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IN THIS ISSUE

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Home health and adult day services come together to provide care

CMS project could result in expanded reimbursement requirements

While the results of the Medical Adult Day Care Services Demonstration will not be presented to Congress by the Centers for Medicare & Medicaid Services (CMS) until 2009, home health managers and adult day care service managers are looking forward to a report that is positive for both types of health care organizations, as well as Medicare patients.

"It makes sense that adult day care services and home health agencies work together to provide the best care for a patient, because it ensures a continuum of care in the community," says **Judith A. Bellome**, RN, BSN, MSEd, CEO of Douglas County VNA and Hospice in Lawrence, KS. The demonstration project is evaluating whether providing medical adult day care to Medicare recipients as part of the home health service improves outcomes. Care provided in a day care setting has not qualified for Medicare reimbursement because of the "homebound" definition required for home health reimbursement.

"Home health agencies focus upon acute episodes that require care, while adult day services are designed as long-term care," says **Nancy Brundy**, MSW, director of external affairs for the Institute on Aging, a community organization in San Francisco that provides a range of services to senior citizens, including adult day services. There is a role for each organization, and if a relationship, formal or informal, is developed, it will benefit both organizations, she points out.

"There are home health and adult day services staff and managers who feel that they are in competition with each other, but we are not seeing the same patients," Bellome says. In reality, home health and adult day care services can be excellent sources of referrals for each other, she says. Also, the continued supervision and observation of the patient in the adult day setting can mean earlier intervention if problems arise, she adds. "This can mean better outcomes and fewer rehospitalizations," she points out.

Although it will be three years before any reimbursement for combined home health and adult day services, there are steps that home health managers should now take to position their agencies to move forward, Bellome suggests. "The first agencies to set up day service

programs, or partner with existing programs, will have the edge in the market," she adds.

The first step is to learn about adult day services, says Brundy. "There is a lot of misunderstanding about day services and what services can be provided," she says. Ask a local center if you can meet with them to learn more about day services, and then plan to spend at least one-half a day to observe the staff and participants at the center, she suggests.

"It's important to realize that if the adult day program provides nursing or therapy, the staff members work together as a team, meeting each morning to discuss who is coming that day and what services they may need. This is similar to home health's team approach to patient care," Brundy explains.

Two types of adult day services

Be aware that there are two types of adult day services that may exist in your community, Bellome says. "The first model is a medical model in which an RN is on staff to dispense medications if needed, check blood pressure, evaluate symptoms the patient may experience, and offer health education," she explains. "Some programs that are medically designed also offer occupational and physical therapy."

The other model for adult day services is designed more as a respite for the family caregiver, points out Bellome. There is no nurse on staff, but patients can come to the center with their medications for the day and staff members will remind them to take them. "These programs are usually geared toward the cognitively impaired who do not need medical supervision and they offer a safe environment for patients to socialize with other people while their family member gets a break," she explains.

"No matter which type of model is used, it is important to remember that 50% of adult day service clients are cognitively impaired," Bellome points out.

After educating yourself, survey your community for adult day service programs. Find out what types of programs are offered, whether or not they are affiliated with a hospital or home health program, and how many participants they have in their program. "Once you know what is already available, you can evaluate the feasibility of setting up an adult day service program, or partnering with an existing program," says Bellome.

Setting up an adult day service program makes sense for hospital-owned home health agencies, as a natural progression in the continuum of care, she says. "This is not a program that will become a big profit center for the organization because most clients pay out of their pocket. In some cases, they do have coverage from long-term care insurance policies; but most don't," she says.

Fees must be kept reasonable, with typical costs ranging between $50 and $60 for an eight-hour day. Ideally, you should plan on about 20 people per day once you are established, with staff members who can run the activities, monitor medications and, if you are offering medical services, make therapy available, she says.

While such a program won't represent a large

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An article that describes how to conduct a feasibility study and identifies issues to address when setting up an adult day services program can be found on the association's web site: www.nadsa.org. On the home page, choose "Starting an adult day service" under the "More things to do" section in the right-hand column.

profit, it will be one more way to keep patients loyal to the hospital, home health agency, and the hospital's physicians, Bellome points out. If patients can receive every type of care they need, even ongoing community-based care such as adult day services, they are less likely to look elsewhere for a physician, hospital or home health care, she explains.

