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DECEMBER 2002

VOL. 19, NO. 12 (pages 133-144)

CMS removes vaccination roadblocks for flu and pneumonia, but will it help?

Agencies still need to look closely at how they address vaccinations

At the beginning of this year's flu vaccination season, the Centers for Medicare & Medicaid Services (CMS) changed the rules for flu and pneumonia vaccinations. Prior to Oct. 2 of this year, each vaccination administered to a home health patient had to be accompanied by an order from the patient's physician. Now, the Conditions of Participation allow for standing orders to be developed and used for both vaccines.

Even without the use of standing orders, however, the CMS change indicates a need for home health agencies to look closely at how they are addressing vaccinations and to ask themselves if a more formalized approach to flu and pneumonia vaccinations is needed to ensure quality patient care.

With the change coming at the beginning of flu vaccination season for most home health agencies, there was little or no time to implement standing orders, but agency representatives interviewed by *Hospital Home Health* say that even with the change in regulation, they probably still will contact physicians on a case-by-case basis for their patients.

"We don't want to cut the physician out of the process of caring for the patient," explains **Jill Bodamer**, RN, BSN, quality improvement and education coordinator for Chesapeake Potomac Home Health Agency in Hughesville, MD. "We also prefer to rely upon the physician's records regarding any adverse reactions from previous vaccinations rather than our patients' recollections," she adds.

"The only time we might rely upon a standing order would be for ongoing home health aide clients who may only see their physician once each year," says **Janet Van Buskirk**, branch manager of Preferred Home Health in Lafayette, IN.

Standing orders are common for community flu vaccination programs, but there is the concern that taking the decision away from the patient's physician can harm the referring physician-agency relationship, Bodamer points out. **(See story on community programs, p. 136.)**

With or without the use of standing orders, home health agencies can play a critical part in protecting elderly against the complications of flu

and pneumonia, says **William Schaffner**, MD, chairman of the department of preventive medicine at Vanderbilt University Medical Center in Nashville, TN.

"Home health nurses can remind physicians that flu shots can be given in the home and make sure that all patients who are at risk for flu or pneumonia can be immunized without having to leave their homes," he says. Vaccinations in the home are attractive to home health patients and their caregivers because it eliminates a trip to the doctor and protects them against illness, he adds. **(See story, p. 137.)**

"We also vaccinate the spouse or family caregiver at the same time," points out **Shirley M. Stevens**, RN-C, clinical manager for Washington County Hospital Home Health Care in Hagerstown, MD. "This way, we can make sure that the caregiver doesn't become ill and unable to help the patient," she explains.

Hospital Home Health® (ISSN# 0884-8998) is published monthly by American Health Consultants®, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Home Health**®, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $449. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $359 per year; 10 to 20 copies, $269 per year. For more than 20 copies, call customer service for special arrangements. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $75 each. (GST registration number R128870672.)

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

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

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THOMSON
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As home health managers evaluate their approach to vaccinations, they need to remember to address the pneumonia vaccine, Schaffner says.

According to the CDC, an estimated 40,000 deaths annually in the United States can be attributed to pneumococcal infection, and immunization of high-risk persons could reduce this number to half.[1]

Because the pneumonia vaccine doesn't get the public attention that an annual flu vaccine does, it may not be seen as critical to patients and their caregivers, Schaffner adds.

Both the pneumonia and the flu vaccines are covered by CMS, Schaffner says. Although the reimbursement represents a break-even proposition for most agencies, it's important to note that these vaccines can prevent hospitalizations, complications from the illnesses, and spread of illness to your own staff, he points out.

Protect staff and patients

Even if all home health agencies don't choose to use standing orders for flu and pneumonia vaccinations, the option of using them will make it easier for home health agencies to formalize their vaccination programs, says **Libby Chinnes**, RN, BSN, CIC, infection control consultant for IC Solutions in Mount Pleasant, SC.

"Standing orders can be an immense timesaver for the nurse administering the vaccine, and it also reduces pressure on physician time," she says. Any policy that includes standing orders also should include an option for a physician to override standing orders for particular patients, she adds.

