

Important news  
about insurance and  
risk management for  
hospices and home  
health care agencies.



## Telemedicine/ Telehealth Initiatives

Barbara Stover Gingerich RN MS FACHE CHCE

Patient care technology [often referred to as either telehealth or telemedicine] initially included the Personal Emergency Response Systems [PERS] and Medication Monitoring and Dispensing Systems [MMDS] home management technology products. These early systems were designed with the focus on enabling individuals to remain safely in their homes. They addressed the basic needs of emergency care and medication management. This early telemedicine implemented in 1989, used standard telephone lines [[www.telemedicinecompanies.com](http://www.telemedicinecompanies.com)].

While the initial focus of telehealth and telemonitoring remains, i.e., care safety and management of individuals within their place of residence, evolving technology has greatly expanded the care needs that can be addressed through its use. Telehealth and telemonitoring systems have grown increasingly complex and they are integral to the management of specific types of care. The American Telemedicine Association [ATA] has provided basic definitions for telemedicine and telehealth. ATA defines telemedicine as the use of medical information exchanged from one site to another via electronic communications [advanced communication and information technologies, including video capability] to improve patients' health status. Telehealth, while closely related, encompasses a broader definition of remote health care that does not always include clinical services [<http://www.americantelemed.org>].

### Technology Evolution

As technology advanced additional services were provided via telemonitoring systems. For example offsite monitoring of in-home medical treatment delivery systems, such as oxygen, infusion and drug delivery systems, provided transmission, via telephone lines, of reports that provided data on the patient's usage and the system's functioning status. Monitoring systems also provide online real-time patient management by transmitting patient statistics, such as respirations and oxygen levels, with appropriate adjustments to oxygen flow being made remotely. Other systems allow for video transmissions and conferencing between patients and providers, along with applications that monitor blood pressure, weight, pulse, respirations, lung sounds and bowel sounds. As technology has advanced the transmission process and approaches have shown significant improvement, and the images transmitted have increased in clarity and resolution.

Telemedicine is usually divided into three groupings, which are based upon the primary function of the technology being used. These three groupings are 1) storing and forwarding data,

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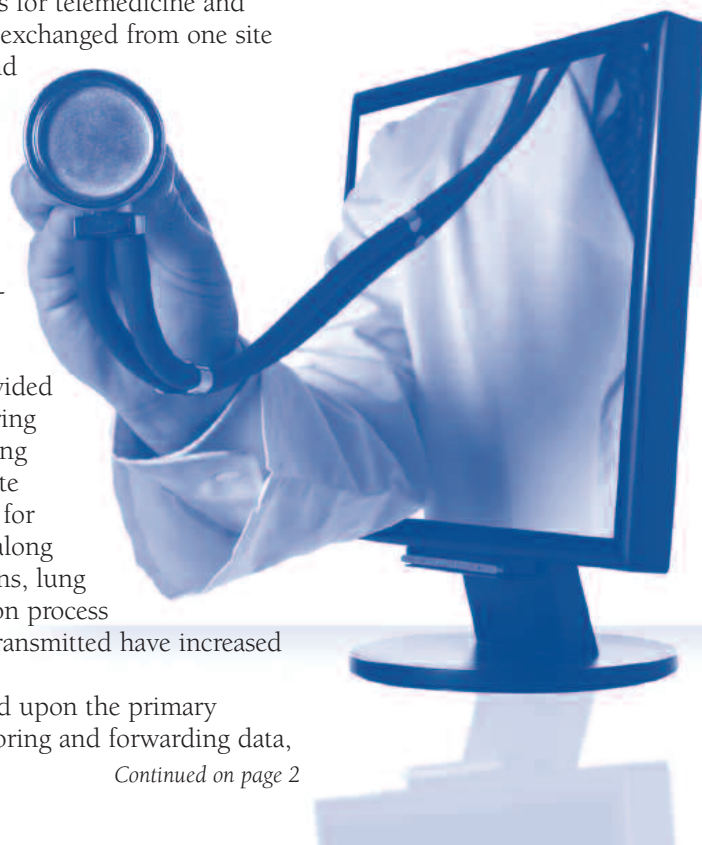
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## Telemedicine/Telehealth Initiatives

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2) providing interactive services and 3) remotely monitoring status and condition. The specific technology modalities used in these groupings include videos, data, summation reports, images, audio sounds and online teleconferencing.

