AMERICAN HEALTH CONSULTANTS®

HOMECARE Quality Management™

INSIDE

■ **Home care agencies discuss the current staffing crisis:** Some locations are doing better than others . . . . . cover

■ **Focusing on keeping staff:** Retention is crucial to maintaining a quality work force. 63

■ **Need to recruit nurses?** Here are some creative strategies 65

■ **Massachusetts VNA works to improve bioethics committee:** Attempts to keep members engaged 67

■ **OSHA ergonomics rule rescinded:** New OSHA developments ease some employer burdens, raise new requirements 70

JUNE 2001

VOL. 7, NO. 6 (pages 61-72)

Coming crisis: Home care agencies face shortfall in staffing industrywide

Some regions fare better than others

The nation's current nursing shortage has spread to some home care agencies, which already are coping with a multitude of other staffing problems including finding qualified home health aides, psychiatric and IV nurses and, even for some agencies, pharmacists.

The National Association for Home Care (NAHC) and the American Hospital Association (AHA), both of Washington, DC, predict the health care staffing crisis will worsen in coming decades as baby boomers, who comprise most of the current nursing supply, age. It will be a double-edged sword because the supply of nurses and other health care professionals may decline as the need for health care services increases.

"Before, there was a trend where multigenerations of people worked for the same hospital, and that's very different now," says **Rick Wade**, senior vice president of the AHA. "Opportunities for women have exploded."

While home care agencies now may have an adequate supply of therapists, there are increasing problems with recruiting home health aides, says **Mary St. Pierre**, RN, BSN, vice president of regulatory affairs for NAHC.

"Aides are finding other sources of work in areas where they get

Stepping up to the staffing challenge, part 2

Staffing home health agencies is an ongoing quality issue that is likely to grow only more complicated in coming years. These articles are part of an occasional series about how the industry is coping with the problem. *Homecare Quality Management's* April 2001 issue has an article on how home care staffing will be a long-term problem. ■

better benefits, better pay, and don't have to have a mode of transportation," St. Pierre notes.

Combined with a nursing shortage that will only grow worse in coming decades, this is bad news for the aging baby boom generation.

"I'm not only concerned about what we need to do on a daily basis to keep operations flowing and growing, but I'm concerned as a baby boomer about who is going to care for me when I retire and need more intensive health care," says **Greg Solecki**, vice president for home health care with the Henry Ford Health System in Detroit.

"My fear is there will be even fewer providers than there are today because the population behind the baby boomers is much smaller and is not looking at health care as a desirable profession," Solecki adds.

Henry Ford Health System's home care agency, which serves the greater Detroit metropolitan area as well as a widespread region that includes cities along the eastern portion of the state, has continuous recruitment needs for RNs and home health aides.

"We have enough LPNs, but we need RNs, depending on which region you're talking about," Solecki says. "Some offices don't need nurses and others do, so we've decided to hire good nurses even when they don't have vacancies at one office because they can pitch in and help another office."

Recruiting home health aides is an even greater challenge in recent years, Solecki says.

"As we faced a lot of managed care growth, we were concerned about having too many home health aides two years ago," Solecki says. However, the opposite has occurred. The city of Detroit has permitted casino gambling in recent years, and three large casinos have lured away potential home health care workers.

"The population that would have been interested in being a home health aide or working in an office position has gone to the casino where they get paid a little better and the work is sexier," Solecki says.

Despite the tight labor market, the home care agency still needs to be selective when hiring home health aides, looking for the highest-quality candidates who could be entrusted with patient care in people's homes, Solecki adds. **(See story on how Henry Ford and other home care agencies retain and recruit staff, p. 63.)**

In New Orleans, the Visiting Nurse Association Inc. also has found it difficult to fill the necessary RN positions.

"When you run an ad, you get very few applicants to apply," says **Katherine France**, RN, MN, executive director.

Home care agencies have two recruitment disadvantages not shared by hospitals. One is that home care agencies cannot afford to offer the bonuses and certain financial incentives that hospitals use to find staff, and the second is that home care agencies need experienced nurses and typically cannot recruit from nursing schools, France notes.

