AMERICAN HEALTH CONSULTANTS

Providing the highest quality information for 18 years

Hospital Home Health.

the monthly update for executives and health care professionals

IN THIS ISSUE

Inserted in this issue:
2001 Salary Survey

JUNE 2001

VOL. 18, NO. 6 (pages 61-72)

There's nothing finer than having your paperwork done at the end of the day

Should it be done in the home or the driveway?

Take any work-related task, and you'll find that home care agency staff have as many different ways to perform it as there are people to handle it. Different approaches can lead to new and, at times, improved ways of handling a requirement.

But there are instances when using a different approach results in lost time and productivity, and in the case of home care assessments, it might even lead to incorrect data. One example is documentation. Some home care nurses and aides prefer to — or are required to — perform it on-site, while others prefer to save it all up for one lengthy paperwork session.

Which way is the right way?

Some home care professionals say that there is already so much paperwork to be done in the home that any documentation that can be done outside the home should be. Otherwise, it takes too much time away from the patient visit.

"For 25 years, I have been trying to convince staff to complete charting in the home," says **Diann Martin**, RN, DNSc, with LM Cantone and Associates in Wilmette, IL. "Most don't like to. However, the ones who get into the habit certainly find it helpful. I try training them on this system from the beginning as new orientees. I can understand why an admit [document] may not be possible, but progress notes are a different animal, and I think it is a real timesaver and an efficiency issue. Sure, some homes are too chaotic with kids bouncing off the walls, but many aren't."

Vicky Tataryn, quality improvement consultant with Continuous Care Services in Nashville, TN, agrees that finishing documentation in the home can be a challenge, up to a point.

"Yes, it is hard to do the paperwork when you are up to your eyeballs in a really gooey dressing change," she says. "However, I also have observed that what takes me 10 minutes to do sitting in a parking lot in my car takes 30 when I try to do it at home or at the office.

"Therefore, my suggestion always has been to complete the paperwork from one visit prior to going to the next visit," Tataryn continues. "Pull over in a parking lot, sit in the patient's driveway a few minutes,

and if you have another patient that you're running late for, that sense of urgency will be there to speed you along. It is heaven to pull into your driveway at the end of the day with your paperwork complete. That's what I tell new home health nurses, and the ones [who] do it are happier campers at the end of six months then the ones who [don't]."

Although she no longer works for a home care agency, when she did, **Meri Shaffer**, RN, now a program manager with Homeadvantage in Fairfax, VA, was a project manager and oversaw the implementation of 150 laptops in the field between two home health agencies. Her agency shared the system with another hospital-based home health agency 70 miles away.

She says that whether paperwork was completed in the home was dependent on the clinician — and not always to the staff member's advantage.

To make it easier on the staff, Shaffer says, "we came up with a semichecklist, where part of it was fill-in-the-blank and some was narrative. We tried to cut down the paperwork as much as possible, and most people did complete it in the home. Still, there were others who would take time to write down all their notes on a steno pad and then take time to transfer the notes onto the form when they got home. We had someone save up her notes for a week before she would transcribe them, and it took her hours. When we went to laptops, she transferred the same work habit, and it took even more time."

For her part, Shaffer finished her paperwork on-site or as soon after the visit as possible. "My feeling was such that I wrote most of the notes in the home unless there was something I didn't want a patient to see. I had one patient who saw that I had written SOB [shortness of breath] on his chart, and he took it completely wrong.

"Whether it's paper or electronic documentation, when I would make visits, I always tried to get all of it done and advised my staff to do the same. Not only did I not have the burden when I got home, but information was fresh in my mind and certainly more accurate," she says.

Getting it right

Accuracy is one of the best reasons for completing the paperwork as soon as possible after, if not during, the visit. "For data accuracy, thoroughness, and to provide clinicians, agencies, and HCFA [the Health Care Financing Administration] with more accurate visit times, seems like in-home documentation is necessary," says **Linda Krulish**, PT, MHS, president of Home Therapy Services in Parker, CO.

But there's more than accuracy at stake when it comes to completing documentation in the home. "The in-home visit time that we report to HCFA is the data that it will use to estimate costs to provide care," she explains.

"If we're doing any or all of our visit documentation in the patient's driveway, Taco Bell drive-through, office, or at our kitchen tables, this will provide HCFA with inaccurately low-time data possibly resulting in HCFA determining future payment rates inappropriately lower than they should be," Krulish explains.

"This is a tough one as there are some visits where the documentation takes longer than the

CE questions

9. One of the best reasons for completing documentation in the home is accuracy in reporting.
   A. True
   B. False

10. Antiseptic gels or towelettes can and should be used in lieu of soap and water as a means of washing ones hands in a patient's home.
   A. True
   B. False

11. Examples of when a waterless antiseptic hand cleanser may be used in lieu of hand washing with soap and water include the following:
   A. during a dressing chance for a patient with multiple wounds when the staff member's gloves are removed several times
   B. after changing gloves to begin wound care at another site
   C. after removing a dirty dressing with sterile gloves
   D. A and B
   E. All of the above

12. The May 31 deadline for submission of cost reports by home health agencies with a fiscal year end of Dec. 31 has been postponed until Aug. 31.
   A. True
   B. False

assessing and rendering of care, and that can make patients wonder if you came to see them or do your paperwork," she notes.

Are there solutions?

