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Hospital Home Health®

the monthly update for executives and health care professionals

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Future brings new challenges and the opportunity to grow your businesses

Q&A: Technology, PPS, mergers, and shortages are expected

The past few years have seen more shrinking of home health than growth. Today's industry leaders say that could turn around in the future. Of course, predicting the future of the U.S. health care system can be as uncertain as predicting the weather, with constantly changing policies on reimbursement, patient privacy and satisfaction, and managed care, just to name a few.

To learn more about where the system and the home health industry is headed, *Hospital Home Health* spoke with a panel of health care leaders: **Gregory P. Solecki**, vice president of Henry Ford Home Health Care in Detroit; **Elizabeth E. Hogue**, JD, a health care attorney in Burtonsville, MD; **John C. Gilliland**, a health care attorney with Locke Reynolds in Indianapolis; and **Diann Martin**, RN, DNSc., LM, with Cantone and Associates, Orland Park, IL. Will home care look the same in terms of its services? Will there be more specialization? What should we expect with reimbursement? Here's what they had to say.

> *"I see an increase in the use of technology — patients will get more remotely delivered care via video, interactive Internet, remote monitoring, and 'smart' technology. In a nutshell, we will visit less but monitor more. I also think there will be an increased need for coordinated, long-term care programs rendering the home care benefit as a round peg in a square hole."*

HHH: In the next five, 10, or even 20 years, do you see the home care industry as being basically the same in terms of the services you provide? If not, how do you see it differing?

Solecki: I think the home health industry still has a lot of untapped pride, potential, and talent. We are not afraid to do the new and difficult,

especially if it makes a difference to our customers. Things like high-tech care in the home are challenges to most of us in the industry, and we embrace that challenge. However, the current and projected future staffing outlook coupled with the enormous paper burden imposed upon home care clinicians adds a degree of difficulty that might be insurmountable.

I still think there is much to do in the area of in-home case management. It seems to make sense that case management is facilitated when the case manager is in the patient's home doing one-on-one teaching of patients, family members, and significant others.

Also, I think those who can support high-tech specialties through the standardization of processes that ensure high clinical outcomes and patient satisfaction — while at the same time reducing costs — will have a competitive advantage in the marketplace. Of course, this is all dependent on our ability to recruit and retain staff.

Hogue: I think that the services provided by agencies will change dramatically. Statistics already indicate that higher percentages of expenditures for home care services are coming from self-pay / private-pay, and Medicaid programs. Amounts expended by the Medicare program as a percentage of the entire amount paid for home care services are dropping fairly substantially each year.

This seems to indicate a shift from skilled services to nonskilled services such as homemakers, companions, etc. This trend is likely to continue from my point of view.

I also think that agencies ultimately will become providers of community services that are not necessarily provided in patients' homes. For example, I think that agencies eventually will establish ambulatory clinics for chronic health conditions such as diabetes.

They will utilize primarily nonphysician practitioners to meet the needs of patients who might not require and / or meet the current eligibility requirements of the Medicare home care program, but who, nonetheless, require ongoing assistance with their chronic conditions.

Gilliland: I think the home care population will continue to greatly broaden to include much more of the attendant / personal care type of services. There will be increasing demand for that type of service.

Most of it will be private pay because the

CE questions

For your convenience each month *Hospital Home Health* is printing the CE questions in the issue. Subscribers will receive a complete test and Scantron sheet in October 2001.

If you are not a *HHH* CE subscriber and would like to become one, call customer service at (800) 688-2421.

5. According to the U.S. Department on Aging, roughly a fifth of the American population will be more than 65 years old in 2030.
   A. True
   B. False

6. From a patient perspective, one of the best way to avoid becoming the victim of a medical error is to put all your trust in your medical team. Asking too many questions may confuse the issues and result in them making a mistake.
   A. True
   B. False

7. Which of the following are not among the new nurse-to-patient ratios put forth by the California Nursing Association:
   A. 1:1 — active labor and delivery
   B. 1:1 — post-partum / normal newborn nursery
   C. 1:2 — for intensive care, burn
   D. 1:3 — medical / surgical units; emergency room; obstetrics; pediatrics

8. According to a recent study, nearly two-thirds of Americans who do not currently have a chronic condition believe they will develop one during their lifetime and fear that when they do, they will be unable to afford needed medical care and will become a burden to their families.
   A. True
   B. False

The Graying of America

Year and Census Date	Number (in thousands) Age in years 65-74	75-85	85+	65 and over	Total, all ages	Percent Age in years 65-74	75-84	85 and over	65 and over
2000	18,551	12,438	4,333	35,322	276,241	6.7	4.5	1.6	12.8
2010	20,978	13,157	5,969	40,104	300,431	7	4.4	2	13.3
2020	30,910	15,480	6,959	53,348	325,942	9.5	4.7	2.1	16.4
2030	37,984	23,348	8,843	70,175	349,993	10.9	6.7	2.5	20.1
2040	33,968	29,206	13,840	77,014	371,505	9.1	7.9	3.7	20.7
2050	34,628	26,588	18,893	80,109	392,031	8.8	6.8	4.8	20.4

Source: U.S. Administration on Aging based on data from the U.S. Census Bureau, Washington, DC.

demand will be so great that third-party payers — both public and private — will be unwilling to meet the costs except, perhaps, for especially vocal constituencies such as the disabled community. That all leads to public payers playing a smaller role than they do today. Of course, Medicare and Medicaid will be important but that will not be the business most home health agencies will want; it will pay too little for the regulatory hassles involved.

Martin: I see an increase in the use of technology — patients will get more remotely delivered care via video, interactive Internet, remote monitoring, and "smart" technology. In a nutshell, we will visit less but monitor more. I also think there will be an increased need for coordinated, long-term care programs rendering the home care benefit as a round peg in a square hole.

