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the monthly update for executives and health care professionals

IN THIS ISSUE

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Don't ignore biological, terrorist threats in your emergency plan

A flexible plan that can adapt to all situations works best

(Editor's note: This is the second of a two-part series that takes a look at why health agencies should address the threat of bioterrorist events. Last month, we looked at the most recent information from the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices in relation to vaccination for smallpox and first-response teams. This month, Hospital Home Health *examines how home health agencies should incorporate bioterrorism into their emergency-response plans.)*

What would you do if a field nurse reported an unusual rash on several of her patients? What would you do if a bomb caused the closure of major roads usually traveled to reach your agency's patients? How would you stay in touch with field staff and patients if cell phones no longer worked?

These are just a few of the questions home health managers should be answering in their emergency plans. Other time-consuming, immediate concerns such as new federal regulations, staffing shortages, and financial pressures, however, have kept many agencies from reevaluating their emergency plans, says **Barbara B. Citarella**, BSN, MS, CHCE, president of RBC Limited, a home care management consulting firm in Staatsburg, NY. "Agencies in some areas, such as New York City, have been at the forefront of putting plans into place, but we are still educating most agencies about the need for planning," she adds.

Although all agencies have some sort of emergency plan to address specific events, what is needed now is an overall, comprehensive plan that takes into account myriad communications, infection control, and coordination issues, says **Cynthia Muller,** RN, BSN, CIC, vice president of operations for RBC Limited. "In general, home health agencies are not prepared for a catastrophe that goes beyond natural events with which we are familiar," she says. "Agencies need to be able to address emergencies with a biological, radiological, or chemical threat as well as emergencies that hinder travel and communication," she adds.

"We have always had a basic emergency plan, but on Sept. 11, 2001, we realized that it did not adequately address some of our needs," says

Orael M. Keenan, RN, MSN, chief executive officer of Visiting Nurse Association of Long Island in Garden City, NY. "Communication was our biggest obstacle," she says. The combination of damaged transmission towers and the volume of calls people tried to make made cell phones and beepers useless, she says.

Because the agency staff had to rely upon telephone land lines, they realized that many of the family contact numbers included on the medical records of priority one patients were cell phones.

"Nurses would arrive at the homes of patients to find them gone. With no way to contact the patient or family members, nurses had to leave notes on the doors, asking someone to call the agency to let them know where the patient was," she says. In all cases, concerned family members had taken the patients to their homes, but did not know how to alert the home care agency, she adds.

The number of roads closed during the days following Sept. 11 also created problems because direct routes to patients' homes sometimes weren't available, and staff members didn't always know direct routes, Keenan says. "We now require all nurses to have up-to-date maps in their cars," she says.

Security concerns following any type of attack also make it necessary for home care workers to have proper identification, Keenan says. "Not only did we make sure our employees have their VNA identification badge, but we also made up VNA of Long Island signs for them to place in their cars," she adds.

Although home care agencies won't be the recipients of patients directly involved in biological or other terrorist attacks, they must be ready to take mass admissions as hospitals clear out their beds to take new patients, Citarella points out. "The emergency plan should address mass

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Emergency Planning Resources

- ***Guide to Emergency Management Planning in Health Care***.
  Published by the Oakbrook Terrace, Ill-based Joint Commission Resources, a subsidiary of the Joint Commission on Accreditation of Health Organizations, the book provides practical advice on revising and implementing an emergency management plan that is flexible enough for a variety of disasters. Information on collaboration with other agencies, creation of communications channels, and training and management of staff during an emergency are addressed. The publication is available for $60. Orders can be made by telephone at (630) 792-5800 or on-line at www.jcrinc.com. Use the order code EMPHC-01 when placing an order.
- ***California Hospital Bioterrorism Response Planning Guide 2002***.
  This guide, published by the California Department of Health Services, Licensing and Certification Program in Sacramento, CA, is geared to hospitals but contains information that home care agencies can incorporate. A variety of biologic agents such as smallpox, anthrax, brucellosis, botulism, tularemia, viral hemorrhagic fever, Q fever, and plague are described. Symptoms, treatments, and incubation periods for each are described as well as proper precautions to use for each suspected disease. Screening forms also are included. The plan can be found at www.dhs.ca.gov/lnc/index.htm.

Patient education crucial for emergency planning

Make sure patients have the essentials

As you let your staff members know about changes to your emergency plans, don't forget that patients also need information, says **Rita Lapham**, RN, director of patients services and owner of Golden Age Home Health in Oklahoma City.

It's not necessary to create many of the materials, Lapham points out. "We use pamphlets from the [American] Red Cross that address natural disasters as well as terrorist attacks and anthrax exposure," she explains.

Because patients are likely to experience weather-related emergencies, the admission packet also includes emergency supply checklists that help patients and families prepare for tornadoes and their aftereffects, Lapham says.

"We want to make sure that patients have essentials such as flashlights, extra batteries, and drinking water," she says. "Whenever I'm in the field, I also check to make sure patients' portable oxygen tanks are full and that patients know to call a family member to come and get them if they lose electrical power."

Another important part of the patient education packet is a list of community services such as the American Red Cross, fire departments, police departments, emergency management offices, senior citizens services department, and other places that a patient might need to contact during or after an emergency, Lapham says. When developing this type of list, also include the telephone numbers of gas and electrical companies that serve your area as well as water department emergency numbers, she adds.

Lapham provides information on how to contact her agency if the patients leave their homes to go elsewhere during an emergency.

"We also make a list of the supplies patients should carry with them if they go somewhere else," she says.

Patients and their family members should know to carry items such as wound care supplies, medications, oxygen, and diabetic-testing supplies with them when they go elsewhere, Lapham adds. ■

admissions from every aspect," she says.

The policy should limit calls for admissions to emergency calls from hospitals involved in the disaster, and multiple referrals should be handled in one call, she suggests. Also, a supply of 100 admission packets with streamlined documentation should be on hand, she adds.

When you are updating your emergency plans, don't forget patient education, suggests **Rita Lapham**, RN, director of patients services and owner of Golden Age Home Health in Oklahoma City. "We have looked carefully at our admission packet to make sure it contains information that patients and their families need in an emergency," she says. **(See related article on patient education, above.)**

Because some staff members may not be able to get to the office during an emergency, it's important to make sure all information related to the patient is in a central place that can be accessed by any employee, Lapham says.