To make sure that time spent with a patient is correctly reported to HCFA, at Cushing (OK) Regional Home Health Agency, explains **Laresa Boyle**, RHIA, business office/medical records coordinator, "Our visit note has time in, time out, documentation time, and travel time. The documentation time is for any time outside the home that is spent on paperwork. Anything done in the home is considered part of their visit time."

A similar approach has been taken at Palliative CareCenter and Hospice of the North Shore in Evanston, IL. "Our visit notes and our visit day sheets both have spaces to document telephone time, documentation time, and travel time, as well as time spent in the home on the visit. It allows us to capture the actual time spent by staff much better than before we changed the notes and day sheets," says **Naomi Rubinstein**, RN, QA/clinical research specialist with Palliative CareCenter and Hospice.

Depending upon the state an agency operates in, differences in Medicare and Medicaid rules could eliminate the possibility that paperwork is completed outside the home. Some states, for example, require the patient to sign all documentation. Regardless of what a state might require, some agencies have taken the approach that it's best not to even allow for a situation whereby documentation can be completed after the visit.

"One of the reasons we went to home charts is that [home care agency staff] must do the charting in the home and leave a copy in the home. The visit includes the documentation completed in the home," explains **Linda Westerman**, RN, MN, education director for Home Health Management Inc. in Florence, SC. Even so, she says, "they have found ways around that, too."

One way to keep employees from getting around the in-home documentation rule, Shaffer says, is by using automation. Companies such as Homeadvantage offer telephonic services. "This enables the clinicians to use the phone to track their comings and goings."

She acknowledges that this system is best suited for home health aides "because the clinical documentation is not very detailed. It utilizes just a task list, so for nurses, it's not in-depth enough. That said, it's still a wonderful tool for payroll purposes."

Some agencies, she notes, use it for their professional staff as well, "so the agency knows they made the visit and can be alerted to the fact that paperwork will be forthcoming. It's an excellent way of using the program because it cuts down on the aggravation of not knowing whether a patient has been seen. And it has caller ID so managers can check where a call comes from."

Using electronic methods

Thomas P. Gordon, a senior account executive with Sandata in Port Washington, NY, points out that there are several types of solutions to try if automation is an option, ranging from telephonic equipment, scanning products, and laptops or personal digital assistants.

Gordon says, "[Sandata, for example], offers an automated time, attendance, and data collection system via 800-phone numbers, so there's no cost to the patient to collect visit information, including mileage and the actual time spent in the home.

"In effect, we replicate the duty sheet over the telephone, and gather any and all data elements that the client needs collected. What is also nice is that you completely eliminate paper, at least for the aides, and are able to export this information directly to your payroll, billing, and scheduling software."

As Shaffer notes, "There are all kinds of vendors for point-of-care things so there is always new stuff out there — everything from laptops to handhelds, CEs [Windows, condensed], and web-based palm pilots. There really is a lot to choose from and because of this, I think agencies have the best of all worlds."

There will always be difficulties in collecting this type of data, says Gordon, "but with discipline and a little work, a more technological solution can help to ease this type of burden."

[For more information, contact:

*• **Laresa Boyle**, RHIA, Business Office/Medical Records Coordinator, CRH Home Health Agency, Cushing Regional Hospital Home Health, P.O. Box 1409, Cushing, OK 74023. Telephone: (918) 225-2915.*

*• **Thomas Gordon**, Senior Account Executive, Sandata Inc., 26 Harbor Park Drive, Port Washington, NY 11050. Telephone: (516) 484-4400, ext 249.*

• ***Linda Krulish**, PT, MHS, President, Home Therapy Services, P.O. Box 2764, Parker, CO 80134. Telephone: (614) 250-5438.*

• ***Diann Martin**, RN, DNSc, LM Cantone and Associates, 900 Amherst, Wilmette, IL 60091. Telephone: (847) 853-8102.*

• ***Naomi Rubenstein**, RN, QA/Clinical Research Specialist, Palliative CareCenter and Hospice of the North Shore, 2821 Central, Evanston, IL 60201. Telephone: (847) 467-7423.*

• ***Meri Shaffer**, RN, Program Manager, Homeadvantage, 10875 Main St., Suite 212, Fairfax, VA 22030. Telephone: (703) 352-1830, ext 8213.*

• ***Vicky Tataryn**, RN, BS, Quality Improvement Consultant, Continuous Care Services, One Vantage Way, Nashville, TN 37228. Telephone: (615) 259-2772.*

• ***Linda Westerman**, RN, MN, Education Director, Home Health Management Inc., 1945 W. Palmetto St., Florence, SC 29502-5599.Telephone: (800) 708-7060, ext. 3050.]* ■

LegalEase

Understanding Laws, Rules, Regulations

Suddenly, HCFA wants agencies to make a profit

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

[Editor's note: This is one of a continuing series about legal and ethical issues related to the implementation of the prospective payment system (PPS).]

Despite the fears spawned by the implementation of PPS, the good news is that it appears the Health Care Financing Administration (HCFA) now wants agencies to make money.

Although it may seem strange to many managers who functioned for so many years under cost-based reimbursement, the current consensus is that HCFA officials correctly perceive that the home care industry must be properly capitalized through modest profits that will make the industry, as a whole, more desirable to lenders.

Medicare-certified agencies are accustomed to operating under rules that clearly indicate that only allowable costs will be reimbursed by the Medicare program. All unallowable costs will not be reimbursed.