When setting up a flu or pneumonia vaccination program, make sure you protect your own employees first, Chinnes says.

Agencies should provide the flu vaccine free to employees and make it convenient for them to get their shot, she says. "You want to make sure you have staff [who] won't catch the flu from patients and won't spread the flu to patients," she points out.

If you choose to use standing orders, have a physician-approved policy that allows for administration of the flu and pneumonia vaccines upon admission, if appropriate, Chinnes says.

The policy also should specify that the nurse will assess contraindications and educate the patient as to the benefits and potential complications of the vaccination, she adds. The assessment

form then can be adjusted to include questions about the need for vaccinations and to gather information that might indicate contraindications, she says.

At Preferred Home Health, every patient is asked if a flu or pneumonia vaccination has been received, Van Buskirk says.

"If the patient indicates that there has been no vaccination, the nurse contacts the physician and asks for a verbal order to administer the vaccination," she says. A copy of the order is sent to the physician for signature after the verbal order is received, she adds.

By calling the physician, Van Buskirk's staff has a chance to verify that no vaccinations have been given. Although the use of standing orders means that you have to rely upon the patient's memory, there is little risk in revaccinating a patient, Chinnes says.

"Of course, the flu vaccine is recommended each year because different strains of influenza predominate each year," she says.

"With pneumococcal vaccine, studies have shown that the risk beyond self-limited local reactions was minimal for a second dose given two to five years after the primary dose and did not contraindicate revaccination with pneumococcal vaccine in the recommended high-risk groups," she says.[2]

Determine safeguards

One issue that needs to be addressed is whether the home health nurse can vaccinate a patient who never has received a flu shot.

"We cannot be the first to administer a flu shot because we don't know if the patients will have a reaction, even after we've assessed them for contraindications," Bodamer says. For this reason, patients who never have had a flu shot must go to the physician's office for the first vaccination, she adds.

"We will give first-time injections, but we make sure the nurse stays at least 15 minutes after the injection to observe potential complications," Van Buskirk says. "The order we request from the physician not only includes the vaccine but also epinephrine if needed," she adds.

Not all home health agencies include the administration of epinephrine if needed on the orders they receive from a physician, but Van Buskirk says that it is essential that nurses have the supplies and authority they need to address complications.

Immunization Resource

- **Delmarva Foundation**, 9240 Centreville Road, Easton, MD 21601. Telephone: (410) 822-0697. Web site: www.dfmc.org.

The Delmarva Foundation developed a flu and pneumonia vaccination project in 2001 for home health agencies in Maryland. While the toolkit has not been updated this year, the information still is accurate and helpful to agencies that are starting up a program. Access the toolkit at http://vaccination.dfmc.org/#. It contains sample policies, consent forms, standing orders, educational material for nurses and patients, billing education, and strategies.

"It's a matter of patient safety," she adds.

Make sure you also have uniform paperwork, educational flyers, consent forms, and a log for billing purposes, Stevens suggests.

This makes it easy for nurses to administer the vaccines from year to year, because they don't have to relearn the process, she explains.

"Our flu vaccination is always successful, with most of our patients vaccinated each year," says Stevens. Her nurses, she says, exhibit responsible enthusiasm for the effort. "The first of October, all of the nurses come by my office wanting to know if the vaccine has arrived."

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Community vaccination: More than good health

The benefits come in many different forms

Operating a community flu clinic is a good way to make sure your home health agency's name is associated with good will in the community, says **Susan R. McCarter**, RN, community educator for Diversified Home Health Services in Towson, MD.

Every year, McCarter's agency vaccinates between 5,000 and 6,000 people within the Baltimore area. "We have a contract with the Baltimore Services for the Aging to provide community clinics at their annual service fair and at senior centers throughout the area," she says.

"We do use standing orders for the community clinics, and the orders address administration of the vaccines as well as epinephrine, if needed," McCarter says. Because the clinics cover such a wide area of the agency's market, McCarter's nurses invite home health patients to the clinics rather than vaccinating them during regular home visits.

"The nurses hand out flyers to all of our home health patients, and if the patient cannot easily ambulate into the clinic area, we send a nurse out to the car to give the vaccination," she says.

