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IN THIS ISSUE

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Supervisors and managers are the keys to employee retention

Feeling valued more important than money for employee satisfaction

(Editor's note: This is the second of a two-part series that addresses strategies of home health agencies, which can be used to successfully recruit and retain qualified employees. In October, we discussed how a home health agency can establish itself as the employer of choice within its community. This month, we provide tips for successful retention of employees by making sure you hire the right supervisor or manager.)

Every home health manager knows that it costs less to retain good employees than to constantly hire and train new employees, but what are the secrets to keeping good employees?

One of the keys to success is hiring the right managers and supervisors, say experts interviewed by *Hospital Home Health*.

"Employees [are given] very specific questions [when] asked to evaluate their satisfaction with their jobs," says **James D. Henry**, MDiv, principal of Positive Strategies, a human resource consulting firm in Puyallup, WA.

"They want to know if [the employees] know what is expected for the job, if they have resources to do their job, if they have the opportunity to do what they do best, if their opinions are respected, and most importantly, does their supervisor care about them," he adds.

Prepare your agency for a very unusual flu season

Vaccine shortages may wreak havoc with hospital EDs, absenteeism

With the unprecedented shortage of influenza vaccine this flu season, hospitals are scrambling to prepare for what may be a record number of flu patients presenting to their already overcrowded emergency departments (EDs) and for staff shortages due to record absenteeism. After almost half of the United States' planned vaccine supply was contaminated, high-risk candidates — including the very young, the elderly, those with chronic

(Continued on page 134)

While providing resources such as equipment and supplies is straightforward, addressing the other concerns requires a commitment to communicate from manager to supervisor to employee, Henry notes.

A good manager or supervisor will make sure the job is well-defined in both written job descriptions and discussion of the job responsibilities with the employee, says **Linda S. Henry** of Positive Strategies.

Don't wait to give the job description to the employee after you've hired him or her. "Have a prospective employee read the description and any expectations you've developed [about] the job during the interview," she suggests. That gives you and the employee a chance to make sure you both have the same understanding, she adds.

Once you've gone beyond the hiring and initial employment period, good managers and supervisors will evaluate employees for their strengths and weaknesses, L. Henry notes.

"Not only will you be able to make sure the employee has every opportunity to succeed and grow professionally, but you'll also know how to communicate with him or her," she explains. "For example, if they are big-picture people, they don't want to sit and listen to a lot of details; so your message will be, 'Here's our goal, and here's what we will do to accomplish it.'"

Employees who like the details will find them reassuring and may not want a lengthy discussion of the global view of how this activity will fit into the big picture, L. Henry adds.

When you are hiring supervisors, make sure they are good communicators, J. Henry suggests. "They should be able to communicate one-on-one as well as in a group setting." That means supervisors need to understand how to plan a meeting with employees and know what messages need to be conveyed and in what manner will work best

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Editorial Questions

For questions or comments, call **Jayne Gaskins** at (404) 262-5406.

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for the people in the audience," he adds.

"I have the best management team I've seen in all of my years in home health," says **Jean R. DeLong**, RN, MSN, director of clinical services for HomeReach in Worthington, OH. "I inherited some of them when I took this position, and I've hired others. We all work well together, and each member of the team has the respect of all of our employees," she explains.

While some people are natural managers and know how to delegate, manage, and communicate with employees, you should be prepared to make management training an ongoing effort to ensure the best supervisors and managers, DeLong suggests.

"At our management meetings, we also discuss performance issues and set clear goals for us as a group as well as for individuals. We also offer leadership training sessions that cover topics such as management styles, communication, problem solving, and utilization of resources," she adds.

Because hiring the right employee is a challenge for some supervisors or managers, DeLong's agency offers support right from the start with a notebook that offers tips on how to select, hire, welcome, and train new employees. "Managers need to feel confident that they begin the relationship with the proper planning and communication, and this resource helps them," she explains.

When there is a management opening at HomeReach, administrators try to promote from within to fill the spot, but that is not always possible in all agencies.

"We have a leadership crisis in home health," says **Greg Solecki**, vice president of Henry Ford Health Care in Detroit. "If all things were equal, I would want to promote from within, but we can't always do it."

