HOSPICE Management ADVISOR™

Integration • Outcomes • Managed Care • Medicare Compliance • Risk Management • QI • End-of-Life Care

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

JANUARY 2005
VOL. 10, NO. 1 • (pages 1-12)

Special Report: Improving Staffing Quality

Improving interdisciplinary teamwork also boosts quality improvement

Even two hurricanes couldn't shatter one team's bonds

Staffing continues to be a major issue for hospices and other health care organizations that must face periodic shortages in nursing and other disciplines, as well as cope with high turnover rates.

For hospices, attempts to implement basic strategies for improving staff morale and retention are challenged by the high demand for employees who embrace the hospice philosophy, which may improve loyalty but can also lead to faster burnout.

"Basic hospice care for patient and family is very holistic," says **Joy Berger**, DMA, BCC, MT-BC, director of the hospice institute at the Alliance of Community Hospice & Palliative Care Services of Louisville, KY.

"It includes physical, emotional, spiritual, and bereavement care, and it goes far beyond the standard medical care model," Berger says. "We provide a lot of emotional support and education for the family, as well."

This is why an interdisciplinary team approach is crucial for a hospice, she adds. **(See story on developing an effective hospice team model, p. 3.)**

"We have an orientation model and process for helping new employees transition from non-hospice, interdisciplinary roles to the hospice model," Berger says. "This is a significant transition for many employees who come from the curative vs. palliative perspective."

Likewise, the Hospice of Lancaster County in Lancaster, PA, helps LPNs make the transition from skilled nursing facilities to hospice care, where they become hands-on providers who provide services that they're accustomed to seeing aides provide, says **Janet Carroll**, MSN, RN, CHPN, vice president of clinical services for the hospice.

The not-for-profit freestanding hospice does not hire home health aides and homemakers. Instead, it has LPNs provide those services, which enhances the quality of care, Carroll says.

"Although we have not analyzed the hard numbers, we know we save money because we don't have the staff turnover we would have, and there are things LPNs can do that home health aides cannot," Carroll explains. "Looking at it from a quality perspective, we've always gotten good feedback."

"By virtue of their license, training, skills, and experience, LPNs are able to help out in numerous ways that complement the RN staff," Carroll adds. **(See story on using LPNs to enhance quality and efficiency, p. 5.)**

One of the chief staffing challenges arising for hospices and their interdisciplinary teams involves communication breakdown.

"Usually when you have any group of professional people and team members, there is some disagreement or conflict," says **Martha Lasseter**, MBA, RHIA, vice president of compliance at Hospice of Martin and St. Lucie of Stuart, FL.

"You have to have team cooperation and have the team mesh so the best interests of patients and caregivers are met," says **Kathy Moon**, RN, BSN, clinical director of day programs for Hospice of Martin and St. Lucie. "Each member of the team has a defined role, and they all have to mesh together to accomplish the end result so that the patient and family experience a peaceful death."

Hospice managers focus on strategies for improving communication and reducing the common staff conflicts that result in a dysfunctional employee team dynamic if left unchecked, Lasseter and Moon say.

For instance, one of the typical conflicts that arise involves staff-patient boundaries.

"Occasionally, a nurse or social worker becomes too involved with family situations and crosses the ethical boundary, and that creates conflict with the rest of the team," Moon says.

"As you're dealing with families, you can't help but get enmeshed," Lasseter says. "Maybe you see a family struggling financially, or maybe you see that there's not enough food in the home."

Hospice of Martin and St. Lucie once had a situation where a nurse saw that the family didn't have enough money to pay for food, so she tried to help them sell some of their belongings to free up their cash, Lasseter recalls.

"Her heart was in the right place, but she went about it the wrong way," Lasseter says. "All she needed to do was let her supervisor know about the problem, and as a not-for-profit agency we could partner with United Way to get the family the food they needed."

In another instance, an employee saw how a patient was struggling with finding a home for a pet, so the employee took the pet home to care for it, Lasseter adds.