Making vaccinations accessible

A special parking area directly in front of the senior citizen center doorway is designated for the drive-up patients.

"If they are receiving either vaccine for the first time, we ask their caregivers to stay in the parking area for 15 minutes, then a nurse checks on them before they leave," McCarter adds.

In Lafayette, IN, all of the flu clinic patients stay in their cars, says **Janet Van Buskirk**, branch manager of Preferred Home Health in Lafayette.

"We vaccinate our home care patients in their homes, using orders from their physicians, but we use standing orders to cover our drive-through clinic," she says.

This year, she and her staff vaccinated just less than 1,700 in one day, she says.

Both McCarter and Van Buskirk admit that a community flu clinic is a great way to make sure your agency's name is familiar in the community, but McCarter also looks at the clinics as good for staff retention and even recruitment.

"Every year I recruit a group of nurses who work during October and November giving flu and pneumonia vaccinations," McCarter says. "A lot of my staff nurses want to work the clinics, even if it means extra hours, because they enjoy the break in routine," she says.

"Home health nursing is so intense, and you are often working with very ill patients," she points out. The clinics give nurses a chance to work with well patients in a very social setting, she explains. "All of my nurses say they look forward to the clinics," she adds.

This year, in addition to her regular network of hospital, physician office, and retired nurses who wanted to work the clinics, McCarter had an influx of graduate school-level nurses who signed up to work.

"I have two staff nurses who are working on their graduate degrees at two different universities, and they each notified their classmates about this opportunity," she says.

"Because students can only work a few days a week and still attend classes, many of their classmates applied for the positions because it fit their schedules," she explains.

Although she doesn't know if any of the students will apply for positions in home health, McCarter says that she feels positive that their exposure to her agency and the services they provide will keep Diversified Home Health in their minds as they consider their career or offer advice to others.

Agency managers planning community clinics have to decide if they will use vials of vaccine or pre-filled syringes. "I recommend pre-filled syringes for large clinics because you have to spend money on extra staff to draw from the vials," Van Buskirk says.

Vaccinations: One size does not fit all

Different populations have varying needs

Although many home health agencies address flu vaccinations, either formally or informally, more agencies neglect the pneumonia vaccine, says **William Schaffner**, MD, chairman of the department of preventive medicine at Vanderbilt University Medical Center in Nashville, TN.

"Pneumococcal pneumonia is the most common type of pneumonia and kills up to 12,500 people each year," he says.

The pneumococcal polysaccharide vaccine is recommended for adults 65 years and older; the vaccine can only be administered every five years, Schaffner adds.

It can, however, be administered at any time of the year, he says.

Flu vaccine is recommended for all adults ages 50 and older, as well as for adults with underlying medical problems such as heart or pulmonary disease, and any metabolic disease such as diabetes, renal disease, or any condition in which the immune system is compromised, Schaffner says.

"The best time to vaccinate high-risk groups is early October through November because this reduces the risk that the patient will become ill if exposed during the height of the flu season," he says.

Don't forget that children also may require flu vaccinations, Schaffner points out.

"The Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices now recommends that children between the ages of 6 months and 23 months be vaccinated because the illness can cause severe complications," he says.

The American Academy of Pediatricians and the American Academy of Family Practitioners endorses this recommendation, he adds.

Any child between the ages of 2 and 19 who has heart disease, diabetes, or any lung disease such as asthma, should also receive the flu vaccine, Schaffner says. ■

McCarter would prefer the pre-filled syringes but says that the cost is prohibitive for her program. "We do bill Medicare, and we do charge non-Medicare patients a fee for their shot; but the reimbursement just barely covers costs," she says. Luckily, she does not have trouble recruiting enough staff to handle the vials, she adds.

Plan ahead

It is important to plan community flu and pneumonia clinics well in advance, McCarter says.

"It is unbelievable how many people will show up," she says. "You have to make sure you have enough consent forms, educational information about potential complications, staff, and vaccine," she says.