While experience in home health often is a good trait for managers or supervisors, it isn't the only one needed, he says. "In home health, we fall into traditional patterns of doing what we've always done before, and we focus on getting the right checkmarks and ensuring that we are in compliance. Sometimes, it is better to have a manager willing to look outside traditional approaches to develop programs and processes to improve the agency's service. Unfortunately, this means hiring someone from a different agency with different experience to bring a fresh perspective."

Clinical managers or supervisors often are the hardest positions to fill, Solecki notes. "Some of our best candidates are nurses with many years

Retain good employees by showing them you care

"Managers do have to develop caring behaviors for their employees, just as nurses care for patients," says **Linda S. Henry** of Positive Strategies in Puyallup, WA. "There are many studies in which the reason for leaving a job isn't related to salary or benefits, but instead the reason is related to a supervisor or manager who didn't care about the employee," she says.

On the other hand, if you ask your longtime employees why they stay, they are likely to cite managers who are honest, respectful, and caring, Henry adds. There are five steps managers can take to make sure they are demonstrating caring behavior, she adds:

1. **Maintain the belief that we work as a team.**
   "This means that the manager truly has a 'We're all in this together' approach and does value the employees' opinions and suggestions," Henry explains.

2. **Know the employee.**
   "Don't make assumptions about an employee because of background, experience, or what you've heard from other people," says Henry. "Form your own opinions of their ability and their contributions," she adds.

3. **Be with the employee during a conversation.**
   It is too easy to be distracted by the meeting you have later in the day or the reports that are due, but you must be an active listener, Henry says. "Listen and paraphrase what the employee is saying to make sure you understand and to make sure the employee knows you are listening," she explains.

4. **Do something.**
   "We can't always give employees exactly what they ask to be given, but we can make sure we follow up on reasonable requests or suggestions, and that we let people know what we've done," Henry points out.

5. **Enable employees.**
   The best way to let employees know they are valuable and the manager or supervisor recognizes their abilities is to offer them a chance to increase their knowledge. "Teach or train employees in group settings or one-on-one to improve their job skills and their job satisfaction," she adds. Be sure the training is applicable to their job or to the job they want to obtain to make it more valuable. ■

of experience and exactly the right personalities to move into management, but they don't want to give up seeing patients. They will tell me that they have a lot of control over their workday, and they get a lot of personal satisfaction from working with patients. They will lose both of those things if they move into management," he continues.

Finding the right personality is important, says Solecki. "It is easy to teach skills such as caring for a patient with an IV, but it is hard to teach someone to relate to their employees and develop a caring relationship," he adds. **(For tips on caring behaviors, see box, p. 135.)**

All home health agencies want to provide the best care possible, but that goal only can be achieved if employees know that management cares about them, L. Henry says. "There are very few top executives who can express this caring attitude, so we need to make sure our managers and supervisors with whom employees deal with every day know how to express it."

[For more information about developing managers who help retain employees, contact:

- ***Linda S. Henry**, Positive Strategies, 2407 36th Ave. S.E., Puyallup, WA 98374. Phone: (253) 864-7309. E-mail: jlhenry@aol.com.*
- ***Greg Solecki**, Vice President, Henry Ford Home Health Care, One Ford Place, 4C, Detroit, MI 48202. Phone: (313) 874-6500. E-mail: gsoleck1@hfhs.org.*
- ***Jean R. DeLong**, RN, MSN, Director of Clinical Services, HomeReach HomeCare, 404 E. Wilson Bridge Road, Suite D, Worthington, OH 43085. Phone: (614) 566-0888. E-mail: jdelong@ohiohealth.com.]* ■

Flu vaccine for health care workers: Liability factors

Sick employees risk to themselves and patients

The severe nationwide shortage of killed flu vaccine has put a stop, at least temporarily, to initiatives in some places that would force health care workers to be vaccinated or risk their jobs, but some health care experts warn that the solution advocated by at least one state — that health care workers forego the vaccine entirely so that more is available for higher-risk groups — could be dangerous to the very people it aims to protect.

The Centers for Disease Control and Prevention (CDC) updated the recommendations following the news that the nation's supplies of flu vaccine would fall far short of need. The revised recommendations advise that "health care workers who take care of patients" should be among the population groups that should be vaccinated against the flu.

The CDC Advisory Committee for Immunization Practices (ACIP), which issues the vaccination recommendations, included health care workers who are in contact with patients in the groups that should be vaccinated because the health care workers are at higher risk of getting sick themselves, and because they are in contact with patients with influenza, are at a high risk of spreading the virus.