Patients' clinical needs will go on and on but the care we can provide is so limited legislatively, we need to push for long-term care coverage. Then, too, I believe we will see an ever-increasing complexity of home care as surgery increasingly moves to ambulatory venues and hospitals become intensive care units. As this happens, the majority of care will be going on in the community.

***HHH*:** How do you see the reimbursement issue shaping up? Do you think it will get better, and if so, do you foresee it getting worse before it gets better?

Solecki: Actually, I am pretty pleased with reimbursement. I don't think the reimbursement rate is the problem . . . getting the reimbursement is the problem.

Home health care billing processes are so cumbersome and time-consuming and the rules that apply to different payers are so numerous and diverse that it is increasingly more difficult to simply get paid for what we do.

This is not only financially threatening, it is frustrating to leadership, staff, and patients. I'm afraid that more money thrown at the paper burden will just continue to price us out of the market. I would prefer that more money be directed at simplifying administrative processes.

Hogue: Based upon the anecdotal comments I receive all over the country, it seems that the prospective payment system (PPS) is working very well.

Although there have certainly been some glitches, agencies are being paid by and large, and cash flow is not an issue. I think that the Health Care Financing Administration wants agencies to be profitable so that the industry will stabilize and be stronger, and I expect this goal to continue to be reflected in reimbursement systems.

Gilliland: As a consequence of the changes in the field overall, I feel Medicare and Medicaid will increasingly have difficulty finding agencies willing to be part of either program. It may be

Who Will Need Help?

	Percent of Population	
Year	Total with ADL Limitations	Severly Disabled
2000	20.0	3.8
2020	19.2	3.7
2040	21.4	4.2

Source: Calculated on the basis of projections of the U.S. population prepared by the U.S. Social Security Administration and preliminary data from the 1982 National Long-Term Care Survey, Washington, DC.

that only some large chains and hospital-based agencies who provide those services participate. For the chains, they will feel they can be profitable in those markets due to their size, but I doubt that will be the case. We will see continuing efforts to make it profitable but all will fail.

For hospital-based, they will try to provide Medicare and Medicaid services because it is part of their missions. But unless they have strong private-pay operations, I doubt they will be able to do so. Neither Medicare nor Medicaid will be attractive financially unless and until most providers cease to participate in those programs. Reimbursement is entirely budget-driven. The government will pay as little as possible until the care cannot be provided at the rates offered.

The problem for Medicare and Medicaid will be a huge demand for services without enough money to pay for it all.

As is the case now, rather than confronting the real problem of demand and an aging society, government will continue to try to blame fraud for the cost of health care and will try to deal with the exploding costs by continuing to reduce reimbursement. As a society, we will still not have come to grips with the real problems.

HHH: Do you foresee any greater changes in terms of what will be reimbursed and what won't?

Solecki: In terms of patient need, I would love to see more reimbursement for "lower levels" of care, for personal care — for the areas that really make a meaningful difference in the patient's ability to remain in his or her home. I doubt we will see this anytime soon. And, again, will we be able to staff such a dream?

HHH: How do you foresee the home care patient population changing, or do you? As a whole will the numbers grow? Will the population get older?

Solecki: We all know the baby boomers are aging. This will present the biggest health care challenge our country has ever faced: more elderly, living with chronic conditions for longer periods of time with fewer people to care for them. **(See "The Graying of America," p. 51.)** We all should have had much larger families!

Hogue: The primary change in the home care population from my point of view, in addition to a large increase in the numbers of patients who want home care services, will be that there will be much greater recognition and willingness on the part of patients to pay for care themselves.

Martin: By 2020, more than 25% of the U.S. population will be over 65 years old, and the entire nation will look like Florida demographically. **(See "Who Will Need Help?" above left.)** The fastest growing segment of the U.S. population is the over-85 group and these people, on average, have three activities of daily living (ADL) limitations. We currently don't have enough facilities to put them in or caregivers to care for them, so home care has to grow to meet these demands.

HHH: Do you foresee more specialties cropping up? More acquisitions / mergers?

Solecki: I think that specialists in other spots of the continuum would love to see our support of their patients in the home. We just need the staff. I'm not sure about acquisitions and mergers. It's difficult to buy staff and customer loyalty. Buying another home health agency doesn't necessarily ensure a larger patient or referral base unless the base feeds an exclusive provider agreement with a third party. I think we will see more concentration on "survival of the fittest" in terms of tackling the administrative burdens before we will see a significant increase in mergers and acquisitions. This is a tough industry with major challenges and little return on investment right now.

Hogue: I think there will be more specialization in home care. I doubt that we will see a significant increase in mergers or acquisitions.

Gilliland: The growth in home care services will be in the nonskilled nursing, private-pay area. That is the only area in which agencies will be able to make a profit. There will be increasing consolidation through mergers of existing agencies. Ten years from now, home care will be composed of a few, large national chains, a few hospital-based agencies and smaller, boutique proprietary agencies. The smaller proprietary agencies will be those that provide high-quality, specialized private-pay services; they will not provide Medicare or Medicaid services.

HHH: What do you see as the legal issues facing home care in the near and distant future?

Solecki: The big issues I see are restriction of care and/or inability to care issues. Clinicians are pretty overtaxed right now. Our industry's ability to meet the demand is being put to the test. This challenge could, inadvertently, be viewed by some as a lack of motivation rather than a lack of resources.

Hogue: A key legal issue for home care providers is whether they are obligated to accept every patient referred to them and whether they are obligated to continue services to patients after admitting them.

Agencies need to establish criteria regarding general appropriateness for home care services that go beyond the eligibility criteria of various payer sources. These criteria might include a requirement that patients either be able to self-care or have a paid or voluntary primary caregiver who can meet their needs in between visits from home care providers.

