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the monthly update for executives and health care professionals

IN THIS ISSUE

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21st century tools: Telehomecare cuts staff costs, gathers quality information

Combination of virtual and real visits provides good care

In George Orwell's *1984*, Big Brother was able to look into people's homes and know what they were doing and how they were feeling. While telehomecare is not as intrusive as the technology Orwell imagined, it does give home health personnel an opportunity to check on patients more frequently without requiring extra staff and travel time.

The Veterans Affairs (VA) Connecticut Healthcare System in West Haven, CT, has used telehomecare since an initial pilot project in 1997. Patients with chronic conditions that typically require frequent home health visits or trips to VA clinics were included in the study, says **Donna Vogel**, MSN, director of continuing care and case management for the system. "Congestive heart failure, diabetes mellitus, and chronic obstructive pulmonary disease patients were included because we believed that ongoing monitoring would result in timely intervention that would reduce the number of visits needed and the number of admissions to the hospital," she explains.

The VA pilot study did show a 21% decrease in emergency department, clinic, and home health visits for the group receiving telehome visits during a six-month period. This translated to a $200 per-patient savings over the per-patient cost of the control group, she says.

The VA telehomecare system uses Internet-based technology to create a link between the patient and the case manager. A monitor that uses touch-screen technology is placed in the patient's home. Along with the monitor, different attachments are available to measure temperature, blood pressure, and weight. "We can tailor each patient's system with the attachments that capture the vital signs we need," says Vogel. "A pulse oximeter, EKG, stethoscope, and fingerstick glucometer are all available," she adds.

"The patient has a schedule of how often to take vital signs," says Vogel. Because the information travels from the patient's home to a database that can be accessed through a secure web site, a nurse does not have to be sitting at a terminal for the information, she says. If the patient's readings are outside parameters that have been preset by the physician, the nurse receives a message as soon as he or she logs on to

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the system. "These alerts enable the case manager to immediately check the patient's information and provide timely intervention," explains Vogel.

In addition to gathering vital sign information, the system also can be used to provide educational information as well as reminders about physician visits and times to take medications, Vogel says. At this time, the messaging capability is one-way from the provider to the patient, she says.

Simple systems also work

The TeleHomeCare Project, coordinated by the University of Minnesota in Minneapolis, has four hospital home health agency participants and has had almost 60 patients use the service, says **Stanley Finkelstein**, PhD, project coordinator.

"We wanted a system that is relatively inexpensive and offers easy access for most patients," he says. For those reasons, the project chose a system that employs a small box that uses the patient's television set as a video monitor and connects to the patient's telephone line. The system's camera is attached to the box by a 6-foot cable, he explains. The camera can stay in one place as the patient talks to the nurse or it can be moved to show the nurse a swollen ankle or a wound, he explains.

Patients have set appointment times to "meet" with the nurse who can be seen on the television. During the visit, patients report vital signs they have taken with equipment provided by the home health agency, Finkelstein says. The nurses discuss any topic that is normally discussed in a face-to-face visit, he says.

During the testing phase of the project, the virtual visits did not replace actual home visits, he says. "We did not want to take a chance that care would be compromised while we tested the system, and we also wanted to compare the two types of visits." Virtual visits were a little shorter than actual visits but the number of topics and quality of information gathered were the same in both types of visits, he adds.

Obviously, the virtual visits were more cost-effective because the nurse did not have to travel to the patient's home, Finkelstein adds.

"When we first started telehome visits, nurses were hesitant," Vogel admits. They quickly realized how they could manage the care of a large group of patients more easily, she adds.

Training is necessary to make sure nurses know how to access the information via the web site, she points out. The greatest advantage of the web site-based system is that nurses can check on patients from any location using any computer, she says.

The most important part of training nurses in the Minnesota telehomecare project is to teach them not to move much, Finkelstein says. "Because we are using telephone lines to transmit images, movements are distorted and can be distracting."

CE questions

Save your monthly issues with the CE questions in order to take the two semester tests in the March and September issues. A Scantron sheet will be inserted in those issues, but the questions will not be repeated.