"Vaccinating a nurse or physician who is in contact with patients has a much greater effect than just the vaccination of that one individual," says **Jane Siegel**, MD, a University of Texas Southwestern Medical School professor specializing in pediatric infectious diseases and an advisory member of ACIP and the CDC's Healthcare Infection Control Practices Advisory Committee.

"You don't just protect that health care worker. You protect everyone that health care worker comes in contact with. It has a very broad effect," she says.

The Minnesota Department of Health determined that vaccinating healthy health care workers is not the best way to utilize the limited resources of vaccine available and has recommended that all health care workers forego the flu vaccine until the shortage is eased.

"The goal of vaccination is to prevent severe complications in those patients at the highest risk, and we didn't have enough vaccine to reach those high-risk groups and to vaccinate health care workers," says **Kristen R. Ehresmann**, RN, MPH, section chief in the Immunization, Tuberculosis, and International Health Section of the Minnesota Department of Health in Minneapolis.

"The state had to step in because the facilities that had [received their full supplies of] vaccine weren't looking at sharing to ensure that as many high-risk patients as possible were covered," she explains.

Ehresmann says the state has encountered resistance from facilities who had vaccine and wanted to vaccinate their clinical staff.

"But we in public health had to advocate for the public health in general, not just the health

of health care workers," she continues.

Siegel says the approach taken by Minnesota and other areas and facilities that are not vaccinating clinicians "is a very disappointing thing. I don't think that was at all the intent of the CDC," she notes. "It's not appropriate to encourage health care workers to not take the vaccine."

FluMist an option

Ehresmann and Siegel agree that health care workers — such as any healthy adults younger than 50 who aren't in contact with immunocompromised patients or relatives — are good candidates for use of the inhaled vaccine FluMist**.**

"Use of FluMist is an alternative for anyone not working in a high-risk population, such as bone marrow transplant patients," Siegel points out.

Minnesota is encouraging health care workers who can take the FluMist vaccine to do so.

"And as we get more flu vaccine — as we hope to do — we'll vaccinate health care workers," Ehresmann says. "We are hoping we're asking them to merely defer getting the vaccine, not forego it entirely."

Unvaccinated nurses and other health care workers often are the source of influenza for their patients in health care settings. Nurses working in settings already strapped for manpower frequently continue to work when suffering with influenza, in an effort to not burden their co-workers.

"Health care professionals have a responsibility to receive the vaccine," explains **Herman I. Abromowitz**, MD, a member of the American Medical Association board of trustees. "Health care professionals run a high risk of exposure and can transmit the virus to patients. The risks are great to ourselves, our families, and our patients," he adds.

"Especially disheartening is the mortality reports of patients with nosocomial influenza as a result of refusal by health care personnel to have their annual required influenza immunization," says **Nancy Bjerke**, BSN, RN, MPH, CIC, a consultant with Infection Control Associates in San Antonio. "Some would classify this occurrence as a sentinel event due to willful noncompliance."

Abromowitz cites studies that indicate vaccination of health care workers in nursing homes has been associated with fewer deaths from influenza in the nursing home populations studied.

For this reason, he says, "even healthy people, if they come into contact with those vulnerable [to serious flu-related complications], should receive the vaccine."

A risk secondary to transmitting the disease is the staffing burden worsened by staff who must stay home with the flu.

Because health care workers with the flu are advised to stay home when sick, the result can be added stresses to noninfected staff. The manpower shortage translates to reduced delivery of health care, and staffing shortages have been linked to poor patient outcome, Siegel says.

A just-as-unappealing alternative is that health care workers whose facilities are already shorthanded will take over-the-counter medications to ease their symptoms and will come to work sick, risking infecting more co-workers and patients.

There currently are no states that require health care workers to be vaccinated against influenza. Massachusetts is among several states that are pushing for mass immunization of health care professionals. The National Foundation for Infectious Diseases earlier this year issued a call for greater immunization rates among health care professionals, and the Massachusetts Department of Public Health is exploring the idea of making the flu vaccine mandatory for doctors in the state.

Not an easy sell

Even in years when the flu vaccine has been plentiful, the nationwide vaccination rate among health care workers has averaged about 38%. The reasons for the low compliance rate are the same as for the general population — from apathy, to fear of contracting the virus from the vaccine, to fear of other side effects.

