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Hospital Home Health®

the monthly update for executives and health care professionals

IN THIS ISSUE

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The modem light is on: Do you know where your employees are?

Home health is not immune to the Internet challenge

It's common knowledge that use of the Internet has experienced inordinate growth over the past several years, not just in the home but in the workplace as well. And with more people working — and working longer hours — it's not surprising to find that the lines between our personal and professional lives sometimes become a bit blurred. Who hasn't received or made a personal call from the office? With the Internet, the same can be said for the occasional personal e-mail.

Now with HIPAA (Health Insurance Portability and Accountability Act) rules, health care agency workers must be especially careful with Internet usage because of the risk of having a patient's confidential records intercepted. But are they treating the Internet carefully?

A 1999 survey by Forrester Research in Cambridge, MA, found that 17% of all holiday shopping was done from the office. Meanwhile, A BizRate.com Flash survey conducted in 2000 found that 70% of respondents shopped on-line while at work. (Mondays and Tuesdays, for some reason, were the peak shopping days.) Apparently, shopping on-line isn't the only pastime to cast its allure over the American public. A recent survey by SurfControl, a California-based provider of Internet filtering technology and products, found that 52% of survey respondents openly admitted to using the Internet for personal reasons while at work — 20% of this traffic was attributed to football-related Web sites.

Further, a second SurfControl survey found that 30% to 40% of worker productivity was lost due to personal use of the Internet, and nearly 75% of those employees with Internet access noted that their personal use slows the company network down.

Now that you know this, where do you stand with your company's Internet usage? Do all employees have access? Should they? And if so, should you monitor their usage?

Greg Solecki, vice president of Henry Ford Home Health in Detroit, explains that his home care agency has taken an as-needed approach to Internet access.

"We have limited access to the Internet [relative] to job responsibilities. Some people, because of their jobs, need to get on the Web and find

information for us," he explains. "Not everyone needs access. Some people might say that's not a fair approach and that everyone should have it. Our philosophy is, if your job requires gathering information, you'll have access, but if you don't need it in any job-related capacity, why give it?"

Solecki says that limiting employees' Internet access is "not a matter of distrust, but an economic one. We don't want it from both a cost and productivity perspective. We also don't want employees tying up our networks — that obviously has productivity implications as well as disk space and memory implications. We try to govern fair use of networks. . . . Again, it's company property and should be administered judiciously."

Still, controlling who has access to the Internet doesn't mean you are controlling the time people are spending on it for nonwork-related visits. Doing that means having a policy, and that means sitting down and thinking through what you do and don't want employees doing.

For instance, says Solecki, Henry Ford tries "to take, like with phone calls, a very fair approach to Internet usage. I know people have to make work calls from home sometimes so if they get a personal call at work, I don't get bent out of shape. And that's the approach we take with the Internet. When I will get upset is when productivity suffers because of it."

Clear, concise, and easily accessible

When devising any office policy, there are a few basic ground rules to which it's suggested a manager adhere. Make sure policies are clear, concise, and easily accessible. In other words, everyone knows them, understands them, and knows who to ask if they have questions.

Elizabeth Hogue, a Burtonsville, MD-based attorney, contends that every agency, no matter its size, should have a policy in place regarding Internet and e-mail usage. She agrees with Solecki that "the Internet should not be for personal [use] and because of this, the matters of tying up the network and using business time for personal reasons should be the beginning of every policy. Managers should make this their policy's first tenet."

What's more, keeping personal things personal and work things professional might save a company a lot of legal headaches down the road. "A lot of these jokes circulating on the Internet could be regarded as sexual discrimination, and that will really get an agency in hot water if someone is using material that's sexually explicit or could be determined to be discriminatory in any way," Hogue explains. "Agencies should be very careful to ensure that any policy they draft says you won't circulate material that has any relationship to discrimination based on race, sex, or age."

Hogue suggests that home care agencies look to colleagues for what they might have included in their Internet policies. "In drawing up a policy, there's no point in reinventing the wheel; get ideas from other people. I hope that agencies are working together more than ever these days, and this is a prime example of an instance where they can pool resources and share ideas."