### Identified Benefits and Outcome Findings

One key benefit to telemedicine technology is that it can eliminate the travel time and expenses to reach the patient's home on a daily basis. It also provides real-time patient data and statistics that allow for accurate monitoring and care management. Telemedicine technology provides an active link between the professional provider and the patient and family and is considered to be a cost-efficient approach to chronic disease management. This is accomplished by closely monitoring and adjusting treatments for patients with conditions such as congestive heart failure, chronic obstructive pulmonary disease, diabetes, asthma and heart disease. Patient benefits include increased monitoring frequency, earlier identification of potential problems, decreased unplanned and emergency care visits, increased quality of life and care satisfaction, as well as the ability to continue living independently with a sense of security and lessened feelings of anxiety and isolation.

In Pennsylvania alone, it has been reported that there are more than 2,000 telemedicine monitors in patient homes. These patients are receiving care through home care agencies, including visiting nurse associations, hospices and home health agencies. Several research studies conducted in Pennsylvania yielded significant cost savings data. For example, the Pennsylvania State University conducted a study with diabetes patients in the Philadelphia area. This study reported a cost savings of over \$145,000 in hospitalization costs for the 86 patients receiving video telehealth visits, as an augment to traditional homecare [Hoak, n.d.].

Another national research project, the Telehomecare Outcomes Study, conducted by Strategic Healthcare Programs, LLC, compared outcomes between congestive heart failure [CHF], diabetic, coronary artery disease [CAD] and chronic obstructive pulmonary disease [COPD] patients who had home care services augmented by telehealth equipment to those who did not receive telehealth equipment. This study conducted in over 40 states included 178 home health agencies using telehealth compared with over 300 home health agencies not using telehealth equipment.



The Centers for Medicare and Medicaid Services [CMS] assessment data was used as the foundation data for the project's cumulative findings, which covered a 27-month period. These findings indicated that patients within each of these diagnostic groups having the benefit of telehealth monitoring had decreased hospitalization rates and emergent care visits along with an increased improvement or stabilization in activities of daily living [ADLs] and instrumental activities of daily living [IADLs] [Strategic Healthcare Programs, LLC, 2004].

### Current Initiatives: Chronic Disease Management

The management of chronic diseases such as asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, end stage renal disease, HIV/AIDS and hemophilia, among others, has long

been a concern of the health care system, including the Centers for Medicare and Medicaid Services. While there exists an increased focus on prevention of these diseases, when possible, there is also an emphasis on using a systematic approach to manage and control the disease process. Care strategies and approaches identified for incorporation into the care management of individuals with a chronic disease diagnosis are implementing best practice and evidenced-based practice standards, focusing on prevention and education, integrating outcomes research and clinical protocols and using information and telemedicine technology. These strategies are to be integrated into the individual's care and treatment plan.

One diabetes case management project reports success with the use of telehealth modalities that provide simultaneous videoconferencing over standard telephone lines, electronic transmission of finger stick glucose and blood pressure readings, patient data analysis, education and alerts and reminders. The functions are accomplished using telehealth transmissions, include adjusting medications in response to blood glucose and blood pressure readings, transmitting photos of feet and skin, providing patient and family education, care instructions and recommendations in the comfort of the home, sending patient reminders and automated care alerts to care professionals and analyzing data and data trends. A secure Web-based messaging and clinical data exchange and Bluetooth cell phones are examples of the technology used in transmitting data and managing care for this diabetes disease management project [Blanchet, 2008].

### Rural Care Management

A key issue facing health care delivery in rural areas is access to care. Creative service delivery approaches and strategies have been sought and implemented to improve both access and care quality within this setting. Telehealth home monitoring systems have demonstrated significant cost savings in rural areas, as well as improved patient outcomes. The rural telehealth care model allows the

patient to be monitored at home via phone lines or Internet with an increased frequency and decreased costs versus the traditional in person home visit care model.

