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Hospital Home Health.

the monthly update for executives and health care professionals

IN THIS ISSUE

NOVEMBER 2001

VOL. 18, NO. 11 (pages 121-132)

On-the-job safety is becoming a priority for home care agencies

Keeping your agency and employees out of trouble

Last month *Hospital Home Health* examined on-the-job safety for home health care employees, looking at ways in which employees can reduce their risk of danger at the workplace and steps home health care workers can take to avoid calling attention to themselves while working in dangerous neighborhoods. While every individual holds some personal responsibility when it comes to playing it safe, the home care agency shoulders a large part of the burden of keeping its employees out of harm's way.

This month, *Hospital Home Health* looks at agencies' responsibility and how to develop an effective safety plan.

"Given the potential for injury or damage to home care workers, we have been awfully lucky," says **Elizabeth Hogue**, Esq., a home care attorney from Burtonsville, MD.

That luck though is not the result of a widespread movement on the part of home care agencies to implement standardized workplace-violence prevention programs. Nor is it due to statewide regulation.

In fact, few states have regulations requiring a workplace-violence plan, although there are some that now have begun mandating them. Washington state is just one example. In 2000, the state passed legislation requiring that by July 1 of that year, all home health, home care, and hospices would have developed and implemented workplace-violence plans. As part of the plans, agencies are now required to keep records of any acts of violence done against employees or clients and must include such detailed information as:

- the specific location that the act took place;
- descriptions of the act itself;
- the person who committed the act, as well as the victim;
- the identification of the employees who witnessed the event;
- the actions the witnesses took in response.

All records, according to the state, must be held for five years and available for inspection upon request.

Washington's legislation goes a step farther, requiring agencies to have developed violence prevention training plans, whereby, with the

exception of temporary employees, all staff must receive training within 90 days of employment. The programs may employ a variety of teaching tools including but not limited to videotapes, brochures, verbal training, and class time. Topics to be covered include:

- general safety and personal safety procedures;
- the violence escalation cycle;
- violence predicting factors;
- obtaining patient history from a patient with violent behavior;
- verbal and physical techniques to de-escalate and minimize violent behavior;
- strategies to avoid physical harm;
- restraint techniques;
- the use of medication as chemical restraints;
- documentation of and reporting incidents;
- how to debrief an employee affected by a violent act;
- resources available to employees for coping with violence;
- agency violence prevention plan.

While Washington agencies have been busy developing violence prevention plans, most other agencies across the country rely on inservices to address the issue. If your agency is lacking a formal safety program, it's not alone. Progressive Home Care in Cleveland doesn't have one either, says **Barb Johnson**, administrator. But her agency does "have security available if it is a seriously unsafe situation" and has its compliance officer, who is trained in security matters, working on developing a program, she explains.

Although most agencies are lacking a formal plan, many do address the subject, either during employee orientation or inservices. Henry Ford Home Health Care in Detroit is one such example, explains **Greg Solecki**, vice president.

"We have a personal safety policy, and we also have personal safety guidelines that we give to staff. Personal safety is stressed throughout new-employee orientation and is bolstered by a mandatory, annual safety inservice, which covers patient safety, in-the-office safety, and personal safety in the field," he says. "In the past, we had our hospital's security department inservice our staff, but that proved to be less helpful than we hoped. In addition to being light on safety precautions for employees not working in a facility, we encountered some judgmental speakers who . . . offered comments like, 'You go where?!'"

Alice Fritz-Warren, RN, BSN, MSN, regional

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CE questions

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

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

5. Washington state passed legislation in 2000 requiring all home health, home care, and hospices to have developed and implemented workplace violence plans by July 1 of that year. Today:
   A. Many states are following Washington's example.
   B. All 50 states now require a workplace violence plan be instated.
   C. Few states have made workplace violence plans part of their state regulations.

6. In the wake of a national disaster or equally stressful event**,** it's especially important that children be watched for signs of stress and anxiety. Which of the following tips should be used when trying to keep children calm?
   A. Children need comforting and frequent reassurance that they're safe; make sure they get it.
   B. Allow them to take in as much information as they can handle.
   C. Encourage children to express their feelings through talking, drawing, or playing.
   D. Vary your daily routines as much as possible to distract them from things that are worrying them.
   E. A and C

7. CMS defines an adverse event as a low frequency negative or untoward event that potentially reflects a serious health problem or decline in health status of an individual patient.
   A. true
   B. false

8. Synthroid is:
   A. a type of plastic often used in medical equipment
   B. a widely prescribed medication is a synthetic hormone taken by patients whose thyroid glands no longer function properly

General Rules for Developing a Workplace Safety Program:

A. Management commitment/employee involvement
Commitment and involvement are essential in any safety and health program. Management provides the organizational resources and motivating forces necessary to deal effectively with safety and security hazards. Employees can be involved, both individually and collectively, through participation in the work site assessment, assisting in developing clear effective procedures and identifying existing and potential hazards. Employee knowledge and experience should be incorporated into any written plan to abate and prevent safety and security hazards.

1. **Commitment by top management.** The implementation of an effective safety and security program requires the public commitment of hospital, clinic, and agency administrators. Such a commitment provides a context for decisions and planning. An effective program should include the following:

a. Demonstration of management's concern for employees' safety and health by placing a high priority on eliminating safety and security hazards.
b. A policy which places employee safety and security on the same level of importance as patient/client safety. The responsible implementation of this policy requires management to integrate issues of employee safety and security with restorative and therapeutic services to assure that this protection is part of the daily hospital/clinic or agency activity.
c. Employer commitment to assign and communicate the responsibility for various aspects of safety and security to managers, supervisors, physicians, social workers, nursing staff, human resources, and other employees involved so that they know what is expected of them; also, commitment to ensure that appropriate records are kept and used.
d. Employer refusal to tolerate violence in the institution and the assurance that every effort will be made to prevent violent incidents.
e. Employer commitment to provide adequate authority and budgetary resources to responsible parties so that identified goals and assigned responsibilities can be met.
f. Employer commitment to ensure that each manager, supervisor, professional, and employee responsible for the security and safety program in the workplace is accountable for carrying out his or her responsibilities.
g. A program of medical care for employees who are assaulted.
h. A process of employee participation which includes receiving input from all levels of workers and managers, and evaluates all reports and records of assaults, incidents of aggression, and employee complaints related to violence. A suitable means of follow-up should be implemented to ensure that all measures taken are implemented properly and their effectiveness evaluated.