"We have one place on the patient's chart that includes all emergency numbers for that patient," she says. The telephone numbers collected are for the next of kin, an alternate for the next of kin, any equipment companies that provide services to the patient, and the patient's physician.

"We make sure we get land-line telephone numbers, and we keep it on the paper chart because a power failure doesn't affect your ability to read a chart," she adds.

It's also important to set up alternate sites for employees to meet in case the office is not accessible, Citarella says. Make sure all employees know where to meet and that they have directions to the site as well as alternate telephone numbers, she adds.

Notifying staff during an emergency can be tricky, Citarella admits. While it is important to designate a radio station for employees to monitor for information on reporting to work, the best way to make sure your employees are notified is by telephone. **(See article on telephone notification, p. 124.)**

Be sure your plan also spells out how you are going to go back and pick up patients whose visits you delayed, Muller says. "It's important to make sure that you don't let any patients fall through the cracks."

Biological, chemical, and radiological emergencies carry their own set of needs that home care agencies typically have not addressed, she says. Dealing with the infection control issues of these types of emergencies can be cumbersome. "Rapid response is essential, so it is important to designate one nurse who knows what to report, to whom to report, and how to handle the patient," Muller says.

In an emergency, make sure your staff can be reached

Make sure your calls get answered

During an emergency, you want to make sure you can call employees to ensure adequate staffing. While telephone notification is the best way to alert employees that they are needed, not all home health agencies have a plan that works, says **Barbara B. Citarella**, BSN, MS, CHCE, president of RBC Limited, a home care management consulting firm in Staatsburg, NY.

"One of the first steps is to make sure you have an up-to-date, accurate organizational chart," she recommends. In some large agencies, employees who put the emergency plan into action may not know who works for whom. A good organizational chart is important if the primary person to contact for one area is not available and the emergency coordinator must contact the next person in line, she adds.

When you are setting up your emergency notification call list, be sure you have telephone numbers for all independent contractors and per-diem staff, Citarella suggests. It may be necessary to call on them if your regular staff cannot work because of their own family situations during the emergency, she adds.

The notification plan is one part of an emergency plan that can and should be tested regularly, Citarella says.

Call everyone on the list, explain that it is a drill, and ask that they call the emergency coordinator as soon as they get the message, she suggests. At the time of callback, the coordinator can make a note as to the staff member's availability and evaluate how many staff members would be on hand for a real emergency.

At the same time, check to see if you can place your hands on a current patient roster that includes telephone numbers, priority status, and geographic location without the help of computers or electricity. "Too many agencies rely upon computers to store their rosters," Citarella says.

If power is lost, or if employees can't get to a computer to access the roster, agency personnel may miss patients, she points out. ■

Not only do home care staff members need to know whether or not to use standard precautions or universal precautions, they also need access to respirator masks, gowns, and gloves, she adds. The nurse also needs to know who has push packs, or large-volume shipments of vaccines, medications, and other related supplies for biological emergencies, she says.

"I don't think most home care agencies can do their biological emergency planning by themselves," Keenan says. "I think it's important to talk with experts, such as consultants in emergency planning, infection control, and biological threats, to make sure your plans are reasonable and effective."

As the events of 9/11 have demonstrated, not all emergencies are handled by only one or two community agencies, so it is important to make sure you're involved in any communitywide planning effort, she says.

Although many communitywide emergency planning committees include hospitals, they may not include home care agencies, so it's up to the agencies to find out what is going on and how they can get involved, Lapham says.

Most importantly, keep in mind that your employees may be victims of the emergency, Muller says.

"Be prepared to offer child care to employees whose normal child care is disrupted, and make sure your plans address your employees' safety as well." Also be prepared with names of part-time employees or independent contractors who can fill in the gaps if your employees cannot work due to their own family situations, she adds.

Protecting employees doesn't just refer to field staff either, Keenan points out. As a result of the anthrax attacks, her agency developed a policy that all mail was to be opened in an enclosed area using gloves. "We've relaxed the enclosed area rule now, but our employees still use gloves, and everyone knows to look at all pieces of the mail closely to determine if they appear suspicious," she says. All employees who handle mail also have a list of people and agencies to call if they are suspicious of any mail items, she adds.

While most home health emergency plans will need to be enhanced to reflect today's needs, don't automatically throw out your old plan, Muller says.

"First, evaluate your current plan and perform drills to identify strengths and weaknesses," she advises. "Focus on your needs; make sure infection control is included; keep it flexible; and be sure you can implement it with less than a full staff."

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Many factors are part of making HHA referrals

Discharge planners provide important tips

Hospital-affiliated agencies have it easy. They automatically get every referral from their hospital. Right? Wrong, say hospital discharge planners interviewed by *Hospital Home Health*. In fact, one hospital discharge planner admits that only 30% to 40% of her referrals go to the hospital-affiliated agency.

While discharge planners usually are more familiar with and have a great deal of confidence in their hospital's affiliated home health agency, many other factors must be considered before a referral is made, says **Sandy McFolling**, director of resource coordination at Rush-Presbyterian-St. Luke's Medical Center in Chicago, whose hospital refers 70% of her home health patients to the hospital-affiliated agency. Therefore, home health agency managers cannot assume that their marketing efforts are better spent on other referral sources.

The discharge planners at Henry Ford Hospital in Detroit refer no more than 40% of patients to their hospital-affiliated agency, says **Denise Allar**, RN, director of case management and social work services.

The reasons for not referring to the hospital-affiliated agency are not related to quality or service, but instead to patient or physician preference for an agency with which they had previous experience, a payer's preferred provider list, or a need for a specialized service, she says.

The best thing you can do is to make sure hospital discharge planners know what services you offer and how to reach you, says **Carol O. Long**, PhD, RN, home care consultant for the Capstone Group in Phoenix.

In a study conducted by Long that included a survey of hospital discharge planners in Arizona,[1] she discovered that discharge planners lack information about many home health agencies in their area.

"I was surprised by the misinformation among discharge planners about the prospective payment system, financial constraints on home health agencies that could affect services, the nursing shortage within home health, and the use of telehealth in home care," she says. There also were concerns about weekend and night coverage, and some discharge planners did not know what agencies offered it, she adds.

While discharge planners do want to know what your agency offers, make sure you present the information in a way that helps the discharge planner do his or her job, Allar suggests.