"Home care nurses have to make decisions without the support that they would have in a

CE questions

9. Home care agencies and other health care facilities face increasing difficulty in maintaining adequate staffing of certain disciplines, and these problems are expected to continue in the next two decades. Which discipline is expected to have the greatest shortage in coming years?
   A. occupational therapy
   B. home health aide
   C. nursing
   D. pharmacy

10. If a home care agency wishes to recruit nurses from overseas, what is a necessary step in the process?
   A. The nurse must pass an English literacy test.
   B. The nurse must pass the College Graduate of Foreign Nursing School test.
   C. The nurse must become a naturalized citizen.
   D. none of the above

11. Posing hypothetical situations to bioethics committee members is of little use because agencies are unlikely to encounter the situations in the future.
   A. True
   B. False

12. The Occupational Safety and Health Administration's (OSHA) new bloodborne pathogen standard requires health care providers include whom in their annual reviews of new safer needle devices?
   A. OSHA inspectors
   B. representatives from needle suppliers
   C. frontline employees
   D. infectious disease specialists

hospital, and you can only do this after you've had experience on a unit, particularly a med-surg unit," France says.

At Pro-Care Home Health Services in Sacramento, CA, the current nursing shortage has convinced the agency's president that it is worth the cost and effort to recruit qualified nurses from overseas.

David Dial, president and CEO, has invested a great deal of time and money into recruiting nurses from the Philippines, where it's easier to find qualified nurses with bachelor's or even master's degrees.

Pro-Care has hired an immigration attorney and set up an office in the Philippines, staffed by a $250 per month full-time employee. When nurses are recruited, their relocation expenses are covered, including initial housing, applying for a work visa, and airline cost. In exchange, the nurses agree to work for at least two years for Pro-Care, Dial says.

"We're figuring it will cost us at least $5,000 per nurse," Dial says. "That's the direct cost per nurse, and I probably have spent $25,000 so far in going back and forth to the Philippines to set everything up." **(See story on recruiting home care staff, p. 65.)**

The Pacific Northwest also has been hit with a very tight supply of quality nurses, especially in specialty areas of home care, says **Tom Berg**, general manager of the American Home Patient, Seattle Infusion Branch. American Home Patient is primarily a respiratory and home medical equipment company with 309 sites, including more than 20 infusion facilities around the country that provide home IV therapy.

"We're starting to go to nurses who don't have home care experience and are mentoring them with current home health nurses to get them up to speed," Berg says.

The area also has a shortage of pharmacists and pharmacy techs, Berg adds. "We have an internship program with a pharmacist where we bring pharmacy students here, and one of those students started out as an intern and has been here for 10 years."

United Home Health Services Inc. of Canton, MI, has had a particularly hard time recruiting psychiatric nurses, says **Penny Rhein**, BSN, RNC, vice president of the mid-sized, hospital-affiliated agency that serves western Michigan. Rhein also is the immediate past president of the Michigan Home Health Association in Okemos.

"We have two psych nurses, but they are not full time," Rhein explains. "It's definitely a need given the fact that you have so many of your patients that have an exacerbation of underlying psychiatric problems."

United Home Health Services has fared better in recruiting and retaining home health aides, with some employees who have been with the agency for more than 10 years, Rhein says.

That may change as the need for home health aide services increases, Rhein adds. "We're able to give patients what they need, and oftentimes patients will want to assume their own care. But as time goes by, we anticipate we'll probably need more home health aides."

St. Elizabeth Home Care Services in Lincoln, NE, traditionally has had more staffing problems with recruiting home health aides than with finding nurses, says **Phyllis Rizzo**, RN, BS, CHCE, director of home care services for the hospital-based agency.

"Home health aides are a pretty mobile group of folks, and recruitment has been a huge problem in the past," Rizzo says. "Lately, we seem to be recruiting better-caliber people, and they're staying with us longer."

However, the nursing shortage will likely cause long-term problems for the hospital and home care agency, Rizzo adds. "That's going to be a huge problem in coming years."

Likewise, Susan B. Allen Memorial Hospital Home Health in El Dorado, KS, has not personally experienced a nursing shortage, mostly because the agency has done a good job of retaining staff, says **Melinda May**, RRT, BHS, director of the agency, which serves two counties in south-central Kansas.

"We retain our nurses, and one of the biggest reasons we retain them is because we're very flexible with staff schedules," May says. "Most of our nurses are wives or mothers, and if they need to take off time for a school program, they can do that." ■

Maintaining staff crucial to agency quality of care

Agencies try different strategies to retain staff

Home care directors and quality managers now must put extra effort into making work a satisfying and even enjoyable experience for staff as it is becoming increasingly clear that the quality of home care is dependent on an agency's

ability to retain its experienced staff.

"You need a qualified staff that are goal-oriented and quality-oriented," says **Penny Rhein**, BSN, RNC, vice president of United Home Health Services Inc. in Canton, MI. Rhein also is the immediate past president of the Michigan Home Health Association in Okemos.

"Home care employees have to believe in your mission and leadership and embrace ethical causes," Rhein says.

Focus on retention

So how does an agency maintain a dedicated and qualified work force during these times of health care staffing shortages? Rhein and other home care directors offer these suggestions:

• Eliminate barriers between staff and managers.