21. According to Stanley Finkelstein, PhD, project coordinator for the TeleHomeCare Project, telehomecare reduces costs by eliminating:
    A. paperwork
    B. travel time
    C. staff training
    D. all of the above

22. Lynn Yadach-Blakey, RN, MSN, clinical manager of Henry Ford Home Health Care, says that offering employees the option of waterless hand rinses increases patient safety by:
    A. enabling the nurse to remain with the patient
    B. reducing the number of hand-washing items the nurse has to juggle
    C. eliminating the need for multiple glove changes
    D. none of the above

23. One way that Barbara Ballard, MPM, director of home health services at Brookwood Medical Center, lets her staff know their importance is to:
    A. present quarterly bonuses
    B. arrange special parking places for staff
    C. give employees access to counseling and support services of the agency
    D. take them to lunch

24. Early inhalational anthrax and flu share many symptoms in common. According to the CDC, which of the following is considered a rare symptom of anthrax?
    A. aches
    B. runny nose
    C. fever
    D. high white blood cell counts

Telemedicine Resources

- **Telemedicine Information Exchange** is a web site that contains information on vendors, funding, news, conferences, and articles related to telemedicine. There is a section devoted to home health. The Telemedicine Information Exchange is maintained by the Telemedicine Research Center, 2121 S.W. Broadway, Suite 130, Portland, OR 97201. Telephone: (503) 221-1620. Fax (503) 223-7581. Web site: http://tie.telemed.org/.

- **The American Telemedicine Association** web site contains news updates related to issues such a Medicare reimbursement, as well as publications, clinical guidelines, and other support material. American Telemedicine Association, 910 17th St., N.W., Suite 314, Washington, DC 20006. Telephone: (202) 223-3333. Fax: (202) 223.2787. Web site: www.atmeda.org. E-mail: info@americantelemed.org

- **The Technology Opportunities Program of the National Telecommunications and Information Administration** offers grants to fund research projects utilizing telecommunications or the Internet. The web site has a description of various projects that have been funded as well as information on the grant application process. Technology Opportunities Program, Office of Telecommunications and Information Applications, National Telecommunications and Information Administration, U.S. Department of Commerce, 1401 Constitution Ave., N.W., Room 4092, Washington, DC 20230. Telephone: (202) 482-2048. Fax: (202) 501-5136. Web site: www.ntia.doc.gov/otiahome/top/index.html. E-mail: top@ntia.doc.gov

For this reason, nurses are taught not to talk with their hands and to limit body or head movements. He videotapes some of the virtual visits to use in training nurses so they can see how they look to patients.

Another key to success is to educate patients as well. Not only do they need to understand how to use the equipment, but they also need to know that a telehomecare system is not to be used for emergencies, Vogel points out.

Both Finkelstein and Vogel see great advantages to using telehomecare. Not only do these systems gather information but they can also be used for further patient education.

"The more information patients have, the more closely they will follow their schedule for medications and other treatments," Vogel says.

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CDC tries to clean up hand-washing guidelines

Waterless washing under review

The most significant change in the hand hygiene guidelines currently under review by the Healthcare Infection Control Practices Advisory Committee (HICPAC) of the Centers for Disease Control (CDC) in Atlanta is the recommended use of waterless, alcohol-based gels or rinses for health care personnel.

"There is now enough scientific data to show that waterless, alcohol-based products can be effective in decontaminating hands," says **Lynn Steele**, MS, CIC, an epidemiologist at the CDC. The comments received on the draft guidelines are currently being reviewed by HICPAC, and Steele expects the final guidelines to be published within the next six months. **(For information on how to get guidelines, see box, p. 28.)**

In addition to the scientific data that supports the use of waterless products, vendors also have developed products that address staff members' greatest concern that the alcohol-based rinses are harsh on the hands, says **Lynn Yadach-Blakey**, RN, MSN, clinical manager of Henry Ford Home Health Care in Detroit.

"Extra emollients in the products mean that the skin doesn't dry out with repeated uses," she says.

Although the guidelines have not been finalized, Yadach-Blakey's agency revised their hand-washing policy in October 2001 to reflect the recommended use of waterless products. "Giving employees an option to use a waterless product makes sense when they are with a patient who

needs care that requires multiple glove changes," she says.

For example, when a patient needs Foley catheter care and a wound dressing change, the staff member must remove gloves and wash hands before putting on fresh gloves to change the dressing, Yadach-Blakey adds. "It is much safer to sit by the patient and clean your hands with a waterless product," she says. "You can be sure that patient doesn't contaminate anything, and you don't have to worry that the patient will fall out of bed."

Yadach-Blakey's staff members have been testing products and say that they like the convenience. "They do point out that after five or more hand washings with the waterless product, they feel the need to wash with soap and water to remove the sticky feeling left from the buildup of emollients," she says.