2. **Employee involvement.** An effective program includes a commitment by the employer to provide for and encourage employee involvement in the safety and security program and in the decisions that affect worker safety and health as well as the well-being of the client. Some methods of obtaining involvement are:

a. An employee suggestion/complaint procedure that allows workers to bring their concerns to management and receive feedback without fear of reprisal.
b. A procedure that requires prompt and accurate reporting of incidents with or without injury.
c. Employee participation in whatever process or system is devised to receive information and reports on security problems, make facility inspections, analyze reports and data, and make recommendations for corrections.
d. Employee participation in case conference meetings to present patient information and to identify problems that may help to identify potentially violent patients and to plan safe methods of managing difficult clients.
e. Employee participation in security emergency teams that are trained in required professional assault response skills.
f. Employee participation in training and refresher courses in professional assault response training, management of assaultive behavior, or disaster-plan response. Such training should include recognition of escalating agitation, diverting or controlling undesirable behavior, and any other methods of handling assaults and of protecting the individual, clients, and other staff members. Programs provided by police departments on "personal safety," or other commonly provided classes on "handling the hostile customer," often can be arranged for employees to participate in on site.

B. Written program
In large organizations in particular, effective implementation requires a written program for job safety, health, and security that is endorsed and advocated by the highest level of management, including professional practitioners or the medical board. In small establishments, the program may not need to be written or heavily documented. The program should establish the employer's goals and objectives.

The written program should be suitable for the anticipated hazards, and for the size, type, and complexity of the facility and its operations. These guidelines should be applied to the specific hazardous situation of each health care unit or operation. A large institution should have different plans and programs for high-risk and low-risk facilities.

The written program should be communicated to all personnel. The program should establish clear goals and objectives that are communicated to and understood by all members of the organization, including housekeeping, dietary, and clerical.

Source: National Security Institute, Albuquerque. NM.

performance director for Sun Plus Home Health in San Leandro, CA, says her agency also relies on inservices to spread the safety message. "We provide safety education on an annual basis both to our office and field staff. Our local police and fire departments come and do inservices, and we use the *Street Smarts* video for all new hires," she explains.

Like Sun Plus, Cuidado Casero Home Health in Dallas addresses workplace safety issues in inservice meetings "maybe once a year or so when we sometimes have a speaker from the police department," says home care nurse **Paul Dewhitt**, RN.

Utilizing off-duty law enforcement is a great asset, says Hogue, who emphasizes the importance and value of using police officers as part of an agency's overall safety program. Their presence, she says, lends credibility to a program and also allows law enforcement people to become familiar with home care and your personnel. "That way if you ever need help, there's already a tie that's been created there." Whenever possible, agencies should provide staff with escorts, Hogue adds. "They have been very effective," Hogue notes, adding that they are most effective when "they meet the nurse outside the area and travel with [that person] to the home and go in and remain in the home until the nurse is finished."

When it comes to developing a program, agencies can take several measures toward ensuring that their employees are as safe as possible while on the job. (**See box, p. 123**.) First and foremost, the agency should practice what it preaches insofar as being supportive of its staff and their impressions of the level of safety in a given area or patient's home. Agencies should also act as the go-between for the staff and patients or their family members who are issuing complaints, notes Hogue. When complaints turn to harassment, she encourages agencies to turn the calls over to their lawyers.

"Over the years, I've had clients that did that when staff were being harassed by former patients, and their strategy was that they relayed the message to me and I would answer. Putting someone in between the agency and the person seemed to really keep a lid on [the harassment], and these people eventually went away in short order when they realized the agency's lawyer was calling."

Home care agencies also should maintain a working log of their staff's locations and require staff to check in and out at every assignment. Another good idea is to develop scenarios about what home care nurses might encounter and how they should handle it. This is an excellent example of how working closely with law-enforcement agencies in your area can be beneficial.

No matter how your agency chooses to deal with violence prevention, it's important that it address the issue, says Hogue. "Violence in home care is nothing to kid around about."

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Coping with mental health needs following a disaster

The elderly and children are particularly at risk

Even now, more than a month after the terrorist attacks on the World Trade Center and the Pentagon, the psychological effects of the disaster still are being seen, and experts warn they will continue to manifest themselves for some time to come.

Within days of the disaster, New York City and Washington, DC, hospitals and clinics opened their doors, offering free psychological counseling to those in need. Some hospitals formed therapy groups, and many mental health professionals volunteered their services to help the friends and families of those missing or lost. Still, health care professionals found that, initially, few people came to make use of their services possibly because for many the shock was still too great and others hoped to cope with their grief and loss by getting involved in rescue and clean-up efforts.

Now with little left to do but mourn and with the holidays approaching, many might find

themselves suffering from symptoms of post-traumatic stress disorder (PTSD) and similar syndromes.

Unlike in times of war, the recent terrorist attacks were particularly devastating because of their unexpected nature. People's sense of personal security was shattered, and the sense that a similar event may occur at any moment pervades. War, on the other hand, is usually foreseen and premeditated, giving people some chance to put it into context.

Mental health professionals note that these symptoms are not only showing up in the survivors and direct witnesses to the attack but in those who perhaps only saw the vivid images on television. Especially at risk are the elderly and children.

Those most at risk

Judi Graser, EdD, a clinical psychologist and neuropsychologist in Burke, VA, points out that children are especially vulnerable in these situations because of their inability to vocalize their fears and accompanying inability to put it in perspective. "Every child will respond differently to stress and anxiety, in part because of their personalities but also because of different levels of maturity and their ability to understand what is happening, she explains. This often makes it more difficult for health care providers and parents to help children cope with their worries and concerns in the aftermath of something catastrophic. That's why it's so important that families sit down together and talk about what is worrying the child."

While Graser points to the importance of comforting children and assuring them that they are being kept safe, she cautions against making false promises. "If something bad does happen," she says, "the child will lose a sense of trust in that adult. Instead of saying that a particular event will never happen again, the adult should say that it's very unlikely it will happen, and if something does, they will keep the child from harm." (**See box on p. 126**.)

The elderly, too, are at risk when it comes to suffering from stress and anxiety. Typically they are well aware of the events but unlike younger, healthier adults are often times incapable of taking an active role in working through their stress and grief.

Says **Mike Ferris**, president of Access Health Education in Chapel Hill, NC: "We need to remember that [these situations are] also very difficult for our elderly patients and clients. They tend to take things very hard and depending upon their health status may be subject to great mood swings and severe bouts with depression. All ages are dealing with tremendous emotions dealing with loss and all of the other issues related to this tragic event.