"We use a NCR form that includes the list of contraindications, potential complications, and consent all together," McCarter says. "We give one copy to the patient to keep or to pass along to their physician," she explains. "Then we have a billing table at which volunteers collect billing information for Medicare patients for whom we submit a roster billing and at which payment is collected for other people," McCarter says.

While McCarter and Van Buskirk do not pre-register flu clinic patients, the Chesapeake Potomac Home Health Agency does.

"We use space donated to us by the three hospitals that own us, so we need to be very organized and efficient so we don't interfere with hospital operations," says **Jill Bodamer** RN, BSN, quality improvement and education coordinator for the Hughesville, MD, agency.

"We do take walk-ins, but we take pre-registrations by telephone prior to the clinic," she says. Pre-registration also enables her to better plan the supplies, forms, and staff that will be needed, she adds.

If you plan to offer the pneumonia vaccine as part of your community clinic, McCarter suggests that you not rely upon the memory of the patients as to when they last had their vaccination.

"We only give the pneumonia vaccine if the patients say they have never had one," McCarter says.

"Because the vaccine should not be given except every five years, I don't want to take a chance that the patient received one six months ago, or one year ago," she says. ■

Time to give your OBQI reports more attention

Mandatory use is coming soon

You've been evaluating your Outcome Based Quality Monitoring Reports, but why worry about Outcome Based Quality Improvement (OBQI) reports?

Because state surveyors have access to the information, and they may be using it to prepare for their visits as early as January 2003, according to the Centers for Medicare & Medicaid Services (CMS) officials.

"The use of OBQI data to evaluate an agency's performance is not required at this time. We do, however, anticipate that the Conditions of Participation will be amended to require an agency to use OBQI data to identify areas of improvement in June 2003," explains one CMS official.

Suggested reading

Even if the use of OBQI data is not mandatory until the summer of 2003, agencies need to start looking and using the reports now, advises **Merryl M. Gottschalk**, RN, director of healthcare consultants for Healthcare ConsultLink in Azel, TX.

"There are a lot of data in the OBQI reports, and it takes time to learn how to read it," she says.

In addition to looking at the reports, it is expected that agencies will have to use the data to choose areas of improvement that need to be addressed once the regulations are finalized, says Gottschalk.

CMS officials agree and say, "An agency would select specific outcomes based on their statistical significance in the report, evaluate the care related to that outcome, and develop plans to improve the care if needed, or reinforce the care if the agency's outcomes are good in that area."

Surveyors will look to see how those plans are implemented and if subsequent OBQI reports show improvement.

OBQI reports contain risk-adjusted outcome data that show how the care your agency provides compares with the care provided by agencies caring for similar patients.

"The 41 outcomes measured by OBQI will help agencies determine if their patients are getting better and what contributes to this improvement," Gottschalk says.

When you pull your OBQI reports, you'll notice asterisks placed beside some outcomes. The asterisks indicate the areas with the most potential for improvement. Two asterisks indicate areas in which there is a 5% or less chance that the difference between your score and the national benchmark is pure chance. One asterisk indicates that there is a 5% to 10% chance that your score is due to chance.

"Focus on the areas with two asterisks first," CMS officials suggest.

By focusing on the outcomes that differ significantly from the national benchmarks, you can evaluate which improvement efforts are going to benefit your patients the most, Gottschalk says.

Once you've identified these areas, look carefully to see if you differed as a result of the care you provided or if other factors caused the difference, she says.

"We know that agencies in the East keep patients shorter lengths of time than agencies in Texas. Rural agencies may not be able to affect how long they keep patients because they have fewer resources for the patients to use after discharge from home health," Gottschalk explains.

Eventually, data will be sorted regionally, but until then, use the national benchmark as a guide, then look carefully at which outcomes you can improve, she suggests.

For example, you may need to add a wound care specialist to your team if your patients have wounds that don't improve at the same rate as other agencies, or contract with a respiratory therapist to provide more aggressive care for respiratory patients, Gottschalk suggests.

Although CMS officials report that 75% to 80% of all home health agencies that submit OASIS [Outcome and Assessment Information Set] data have requested their OBQI reports, they do admit that they don't know how many are truly using the data to develop quality improvement projects.