The hand-washing policy at Athens (GA) Regional Home Health does allow staff to use waterless products if there is no running water available, says **Marta L. Guizar**, director of professional services for the agency.

"We provide our clinicians with an antimicrobial soap that they are to use if there is running water. They use the waterless gel if there is no water, then wash with soap and water as soon as possible," she says.

"We limited the use of waterless products after a surveyor discouraged us," says **Kathy Stockton**, RN, BSN, supervisor officer for performance improvement at Mercy Home Health and Hospital in Nampa, ID. "We will take a look at the new CDC guidelines when they are finalized and evaluate what changes we need to make," she says.

Before changing policies to reflect recommendations in any one guideline, you do need to check requirements of any regulatory or accreditation agency with which you work, Yadach-Blakey says. Because most regulatory and accreditation agencies base their standards on federal guidelines, she expects that all standards will eventually reflect the CDC guidelines that are finalized.

A good hand-washing policy does include instructions on how to use hand-washing products as well as when to use them, says Yadach-Blakey. **(For sample hand-washing policy, see *Hospital Home Health*, June 2001, p. 66.)**

"We've monitored hand-washing compliance among our staff for about nine years. We routinely report 95% to 98% compliance," she adds.

The less than 100% rate primarily is due to protocol requirements that are complicated and not always feasible, Yadach-Blakey says. For example, when using running water, staff members are to use one paper towel on the counter as a clean field on which to place two other paper towels and the soap. Physical constraints within the patient's home such as little open counter space may make this protocol difficult to follow, she explains.

"When evaluating your hand-washing policy, be sure your requirements are clear but reasonable," she says.

Another suggestion is to require alcohol-based waterless products that contain at least 60% alcohol, Yadach-Blakey says. "We also insist on fragrance-free products."

Her agency provides staff with the proper products, she says. "We don't want our staff members picking up products at the local pharmacy or a nearby candle and scents store. There would be no way to guarantee the effectiveness of those products."

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Additional Resources

For additional info on HICPAC activities and updates on the guidelines, visit:

- **www.cdc.gov/ncidod/hip/**. This is the web site for the Centers for Disease Control's Division of Healthcare Quality Promotion. News updates and information on where to find information on final hand-washing guidelines will be available on this site.
- **www.cdc.gov/ncidod/hip/HICPAC/Hicpac.htm**. This web site contains information on the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) with a description of the committee's activities and a list of members. Updates on committee meetings and actions can also be found here.

Effective recruiting = successful retention

Work environment, respect, appreciation keep staff

Just like peanut butter and jelly, recruitment and retention are two words that always seem to go together. Home health managers rarely talk about one without the other, and with good reason, according to experts who talked to *Hospital Home Health.*

While everyone in health care is aware of a shortage of nurses, home health managers have the added challenge of finding nurses with very specific skills who are willing to go into patients' homes and to work independently. Once these nurses are found, no manager wants them to leave after a short time.

Sometimes, addressing your approach to recruitment can help with retention as proven by Henry Ford Home Health Care in Detroit. "We realized a few years ago that we had a big retention problem," says **Greg Solecki**, vice president of Henry Ford Home Health Care. To address the problem, the agency put together a strategic planning team composed of staff members involved in the different aspects of both recruitment and retention, he says. One of the primary objectives was to attract the right type of nurse to the job in order to increase the likelihood that the nurse would stay with the job, he adds.

"We knew that we didn't want to run a ton of ads in the newspapers and that we didn't want to offer signing bonuses," Solecki says. He questions the effectiveness of signing bonuses and adds that he believes signing bonuses "don't enhance the profession of nursing."

"We also knew we couldn't promise a 9-to-5 job with little or no paperwork," says Solecki. "In the early days, hospital nurses would burn out and come to home health to get away from long hours and paperwork," he explains. "The amount of paperwork required today is our No. 1 barrier to recruitment of many nurses," he adds.

Committee members also wanted the ads to attract nurses who were coming to something they wanted rather than running away from a job that they didn't like, says Solecki. The ads approved by the committee focused on themes such as community service, one-to-one patient care and teaching, and making a real difference in someone's life, he explains.

The ads were successful, he says. "We did attract a higher caliber of nurse than we had attracted previously, and the nurses were not disappointed to find that home health is a hard job," Solecki says. Nurses who responded by telephone or letter to the ads received an information packet and an invitation to call or visit a staff member. "If the nurse wanted to go with a staff member on a home visit, we would arrange it."