"Or staff will give up their private home phone number and have chats, answering the patient's questions at all times of the day and weekend," she says.

Even the more benign of these examples can have a negative impact on team morale, Moon says.

For instance, if the nurse crosses a boundary by handling financial issues with a patient, then the social worker might feel as though this hinders her from doing her job, Moon says.

"Rather than working together and collaborating as a team, the nurse's actions have created a divided team," she adds.

When these issues arise, managers counsel

Hospice Management Advisor™ (ISSN# 1087-0288) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. First-class postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospice Management Advisor™**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). **Hours**: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: One year (12 issues), $399. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $58 each. (GST registration number R128870672.)

Editor: **Melinda Young**, (864) 241-4449.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@thomson.com).
Production Editor: **Brent Winter**.

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

employees individually and then pull the team together to determine how best to correct boundary problems, Moon says. **(See quick tips for creating an effective team, p. 6.)**

"Sometimes we may have to reassign the patient to another staff member if the situation can't be resolved without further harm to the team or the patient's care plan," Moon says.

Lasseter and Moon, along with other hospice managers, learned how important a fully dedicated and integrated staff could be during the fall 2004 hurricanes that pounded Florida.

When hurricane Frances struck the Stuart area on Labor Day weekend and then hurricane Jeanne struck the same coastline three weeks later, many staff members and patients were displaced, Lasseter says.

"You're taking care of patients, but at the same time thinking about how you don't have a roof over your house or your bedroom is ruined and the carpet is soaked," Lasseter says. "All of these are the types of things our staff was having to deal with."

From the beginning of the hurricane disasters, hospice managers had to keep the teams cohesive and help people deal with personal losses and patient losses, Moon recalls.

Under adversity, team pulled together

"We had to identify the staff that had a need and work with them so they could continue to function to provide for their patients," Moon says.

The team cohesiveness was readily apparent: "Our staff came through with flying colors," Lasseter says. "I can't say enough about how unselfish they were. People came to work without electricity in their homes; they had to use the water and electricity here to do laundry and take showers."

The entire agency pulled together to make certain all of the patients were taken care of and to make certain new patients were handled as well, Lasseter and Moon add.

The hospice's 16-bed inpatient residence doubled to 32 beds when some patients were brought in because they had lost their homes and when another hospice needed to find a place for the patients in its residential facility after the hurricane had damaged it, Moon explains.

When the agency's telephones were down for three days, the entire staff contacted patients and kept track of one another through three cell phones shared by the only employees who had cellular phone service, Moon notes.

"We had staff members who worked on their time off so others could contact FEMA [Federal Emergency Management Agency] and their insurance companies," Moon says. "It was truly a team effort, and everyone pitched in wherever they were needed to help their fellow co-workers, as well as the patients." ■

Special Report: Improving Staffing Quality

Self-appraisal is key to training new employees

Facility's training program has nine modules

Training new staff to follow the hospice team model requires a comprehensive approach that helps people new to hospice make the transition to the hospice philosophy, and that helps create a better understanding of the role of each hospice discipline.

"Whichever discipline new employees are, they need to get comfortable in their own shoes in being with dying people and talking about end-of-life decisions and hearing others' beliefs and values without pushing their own," says **Joy Berger**, DMA, BCC, MT-BC, director of the hospice institute at the Alliance of Community Hospice & Palliative Care Services in Louisville, KY.

The alliance has a holistic approach to hospice staff training that empowers people to provide the best front-line care and turn the squeaky wheels into advocates for the partnership of hospice teams and management, Berger says.

"Our hospice is the first accredited Practice Development Home Health Agency in the United States," Berger says. "This was through Leeds University in the United Kingdom. A group of 12 to 15 care providers went through training, goal setting, and implementation for developing leadership in every person within the scope of their jobs."

However, the chief component of the hospice's training and education is its nine-module staff orientation session.

"We guide and empower the new employees to apply the information coming from the orientation presenters to their own job descriptions

and roles," Berger says. "They do self-appraisals throughout the orientation process."