"New agencies have come into our area and given us trinkets and lunches, but that doesn't guarantee that we'll call them with our next referral," she says. "If the patient or physician doesn't have a choice of agency, we will refer to agencies that offer the services we need and that have a proven track record with us," she adds.

New agencies can introduce themselves to Allar's employees through letters and with collateral materials that she distributes. "We don't have agencies come in and make presentations because it is too time-consuming, but we do have vendor fairs once or twice a year at which agencies can display their services," she explains.

Instead of spending a lot of money on brochures for discharge planners, McFolling suggests that home care agencies produce a single page information sheet that lists specialty services provided by the agency, payer plans in which the agency is a preferred provider, geographic boundaries, a telephone number that is answered by a person at the agency (not a recorded message) seven days a week and at night, and an explanation of the type of weekend coverage provided.

Having a telephone number that is answered by a home health agency employee is important, McFolling says. "I prefer not to leave messages with an answering service." She suggests that home health agencies have a staff member on call to answer a cell phone that is for weekend or night referrals. An answering service should have the capability to connect the caller directly to the staff member on call, she adds.

Discharge planners are interested in one-stop shopping, Long says. "They want to make one telephone call and know that the patient will be seen in a timely manner and all home medical equipment needs will be arranged," she says. "A discharge planner does not want to get a call from the patient asking why the visit hasn't occurred several days after discharge," she explains.

"Feedback is important," McFolling says. "It is nice to get a brief report that the patient was seen and that a plan has been developed and the patient is doing well."

It is important to let the hospital discharge planner know if there is a problem, she adds. "We want to know about re-hospitalizations, errors in the discharge orders, or patients who went home without medications. We need to know if the picture we painted of the patient was wrong," she says.

When you are introducing your agency to discharge planners, be sure to ask how they want to get information, McFolling suggests. "E-mail updates are a great, efficient way to let us know if an agency is adding services or changing telephone numbers or hours." Faxed notes also are another easy way to communicate, she adds.

Although most discharge planners don't have time to hear a presentation on an agency's services, one agency in Allar's area provides inservice education with continuing education units (CEUs). "The topics cover infectious disease, adult protective services, and disease management," she says. The home health agency uses a meeting room in the hospital and offers the course during lunch. Because RNs must earn CEUs to maintain their license, this is a great way for an agency to demonstrate its clinical competence and help discharge planners maintain their professional licenses and stay up to date on current issues, Allar explains.

Allar can't overemphasize the need for home health agencies hoping to get hospital referrals to offer weekend and evening service. "It is critical for my staff to be able to refer patients to home health on the weekends. We know who can and can't accept weekend referrals, and we know which agencies will see new patients on a Sunday and deliver equipment on Sundays," she says.

"Agencies that are able to handle referrals on weekends and weekdays are more likely to get the weekday referrals because the discharge planners know they can depend on good service," Allar adds.

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Reference

1. Long CO. *Meeting Community-Based Care Needs in Arizona.* Phoenix: St. Luke's Health Initiative, School of Public Affairs, Arizona State University; 2002. ■

Are your ads falling flat? Try a different approach

Headlines are key to success in Yellow Pages ads

Read the following statements and see if any sound familiar:

"After years of paying outrageous rates with no returns, we dropped our display ads."

"Yellow Pages ads may be good for private-duty agencies, but not us."

"I don't think we've received any referrals from Yellow Pages ads."

Advertising in the phone book isn't cheap. For some agencies, it represents a major part of their marketing budget, but many home health agency managers still don't believe it is an effective expenditure of money.

"Yellow Pages advertising can be effective for home health agencies," says **Adam D. Bishop**, MBA, partner in The ADAM Group, a marketing firm located in Franklin, TN. The problem with most home health agency ads is that they look like everyone else's ad, he says.

"Look in the home health section of any Yellow Pages directory, and you'll see a logo at the top, services listed as bullet points, and a telephone number at the bottom. There is no way for a consumer to differentiate between agencies or tell what is unique about your agency," he says.

One reason many ads look the same is that home health managers let the directory staff design the ad. "It's important to remember that

the directory employees are there to sell space, not design ads, so they will use the same, simple design whenever possible." Bishop recommends that agencies use their own ad designer and test the ad in local newspapers or magazines before running it in a Yellow Pages directory.

Test an ad by running it locally and making sure you have a "call to action" in the ad, he says. A call to action can be anything from calling the office to request a brochure, receive a free assessment for Medicare qualification, reach a prerecorded message with educational information about home health, or register for a seminar that presents information on a timely, home health-related topic. Without a "call to action," you never will know who is reading your ad, and you may not get a chance to interact with them, he points out.

Evaluate response to the ad by tracking the number of responses, Bishop says. The next time you run the ad, change one variable such as the headline, the call to action, or the description of services. Don't change more than one variable at a time during your testing, or you won't know what causes response to increase or decrease, he says.

Once you've found the right combination of the headline, body copy, and call to action, use that as your Yellow Pages ad, he advises.

When you're designing your ad, remember that the headline is an ad within an ad, Bishop says. Use a headline that describes the unique benefit you offer consumers, and move your logo to another location, he adds.

In the body of the ad, don't just list services that everyone offers, Bishop explains. "Talk about your uniqueness; tell readers that you have bilingual services, staff on call 24 hours, or specialty services such as pediatric or cardiac care."

The people looking through Yellow Pages for information about home health agencies are not just private-duty patients, he says. Elderly adults or their family members may be evaluating options if they anticipate the need for home health or want to change providers, he adds.

"It's important to remember that 60% of the people who go to the Yellow Pages for information do not have a provider in mind. Of the 40% of the people who have a provider in mind, 20% can be swayed to make another choice." For this reason, your ad should contain useful, informative descriptions of the services that make your agency different, he points out.

Bishop recommends that home health clients have prerecorded information that consumers can call 24 hours a day. "If someone is looking through the Yellow Pages after business hours and sees that he or she can call a number and get more information about home health, [that person] will call. If at the end of the prerecorded message, the caller can leave a name or number or be connected to a staff person, you've gotten that much closer to [the caller] choosing your agency," he says.

For the same reason, be sure your web site is listed in your ad, Bishop continues. "Web sites are great resources for providing educational information to potential patients and for giving agency information to potential employees." Give web site visitors a chance to contact you with their names and telephone numbers, he says.