Officials at HCFA have clearly indicated that these rules will remain in effect under PPS. HCFA will continue to identify unallowable costs on cost reports that agencies will continue to submit under PPS.

What about unallowable costs?

So then, what will become of the familiar rules governing allowable vs. unallowable costs when agencies are reimbursed under PPS? What will HCFA do when unallowable costs are identified on providers' cost reports? Fortunately, HCFA officials also have made it clear that unallowable costs will not result in overpayments. In other words, the episodic payments made to providers under PPS are considered to be payment in full.

In recognition of this key difference under PPS, as opposed to cost-based reimbursement, providers may conclude that they now have a "ticket to ride." That is, some agencies anticipate operating in an environment in which they can ignore the rules governing allowable costs.

For example, it appears that some consultants are advising agencies that they may openly market their services. Under cost-based reimbursement and the interim payment system (IPS), only so-called community awareness activities were allowable. In view of the change in reimbursement to a prospective rate, industry advisors may conclude that it is acceptable to ignore the old rules related to allowable costs.

This advice may prove to be a double-edged sword for providers. On the one hand, it may assist the industry in stabilizing and further developing in some significant directions to ignore the rules governing allowable costs. On the other hand, HCFA has indicated that it will review cost reports to determine whether costs reported are allowable. Although agencies will not be liable for overpayments as a result of unallowable costs as they have been in the past, unallowable expenses on cost reports will impact future rates under PPS.

Unallowable costs also are likely to influence whether HCFA perceives that agencies are making money and, if so, how much. If officials at

HCFA perceive that agencies are making too much money, rates under PPS may be reduced.

Given that HCFA now seems to accept that home care agencies need to turn a profit to survive, the $64,000 question is: "How much profit will HCFA find acceptable?" Clearly, agencies cannot expect huge windfalls; PPS rates are likely to be adjusted to prevent them. But after eliminating unallowable costs from cost reports, it appears that HCFA will allow for a modest profit.

So while it may be tempting to ignore the rules governing allowable costs under PPS, agencies should be mindful of the fact that the rules are still operative and will influence PPS rates in the future.

To the extent that unallowable costs appear on agencies' cost reports, it may hamper HCFA's efforts to achieve this objective. The wisest course of action may be to treat this issue as it was treated under cost-based reimbursement and IPS, at least until the PPS system, including the establishment of reasonable rates, stabilizes.

[A complete list of publications is available from Elizabeth E. Hogue's office. Call (301) 421-0143 or send a fax request to (301) 421-1699.] ■

Speak out and be heard

Do you have an idea where the home health industry is headed in the future that you'd like to share? *Hospital Home Health* wants to hear from you.

Worried about cash flow under the new PPS rule? Concerned about the nursing shortage? Does the lack of money to fund technological improvements in the industry have you down? Do you think that in a country where record numbers of people are living longer that we are not prepared to care for them?

What top issues are on your mind? What do you think is the largest problem or hurdle facing home care today, and on the contrary, what do you see as the most positive things to happen in home care in recent months?

Write us your opinions, and we'll print them. Please keep your answers to a single paragraph, single-spaced and include your name, address, and home care agency.

Send them to: Lee Landenberger, *Hospital Home Health*, P.O. Box 740059, Atlanta, GA 30374. ■

Get a grip on the proper way to wash your hands

A few experts comes clean on their methods

Everyone in the health care profession should know the importance of proper hand washing as a means of infection control. Even so, there are some gray areas as to what constitutes proper hand washing, when it should be performed, and by whom. Do social workers fall under the same rules as home care aides? Can an antiseptic gel be used in place of soap and water?

Hospital Home Health talked to a few experts in the field to get a better grip on the rules for hand washing. Here's what we learned:

No exceptions

First, **Kim Stout**, RN, BSN, home health director for McAlester (OK) Regional Health Center Home Health, states, "every employee that enters a patient home should wash his or her hands prior to beginning the visit."

Stout learned this the hard way. "We were given a deficiency by our state surveyor three years ago due to this very thing. Our speech language pathologist did not wash her hands. She did not touch the patient, but the surveyor stated that all home health employees are to wash hands using proper hand-washing techniques." The change in policy to reflect this, she says, has worked well for her agency since its implementation.

Kathy Stockton, RN, BSN, supervisor officer / performance improvement with Mercy Home Care and Hospice in Nampa, ID, says her agency also implemented a hand-washing policy after a Joint Commission on Accreditation of Healthcare Organization survey.

"It was recommended that we tighten our policy and make it uniform," she explains. "Up until that point, we had one that said nothing much more than 'you'll do it,' but nothing was spelled out."

Since that survey, Mercy Home Health has developed a written, formal policy that spells out exactly who should be washing their hands, when it should be done, and how. **(See box, p. 66.)**

The new policy, Stockton explains, is used "for understanding of accountability so that all the

(Continued on page 67)

Hand Washing: Policy and Procedures

Purpose: To cleanse the hands of germs and prevent contamination between patients and home care personnel.

Policy: All personnel providing direct or indirect care/service will wash their hands in the home prior to contact with the patient.

Personnel also will wash their hands:
- ✔ after gloves are removed*;
- ✔ after taking care of a patient who is infected or colonized with TB or a multidrug-resistant microorganism;
- ✔ when hands are visibly soiled;
- ✔ after using the toilet, blowing the nose, or covering a sneeze;
- ✔ after assisting a patient in using the toilet or changing diapers/protective undergarments;
- ✔ before eating, drinking, handling, or serving food;
- ✔ before leaving the patient's home, as appropriate to the situation.