At Pro-Care Home Health Services in Sacramento, CA, there are no closed doors between hourly staff and managers, says **David Dial**, president and CEO of the large agency.

"The nurses can walk in the front door, and no one will see if the boss is available," Dial says. "Our office is their office, and we don't want any barriers between us and our staff because they're our lifeblood."

• Create a flexible work environment.

At the Visiting Nurses Association Inc. in New Orleans, the philosophy is if home care nurses can't take care of their own families first, then they can't take care of the patients adequately, says **Katherine France**, RN, MN, executive director.

"I want staff who are family-oriented, and it's OK if the school calls and they have to run for their child," France says. "It's OK for them to leave, and my staff do not have to wait for their supervisor's permission."

Also, staff are not docked pay when they have to leave work to handle a family emergency, France adds. "You can't take care of your patients if you're out there worrying about your child; so if your child's ill, you take care of it."

Susan B. Allen Memorial Hospital Home Health in El Dorado, KS, provides nurses with flexibility in scheduling so they can plan time off to attend school programs or other family events, says **Melinda May**, RRT, BHS, director.

"We try to foster autonomy and not have nurses on a set schedule as long as the patients are being taken care of," May adds.

• Give staff learning and advancement opportunities.

United Home Health Services has a number of projects that give staff opportunities to learn and grow. They include a cancer pain initiative study, an infectious disease study, developing clinical pathways, and implementing quality improvement projects using OASIS data, Rhein says.

"We have a long-standing retention of staff that's very good for our agency," Rhein says. "I believe we've really tried to address the needs of our staff, and we're very much motivated to incorporate field staff in our projects."

Susan B. Allen Memorial Hospital Home Health gives home health aides the opportunity to learn additional skills, including phlebotomy, taught on the job by a phlebotomist. Aides also are taught how to set up Lifeline services for patients, which is the alert system that patients can use to seek emergency help, May says.

• Reward, recognize, and celebrate.

Susan B. Allen Memorial Hospital Home Health holds "pat-on-the-back" parties for employees, in which staff are recognized for their success with an accreditation survey or other projects, May says.

St. Elizabeth Home Care Services in Lincoln, NE, places a strong emphasis on recognizing and rewarding employees, says **Phyllis Rizzo**, RN, BS, CHCE, director of home care services.

The hospital, in which the agency is based, has given employees free movie tickets and coupons for popcorn and beverages as a tangible reward for their loyalty and hard work.

"When we do our annual budget, we are asked to include $17 per employee for recognition and reward, and we're expected to spend that much," Rizzo says. "I have a number of gift certificates for the mall, bookstores, etc. in a drawer."

Rizzo gives out the gift certificates whenever she learns of an employee doing something extra special. For example, a supervisor might tell her of an employee who usually doesn't work on the weekend but came in one weekend to help with staffing, and Rizzo will give this worker a gift certificate.

The agency also has a "wooden nickel" program in which employees receive wooden nickels for going above and beyond their call of duty. This recognition can come from supervisors or co-workers. The employee then can save the wooden nickels and trade them in for T-shirts, gift certificates, and other prizes, Rizzo says.

Henry Ford Health System's home care agency in Detroit has implemented a recruitment and retention task force and an employee recognition committee that is charged with making sure the

staff feel appreciated and recognized for their contributions, says **Greg Solecki**, vice president for home health care.

The agency presents annual awards for nurse of the year, home health aide of the year, therapists, office staff, private duty staff, and volunteers. The honors are presented at an annual employee recognition luncheon that has become a much-anticipated event, Solecki says.

Another strategy for retaining staff is the agency's annual employee recognition raffle. The agency solicits donations from southeastern Michigan businesses and typically receives more than 100 gifts, including professional sports tickets, theater tickets, restaurant gift certificates, free hotel stays, beauty kits, oil changes, and other items, Solecki says.

Throughout the year, employees receive compliments from patients and staff, and they save these compliments to use as their raffle tickets. The compliments might be the result of any occasion in which an employee did something extra special.

"Everyone walks away with something from the raffle," Solecki says. "We make the agency a nice environment and recognize people for going above and beyond," he adds. ■

Getting creative to recruit staff in a tight economy

One agency even searches overseas for nurses

Finding home care nurses, aides, and other staff is a great deal more challenging these days and requires agencies to try some innovative strategies.

For example, Pro-Care Home Health Services in Sacramento, CA, has been working on recruiting skilled nurses from the Philippines. While there are considerable costs and many bureaucratic hoops through which to jump, international recruiting might be the best long-term solution for the agency, says **David Dial**, president and CEO.