"You must offer two different types of activity throughout the day to fit the needs of different clients," says Bellome. "One activity might be reading the newspaper and talking about the news to reorient the participants; the other activity might be more active or more challenging, such as a craft project." Both activities should be designed to promote interaction among participants, she says.

Cross-train staff to offer options

The best person to run an adult day program is a nurse, social worker, or someone with a degree in therapeutic activities, suggests Bellome. "Whatever the director's background may be, look for a creative individual who understands that adult day services is not a baby-sitting program." All staff members must enjoy working with geriatric patients, she adds.

If the home health agency and the adult day service program are in the same organization, there is also the opportunity to cross-train staff, says Brundy. Not only does cross-training improve understanding of both types of service, but it offers new opportunities to each staff member and could help with recruitment and retention of employees for both programs, she adds.

Because most adult day service clients are private-pay, it is important to make sure that the center is attractive and that activities are varied and interesting, says Bellome. "Clients want to know that they are going to see friends and that they will be comfortable, safe, and busy throughout the day," she says, pointing out that setting up an adult day service program is different from state to state. "Some states require licensure for any program, others require it only for medical model programs, and others don't require any license." She suggests checking your state's requirements carefully before beginning.

If it's feasible . . .

If your feasibility study shows that there already are plenty of well-established programs in the area that would make it difficult to set up a successful program, look at partnering with an existing program, Bellome says. If your partnership is a formal one, it will allow both programs to share patient information more easily, thus providing more consistent care, she says.

"This will be beneficial if the patient is receiving home health care and going to adult day services at the same time," she says. Be sure to double-check your organization's privacy policies and HIPAA regulations if you do share information, she warns.

Another option, if your agency wants to add adult day services to the organization, is to purchase an existing program, says Bellome. "This has happened in some locations, and it can be a good way to enhance your services."

Informal partnerships in which both organizations share information about services and programs and refer patients to each other when appropriate also are beneficial, says Bellome. Being able to refer patients to another organization that offers high-quality care and shares the same goals of improving outcomes enhances your ability to ensure your patient gets the care or follow up that is needed, she explains. It also is helpful to family members who may need the extra help but do not know where to find it, she adds.

Brundy looks forward to more home health and adult day service programs working together. "There is a real synergy in the type of care that

home health and adult day services offers. This is a win-win for everyone — home health, adult day services, and patients." ■

Solve oral medication management problems

Unintentional noncompliance easier to address

(Editor's note: This is the second of a two-part series that identifies the obstacles home health staff members face when helping patients improve their oral medication management. Last month, we highlighted some major challenges staff members face along with strategies that can be used to overcome them. This month, we discuss specific staff and patient education tactics to improve medication management.)

A range of factors affects a patient's ability to manage oral medications: cognitive ability, number of medications, and understanding why and how to take medications. To help patients better manage their medications, it is important to identify the reasons they don't and address those in the simplest manner possible.

"There are several reasons for noncompliance and some reasons are unintentional and others are intentional," says **Diana Hildebrand**, RN, BS, CPHQ, project coordinator at TMF Health Quality Institute in Austin, TX. The main unintentional reason is lack of education, leading to misunderstanding the reason for the medication and how to take it, she says.

As a home health nurse, not only do you need to continuously educate patients about medication, but when you evaluate patient education techniques don't forget that illiteracy may be a problem that patients won't readily admit, Hildebrand points out. "Even if the person can read at some level, he or she may not be able to comprehend medical information easily."

When talking with the patient and the patient's family at the first visit, ask questions about daily routines, such as brushing teeth and meal times, Hildebrand says. "Their answers to these questions will tell you how organized they are and how well they stick to a schedule," she points out, adding that this information will help you tailor your education and will provide tips on managing medications.

Because helping the patient understand the proper timing and dose of each medication, a medication calendar or schedule posted in an easy-to-find location is important. Write the name of the medication exactly as it appears on the label so there is no confusion, Hildebrand suggests. If the patient is not able to read, paste one of the pills to the calendar, she says.