Because there are no universal mandatory regulations for immunizing clinicians against the flu, mandating vaccinations has not been easy for facilities that have attempted it. While the CDC has long included health care workers on its list of those who should be immunized each year, obstacles include the individual rights of the clinicians and questions about what happens when a the vaccine is not an option because the clinician has an allergy to eggs (flu vaccine is grown in egg media), has a history of Guillain-Barré syndrome, or is running a fever.

The vaccine shortage came along just in time to derail, at least temporarily, a fight brewing in Seattle that started when Virginia Mason Medical Center attempted to become the first facility in the country to make flu shots mandatory for its staff and volunteers.

In eligible employees (those for whom the vaccination was indicated), compliance with the vaccination was linked to continued employment. The state nurses' union reacted swiftly, filing suit in federal court seeking to stop the vaccination program.

Virginia Mason administrators said the mandated vaccines were merely good medicine — that by requiring the vaccine, it would boost the facility's overall vaccination rate from 55% of workers to 100%, protecting more patients.

"This new policy will save lives," **Robert M. Rakita**, MD, infectious disease section head at Virginia Mason, announced in a press release in early October. But Virginia Mason only received about one-fourth of the amount of vaccine needed, and Rakita and the facility were forced to put their staff vaccination program on hold.

"Virginia Mason places a high value on patient safety and believes a medical center staff flu vaccination requirement can save lives," he adds. "But because the U.S. flu vaccine supply has been cut in half, we will not implement our 100% staff flu immunization program this year."

What risks are there for facilities whose employees become ill, and what legal standing do they have to require immunizations? What legal recourse do employees have who want to refuse vaccines?

As far as a facility's responsibility to protect patients and other employees from contracting the flu from a sick worker, "I think the ethical implications are that ill employees must be tested with rapid flu nasal swab; and if they are negative, they work, and if they're not [negative], they do not," says **James R. Hubler**, MD, JD, clinical assistant professor of surgery at the University of Illinois College of Medicine at Peoria.

"Even universal precautions in a high-risk population may not provide enough protection," he explains. "A [facility] that does not protect its patients would be at risk for lawsuits, but it would be nearly impossible to prove that they contracted the disease from a health care provider and not [out in the community]."

There is some scant case law pertaining to institutions' responsibilities should employees become ill as a result of a facilitywide immunization process. In one case in Louisiana, *Guillory v. St. Jude Medical Center*, a health care technician was ruled to be due workers' compensation because she developed encephalomyelitis triggered by a hepatitis vaccination administered by her employer, and the inoculation program was within the scope of her employment. In a related case in Texas, a firefighter who became incapacitated from a swine flu vaccination was awarded workers' compensation, even though he received the vaccination voluntarily because his job was considered critical to the community in the event of a swine flu epidemic and the city offered the vaccine to these critical employees.

In the case of the Virginia Mason mandatory vaccination plan, a spokesperson for the nurses union that represents the 600 nurses at Virginia Mason says, while nurses support the idea of vaccinations, the issue in this case is one of workers' rights.

"Federal and state laws require that, if you're going to change a working condition — which requiring this vaccination is — the employer must bargain with the union," notes **Barbara Frye**, BSN, RN, director of labor relations for the Washington State Nurses Association.

The CDC plans to focus attention on the health care community prior to the next flu season in hopes education will prompt a greater number of workers who come in contact with patients to voluntarily be immunized.

[For more information, contact:

- ***Herman I. Abromowitz,** MD, AMA Foundation, 515 N. State St., Chicago, IL 60610. Phone: (312) 464-5357.*
- ***Nancy Bjerke**, BSN, RN, MPH, CIC, Consultant, Infection Control Associates, San Antonio. E-mail: nancy@icabjerke.com.*
- ***Kristen R. Ehresmann**, RN, MPH, Section Chief, Immunization, Tuberculosis, and International Health Section, Minnesota Department of Health, 717 Delaware St. S.E., Minneapolis, MN 55414. Phone: (612) 676-5707. E-mail: kristen.ehresmann @health.state.mn.us.*
- ***Barbara Frye**, BSN, RN, Director, Labor Relations, Washington State Nurses Association, 575 Andover Park W., #101, Seattle, WA 98188. Phone: (206) 575-7979.*
- ***James R. Hubler**, MD, JD, **C**linical Assistant Professor of Surgery, University of Illinois College of Medicine at Peoria. E-mail: James.R.Hubler@ osfhealthcare.org.*
- ***Robert M. Rakita**, MD, Department Head, Infectious Disease Department, Virginia Mason Medical Center, 1100 Ninth Ave., Seattle, WA 98101. Phone: (206) 341-0846.*
- ***Jane Siegel**, MD, UT Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd., Dallas, TX 75390-9063. Phone: (214) 456-6000.]* ■

Hands off or on when it comes to patient care?