The Visiting Nurses Association Inc. of New Orleans offers staff 12 paid holidays a year and rewards staff with bonuses according to their dependability and work quality, says **Katherine France**, RN, MN, executive director.

The home care agency at Henry Ford Health System in Detroit tracks its response to classified help-wanted ads to see which ads and placements are soliciting the desired response, says **Greg Solecki**, vice president for home health care.

Also, the agency is considering offering free training classes for home health aides, Solecki adds. Here are some of their strategies for recruiting staff:

• Finding staff who have a caring philosophy.

Henry Ford Health System's home care agency has changed its employer image in recent years in an effort to attract not just any nurse, but the types of nurses who work in the field because they embrace the philosophy of home health care, Solecki says.

"We may not be attracting the numbers of nurses we had hoped to attract, but the nurses we're attracting now embody the spirit of who we are and what we want to be and that has made a world of difference," Solecki says. "This is a way of recruiting nurses who view home health care as their mission, as opposed to coming to work because of the perks, flexibility, and getting home earlier in the day."

The agency encourages nurse recruits to follow a staff nurse on home visits before accepting a job. This way, the nurse can see if the home care environment is what he or she expected, and if it isn't, then the nurse and agency can part company without having to go through a great deal of expense and energy, Solecki explains.

Long-term staff desirable

Another strategy is to send a Henry Ford home health care package to all nurses who call to inquire about employment with the agency. The packet includes information about the agency, newspaper clippings of agency nurses who have won awards, and a summary of benefits, Solecki says.

The idea behind carefully screening nursing candidates, even in these days of a nursing labor shortage, is that those who are hired will be more apt to stay at the job because they truly want to do that type of work, Solecki says.

• Entice nurses from hospitals by offering greater scheduling flexibility.

It has become harder for home care agencies to recruit nurses from hospitals because hospitals, also feeling the nursing pinch, have begun to offer sign-on bonuses and other incentives to staff, France says.

However, home care still has better hours than hospital shift work, and home care agencies can

discuss that advantage when interviewing potential staff.

"My staff has rotating on-call duty, and they are only on-call once every two months. We rotate holidays-on-call so that the same person doesn't always get the holiday work," France explains. "A lot of home care agencies don't allow staff to take off any time at all during a holiday week because it's difficult to staff those days."

At the Visiting Nurse Association in New Orleans, nurses may elect to have off one major holiday a year, and this way, they can go out of town to visit family, France says. "When someone comes in for an interview, those are the things I emphasize."

Consider hiring from overseas

Probably the most important recruiting strategy, however, is making the home care agency an enjoyable work setting so that when staff nurses meet with other nurses, they will boast about how much they like their jobs.

"I would like to have employees — if they have to leave our employment to be able to say, 'If you want to go work for a good place that's very understanding, then you need to work at the Visiting Nurse Association,'" France says.

• Consider opening potential labor pool to include overseas nurses.

With a staff of 170 in one of the tightest health care markets in the country, Pro-Care Home Health Services is poised to take drastic measures to protect the agency's future employment.

"We do a lot of shift nursing, and we need more LPNs than most," Dial says, adding that the agency's employment is fine now, but likely will have difficulty keeping up with future need.

Keeping the long-term nursing shortage in mind, Dial has begun the lengthy process of recruiting nurses from the Philippines. This effort includes hiring an attorney who specializes in immigration and filing state and federal forms, including applications for H-1 visas for professionals.

The H-1 visa allows employers to hire workers from overseas in certain professions that have a demonstrated labor pool shortage among U.S. workers. However, all of the various professions, including engineering and various health care disciplines, must share the same set number of available visas, Dial explains.

Pro-Care Home Health Services also had to open an office in the Philippines and keep a full-time employee in the office. Then there is a waiting period before the recruit is permitted to enter the United States. After working on the process for more than two years, Dial finally was able to bring over two employees.

Once nurses are flown, at the company's expense, to the United States, they are placed in temporary housing while they study and take their College Graduate of Foreign Nursing School test, which is a standardized test given to anyone who claims nursing education from a foreign school. The recruits also must meet LPN criteria and some may take an RN test, Dial says.

The immigrant nurses are asked to sign a two-year contract, which was designed to be fair to the nurses while still giving the agency enough employment time to recoup its recruitment expenses, Dial explains.