There are many national initiatives that support the use of telehealth and technology within the rural care setting. The Department of Health and Human Services [DHHS] has established a Rural Assistance Center [RAC] and the Agency for Health Care Research and Quality [AHRQ] has many initiatives for funding and implementing the use of technology in these geographic areas. The AHRQ's primary foci of the use of technology in rural care delivery areas are addressing measurements and outcomes relative to clinical goals/outcomes, clinical processes, provider adoption and attitudes, patient acceptance and adoption and workflow and financial impact. These measurements and outcomes are taken into consideration in the resources developed and available through AHRQ. One resource provided by AHRQ is its Health Information Technology Selection and Implementation in Rural Settings Toolkit. While this toolkit is designed for use within rural settings, its approach and resources are easily adapted and used by home care and hospice providers in all geographic settings. The toolkit is available for download at [http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS\\_0\\_1248\\_875888\\_0\\_0\\_18/09\\_0083\\_EF.pdf](http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_1248_875888_0_0_18/09_0083_EF.pdf).

### Summary

The ATA developed guidelines and standards, which includes one of its earliest releases, the Home Telehealth Clinical Guidelines. The ATA's guidelines included a focus on technology and telemedicine within the home/community care setting, i.e., virtual visits, which collect and transmit one or more personal vital signs. The ATA Home Telehealth guidelines cover these applications and are intended to provide guidance, as well as to establish a set of universal principles and patient criteria to guide development and deployment of in-home telemedicine in the future. Its more recent service offerings and guidelines include interactive video recording, storing and forwarding data, remote monitoring, and other diverse applications such as hospice (palliative care)

programs, rehabilitation care, case management, chronic disease management, virtual house calls and post-surgical follow-up. Guidelines are available in detail by accessing the ATA's website <http://www.americantelemed.org>.

In addition to the ATA guidelines, many other resources are available to providers to access and consider as the community health care technology integration moves forward. Grants and funding continue to be available to assist in the accomplishment of this integration, and providers are encouraged to give consideration to technology as one strategy to use in efforts to increase care quality and improve outcomes while concurrently decreasing care costs and improving care efficiency. ♥

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## Tips for Completing a Loss Notice

*Dennis Ryder, Claims, First Party, Property Manager*

### Your role in the claims process is important!

When an insured calls to report a claim, they are giving both you and Glatfelter Claims Management an opportunity to fulfill our promise of exceptional claim service. We are better able to meet those expectations when you report the claim promptly and with all of the necessary information. Timing is crucial. The sooner the insured is contacted after a loss or occurrence, the better Glatfelter Claims Management's chances are for providing a prompt settlement on a first party claim or an effective defense on a third party claim. Help us make you look good and respond to the insured's needs quickly.

#### *Here are few things to consider when completing a Loss Notice.*

- If you prefer to hand write the Loss Notice, remember, penmanship is important. If you use a computer (and your software program permits), please select a font size of 10 or 12. When a Loss Notice is illegible, the time spent obtaining the basic information can offset the benefit of prompt reporting.
- Be sure to accurately identify the insured entity, their policy number, the date of loss, and location of loss. If an insured vehicle is involved, please identify it. On liability claims, provide as much information as possible about the claimant. Include your contact information as well.
- Provide the name and current telephone number(s) for the contact person of the insured organization. This information should be verified with the individual reporting the claim to avoid any unnecessary delays.
- Provide a good description of the loss. Here is an excellent example from a recent report, "The truck was backing out of the station, and an open compartment door caught the bay door, causing the front of the station to fall down." The details provided for this loss were very descriptive and much more informative than the often utilized "See Attached."
- Please do not hold the Loss Notice in your office pending receipt of additional information. Submit the Loss Notice as soon as you complete it.