Offering comfort can be thwarted by culture

For as long as humans have been taking care of other humans who are sick or hurt, the rendering of solace and physical comfort has been the core from which all other types of aid have grown. But a nurse and ethicist in California says that ignoring the value of giving of solace and comfort amounts to turning away from the prime reason for the practice of medicine.

Rapid advances in technology, cultural differences between nurses and patients, and the current nursing shortage all have contributed to a hands-off approach by some nurses, says **Patricia Benner**, RN, PhD, professor in the department of social and behavioral sciences and the department of physiological nursing at the University of California at San Francisco.

"One colleague felt like it didn't occur to nurses to reach out physically to patients and to offer comfort other than medication, and I think that's a real deterioration of the practice," she adds. "It's a loss of self and ethos of the practice."

Benner disagrees with the opinion that nurses are not being taught in school the value of being there for patients, or presencing (being present and available to the patient) oneself and offering comfort.

But she agrees that cultural differences and concerns about the possibility of unwelcome touch possibly offending the patient or family members have led some nurses to not engage in hands-on comforting.

Offering comfort of the human type, and not just medications and technology, is what nursing always has been about, says Benner, a belief echoed by American Hospital Association president **Dick Davidson**.

"There will always be personal contact and caring," he says. "We will always have hands touching patients. Everything we do is about human need. That's the constant over time."

Nursing and medical students still are being taught the arts of gentle touch and hands-on comfort measures, such as simply being present in a reassuring manner, says Benner, who works as a consultant in the development and enhancement of delivery of nursing care. "However, there are threats to this central nursing practice. It is invisible; it is rarely charted; and it is never mentioned in a nursing care plan."

This leaves nurses to decide individually, patient by patient, what role comfort and presencing will play.

Just how much physical comfort a nurse should impart on a patient, if at all, largely will depend on the patient.

"It *always* has to be lodged in the relationship," Benner stresses. "Just as you can't suggest that you'll do it for all patients, it would also be very wrong to say you won't do it at all. And of course, if a patient does not want comforting, it would be wrong to force it," she adds.

Cultural diversity plays a role, as well; some cultures have deeply ingrained attitudes toward physical touching.

"You have multiculturalism on the side of both nurses and patients, and both groups are diverse [in their ethnicities]," Benner says. "The language of presencing and comforting practices are deeply cultural, and there are even status barriers that might prevent a nurse from offering solace or prevent the patient from accepting it."

She adds that for medical staff to know how to give a patient the comfort and solace he or she needs, and to the degree that he or she needs it, the clinician must first get to know that patient to determine what his or her needs and preferences are.

Staffing can have an impact on what kind of care can be rendered. If manpower is short, so is the time a nurse or physician can spend with individual patients.

"If you are short-handed, there isn't going to be lots of time for sitting with a patient, listening, just presencing," Benner points out. "But with adequate staffing, there's no reason comfort and caring can't be part of the delivery of care."

Delivery of comfort is taught in medical and nursing schools and is an integral part of the ethos of the practice, she adds. "You really couldn't have good judgment or trust without good relational care, at least in some specialties."

One specialty, in particular, gets it right when it comes to giving patients individualized, hands-on, comforting care. "I've always felt it was very sad that veterinarians give much more individualized care to their patients than we who take care of humans," says Benner.

Without that human element — the willingness to sit and hold a patient's hand, to listen, to massage cramping legs or bed-weary backs — "we have nothing but a technical enterprise of

delivering goods and services to patients."

When someone is ill, she says, that person needs more than just the best drugs and most advanced treatment available. "They need more than justice and rights; they need comfort and goods."

Simply being there for a patient, even without offering anything in the way of real care, becomes more difficult as facilities continue to struggle with staffing. But it's a care delivery method that patients really shouldn't have to do without, Benner says.