If this low-pressure approach to recruitment resulted in an application, Solecki's staff responded within 24 hours. "At least, we tried to respond in 24 hours so that we showed the applicants we respected their time and their interest," he says.

Home health experience not required

Solecki's agency doesn't require home health experience and offers a 12-week orientation that teaches nurses the skills they need, he says.

"Obviously, an experienced home health nurse moves through the orientation program more quickly, but we make sure everyone feels comfortable with every aspect of the job," he explains.

At one time, Henry Ford Home Health partnered with a local nursing school to offer a six-month intern program that gave graduate nurses training in a wide variety of skills that are used in home health. "The program resulted in some very skilled nurses who stayed in home health, but it was inordinately expensive for one organization so we discontinued it," says Solecki. This is, however, one idea he recommends to others who might find multiple partners to share the costs.

Barbara Ballard, MPM, director of home health services at Brookwood Medical Center in Birmingham, AL, enjoys a low turnover rate at her agency and attributes it to "the family feeling" of her staff.

"I am able to attract staff members because our salaries are competitive, but they stay because this is a nice place to work," she says. In addition to treating all staff as professionals and asking for their input, it is important to recognize that supporting employees in their personal lives also is a good way to keep employees, Ballard adds.

"We make our social workers, chaplains, and counselors available to staff members when they have difficulties in their lives." This access to support demonstrates to employees that they are valued, she says.

"I also respect their specific skills," she says. Although Ballard oversees home health and hospice services, she does not cross-train employees

to work in both areas, she says. "Home health nurses want to help patients get better, and hospice nurses want to help patients die peacefully." These two tasks require two different approaches and personalities, and it creates job dissatisfaction when you try to force a nurse to do something for which he or she is not suited, Ballard adds.

Nurses also want to be appreciated, Solecki says. A simple recognition program at Henry Ford uses a form titled, "I heard something good about you." The forms can be generated by any employee who passes the note on to his or her supervisor who then routes it to appropriate department managers. The employee receives a handwritten note from Solecki. "At first, I didn't know how effective these notes would be, but I get calls from employees telling me that I made their day. I also see the notes posted in their cubicles."

Employees have potluck dinners, raise funds for local charities, and receive special recognition at quarterly events, Solecki says.

The key is to create a culture of respect and appreciation, he says."If the nurse enjoys working with the patients and being around the coworkers, he or she isn't going to leave for another 50 cents or dollar an hour."

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It takes flexibility to manage end-of-life pain

When medication doesn't succeed, trial, trial again

The goal of pain management is the same, whether patients are at the end stage of life or are recovering from surgery.

"In all instances, the goal for pain management should be to help the patient be as comfortable as possible while keeping the patient as safe as possible," says **Ann Quinlan-Colwell**, RN, MS, CHPN, HNC, advanced practice nursing team leader for the pain / stress / palliative care team at Duke University Health Systems in Durham, NC.

However, pain management is very individualized. Some people don't want any pain; others want some so they know they are still alive or want to be comfortable but alert. "I like to tell hospice patients that they are the directors and we are the supporting cast, and our goal is to help them to live every day the best and most comfortable that they can," Quinlan-Colwell says.

While the goal may be comfort, often it takes more than medication to ease the pain at the end of life. Psychological and spiritual issues can compound the suffering, says **Justin Engleka**, MSN, CRNP, CHPN, nurse practitioner in the palliative care and chronic pain service at the University of Pittsburgh Medical Center. "Anxiety, worries, and concerns about death itself or loved ones left behind all add to the whole component of suffering."

Therefore, while pain medicine is used to control the physical part of pain, spiritual counselors or clergy and experts from behavioral medicine also are involved in pain management because anxiety and worry can exacerbate pain.

To determine patients' needs in these areas, they are asked about spiritual issues, such as what religion they are and its importance in their life during the initial screening. A symptom assessment scale touches on several psychological factors such as anxiety and depression. Sometimes, these issues come up in conversation as well, prompting a referral to the appropriate health care professional, Engleka says.

Individualize pain assessment

For end-of-life patients, the pain assessment must be very individualized with the frequency determined by the patient's condition and needs. "End-of-life care is very fluid and needs to be flexible to meet the needs of the individual patient and family," Quinlan-Colwell says.

Generally, pain scales are used, and if the patient becomes noncommunicative, pain management goals are based upon what patients have previously established. Also, the care team pays close attention to the patient's nonverbal communications such as facial expressions, hand movements, vital signs, and irritability, she says.