"Even if the patient can't read, he or she can match the pills in the bottle to the pill on the calendar." If you do paste pills to the calendar, be sure to check the prescriptions regularly to make sure that the pharmacy has not changed brands of the medication, as this may mean a change in the color, size, or shape of the pill, she warns.

You also can add a label to the bottle to identify the medication's purpose, suggests Hildebrand. "Water pills or heart pills are easier to understand and a label with larger print is easier to read," she says.

Ask patient to demonstrate understanding

"Our nurses don't just ask the patient to show us where the medications are; we also ask them to open the bottle, take out a pill, and tell us why they take it and how often," says **Lisa Sprinkel**, RN, BA, MSN, executive director of home health and hospice for Carilion Home Care Services in Roanoke, VA. "This gives us a chance to evaluate their manual dexterity and ability to open the medication, and it gives us a chance to see how well they can read and understand the labels." If the patient is unsure about a medication, the nurse can immediately explain the reason for taking it, she adds.

Not all patients remember to ask for bottles with traditional caps as opposed to child safety caps, so be sure to tell patients that they can ask for traditional caps for all of their medications, Sprinkel suggests.

Another option to explore with pharmacists is the use of blister packs, suggests Hildebrand. "Some pharmacists will package individual doses for the day in a blister pack from which the patient can easily pop the pill," she says. Not only is it easier to open but if all of the medications that are to be taken at one time are together in the pack, the patient won't forget anything, she adds.

If there is a physical reason that the patient cannot open the medication, ask for a therapy consult, suggests Hildebrand. "There are a number of assistive aids that can be used to help patients open bottles," she explains.

Financial concerns also might cause a patient not to fill the prescription when needed, says

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Hildebrand. "If finances are a challenge for the patient, ask a social worker to visit to find out what assistance is needed," she recommends.

There are instances in which patients choose not to follow instructions about medications, says Hildebrand. "Intentional noncompliance is usually the result of a patient's opinions, beliefs, and values, as opposed to physical, mental, or financial reasons," she explains. "A patient might believe that suffering is a part of life because this is part of the patient's cultural background."

Other patients might be afraid of becoming addicted to the medication, Hildebrand points out. While there are medications that can be addictive, proper education about the use of the medication might alleviate some of these patients' concerns, she says.

"You can also offer alternatives, such as ointments, muscle rubs, or heat, as one way to reduce pain or soreness and reduce the need for pain medications," says Hildebrand. These alternatives might also be more acceptable for patients who don't want to use multiple medications due to their beliefs, she adds.

While there are many reasons for a patient's mismanagement of oral medications, the key to improving the situation is to first identify the real cause of the mismanagement, says Hildebrand. "It is impossible to find the best solution if you don't start by finding the cause of the problem." ■

LegalEase

Understanding Laws, Rules, Regulations

What referral sources need to know about home care

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

The importance of referring patients for home care and hospice services is becoming increasingly clear to referral sources. Other providers have a better understanding that referrals for home care, home medical equipment (HME), and hospice are likely to enhance quality of care for patients, improve financial performance, and manage the risks of legal liability, especially as inpatient stays become shorter.

In order to help ensure that these benefits are realized, it is helpful for referral sources to know more about which patients are appropriate for these types of services. Specifically, patients who are referred for home health, HME, and hospice services must meet the following criteria, regardless of payer source:

- Patients' clinical needs must be able to be met in their homes.
- Patients must either be able to care for themselves or they must have a paid or voluntary caregiver available to meet their needs in between visits from professional staff.
- Patients' home environments must support home health services.

In other words, some patients are not appropriate for home health, HME, and hospice services. The idea that all patients who do not have another source of care should be referred for these types of services is definitely risky business for referral sources.

Home care and hospice providers usually can meet the clinical needs of patients in their homes in view of the complex types of care they can render. Referral sources will undoubtedly have difficulties evaluating patients' home environments without going to visit. Home care and hospice providers will surely do so during the initial assessment visit.