In devising its Internet usage policy, Henry Ford Home Health fell back on something tried and true: its overall corporate policies.

"With the Internet, in many ways as with the intranet, our policies reflect the more salient points of our overall policies," notes Solecki. "We have organizational policies that govern confidentiality, security, legal rights, fair use of networks, and personnel protection from things such as abuse and sexual harassment so when developing our Net policy, we just borrow the pertinent points from existing policies."

Lest an employee be found abusing the system, Solecki says it would be dealt with as all other problems are. "If an employee was using it inappropriately, whether to harass someone or for personal gain or to download inappropriate information, we would take it up with human resources — that the employee was wasting time on the job, holding back productivity."

Hogue says that much of the problem surrounding Internet use — and e-mail usage, especially — stems from how people view the technology. "I see the main problem as being that for some reason people forget when they're using e-mail how very public it really is. If anything, the recent Microsoft trial reminded us of that. Bill Gates' own e-mails got him into trouble. They were deleted but still retrievable," she points out. "People treat it like verbal communication, but it's not. There's a permanent record, and this should be reflected in any policy that is written.

"People just are not thinking carefully about how to appropriately use e-mail," she continues. In Hogue's opinion, it's not out of the question to imagine a "situation where people have been e-mailing back and forth about an adverse relationship with a patient, and the e-mail not be protected by state law. The e-mails could be completely

discoverable, and all of that material would then be available to a patient's attorney who wanted it."

For this reason, she says, "a home care agency's policy should also include a requirement that people not share confidential patient information over e-mail, especially if there's been a problem with care that resulted in an accident report. The mere fact that an agency has a policy will help them in the case of a lawsuit because it shows that the agency made reasonable efforts to prevent violations of policy."

To really add teeth to the policy, she cautions that it must mention that employees who violate it will be subject to disciplinary actions in accordance with the agency's progressive disciplinary program.

Fortunately, Henry Ford Home Health hasn't experienced a case of abuse yet, Solecki says, perhaps because employees are aware that they might be monitored.

"We've long had an electronic medical record system," he explains. "Staff who are able to access the network and to get into clinical applications know that that access is recorded, and even if they go into a restricted file with permission, it will be recorded who is accessing what files. . . . We can find out who's been anywhere. They are aware of it from a business perspective, so that does make people a little more cautious.

"We tell our employees: 'Don't think your electronic correspondence will never be monitored.' Fair, I understand, has a broad definition, but we know what we know and . . . most people know what is and isn't fair, and I think our staff understand that."

Companies' Internet usage policies can be as varied as the types of Web sites currently found on the Internet, but all share at least one thing in common: their need to protect the company from liability. In doing so, Internet usage policies fall into three broad groups, explains **Jim Masur**, chair of the labor and employment practices group at Locke Reynolds, an Indianapolis-based law firm.

As Masur points out, an agency's primary concern, especially in the age of HIPAA, is "to preclude dissemination of the employer's proprietary information. You don't want patients' health records being freely bandied about on the Internet, and as a result, employers need to propound a policy that says as much to its employees, as well as informs them that there are disciplinary consequences for failing to adhere to the policy."

A second concern, according to Masur, is one involving libel and defamation. "The last thing an agency wants is to have an employee go off on a half-cocked Dennis Miller-like rant against General Motors, the new World Order, or whatever it might be that's annoying the employee." Masur's advice is that agencies incorporate into their Internet usage policies sections that preclude this kind of behavior. Masur says having a clause that addresses these types of situations will help an employer if "an employee goes off on his or her own and does these kinds of things."

Prevent X-rated downloading

Lastly, but certainly not least in importance, are matters relating to internal communications, such as downloading pornography and distributing it to co-workers. "This could subject an employer to liability for sex harassment," notes Masur, "so in that context, you want to make sure policies prohibit that activity and that disciplinary actions follow for those who engage in it. As part and parcel, many employers are adopting Internet and e-mail access policies because federal statutes include language that talks about intercepting such communications.