The orientation involves 30 presenters to cover three hospices, two inpatient units, and three bereavement centers, Berger says.

"Within this, we have educational tools and some reflection synthesis pieces built into the week for them to reflect on changes from their previous job roles," Berger says. "We put a lot of emphasis on how their role fits within the whole organization, including the clinical team, the finance department, and the thrift shop where goods that have been donated to the hospice are sold."

For example, an employee who works in the thrift shop will need to understand that thrift-shop donations often come from bereaved families, Berger notes.

"We emphasize the importance of the person doing the medical records to understand the interdisciplinary team concept and know the time line of the patient and family," she says.

Here's how Berger's orientation program is structured:

• **Understanding "who":** Module one involves sessions that describe hospice staff, employee and regulatory requirements, human resources, and contact information. Module two has a Hospice 101 session, along with sessions that describe hospice patients and families and their psychosocial, physical, and spiritual needs. This module is followed by a self-awareness exercise.

Trainees responsible for synthesizing info

On Monday mornings, the orientation begins with the image of a compass and the question, "What does being oriented mean?"

With the compass metaphor, new employees are told it's their responsibility to process what they learn and synthesize information with what they know about their own skills and discipline, Berger says.

"I ask them after each session, 'What is it you really understand?'" Berger says.

• **Understanding "how":** On Tuesdays, sessions in module three discuss the admissions process, visiting patients, interdisciplinary plan of care, emergency needs, documentation for clinical staff, and job-specific applications for non-clinical staff. In module four, employees are taught how the hospice provides care at and after death, including a focus on bereavement care.

"At the end of Tuesday afternoon, after everything has been so stressful — discussing the timetable of patients from admission through death and bereavement — I go in and have them do the Hokey Pokey," Berger says. "I play off of the song, saying, 'When you come in here in the morning, you put your whole self in, and when you leave in the evening, you take your whole self out.'"

Employees trained to assess grief risks

Part of the hospice's clinical process is assessing risk among survivors for complicated grief, and there's a specific tool that's used to assess that risk, she notes.

"So it's important the employee makes a visit to the funeral home and greets the family with 'You did a great job' and 'How are you doing?'" Berger says. "We also do some assessment for what kinds of complications might set in, and we make sure the appropriate people know about our bereavement services."

This also is discussed during the module about the patient, death, and the family.

• **Job and regulatory details:** On Wednesdays, the fifth module focuses on specialty services provided by the hospice, including music therapy, volunteer services, inpatient units, continuous care and caregiver training, and child and adolescent grief. The sixth module discusses regulatory issues and policy details, including personal wellness, performance improvement, corporate compliance, privacy regulations, infection control, employee health and safety laws, and volunteer services.

In the first session, the music therapist comes in and describes the use of music therapy with hospice patients and how referrals are made for the service, Berger says.

Music therapy and the other specialty services are not used by every patient, but every employee needs to know they are there and available, she adds.

• **Putting financial, productivity, and community pieces together:** On Thursdays, new employees learn in module seven about financial stewardship, productivity standards, customer service, and computer use. In the eighth module they are provided an overview of cultural diversity, local public relations in the community, personal and professional boundaries with patients, hospice ethics, and their personal career paths and future.

The hospice's chief financial officer had asked to conduct a financial stewardship session so employees would understand how the organization makes and spends money and how each employee's individual decisions may affect the team and the hospice's overall health and well-being, Berger says.

"We are a nonprofit organization, but the CFO also says, 'We're a not-for-loss organization,'" Berger adds. "We have to provide financial stewardship and be productive in our day."

Employees are asked to do a self-appraisal on Thursday afternoon. The self-evaluation summary encompasses these seven items:

— My greatest strengths I bring to this job are:

— Reflecting on my "self-appraisals," my previous experience, my "Job Description," and my self-knowledge, my greatest learning needs are:

— I know I've done a really great job when:

— A fear for me in this new job is:

— An important hope for me in this new job is:

— Currently, I find feedback and support for myself from:

— In the days, weeks, and months ahead, I will look for new feedback and support through:

Closing ritual affirms individuals

"We close with a ritual in which I use a Buddhist chime, and we affirm each person in that room, their strengths, fears, and hopes," Berger says. "That has always been rich and meaningful, and we've been doing this module every month since April 2003."