Towels, either cloth or paper, and liquid soap will be used if appropriate to the home setting. Waterless hand-washing products may be used if liquid soap and running water are unavailable or when waterless hand washing is more appropriate to the situation (also see "washing without water," below).

GUIDELINES

Washing with water
- ✔ Turn on the water, adjust temperature, and wet hands.
- ✔ Apply the soap and work into a lather using friction, covering the entire hand, top and bottom, for a minimum of 15 seconds.
- ✔ Pay special attention to the nails and between the fingers and the back of hands.
- ✔ Rinse hands thoroughly with running water. Dry hands with a paper towel or clean cloth towel.
- ✔ Turn off faucet with clean paper towel or cloth towel.

Washing without water
- ✔ Use an approved antiseptic hand cleanser and towels or antiseptic towelettes according to instructions.
- ✔ Dry hands with a paper towel or clean cloth towel as need.

Examples of when a waterless antiseptic hand cleanser may be used in lieu of hand washing with soap and water include the following:**
- ✔ during a dressing change for a patient with multiple wounds when the staff member's gloves are removed several times;
- ✔ after changing gloves to begin wound care at another site;
- ✔ after removing a dirty dressing with nonsterile gloves and applying a sterile dressing with sterile gloves;
- ✔ when patient safety would be comprised if the clinician left the room to wash his/her hands;
- ✔ when the discipline is social worker, chaplain, or dietitian and hands-on care*** is not anticipated during the visit.

Premoistened towelettes or waterless hand-washing products should not be used as a substitute for washing hands with soap and running water when appropriate as described above.

When a waterless product has been used, the staff member must wash his/her hands with soap and running water as soon as feasible thereafter. (Hands should be washed after six or seven hand washes with waterless soap.)*

* Occupational Safety and Health Act, Paragraph (d)(2)(iv)(v).
** Rhinehart E, Friedman M. *Infection Control in Home Care*. Gaithersburg, MD: Aspen Publishers; 1999.
*** Hands-on care is an assessment, procedure, or treatment that requires physical contact with the patient.

Source: Mercy Home Health & Hospice, Nampa, ID.

staff are held to same standard. It's important staff understand that infection control is a really big item and that it's best to be proactive."

Both Stockton and Stout agree. Everyone who enters a patient's home must wash his or her hands.

As for what types of cleansers to use, Stockton says her policy "specifies the preference for soap and water as opposed to gel. You can use gels when there's no running water, but that's basically the bottom line. It's also allowed in cases where the practitioner feels the situation is such that washing hands in the patient's sink would be totally impractical."

Across the board though, she says, using gel instead of soap is discouraged. To get around the problems with using a patient's soap and/or towels, both Stout's and Stockton's agencies have provided their staff with soap and paper towels, and in the case of McAlester Home Care, germicidal hand wipes are provided. Like Mercy Home Care, however, Stout notes that the hand wipes are to be used only in instances where running water is not available.

Staff are required to wash their hands both prior to touching the patient and before leaving the home, Stockton says. "Getting staff to wash their hands with running water before leaving the home is more problematic because they would just as soon use the gel."

She says using soap and running water is the biggest obstacle to compliance. "It's truly the problem child with the nonclinical staff. They understand why. It's just getting them to do it, and social workers have trouble understanding why it should be done before patient contact."

A good hand-washing policy also will point out that staff members should wash their hands for a minimum of 15 seconds, or about as long as it takes to sing your ABCs. It also should require employees to turn off the faucet using a paper or cloth towel.

For employees who wear a lot of rings, care should be taken to clean around and under the jewelry. The same goes for women with long fingernails.

Luckily for Stockton, "that's just not an issue for any of us. I imagine if the hospital with which we are associated implemented a specific policy with respect to this we would, too, but so far, it's just not been much of a problem."

As for any advice to agencies looking to revise their hand-washing policies, Stockton says this: "Keep it as simple as you can. You want a policy that you can hold staff to, but on the other hand, you want to make it easy to understand and explain so that there are not too many opportunities for working around it."

[For more information, contact:

*• **Kim Stout**, RN, BSN, Home Health Director, McAlester Regional Health Center Home Health, One Clark Bass Blvd., McAlester, OK 74501. Telephone: (918) 421-8019.*

*• **Kathy Stockton**, RN, BSN, Supervisor Officer/Performance Improvement, Mercy Home Health and Hospice, 1512 12th Ave. Road, Nampa, ID 83686. Telephone: (208) 463-5220.]* ■

Going home after a stroke: A guide for care

Adjusting to the change is made easier

(Editor's note: A Spanish-language version of this story is included ***on page 69*** *for Spanish-speaking patients.)*

Going home to the old home or a new one is a big adjustment for the stroke survivor. It may be hard to transfer the skills learned during rehabilitation to a new location. Also, more problems caused by the stroke may appear as the person tries to go back to old activities. During this time, the stroke survivor and family learn how the stroke will affect daily life and can make the necessary adjustments.

These adjustments are a physical and emotional challenge for the main caregiver as well as the stroke survivor. The caregiver has many new responsibilities and may not have time for some favorite activities. The caregiver needs support, understanding, and some time to rest. Caregiving duties that fall too heavily on one person can be very stressful. Even when family members and friends are nearby and willing to help, conflicts over tasks can cause stress.