Procrastination would be a mistake

"Home health managers are overwhelmed these days, so most will wait until the use of OBQI data is mandatory," Gottschalk points out. That would be a mistake, however, because it takes time to review and evaluate the data, and identify a project, she says.

"It is better to start now, so that when it is mandatory, you already have a process in place," she adds.

When you pull your OBQI data for the first time, you automatically receive one year's worth of data. For subsequent reports, you can specify what length of time you want to data to cover, say CMS officials.

CMS recommends that agencies download reports no more than once per quarter with the ideal time frame being once every six months. This gives the agency time to implement the quality improvement plan and see changes.

Home health managers can download their OBQI reports through the same system in which they submit OASIS data. Once you reach the server through which you submit OASIS data, choose the OBQI/OBQM link. Choose the reports option then choose which reports you want downloaded.

CMS has published manuals on the use of OBQI data. To download the manual, go to www.cms.hhs.gov/oasis and choose OBQI manual.

Even though the initial reports can be daunting, the effort to evaluate them and develop quality improvement projects is exciting, Gottschalk says.

"This is the first time we've had comprehensive outcomes data in home health to evaluate our care. And we need to remember that the point of outcomes-based quality improvement is better care for our patients," she says.

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Beyond baby boomers: Managing various ages

Varying factors require creative management

We all know that people of different ages react differently in the same situations, but when you have to take people of varying ages and create a positive work environment that results in high productivity and happy patients, you have to look at why each age group acts differently.

Although each employee has his or her own personality and value system, it helps to understand the four distinct generations that are represented by your employees and patients, says **Sue Romero**, owner of Susan Romero Consulting, an Englewood, CO-based human resources consulting firm.

Each group — the veterans, the baby boomers, Generation X, and the nexters — has a different value system and is motivated by different factors, Romero says. "No one group's value system is better than another; they are just different," she points out. **(See definitions, p. 141.)**

While most of the veterans (born between 1922 and 1943) that your agency sees on a regular basis may be patients, it is possible that some veterans have re-entered the work force on a part-time basis, Romero says.

"Not only do these folks want extra insurance coverage or other benefits, but they also are living longer and want to do something that makes them feel as if they are contributing to the community," she explains.

The majority of employees are baby boomers (born between 1943 and 1960), and the next largest group is Generation X (born between 1960 and 1980), Romero says.

The youngest group of employees that home health managers may have is the nexters (born after 1980), she says.

Different ages = different work styles

Each employee group approaches work in a different way, and it is important to make sure that managers and other staff members understand that just because someone works differently, it doesn't mean that person has a lesser work ethic than you, Romero says.

The biggest differences that home health managers notice among employees are between baby boomers and Generation X-ers, says **Beckie Hinze,** RN, BSN, CHCE, vice president of operations for Foundation Management Services, a Denton, TX-based company that manages several home health agencies.

Baby boomers share some values with veterans: They want to be loyal to their employer and to contribute to success of their employer, Romero says.

They also have a respect for authority, but unlike veterans, baby boomers are comfortable acting as "change agents," she says.

"This means that they thrive on collaborative, team-oriented projects that have specific goals to

change processes," she adds.

Baby boomers also are more willing to share their knowledge and teach others, Hinze points out.

Gen X-ers like independence

Generation X-ers are skeptical of authority and don't want to be closely managed, Romero says.

"This generation is also referred to as the latchkey generation, and the members of this generation grew up very self-reliant," she says.

Because they value their time, they look for ways to work efficiently, even if it means not doing a job the same way everyone else does, Romero adds.

"Generation X-ers are more flexible, vocal, and outgoing," says **Judith P. Walden**, BSN, MHA, director of Castle Home Care in Kaneohe, HI. Walden's staff is 68% baby boomers and 32% Gen X-ers.

"With few exceptions, employees in the Gen X category tend to be more flexible and more motivated to take on additional responsibility," she says.

"On the other hand, since these also are the employees that have small children, they are less likely to work nontraditional hours or shifts," Walden adds.

Because Gen X-ers raised themselves, they value family time and personal time, Romero says. "They want balance in their lives and they are more loyal to their families than to their employers," she says. For this reason, it is important to keep looking for ways to challenge Gen X-ers to keep them interested in their jobs, she adds.