"In order to make sure policies on those three areas are followed, employers need to monitor voice mail and e-mail and similar kinds of communications. To do so, it's important to create at the outset of the employment relationship an impression with employees that there is no reasonable expectation of privacy around Internet use or phone," Masur continues.

A 1999 survey by the American Management Association found that 27% of employers surveyed both store and review their employees' e-mail messages. The previous year, only 20.2% reported monitoring employee e-mails. Interestingly, while the number of employers who monitored their employees grew over that year, the number who reported this information to their

Correction

The January 2001 *Hospital Home Health*'s *Home Health Business Quarterly* listed incorrect third-quarter financial results for New York Health Care in Brooklyn, NY. The company reported net income for the quarter of $67,800 or 2 cents per diluted share, more than double the $27,500 or 1 cent per share for the same period in 1999. ■

employees dropped by 8.3%. Masur says that's the wrong approach.

"You want them to be thinking 'any time we dial up, this call may be monitored.' . . . It's important that employers tell employees in a written policy that all electronic communications are the property of the employer and should not be considered private even with passwords . . . — and that the employer reserves the right to monitor all those communications — so that the employee doesn't have any expectation of privacy. Many, many employers are going the additional step of having employees acknowledge receipt of that kind of policy by signing a disclaimer or waiver to make it of record that the employees know they shouldn't consider those communications private."

Henry Ford for all its success hasn't been without its troubles, however. As Solecki explains, years ago the agency gave long-distance calling cards to its field staff. "When we looked at the detailed itemizations, we found that people were making a significant number of calls after hours. In some cases, they were even calling foreign countries and talking for significant periods of time. It was a real eye-opener. It was a real learning experience for us, and after that, we imposed some restrictions on all our long-distance credit card usage.

"Because we have hundreds of field staff, reviewing monthly detailed itemization records was difficult, so we built in some restraints and began to examine calls over 20 minutes, calls after a certain time at night, and those kind of things. Most patient interactions won't take 20 minutes, so if someone is over the 20-minute limit discussion or outside any of the parameters, then we'll talk to you. We communicated fair parameters and communicated them to staff and the same approach can be taken from [the] Internet perspective. If someone is downloading information at inappropriate times or for odd lengths of time and at some odd sites, you might want to talk to them."

The bottom line, he says, is that "you are using corporate instruments, and the fact you're able to engage in personal correspondence is a perk and something that one should be grateful for — not take advantage of."

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LegalEase

Understanding Laws, Rules, Regulations

New rules on culturally appropriate services

Easing the burden of compliance

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

The regulatory requirements of the Balanced Budget Act of 1997 (BBA) and other initiatives of the Health Care Financing Administration (HCFA) placed a huge burden of compliance on Medicare-certified home health agencies.

Accordingly, many agency managers have expended enormous resources in order to achieve compliance with an abundance of new requirements.

Now comes one more set of requirements from the U.S. Department of Health and Human Services (HHS), Office of Minority Health — yet another wrinkle in the form of 14 final regulations regarding "culturally and linguistically appropriate standards" for health care organizations. (According to the final regulations, health care organizations include all public or private institutions involved in any aspect of delivering health care services, meaning home health agencies must comply.)

As of now, these standards are considered merely recommendations, intended to assure patients of "effective, understandable, and respectful care . . . provided in a manner compatible with their cultural health beliefs and practices and preferred language," explains HHS. The standards largely mirror the 14 draft standards that HHS proposed a year ago for public comment.

Agency managers may be tempted to view this newest set of regulations as yet another burdensome requirement that must be met. But upon review of the final regulations, it appears that compliance may not be as difficult as some managers may fear.

First, it is important to acknowledge that the concept of culturally and linguistically appropriate services is consistent with good risk management. That is, providers will undoubtedly have difficulty rendering care consistent with applicable standards of care if they cannot communicate appropriately, both culturally and linguistically, with their patients.

Vital information may be omitted in encounters with patients. Lack of understanding may also result in misdiagnoses, inappropriate treatment, and lack of compliance. From the point of view of good risk management, it has also been clear to many providers that reliance on family members to translate in health care settings is a potentially risky proposition.