Gilliland: The biggest legal issue in the short term for agencies will be to comply with issues of patient privacy such as the [Health Insurance Portability and Accountability Act] HIPAA privacy regulations and similar state laws. **(See *LegalEase,* p. 55, for further discussion of HIPAA compliance.)** In the longer term, the issues will be that of privacy protection and compliance with various employment laws such as wage and hours and OSHA.

Employment regulatory agencies are "discovering" home care and enforcement will increase. For agencies that continue to participate in Medicare and/or Medicaid, fraud and abuse enforcement will increase.

HHH: What do you think might happen to the national health care situation in the coming years?

Gilliland: A considered speculation: Over the next 20 years, the demand for inpatient acute care services will decrease dramatically with most patients opting for outpatient procedures, care at home, and even the procedures at home. Hospital systems that continue to rely on "bricks and mortar" rather than adapting to the care at home model will go bankrupt. Of course, none of it will be affordable.

Public demand for services will outstrip what the public/government is willing to pay. In desperation, the federal government will try nationalizing health care . . . which won't help either. Services will be provided through either the nationalized health care system or, for those who can afford it, through private payment arrangements. Only those who can pay privately will have complete access to care.

Hogue: Within five years, I hope to see a truly reformed health care delivery system. In a reformed system as I envision it, the emphasis will be upon community-based, primary, preventive care. Nonphysician practitioners will play a key role in providing this care.

So where will home care be in 10 years? No one can know for sure, but as Gilliland notes, "Having said all this, I will undoubtedly be completely wrong! As I think about the future of the industry, the thing that keeps going through my mind was that who in 1990 would have been able to predict all that occurred for home care during the 1990s? I doubt anyone could have."

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Stepping from supervised to home care supervisor

Making the transition painless

No matter how hard you work or how fast you clear things off your desk, you just can't catch up.

For every five things you accomplish, 10 more need to be done and the piles of papers to be read and filed just keep growing. Sound familiar? Americans in supervisory and management jobs indicate that their No. 1 stressor is too much to do and not enough time in which to get it done.

One of the biggest myths that people in supervisory roles have is that they will be able to get absolute control of the job and accordingly, catch up. The reality is a far cry, and a hard lesson for new and first-time supervisors to learn.

So what's a new home health care agency supervisor to do? Take a few tips from the staff at Overland Park, KS-based Fred Pryor Seminars, one of the country's leading training providers.

Do your homework

Regis Smolko, an instructor for Fred Pryor Seminars, says that the first thing any supervisor should do upon getting to the office each day is to set aside some time to plan. "Take the first 30 minutes of your day to plan," he says. "For every minute planning, you will save yourself 12 minutes of work."

A hard concept for many managers to grasp is that they are no longer accountable only for their time, but that of their employees as well — a home care agency is no exception to the rule. As such, Smolko says that it is important that supervisors and managers set a solid example by prioritizing their work and making a consistent effort to stay on top of things.

Learning to prioritize

He recommends that people tackle short-term projects in the morning when their thinking is sharpest, and in the afternoon, take on longer-term projects. Within each of these categories, he further prioritizes his work to "tackle the 'ugly' things first. If I try and do something in fits and starts that I've been putting off or don't want to do, it takes me four times as long."

Smolko also recommends that all first-time managers and supervisors take advantage of all the tools at their disposal. This means taking seminars or classes on management techniques, reading articles, and even keeping a useful tips file.

Home care professionals should look into taking not only general management courses, but courses specific to motivating people in the health care industry.

As every home care agency employee knows, motivation can be a particular challenge when faced with deep budget cuts, long hours, and in some instances, chronically ill patients. Even experienced managers should take a management seminar — everyone needs a refresher from time to time, and "old dogs" can learn new tricks.

Can't get no satisfaction

Smolko warns first-time managers and those who are new to the job that not only are their responsibilities and tasks different, but the kind of satisfaction they garner from their jobs also will be different.

"Satisfaction becomes more abstract," he says. Whereas once you could look at a completed project or task and see the fruits of your work, people who manage other employees find that all too often their days are filled more with solving people-related problems and handling complaints than actually completing projects." He notes that it becomes very difficult to motivate employees when you can't visibly see your day's accomplishments.

> *"As a manager, your problems are now long-term. Almost as soon as you've finished one, several more will pop up that demand your attention. It seems that you never really get them all out of the way, and that developing your people is an endless process."*

"Satisfaction," he says, "must come from an inner sense of knowing that you've helped someone develop, you've managed a crisis

effectively, or you just got the job done with very little hassle."

It seems that for every project you accomplish there are several more waiting in the wings. There is always something else to be scheduled, another meeting to attend, another crisis to be solved, Smolko points out.

The problems keep popping up

"As a manager, your problems are now long-term," he explains. "Almost as soon as you've finished one, several more will pop up that demand your attention. It seems that you never really get them all out of the way, and that developing your people is an endless process."

"Making your employees productive is extremely key. Everyone needs to realize that they are in it together, sink or swim," Smolko points out. "Give people a sense of self-esteem, and they will work for you."

Part of self-esteem comes from having an inner faith that you can do the job, and part of earning that is making mistakes. "Sometimes we need to allow people to experience the consequences of their problems," he says. "Allowing people to make mistakes is how we teach them."

Teach staff how to handle problems

Smolko warns managers not to accept "monkeys." By that he means employees for whom "if you solve a problem for that them today, they will come back with two problems for you to solve tomorrow." The trick in these cases, he says, is to put the problem back on them to solve.

"Ask them what they think needs to be done and how they would do it. Tell that person to go ahead and handle it and get back to you with the results. If it helps, ask them what they would do if you were on vacation."