"We must remember that every generation will respond differently to this tragic situation. The senior population has a totally different vantage point having experienced World War II and everything that followed. One 82-year-old told me that she felt that it was her generation's fault for letting the country get soft. All I know is that none of our

(Continued on page 127)

How to Help Others Cope

Sometimes the best way to help others, and yourself, is simply to be there for other people. Whether it's running errands, preparing a meal or listening to their fears, sometimes the best cures are the simplest ones. Here are a few suggestions for helping your friends, families, and patients deal in the wake of a disaster.

- **Provide practical help in dealing with the disaster.** Furnish meals if someone is incapacitated, either physically or emotionally. Provide a place to stay.
- **Listen.** When others talk about their experiences and feelings, their emotional load seems lighter to bear. One of the best ways you can help is to just listen. You don't have to come up with solutions or answers.
- **Show by words and actions that you care.** Go ahead and act. Don't be afraid of saying or doing the wrong thing. A friendly arm around troubled shoulders or a few words of support and encouragement can help in times of crisis. Small, kind deeds and sincere expressions of affection or admiration mean a lot.
- **Care for the kids.** If affected friends or loved ones are parents, offer to spend some time with the children to play and to listen to their concerns.
- **Keep helping.** The disruptions caused by a traumatic event may continue for some time. Recovery may take even longer. Your friends or family members will need regular, small acts of kindness to maintain their morale and to put their lives back together.

Source: Kansas State Cooperative Extension Service, Manhattan. University of Illinois, Urbana.

Helping Children Cope with Disaster-Related Anxiety

Like adults, children are able to sense anxiety in those around them, especially adults who are close to them. Unlike adults, though, children often have no way to communicate their fears and are often unable to put those fears in perspective.

To help you help your children and your pediatric patients, the National Mental Health Association in Alexandria, VA, has put together the following tips.

Quick Tips

- ✔ Children need comforting and frequent reassurance that they're safe; make sure they get it.
- ✔ Be honest and open about the disaster, but keep information age-appropriate.
- ✔ Encourage children to express their feelings through talking, drawing, or playing.
- ✔ Try to maintain your daily routines as much as possible.

Preschool-Age Children

Behavior such as bed-wetting, thumb sucking, baby talk, or a fear of sleeping alone may intensify in some younger children, or reappear in children who had previously outgrown them. They may complain of very real stomach cramps or headaches, and be reluctant to go to school. It's important to remember that these children are not "being bad"; they're afraid. Here are some suggestions to help them cope with their fears:

- ✔ Reassure young children that they're safe. Provide extra comfort and contact by discussing the child's fears at night, by telephoning during the day, and with extra physical comforting.
- ✔ Get a better understanding of children's feelings about the disaster. Discuss the disaster with them and find out their particular fears and concerns. Answer all questions they may ask and provide them loving comfort and care. You can work to structure children's play so that it remains constructive, serving as an outlet for them to express fear or anger.

Grade-School-Age Children

Children this age may ask many questions about the disaster, and it's important that you try to answer them in clear and simple language. If a child is concerned about a parent who is distressed, don't tell a child not to worry; doing so will just make him or her worry more. Here are several important things to remember with school-age children:

- ✔ False reassurance does not help this age group. Don't say disasters will never affect your family again; children will know this isn't true. Instead, say "You're safe now, and I'll always try to protect you," or "Adults are working very hard to make things safe." Remind children that disasters are very rare. Children's fears often get worse around bedtime, so you might want to stick around until the child falls asleep in order to make him or her feel protected.
- ✔ Monitor children's media viewing. Images of the disaster and the damage are extremely frightening to children, so consider limiting the amount of media coverage they see. A good way to do this without calling attention to your own concern is to regularly schedule an activity — story reading, drawing, movies, or letter writing, for example — during news shows.
- ✔ Allow them to express themselves through play or drawing. As with younger children, school-age children sometimes find comfort in expressing themselves through playing games or drawing scenes of the disaster. Allowing them to do so, and then talking about it, gives you the chance to "re-tell" the ending of the game or the story they have expressed in pictures with an emphasis on personal safety.
- ✔ Don't be afraid to say "I don't know." Part of keeping discussion of the disaster open and honest is not being afraid to say you don't know how to answer a child's question. When such an occasion arises, explain to your child that disasters are extremely rare and they cause feelings that even adults have trouble dealing with. Temper this by explaining that, even so, adults will always work very hard to keep children safe and secure.

Adolescents

- ✔ Encourage older youth to work out their concerns about the disaster. Adolescents may try to downplay their worries. It is generally a good idea to talk about these issues, keeping the lines of communication open and remaining honest about the financial, physical, and emotional impact of the disaster on your family. When adolescents are frightened, they may express their fear through acting out or regressing to younger habits.
- ✔ Children with existing emotional problems such as depression may require careful supervision and additional support.
- ✔ Monitor their media exposure to the event and information they receive on the Internet.
- ✔ Adolescents may turn to their friends for support. Encourage friends and families to get together and discuss the event to allay fears.

Source: National Mental Health Association, Alexandria, VA. Web site: www.nmha.org.

most senior citizens should suffer any more than is necessary to grieve properly. The economic uncertainties become more difficult to understand and seniors typically create additional worries related to recessions. That may show up as concern for their family or even concern that they will not have the means to stay at home under your care. [Home care] staff should be ready to discuss and assist with these concerns."

Those who lived through the disaster will surely never be the same emotionally; the same can be said for those who witnessed the attack on television for they too will have horrifying images burned into their memories. Thanks to television, the Internet, and host of other electronic media, people across the world were exposed to graphic details and images that may in some cases cause severe stress reactions in some individuals. These reactions may have lasted only a short time in some people, but for others they may be more long-lasting.

Stress reactions refer to a host of emotional and behavioral responses occurring when a person's normal functioning is disrupted or challenged. It's important, from the perspective of a health care provider as well as friend and family member, that home health staff recognize the symptoms of stress disorders.

Among the ways in which stress may manifest itself are through somatic complaints which may include an array of nonspecific aches and pains: headaches, backaches, abdominal cramping, chest pain, sleep disruptions, or changes in appetite, as well as a heightened startle response and/or lowered immunity to infections. Some people may experience more emotional reactions. In these cases, individuals actually may be experiencing anxiety, dysphoria, anger, shock or disbelief, grief, irritability, and restlessness, not to mention a sense of denial and/or numbing. For some, a sense of survivor guilt may exist, and in extreme cases, nightmares and flashbacks may indicate the onset of a PTSD. Substance abuse, too, may begin to manifest itself in those who are unable to cope through constructive means.