"Presencing yourself when someone is in distress — not abandoning them — is a very important comfort strategy," she adds. "This is especially true when someone is trying to get his own equilibrium back, regulate his breathing, get his heart rate back in tow.

"Just having someone with them can be a real source of comfort," Benner stresses.

[For more information, contact:

- ***Patricia E. Benner**, RN, PhD, FAAN, Professor, Thelma Shobe Endowed Chair in Ethics and Spirituality; Chair, Department of Social and Behavioral Sciences; Joint Appointment, Department of Physiological Nursing, University of California at San Francisco. Phone: (415) 476-4313. E-mail: benpat @itsa.ucsf.edu.]* ■

Inappropriate meds still prescribed to the elderly

Limited study should be reminder to pharmacists

Many elderly Americans still are being prescribed potentially inappropriate medications, according to a study published in the August issue of the *Archives of Internal Medicine.*

The study should be a red flag to pharmacists, to remind them to take a second look at an elderly person's medications, explains **Nicole Brandt**, PharmD, CGP, BCPP, assistant professor of geriatric pharmacotherapy and director of clinical and educational programs at the Peter Lamy Center on Drug Therapy and Aging. The center is located in the Department of Pharmacy Practice and Science at the University of Maryland School of Pharmacy in Baltimore.

"Many of these drugs may not be entirely effective for older individuals compared to other drugs, and they may also have more side effects and potentially lead to other negative consequences," she says.

Researchers look at a PBM

To examine the number of potentially inappropriate medications prescribed to the elderly, the researchers conducted a retrospective cohort study using the outpatient prescription claims database of a large, national pharmaceutical benefit manager (PBM) — AdvancePCS of Irving, TX, and Scottsdale, AZ, which now has merged with Caremark Rx Inc. The researchers compared the database with the Beers revised list of medications that usually should be avoided in elderly patients.

"In the whole scheme of things, [the drugs on the list] have been deemed inappropriate medications because there are other, safer alternatives for older individuals," Brandt says. "Other drugs are available that have fewer side effects, have fewer drug interactions, and have a better efficacy profile."

In the study, the researchers found that 162,370 subjects (21%) filled a prescription for one or more drugs of concern. Amitriptyline and doxepin accounted for 23% of all claims for Beers list drugs, and 51% of those claims were for drugs with the potential for severe adverse effects. More than 15% of subjects filled prescriptions for two drugs of concern, and 4% filled prescriptions for three or more of the drugs within the same year. The most commonly prescribed classes were psychotropic drugs and neuromuscular agents.

Amitriptyline in older individuals is very anticholinergic, Brandt says. "You could monitor for anticholinergic activities, but the key thing is that a lot of our older individuals have memory problems. This potentially could worsen it and cause them to be delirious."

Other agents in the realm of tricyclic antidepressants aren't as anticholinergic and can be just as beneficial without having as many side effects, which include dry mouth, confusion potential, constipation, and worsening of their glaucoma, she adds. "They seem to be tolerated a little bit better in terms of their side effect profile."

Ruth Emptage, PharmD, assistant professor of clinical pharmacy, pharmacy practice, and administration at The Ohio State School of Pharmacy in Columbus, agrees that there are other choices in most of the cases of the medicines that are on the Beers list of inappropriate drugs. Amitriptyline might not be a bad choice for some of these

patients; however, limitations in the study do not make it possible to know for sure, she says.

The researchers admit to several limitations:

- The results reported may overestimate potentially inappropriate prescribing for the uninsured.
- Certain drugs may be used at very low doses as last-resort treatments for the management of pain (amitriptyline) or urinary incontinence (doxepin).
- These data provide no direct insight into the outcomes associated with the use of prescription drugs.
- The researchers cannot be certain that the drugs prescribed and dispensed actually were consumed.
- Finally, and most importantly, there are no data on the reasons why certain prescription choices were made by a specific clinician for a specific patient.

Amitriptyline is listed as an antidepressant, but it may not necessarily be used for that property, Emptage says. "It appears to be the agent most effective for treating diabetic neuropathy.

"I'm sure that in some of the cases [with the elderly patients], amitriptyline is not the best," she continues. "But some of the alternatives for diabetic neuropathy aren't all that effective, or the formularies may not cover them."