A stroke is always stressful for the family, but it is especially hard if one family member is the only caregiver. Plenty of time may be required to meet the needs of the stroke survivor. Therefore, the caregiver needs as much support as possible from others. Working together eases the stress on everyone.

The following tips for reducing stress are for

both caregivers and stroke survivors:

• Take stroke recovery and caregiving one day at a time and be hopeful.

• Remember that adjusting to the effects of stroke takes time. Appreciate each small gain as you discover better ways of doing things.

• Caregiving is learned. Expect that knowledge and skills will grow with experience.

• Experiment. Until you find what works for you, try new ways of doing activities of daily living, communicating with each other, scheduling the day, and organizing your social life.

• Plan for breaks so that you are not together all the time. This is a good way for family and friends to help on occasion. You can also plan activities that get both of you out of the house.

• Ask family members and friends to help in specific ways and commit to certain times to help. This gives others a chance to help in useful ways.

• Read about the experiences of other people in similar situations. Your public library has life stories by people who have had a stroke as well as books for caregivers.

• Join or start a support group for stroke survivors or caregivers. You can work on problems together and develop new friendships.

• Be kind to each other. If you sometimes feel irritated, this is natural and you don't need to blame yourself. But don't take it out on the other person. It often helps to talk about these feelings with a friend, rehabilitation professional, or support group.

• Plan and enjoy new experiences and don't look back. Avoid comparing life as it is now with how it was before the stroke.

Follow-up appointments

After a stroke survivor returns to the community, regular follow-up appointments are usually scheduled with the doctor and sometimes with rehabilitation professionals.

The purpose of follow-up is to check on the stroke survivor's medical condition and ability to use the skills learned in rehabilitation. It also is important to check on how well the stroke survivor and family are adjusting. The stroke survivor and caregiver can be prepared for these visits with a list of questions or concerns.

Information about stroke

A good place to start is with the books and pamphlets available from national organizations that provide information on this subject. Many of their materials are available free of charge.

Look into local stroke clubs or other support groups. These are groups where stroke survivors and family members can share their experiences, help each other solve problems, and expand their social lives.

Home health services are available from the Visiting Nurses Association, public health departments, hospital home care departments, and private home health agencies.

Services may include nursing care, rehabilitation therapies, personal care (for example, help with bathing or dressing), respite care (staying with the stroke survivor so that the caregiver can take a vacation or short break), homemaker services, and other kinds of help.

Other sources of help

• Meals on Wheels delivers hot meals to the homes of people who cannot easily shop and cook.

• Adult day care is available for people who cannot be completely independent. There they get meals, participate in social activities, and may also get some health care and rehabilitation services.

• Friendly Visitor (or other companion services) offers a paid or volunteer companion to make regular visits or phone calls to a person with disabilities.

• Transportation services: Most public transportation systems have buses that a person in a wheelchair can board. Some organizations and communities provide vans to take wheelchair users and others on errands such as shopping or doctor's visits.

Many communities have service organizations that can help. Some free services may be available or fees may be on a "sliding scale" based on income.

It takes some work to find out what services and payment arrangements are available. A good way to start is to ask the social workers in the hospital or rehabilitation program where the stroke survivor was treated.

Also, talk to the local United Way or places of worship. Another good place to look is the Yellow Pages of the telephone book, under "Health Services," "Home Health Care," "Senior Citizen Services," or "Social Service Organizations." Just asking friends and neighbors may turn up useful information. The more you ask, the more you will learn.

Source: Agency for Healthcare Research and Quality, Rockville, MD.

Llegar a casa: Ajustarse al cambio

Regresar a su hogar, o al nuevo lugar donde vivirá, es un gran cambio para la persona. Así es que usar las capacidades que aprendió durante la rehabilitación puede serle difícil en un ambiente nuevo. Mientras que la persona trata de realizar actividades que hacía en el pasado, pueden surgir nuevos problemas relacionados con el ataque cerebral; así es que durante este período, el paciente y su familia tienen que adaptarse a las nuevas necesidades.

Los ajustes son una carga emocional y física tanto para la persona que proporciona el cuidado como para el paciente. Las nuevas responsabilidades para la persona a cargo del cuidado diario pueden impedirle realizar sus propias actividades favoritas; así es que es importante apoyar, entender y tratar de darle tiempo para que descanse. Cuando la responsabilidad de cuidado sólo cae en un individuo, puede causar mucha tensión. Incluso cuando otros familiares están disponibles para ayudar, los conflictos que surgen en cuanto al cuidado, resultan en tensiones.

El ataque cerebral siempre causa tensión, pero ésta es especialmente alta si sólo un miembro queda a cargo del cuidado, ya que el paciente necesita mucho tiempo y atención. Así es que el resto de la familia tiene que hacer un esfuerzo para apoyar a la persona a cargo del cuidado y tratar de cooperar para aliviar la tensión para todos los participantes.

Recomendaciones para reducir la tensión

• Las siguientes son recomendaciones para reducir la tensión para la persona que sufrió el ataque y los encargados de su cuidado.

• Mantenga la esperanza, y tome la recuperación de un ataque cerebral día con día.

• Recuerde que adaptarse a las consecuencias de un ataque lleva tiempo. Alégrese por cada pequeño logro, conforme descubre nuevas formas de hacer las cosas.

• Cuidar a un enfermo es algo que se aprende. Con la experiencia, su conocimiento y capacidades irán mejorando.