Just as there are a range of symptoms, there is a wide variety of coping mechanisms that your agency and staff can implement. For example, says Ferris, it's often "helpful to find initiatives to help [the elderly] deal with their emotions and feel that they are making a difference.

"Blood drives and supplies, food, clothing, and money raising for the victims and to support those working to resolve the myriad of issues are all very beneficial activities," he adds

Key to this, he says, is to "make it an agency-wide initiative to help your patients understand what has happened and deal with their special grief. Maybe you can also let your patients know what you are doing as an agency to help."

Graser suggests allowing patients, be they children, the elderly, or anywhere in between, talk through their fears — but only if they want to. "Give them the chance to talk, but never force a person to do so. For some people, denial is their most effective means of coping," she says. Whether someone wants to talk, friends and family support can make a critical difference. In lieu of this — and sometimes, in addition to — professional counseling groups can be helpful.

Home care professionals should remember that there is no set timetable for getting over a shock or traumatic event — people cope in their own ways and on their own schedules, Graser says. "When [people] experience such a traumatic event, the best thing others can do . . . is to be there, to be accepting of their pain, and to help them work through it."

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LegalEase

Understanding Laws, Rules, Regulations

These reports raise issues for home care

By **Elizabeth E. Hogue**, Esq.
Burtonsville, MD

The Centers for Medicare and Medicaid Services (CMS) has issued guidelines that will govern Case Mix and Adverse Event Outcome Reports. CMS intends to use Outcome and Assessment Information Set (OASIS) data transmitted by all home health agencies as a "reference sample" to

compare data for individual home health agencies with regard to both case mix and adverse event outcomes.

CMS's development and use of Adverse Event Outcome Reports raises a number of significant legal issues for home health agencies:

1. CMS defines an adverse event as a low frequency negative or untoward event that potentially reflects a serious health problem or decline in health status of an individual patient.

According to CMS, adverse events are "markers" of quality of care provided by agencies. In other words, by definition, adverse events are similar to what many agencies often call "incidents" that may be caused by the failure of agencies to provide appropriate care that in turn resulted in an adverse result for patients. Substandard care may also constitute fraud and abuse.

Many agency managers will immediately recognize that placing information regarding adverse event reports in certain individuals' hands is potentially problematic for agencies. Specifically, if patients, their families, and their malpractice attorneys have access to information regarding agencies' Adverse Event Outcome Reports, agencies could be subjected to liability for adverse events. Regulators may also use adverse event reports to pursue allegations of fraud and abuse against providers.

Lawsuits may follow

The fact that CMS regards certain events as "adverse" may reinforce the appropriateness or even serve as the basis for lawsuits against agencies and fraud investigations.

In addition, the material CMS published regarding these reports does not indicate whether this information will be available to patients, their families, or perhaps the general public. But there is certainly cause for concern about this issue in view of the fact that CMS says the information will be used by surveyors during the survey process. Home care managers can readily envision circumstances in which surveyors quote directly from agencies' Adverse Event Outcome Reports or perhaps even attach copies to Statement of Deficiencies.

Since Statements of Deficiencies are public information and readily available to the public, not to mention to patients and their families, agencies have legitimate concerns about the implications for good risk management based CMS's use of these reports.

2. Agencies should also be concerned about several of the specific adverse events that CMS has indicated will be routinely included in agencies' Adverse Event Outcome Reports. Events include:

• **"Discharged to community needing wound care or medication assistance**. Patient was discharged to the community without paid or resident assistance, while confused or nonresponsive, and while unable to take medications without assistance, or with either a Stage 3 or Stage 4 pressure ulcer or a nonhealing surgical wound." (Confused and/or nonresponsive patients presumably cannot dress their own wounds.) The underlying assumption of this event is that agencies might actually admit or continue care for such patients. On the contrary, patients that fit the description of this adverse event are not appropriate for home care and should not be admitted. When agencies discover that patients whom they thought would have paid or voluntary resident assistance, i.e., a reliable primary caregiver, do not have such help, agencies should immediately discontinue services to such patients. To do otherwise will place patients, agency staff, and agencies at unacceptable risks for legal liability.

• **"Discharged to community needing toileting assistance.** Patient was discharged to the community without paid or resident assistance while chairfast/bedfast and totally dependent in toileting." Again, agencies should not admit or continue services to patients who fit this category. The fact that CMS apparently envisions that agencies may do so is sobering indeed. When agencies fail to take action in the face of continuing adverse events, they may, in fact, jeopardize their Medicare certification.

3. Although it is clear that agencies should not admit or continue services to the types of patient described above, agencies cannot always tell whether there is a reliable paid or voluntary resident caregiver, especially when patients are newly admitted.

CMS may also attempt to use Adverse Event Reports to prevent agencies from discharging patients after admission when circumstances make it clear that patients do not have paid or voluntary resident assistance. If such circumstances occur, agencies always should bear in mind that, if all efforts fail to find appropriate placement for patients, including patients' refusal to accept appropriate referrals to other levels or care, agencies can discharge patients and have them transported to the local hospital emergency department.

Implementation of the prospective payment system for home health agencies will continue to present new challenges for agencies. Savvy agency managers will promptly modify current practices in order to avoid pitfalls. ■

Resources

Clinical respiratory booklet from JCAHO

Now available from the Joint Commission on Accreditation of Healthcare Organizations is the free booklet, *Understanding Clinical Respiratory Services.* Designed specifically for preparing home medical equipment organizations that supply clinical respiratory services for accreditation, the booklet looks at eligibility requirements and applicable standards through a question-and-answer format. All home care organizations that are accredited for home medical equipment, regardless of whether they provide clinical respiratory services, will automatically receive the booklet.

Others interested in receiving a copy should contact Bob Floro, associate director, Home Care Accreditation Program, (630) 792-5741, or e-mail him at rfloro@jcaho.com. ▼

Reasonable safeguards for HIPAA published

If the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is giving you headaches, consider taking the time to visit www.hhs.gov/ocr/ hipaa, where the Department of Health and Human Services has published its suggested tips for complying with the standards due to be enacted on April 14, 2003. The document looks at a variety of topics, among them patient consent, parental rights, marketing, government access, and medical research and address some of the key concerns that came as the result of a 30-day comment period in March. Among the examples, the guidance makes clear that hospitals do not have to build private, soundproof rooms to prevent overheard conversations about a patient's condition, as some mistakenly believed. Rather, the rule simply requires that hospitals provide reasonable safeguards to protect confidential information, such as using curtains, screens or similar barriers, which often are already used. The guidance also indicates that the rule allows a friend or relative to pick up a patient's prescription at the pharmacy, as often occurs today.