One of the advantages to hiring nurses from the Philippines is that they already speak English, so there are no language barriers to overcome, Dial adds. ■

Sources

- **Tom Berg**, General Manager, American Home Patient, Seattle Infusion Branch, 13035 Gateway Drive, Suite 131, Seattle, WA 98168. Telephone: (360) 377-3800.
- **David Dial**, President and CEO, Pro-Care Home Health Services, 7880 Alta Valley Way, Suite 103, Sacramento, CA 95823. Telephone: (916) 681-4949.
- **Katherine France**, RN, MN, Executive Director, Visiting Nurses Association Inc., 2475 Canal St., Suite 248, New Orleans, LA 70119. Telephone: (504) 822-1477.
- **Melinda May**, RRT, BHS, Director, Susan B. Allen Memorial Hospital Home Health, 119 Jones, El Dorado, KS 67042. Telephone: (316) 322-4540.
- **Penny Rhein**, BSN, RNC, Vice President, United Home Health Services, 2200 Canton Center, Suite 250, Canton, MI 48187. Telephone: (734) 981-8820.
- **Phyllis Rizzo**, RN, BS, CHCE, Director of Home Care Services, St. Elizabeth Home Care Services, 555 S. 70th St., Lincoln, NE 68510. Telephone: (402) 486-7043.
- **Greg Solecki**, Vice President for Home Health Care, Henry Ford Health System, Home Health Care, One Ford Place, 4-C, Detroit, MI 48202. Telephone: (313) 874-3135.
- **Mary St. Pierre**, RN, BSN, Vice President of Regulatory Affairs, National Association of Home Care, Washington, DC 20003. Telephone: (202) 547-7424.
- **Rick Wade**, Senior Vice President, American Hospital Association, 325 7th St. N.W., Washington, DC 20004. Telephone: (202) 626-2284.

Maintaining committee's interest a challenge

MA agency's group still in 'infancy'

Since reorganizing its bioethics committee in early 2000, the Visiting Nurse Association (VNA) of Southeastern Massachusetts in Fall River has made great strides, pulling together a diverse group of members and educating them on clinical ethical issues.

Cynthia Cardoza, MS, RN, president and CEO, says the committee has provided a valuable service for staff who need guidance on ethical questions. And it has brought the community into discussions of important issues, both through representation on the committee and presentations that invited outside groups to join discussions of issues such as death and dying.

But even with this early success, Cardoza considers the effort to be in its infancy and still sees areas for improvement. In particular, she says, the committee has to provide enough interest for volunteer members to keep coming to meetings — even though the agency often doesn't have a steady stream of ethical dilemmas to discuss.

"I guess as the administrator, I should be grateful for that, but it presents a problem for us because we're trying to keep the people interested in serving on the committee," she says. "They like to come in and hear a juicy problem, and we don't always have one."

Cardoza is considering ways in which the committee can pose hypothetical situations for members to discuss to provide ongoing interest and prepare the agency for issues it hasn't yet encountered.

Committee reinstituted after mergers

Cardoza says the VNA previously had another ethics committee that struggled to find things to do and fell by the wayside as the agency underwent a number of mergers.

After the mergers, she says, it became clear the Joint Commission on Accreditation for Healthcare Organizations found the ethics committee process to be a useful mechanism for handling ethical issues.

"So we put it back together and reorganized in early 2000," Cardoza says.

From the beginning, she says, the decision was made to have the committee focus only on bioethical issues — those relating to care, as opposed to business ethics issues such as conflict of interest and billing.

Business issues are handled through the VNA's corporate compliance program. Cardoza says the skills and education needed for each set of problems are so different that they wouldn't make sense to have one group discussing both.

"You'd be looking for different expertise, a different set of skills," she says. "I think it kind of mucks up a committee if you have both the business ethics and the clinical or medical ethics being handled by the same people. We said from the very beginning that we wanted this to be a discussion of clinical issues and patient-centered issues, not business issues."

Diversity may be the key

The VNA invited committee members from a wide range of disciplines — not just home health nurses, aides, hospice employees, and administrators associated with the organization — but a representative from the VNA's board of trustees, physicians, clergy, rehab services and representation from the risk management department of a local hospital.

Cardoza also has sought out community representation — tapping former board members, a member of a Friends of the VNA support organization, and a representative from a local facility for terminally ill indigent patients.

She hopes to add even more members from outside the VNA and is particularly hopeful she can recruit an ethicist to join the committee.

"The concern I have with the committee as comprised is that I don't think we have a group that is comprehensive and educated enough in terms of ethical issues to deal with hard problems should they occur," Cardoza says. "I think we have a bunch of people who have an interest and are dabbling in ethics, but we need a lot of education. If we had someone such as an ethicist, that would help us."

One area not represented on the committee is the law; Cardoza says she purposely has refrained from inviting an attorney to join.

When matters come up that could have a legal component, Cardoza runs them by the agency's own attorneys. In rare cases where she's unsure, she discusses the issues with contacts she has in hospital risk management, contacts she developed by serving as a member of

the local hospital's ethics committee.