However, referral sources can evaluate whether or not patients are likely to be able to care for themselves and, if not, whether they have relatives or friends who are willing to serve as primary caregivers. Referral sources should educate patients before they make referrals for these types of services. Home health, HME, and hospice are different models of care from institutional care. Unlike institutional care, there is a crucial role for primary

caregivers to play when patients receive these types of care. This role must be made clear to patients and primary caregivers before referrals are made for home care and hospice services.

Referral sources should be as specific as possible about at least the initial role of primary caregivers. They may, for example, help patients and their families understand some of the tasks that primary caregivers initially will have to perform. Potential primary caregivers may be especially reluctant to care for incontinent patients, to dress wounds, or to give injections. If these types of care are needed, referral sources should clearly explain these activities to potential caregivers.

Referral sources should also make it clear to potential primary caregivers that their role is likely to change over time. Their activities and responsibilities are likely to change as patients' conditions either improve or deteriorate further. Or perhaps patients' conditions are chronic with little likelihood that they will improve or deteriorate; in this case potential primary caregivers should be aware that they may be involved over the long haul.

It may also be helpful for referral sources to help potential primary caregivers realistically evaluate whether they can fulfill the role of primary caregiver. Depending upon patients' needs, potential primary caregivers who work may not be able to perform the activities required of them. If patients need assistance with multiple transfers and potential primary caregivers have back problems, for example, they may not be appropriate for this role.

When patients cannot care for themselves and no primary caregivers are available on a voluntary basis, referral sources should also explore the possibility of using paid primary caregivers. Home health and hospice agencies are often able to provide so-called private duty services that may include "sitters," live-ins, aides, etc. Paid private staff may serve as primary caregivers.

When referral sources recognize that patients cannot care for themselves at home in between visits from home care and hospice staff and they cannot identify either a voluntary or paid primary caregiver, patients should not be referred for home care or hospice services except for hospice services provided in inpatient hospice units. Referrals should not be made for these types of services on the basis that patients will have no services if referrals are not made and that "something is better than nothing."

This is especially true when referral sources know that patients need institutional care, but patients refuse these types of care. Patients have an absolute right to refuse services. That does not mean, however, that home health, HME, and hospice providers must provide services to them in inappropriate settings.

Provision of services to patients at home when they cannot care for themselves and have no primary caregiver greatly enhances the risk of legal liability. It is also likely to violate the important ethical principle of justice, which dictates that all patients are entitled to appropriate care.

Home health, HME, and hospice services are often extremely beneficial for both patients and referral sources, but only if referrals are appropriate; otherwise, they are likely to enhance risks of legal liability for referral sources and violate important ethical principles. Now is the time for referral sources to appropriately evaluate patients before they make referrals for these types of services. ■

Geriatric CM is a fast-growing field

As baby boomers age, the need will become acute

The profession of geriatric care manager has evolved because of the tremendous challenges that health care professionals and families face in managing the care of senior citizens, says **Beverly Bernstein Joie**, MS, CMC, president of Elder Connections in Philadelphia.

"In the 1980s, a group of social workers saw that seniors were in and out of the hospital frequently because of problems at home. Our profession tries to keep people safely in their homes. It's one thing to take care of a senior's physical problems but there are a lot of other dimensions to providing care," Joie says.

It's a profession that has been rapidly growing as today's senior citizens outlive their counterparts of a generation ago. As the baby boomer population ages and the health care field is challenged to provide care for them, the need for this niche profession is likely to increase.

Geriatric care managers usually are hired by the children of senior citizens and are paid an hourly fee for their services.

"A geriatric care manager is the middle link who can provide family members with peace of mind by assessing the situation, identifying the

senior's needs, and helping them connect with the services they need. We have a vast knowledge base of gerontology, including medical problems, pharmaceutical problems, and mental health issues faced by the elderly. We can identify what the patient needs and communicate their condition to all the health care providers," says **Susan Fleischer**, LCSW, DCSW, CSWM, CMC, chief operating officer for Rona Bartelstone Care Management and Home Healthcare in Fort Lauderdale, FL.