Bishop points out that size of ad and color are not going to increase your visibility as much as a good headline and copy that differentiates your agency. In-column ads are good if you can get your benefit headline in them, but you miss a chance to place a call to action. "Your ad should be self-serving to the patient. Point out why a call to your agency will offer him or her the most benefit," he says.

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Urge diabetics to quit smoking, exercise more

Monitor weight loss carefully

(Editor's note: This is the second of a two-part series that takes a look at diabetes management for home health patients. Last month, we looked at proper diagnosis and clinical management of diabetes for home health patients. This month we examine how lifestyle changes can be addressed in home health.)

For both Type 1 and Type 2 diabetes, weight control, exercise, and elimination of tobacco use are essential for controlling blood sugar levels and minimizing complications, says **Faith Thibodeau**, MS, RD, LD, CDE, a diabetes educator for Visiting Nurse Service in Saco, ME.

Because many Type 2 diabetics are overweight, diet and exercise are very important, she says. "Typically, an overweight diabetic patient can lose 10 pounds and gain greater control of their diabetes, but more than 20 pounds weight loss is not helpful," she says.

The most important part of planning a diet plan for a diabetic patient is to keep the recommendations realistic, Thibodeau says.

"Nurses need to understand that the [Alexandria, VA-based] American Diabetes Association's exchange plan is not suited for the way most people eat," she says. Because most Americans get too much fat in their diet, she suggests that a diet plan for diabetics focus on reducing fat.

Linda C. Pearce RN, C, BSN, a consultant with Diabetes Education Consulting in Blacksburg, VA, suggests that nurses evaluate patients carefully before recommending weight loss. It is risky to put many elderly patients on a weight-loss diet because they need carbohydrates, she says.

"It is important that these patients receive careful meal-planning advice because many elderly patients are undernourished and may not be getting the combination of carbohydrates and other food groups they need," she adds.

Although you might not think your home health patient can exercise, there are activities that can help, Pearce says. "Something as simple as walking around a dining room table and setting a timer to gradually increase walking time can help a patient who can walk," she says. If your patient can't walk, simply rocking in a rocking chair will add some activity to their daily routine, she adds.

Getting your patient to stop smoking also is important, says Pearce. Not only does smoking damage and constrict blood vessels that worsens foot ulcers and leads to other leg and foot diseases, but smokers with diabetes are more likely to suffer from nerve damage, kidney disease, and cardiovascular problems. She also points out that smoking raises blood sugar levels, which makes it harder to control diabetes.

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LegalEase

Understanding Laws, Rules, Regulations

How do you protect your employees from violence?

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

Home care providers owe their employees a duty of reasonable care. That is, they are responsible to take reasonable precautions to protect their employees from harm.

This obligation is becoming far easier to talk about than to fulfill. Agencies must, for example, deal with the potential for violence. The murder of a home care nurse in Maryland, along with the patient and the patient's mother, received national attention from the media. And managers of home care agencies in more rural areas worry about the well-being of staff members in areas that are geographically isolated.

Of course, a key question regarding this obligation on the part of home care providers is: What is reasonable? Reasonableness is determined by what other home care providers are doing all across the country. Whether or not agencies are taking reasonable precautions to protect workers will be judged by comparison to what other providers throughout the country would have done under the same or similar circumstances.

This definition of reasonableness poses particular difficulty for home care providers. There is a lack of data, or even anecdotal information, about how other agencies are dealing with a number of key issues in home care, including protecting workers from harm.

Failure of agencies to fulfill their obligation of reasonable care can take different forms: acts or errors and omissions.

Providers' obligations to employees include a requirement to avoid doing anything that causes injury or damage to them. Agencies will be found to have caused injury to employees if the damage to employees would not have occurred "but for" an act or omission by agencies.

Finally, the primary obligation of agencies is to avoid errors or omissions that cause physical injury

or damage to employees. Courts generally require proof that employees were injured physically, as opposed to only emotionally, in order to compensate them for their injuries.

Agencies that fail to meet their obligations in this regard may be the target of suits for negligence by employees and/or workers' compensation claims. Since occupational health and safety requirements include a general mandate to employers to provide a safe working environment for their employees, agencies also may face Occupational Safety and Health Administration violations when workers allege that conditions are unsafe.

It is important that managers must listen and take action when workers complain about safety hazards.

One of the strengths of the home care industry always has been that staff are willing to go well beyond the extra mile to care for patients. The perception of many who know the industry well is that workers tend to put up with safety hazards that others would not hesitate to avoid. So it becomes essential for supervisors to listen carefully to staff members who complain about safety hazards.

Most staff have a natural inclination to stay in unsafe situations, as opposed to terminating services to patients whose care involves exposure to risk.

Listen to complaints

It also is extremely important for managers to take action in response to complaints by personnel. There is an old legal adage that "every dog is entitled to one bite." This means that as soon as the dog has bitten one person, those responsible for the animal are on notice that the dog is dangerous, and they must take reasonable precautions to prevent further injury or damage.

Likewise, once employees have registered even a single complaint regarding dangers associated with the care of particular patients, the employer is on notice that further care may involve harm to workers. In view of this "first bite," so to speak, agencies must take appropriate action or face almost certain liability for injuries to their personnel.

What kinds of actions are appropriate by agencies? An increasing number of providers are, for example, using off-duty police personnel to accompany home care workers as a result of specific concerns or to areas that are generally viewed as dangerous. They usually are dressed in street clothing, but are armed with concealed guns. These so-called "escorts" have proven to be effective deterrents of injuries to workers.

Some home care personnel, however, have objected to accompaniment by escorts, in the face of situations that clearly warranted such precautions. The basis for their refusal may be that they feel that the presence of an escort interferes with their relationships with patients. They point out that there is an essential inconsistency between the caring and nurturing relationships they wish to foster with patients and their families and the use of armed escorts. Some workers also express concern about their reputations in the community, especially if they live in the community in which they make home care visits.

When escorts are offered and workers refuse them, agencies may be able to avoid liability for resulting injuries by claiming that workers assumed the risk by their refusals of assistance. From the point of view of risk management, a far better tack for agencies to take is establish and implement a policy that workers may not reject escorts when management deems that their use is appropriate.

