’s in her office and the patient is in his home; and when a cardiologist checks up on a patient while she’s on vacation—these are all examples of telehealth practices. E-mailing lab results to a patient, sending medical images to a specialist for interpretation, conducting a live two-way video consult between a patient and a provider and remotely capturing and sending data for a home-bound patient’s blood glucose monitor: these are all ways healthcare providers can use technology to communicate more effectively with their patients.

The telehealth movement has been around for more than 40 years, but has gained momentum today because telecommunications services have improved, allowing healthcare providers to greatly expand their physical reach and help patients in the remotest of locations, all while helping to keep costs down. And as consumers increasingly embrace technology in their day-to-day lives, the demand for telehealth services will only increase.

The American Telehealth Association reports that roughly 200 telemedicine networks are in place throughout the country, which link tertiary care hospitals and clinics with outlying clinics and community health centers in rural or suburban areas. Of these programs, about 100 are providing patient care services on a daily basis, while the others are used only occasionally for patient care and primarily for patient education and administrative functions.

For home health care, the possibilities are exciting. Providers can be linked via a phone line to phone-video systems to provide interactive consultations. Home-to-monitoring-center links are being used for cardiac, pulmonary and fetal monitoring to in-home patients. And the Internet has become the tool for providing education and information services to all.

Although telehealth services provide such advantages, federal funding, on an ongoing programmatic basis is not available to develop and promote these technologies. At this time only grants are available for demonstrations and research, and federal agencies do fund limited telemedicine services for covered populations. In some states, to better provide remote medical services, Medicaid recognizes certain telehealth services, although, unfortunately this is not true in Florida. This is unfortunate, for in home health, telehealth solutions can play an important part in successfully and effectively carrying out the patient’s plan of care.
In Florida, a telehealth research center is housed at the University of Florida in Gainesville. The University of Florida Center for Telehealth supports scientific investigation and clinical training in telehealth technology by providing specialized technology research, educational and clinical support services. It is hoped that this center will play an important role in gaining the full support of health care payers for this technology in the near future.

At this time, a wide variety of programs and services have been supported at the Center, including:

- **Alzonline**, an Internet and telephone-based telehealth project that provides caregivers of persons with Alzheimer’s and other memory problems a place where they can participate in classes, find support and find the latest information on caregiving.

- **The Florida Dental Network for Distance Learning and Teledentistry**, which promoted the use of videoconferencing and educational technology for pre- and post-doctoral students and community-based clinics around the state, adding video-based instruction, digital radiography and telemedicine video consultation.

- **The University of Florida’s Developmental Disability Telehealth Project**, which measured whether telehealth services would help to increase healthcare access for people with development disabilities.

- **Project HeArts and Hope**, where a grant from the Center helped with the development of a multifaceted network of streaming video broadcast and video-on-demand for children with cancer and sickle cell disease.

- **The TeleCIMT pilot**, where the Center coordinated video teleconferencing and telecommunication support between research participants’ homes and UF researchers. The pilot study considered the feasibility of providing follow-up Constraint-Induced Movement Therapy (CIMT) within a home setting using telehealth technology.

- **Home-based Video Counseling for Rural Teenagers with Seizure Disorders**, which also provided video teleconferencing and telecommunication support between research participants’ homes and UF researchers.

For the latest information and resources on telehealth, visit the American Telemedicine Association Web site at www.americantelemed.org and the University of Florida Center for Telehealth at www.telehealth.phhp.ufl.edu.

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