• **Specific nursing information:** The ninth module on Fridays is specific to RNs and LPNs, and includes information on patient care guidelines, durable medical equipment, advanced pain management, medication titration, case management issues, hospice pharmacia, forms and documentation, symptom management, and comfort in the chaos of care.

The key to the comprehensive, week-long orientation program is to give employees a jump start on setting personal learning goals rather than having them wait until their first year's job appraisal, Berger notes.

"We are helping them set their own goals, and it might be to learn the computer system or to learn more about a particular medication, or it might be for a social worker to learn more about advance directive forms," Berger adds. "One person said her greatest learning curve is to learn more about cultural diversity and to be more open in herself, and that is huge." ■

Special Report: Improving Staffing Quality

Expanding use of LPNs boosts staffing flexibility

Hospice exceeds requirements, aims for top quality

The Hospice of Lancaster County in Lancaster, PA, never hired home health aides and homemakers because when the not-for-profit hospice was founded 25 years ago, hospice managers chose to go a step beyond the minimum requirements.

"We think outside the box," says **Janet Carroll**, MSN, RN, CHPN, vice president of clinical services for the hospice.

Replacing home health aides with LPNs provides the hospice organization with flexibility, as well as providing opportunity for quality improvement, Carroll says.

"For example, if an aide was going into the home and the patient was incontinent, and the aide changed the bed, now the patient would need a Foley catheter, which would require another visit by a licensed person," Carroll says. "By the time that person got there, the patient would be incontinent again, and the bed would need to be changed again, and that would be more disruptive for the patient and family than if the LPN was there from the start to make that assessment and intervention."

Likewise, the hospice hires social workers with MSWs, instead of settling for the minimum requirement of BSW, Carroll says.

"I think it's important for our industry to be continually stretching itself," she adds.

While it may cost extra for a hospice to go beyond the minimum requirements, the overall financial bottom line probably will benefit, Carroll notes.

For example, in the situation in which an LPN is able to provide a nursing service that an aide cannot provide, the agency is saving money by not having two disciplines making a visit to the home, with the double cost in mileage and salary, Carroll says.

"There's also an issue with training and supervision, and when you have licensed staff, you start a little ahead of the game," she notes.

Also, there is the cost of staff turnover to consider.

"Our experience has been that LPNs have a high degree of job satisfaction because there's an

independence in their practice that they might not have in another setting," Carroll says. "And we do expect them to do more; they provide LPN and homemaker services."

For instance, LPNs will provide some complex wound care, as well as blood draws, and they may give hospice management feedback on symptom management, Carroll says.

"The LPN works closely with the RN and the coordinated plan of care," she says. "We look to the LPN's input and experience to complement what the RN care manager is doing."

One of the reasons why job satisfaction is high among LPNs at the hospice is that these employees are given more autonomy and bedside work, Carroll notes.

The LPN staff typically have moved to hospice care after working in other health care settings where they were given greater desk responsibilities that took them away from hands-on patient care, she says.

"Basically, we look for people who want to get back to hands-on care and want to spend time with patients," Carroll says. "They let go of the role of being the charge nurse, which is often their role in a nursing home."

At the same time, the hospice LPN works with a strong interdisciplinary team that shares responsibility for patient care.

When hiring new LPN staff, Carroll often hears this refrain: "We've heard your nurses get to spend time with their patients; that's why I became an LPN instead of an RN, because I want to spend time with patients."

One of the challenges in using LPNs instead of aides is that there's a potential for role-blurring, Carroll notes.

"There isn't anything that an LPN does that an RN can't do," she says. "Then there's a component that only an RN can do."

Since LPN staff may vary in skills, hospice managers work on maximizing each employee's gift and skills, Carroll says.