The PBM's preferred formularies definitely may affect which medications the elderly patients are being prescribed, she says. The researchers conclude that the "common use of potentially inappropriate drugs should serve as a reminder to monitor their use closely.

The key is to remember that you are dealing with a cohort of older individuals, Brandt suggests. "Is this person really tolerating the drug? [Older individuals] are more sensitive to these side effects. They are more likely to experience these adverse effects or use additional concomitant medications that can be problematic." ■

LegalEase

Understanding Laws, Rules, Regulations

Patients' right to freedom of choice of providers

Avoid fraud and implications of violations

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

Regulators have indicated they are serious about patients' right to freedom of choice of providers. Specifically, the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services published draft supplemental compliance guidance for hospitals. This supplemental guidance includes requirements related to patients' right to freedom of choice of providers as described here:

Specifically, the OIG directly addressed the compliance issues related to freedom of choice in the following:

"When referring to home health agencies, hospitals must comply with Section 1861(ee)(2)(D) and (H) of the Act, requiring that Medicare participating hospitals, as part of the discharge planning process, (i) share with each beneficiary a list of Medicare-certified home health agencies that serve the beneficiary's geographic area and that request to be listed, and (ii) identify any home health agency in which the hospital has a disclosable financial interest or that has a financial interest in the hospital."

Based upon that, the OIG has indicated a clear willingness to treat violations of the requirements of the Balanced Budget Act as a form of fraud and/or abuse of the programs.

The OIG also indicated that it has authority to exclude any individual or entity from participation in the federal health care programs if the they provide unnecessary items or services (i.e., items or services in excess of the needs of patients or substandard items; or services, i.e., items or services of a quality which fails to meet professionally recognized standards of health care).

The OIG further stated that neither knowledge or intent is required for exclusion under this provision. The exclusion can be based upon unnecessary or substandard items or services provided to any patient, even if that patient is not a Medicare or Medicaid beneficiary.

The OIG went on to state that violations of Medicare hospital conditions of participation (COPs), including those that govern discharge planning, or any other applicable standards of care may result in either over- or underutilization of services and sanctions by the OIG.

It is logical to add that applicable standards of care also include the requirements of the Balanced Budget Act of 1997.

Consequently, hospitals that violate applicable standards of care related to patients' right to freedom of choice of providers and discharge planning may be subject to sanctions by the OIG.

It also is important for all providers to be aware that there now is an impressive array of tools available to them for use in dealing with referral issues, including:

- Assisting patients to pursue violations of their common law rights to freedom of choice of providers regardless of payer source or type of care rendered primarily through the use of signed statements that describe violations.
- Assisting patients to pursue violations of two federal statutes that guarantee Medicare and Medicaid patients, except waiver patients, the right to freedom of choice of providers primarily through the use of signed statements that describe violations.
- Reporting to the Centers for Medicare & Medicaid Services regional and central offices on violations of patients' right to freedom of choice of providers by providers who participate in the Medicare/Medicaid programs.
- Reporting to state surveyors about violations of patients' rights. The surveyors treat such information as complaints and conduct surveys of hospital and other providers that may result in statements of deficiencies, corrective action, and follow-up surveys.
- Reporting to the OIG on violations of patients' rights to freedom of choice of providers and/or violations of applicable standards of care, which may result in sanctions against providers.

Providers also should be aware that a number of these avenues are available to providers who do not participate in the Medicare Program.

Although the OIG's supplemental guidance focuses on hospitals' compliance, it also is important for providers to bear in mind that other types of providers sometimes violate patients' right to freedom of choice of providers, including physicians.

It is reasonable to conclude that the OIG would be willing to sanction all types of providers for violations of patients' right to freedom of choice of providers.

There are an increasing number of avenues for both patients and providers to pursue violations of patients' right to freedom of choice of providers. Providers of all types should be proactive when they encounter such violations.

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

CMS initiates Scope of Work quality program

A new proposal for its quality improvement organizations (QIOs) has been unveiled by the Centers for Medicare & Medicaid Services (CMS).

QIOs are local organizations that by law, contract with CMS to provide quality improvement assistance to health care providers, such as physicians, hospitals, nursing homes, and home health agencies, and health plans that contract with Medicare.

Mark McClellan, MD, CMS administrator, said the QIOs are a key part of the center's efforts to improve the quality of care offered by the U.S. health care system.