The services of geriatric care managers are needed especially in areas where there are a lot of retirees with children living in other parts of the country, says **Pearlbea LaBier**, MSW, ACSW, owner of Elder Options, a Washington, DC, geriatric care management firm.

"Adult children find themselves flying back and forth through one crisis after another. They can't stay on top of their parents' problems and need someone locally to manage the situation and provide them with information," she says.

When adult children talk to their parents and things don't seem right or they visit and see changes they don't understand, they may call on a geriatric care manager to help manage the care, Joie says.

"There is a tremendous need for answers about what steps people need to take when they see a change in status with their parents," she says.

The decisions that family members will make will affect the rest of the patient's life. As a geriatric care manager, Joie often coaches families about the right thing to say when they talk to their parents.

"There are ways of communicating that are more successful. The children need to have realistic expectations and to understand what the senior is going through. Our job is to be a coach who teaches the family how to communicate to make change occur," she says.

When a geriatric care manager is called in, he or she will perform a comprehensive geriatric assessment to determine the status of the person. The assessment is conducted face-to-face wherever the senior is residing.

"I can't emphasize enough the value of face-to-face care management. Seniors don't really hear well, so phone conversations may produce accurate information or they may not be able to process all the information you give them," says **Amy Siegel**, RN, CCM, CRRN, owner of Advocare Geriatric Care Management of South Florida, `with headquarters in Fort Lauderdale.

In some cases, the geriatric care manager conducts the assessment in the hospital and works with the discharge planner to develop a plan of care for the patient.

Assessment looks at many areas

The comprehensive assessment looks at many areas, including financial status, spiritual needs, legal issues, and end-of-life decisions, as well as physical health, safety in the home, and medication management.

A comprehensive geriatric assessment looks at finances to make sure the senior has the funds to cover the care they need and if they qualify for community resources.

Aging in place is important to most seniors, and they need to have the resources necessary to continue to live in their own homes.

One of the most important things that a case manager can do for an elderly client is to adequately support the resources that the senior has available, Joie says.

"When people get to be a certain age, all their money is going out and not coming in. I don't like to see people make mistakes on where to spend money," she says.

A legal assessment ensures that the seniors have advanced directives and a living will in place and that they have designated someone who can have power of attorney.

The care managers conduct a medication assessment, but it's more than just asking the senior what they're taking.

"We look in the kitchen, the bathroom, the bedroom to make sure we identify every medication that the client is taking. We call on a pharmacist to evaluate all the medications we find and advocate with the client's doctors and other health care professionals about what we find," Fleischer says.

Home assessment

Seniors often have safety issues in their homes or physical disabilities that impair their ability to complete the activities of daily living, such as personal grooming, toileting, or dressing without some assistance. Or, they may need total hands-on assistance — someone who can cook, clean, and take them to the doctor.

"When a care manager goes into the home, they can see what really happens. We're kind of like Sherlock Holmes in our clients' lives and

RESOURCES

For more information about geriatric case managment, contact:

- **National Association of Professional Geriatric Care Managers**, www.caremanager.org.
- **American Institute of Financial Gerontology**, www.aifg.org.
- **American Association of Nurse Life Care Planners**, www.aanlcp.org.
- **American Society on Aging**, www.asaging.org.
- **American Association for Retired People**, www.aarp.org.

homes, putting together clues and discovering minor changes that may cause a major change in the future," she says. "We become the eyes and ears for the doctor and for the family members," Fleischer says.

After the assessment is completed, the geriatric care manager develops an individual plan for the client that includes setting up any community resources needed, such as food deliveries or transportation to and from the doctor or a senior center. They call in consultants, such as financial gerontologists or life care planners, when necessary, and develop a timetable for when they'll be back in touch.

"One client may need to be seen in the home once a week. Another may require a phone call once a week and a visit each month. We develop an individual plan that can change at any moment, based on problems and issues," Siegel says. ■

Ignorance 1: Education 0 Time to mandate flu shots

Voluntary vaccine approach has failed

Voluntary annual influenza immunization programs that use educational efforts and other incentives to vaccinate health care workers have been an abject failure, a leading proponent of mandatory flu shots said in Tampa at the annual conference of the Association for Professionals in Infection Control and Epidemiology (APIC).