"Sometimes it's hard for RNs to give up tasks, so it's important to build relationships and trust, so the right hand feels good about what the left hand is doing," she explains.

Team leaders may work with RNs to encourage this trust. For instance, a team leader might say to an RN, "The LPN is going there today, and perhaps the LPN could ask this question or assess this point and get back to you, vs. making two visits to the patient if that's unwarranted," Carroll says.

Training LPNs for hospice care is similar to RN training, but with the omission of case management and physician orders, Carroll says.

The hospice provides education in pain and symptoms, spiritual care, grief and loss, reimbursement, overall benefits, and raising the level of the agency's practice to provide greater flexibility in responding to patients' needs, she says. ■

Special Report: Improving Staffing Quality

Quick tips for creating an effective hospice team

Conflict resolution is key to success

In any group of people who work together under stressful and demanding circumstances, there are bound to be interpersonal conflicts that can reduce the team's effectiveness.

However, hospice managers who would like to prevent some of the more common conflicts and resolve the inevitable ones might follow these tips from **Martha Lasseter**, MBA, RHIA, vice president of compliance, and **Kathy Moon**, RN, BSN, clinical director of day programs, for the Hospice of Martin and St. Lucie in Stuart, FL:

• Let experts do their jobs.

Conflicts often arise when one member of the team decides to provide a service that is outside his or her expertise, and this steps on the toes of another member of the team, Lasseter and Moon say.

"Say the nurse tries to handle the financial end of a patient's care. This can hinder the social worker from doing her job," Moon says.

"You have to respect the experts on the team," Lasseter says.

"We've had a situation where an LPN on the team was proselytizing or trying to deal with the spiritual, religious issues that are the domain of the chaplain," Lasseter adds. "That's what we're talking about in respecting other people's expertise and boundaries. She wasn't doing it the right way."

• Recognize that each team has its own personality.

Hospice managers need to recognize that teams will develop their own personalities as they become effective and cohesive, Lasseter notes.

"Each team has its own personality, and each becomes very protective of their patients," Moon says. "So when you move a patient from the home to a hospice residence, it's hard for the home team to let go of that patient and to allow the staff in the residence setting to do their jobs."

This could lead to staff crossing boundaries and creating conflict with other teams, she adds.

So it's important for managers to address this potential conflict up front and let teams know that they will have to trust that the services they provide will be handled satisfactorily by the new team taking over the patient's care, Moon says.

• **Provide grief support to staff.**

"We have grief support services and specialists in our agency, and we make that service available to our team members, as well," Lasseter says.

"For example, there isn't anything as hard-hitting for a team as experiencing the death of a young child or a baby," she notes. "During team meetings, if a supervisor sees that her team is struggling with grief, she'll have them take extra time to talk among themselves."

Remembrance services held for staff, families

Also, there is an employee assistance program that provides counseling to staff free of charge, Lasseter says.

"We have services of remembrance held several times a year, and this is where staff can share that grief with family members and co-workers," she says. "And we have remembrance services specifically addressing children."

Since the hospice provides grief support to families for 13 months after the patient's death, staff are encouraged to remain involved, Moon says.

• **Make standards of conduct very clear.**

The standards of conduct spell out what's appropriate and what is not, Lasseter says.

"We ask employees not to take advantage of a patient's hospitality or to get into the middle of family conflicts," Lasseter says. "We have guidelines in terms of what they are able to accept in terms of a gift, and it must be valued at $25 or less."

While hospice staff are not expected to hurt a family's feelings by turning down some small token, they are not permitted to accept significant gifts. Instead, they should suggest the person make a donation to the agency by contacting the agency directly, Lasseter says.

Also, staff are told to not give out their home telephone numbers or associate with patients and family on their days off, Lasseter says.

• **Focus on improving communication.**

"You always have communication issues, and we try to resolve those by making sure that if we have a nurse or social worker who's going to be off for a few days, then the person who is filling in is made aware of the patient's situation," Moon says. "Or a night nurse can call and leave a report that the staff can listen to."