According to the guidance, HIPAA's privacy rule does not require hospitals to make capital improvements or encrypt emergency medical radio communications that can be intercepted by scanners.

"Covered entities must provide reasonable safeguards to avoid prohibited disclosures," the guidance says, and gives the following examples:

- asking waiting customers to stand a few feet back from the pharmacy counter where patients are counseled;
- adding curtains or screens to areas where oral communications occur between doctors and patients or among professionals treating the patient;
- using cubicles, dividers, shields, or other barriers in areas where multiple patient-staff communications routinely occur;
- providers are not required to document oral information that is used or disclosed for treatment, payment, or health care operations;
- providers are not prohibited from talking to each other at the risk of being overheard when it is necessary to ensure appropriate behavior, such as in a busy emergency department;
- nurses and other health care professionals are not prohibited from discussing a patient's condition over the phone with the patient, a provider, or a family member.

For more information, write: Department of Health and Human Services, 200 Independence Ave. S.W., Washington, DC 20201. Telephone: (202) 690-2000. Web site: www.hhs.gov. ▼

Channing Bete offers Spanish resources

If you're looking for patient handouts written in Spanish, you might want to consider visiting Channing Bete, a Massachusetts publisher of health care pamphlets and guidebooks in both English and Spanish. Among the offerings are medical illustration booklets that offer detailed,

full-color anatomical illustrations to give patients a better understanding of their diseases and bring them on board with their therapy. Handbooks cover such topics as *Understanding Pain Management, Living Well with Diabetes, Patient Safety In The Home,* and *About Infusion Therapy At Home.* Channing Bete also offers patient care skills sheets that provide step-by-step instructions in specific self-care skills, and help patients and caregivers remembers critical point-of-care details.

Illustrated, these sheets offer space to jot down notes and encourage patients to record health care provider instructions, personal health information, and more.

To order, call (800) 477-4776 (Monday-Friday, 8 a.m. to 8 p.m., EST) or go on line to www.channing-bete.com. To contact them by mail, write Channing L. Bete Co. Inc., 200 State Road, South Deerfield, MA 01373-0200. ▼

New from Healthcare Intelligence Network

The *Psychopharmacology Desktop Reference, Third Edition* is now available from the Healthcare Intelligence Network.

This latest edition gives health care providers a host of reference materials covering the many new psychotropic drugs that have been developed in the past several years. Included in the volume are:

- case studies that outline the effectiveness and adverse effects of certain drugs;
- authoritative information on the pros and cons of each drug, including how it compares to other medications available;
- an overview of drug mechanisms of action, including pharmacokinetics;
- special sections on adverse reactions and drug interactions;
- quick reference tables that show health care providers at a glance what the drugs of choice are for various conditions.

The *Psychopharmacology Desktop Reference* is available from the Healthcare Intelligence Network for $149. For more information, please visit their on-line bookstore at www.hin.com/store/p1226.html, or call (888) 446-3530.

Also out from the Healthcare Intelligence Network is the *Healthcare Price, Cost, & Utilization Benchmarks, Volume II,* filled with data and benchmarks in the three most critical areas of performance for health care organizations. The book provides readers with hard-to-find pricing models, rate development strategies, and capitation rate benchmarks, including coverage of these areas: risk adjustment; global risk allocation; contract evaluation; PMPM rate analysis; and shared risk agreements.

The cost benchmarks volume features advice and data on benchmarking costs and monitoring performance, Relative Value Unit (RVU) costing, identifying core costs, and reducing fixed expenses.

Topics covered include: RVU costing methodology; monitoring contract performance; competitive market analysis; drug cost analysis; and administrative costs.

Healthcare Price, Cost, & Utilization Benchmarks is available for $134.95. To order, please call (888) 446-3530 or visit www.hin.com/store/p18.html. ■

Patient Protection Act under fire in House

Consumers Union, publishers of *Consumers Reports,* says that the House version of the patient protection act fails to protect patients and in some instances actually restricts patients' rights in states that currently have tougher patient rights laws in effect. Moreover, the group claims that the bill, which has received President

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Bush's support, gives HMOs advance warnings as to the costs of violating certain terms of the act. The House version, says Consumers Union, contains "hidden hurdles" that prevent patients from exercising their full rights under the law. As an example, the group points to the fact that currently 40 states have tougher external review laws than the proposed federal measure. Federal law would pre-empt state regulations, the group notes, and in effect would further limit patients' rights. Another fault with the proposed legislation, says the group, is that it places the burden of proof on patients and also limits the amount a patient can collect in damages from a lawsuit. ▼

Doctors sue HHS over HIPAA regs

Privacy regulations in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are the basis of a lawsuit brought against the Department of Health and Human Services (HHS) and its secretary, Tommy Thompson, by Congressman Ron Paul (R-TX) and the Association of American Physicians and Surgeons.

The regulations, say the plaintiffs, are illegal and "violate the First, Fourth, and 10th Amendments, as well as the Paperwork Reduction and Regulatory Flexibility Act. Further, HHS failed to promulgate the final regulations within the time period specified under HIPAA."

In a statement seeking declaratory judgments, the physicians' group states that the regulations "violate the First Amendment because they will chill patient-physician communications by requiring them to be subject to warrantless review by government; violate the Fourth Amendment by requiring physicians to allow government access to personal medical records without a warrant or patient consent and authorize the government construction of a centralized database of personal medical records with personal health identifiers; violate the 10th Amendment because they govern purely intrastate activities by physicians in using and maintaining medical records for patients; violate HIPAA and lack statutory authorization because they regulate medical records other than electronic transmissions, were not promulgated within the time period expressly required by Congress and increase administrative costs; and violate the other act because they impose an immense and unjustified regulatory burden on small medical practices."

The statement goes on to say that the regulations "conflict with a number of state constitutions, such as California and Florida that grant a specific right to privacy. . . . The most heavy-handed aspect is the unprecedented government access to everyone's private medical records. While masquerading as patient protection, the rules would actually eliminate any last shred of patient confidentiality. They allow government virtually unrestricted access to those same records without a warrant."

Moreover, the statement notes that not only can "doctors be fined or imprisoned — up to $50,000 and for one year — for withholding records, patients can be denied treatment if they refuse to sign the consent form." ▼

Hospital Home Health® (ISSN# 0884-8521) is published monthly by American Health Consultants®, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Home Health**®, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $427. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $342 per year; 10 to 20 copies, $256 per year. For more than 20 copies, call customer service for special arrangements. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $71 each. (GST registration number R128870672.)