Pain assessment can be more difficult toward the end of life, not only when patients are less responsive but when they are concerned that medication may be used to slow down body functions and hasten death, says **Linda E. Hood**,

RN, MSN, AOCN, oncology clinical nurse specialist at Duke University Health Systems.

Also, the assessment is complicated by other changes at the end of life. For example, patients may have some dementia or delirium that comes at end of life but can be attributed to the medications they are on as well. "It takes small trials and changes in medication to determine the cause," says Hood. If one change doesn't work, another must be tried until it can be determined what is going on with the patient, she says.

Confusion also can result as a side effect of some medications, and family members usually want the patient to be as alert as possible. "This may require negotiating and adjusting medications. It also may mean using a combination of preparations to reduce the confusion with optimal analgesia," Quinlan-Colwell says. Often, nonpharmacological interventions can help ease pain and relieve confusion. They also complement a medication regimen to bring comfort. They might include relaxation exercises, progressive muscle relaxation, breathing strategies, touch therapies, and guided imagery.

Communication between the health care team and the patient is critical for pain control. "We teach patients that their pain should be treated. Often people feel they are complainers or they don't want to be a bad patient, so they are reluctant to really communicate with their health care providers," says Engleka.

It's also important for people to get teamed up with the person on the health care team that has expertise in treating pain but whom they feel comfortable with, he says. This could be the oncologist, a palliative care hospice specialist, or the patient's primary care physician. This enhances communication.

It is possible to keep pain for terminally ill patients under control if there is frequent and open communication with the patient, family, care team, and physician, Quinlan-Colwell says.

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Q&A: Learn the difference between anthrax and flu

Q. Influenza and inhalation anthrax can have similar symptoms. Does the Centers for Disease Control and Prevention (CDC) recommend getting a flu shot to help diagnose anthrax?

A. A person should get a flu shot only to prevent the flu. CDC does not recommend a person get the flu shot so doctors can tell whether the patient has the flu or anthrax. Many illnesses (including anthrax) begin with flu-like symptoms, which include fever, body aches, tiredness, and headaches. In fact, most illnesses with flu-like symptoms are not the flu or anthrax. Using the flu vaccine is the best way to prevent the flu and its severe complications, especially among those who are at the highest risk (e.g., people older than 65 years old or younger people with chronic disease such as diabetes or heart disease). The flu shot can prevent 70% to 90% of flu infections, but it will not prevent illnesses with flu-like symptoms caused by anything other than influenza.

Q. Is there a way to distinguish between early inhalational anthrax and flu?

A. Early inhalational anthrax symptoms can be similar to those of much more common infections. However, a runny nose is a rare feature of anthrax. This means that a person who has a runny nose along with other common flu-like symptoms is by far more likely to have the common cold than anthrax. Most people with inhalational anthrax have high white blood cell counts and no increase in the number of lymphocytes, but people with infections such as flu usually have low white blood cell counts and an increase in the number of lymphocytes. Chest X-rays also are critical diagnostic tools, which show that all patients with inhalational anthrax have some abnormality, although for some patients, the abnormality is subtle. CT scans can confirm these abnormalities.

Q. Is there a quick test doctors can use to tell if a person has anthrax or an illness like the flu?

A. Some influenza detection tests give results fairly quickly. However, these tests are not perfect and are not appropriate for every patient. Rapid influenza tests can provide results within 24 hours; viral culture provides results in three to 10 days. However, as many as 30% of samples that test positive for influenza by viral culture may give a negative rapid test result. Some rapid test results may indicate influenza when a person is not infected with influenza.

Q. How many cases of flu and anthrax occur each year?

A. Each year, several tens of millions of people get "influenza-like illness" from many different infections during the fall and winter months. This happens every year and is expected. These illnesses are due to many different viruses and agents, including influenza viruses and common cold viruses. By contrast, few people ever get anthrax. Since October 2001, when the first cases of inhalational anthrax related to bioterrorism were diagnosed, only 10 cases have occurred in a few communities, and most of those cases occurred within particular groups of people (e.g., postal workers). Inhalational anthrax has not been diagnosed in most communities in the country.

Source: Centers for Disease Control and Prevention, Atlanta.

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Getting to the root of the staffing shortage problem

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

Agency managers diligently are trying to work the kinks out of the prospective payment system (PPS). After some of the current difficulties providers are encountering during early implementation of PPS are resolved, it appears that the industry may stabilize.