While there are many aspects to the claim process, none are more important than getting a good start. By providing adequate and accurate information, you will assist us greatly in fulfilling our combined promise of exceptional claims service. ♥

COMPLIANCE CONCERNS:

# Accreditation and Deemed Status

Barbara Stover Gingerich, RN MS FACHE CHCE

In October 2007 the Florida Agency for Health Care Administration (AHCA) announced that it was no longer going to perform the initial Medicare and Medicaid certification survey ([www.ahca.myflorida.com/mchq/.../How\\_to\\_Get\\_Medicare\\_10-21-2009.doc](http://www.ahca.myflorida.com/mchq/.../How_to_Get_Medicare_10-21-2009.doc)). Since some states have indicated that new providers need to go through the accreditation process for the completion of start-up and Medicare certification, accreditation has taken on more significance, especially for individuals seeking to start new home health agencies. In states that no longer perform the initial Medicare and Medicaid certification survey, new providers need to choose a national accreditation organization (that has deemed status) to conduct the initial Medicare and Medicaid Conditions of Participation compliance survey, as well as the accreditation survey.

## Deemed Status/Accreditation Process

There are three national accreditation organizations that have been granted deemed status for home health and hospice programs. Deemed status indicates that the accrediting organization has gone through a lengthy qualification process, so it can grant accreditation status and also conduct Medicare Conditions of Participation certification surveys. Deemed status surveys are conducted for initial and ongoing verification that the provider meets the Medicare CoPs as well as the accreditation standards of the accrediting organization.

### Home Health and Hospice Accrediting Deemed Status Organizations

- **Accreditation Commission for Health Care:** (919) 785-1214 or visit their web site at <http://www.achc.org/index.php>
- **Community Health Accreditation Program:** 1-800-656-9656 or (202) 862-3413 or visit their web site at <http://www.chapinc.org>
- **The Joint Commission:** (630) 792-5000 or visit their web site at [www.jointcommission.org](http://www.jointcommission.org)

Both existing and new home health and hospice providers can choose one of these three organizations when they select the deemed status accreditation survey option. Upon successful completion of this option, the provider simultaneously achieves CMS certification, as well as accreditation. As a follow-up to the survey, conducted by the accrediting organization, CMS has the right to conduct its own random validation surveys to verify the accreditation organization findings.

## Accreditation Commission for Health Care, Inc. (ACHC)

### Background

In North Carolina in the mid 1980's a provider initiative was undertaken to develop and provide accreditation for home care aides within the state. In 1985, the state home care association, government representatives, and home care providers came together to spearhead the process. ACHC was initially established as the Accreditation Commission for Home Care and in 1987 it conducted its first accreditation survey. In 1996 ACHC expanded its accreditation services to other provider

types and embraced a national focus. Currently ACHC offers accreditation for a diverse group of community-based health care providers, including home health and hospice.

The ACHC management team and volunteer board decided to become certified by the International Organization for Standardization (ISO) 9001-2000 standards in order to highlight ACHC's focus on quality and excellence. The ISO is the world's largest standards-developing organization, which initially focused on industrial standards of quality and excellence. ACHC successfully met and continues to maintain ISO 9001-2000 certification ([www.achc.org](http://www.achc.org)).

### The Accreditation Process

The first step to accreditation is to obtain and review the standards. ACHC provides its standards free to providers, in an electronic format, through its Customer Central website registration process. Along with a username and password, an account manager is assigned to assist providers throughout the process. The CORE standards, along with any Scope of Services standards applicable to the provider, are available for downloading and use in survey preparation.

ACHC takes a consultative approach to accreditation, wherein the provider is asked to complete a self-evaluation and organize specific materials into a Preliminary Evidence Report (PER). The provider then submits the PER along with the application and non-refundable application fee. Following the submission of the PER, a contract is executed and ACHC conducts a general review of the documents submitted. This PER is sent to the onsite survey team for review prior to the on-site survey.

In the submission/application process, providers can identify surveyors

that they perceive might have a conflict of interest and indicate up to ten days in the upcoming time frame when they prefer not to be surveyed. The surveys are unannounced and generally scheduled between three to seven months after the contract date and the PER receipt.

The basic elements of an ACHC survey include onsite arrival and introductions, opening conference, a general outline of the survey schedule, facility tour, quality improvement/performance improvement presentation, a review of PER materials, home visits, hospice residential visits, document review, clinical and human resource record reviews, interviews with patients, staff, management and board members, survey of facility storage, space and equipment, a question/answer period and a closing/exit conference.