• Experimente. Hasta que hayan encontrado lo adecuado para ustedes, intente hacer las cosas de la vida diaria de diferentes maneras. Por ejemplo, las maneras en que se comunican, el horario del día, y las actividades de la vida social.

• Haga planes para tener "descansos" de tal manera que no tengan que estar juntos todo tiempo. Esta es una buena oportunidad para que le ayuden familiares y amigos. También pueden buscar actividades para ambos fuera de la casa.

• Pida a familiares y amigos que le ayuden en formas y tareas específicas y pídales que se comprometan a hacerlo. Esto les da la oportunidad de ayudar de maneras significativas.

• Lea sobre personas que han pasado por experiencias similares. Su biblioteca pública tiene libros sobre historias reales de personas que han tenido ataques cerebrales y libros sobre personas que cuidan enfermos.

• Tome parte o integre un grupo de apoyo para supervivientes y quienes les cuidan. Entre los miembros del grupo, pueden encontrar soluciones a problemas comunes y desarrollar amistades.

• Sean bondadosos uno con el otro. Sentirse irritado y frustrado de vez en cuando es natural, pero no alivie estos sentimientos tratando "mal" a la otra persona. Frecuentemente, le ayudará hablar sobre estos sentimientos con un amigo, un profesional de rehabilitación, o los miembros del grupo de apoyo.

• Haga planes para disfrutar nuevas experiencias y no mire atrás. Evite comparar su vida ahora a la que tenía antes del ataque.

Citas de seguimiento médico

Después que se ha dado de alta al paciente, tendrá citas de seguimiento con un médico o con los profesionales de rehabilitación. El propósito de estas citas es revisar la condición médica de la persona, las capacidades que aprendió durante el proceso de rehabilitación, y la manera en la que la persona y su familia se están adaptando a las nuevas condiciones. El paciente y la persona a cargo de su cuidado deben estar preparados para estas citas con una lista de sus preocupaciones y preguntas.

Dónde obtener asistencia

• Existen muchas fuentes y recursos de asistencia. Algunos de éstos son: Información sobre ataques cerebrales.

Un buen lugar para iniciar su búsqueda son los libros y folletos disponibles a través de organizaciones nacionales que cuentan con información sobre este tema. Muchos de los materiales son gratuitos.

• Grupos de apoyo o clubs para pacientes de ataques cerebrales.

En estos grupos, las personas que han sufrido

un ataque y sus familias pueden compartir sus experiencias, ayudarse a resolver problemas y ampliar su vida social.

• Servicios de la salud en el hogar.

Disponibles a través de la "Visiting Nurses Associations (VNA)", los departamentos de salud locales, departamentos de cuidado en el hogar de hospitales, y agencias privadas.

Pueden incluir cuidado de enfermería, terapias de rehabilitación, cuidado personal (por ejemplo, para bañarse y vestirse), cuidado de alivio al cuidador (alguien se queda con el paciente, mientras que la persona que normalmente le cuida toma un descanso), labores del hogar, y otros tipos de ayuda.

• Comidas ambulantes "Meals on Wheels."

Se distribuyen comidas calientes a los hogares de las personas que no pueden salir de compras o cocinar.

• Cuidado diurno de adultos.

Las personas que no pueden ser totalmente independientes a veces pasan el día en un centro de cuidado diurno. Ahí comen, participan en actividades sociales y pueden recibir ciertos servicios de cuidado médico y de rehabilitación.

• Un compañero visitante.

Un compañero pagado o voluntario que hace visitas regulares y llama por teléfono a las personas incapacitadas.

• Servicios de transportación.

La mayoría de los autobuses públicos cuentan con una rampa para subir una silla de ruedas. Algunas organizaciones y comunidades cuentan con vehículos especiales que permiten transportar a personas en sillas de ruedas a sus mandados tales como ir de compras o visitar al médico.

Muchas comunidades cuentan con organizaciones de servicio que pueden ayudar y proveen servicios con costos apropiados al ingreso y recursos del individuo, o son gratuitos. Encontrar estos servicios lleva esfuerzo, así es que puede pedir asistencia de los trabajadores sociales que estuvieron a cargo del paciente durante el proceso de rehabilitación.

También consulte con el "United Way" y su iglesia, o las páginas amarillas bajo las palabras "Health Services" (servicios de salud), "Home Health Care" (cuidado en casa), "Senior Citizen Services" (servicios para ancianos), o "Social Service Organizations" (organizaciones de servicio social). Simplemente hablar con sus amigos podría proporcionarle información útil, mientras más pregunte, más lejos llegará.

Otros recursos

Para aprender más sobre la rehabilitación de los ataques cerebrales, y cómo tolerar los efectos de éstos, puede solicitar ayuda de (pregunte si cuentan con asistencia y publicaciones en español).

Source: Agency for Healthcare Research and Quality, Rockville, MD.

Senate votes against 15% cut

Early last month, the Senate voted 99-1 to cancel the 15% cut in Medicare home health rates that is scheduled to take effect Oct. 1, 2002.

This is the second time the cut has been postponed since the decision to implement it was first made. But cancellation of the 15% cut is far from a sure bet. The House of Representatives passed its budget resolution in March without the inclusion of any provisions geared toward eliminating or postponing the cut. As such, the final budget resolution will have to be hammered out by a House and Senate committee.