Gen X-ers dislike team-building activities as much as most baby boomers like them, Romero says. "Don't force your Gen X-er to participate in teams but do ask for their expert help in technology-related issues," she suggests.

Because many home health patients are members of the veterans or baby boomer generation, you may have to address different approaches with your Gen X-ers, Hinze says. "Gen X-ers are vocal and speak their mind," she says. "While they don't mean to be disrespectful, older staff members and patients sometimes see this plain talk as disrespectful," she says.

Be careful how you correct a Gen X-er, Hinze warns. "It's easier to change the Gen X-ers' behavior if you remember that they want to succeed and want to improve their skills," she points out.

"Remember, too, that Gen X-ers tend to focus on themselves, and they don't always see themselves as others see them," she adds.

In the case of the employee who offended patients or other employees by speaking her mind, Hinze suggests that you point out that she's doing her job properly but because other people value different behaviors, they perceive the employee as disrespectful. "You might also suggest specific ways to correct this perception," she adds.

While baby boomers are comfortable with authority, Gen X-ers are not, Romero says.

"Manage for results, and you'll get the most out of all your employees," she suggests.

"Let each generational group meet their goals in the way that fits their personalities and provides good care, rather than dictating that each job activity must be done a specific way," Romero says.

"Gen X-ers are wonderful field nurses and therapists," Hinze says. "They never get bored; they enjoy the independence; and they excel in dealing with change," she explains.

Understand differences when recruiting

When recruiting nurses, be sure you have things in place that appeal to experienced baby boomers, Romero says. "Baby boomers believe they've paid their dues, and they want a chance to be recognized for their contributions," she says.

"They will be looking for opportunities to supervise, to participate on committees, and to have a good benefits package that allows them time to spend with their families," Romero adds.

"Gen X-ers are going to work for agencies that don't force them to do their job in one way only," Romero says.

"They are also going to look for agencies that have up-to-date technology, offer educational support so they can continue to learn, and give them a chance to advance as quickly as their skills and ability allow," she says.

Salary and benefits are more important to baby boomers, Romero says. Gen X-ers and nexters are less concerned with salary and benefits when choosing a place to work, she adds.

Although not many nexters (born between 1980 and present) are working in home health at this time, they may be the best work force we've seen, Romero says.

"They represent a combination of Gen X-ers

Defining the generations leads to management clues

While it's dangerous to place employees in categories and then expect them always to act the same as other employees within their group, it is necessary to look at generational differences to understand why different employees approach their jobs differently from others or have different motivators.

"Although these descriptions are accurate, remember that people born near the end or the beginning of a particular generational group can exhibit characteristics of the group just following their birthday or just preceding it, says **Sue Romero**, owner of Susan Romero Consulting, an Englewood, CO-based human resources consulting firm.

"You also have to take into consideration the employee's cultural background since the events that affected people growing up in the United States may not have been occurring in other countries," she adds.

VETERANS

People born between 1922 and 1943 witnessed the 1929 stock market crash, the Great Depression, Roosevelt's New Deal, World War II, and the Korean War. They were accustomed to working in organizations in which the executives did the thinking and the employees followed directions, says Romero. "This group values loyalty, dedication, sacrifice, hard work, rules, and respect for authority and seniority," she adds.

BABY BOOMERS

People who grew up between 1943 and 1960 grew up in positive times. The economy was expanding and baby boomers received a lot of attention from their parents, says Romero. This is the first generation that was evaluated on how it interacted with others, she adds. Baby boomer values include optimism, team playing, personal gratification, health, wellness, and work contribution, she adds.

GENERATION X

Children who were born between 1960 and 1980 experienced Arab terrorists at the Munich Olympics, the Watergate scandal, massive layoffs in U.S. corporations, and Los Angeles riots over the Rodney King beating. "It's not a surprise that this generation is pessimistic and skeptical of authority," says Romero. Because members of this generation often had two working parents, many of them were "latchkey" children and learned self-reliance, she says. "They also are seeking a sense of family and want a balance of work and family in their lives," she adds. "They value independence and don't want to be closely managed," she says.