With Smolko's employees, he has a weekly meeting for which his staff creates the agenda. "It gives you a chance to put the problems back on them and for them to grow."

Finally, says Smolko. "Sometimes it feels good to be the boss, but in most cases you grow into it."

[For more information, contact:

• Regis Smolko, Fred Pryor Seminars, 9757 Metcalf Ave., Overland Park, KS 66212. Telephone: (800) 905-8442.] ■

LegalEase

Understanding Laws, Rules, Regulations

HIPAA: What you should do now

By **John C. Gilliland II**
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In late December 2000, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the U.S. Department of Health and Human Services published its long-awaited final rule concerning "Standards for Privacy of Individually Identifiable Health Information."

The privacy rule covers health care providers, health care clearinghouses, and health plans (collectively called "covered entities") that conduct certain financial and administrative transactions electronically (e.g., electronic billing and funds transfers).

It provides extensive and comprehensive federal protection for the privacy of health information addressing these areas:

- use and disclosure of protected health information;
- individual rights with respect to the individual's protected health information;
- notice of privacy practices for protected health information;
- various administrative requirements.

The rule's impact is anticipated to far exceed that of Y2K, both in time and expense, but unlike Y2K, it will not be a one-time effort and expense — privacy compliance will be an ongoing obligation.

Health care providers must comply with the many requirements of the rule by April 14, 2003. However, the Bush administration reopened the comment period for the rule until March 30, 2001, and some efforts are under way in Congress to modify or even repeal the rule.

Changes to the rule's requirements may or may not be made as a result of those actions, but it seems clear the basic thrust of protecting individually identifiable health information will continue.

As the saying goes, "The devil's in the details,"

not in the goal. Although there may be changes forthcoming as a result of the reopened comment period or congressional action, there are several things hospital-based home health agencies should do now to prepare.

Take action early

Much of the effort to comply with the privacy rule probably will be borne by your hospital, but, as often is the case for hospital home care, hospital management may not be aware of the rule's complete impact in the home care setting.

Taking the following actions now is the first step to helping your agency and hospital comply:

- **Obtain a copy of the final rule and comments.**
  The final rule and comments were published in the Dec. 28, 2000, issue of the *Federal Register* (it is more than 380 pages).[1,2] It can be obtained on-line from the government's administrative simplification page at http://aspe.os.dhhs.gov/admnsimp.

- **Identify the key individuals in your agency to spearhead HIPAA compliance efforts.**
  Include management, in addition to representatives of each of your agency's operational areas. You need the input of every area of your agency that deals with individually identifiable health information.

- **Inventory all individually identifiable health information your agency uses or maintains.**
  You need to know what and where the information controlled by the privacy rule is in your agency. Do not think "medical records." Think "health information." Do not forget personal computers and laptops, both at work and at home.
  Individually identifiable health information means: ". . . any information, whether oral or recorded in any form or medium that:
  — is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse;
  — relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual."[1]
  Health information becomes "individually identifiable" if it identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The privacy rule provides specific requirements to determine whether or not information is individually identifiable.
  De-identification of health information may occur if all of 18 specific identifiers stated in the regulation are removed (e.g., geographic subdivisions smaller than a state, including, with certain exceptions, zip codes; telephone and fax numbers; URLs; e-mail addresses; health plan beneficiary numbers; license plate numbers).

- **Collect together all of your agency's existing policies and procedures that deal with identifiable health information and organize them into the subject areas addressed by the privacy rule.**
  This will save you a great deal of time in the future.

- **Inventory all the entities who are "business associates" of your organization.**
  Under the final privacy rule, a covered entity may disclose protected health information to a business associate and may allow a business associate to create or receive protected health information on its behalf, only if the covered entity obtains satisfactory assurance that the business associate will appropriately safeguard the information.
  A covered entity must document those assurances through a written contract or other written agreement or arrangement with the business associate. The privacy rule states what must be included in the contract.
  A "business associate" is ". . . a person, other than in the capacity of a member of the covered entity's work force, who performs or assists in the performance of either:
  — a function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing, or any other function covered by HIPAA;
  — provides legal, actuarial, accounting, consulting, data aggregation, management,

administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person."[2]

- **Begin to educate supervisors and staff concerning the privacy rule.**

  As you learn about the privacy rule's requirements, share that information with the supervisors and staff of your agency. Supervisors and staff can be very helpful in assessing the rule's impact on your agency. Besides, it is much better for them to be part of planning for the rule's impact rather than to have it be thrust upon them with little warning two years from now.

- **Develop a work plan to address and implement the privacy rule's requirements.**

  Two years may seem like a long time, but when you learn all of the rule's requirements, you will see there is a great amount to do. It will take months to accomplish all that is required, but it can be done without undue turmoil if you are proactive in identifying what you must do and proceed in an organized way without putting it off until the final few months.

(Editor's Note: The HIPAA privacy rule was reopened for additional comment during March 2001, and some members of Congress were taking actions to try to change its requirements or even to repeal it entirely. At press time, it was unclear whether or not any changes to the HIPAA privacy rule would occur. If changes do occur, they will be addressed in a future issue of Hospital Home Health.*)*

References

1. 65 *Fed Reg* 82,804 (Dec. 28, 2000)
2. 65 *Fed Reg* 82,798 (Dec. 28, 2000) ■

NEWS BRIEFS

JCAHO releases 2001-2002 home care manual

Joint Commission Resources, a subsidiary of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), has released its *2001-2002 Comprehensive Accreditation Manual for Home Care* (*CAMHC*).