The Senate will face stiff opposition from the House, where there is a strong desire by House Democrats to fund a Medicare prescription drug benefit. ▼

COMING IN FUTURE MONTHS

- Coping with verbal abuse
- Adult day care
- Electronic records: Should you keep them?
- Changes in workers' comp
- Case management: and case loads

Summit scheduled for pain management

The Joint Commission Resources of the Joint Commission on Accreditation of Healthcare Organizations will present two seminars in 2001 as part of its Second Annual Joint Commission Leadership Summit on Pain Management.

The Summit, which is supported in part by an unrestricted educational grant provided by Purdue Pharma L.P. and Triad Technologies Inc., will be held June 25-26 in Phoenix and Sept. 20-21 in Atlanta.

It has been expanded this year to 1½ days of educational events to allow additional time for more in-depth coverage of the issues.

Among the subjects that will be covered are:

- proven strategies for building institutional commitment to pain management;
- precise examples of implementation of the standards as they relate to special populations and issues;
- validated methods for measuring, monitoring, and tracking outcomes to gauge effectiveness of programs;
- powerful techniques for educating patients to assist in managing their pain;
- efficient and effective ways to define and assess the competency of clinicians involved in a multidisciplinary approach;
- insightful poster presentations of good practices from practicing clinicians.

To learn more or to register for either conference, send an e-mail to: marktingcs@jclserv.jcaho.org. Be sure to include your e-mail address, name, title, organization, address, and phone number. Or call (630) 792-5800. ▼

Hospital Home Health® (ISSN# 0884-8521) is published monthly by American Health Consultants®, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Home Health**®, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: customerservice@ahcpub.com. World Wide Web: http://www.ahcpub.com. Hours: 8:30-6:00 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $319 per year; 10 to 20 copies, $239 per year. For more than 20 copies, call customer service for special arrangements. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

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

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

Editor: **Kristina Rundquist**, (703) 836-2266.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Senior Production Editor: **Ann Duncan**.

Editorial Questions

For questions or comments, call **Lee Landenberger** at (404) 262-5483.

AMERICAN HEALTH CONSULTANTS
THOMSON HEALTHCARE

Leadership conference addresses big picture

The American Association for Homecare holds its AAHomecare Leadership Conference on May 30 to June 1. The conference, which includes an annual membership meeting, is slated to examine such issues as the changing health care continuum and benchmarking breakouts featuring industry practitioners. All sessions will consider the issues, challenges, and opportunities associated with new technologies used to treat and manage patient care at home.

The Leadership Conference will be held at the Grove Park Inn in Asheville, NC. To make reservations, call (800) 438-0050. For member updates, visit AAHomecare's web site at www.aahomecare.org. ▼

MedPAC boosts rural health care

The Medicare Payment Advisory Commission (MedPAC) has agreed to recommend increasing payments to low-volume hospitals, as well as the caps on Medicare Disproportionate Share Hospital funding from 5.25%, as stipulated under the Medicare, Medicaid, State Children's Health Improvement Program Benefits Improvement and Protection Act of 2000, to 10%. The one-year increase would provide low-volume hospitals with an additional $22 million. Moreover, MedPAC requested that a study be conducted on making wage-index adjustments to increase payment parity between urban and rural facilities. ▼

Flying, defibrillators make an aerial duo

As of April 12, all airplanes must be equipped with automated external defibrillators (AED), and airline personnel must be trained in their use, according to a final rule handed down by the Federal Aviation Administration. AEDs automatically determine whether the patient should get the electrical shock.

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. Cite practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

Ventricular fibrillation, according to the report, is the most common form of treatable cardiac arrest, and survival rates can be as high as 90% if defibrillation is provided during the fist minutes following collapse. The final rule also mandates that airlines update their emergency medical kits within three years. The Aviation Medical Assistance Act of 1998 required the rule. Nine airlines now carry AEDs or have committed to do so. Airline emergency medical kits must now include, among other things, aspirin, CPR masks, oral antihistamine, atropine, and a bronchodilator inhaler. ■

Hospital Home Health®
the monthly update for executives and health care professionals

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this salary survey and the overall state of employment in your field.

Instructions: Circle the appropriate answer directly on this form. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be held strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?
   A. VP/executive
   B. clinical nurse supervisor
   C. director of QM
   D. quality manager/PI coordinator
   E. staff assistant
   F. other _____

2. Please indicate your highest degree.
   A. diploma (2 yr) C. BSN E. MSN G. MS I. MBA K. other _____
   B. BA D. RN F. MA H. MPH J. PhD

3. Please indicate which of you certifications best represents your current position. (Choose only one.)
   A. CNOR C. CPHQ E. ONC G. CIC I. other _____
   B. FAAN D. CHE F. RN-C H. CRRN

4 Including your past and present employers, how long have you worked in positions with the same or similar responsibilities as your current position(s)?
   A. less than 1 year C. 4 to 6 years E. 10 to 12 years G. 16 to 18 years I. 22 to 24 years
   B. 1 to 3 years D. 7 to 9 years F. 13 to 15 years H. 19 to 21 years J. 25 or more years

5. Including your present and past employers, how long have you worked in the health care field?
   A. less than 1 year C. 4 to 6 years E. 10 to 12 years G. 16 to 18 years I. 22 to 24 years
   B. 1 to 3 years D. 7 to 9 years F. 13 to 15 years H. 19 to 21 years J. 25 or more years

6. What is your age?
   A. 20 to 25 C. 31 to 35 E. 41 to 45 G. 51 to 55 I. 61 to 65
   B. 26 to 30 D. 36 to 40 F. 46 to 50 H. 56 to 60 J. 66 or older

7. What is your sex? A. male B. female

8. What is your annual gross income from your primary health care position. Please exclude additional income from teaching, consulting, bonuses, etc. To answer this question, circle the correct salary.