Also, staff leave three days' worth of notes, called a "traveling chart," in the patient's home so if a nurse calls in sick, she'll know what happened on the last three visits with the family, Moon adds.

• **Encourage teams to go the extra mile.**

There was one hospice patient who had never received his Purple Heart for being wounded in action, and the team social worker set about to correct that problem, Moon recalls.

Patient receives long-lost medals

"So she made some contacts, and the gentleman not only received his Purple Heart, but there were several other medals he never received, and she was able to get those and present them to him," Moon explains. "The nurse had notified the social worker, and together they figured out a way to do this and ended up creating a media event of the gentleman receiving his medals."

• **Managers should make sure to have an open door.**

"Team managers are responsible for making sure the team is cohesive and works as one with respect for one another," Lasseter says.

"We encourage managers to be approachable, not to build this wall between them and their staff," Moon says. "But managers have boundary issues too — you don't want a manager to become your best friend."

The hospice had one manager who treated staff that way, and when she left the organization, her team had a difficult time adjusting to a new team manager who had a more appropriate approach, Moon says.

"There was difficulty with the trust factor, but eventually the team learned that she was there to guide them and not to be their best friend, and now they trust her," Moon adds. "Once a team trusts you and knows you have their backs, so to speak, then you develop loyalty and have a true team."

• **Keep it light.**

"You are never too busy to laugh," Lasseter says. "In the field of hospice, you have to defuse a lot of situations with laughter."

For instance, the hospice has had a manager show up for a team meeting dressed in bedroom slippers, a bathrobe, and curlers, Lasseter recalls.

"This was just for a few minutes of the team meeting so she could make them laugh," Lasseter says. ■

Managers can be key to employee retention

The value of being valued

Every 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.

"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 resources 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.

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 until after you've hired the employee to give him or her the job description. "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, Linda 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 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, Linda Henry adds.

When you are hiring supervisors, make sure they are good communicators, James Henry suggests. "They should be able to communicate one on one as well as in a group setting," he says. 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 for the people in the audience, he adds.

Management training should be ongoing

"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 you have the best supervisors and managers, DeLong suggests.

"At our management meetings, we 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 provides support right from the start with

How to show employees you care

"Managers do have to develop caring behaviors for their employees, just as nurses care for patients," says **Linda S. Henry** with 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," Henry 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, she adds.

Henry says there are five steps managers can take to make sure they are demonstrating caring behavior:

1. Maintain the belief that you work as part of 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."

3. Be with the employee during 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, says Henry. "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 for the employee.

"We can't always give employees exactly what they ask for, but we can make sure we follow up on reasonable requests or suggestions and that we let people know what we've done," says Henry.

5. Enable employees.

The best way to let employees know that they are valuable and that 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 make it more valuable. ■

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 often 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 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 story, above.)**

All home health agencies want to provide the best care possible, but that goal can only be

achieved if employees know that management cares about them, Linda Henry says. "There are very few top executives who can express this caring attitude, so we need to make sure our managers and supervisors who deal with employees every day know how to express it." ■

Inappropriate meds still prescribed to the elderly

Limited study should be a 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 reminding pharmacists to take a second look at an elderly person's medications, says **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 being prescribed to the elderly, 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. The researchers compared the database with the Beers revised list of medications that should usually 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 glaucoma, she adds. "They seem to be tolerated a little bit better in terms of their side effect profile."

Amitriptyline common for diabetic neuropathy

Ruth Emptage, PharmD, assistant professor of clinical pharmacy, pharmacy practice and administration at The Ohio State University 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, but limitations in the study do not make it possible to know for sure, she says.

The researchers admit that the study has 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 were actually 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; 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 may definitely 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." ■

News From the End of Life

Accounts receivable reach lowest level in 5 years

The 2004 financial and operational survey conducted each year by the American Association for Homecare (AAHomecare) shows that accounts receivable days outstanding averaged 74 days — the lowest reported in more than five years.