"We're not a hospital-based agency, we're not a subsidiary of a hospital," she says. "But I've developed relationships with people serving on the ethics committee. They don't exist to hear our cases, but if I have a problem, they'll walk through it with me."

The purpose of the ethics committee is to provide a forum for the discussion of ethical issues and present recommendations to the administration and VNA board. The board has final approval over all decisions.

Currently, the committee is led by the VNA's hospice director, although Cardoza says that ideally, she'd like to see an external member lead the group.

Practical decisions gleaned

The committee's mission statement outlines the group's role in helping the VNA to achieve its philosophy of supporting patients' rights to self-determination, comfort, and dignity.

The ethics committee serves in a case consulting role, often after the fact, listening to the details of a particular ethical issue raised in daily practice and providing recommendations on how it or similar situations should be handled.

Some examples:

• The committee heard about a case in which a home health nurse felt threatened by a member of a patient's family, although the patient personally caused no problems and truly needed care.

The agency eventually worked out an agreement with the patient requiring that the relative be absent during the nurse's visits, Cardoza says.

• The committee called a special emergency meeting last year in the wake of what VNA staff believed had been a deliberate overdose on the part of a patient's caregiver. The committee affirmed the way the nurse handled the situation. Most of the cases the committee deals with tend to come from the hospice side of the organization, Cardoza says.

"We keep reminding people that it isn't a hospice committee, it's an agency committee," she says. "But the fact of the matter is, just like on the hospital committee, where most cases come from intensive care here, most cases come out of hospice. Not only do the [hospice staff] care for their patients, they also care for the palliative care patients from the VNA."

Cardoza says hospice nurses also have a good understanding of the ethics committee and have made use of it. She's had more difficulty getting the home health nurses to participate by referring cases to the committee. She says the committee would like to do a yearly educational program for all VNA staff to help them recognize ethical dilemmas so they know to ask for help with them.

Keeping members interested

An equally challenging goal has been to keep the volunteer committee members engaged enough to keep coming back to meetings and participating, even when there aren't interesting cases on the agenda.

Fighting disinterest can be a problem with any committee that doesn't have authority to make decisions on its own, Cardoza says.

"Figure out what you need to learn. Spend the first year learning how this committee should operate before even attempting to bring anybody in to consult."

"Sometimes they wonder what they're there for: 'Why am I taking the time to be here?'" she says.

Based on advice she's gotten from other agencies, her plan is to keep interest high by presenting hypothetical situations, covering issues that the VNA hasn't yet encountered but conceivably could in the future.

One such possible topic? Assisted suicide, which Cardoza says patients do occasionally ask about.

"They make statements that lead you to believe that's the direction they'd like to head in," she says of the patients. "It's something that we need to talk about."

While the agency obviously would have nothing to do with an assisted suicide, Cardoza says it currently has no policy outlining what staff should do in the event that a patient discusses it — something the ethics committee could help to formulate.

"One of the things we talked about was finding answers for people who are terminally ill," she says. "If you can get your message out that there are alternatives, that hospice is an alternative and that pain control is possible, it could help."

Another area she hopes to discuss is how to deal with the dilemma of accepting high-cost patients into service at a time of dwindling resources.

Because the VNA is a not-for-profit agency, it doesn't have the same financial pressures that for-profit agencies may have. But there's still the

challenge of balancing a not-for-profit mission with the realities of life under the prospective payment system.

Cardoza says that providing those types of "what-if" scenarios at every meeting will help address the needs of committee members and better prepare the VNA for coping with tough issues.

The committee already has passed out reading materials on subjects such as confidentiality for patients with HIV and the role of tube feeding in cases of advanced dementia.

There also have been outreach efforts to the community, notably one focused on the recent PBS series by Bill Moyers about death and dying, "On Our Own Terms: Moyers on Dying."

The VNA showed the series and then held a public forum so that the community could discuss issues raised in the presentation.

Start slowly, educate members

Cardoza offers these other suggestions for operating a successful ethics committee:

1. Start slowly.

Cardoza says one mistake she believes her agency made early on was leaping too quickly into the nitty-gritty of ethical cases without first working out how the committee should operate and educating members.

"I think [committees] shouldn't plan to do any case presentations for the first year and plan their agendas around talking about what the committee is supposed to do," she says. "Figure out what you need to learn. Spend the first year learning how this committee should operate before even attempting to bring anybody in to consult.

"That way you don't set up your expectations," Cardoza says. "I think that's where we went wrong, we just jumped right in taking cases."