Refusal of escorts should be defined as insubordination in agency personnel policies and procedures, and appropriate disciplinary action, including termination of employment, should be taken in response to this type of insubordination.

To provide protection for workers, many agencies provide employees with cellular telephones. Use of cell phones enhances the ability of workers to summon help in the event that they encounter danger. Provision of such equipment is rapidly becoming the norm among home care providers.

Termination of services to patients also is an appropriate response to concerns regarding the safety of home care staff members.

Home care personnel knock on the doors of thousands of patients each day unaware of what may be inside the patients' homes.

These unknown risks likely are to become even greater as the use of home care services continues to expand. Managers and field staff must be prepared to deal with a constant potential for compromised safety.

[A complete list of Elizabeth Hogue's publications is available by contacting: Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Telephone: (301) 421-0143. Fax: (301) 421-1699. E-mail: ehogue5@comcast.net.] ■

NEWS BRIEFS

HHS releases final HIPAA privacy regulations

You may be proud of meeting the Oct. 16, 2002, deadline for the transaction standards portion of the Health Insurance Portability and Accountability Act (HIPAA), or you may have successfully filed your request for a one-year extension, but it is now time to look carefully at how your agency will comply with the privacy standards.

The final modifications to the HIPAA privacy rule appeared in the *Federal Register* on Aug. 14, 2002. Some of the most significant changes for home health providers include:

- **Consent.** The previous requirement that written consent of the individual would be required to use or disclose the individual's protected health information for treatment payment and health care operations has been removed.
- **Notice of privacy practices.** Providers must provide patients with a notice of patient privacy rights and make a good-faith effort to obtain patient's written acknowledgement of the notice. If written acknowledgement cannot be obtained, the provider must document its efforts and the reason acknowledgement could not be obtained.
- **Incidental use and disclosure.** Uses or disclosures of a patient's protected information are permitted if they are incidental to an otherwise permitted use or disclosure. They are not considered a violation of the rule if the covered entity has met the reasonable safeguards and minimum necessary requirements.
- **Written authorization.** Only one form for written authorizations is required.
- **Minimum necessary.** The minimum necessary rule no longer applies to disclosures that have been authorized by the individual whose protected health information is being disclosed.
- **Business associate contracts.** The final rule now gives an additional year to change existing contracts to come into compliance.
- **Accounting of disclosures.** It no longer is necessary to account for disclosures that have been authorized by the individual.
- **Marketing.** The final rule requires a covered entity to obtain an individual's prior written authorization to use his or her protected health information for marketing purposes except for

CE *questions*

5. What was the biggest obstacle her agency faced in the wake of 9/11, according to **Orael M. Keenan**, RN, MSN, chief executive officer of Visiting Nurse Association of Long Island?
   A. supplies
   B. claims processing
   C. referrals from hospitals
   D. communication

6. What is the most essential service that home health agencies must provide from a hospital discharge planner's perspective, according to **Denise Allar**, RN, director of case management and social work services for Henry Ford Hospital?
   A. cardiac care
   B. wound care
   C. weekend coverage
   D. comprehensive brochures

7. Why are many Yellow Pages ads ineffective, according to **Adam D. Bishop**, MBA, partner in The ADAM Group?
   A. They are too small.
   B. No photos are used.
   C. Headlines don't promote benefits.
   D. Text doesn't describe unique services.
   E. A and C
   F. C and D

8. Because exercise is important to control diabetes, what does **Linda C. Pearce** RN, C, BSN, a consultant with Diabetes Education Consulting, recommend for patients with limited mobility?
   A. Walk around the dining room table, increasing time each day.
   B. Rock in a rocking chair.
   C. Don't worry about exercise since it may increase risk of falls.
   D. Decrease amount of food eaten to avoid gaining weight.
   E. A and B
   F. B and D

Answers: 5. D; 6. C; 7. F; 8. E

a face-to-face encounter or a communication involving a promotion gift of nominal value.

The Department of Health and Human Services (HHS) has published a fact sheet that summarizes the changes. To download the fact sheet as well as the changes published in the *Federal Register,* go to the HHS Office for Civil Rights' web site: www.hhs.gov/ocr/hipaa. ▼

CMS allows standing orders for vaccinations

Home health agencies now may use standing orders to immunize patients for pneumonia and flu according to a new Centers for Medicare & Medicaid Services policy published in the Oct. 2, 2002 *Federal Register* (Vol. 67, No. 191).

The first sentence of the current requirements in the Conditions of Participation for Home Health Agencies at §484.18(c) now reads:

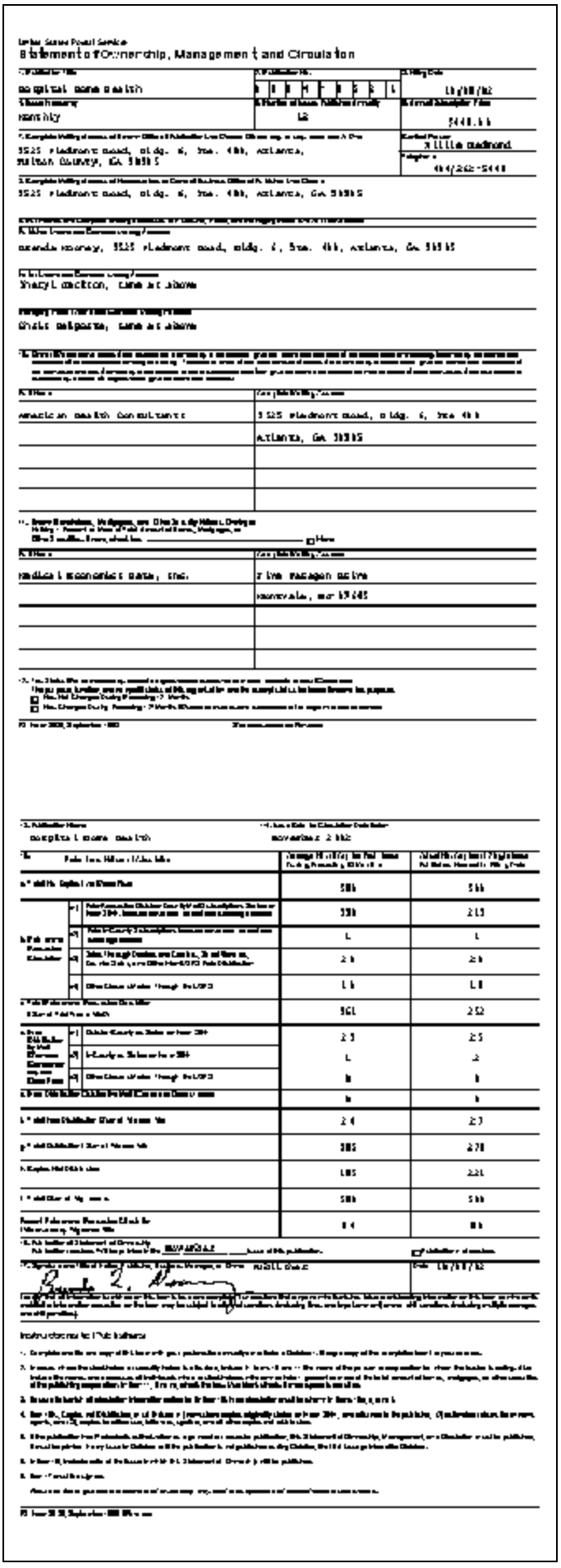
"Drugs and treatments are administered by agency staff only as ordered by the physician, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per agency policy developed in consultation with a physician, and after an assessment for contraindications."