"We have to acknowledge that voluntary immunization programs have never resulted in high immunization rates in any setting for any age at any time for any reason at any location with any vaccine," said **Gregory D. Poland**, MD, director of the vaccine research group at the Mayo Clinic in Rochester, MN. "It does not work. Those data are clear and unambiguous. We have got to get past this."

Moreover, decades of voluntary programs chock full of incentives and educational outreach have reached a level of diminishing and dismal returns: little more than one-third of health care workers bother to be vaccinated during any given flu season.

"I want to believe and you want to believe that education works," Poland said. "It does not when it comes to this topic. I am sorry, it doesn't work. I wish it were otherwise. No study has been able to demonstrate significant sustained [vaccination] increases for any sustained time period as a result of educational efforts. It is not the answer. This has failed as the only strategy we have had — trying to encourage people, provided free [vaccine and] education. It simply hasn't worked."

The health care system will "either lead or be lambasted" on the issue given trends for patient safety and empowerment, consumer demand for health care accountability, and increasingly negative press coverage.

"We have to take responsibility for this parade of deaths that happens year in and year out in our hospitals," Poland said. "Personal preference, I do not believe, is defensible in any way for a health care worker. We will be called to account here. Only 36%-40% are getting immunized each year. The vast majority of us are not getting the vaccine."

Given the situation, the APIC board of directors voted earlier this year to endorse mandatory influenza vaccination for health care personnel who have direct contact with patients. "I am just overjoyed that you took one of the early leadership positions in this and endorsed mandatory flu immunization," Poland told APIC attendees.

Ethical duty becoming a legal one

Health care workers and their employers have an ethical and moral duty to protect vulnerable patients from transmissible diseases, Poland said. "I believe they will have a legal duty, too, " he added, noting that flu vaccination for health care workers in acute care is now mandatory in seven states. Fifteen states mandate the shots for workers in long-term care, he said.

"There are now six lawsuits against physicians

and health care institutions that failed to deliver the vaccine, and there was the suspicion that [flu was nosocomially] transmitted," Poland said. "You leave yourself vulnerable."

While short of a mandate, the current standard of care is requiring workers who decline flu shots to sign declination statements. "This should be seen as a matter of meeting professional and ethical standards, not personal preference," he said. "Unvaccinated health care workers should be excluded from direct patient care."

The situation is particularly disconcerting in an era of patient safety, when more and more public and media attention is focused on adverse outcomes in health care.

"Your colleagues do not necessarily understand," Poland said. "The reason for them to get vaccine is to protect somebody else. That is the primary reason — first, do no harm. It is a patient safety issue and a moral and ethical imperative. It is a win-win-win-win: the patient benefits, the employee benefits, the institution benefits, and the community benefits."

Poland cited numerous studies showing nosocomial transmission of influenza from unvaccinated workers to patients. "Influenza-infected health care workers transmit this deadly virus to their patients," he said. "A fact many of you do not know is that health care workers with asymptomatic influenza can transmit this virus to patients and to other staff. In fact, they can do so for about 24-36 hours before they develop symptoms or even if they never develop symptoms. Multiple studies show that about 70% of health care workers continue to work despite the fact that they are symptomatic for influenza."

Complications of influenza are particularly burdensome on certain subsets of patients, including children younger than 2 years old. "Until recently I was not aware of this," Poland said. "They have a mortality rate as high as 15%. That is sort of stunning."

Poland cited a flu outbreak in an NICU in which a baby died after being exposed to infected health care workers. "This one is a tough one for me," he said. "Try to get your head around this. You go to a hospital to deliver your high-risk baby in the United States in 1998 — best health care system in the world, right? And your baby dies of an infection that was preventable by a $15 vaccine. In fact, for the health care worker, it wouldn't have cost anything at all."

Other vulnerable patient groups include the elderly, the immunocompromised, and critically ill patients. Patients acquiring flu in the hospital results in increased costs, extended lengths of stay, and death.