Following the completion of the survey, the designated lead surveyor consolidates all surveyor data collection tools and comments onto a master tool. A cover letter accompanies these tools to the ACHC office, with the survey team's recommendation. Any clarification of findings is resolved and an accreditation decision is made.

## **Community Health Accreditation Program (CHAP)**

### Background

CHAP was established as a joint venture of the American Public Health Association (APHA) and the National League for Nursing (NLN). The primary focus is to create standards designed specifically for the community health care setting. In 1988 CHAP became a separate corporation and a not-for-profit subsidiary of the NLN. In 2001 CHAP was made an independent not-for-profit corporation.

CHAP's continued focus is on providing accreditation services to community-based providers, including community nursing centers, home care aides, home health services, home medical equipment, hospice, infusion therapy nursing, pharmacy services, private duty nursing and public health and supplemental staffing providers. CHAP maintains a dual focus on provider stability and operational excellence in its operations and accreditation standards (<http://www.chapinc.org/aboutus.htm>).

### The Accreditation Process

CHAP has outlined a six-step accreditation process. However prior to beginning these steps, the provider should obtain the applicable standards. CHAP has core and service-specific standards that providers can order directly from the CHAP website.

The first step in the CHAP accreditation process includes determining that prerequisites have been met and completing and submitting an application, along with the non-refundable application fee, and proof of licensure to the CHAP offices. Following this application, CHAP provides an original accreditation service contract, which includes fees, for the provider to review, sign and return.

Home health and hospice providers can choose one of the three organizations listed here when selecting the deemed status accreditation option.

Once this paper work is completed, the provider begins step 2 – a self-study, specific to the core and service standards. This self-study is to be completed within three months of the original contract date. CHAP provides a client portal online for this process – the Computer-based Accreditation Review System (CARES) Client Portal.

Step 3 is the onsite evaluation of the provider's adherence with the CHAP standards. The components of the site visit are similar to those noted in the ACHC onsite survey above. The site visitors submit the documentation and findings of the site visit to CHAP's central office, along with follow-up actions and recommendations. In a case where a Plan of Correction (POC) is needed as a result of this site visit, step 4 – notification to the provider is made within ten business days following the site visit conclusion. CHAP provides online access to its POC Toolkit, where

provider leaders develop and submit the plan of correction within ten calendar days from the receipt of notice regarding the need for a POC. Once the POC is accepted, or in the case where no POC was required, step 5 occurs, where CHAP's Board of Review goes over the onsite visit documentation and the POC, when needed. Upon review of these documents, an accreditation determination is made. The final step, step 6, is issuing the certificate of accreditation and posting the accreditation on the CHAP website (<http://www.chapinc.org/process6.htm>).

## **Joint Commission on the Accreditation of Health Care Organizations**

### Background

Five organizations came together in 1951 to form the Joint Commission on Accreditation of Hospitals (JCAH). They were the American College of Physicians (ACP), the American Hospital Association (AHA), the American Medical Association (AMA), the Canadian Medical Association (CMA), and the American College of Surgeons (ACS). The first JCAH hospital accreditation standards manual was released in 1953.

Through its many years of providing accreditation, the Joint Commission has undergone many changes in its structure, as it continually expanded its accreditation and service options. In 1987, JCAH changed its name to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), with a subsequent name change in the late 1990s to the Joint Commission. The Joint Commission also has extended its global reach through Joint Commission International and the Joint Commission International Center for Patient Safety. It also worked to develop National Patient Safety Goals and to provide consulting and resources through its Quality Healthcare Resources® (QHR®), Inc and Joint Commission Resources, Inc.™ (JCR).

The Joint Commission has expanded its programs far beyond its initial hospital focus. It now includes accreditation standards for addiction services,

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## Accreditation and Deemed Status

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ambulatory care providers, such as group practices, free-standing surgery and rehabilitation centers, and behavioral health care organizations, home care organizations, including home health, hospice, and medical equipment providers, hospitals, including children's, critical access, general, psychiatric, and rehabilitation, independent and free-standing laboratories and nursing homes and other long-term care facilities ([www.jointcommission.org](http://www.jointcommission.org)).