As providers look forward to a less difficult environment in which to conduct business that will allow time for diversification and other endeavors crucial to the future of home care, the home care industry may face a barrier to continued growth and development in the form of staff shortages. Specifically, lack of staff to provide services to all patients who are appropriate for home care may slow the development of the strong home care industry that many providers envision.

There is a great deal of speculation about why agencies are experiencing staff shortages, especially with respect to RNs and home health aides. Some managers blame implementation of the interim payment system (IPS) and resulting reductions in the numbers of visits home care agencies can make. Staff were laid off and now may be reluctant to return to a segment of the health care industry that they view as volatile and uncertain. Others point to the increased paperwork needed to complete the Outcome and Assessment Information Set requirements as the reason why agencies may have difficulty hiring necessary staff.

But it appears that there may be something more fundamental that accounts, at least in part, for the lack of availability of staff. Specifically, many nurses have stated that they were taught in nursing school that their only job was to take care of people. The costs of care provided, levels of reimbursement, and availability of reimbursement to cover services rendered were issues that nurses were taught did not require their involvement. In other words, nurses were taught to "think" only with their hearts when providing care to patients.

The idea that nurses' only job were to care for patients who need their help was reinforced by the cost-based reimbursement system of the Medicare Home Health Benefit that was in effect prior to passage of the Balanced Budget Act of 1997 and implementation of IPS and PPS. That is, agencies were rewarded under cost-based reimbursement for serving as many patients as possible and for making as many visits as possible to their patients. Under this reimbursement system, nurses could do exactly what they were trained to do in nursing school — take care of patients without regard to cost.

In view that nurses are the gatekeepers of the Medicare Home Care Benefit, implementation of IPS and PPS required a fundamental shift in the focus of home care RNs. Specifically, it became clear that nurses and aides must become conscious of the costs of providing care to patient. Instead of

focusing solely on quality of care, field staff must learn how to provide quality, *cost-effective* care. In other words, they must use case management skills more intensively than ever.

This new focus for home care staff is inconsistent with the reason many nurses chose their profession and what they learned in their professional training. The need to focus on the costs of care, in addition to quality, is unacceptable to many nurses. In fact, this shift in thinking is so difficult for some staff that they will not be able to accomplish it. When combined with some of the other reasons mentioned above, nurses may conclude that they no longer wish to work in home care.

This point of view is understandable and deserves our support. We are asking nurses to fundamentally change their perspective with regard to their profession. Previously, home care nurses could say: "Give us your tired and poor, those yearning to be cared for and whatever the problem is, we will fix it. Had a dysfunctional family for 30 years? Don't worry. We will call in a social worker, and in three short visits, we will solve the problem." The ability to meet the needs of patients without regard to cost and other factors consistent with many nurses' view of their profession made it relatively easy to work in the home care industry.

Now, under PPS, nurses are being asked to meet different goals: to provide quality, cost-effective care. At least initially, these two goals seem inconsistent to many nurses. Concerns about costs seem to get in the way to providing quality of care.

On the contrary, the goal for nurses under PPS must be to gain an understanding that quality of care and cost-effectiveness are consistent with each other. Agencies can provide care to patients that meets both of these goals. Nurses must now think with both their heads and their hearts.

Managers need to hear these and other concerns from staff and work to resolve them to solve staffing difficulties. A useful practical strategy may be to establish a policy and procedure that requires staff who wish to resign to meet with the administrator of the agency prior to terminating their relationship with the agency. When managers can be responsive to professional and other concerns, they are likely to make some inroads in reducing the transient nature of staffing and home care. Retention of existing staff will help to relieve staffing difficulties.

Lack of staffing presents new challenges for home care providers. As nurses learn to use both their heads and their hearts, as opposed to only their hearts, support for staff in the face of fundamental change will help agencies meet this challenge.

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Conference replays offer educational opportunity

Have you missed one of American Health Consultants' recent audio conferences? If so, two upcoming conference replays offer another opportunity to take advantage of excellent continuing education opportunities for your entire facility.

Disaster Response at Ground Zero: How NYU Downtown Hospital Handled Mass Casualties With All Systems Down, originally held Jan. 10, takes participants to the heart of the World Trade Center disaster on Sept. 11.

Just a few blocks away from the crash site, NYU Downtown was cut off from crucial lifesaving supplies and power, even as hundreds of injured came through the emergency department doors. HazMat teams on the roof of the hospital had to vacuum all of the debris out of air ducts to maintain air quality and keep generators running. Physicians and nurses had to balance urgent care with proper documentation.