Home health agencies must develop a policy for vaccination standing orders with input from physicians and must develop an assessment protocol so nurses can evaluate patients for contraindications before administering the vaccines.

Although a signed physician order is not needed, home health nurses also must include the immunization information on the patient's plan of care. Prior to this change, a physician order was required for every vaccination administered. The effective date of this change was Oct. 2, 2002. ■

COMING IN FUTURE MONTHS

- Are you testing employees for drug use? What you need to know
- Tips to help you reduce your accounts receivable days
- State inspectors on your doorstep? How to survive the day(s)
- Infection control benchmarks and how to use them
- Pain control for the elderly: Techniques and new information



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Instructions to Publishers

PS Form 3526, September 1998

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. ■

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

Motivating staff, reducing stress: Important for managers

Communication, recognition, and support key to success with staff

With all of the changes and new job pressures experienced by home health employees in just the past few years, how do managers stay energized and motivated? Just as important, how do they inspire their staff members to do the same?

Almost 73% of the respondents to the 2002 *Hospital Home Health* Salary Survey have worked in health care for more than 21 years and more than 36% of respondents have been in home health for more than 21 years. **(See charts, below and p. 2.)**

While these employees have seen the most dramatic changes of all home health employees and may experience more stress as a result of the changes, experts interviewed by *HHH* say that the more experienced employees are not hard to motivate.

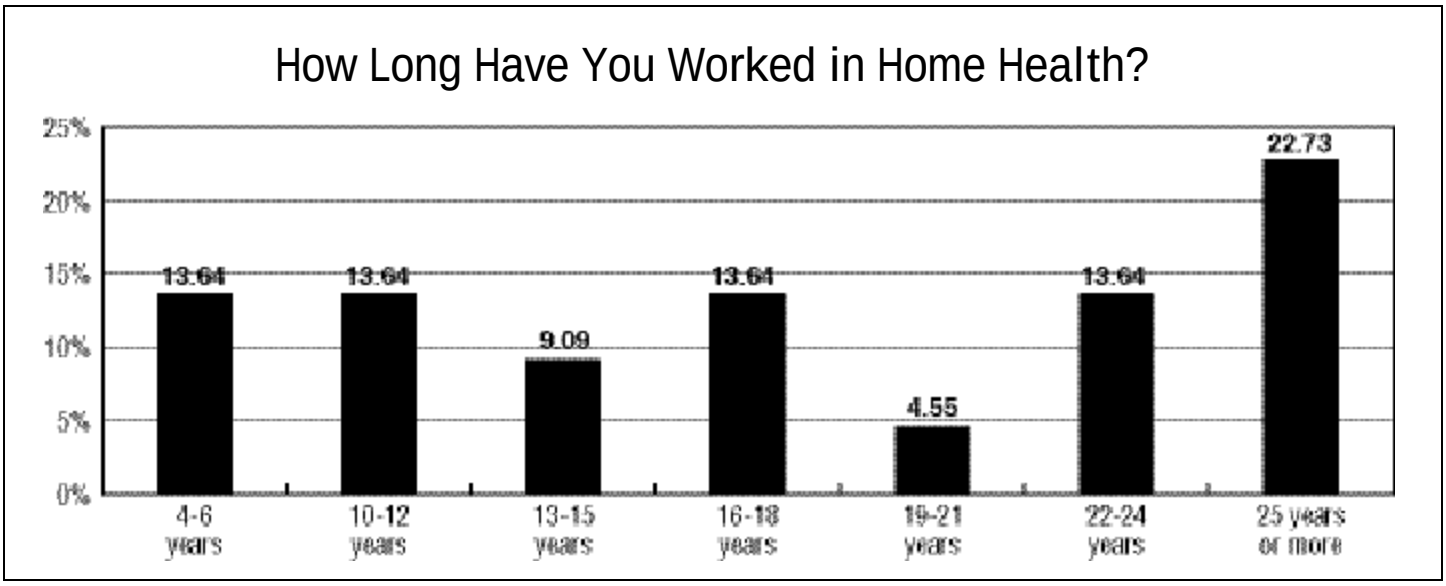
"It is my experience that people who stay in home health really love this area of practice," says **Theresa E. Uhl**, RN, BSN, nurse manager of Southern Home Care in Jeffersonville, IN.

Salary levels, benefits, recognition programs, and a good relationship among employees are important for retention of employees, but the bottom line is that people have to like home health to stay in it, she explains.

Recognize your veterans' contributions

One way to motivate your "veteran" employees is to make sure they are recognized for their experience, says **Greg Solecki**, vice president of Henry Ford Home Health Care in Detroit. "We call upon our experienced employees to act as mentors because they have valuable information and tips to share," he says. "Mentoring also reminds them of their special qualities for which they are appreciated," he adds.

Another way to motivate staff members and



identify areas in which there may be problems that are creating stress or lowering morale, is to make sure your lines of communications are open, Uhl says.

"A number of obstacles we face as managers are caused by communications problems. You can remove some of those obstacles by increasing the levels of communications," she suggests.