Surprisingly, nursing is the health care work segment with the greatest entrenched resistance to being vaccinated against flu, Poland said. "[Nurses] have consistently lower vaccination rates than any other group, and the big concern is that there is no other group of health care workers who have closer and more prolonged contact with patients," he said. "There are no data that show education changes this. Furthermore, nurses have more reasons for rejecting vaccine than all other health care workers and are more likely to believe it is not safe or effective."

'Ignorance is killing people'

The reasons typically given by health care workers for refusing the vaccine include that they never get the flu, pose no risk to patients, fear of vaccine side effects, fear of needles, or belief that the vaccine causes flu. The vaccine is safe and effective and does not cause the flu, Poland emphasized, adding that he personally conducted a study that showed that a sore arm at the immunization site is the only actual side effect that has statistical significance when comparing flu vaccine to a placebo.

Beyond the health care setting, flu is somewhat underappreciated as an infectious disease threat during a typical, nonpandemic year. Yet seasonal flu kills an average of 36,000 Americans annually, almost as much as breast cancer (40,000), and three times as many as HIV/AIDS (14,000).

"If I got up here today and announced we had discovered a safe and effective vaccine against breast cancer, do you think it would take me six decades to get 36% of the women of this room to take that vaccine?" Poland said. "One out of every 10,000 Americans that are alive today will be dead by next flu season because they didn't get a flu shot."

While it is not clear how many flu deaths are directly linked to health care, all evidence shows transmission is occurring. "We know from serologic studies that about 25% of health care workers each season actually have antibodies that show that they are infected with one of the currently circulating strains," he said. "About 50% of the health care workers who have that evidence were unaware that they had influenza. One of the things that I hear a lot is that 'I never get the flu.' Yes you do, you just don't know it, and that ignorance is killing people." ■

Rapid growth predicted for health manager jobs

Degrees, quality expertise important

Future health services managers must be prepared to deal with evolving integrated health care delivery systems, technological innovations, an increasingly complex regulatory environment, and restructuring of work.

They increasingly will work in organizations in which they must optimize the efficiency of a variety of related services.

On the plus side, employment of managers is expected to grow faster than average through 2014, as the health care industry continues to expand and diversify.

That's all according to the 2006-2007 edition of the Bureau of Labor Statistics' (BLS) *Occupational Outlook Handbook.*

Access directors and managers who would like to take advantage of this growth environment should be prepared with advanced degrees and expertise in quality improvement, suggests **Deedra Hartung**, MA, vice president in the executive search division of St. Louis-based Cejka Search.

"I can't stress the advanced degree enough for those who go to market and try to be competitive in vying for manager/director positions," she says. "People really want expertise these days. Health care is complex, and [employers] want candidates with strong knowledge, not those who require on-the-job training."

A 2005 hospital CEO leadership survey conducted by Cejka Search and Solucient found that 77% of the top leadership team at "best of breed" hospitals had a master's or doctorate degree, Hartung points out, compared to 56% at "median" hospitals.

"Best of breed" referred to hospitals rated in the top 100 based on a number of measurements, she notes, while "median" hospitals were those just below that level.

Hospitals looking for top executives also are mindful that "the nation's health care agenda right now is all around quality of care, clinical outcomes, and patient safety," Hartung continues. "Just as hospitals are looking for medical executives [with this expertise], they are also looking for nonclinical leaders in the quality arena."

She cited financial incentives put in place by the Centers for Medicare & Medicaid Services to reward hospitals for quality care work, noting that facilities in the top 20% of each clinical category can expect to receive Medicare incentive payments.

"Hospitals obviously want to participate in this 'pay-for-performance' program that Medicare has in place," Hartung says. "That requires having people to lead those quality initiatives, and it's a huge undertaking."

As for gaining expertise in quality improvement, she says besides coursework and an additional degree, "there are a lot of conferences devoted to [quality] right now," she notes.

Patient satisfaction is among the quality indicators that are being monitored, Hartung points out, "which starts with the admissions director, the access director."

Issues surrounding the widespread implementation of electronic patient records will be a big part of the technology challenges facing health care managers in the next decade. The BLS handbook notes that recent regulations enacted by the federal government require that all health care providers maintain electronic patient records and that these records be secure.