The manual is divided into two main sections:

1. **common standards** that apply to all types of home care organizations;
2. **specific standards** for:

- home health (including personal care and support services);
- hospice;
- pharmacy (including home care and long-term care pharmacies and nonphysician-based ambulatory infusion center);
- home medical equipment (including respiratory therapy and rehabilitation technology services).

The Joint Commission also has included in the publication various segment-specific standard intent statements as well as a separate section on compliance tips.

Cost for the publication is $225. Cost for an electronic version of the *CAMHC* and a traditional print version is $550. When ordering, please use code CAHC-01XY. **(See related brief, p. 58, for more about the new manual.)**

Also released: the *Automated 2001-2002 Comprehensive Accreditation Manual for Home Care.*

This electronic version of the traditional accreditation manual provides information for PCs, LANs, and Intranets and allows users to: search by key words / phrases, link to corresponding information, print selected text and graphics for easy reference, and view HTML files on an intranet.

Cost is $395 for a single personal computer license, or $1,195 for a site license. Please reference AO-01CXY when ordering.

Joint Commission Resources also has released a line of segment-specific accreditation manuals for home health, hospice, pharmacy, and home medical equipment organizations.

Each book features standards, intent statement,

and scoring specific to particular service segments. Cost is $95 each, or $350 for four.

To order, call the Joint Commission customer service center at (630) 792-5800 between 8 am and 5 pm Central Time, Monday through Friday, or go on-line to www.jcrinc.com. ▼

Wading through the new JCAHO manual

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) offers the following useful advice for using its revised *Manual for Home Care*:

Q. Is there an easy way to determine whether a standard is still applicable to your type of home care organization?

A. In the 2001-2002 *Comprehensive Accreditation Manual for Home Care*, many standards have been reorganized, and in some cases, consolidated and reduced for specific service segments. Use the Crosswalk located at the back of the manual to determine if a previous standard still exists and whether or not it has been renumbered.

Review the Table of Standards in the manual to determine whether a standard is applicable to your service segment. The first column lists standards that are common across all types of services. The other columns indicate standards that are applicable to specific services.

Read the intent statement for each standard carefully. Although a standard may be applicable to more than one service segment, requirements within the intent of the standard may vary. For example, standard IM.7.2 (The patient record contains sufficient information to identify the patient, document and support the care and services required, and promote continuity of care) is applicable to all service segments.

However, the standard intent has considerably fewer requirements for an individual receiving only home medical equipment services than for an individual under hospice care.

For more information, contact John Herringer, Associate Director, Standards Interpretation Group, jherringer@jcaho.org or (630) 792-5980. Or go to the web site: www.JCAHO.org. ▼

Proposed nurse-to-patient staffing ratios from CNA

The California Nursing Association (CNA), a leader behind the 2000 California law requiring minimum nurse-to-patient ratios for the state's general acute and acute psychiatric hospitals, has announced its proposal for minimum nurse-to-patient staffing ratio.

The ratios are based on discharge records of California hospital patients over the past six years by the Institute for Health and Socio-Economic Policy and the diagnosis-related group (DRG) designations for the acuity of those patients.

Those ratios are as follows:

- 1:1 — active labor and delivery
- 1:2 — for intensive care, burn
- 1:3 — medical/surgical units, telemetry, or other specialty care; emergency room; step down/intermediate care, definite observation; obstetrics; pediatrics
- 1:4 — psychiatric; subacute and transitional inpatient care
- 1:5 — post-partum/normal newborn nursery

The California Healthcare Association, University of California Hospitals, Service Employees International Union, and United Nurses Association of California/Union of Healthcare Professionals also have submitted proposals for consideration by the California Department of Health Services, which expects to release draft regulations for public comment in early fall. ▼

COMING IN FUTURE MONTHS

- Hand-washing rules and techniques
- Falls in the home
- Who should be on call
- Documentation: Should it be done in the home?
- PPS: Allowable and unallowable costs

Medicare reform bill introduced in Senate

On March 7, Sens. Frank Murkowski, (R-AK) and John Kerry (D-MA) introduced S. 452, the Medicare Education and Regulatory Fairness Act of 2001.

The bill aims to establish a health provider's right to challenge the Health Care Financing Administration's (HCFA) regulations, and if passed, will allow providers to contest an overpayment determination and prohibit the HCFA practice of recovering overpayments by withholding future payments.

According to Sen. Murkowski, many health care providers today are dropping out of Medicare plans for seniors because they can't afford financially to make a mistake with respect to HCFA's regulations.

The bill states: "Physicians and other providers of services that participate in the Medicare program often have trouble wading through a confusing and sometimes even contradictory maze of Medicare regulations. . . . Due to the overly complex nature of Medicare regulations and the risk of being the subject of an aggressive government investigation, many physicians are leaving the Medicare program, limiting the number of Medicare patients they see, or refusing to accept new Medicare patients at all. If this trend continues, health care for the millions of patients nationwide who depend on Medicare will be seriously compromised. Congress has an obligation to prevent this from happening."

For more information on this bill, go to: http: / / thomas.loc.gov. ▼

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Chronically ill Americans not getting proper care

A Harris Interactive survey of 1,663 adult Americans has found that Americans fear the 125 million people living with chronic diseases are not getting the care they need.

The survey, which was done in conjunction with Partnership for Solutions, an initiative to raise awareness of the challenges faced by children and adults with chronic conditions and help policy-makers identify possible solutions, found the following information:

• 72% of Americans say it is difficult for people living with chronic conditions to get necessary care from their health care providers.

• 74% say it's difficult to obtain prescription drug medications.

• 89% say it's difficult to find adequate health insurance.

• 78% say it's difficult to get help from their own family.

The study also found that nearly two-thirds of those polled who do not currently have a chronic condition believe they will develop one during their lifetime, and fear that when they do they will be unable to afford needed medical care and will become a burden to their families.