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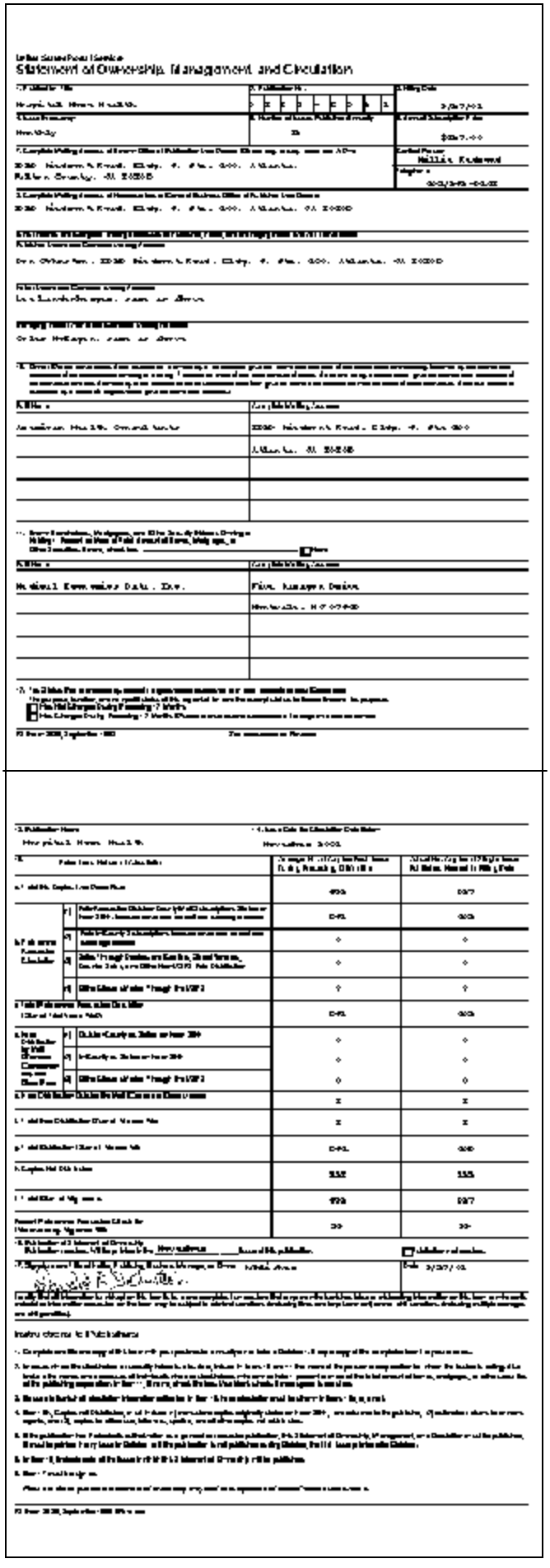

Statement of Ownership, Management and Circulation

Safety of Synthroid is questioned

Consumer advocates are demanding that pharmaceutical company Abbot Laboratories take Synthroid (the brand name for levothyroxine sodium) off the market, at least until the Food and Drug Administration (FDA) has had time to evaluate its safety. A group of patient watchdog groups, led by the Gray Panthers, has raised issue with the drug's effectiveness and safety. A host of problems in 1997 forced the FDA to request that all levothyroxine manufacturers submit new drug applications. Synthroid and other levothyroxine drugs have been on the market for more than 40 years and their manufacturers never had been forced to submit a drug application. Rather than do so now, Abbott opted to submit a "citizen's petition" asking the FDA to waive the requirement that Synthroid be regulated as a new drug because of the time the medication has been on the market and its proven safety and efficacy.

The FDA refused to grant Abbott's request in April, citing changes in the medication's recipe over the years and problems with inconsistent dosing from batch to batch. ■

Hospital Home Health.
the monthly update for executives and health care professionals

Job opportunities in home health will grow as seniors age

According to the Department of Labor's *Occupational Outlook Handbook, 2000-01 Edition,* the outlook for the home health care field is promising.

In fact, the Department of Labor predicts that employment opportunities within the field will grow by more than 36% between now and 2008, partly because of the projected rise in the number of Americans who are or will be in their 70s and older in the coming years.

Not surprisingly, these people will experience a greater need for health care and accordingly, for home health care services.

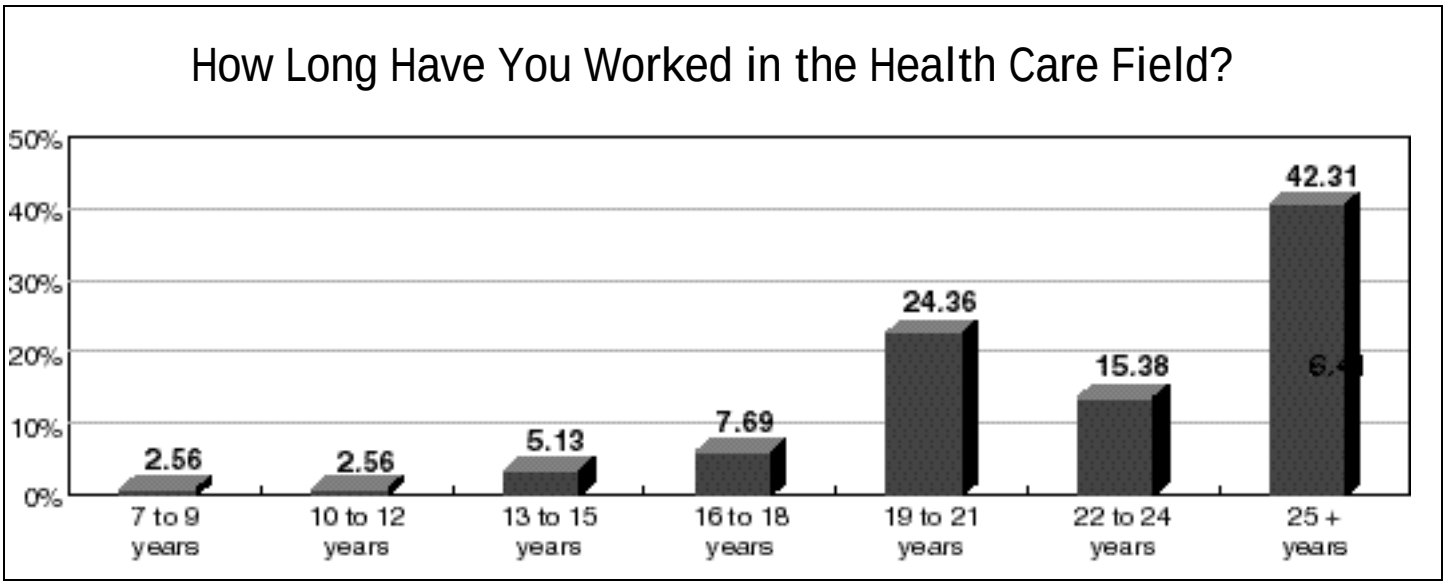
Another factor adding to the projected boom within the home care industry is the health care system's increasing efforts to reduce costs by moving patients from the hospital environment into the home as soon as possible.