### The Accreditation Process

The provider is asked to access the Joint Commission's online informational toolkit and complete its online application. The Joint Commission provides a password to allow access to the application, and asks the provider to choose a month during the next 12 calendar months when they anticipate they will be ready for the survey. One copy of the standards manual (paper and electronic) is provided upon receipt of the provider's application and non-refundable application fee. Joint Commission provides resources to assist the provider in the process, and an onsite survey is conducted to determine the provider's adherence to the standards and national patient safety goals. Upon completion of the survey, which consists of elements similar to the other accreditation organizations, but focuses more on care processes and tracing patients through care, treatment and services, a summary report is completed. This Priority Focus Process (an automated tool) and tracer process allow surveyors to use presurvey online information to conduct a provider-specific survey addressing key operational systems and patient care safety and quality. Upon completion of the onsite survey, an accreditation decision is made ([http://www.achc.org/accreditation\\_process.php](http://www.achc.org/accreditation_process.php)).

### Summary

This article has focused on the selected accreditation organization's (AO) history and focus, along with each organization's accreditation process. The first step providers need to undertake is to determine the AO's compatibility with the provider's organization and to gather information about the AO's mission, philosophy, and approach to the survey. This information, along with information about the associated costs and expenses, can assist providers in making an informed decision. Additional specifics that providers need to gather before finalizing their choice of accreditation organization are the AO's standards format and content and the anticipated timeframe from application submission to the onsite survey and accreditation decision. Additional information regarding each of these organizations discussed is available on their websites, noted at the beginning of the article. ♥

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# Workplace Violence: Job-Related Risks for Hospice/ Home Healthcare Workers



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BSN, MBA,  
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The National Institute for Occupational Safety and Health (NIOSH) recently completed

a research study regarding on-the-job risks to home healthcare workers from work related violence. The study is an effort to identify how these specific occupational risks can be reduced. Over 600 home healthcare aides and nurses were surveyed. Although the final research results have not yet been published, preliminary findings include:

- ✓ Thirty-one (4.6%) of survey respondents report having been assaulted by a patient during the prior 12-month period.
- ✓ Certain factors were predictive of the risk of physical assault: patient handling (lifting/moving/bathing/dressing), caring for patients with dementia, and feeling threatened by violence from others in and around the patient's home.



### Risk Control Measures

It is important that hospice and home care organizations complete a thorough risk assessment of the safety and security risks that are inherent in providing care and services in the relatively uncontrolled community and home environment. Some identified risks include: unsanitary conditions, conditions conducive to slips/trips/falls, presence of aggressive pets, poor lighting, neighborhood violence/crime, drug use in homes, and racial/ethnic discrimination.

Staff education is one of the most important risk control measures, since it provides the foundation for effective risk control and loss prevention. A well informed staff will better understand the job related security exposures, administrative and department-specific policies and procedures addressing these exposures, any documentation requirements, and related regulatory standards.

In addition to staff training and education, it is also important to have an open environment for reporting employee concerns related to threats or actual incidents. These incidents can also be discussed at interdisciplinary group meetings and a patient specific plan developed for how to manage the risk, if appropriate.

### Workplace Violence Prevention Programs

In 2004, the Occupational Safety and

Health Administration (OSHA) published Guidelines for Preventing Workplace Violence for Healthcare and Social Workers. While they are advisory in nature, these guidelines provide a good foundation for an assessment of the risks and development of appropriate policies and procedures ([www.osha.gov](http://www.osha.gov)).

A written program for job safety and security, incorporated into the organization's overall safety program, offers an effective approach for larger organizations. In smaller agencies, written safety and security policies, along with staff education may be satisfactory. There should be clear goals and objectives to prevent workplace violence, which are suitable for the size and complexity of the workplace operation and adaptable to specific situations that may be encountered.