A. less than $20,000	H. $50,000 to $54,999	O. $85,000 to $89,999	V. $120,000 to $124,999
B. $20,000 to $24,999	I. $55,000 to $59,999	P. $90,000 to $94,999	W. $125,000 to $129,999
C. $25,000 to $29,999	J. $60,000 to $64,999	Q. $95,000 to $99,999	X. $130,000 or more
D. $30,000 to $34,999	K. $65,000 to $69,999	R. $100,000 to $104,999	
E. $35,000 to $39,999	L. $70,000 to $74,999	S. $105,000 to $109,999	
F. $40,000 to $44,999	M. $75,000 to $79,999	T. $110,000 to $114,999	
G. $45,000 to $49,999	N. $80,000 to $84,999	U. $115,000 to $119,999	

9. If you or your company charges clients by the hour, please indicate the hourly amount. If you do not charge by the hour, please mark answer I.
   A. less than $30 C. $51 to $70 E. $91 to $110 G. $131 to $150 I. do not charge by the hour
   B. $31 to $50 D. $71 to $90 F. $111 to $130 H. $151 or more

10. On average, how many hours a week do you actually work? (Regular hours plus overtime, regardless of whether you're paid extra.)
   A. less than 20 hrs/week C. 31 to 40 E. 46 to 50 G. 56 to 60 I. more than 65 hrs/week
   B. 20 to 30 D. 41 to 45 F. 51 to 55 H. 61 to 65

11. In the past 12 months, how has your salary or income increased or decreased?
    A. salary decreased C. 1% to 3% increase E. 7% to 10% increase G. 16% to 20% increase
    B. no change D. 4% to 6% increase F. 11% to 15% increase H. 21% or more increase

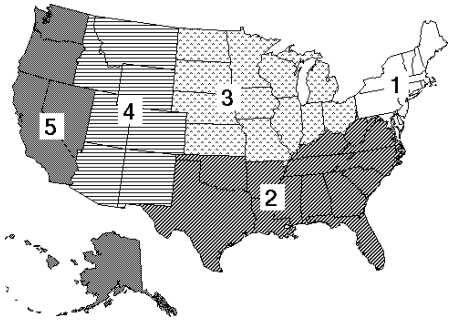
12. In the past 12 months, how has the number of employees in your company or department changed?
    A. increased B. decreased C. no change

Please rate the following benefits according to how important they are in determining your job satisfaction. Use the following scale, and be sure to mark the benefit's importance only if your employer currently provides that benefit to you. If your employer does not currently provide that benefit, or if your company has no benefits, mark 5.

	Extremely important		Somewhat important		Benefit not provided		Extremely important		Somewhat important		Benefit not provided
13. medical coverage	1	2	3	4	5	20. pension plan	1	2	3	4	5
14. dental coverage	1	2	3	4	5	21. profit-sharing plan	1	2	3	4	5
15. eyecare coverage	1	2	3	4	5	22. annual or semi-annual bonus	1	2	3	4	5
16. life insurance	1	2	3	4	5	23. elder care	1	2	3	4	5
17. 401k or other plan	1	2	3	4	5	24. maternal/paternal leave	1	2	3	4	5
18. child care	1	2	3	4	5	25. some freedom to choose work schedule	1	2	3	4	5
19. tuition reimbursement (including CE credits)	1	2	3	4	5	26. exercise facilities or health club membership	1	2	3	4	5

27. Over the last 12 months, has your contribution to the cost of your medical benefits increased, decreased, or stayed the same? (Don't include deductibles or copayments. If you don't contribute to your medical plan or don't receive medical benefits through your job, please mark either D. or E.)
    A. increased C. no change E. I don't contribute to my plan
    B. decreased D. I don't receive medical benefits

28. Using the map provided here, please indicate where your employer is located.
    A. region 1 C. region 3 E. region 5 G. other _____
    B. region 2 D. region 4 F. Canada



29. Which of the following best describes the location of your work?
    A. urban (within a large city) C. medium-sized community
    B. suburban (in a community within a metropolitan area dominated by large city) D. rural

30. Which best describes the ownership or control of your employer?
    A. college or university D. nonprofit (church-operated, volunteer, etc.)
    B. federal government (VA, military, and federal agencies) E. for profit (individual, private practice, or corporation, etc.)
    C. state, county, or city government

31. Which of the following best categorizes the work environment of your employer? Choose only one answer.
    A. academic C. city or county health department E. college health service G. hospital
    B. agency D. clinic F. consulting H. private practice

32. If you work in a hospital, what is its size? (If you don't work in a hospital, please mark J.)
    A. < 100 beds D. 301 to 400 beds G. 601 to 800 beds J. I don't work in a hospital
    B. 101 to 200 beds E. 401 to 500 beds H. 801 to 1,000 beds
    C. 201 to 300 beds F. 501 to 600 beds I. > 1,000 beds

Deadline for responses: July 15, 2001

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, American Health Consultants, P.O. Box 740058, Atlanta, GA 30374.