COMING IN FUTURE MONTHS

- Marketing in an electronic world
- HIPAA update
- Clean claims mean faster payments
- Recruitment tips from successful HHAs

As a result, health information managers — as well as access managers and directors whose oversight extends into that area — must keep up with computer and software technology and with legislative requirements, it points out. As patient information becomes more frequently used for quality management and medical research, the report continues, the focus must be on ensuring that databases are complete, accurate, and available only to authorized personnel.

Job opportunities for health services managers will be especially good in the offices of health practitioners, general medical and surgical hospitals; home health care services; and outpatient care centers, according to the BLS handbook.

Managers in all settings will be needed to improve quality and efficiency of health care while controlling costs, as insurance companies and Medicare demand higher levels of accountability, the report states. Additional demand for managers, it continues, will stem from the need to recruit workers and increase employee retention, to comply with changing regulations, and to implement new technology.

Management- and executive-level hospital jobs paying a minimum annual salary of $100,000 are listed at the web site of Hartung's firm, www.cejkasearch.com. Up to two new jobs are added daily, and the site averages about 50 jobs.

Senior- and midlevel finance jobs at hospitals are listed at www.hfma.org, the web site of the Healthcare Financial Management Association. A range of openings also is available at www.hospitaljobsonline.com. ■

ISMP, FDA provide free toolkit to reduce errors

The Institute for Safe Medication Practices and the FDA have launched a national education campaign designed to reduce medication errors.

As part of the campaign, they are offering a free toolkit that includes:

- an error-prone abbreviations list;
- a brochure for use in staff education;
- a print public service ad;
- a slide show and video that can be used in presentations on the topic.

To access a copy of the toolkit, go to www.ismp.org/tools/abbreviations. ▼

Oxygen study shows true cost of equipment

Nearly three-quarters (72%) of the cost of providing home oxygen therapy to Medicare patients in their homes represent services, delivery, and other operational expenses that benefit patients, according to a new survey of current costs by Morrison Informatics, commissioned by the American Association for Homecare. Only about one-quarter, or 28%, of the cost represents oxygen equipment.

"The study shows that, contrary to some perceptions, home oxygen therapy involves much more than a piece of equipment," said **Tom Ryan**, chairman of the American Association for Homecare and CEO of Homecare Concepts in Farmingdale, NY.

Morrison collected and analyzed data from 74 home care providers that collectively serve more than 600,000 Medicare beneficiaries receiving oxygen therapy in their homes, which represents more than half of the Medicare population receiving oxygen therapy at home. To access a copy of the free report, go to www.aahomecare.org. Under the heading "Advocacy Updates" on the home page, choose "Morrison Informatics Oxygen Study." ▼

Language growing barrier to high-quality health care

According to the author of an article in the July 20 issue of the *New England Journal of Medicine* addressing the growing issue of language as a barrier in health care, 19% of the population in the United States speak a language other than English at home and 22 million have limited English proficiency.

At present, only 13 states provide third-party reimbursement for interpreter services. And most of the states with the largest number of patients with limited English proficiency do not. Though legislation is in the works, the author says it's hardly enough.

A government report estimated that on average it would cost only $4.04 more per physician visit to provide language services to patients who need them. ■

CE *questions*

17. What are the benefits of adding adult day services to your home health program, according to Judith A. Bellome, RN, BSN, MSEd?
A. Higher profits
B. More insurance reimbursements
C. Increased patient loyalty
D. Education of staff

18. What tips are suggested by Diana Hildebrand, RN, BS, CPHQ, to overcome a patient's illiteracy and improve the ability to understand a medication schedule?
A. Simple labels such as "heart pill"
B. Paste pill on schedule/calendar
C. Have family members call patients during day
D. A and B

19. What does a geriatric case manager include in a patient assessment?
A. Financial status
B. Spiritual needs
C. Medication management
D. All of the above

20. According to Gregory D. Poland, MD, what percent of health care workers are getting flu immunizations each year?
A. 36%-40%
B. 41%-45%
C. 46%-50%
D. 51%-60%

Answer Key: 17. C; 18. D; 19. D; 20. A.

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. ■

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **September** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■