The survey also found, on average, that family caregivers provide care for their loved ones for 4.5 years, with the unpaid help of four friends or family members. ▼

Upper-level hiring in health care looks strong

People looking for executive and professional positions in the health care field should have little trouble finding a job, according to a recent hiring survey conducted by search and recruitment firm Management Recruiters International Inc. of Cleveland.

The survey reported that 54.3% of the health care executives with responsibility for hiring said they plan to increase their staffs in the first half of this year, up 8.5 percentage points from the 45.8% level of the second half of 2000.

Another 42.5% of those surveyed said they plan to maintain current staff size, up 10.3 points from second-half 2000, while only 3.2% plan staff decreases, a decline of 18.8 points from last year's second half. Across all industries, 58.8% of hiring executives projected new hires during the current half, 35.2% plan to maintain current levels, and 5.9% plan decreases.

For more information, see MRI's web site at www.BrilliantPeople.com. ■

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. ■

20 Tips to Help Prevent Medical Errors

A patient fact sheet

Medical errors are one of the nation's leading causes of death and injury. A recent report by the Institute of Medicine estimates that as many as 44,000 to 98,000 people die in U.S. hospitals each year as the result of medical errors. This means that more people die from medical errors than from motor vehicle accidents, breast cancer, or AIDS. Government agencies, purchasers of group health care, and health care providers are working together to make the U.S. health care system safer for patients and the public. This fact sheet tells what you can do.

What are medical errors?
Medical errors happen when something that was planned as a part of medical care doesn't work out, or when the wrong plan was used in the first place.
Medical errors can occur anywhere in the health care system:

- ❒ Hospitals
- ❒ Clinics
- ❒ Outpatient surgery centers
- ❒ Doctors' offices
- ❒ Nursing homes
- ❒ Pharmacies
- ❒ Patients' homes

Errors can involve:

- ❒ Medicines
- ❒ Surgery
- ❒ Diagnosis
- ❒ Equipment
- ❒ Lab reports

They can happen during even the most routine tasks, such as when a hospital patient on a salt-free diet is given a high-salt meal. Most errors result from problems created by today's complex health care system. But errors also happen when doctors and their patients have problems communicating. For example, a recent study supported by the Agency for Healthcare Research and Quality (AHRQ) found that doctors often do not do enough to help their patients make informed decisions. Uninvolved and uninformed patients are less likely to accept the doctor's choice of treatment and less likely to do what they need to do to make the treatment work.

What can you do? Be involved in your health care

1. The single most important way you can help to prevent errors is to be an active member of your health care team. That means taking part in every decision about your health care. Research shows that patients who are more involved with their care tend to get better results. Some specific tips, based on the latest scientific evidence about what works best, are listed below.

Medicines

2. Make sure that all of your doctors know about everything you are taking. This includes prescription and over-the-counter medicines, and dietary supplements such as vitamins and herbs. At least once a year, bring all of your medicines and supplements with you to your doctor. "Brown bagging" your medicines can help you and your doctor talk about them and find out if there are any problems. It can also help your doctor keep your records up to date, which can help you get better quality care.
3. Make sure your doctor knows about any allergies and adverse reactions you have had to medicines. This can help you avoid getting a medicine that can harm you.
4. When your doctor writes you a prescription, make sure you can read it. If you can't read your doctor's handwriting, your pharmacist might not be able to either.
5. Ask for information about your medicines in terms you can understand — both when your medicines are prescribed and when you receive them.
   What is the medicine for?
   How am I supposed to take it, and for how long?
   What side effects are likely?
   What do I do if they occur?
   Is this medicine safe to take with other medicines or dietary supplements I am taking?
   What food, drink, or activities should I avoid while taking this medicine?

6. When you pick up your medicine from the pharmacy, ask: Is this the medicine that my doctor prescribed? A study by the Massachusetts College of Pharmacy and Allied Health Sciences found that 88% of medicine errors involved the wrong drug or the wrong dose.
7. If you have any questions about the directions on your medicine labels, ask. Medicine labels can be hard to understand. For example, ask if "four doses daily" means taking a dose every 6 hours around the clock or just during regular waking hours.
8. Ask your pharmacist for the best device to measure your liquid medicine. Also, ask questions if you're not sure how to use it. Research shows that many people do not understand the right way to measure liquid medicines. For example, many use household teaspoons, which often do not hold a true teaspoon of liquid. Special devices, like marked syringes, help people to measure the right dose. Being told how to use the devices helps even more.
9. Ask for written information about the side effects your medicine could cause. If you know what might happen, you will be better prepared if it does, or if something unexpected happens instead. That way, you can report the problem right away and get help before it gets worse. A study found that written information about medicines can help patients recognize problem side effects and then give that information to their doctor or pharmacist.

Hospital stays

10. If you have a choice, choose a hospital at which many patients have the procedure or surgery you need. Research shows that patients tend to have better results when they are treated in hospitals that have a great deal of experience with their condition.
11. If you are in a hospital, consider asking all health care workers who have direct contact with you whether they have washed their hands. Hand washing is an important way to prevent the spread of infections in hospitals. Yet, it is not done regularly or thoroughly enough. A recent study found that when patients checked whether health care workers washed their hands, the workers washed their hands more often and used more soap.
12. When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will use at home. This includes learning about your medicines and finding out when you can get back to your regular activities. Research shows that at discharge time, doctors think their patients understand more than they really do about what they should or should not do when they return home.

Surgery

13. If you are having surgery, make sure that you, your doctor, and your surgeon all agree and are clear on exactly what will be done. Doing surgery at the wrong site (for example, operating on the left knee instead of the right) is rare. But even once is too often. The good news is that wrong-site surgery is 100% preventable. The American Academy of Orthopaedic Surgeons urges its members to sign their initials directly on the site to be operated on before the surgery.