"We know there are areas where there are substantial gaps between known good practice and actual practice, and we know dramatic improvement is possible," he said. "We now have more opportunities than ever to close those gaps, so that every Medicare beneficiary gets the right care every time he or she receives medical treatment."

Program focuses on three key areas

CMS has proposed what it calls the 8th Scope of Work, calling it a plan that represents significant enhancements over previous QIO contracts.

According to CMS, compared to previous contracts, the new proposal is different in three key areas.

1. It recognizes that although the U.S. health care system "has been leading the way in many improvements, the full potential of our health care system to improve health is not being achieved," CMS said.

The plan is intended to promote dramatic improvements in the quality of health care so every person receives proper care.

2. The plan proposes that QIOs may need to build on their current efforts to involve other organizations and entities to provide the best expert assistance in increasingly specialized areas, and it invites comments on options for accomplishing that via subcontracting and other partnerships.
3. The design of the program will be organized to better distinguish QIO impact from improvement that may occur without QIO assistance, such as increased awareness of clinical guidelines by physicians.

McClellan said CMS, working with the QIOs, wants to see improvements that could transform the quality of life for Medicare beneficiaries.

For example, according to CMS, 27% of people with Medicare did not receive annual flu vaccinations in 2002, vaccinations that could prevent as many as 22,000 deaths annually.

McClellan said that under this plan, QIOs will assist in closing the gap between poor performing nursing homes and those practicing right care.

The 8th Scope of Work focuses attention in four settings: nursing homes, home health agencies, hospitals, and physician offices.

It also will protect beneficiaries and the Medicare Trust Fund through work on appeals, beneficiary complaints, payment error, and other case review activities, CMS said.

The agency said the new plan also moves past the 7th Scope of Work in various respects:

- QIOs will work to promote the adoption and effective use of health care information technology, performance measurement, process redesign, and organizational culture change. For example, working with partners in a pilot project, QIOs are assisting small- to medium-sized physician offices in California, Arkansas, Massachusetts, and Utah in adopting office-based electronic health record systems and using the systems to improve efficiency of care delivery, quality of care, and patient safety.
- QIOs will work with prescription drug plans to ensure quality care to people with Medicare on improvement projects such as measures to detect inappropriately prescribed drugs and ways to identify patients who may be at risk for harmful interactions.
- QIOs will work to improve care for disadvantaged populations by focusing on physician office-based care to make sure all Medicare beneficiaries get the right preventive services and appropriate care for chronic diseases such as diabetes.
- QIOs are expected to continue offering mediation as a service to Medicare beneficiaries. The service involves direct provider involvement in responding to beneficiary complaints, which often results in improved communication between provider and patient to resolve quality-of-care issues.

CMS said this multipronged approach includes helping consumers make decisions using timely and accurate quality-of-care information and urging providers to improve quality using free assistance from the QIOs and through pay-for-performance demonstrations.

Beginning in early 2005, hospital quality data will be available at www.medicare.gov. CMS currently publishes quality information on its

web site for Medicare and Medicaid-certified nursing homes and Medicare-certified home health agencies.

The 8th Scope of Work will guide the work of the QIOs for the three-year cycle beginning in August 2005.

CMS invited public comment on the proposal to assist in developing the full plan and for determining the level of program funding. ■

CE *questions*

For more information on the CE program, call customer service at (800) 688-2421.

9. At what point in the hiring process should you give a prospective employee the job description, according to Linda S. Henry with Positive Strategies in Puyallup, WA?
   A. after orientation
   B. prior to the initial interview
   C. first day on the job
   D. during the interview

10. According to the results of the annual American Association of Homecare's survey of financial and operational benchmarks, what is the average for accounts receivables days for survey respondents?
   A. 33 days
   B. 52 days
   C. 74 days
   D. 85 days

11. In facilities where the supply of killed flu vaccine is inadequate to cover both high-risk patients and healthy employees, those healthy employees who are younger than 50 years and are not in contact with immunocompromised patients or relatives should consider the inhaled vaccine FluMist as an alternative.
   A. true
   B. false

12. Which of the following is NOT an obstacle to offering patients physical comfort and solace, according to nurse ethicist Patricia Benner?
   A. cultural views
   B. time pressures
   C. the desire of the patient to receive comfort and solace
   D. fear of offending the patient

Answer Key: 9. D; 10. C; 11. A; 12. C

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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