Still a third factor contributing to home care's growth is a high turnover rate — home care is highly demanding and stressful work that is often accompanied by low salary and poor benefits. However, the personal rewards of helping others in many cases outweighs the industry's low points and many in the field say they cannot imagine leaving it.

Not too long ago, *Hospital Home Health* sent out a survey, polling our readers on a variety of topics relating to their job duties, agency setup, salary, and position. Now the results of *HHH*'s 2001 salary survey are in.

If you've ever wondered who your fellow readers are, they are overwhelmingly well-educated women in their 40s and older, according to responses we received to the survey.

A little more than half of *HHH* readers participating in this year's survey (52.6%) are in their 40s — in fact, only 12.8% are younger (1.3% are between 26 and 30 years old, 2.6% are between the ages of 31 and 35, and 8.9% are between 36 and 40) — while a substantial number of survey participants are in their early 50s (23.1% are between the ages of 51 and 55, while 6.4% are between 56 and 60). Home



care professionals age 61 to 65 comprise 2.6% of *HHH* survey participants.

Slightly more than 83% of our readers who participated are women (83.3%) and of those, the majority have advanced degrees such as BSN (16.7%), MBA (16.7%), MS (8.9%), MSN (15.4%) and MA (3.9%).

Slightly more than 10% (10.3%) hold a Bachelor of Arts degree. The high number of advanced degrees is reflected in the number of survey respondents whose current jobs are either that of vice president or upper management — 41% say they fall into executive positions, while 50% further differentiate their titles as director of home care service or clinical operations, CEO, and director/administrator.

As for your job certifications, 68.3% of *HHH* readers have certifications other than FAAN, CHE, or RN-C.

Where you work

While it's no surprise, the bulk of HHH survey participants (69.2%) are employed by hospitals or hospital-affiliated home care agencies while slightly more than a quarter (26.9%) work for independent home care agencies.

Of those who work in other environments, 1.3% work in private practices and 2.6% work in academic settings.

Whether *HHH* readers work for a hospital-based agency or somewhere else, 78.2% of you work for nonprofit entities, while another 14.1% work in the for-profit arena. Colleges or universities and county government account for 2.6% and 5.1%, respectively.

What's more, 88.5% of survey participants' agencies do not charge patients by the hour. That said, 7.8% are evenly divided in charging hourly fees in each of the following categories: less than $30, between $31 and $50, and between $91 and $110. Only 1.3% charge an hourly rate of between $71 and $90 per hour.

While most of our respondents work in a hospital-related setting, most are in hospital-based agencies. A little more than a third (38.5%) say they don't work in hospitals.

However, those that do work in smaller hospitals of 400 beds or less — the largest percentage (15.4%) say they work in hospitals with between 101 and 200 beds.

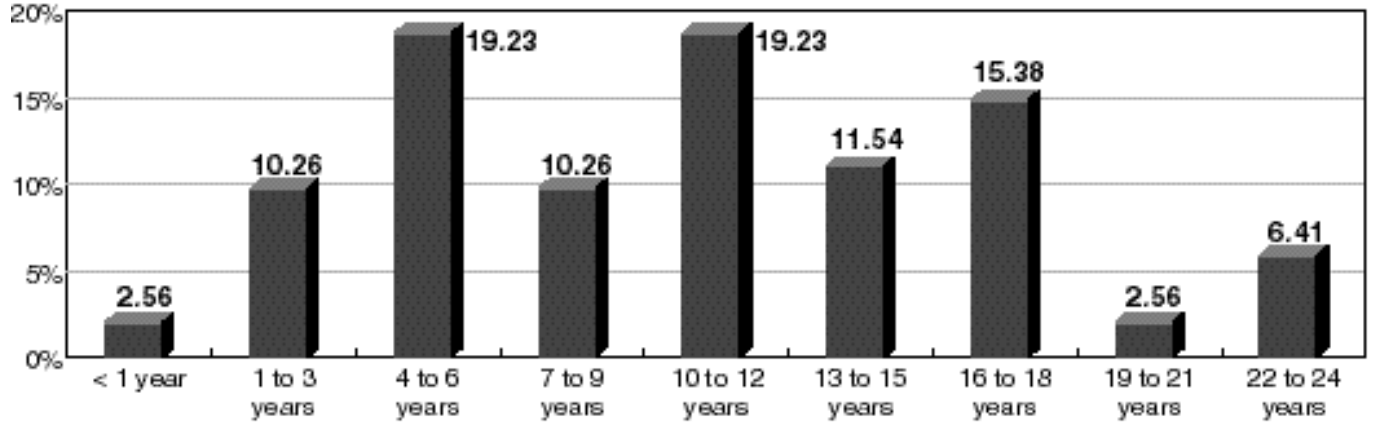
Following closely behind are those who work in hospitals with between 301 and 400 beds (12.8%).

Employees of hospitals with between 201 and 300 beds make up another 8.9% of *HHH* survey participants. A little more than 7% are employed in hospitals with between 401 and 800 beds, while 10.3% work in hospitals with more than 800 beds.

Readers who replied to the salary survey are evenly split according to their agency location both with respect to the country as a whole and within any given region. Roughly 28.2% report their agency is located in an urban area, while 26.9% and 29.5% say their agency is located in a suburban or medium-sized community, respectively. Only 15.3% report that their agencies are located in rural settings.

Midwesterners make up 42.3% of *HHH* survey

How Long Have You Worked in Your Current or Similar Positions?



participants, while the Northeast and Southeast / Southwest comprise nearly the remaining half with 24.4% and 26.9% of readership, respectively.

No matter where *HHH* readers work, the vast majority (42.3%) of those participating in our survey have worked in the health care field for more than 25 years, (**see chart on p. 1**) while almost as many (39.7%) have worked in the field for between 19 and 24 years.