2. Commit to a reasonable meeting schedule.

The VNA's committee meets quarterly: "I don't know what we'd do if we met more often," she says. Meetings are held in the late afternoon, in an effort to accommodate as many members as possible. Physician members are particularly hard to get to meetings, Cardoza says. "You've either got to do it early in the morning if you want those guys or you've got to do it at lunchtime and feed them, or you've got to do it at night."

Whatever schedule you choose, she is adamant that the committee should stick to the schedule. Canceling meetings because of a light agenda or because other events conflict sends the wrong message to members, Cardoza says.

"Once you start canceling meetings because other more important things come up, then you're dead," she says. "If members see that your commitment isn't there, they aren't going to want to make a commitment to you either."

Educate committee

3. Gather resources.

When dealing with a new committee, especially one that includes members who don't have a lot of experience with ethical issues, Cardoza says it's important to provide adequate educational resources. The VNA currently is building a resource library for the agency and its ethics committee. The committee has solicited suggestions on literature that can help members and is slowly stocking up on needed journals and other publications.

In her role as a member of the hospital's ethics committee, Cardoza says she regularly receives a large amount of reading assignments and finds them extremely helpful.

Two suggested publications from Cardoza: *The Hastings Center Report*, from the Hastings Center on Bioethics [www.thehastingscenter.org or (845) 424-4040] and *The American Journal of Hospice and Palliative Care* [www.pnpco.com or (781) 899-2702].

Cardoza says that while the VNA's ethics committee still has a long way to go before she'll be satisfied with it, she's reassured by knowing that other health care providers have had similar problems getting their ethics programs up and running.

Even the hospital's ethics committee, one she sees as successful, spent a lot of time establishing a workable structure and working to ensure meetings would be of interest to the members.

"I think it's hard," she reports. "I haven't talked to too many people who've found it easy." ■

Source

- **Cynthia Cardoza**, President and CEO, Visiting Nurse Association of Southeastern Massachusetts, 502 Bedford St., Fall River, MA 02720. Phone: (508) 676-8251. Fax: (508) 646-4017. E-mail: ccardoza@vnasm.org.

OSHA ergonomics rule rescinded for now

New regulations announced

Home health agencies, along with other employers across the nation, got a last-minute reprieve earlier this year when Congress repealed a new ergonomics standard issued by the Occupational Safety and Health Administration (OSHA).

The standard would have required businesses to implement comprehensive programs for preventing, recording, and responding to musculoskeletal injuries employees suffered on the job. Business leaders, including those in the home health industry, protested that the new rules were too burdensome and costly.

In response, Congress voted to rescind the directive in March.

But that doesn't mean that agencies are off the hook for protecting their employees from workplace injuries. And there's a chance that the ergonomics standard could reappear in some form — Labor Secretary Elaine Chao has promised to revisit the issue, and legislation has been introduced in Congress that would require OSHA to develop a new standard within two years.

Regulations in limbo

Chandra Branham, associate director of regulatory affairs for the National Association for Home Care, says it's not clear whether these new efforts at increased ergonomics regulation will go anywhere.

"I think that for everyone who's in favor of an ergonomics rule there's somebody else who's opposed to it because it's too burdensome," Branham says. "There's still a lot of opposition, however, if a law gets passed, mandating a standard within two years, then we would have to work with that."

The reversal of the ergonomics standard wasn't the only recent OSHA activity that will affect home health agencies and their employees.

Revised bloodborne pathogens requirements increase agencies' responsibilities to include employees in reviews of devices designed to prevent needlesticks. OSHA is set to implement a new form for reporting on-the-job injuries and illnesses, including more detailed reporting on both musculoskeletal injuries and needlesticks next year.

"They're not home health-specific, but they're going to have an impact on home health," Branham says.

The ergonomics standard that was rescinded in March had been envisioned by OSHA as a tool to combat crippling disorders such as carpal tunnel syndrome, herniated spinal discs, tendinitis, sciatica, and lower back pain. These disorders often are caused either by repetitive motions or movements that require people to contort their bodies in unsafe ways, and can be suffered in the workplace.

OSHA particularly had noted that patient handling, associated with nursing home employees and home health aides, was a typical task that would be covered by the standard.

Agencies are not off the hook

The new standard would have required employers to designate someone to be responsible for ergonomics issues and report risk factors for workplace injuries. If an employee was injured, an employer would have to work to eliminate or reduce ergonomic risks in that job and pay the injured employee up to 100% of pay and benefits while the employee was restricted or even barred from working.

No wonder home health agencies were among the businesses vehemently protesting that the new rules were too expensive to implement.

But Branham says even without an enhanced ergonomics standard, employers still are bound by OSHA's "general duty" clause, which states that employers have a duty to provide a safe working environment for their employees.