Learn how to prepare your facility for the unthinkable. The replay will be available from 8:30 a.m. on Tuesday, April 16, until 5:30 p.m. on Wednesday, April 17. Current AHC subscribers pay $249, which includes free CME and CE credit. The cost is $299 for nonsubscribers.

On April 23 and 24, **What to Say When Something Goes Wrong: Do the Right Thing When Trouble Strikes** also will be available for replay. This successful audio conference covers the major fear factors clinicians experience when confronting issues of medical disclosure. Learn benefits for both patient and provider, as well as the risks of litigation and how to avoid costly legal battles. Free CE for your entire facility is included in the $249 fee for AHC subscribers.

To register for either one of these replays, contact American Health Consultants' customer service department at (800) 688-2421. Customer service representatives will provide you with all of the necessary information on dial-in procedures and how to download conference handouts and material on line. ■

Group purchaser requires bar codes on medications

In an effort to reduce medical errors, Premier Inc. in Springfield, VA, which operates one of the nation's largest group-purchasing organizations serving hospitals, will require group contracts that cover medications and biological products to have consistent product numbers and unit-of-use bar codes.

By requiring scannable bar codes for hospital pharmaceutical products similar to those used on grocery items, "medication errors in hospitals will be reduced with more assurance that patients get the right medicine at the right time in the right dosage," says **Howard E. Sanders**, a Premier executive responsible for group purchasing.

The move also should reduce costs in the hospital supply process, he says. Premier will implement the new requirement for product numbering and bar coding as current group contracts for existing pharmaceutical products expire, Sanders says. A leading alliance owned by not-for-profit health systems, Premier provides group-purchasing services for approximately 1,600 hospitals. Premier members purchase more than $14 billion a year in supplies and equipment through Premier group contracts, including more than $6 billion a year in pharmacy products.

Premier has about 150 group contracts in place for pharmaceuticals, covering more than 12,000 items. The Department of Health and Human Services earlier announced that it expects to propose a rule next year requiring the bar-code labeling of hospital-administered medications and biological products.

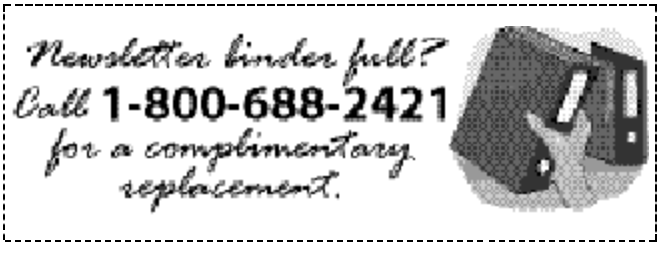
"Premier's decision to move in advance of any regulation was made out of a commitment to patient safety," Sanders says. "We know this technology can save lives, and we won't wait to see if a regulation is approved to make sure it is available to our hospitals and the patients they care for."

Premier will make its support of unit-of-use bar coding clear to the companies that supply pharmaceuticals to its members, and it will urge those companies to become early adopters of this technology. Starting in 2003, when the bulk of current contracts expire for existing products, Premier will make implementation of unit-of-use bar coding a requirement of all new and renewed contracts, he says. Premier also expects to move toward requiring bar codes for medical devices and medical-surgical supplies in the future. No timetable has been set for group contracts in those areas, since their contracting periods vary.

"We understand that implementing unit-of-use bar coding will not be a simple task," Sanders says. "For companies that have not undertaken such approaches, implementation may necessitate process changes in both the clinical and manufacturing settings, perhaps even the retooling of internal and external information and manufacturing systems. Although some manufacturers and suppliers have concerns regarding such an investment, we believe the lives saved and ultimate supply-chain savings clearly outweigh any initial investment."

Premier will work closely with its business partners to facilitate the bar-code implementation, Sanders says, and it will also support streamlining of Food and Drug Administration approvals related to labeling changes.

In addition to improving safety and cutting costs, the use of bar coding would improve the ability of individual hospitals to track their data to improve the quality of patient care over time, according to **Bert Patterson**, vice president of the Premier Contracting Center of Excellence, and a clinical pharmacist. Many Premier member hospitals pool clinical, financial, and operational data in the alliance's databases, and hospitals compare performance indicators to identify areas for improvement. ■



COMING IN FUTURE MONTHS

- How to deal with out-of-state physicians
- Using patient satisfaction surveys
- The basics of workers' compensation
- Prepouring meds: You might want to rethink your policy
- Joint Commission compliance issues

NEWS BRIEFS

CAH numbers experience a big jump in past year

The number of critical access hospitals (CAH) increased 69% in 2001, as struggling rural hospitals identify the program as a means toward financial viability.