Other steps you can take

14. Speak up if you have questions or concerns. You have a right to question anyone who is involved with your care.
15. Make sure that someone, such as your personal doctor, is in charge of your care. This is especially important if you have many health problems or are in a hospital.
16. Make sure that all health professionals involved in your care have important health information about you. Do not assume that everyone knows everything he or she needs to.
17. Ask a family member or friend to be there with you and to be your advocate (someone who can help get things done and speak up for you if you can't). Even if you think you don't need help now, you might need it later.
18. Know that "more" is not always better. It is a good idea to find out why a test or treatment is needed and how it can help you. You could be better off without it.
19. If you have a test, don't assume that no news is good news. Ask about the results.
20. Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources. For example, treatment recommendations based on the latest scientific evidence are available from the National Guideline Clearinghouse at http://www.guideline.gov. Ask your doctor if your treatment is based on the latest evidence.

More information

Visit www.ahcpr.gov/qual/errorsix.htm for more about medical errors. A Federal report on medical errors from the Quality Interagency Coordination Task Force can be accessed at www.quic.gov/report/ and a print copy (Publication No. OM 00-0004) is available from the AHRQ Publications Clearinghouse. Telephone: (800) 358-9295.

Source for English and Spanish versions: 20 Tips to Help Prevent Medical Errors. Patient Fact Sheet. AHRQ Publication No. 00-PO38, February 2000. Agency for Healthcare Research and Quality, Rockville, MD. Web site: http://www.ahrq.gov/consumer/20tips.htm.

20 recomendaciones para ayudar a prevenir los errores médicos

Información para pacientes médicos

Los errores médicos son una de las razones principales de muerte y lesión en los Estados Unidos. Un reporte reciente del Institute of Medicine (Instituto de medicina) estima que tantas como 44,000 a 98,000 personas mueren en los hospitales del país anualmente como resultado de errores médicos. Esto quiere decir que mueren más personas a causa de los errores médicos que de accidentes en vehículos, cáncer del seno, o el SIDA. Las agencias del gobierno, los compradores de cuidado médico, y el personal de atención médica están trabajando juntos para hacer que el sistema de cuidado médico de los Estados Unidos sea más seguro para los pacientes y el público. Esta hoja de datos le dice lo que usted puede hacer al respecto.

¿Qué son los errores médicos?
Los errores médico ocurren cuando algo que se había planeado como parte del cuidado médico no funciona; o cuando se usa un plan equivocado para el problema de salud.
Los errores pueden suceder en cualquier ámbito de cuidado médico:

- ❒ En los hospitales
- ❒ Clínicas
- ❒ Centros de cirugía para pacientes ambulatorios
- ❒ En los consultorios de los médicos
- ❒ Los asilos de ancianos
- ❒ Las farmacias
- ❒ Los hogares de los pacientes

Los errores pueden involucrar:

- ❒ Los medicamentos
- ❒ La cirugía
- ❒ Los diagnósticos
- ❒ El equipo
- ❒ Los reportes de los laboratorios

Pueden suceder incluso cuando se están llevando a cabo la mayoría de los procedimientos de rutina, tal como cuando un paciente hospitalizado que necesita recibir una dieta sin sal recibe una comida que contiene mucha sal. La mayoría de los errores resultan de problemas creados por la complejidad del sistema de cuidado médico de hoy en día. Pero también ocurren errores cuando los pacientes y sus médicos tienen problemas de comunicación. Por ejemplo, un estudio reciente patrocinado por la Agency for Healthcare Research and Quality (AHRQ) (agencia federal que investiga maneras de mejorar la calidad de la atención médica) encontró que frecuentemente los médicos no hacen lo suficiente para ayudar a los pacientes a tomar las decisiones más informadas. Los pacientes que no están involucrados y que no están informados tienen menor probabilidad de aceptar el tratamiento que ha elegido el médico y tienen menor probabilidad de hacer lo que deben para permitir que el tratamiento funcione.

¿Qué puede hacer usted? Participe en su propio cuidado médico

1. La cosa más importante que puede hacer para ayudar a prevenir errores es hacerse un miembro activo en el su propio equipo de cuidado médicos. Eso quiere decir que tome parte en cada decisión en cuanto a su cuidado. La investigación demuestra que los pacientes que están involucrados en su cuidado tienen mejores resultados. A continuación están algunas recomendaciones específicas basadas en la más reciente evidencia científica acerca de lo que funciona mejor:

Medicamentos

2. Asegúrese que todos sus médicos sepan todos los medicamentos que usted usa. Esto incluye tanto los que obtiene con receta, como los que compra sin receta y los suplementos de dieta tales como las vitaminas y la hierbas. Por lo menos una vez al año, llévelos todos a su doctor. Llevar sus medicamentos puede ayudar a que usted y su médico hablen sobre sus medicamentos y que determinen si existe algún problema. Tambíen permite que su médico mantenga su archivo al día, lo que puede ayudar a que reciba mejor cuidado médico.
3. Asegúrese que su médico sepa acerca de cualquier alergia o reacción adversa que haya tenido a los medicamentos. Esto puede ayudar a que usted no reciba un medicamento que pudiera causarle daño.
4. Asegúrese que puede leer las recetas de medicamentos que le escribe su médico. Si usted no puede leer la escritura de su médico, es probable que tampoco la pueda leer el farmacéutico.
5. Haga preguntas sobre sus medicamentos y pida información fácil de entender acerca de los medicamentos, tanto cuando se los receta el médico, como cuando los recibe en la farmacia:
   ¿Para qué es el medicamento?
   ¿Cómo lo debo tomar y por cuánto tiempo?
   ¿Cuáles son los posibles efectos secundarios y qué debo hacer si se presentan?