Close to one-fifth of survey respondents (19.2%) have worked in their current position or in jobs with similar responsibilities for between four and six years or between 10 and 12 years, respectively, while another 15.4% have worked in their current jobs for between 16 and 18 years. (**See chart on p. 2**.) Close to 7% of readers have held similar positions for more than 22 years.

Despite the Department of Labor's position on high turnover, *HHH* readers are committed to not only their jobs but the profession as a whole.

The benefits of home health care

According to survey responses, the *HHH* readership may be atypical in that the average salaries are relatively high, depending, of course, on where you live. Whether it reflects an increase in salaries or fewer people at the lower levels of the home care profession, 15.4% of readers are earning salaries between $50,000 and $59,999, compared with 20.5% in 2000.

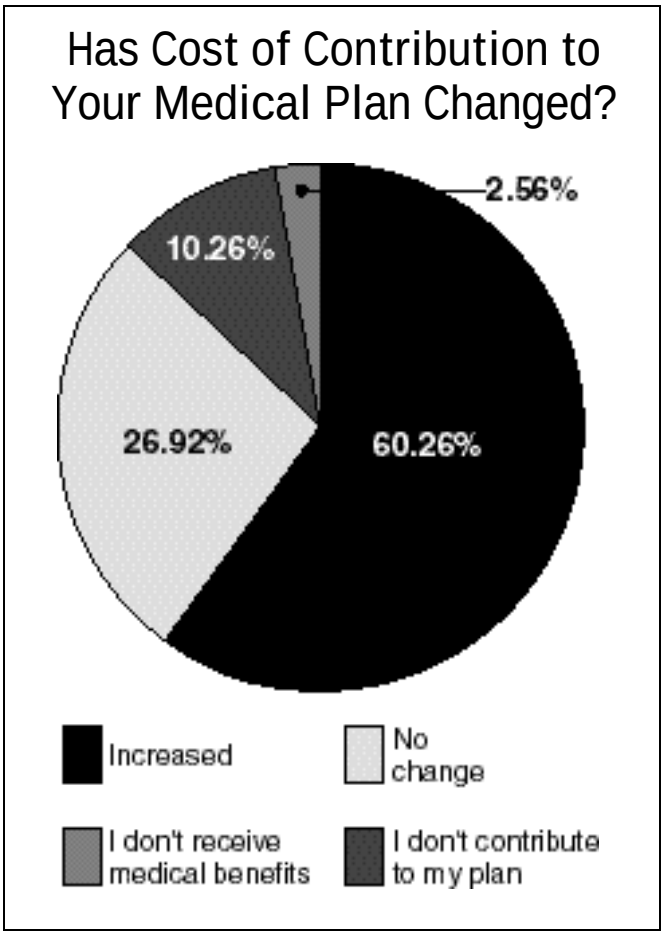
Perhaps almost as interesting in the number of those earning salaries that are substantially higher — some 25.6% said their annual salaries were between $60,000 and $69,000, while another 23.1% said they earned between $70,000 and $74,999 (10.3% last year reported earning in this category).

As for the rest of our readers, the pay scales range from $30,000 to $39,000 (2.56%) on the low end to more than $130,000 (5.13%) on the uppermost reaches of the scale. In this year's survey, no respondent reported a drop in income.

In fact, 46.2% said their income had risen by between 1% and 3%, while another 28.2% said their earnings were up by between 4% and 6%. Slightly more than 5% (5.12%) said their salaries had risen by 16% or more over the past year.

This is compared to a 2000-2001 survey from the Department of Labor, which showed that the median hourly earnings of home health and personal care aides were $7.58 in 1998.

The middle 50% earned between $6.41 and $8.81 an hour, while the lowest 10% earned less than $5.73 and the highest 10% earned more than



$10.51 an hour. Median hourly earnings in the industries employing the largest number of home health aides in 1997 were as follows: home health care services earned $8, hospitals paid $7.90, personnel supply services paid $7.70, and residential care programs and individual and family services paid $7.20.

Benefits, too, play a large part in job satisfaction, with the most survey respondents ranking a variety of benefits from medical (78.2%) and dental coverage (30.7%) to life insurance (44.9%) and having a flexible work schedule (57.7%) as being extremely important.

Also ranking as extremely important to *HHH* survey respondents were 401K plans or similar retirement programs (70.5% and 74.4%, respectively), and the chance for annual and semi-annual bonuses (43.6%). Nearly 40% of readers (39.7%) said that there was no opportunity for bonuses at their current place of employment.

Home health still has along way to go in some of the newer benefits that a growing percentage of American workers are seeing. Nearly three-quarters of respondents (74.3%) said their agency or company did not offer elder care, 41% said there were no exercise facilities available to them

though the workplace, 58.9% said they did not receive child-care services through work, 69.2% reported no chance at profit-sharing, and 15.4% said that maternal / paternal leave was not counted as an employee benefit.

And in a trend that has apparently left not even the health care profession untouched, home health care employees are paying more this year than in year's past for health care coverage. Of those responding, 60.3% of readers said their contributions have increased while 26.9% reported no change. **(See related chart, p. 3.)**

Of course, high salaries come with a cost. Interestingly, when compared to last year, while the average number of readers who reported working between 46 and 50 hours in a given week rose (43.6% in 2001 compared to 27.3% in 2000), there was enough of a shift when compared to last year to indicate that at least some are working fewer hours than they did at this time last year.

In 2000, a third (33.3%) worked between 41 and 45 hours each week; that number is down to 24.4% in 2001. Similarly, in 2000, 18.2% of you were working between 51 and 55 hours each week. This year, the number of respondents reporting a similar time commitment dropped to 11.5%. As for those working even more, the trend ended. This year, 12.8% said they are working between 56 and 60 hours in any given week, compared with 9% at this time last year.

Perhaps part of the drop in hours worked can be attributed to an increase in the number of agency employees. Of those responding, 44.8% of readers said their agency staff had increased over the past year, while 17.9% reported no change. This compared to last year, when more than 27% said that their number of co-workers had increased with 15.2% reporting their department or agency has experienced no changes in the number of staff.

When the analysis is said and done, the *HHH* reader is typically a woman in her 40s or 50s who holds either a BSN, MSN, MBA, or BA degree and has a professional certification to her name. For the most part, she is committed to home care having worked in the field for more than 19 years, typically in the same type of position or at the same level for anywhere from 4 years to 18 years. She works long hours but not as long as she did last year and has seen her salary and the help she receives on the job rise over the past year. Perhaps the government is right after all, and home health care is an industry on the rise. ■