NEXTERS

People born after 1980 live in an age-diverse population that wants children to have every advantage, says Romero. "They are optimistic high-achievers who are street-smart and possess excellent social skills," she adds. "They combine the work ethic of veterans with the teamwork focus of baby boomers and the technological expertise of Gen-Xers," she says. Nexters are looking for clear expectations, discussions of personal career goals, gender blindness, team orientation, and training opportunities," she adds. ■

and baby boomers, and they've also been influenced by grandparents from the veteran generation," she says. "They are technologically savvy, have good social skills, and are, in general, very high achievers," she says.

"Of all the generations, the nexters seem most able to accept and respect diversity of cultures and ages in the workplace," she adds.

Romero says the best way to get the most out of all generations is to include all employees in setting goals for themselves and for the agency.

After goals are set, be sure to evaluate performance on results, not on how the results were achieved, she adds.

While understanding the differences in each generation is helpful, be careful not to think that all employees will follow their generational description to a tee, Walden says.

"Each employee has unique needs, expectations, and personalities," she says.

"I was recently amazed when I expected an older nurse to balk at learning a new computer program," she explains. "She readily accepted this new challenge, almost eagerly, while some of the younger nurses complained about having to spend more time on a program that wasn't 'windows-friendly.'"

[For more information about managing different generations, contact:

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LegalEase

Understanding Laws, Rules, Regulations

Stay on top of wound care consultants, product reps

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

Agencies feel increasingly under the gun. Generally speaking, as is the case with many industries today, they perceive that they are under great pressure to be more cost-effective.

Nonetheless, patients, especially those receiving home care, often need intensive, expensive, and complex treatment in order to prevent or heal pressure ulcers.

Providers sometimes are tempted to turn to wound care consultants and representatives of the wound care industry for expertise in order to achieve efficiency in the problematic area of care. A primary concern raised by such relationships is the potential for violation of fraud and abuse prohibitions.

Specifically, providers must be mindful of a federal statute that prohibits illegal remunerations, kickbacks, or rebates as follows:

"Whoever knowingly and willfully offers or pay any remunerations, including kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person:

A. to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter;
B. to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter; shall be guilty of a felony and upon conviction thereof, shall be fined not more the $25,000 or imprisoned for not more than five years, or both."

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, the primary enforcer of Medicare/Medicaid fraud and abuse publications, has been quite clear that free services may constitute an impermissible kickback or rebate.

Violations of the above statute may result in dire consequences for wound care consultants, representatives of wound care companies, and providers.

What can wound care consultants and representatives of wound care companies appropriately provide to agencies?

Although it is difficult to draw 100% clear definitions, at least at this time, the following seems clear:

- For the most part, consultants and representatives of wound care companies must be careful not to provide services free of charge that providers otherwise would be financially responsible to render. When such services are provided free, the OIG may conclude that providers received an inappropriate kickback or rebate.
- Consistent with this general principle, wound care professionals and companies should not examine patients and chart the results of their examinations in the patients' charts.

The full scope of services rendered by wound care consultants may, of course, be provided to agencies consistent with an agreement that meets the requirements of the personal services and management contract "safe harbor," including the following:

- The parties must sign written agreements for the provision of such services that include a term of at least one year.
- Services to be provided must be spelled out in such written agreements.
- Providers must pay for services received at fair market value, without taking into account the volume or value of referrals made.
- Such services genuinely must be needed and,

to some extent, be standard in the industry.

Wound care companies and consultants historically have been an important source of expertise in a troublesome area of care for many providers. Greater clarity is needed regarding limits on services related to wound care, so that everyone involved can avoid potential fraud and abuse issues.

[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.] ■

Smallpox vaccinations imminent for hospitals

Know the consequences for your facility

The Atlanta-based Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) recently approved a plan that calls for smallpox immunization of 510,000 health care workers.

The plan suggests that all hospitals should designate a "smallpox care team" that should be immunized prior to any release of the virus.