Currently, violations or citations that result from

COMING IN FUTURE MONTHS

- VNA succeeds with wound care QI project
- Improve quality in leadership through implementing a leadership institute
- OASIS benchmarking project makes QI efforts crystal clear
- Keeping it confidential: What does the HIPAA privacy standard mean to home care?
- Assisted suicide: Does your agency need a policy to deal with patient requests?

this general duty clause usually occur after someone has made a complaint about an employer prompting an OSHA inspection, she says. "They don't go out and inspect annually, like [Joint Commission] surveyors do."

And of course, OSHA still requires an agency to report any injury or illness an employee suffers on the job.

Branham says that based on her information from home health agencies, most have some sort of employee safety program that includes educating workers about the reporting process for injuries.

Denton TX-based Foundation Management Services has always provided education to its employees on ergonomics issues during orientation and through annual safety updates, says **Larry Leahy**, vice president for business development.

"We're going to spend a little bit more time on it this year," Leahy says, including a presentation to management that covers employers' responsibilities under the general duty clause.

Both he and Branham say if employers are willing to continue those types of programs, it's possible there wouldn't be a need for a stronger standard.

"I feel we have an opportunity to show that we can police ourselves, and through employee input, come up with some good preventive measures that can prevent injuries," Leahy says.

Needlestick prevention

In November 1999, OSHA issued a directive to its inspectors requiring that health care providers beef up their bloodborne pathogen exposure control plans.

The plans now must include the use of "engineering controls" such as sharps injury protection or needle-free devices. The goal is to reduce employee exposure to bloodborne diseases such as HIV, hepatitis B, and hepatitis C.

Last year, Congress passed the Needlestick Safety and Prevention Act, calling for OSHA to revise its bloodborne pathogens standard. In January, the new standard was published, clarifying health care employers' responsibilities in preventing accidental needlesticks.

Branham says there was only one provision in the new standard that amounted to a new requirement for agencies: They now must include employees in ongoing review of new needle safety devices.

The change doesn't require agencies to rush out and stock up on every new safety device that

CE objectives

After reading each issue of *Homecare Quality Management*, the quality manager will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care management.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Cite practical solutions to the problems that their profession encounters in home care and integrate them into their daily practices. ■

Homecare Quality Management™ (ISSN 1087-0407) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Homecare Quality Management™**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday, 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $319. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies. $191 per year; 10 or more additional copies, $128 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $53 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Contributing Editors: **Melinda Young, Suzanne Koziatek**.
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@ahcpub.com).
Executive Editor: **Jim Stommen**, (404) 262-5402, (jim.stommen@ahcpub.com).
Editor: **Holland Johnson**, (404) 262-5540, (holland.johnson@ahcpub.com).
Production Editor: **Nancy McCreary**.

AMERICAN HEALTH CONSULTANTS™
THOMSON HEALTHCARE

Editorial Questions

For questions or comments, call **Holland Johnson** at (404) 262-5540

Sources

- **Chandra Branham**, Associate Director of Regulatory Affairs, National Association for Home Care, 228 Seventh St. S.E., Washington, DC 20003. Telephone: (202) 547-7424. Fax: (202) 547-3540.
- **Larry Leahy**, Vice President for Business Development, Foundation Management Services, 2220 San Jacinto, Denton, TX 76206. Telephone: (940) 243-5858. Fax: (940) 380-9605. E-mail: larryleahy@earthlink.net

comes on the market, Branham says.

"Health care providers don't have to constantly replenish their supplies with the newest, best, safest technology that's out there," she says. "But they would have to document why they didn't choose it. It could be that the device isn't compatible with other equipment being used by the patient. Or it could be that a device being used currently is considered safe, and staff have mastered using it."

This review, including the employee input, would be required as part of an annual review of the employer's exposure control plan.

Branham says some agencies already have figured out efficient ways to get that employee input. Foundation Management Services, for example, already has surveyed its frontline" staff to find out about their experiences with needlesticks and the merits of safer devices they may have encountered at other jobs, Leahy says.

Branham says she doesn't believe the requirement will entail more effort from employers than they're already exerting. She says many agencies already have switched to safer devices, seeing that the investment can save them costly follow-up from accidental needlesticks.

A new OSHA reporting form for injuries and illnesses is slated for use beginning in 2002, Branham says.

The new form will require agencies to break out both needlesticks and musculoskeletal injuries and report them separately from other injuries.

The new form also will require health care providers to report specifically on tuberculosis exposures that result in infection.

Leahy calls the new reporting form a "step forward" for OSHA.

"I wouldn't call it a simplified format for reporting injuries, but I think it's more user-friendly than in the past," he says. ■