*At a minimum, workplace violence prevention programs should:*

- Create and disseminate a clear policy of zero tolerance for workplace violence, verbal and nonverbal threats and related actions. Ensure that managers, supervisors, coworkers, clients, patients and visitors know about this policy.
- Ensure that no employee who reports or experiences workplace violence faces reprisals.
- Encourage employees to promptly report incidents and suggest ways to reduce or eliminate risks. Require records of incidents to assess risk and measure progress.
- Outline a comprehensive plan for maintaining security in the workplace. This includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence.
- Assign responsibility and authority for the program to individuals or teams with appropriate training and skills. Ensure that adequate resources are available for this effort and that the team or responsible individuals develop expertise on workplace violence prevention in health care and social services.
- Affirm management commitment to a worker-supportive environment that places as much importance on

employee safety and health as on serving the patient or client.

- Set up a company briefing as part of the initial effort to address issues such as preserving safety, supporting affected employees and facilitating recovery.

Along with utilizing the OSHA guidelines, the following self-assessment tool may help you evaluate your existing policies and assist you in developing a safety and security plan that better identifies the risks and protects your staff from job related incidents of violence.♥

### Staff Safety/Security Self-Assessment Checklist

1. All field staff are trained in:
  - a. Personal risk assessment
  - b. Avoidance and management of confrontation
  - c. De-escalation of aggressive behavior
  - d. Self-defense
  - e. Cultural diversity sensitivity
  - f. Management of disruptive patients, family members and other visitors to the home
2. Written Policies and Procedures address:
  - a. Steps to take if a visit is terminated or cancelled because of personal safety concerns
  - b. Firearms/weapons in home
  - c. Security escorts, if needed
  - d. Plan of action if vehicle is disabled while in field
  - e. Management of aggressive pets in field
3. Daily Work Plan:
  - a. All field staff prepare, and/or follow, a daily work plan
  - b. There is an office contact person who is aware of that work plan and informed of the healthcare worker's whereabouts throughout the day.
  - c. There are emergency follow-up procedures in the event there is a concern regarding staff whereabouts or safety.
4. Incident Reporting:
  - a. Records of incidents of abuse, verbal attacks or aggressive behavior that may be threatening, such as pushing or shouting and acts of aggression should be reported through the routine incident reporting process.
  - b. Incidents are reviewed by Risk Management or Senior Management to assure that appropriate follow-up measures are taken.

## GoGlatfelters EPL Best Practices Help Line

Betty Norman, BSN, MBA, CPHRM

GoGlatfelters can help you stay on top of evolving employment practice issues. We encourage you to identify the right person within your organization—usually the Human Resources administrator—and have them register at [www.hccis.com](http://www.hccis.com). Click on Risk Control Services/Employment Practices Liability.

Our website now includes a **Best Practices Help Line**. This provides phone or online consultation on how to address day-to-day workplace concerns including: termination, discipline, hiring, responding to incidents of wrongdoing, threats of litigation, crisis management, and lowering exposure, as well as other events.

Best practice advice focuses on risk management, loss prevention, and litigation avoidance.

Help Line calls are scheduled on weekdays 10:00 a.m. to 5:00 p.m. EST, often within 24 hours of the receipt of the request. There is no limit to the amount of times a user may request a call or the time a caller is allotted.

Once you are registered as an insured you will have access to the latest employment practices hot topics, and best practices consultation via the Help Line.  
**Sign up today!** ♥

## Who to Contact

Hospice and Community Care Insurance Services • P.O. Box 2726, York, PA 17405  
1-800-233-1957 • Fax: 717-747-7021 • [hccis.com](http://hccis.com)

Members who insure directly with us (not through another agent or broker), please request Certificates of Insurance, submit claims, make policy changes, or ask questions about your policies, by contacting the Customer Service Representative responsible for your state.

**Kristine Yohe**, Ext. 7533

*Western States:* AK, AR, AZ, CA, CO, HI, IA, ID, IL, IN, KS, LA, MI, MN, MO, MT, ND, NE, NM, NV, OK, OR, SD, TX, UT, WA, WI, WY

**Sheila Simmons**, Ext. 7595

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