¿Es seguro tomar este medicamento con los otros medicamentos que tomo o con los suplementos dietéticos? ¿Qué comida, bebidas o actividades debo evitar cuando esté tomando este medicamento?

6. Cuando recoja su medicamento en la farmacia, pregunte: ¿Es este el medicamento que me recetó mi médico? Un estudio del Massachusetts College of Pharmacy and Allied Health Sciences (Universidad de farmacología de Massachusetts) encontró que el 88%de los errores de este tipo son cuando los medicamentos recetados o las dosis están equivocados.
7. Si tiene alguna pregunta en cuanto a las instrucciones de uso del medicamento, hágala. Las etiquetas de los medicamentos pueden ser difíciles de entender. Por ejemplo, pregunte si "cuatro dosis al día" quiere decir que debe tomar el medicamento cada seis horas durante todo el día y la noche, o si los puede tomar durante las horas que está despierto.
8. Pregunte al farmacéutico sobre el mejor instrumento para medir la medicina líquida. También hágale preguntas si no está seguro de cómo usarlo. La investigación muestra que muchas personas no entienden la manera correcta de medir medicamentos líquidos. Por ejemplo, muchos usan cucharas pequeñas de cocina, que frecuentemete no miden una verdadera cucharadita de líquido. Los instrumentos especiales, cómo las jeringas con números, ayudan a las personas a medir la dosis adecuada. El que le digan cómo usar los instrumentos le puede ayudar aún más.
9. Pida información por escrito sobre los efectos secundarios que podría ocasionar el medicamento. Si sabe que los efectos secundarios podrían suceder, estará mejor preparado con esta información; y también estará preparado si sucede algo que no esperaba. De esta manera, puede reportar el problema de inmediato y recibir ayuda antes de que la situación empeore. Un estudio determinó que recibir información por escrito sobre los medicamentos ayuda a los pacientes a reconocer los efectos secundarios problemáticos y así pasar esa información a su médico o farmacéutico.

Estadías en el hospital

10. Si tiene la opción, elija un hospital en el que muchos pacientes ya han recibido el procedimiento o la cirugía que usted necesita. La investigación muestra que los pacientes tienden a tener mejores resultados cuando reciben tratamiento en los hospitales que cuentan con amplia experiencia en el problema que padecen.
11. Si está en un hospital, considere preguntar a quienes lo atienden y tienen contacto directo con usted, si se han lavado las manos. Lavarse las manos es importante en la prevención de esparcir infecciones dentro de los hospitales. Sin embargo, esto no se hace regular o adecuadamente. Un estudio reciente encontró que cuando los pacientes hacen esta pregunta, el personal de cuidado se lava las manos más frecuentemente y usan más jabón.
12. Cuando se le dé de alta en un hospital, pida a su médico que le explique el plan de tratamiento que necesitará en casa. Esto incluye aprender lo necesario en cuanto a los medicamentos y averiguar cuándo puede volver a hacer sus actividades normales. La investigación muestra que, en el momento en que dan de alta a sus pacientes, los doctores piensan que entienden más de lo que realmente saben en cuanto a lo que deberían y no deberían hacer cuando regresen a casa.

Cirugía

13. Si lo van a operar, tiene que estar seguro de que su doctor, el cirujano, y usted están de acuerdo y tienen claro exactamente lo que se va a hacer. Hacer la operación en la parte equivocada del cuerpo (la rodilla izquierda en vez de la derecha) es raro. Pero si esto sucede aunque sea una vez, es demasiado. La buena nueva es que las operaciones en la parte equivocada del cuerpo son 100 por ciento prevenibles. La American Academy of Orthopaedic Surgeons (Academia americana de cirujanos ortopédicos) recomienda a sus miembros que antes de realizar el procedimiento, escriban sus iniciales directamente en el lugar del cuerpo en donde van a operar.

Otras pasos que puede tomar

14. Exprese sus preguntas y preocupaciones. Tiene el derecho de hacer preguntas a cualquier persona involucrada en su cuidado médico.
15. Asegúrese que alguien, como su médico personal, esté a cargo de su cuidado. Esto es especialmente importante si tiene muchos problemas de salud, o si se encuentra internado en un hospital.
16. Asegúrese que todos los profesionales involucrados en su cuidado cuenten con su información importante de salud. No asuma que todos saben todo lo que deberían saber.
17. Pida que un familiar o amigo le acompañe y sea su defensor (alguien que pueda ayudar a que se hagan las cosas). Incluso si piensa que no necesita ayuda ahora, puede ser que la necesite más tarde.
18. Sepa que "más" no siempre significa mejor. Es buena idea averiguar el por qué un examen o tratamiento es necesario y las maneras en que le podría ayudar. Pero tambíen es posible que usted estaría mejor sin hacerlo.
19. Si le hacen un examen, no asuma que el que no le den noticias indica que todo está bien. Pida usted mismo los resultados.
20. Aprenda sobre su condición y tratamientos haciendo preguntas a su médico y enfermera y usando otras fuentes confiables de información. Por ejemplo, existe información sobre las recomendaciones de tratamiento basadas en la evidencia científica más reciente a través de la National Guidelines Clearinghouse al http://www.guideline.gov. Pregunte a su médico si el tratamiento que le da está basado en la más reciente evidencia científica.

Más información

AHRQ ofrece más información acerca de los errores médicos en inglés. Si le interesa esta información adicional, visite el sitio del Web del la agenica (http://www.ahrq.gov/qual/errorsix.htm) o pida el reporte federal, OM00-0004, sobre los errores médicos, llamando al AHRQ Clearinghouse: (800) 358-9295. Hay personal que atiende en español.