"At Southern Home Care, we have a morning report at which we meet as a team to plan our day. Managers, clinical staff, and intake staff meet to listen to on-call report, plan for admissions, problem solve on special issues, and share a 'joke of the day,'" Uhl says.

At this meeting, special recognitions are given to team members who go above and beyond the call of duty and the goals of the agency are reviewed to make sure everyone stays focused, she adds.

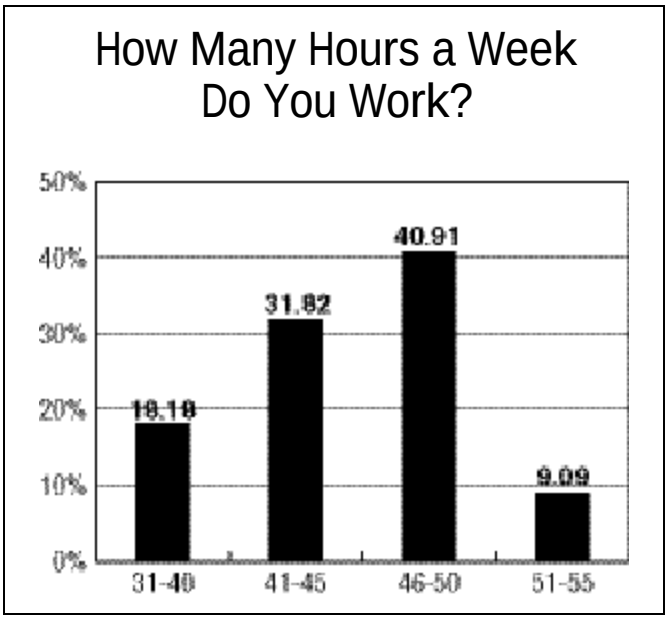
"There is also a Friday team meeting for the weekend team," Uhl explains.

"The group that is working the weekend prepares for the task ahead so that everyone has input on assignments, on-call duties, and patient problems," she says.

Working more hours

Recognizing employees for a job well done is essential for motivation. With home health employees and managers working increasing numbers of hours, it is important to reward them for their extra efforts.

Only 18% of the salary survey respondents report working 40 hours or less during a week, while almost 41% report working between 46 and 50 hours per week. Nine percent of survey respondents report working more than 51 hours each week. **(See chart on hours worked, above.)**

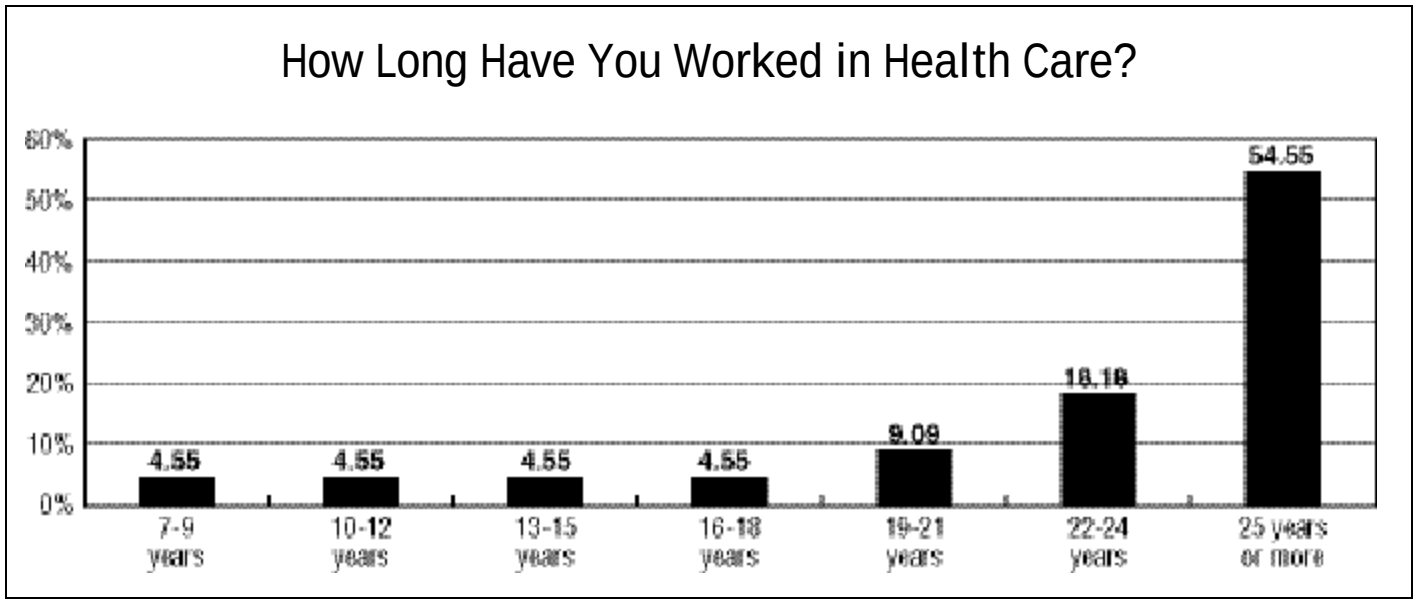


Reducing the burden of paperwork

With an increasing amount of time required for paperwork, Henry Ford Home Health Care has promised, in writing, to staff members that managers and administration will be proactive in trying to reduce regulatory burdens and pursue technological advancements that will improve processes, Solecki says.

"We expect our employees to be happy doing the right thing in their job and have fun while they work," he says.

"We have also promised to acknowledge the



goodness of our employees and celebrate their accomplishments," Solecki adds.

An employee recognition committee at Henry Ford, comprised of employees from all levels and areas of the agency, is charged with making sure that employees are recognized for their efforts, Solecki explains.

"Quarterly potluck dinners with games and prizes, quarterly employee awards for continuing education and quality improvement efforts, and an annual employee appreciation luncheon are a few of the activities the recognition committee oversees," he says.

"A group of Southern Home Care employees, known as the Southern Comfort Group, plan social events such as an annual chili cook-off, a Christmas ornament exchange, and a 'death by chocolate' party, that help us relax and not take life too seriously," Uhl says.

Salaries aren't motivators

Salaries for survey respondents mostly increased, with the exception of 4.5% of respondents who reported a decrease, but the majority (almost 82%) of increases were between 1% and 6%. More than 13% of respondents reported increases between 7% and 15%. **(See chart, below.)**

While competitive salaries are important for attracting new employees and for on-call pay, it is more important to employees to have a good relationship with senior staff, Uhl says.