"This report is the leading industry benchmark for the financial and operational management of home care providers," says **Kay Cox**, president and CEO of AAHomecare. "It provides an opportunity for our diverse membership to see how they measure up against industry averages with companies of similar size and market segment. The comparative information in this survey is an essential tool for management teams within the home care industry."

Key findings in this year's survey include:

• **2005 Medicare oxygen reimbursement rate cuts:** As of December 2003, only 35% of firms indicated that they had developed plans for addressing the Medicare oxygen reimbursement cuts. Another 36% of responding firms stated that they had "sort of" developed a plan, while 29% of respondents had not developed a definite plan.

• **Hospital ownership:** Hospitals owned 28% of firms in 2003. In past surveys, the proportion of hospital ownership has ranged anywhere from 25% to 35%, putting this year's results at the lower end of the range.

• **Accounts receivable:** In 2003, overall accounts receivable days outstanding averaged 74 days — the lowest reported in more than five years. The percentage of receivables of more than 120 days remained high, at 25%.

• **Acquisition revenue impact:** The 11% of participating companies that reported making an acquisition had an overall growth rate of 17% (higher than the industry average of 10%). But their average growth rate for continuing business remained at 9%, closer to the industry average.

The entire study can be purchased by visiting the AAHomecare web site (www.aahomecare.org) or by calling Nick Burton at (703) 535-1882. The cost is $250 for AAHomecare members, $500 for nonmembers. ▼

Safety group offers fall prevention resources

The Safety Institute of Premier Inc. has launched a publicly accessible, web-based clearinghouse of resources and tools for fall prevention to define and measure falls, identify risks, and target prevention strategies among patients and residents.

The resources include: risk factor identification and evidence-based interventions; sample prevention programs with policies and procedures; tools for risk assessment, fall rate calculations, targeted interventions, and patient monitoring guidance; definitions, consensus standards, classifications from national organizations, and annotated references; and education and training programs.

These web resources are part of the institute's web site on patient, worker, and environmental safety, which includes downloadable tools, an on-line safety store, resources, and an electronic newsletter.

The information is available free of charge at www.premierinc.com/safety. Click on "fall prevention module" or the Worker safety icon for back injury and fall prevention resources. ▼

Stiff penalties for violating HIPAA privacy rules

A federal judge has delivered a message that violations of the Health Insurance Portability and Accountability Act (HIPAA) privacy rules will be met with severe penalties. In sentencing former cancer treatment center technician Richard W. Gibson, of SeaTac, WA, U.S. District Judge Ricardo Martinez added four months to the 12-month plea-bargained sentence agreed to by prosecutors. Martinez sentenced Gibson to 16 months in prison and charged him with at least $15,000 in restitution.

Gibson was the first person convicted of a breach of the privacy portion of HIPAA. He admitted that he used a patient's personal information to get four credit cards on which he charged more than $9,000. ▼

Free help with HIPAA security rule

Three white papers on Health Insurance Portability and Accountability Act (HIPAA) risk analysis and employer issues related to security implementation are available from the Reston, VA-based Workgroup for Electronic Data Interchange (WEDI).

The risk analysis white paper outlines different approaches that home care agencies can take to assess their potential risks and vulnerabilities of confidential patient information. The employer white paper discusses the role of the employer with respect to employee health information, employer relationships to insurance companies, and employee-sponsored ERISA plans.

To find these and other WEDI publications related to HIPAA privacy, security, and transaction code set requirements, go to www.wedi.org, choose SNIP (which stands for Strategic National Implementation Process) on the left navigational bar, then choose SNIP work products. ▼

Home health payments to climb 2.3% in 2005

The Centers for Medicare & Medicaid Services (CMS) announced that the Medicare payment rates for home health agencies will increase by 2.3% in 2005. CMS says the increase would bring an additional $250 million in payments to home health agencies next year.

The 2.3% update reflects a reduction of .8% for calendar year 2005, as mandated by the Medicare Modernization Act of 2003. "As home health continues to play a greater role in caring for America's seniors, the payment increases for home health agencies are critical to our providers," says **Kay Cox**, president and CEO of the American Association for Homecare. ■