The committee recommends that the team include a minimum of 40 health care workers per hospital, with some hospitals vaccinating 100 or more, including emergency department physicians and nurses, infection control professionals, intensive care unit nurses, infectious disease consultants, radiology technicians, respiratory therapists, engineers, security, and housekeeping staff.

CE *questions*

9. What is one reason that Jill Bodamer, RN, BSN, quality improvement and education coordinator for Chesapeake Potomac Home Health Agency in Hughesville, MD, won't institute standing orders for flu and pneumonia vaccinations in her agency?
   A. New policies are too difficult to develop.
   B. She trusts physician records of adverse reactions more than the patient's memory.
   C. Referring physicians are opposed to vaccinations in the home.
   D. Patients don't want vaccinations given in the home.

10. According to Susan R. McCarter, RN, community educator for Diversified Home Health Services in Towson, MD, what are some of the benefits of a home health agency conducting community flu and pneumonia vaccination clinics?
   A. builds physician referral base
   B. potential recruitment for new employees
   C. good retention tool for current staff
   D. significant source of new income
   E. A and C
   F. B and C

11. When do officials of the Centers for Medicare & Medicaid Services expect the use of Outcomes Based Quality Improvement Reports to become mandatory for home health agencies?
   A. January 2003
   B. June 2003
   C. October 2003
   D. January 2004

12. According to Sue Romero, owner of Susan Romero Consulting, an Englewood, CO-based human resources consulting firm, which generation of employees is most likely to enjoy serving on committees or task forces?
   A. veterans
   B. baby boomers
   C. Generation X-ers
   D. nexters

Answers: 9. B; 10. F; 11. B; 12. B

COMING IN FUTURE MONTHS

- Avoid denials with these techniques
- Exceed, don't just meet, your customers' expectations
- Purchasing insurance? What you need to know
- How training programs help with staff retention
- Find new sources for educational materials

To help you prepare for sweeping procedural changes, American Health Consultants offers **Imminent Smallpox Vaccinations in Hospitals: Consequences for You and Your Facility**, a 90-minute audio conference Wednesday, Dec. 11, from 2-3:30 p.m., EST.

This session is designed to help you and your staff answer serious questions and prepare your facility for the inevitable. How will being vaccinated affect you? How do you protect yourself, patients, and family? What are the logistics of implementing a smallpox care team? How do you deal with vulnerable populations? How do you minimize side effects?

This panel discussion will be led by **William Schaffner**, MD, chairman of the department of preventive medicine at Vanderbilt University Medical Center in Nashville, TN. A veteran, award-winning epidemiologist who has seen actual cases of smallpox and currently oversees a volunteer smallpox vaccine study at Vanderbilt, Schaffner began his distinguished medical career as a medical detective in the CDC's Epidemic Intelligence Service. He also is a liaison member of ACIP. Schaffner and an expert panel of emergency and infection control professionals will help you prepare for this critical task.

The second speaker, **Jane Siegel**, MD, is a professor of pediatrics at the University of Texas Southwestern Medical Center in Dallas. The author of several books on infection control issues, Siegel has emerged in recent years as a key CDC advisor.

As a member of the CDC Healthcare Infection Control Practices Advisory Committee, she is on a bioterrorism working group that reviewed the critical issues regarding smallpox vaccine. Showing a clear knowledge of the pros and cons of the various options, Siegel presented the working group's research to ACIP.

The third speaker, **Joseph J. Kilpatrick**, RN, NREMT-P, is an adjunct instructor with the Texas A&M University Texas System in College Station, where he develops courses and provides training on weapons of mass destruction and emergency medical services (EMS) courses to EMS professionals throughout the United States. Trained as an emergency department and flight nurse, Kilpatrick also recently has worked as an independent nursing contractor, providing critical care, flight, and emergency nursing services to various health care and corporate organizations.

The cost of the program is $299, which includes 1.5 hours of free CE, CME, and Critical Care credits. ACEP Category I credit approval for the conference is pending. You can educate your entire facility for one low fee.

The facility fee also includes handout material, additional reading and references, as well as a compact disc recording of the program for continued reference and staff education. For more information, or to register, call customer service at (800) 688-2421. When ordering, please refer to the effort code: **65341**. ■

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. ■

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