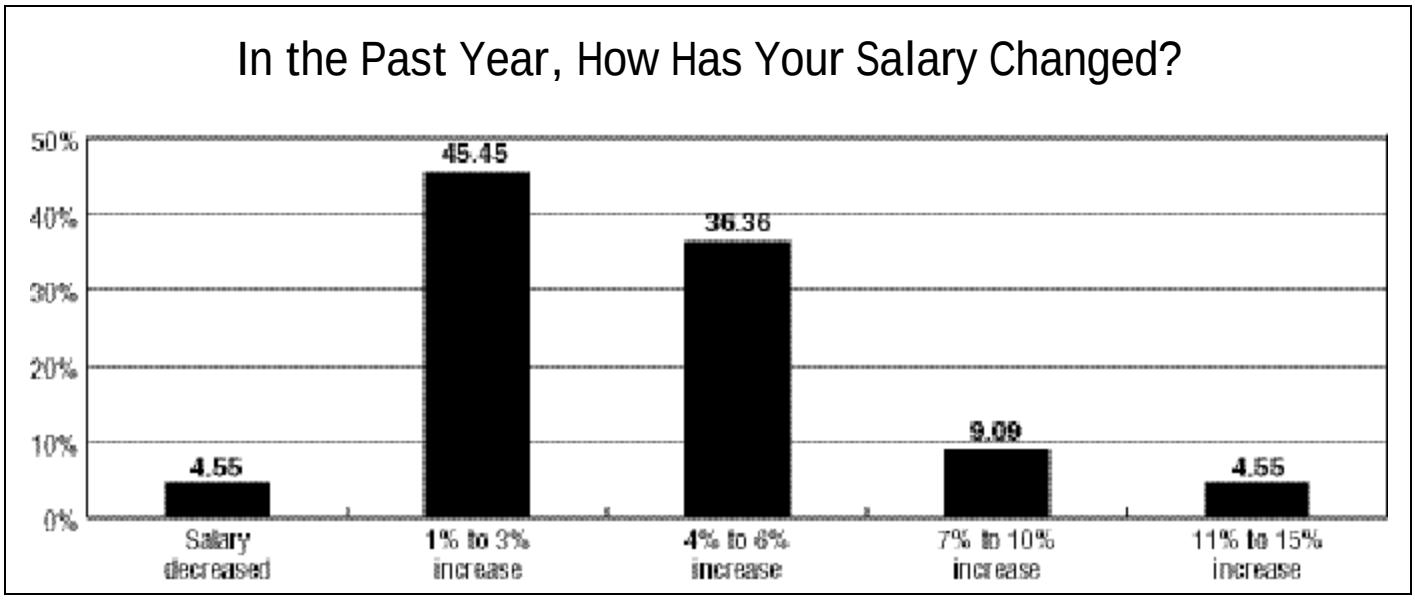
"Competitive salary and benefits are necessary, but are not the prime motivators or contributors to retention success," Solecki adds.

"We have found that the important areas on which to focus for motivation are cultural in nature. Our staff wants Henry Ford Home Health to be an agency for which they are proud to work because we exhibit integrity and a respect for doing the right thing," he explains.

Retention is not a problem at Henry Ford. The average employee's length of service is 5.5 years, he says.

Work environment

Not all respondents to the 2002 salary survey work in a hospital-affiliated agency. Almost 73% of respondents do work for an agency affiliated



with a hospital, but other respondents report working for freestanding agencies or city and county health departments. **(See chart, p. 3.)**

No matter which type of agency is your employer, it is important to know that administration supports the home health agency, Uhl says.

"Our hospital administration considers our agency to be an important part of its mission and their support has been invaluable for increasing staff morale," she adds.

Learn how to find balance in your life

Once you've taken care of addressing the issues that create stress for your employees and you find ways to motivate them, take a few moments to alleviate your own stress and get excited about what you do, Solecki says.

"Management stress is a serious issue, but there are a few things that can help energize us," he explains. "First, remember to count your blessings. Things can always be worse, and we need to keep things in perspective," Solecki says.

"Second, surround yourself with good people by hiring staff members who fit the agency's culture and will make it easy to succeed and have fun," he adds.

"The third task is to find a balance between family, friends, fun, and work. Our industry can eat you up, but you need to remember that sometimes you have to leave it at work," Solecki says.

Get out in the field

Solecki's final suggestion for administrators, directors, and managers is to make a home visit.

"Home visits remind us of our mission and give us an opportunity to better understand staff issues and patient concerns. All leaders need to embrace this chance to see why we do what we do. I always return from home visits with a sense of renewed commitment and pride in what we do," he explains.

[For more information about motivating staff members and salary issues, contact:

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- ***Greg Solecki**, Vice President, Henry Ford Home Health Care, One Ford Place, 4C, Detroit, MI 48202. Telephone: (313) 874-6500. E-mail: gsoleck1@hfhs.org.]* ■

Homecare revenue up by 10% in 2001

The overall homecare industry revenue growth in 2001 was 10%, which is a decrease of 3% from the revenue growth experienced in 2000, according to results of the 2002 Financial Performance Survey Report, an annual benchmarking survey of financial and management practices conducted by the Alexandria, VA-based American Association for Homecare.

Other findings included:

- Nine percent of the companies participating in the survey that reported making an acquisition experienced an overall growth rate of 16%, which was down from 31% reported in 2000. The average growth rate for these respondents on continuing business was 8%.
- Overall accounts-receivables days outstanding increased in 2001, the first increase since 1998.
- Medicare and Medicaid represent 46% of homecare revenue.
- Hospital ownership of home health firms decreased to 25% in 2001, a 10% drop from the 35% figure seen in 2000.
- A new section on clinical efficiencies reveals that 52% of a respiratory therapist's time is spent on patient visits, with the remaining time focused on documentation, communications, and scheduling.

The report, which reflects input from 119 firms representing $3 billion in total annual revenue and operating 1,686 locations, is available from the American Association for Homecare.

There is no charge for study participants. Association members can purchase the report for $250, and the price for nonmembers is $500.

To order a copy of the report, contact Allison Barton-Kramer at (703) 535-1883. To order through the web site, go to: www.aahomecare.org. ■