The number of CAHs jumped by 211 in 2001 to a total of 526, according to information from the Centers for Medicare & Medicaid Services database. Another 10 hospitals had been designated CAHs by late January 2002.

Nebraska and other Great Plains states continue to lead the nation in number of facilities. Nebraska has 54, followed by Kansas (40), Iowa (32), North Dakota (24), and South Dakota (23). Iowa saw the biggest increase in the number of CAHs in 2001, adding 20. Minnesota and North Dakota each added 14. ▼

HIPAA is top concern, say hospital IT leaders

Information technology (IT) leaders at health care institutions say their top priorities for the next year are upgrading security to meet Health Insurance Portability and Accountability Act (HIPAA) requirements and building systems that promote patient safety and reduce medical errors.

An audio conference from the Publishers of Healthcare Risk Management, Hospital Employee Health, Hospital Infection Control, Drug Utilization Review, Hospital Peer Review, ED Management, and Same-Day Surgery

AVOIDING MEDICATION ERRORS:
Saving Lives, Time, and Dollars

Thursday, April 18, 2:30 to 3:30 p.m., ET
Educate your entire facility for one low fee including FREE CE or CME!

Presented by Leilani Kicklighter, RN, ARM, MBA, DFASHRM, and R. Stephen Trosty, JD, MA

Medication errors are a terrifying fact of life. It's estimated that more than 7,000 people annually die in hospitals from medication errors and that 16% of all medical errors come from errors in medication. As if the cost in lives is not horrifying enough, the cost in dollars and to reputations can be staggering.

In this audio conference, two highly experienced risk managers will:
- Give practical strategies and advice on how you and your facility can avoid medication errors
- Provide tips on how you can avoid the damage medication errors can cause to your patients and to your institution
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Invite as many participants as you wish for the low facility fee of just $249 for AHC subscribers and $299 for non-subscribers, and each participant will have the opportunity to earn CE or CME.

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American Health Consultants is accredited by the Accreditation Council on Continuing Medical Education (ACCME) to provide continuing medical education for physicians.
This CME activity was planned and produced in accordance with ACCME Essentials.
At the conclusion of this audio conference, participants will be able to describe how to develop procedures that will help them prevent medication errors.

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THOMSON
AMERICAN HEALTH CONSULTANTS

The findings are from the annual IT survey conducted by the Chicago-based Healthcare Information Management Systems Society (HIMSS).

About 60% of the responses listed compliance with security-related provisions of HIPAA as the greatest concern, while 46% are working on error reduction and patient safety. Forty-two percent planned to upgrade inpatient clinical systems.

The survey also suggested there is sharply increased desire from last year for acquiring enterprise resource planning (ERP) systems that promote efficiency within the hospital. Fifty-eight percent of respondents identified ERP systems as important to their organization over the next couple of years, compared to 11% in 2001.

Deploying Internet technology, on the other hand, while last year's second highest IT priority, decreased eight points on this year's survey. The projected importance of Internet technology over the next two years decreased 14 points and reduced demand for Internet-based solutions. Only 38% of respondents identified web applications as important in health care in the next two years, down from 50% in 2001.

"I see a narrowing of focus in health care to initiatives related to quality and cost," says **Charles O. Bracken**, executive vice president of Superior Consultant Company, which sponsored the survey. "Web strategies are being limited to those emphasizing practical application and positive business impact." ▼

Software vendors say they're ready for HIPAA

Most of the leading health care information technology (IT) software companies expect their products to be Health Insurance Portability and Accountability Act (HIPAA) compliant by the October 2002 deadline.

That's the conclusion of a study by the Chicago-based Healthcare Information and Management Systems Society that surveyed 28 leading health IT companies on the compatibility of their products with the HIPAA's Transaction and Code Sets Rule.

Data on 25 software products was collected, representing 4,700 installations in industry segments such as hospitals, ambulatory care, professional practice settings, payer organizations, and sub-acute care facility markets. ■

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CE objectives

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

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

Correction

The *Home Health Business Quarterly* supplement in the January 2002 issue of *Hospital Home Health*, incorrectly reported that New York Health Care (NYHC) in Brooklyn, NY, had completed a deal to buy the Bio Balance Corp. The purchase of Bio Balance by NYHC is not yet complete. ■