It is also important to note that mandatory requirements regarding the use of translators do not necessarily impose additional requirements on home health agencies. Title VI of the Civil Rights Act of 1964 has been the basis for longstanding requirements that providers must use translators to communicate with patients of limited English proficiency (LEP). (According to HHS, under Title VI, a LEP is someone who "cannot speak, read, or understand the English language at a level that permits him or her to interact effectively with clinical or nonclinical staff.")

What does this mean for you?

Finally, agency managers also should recognize that few of the standards included in the final regulations are mandatory for home health agencies. Of the 14 standards, Standards 4, 5, 6, and 7 require compliance by all providers who receive federal funds. Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13 are activities recommended for adoption by federal, state, and national accrediting agencies. Compliance with Standard 14 is voluntary for all health care providers. This means that agencies should focus attention on:

- **Standard 4.** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with LEP at all points of contact, in a timely manner during all hours of operation. **(For a list of on-line resources for language assistance, see story, p. 33.)**
- **Standard 5.** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- **Standard 6.** Health care organizations must assure the competence of language assistance provided to LEP patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- **Standard 7.** Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Steps to follow

Providers may readily observe that these mandatory requirements are not significantly different from those to which they must already comply under Title VI. In light of this, what exactly should agency managers do? First, managers should give a close review of measures already in effect as a result of Title VI. Second, managers should consider "beefing up" current efforts in any ways that may be appropriate; and lastly, conclude that they have crossed another regulatory hurdle.

In doing so, these practical suggestions should be emphasized:

- Staff should routinely ask patients about their preferred language and record patients' responses in their charts.
- When patients want to use family members or friends to interpret for them, as opposed to other interpreters supplied by agencies, staff should document these requests in patients' charts.

The regulatory burden for agencies has been significant and has taxed the resources of many managers. But compliance with mandatory regulations governing culturally and linguistically appropriate communications with patients does not appear to be nearly as taxing as the obstacles providers have already successfully negotiated.

[To obtain a complete list of publications available from the offices of Elizabeth E. Hogue, Esq., call (301) 421-0143, or send a fax request to (301) 421-1699.] ■

Neurology group offers concussion indicators

Here are some signs to look for

When it comes to concussions, proper diagnosis can make the difference between a full recovery and permanent disability, and in some instances, even death. Just as dangerous is "second impact syndrome" where a second brain injury that occurs while a patient is recovering from the first can prove fatal.

To help you determine whether it's likely a patient has suffered a concussion, the American Academy of Neurology Education & Research Foundation in St. Paul, MN, has come up with an easy reference guide.

Immediate signs of concussion (seen within seconds or minutes)

- Any loss of consciousness
- Impaired attention: vacant stare, delayed responses, inability to focus
- Slurred or incoherent speech
- Lack of coordination
- Disorientation
- Emotional reactions out of proportion
- Memory problems

Later signs of concussion (If the following symptoms appear hours, days, or even weeks later, consult a neurologist)

- Persistent headache
- Dizziness / vertigo
- Poor attention or concentration
- Memory problems
- Nausea or vomiting
- Fatigue
- Irritability
- Intolerant of bright lights and or / loud noises
- Anxiety and / or depression
- Disturbed sleep ■

Neuro disorder Web pages that are worth a visit

If you're interested in learning more about a particular neurological disorder or simply looking for resources for a patient's family, consider checking out the following Web sites:

- ✔ ALS Association: www.alsa.org
- ✔ Alzheimer's Association: www.alz.org
- ✔ American Council for Headache Education: www.achenet.org
- ✔ American Epilepsy Society: www.aesnet.org
- ✔ American Headache Society: www.ahsnet.org
- ✔ American Neurological Association: www.aneuroa.org
- ✔ American Parkinson Disease Association: www.apdaparkinson.com
- ✔ American Stroke Association, A Division of the American Heart Association: www.Stroke Association.org
- ✔ Brain Injury Association: www.biausa.org
- ✔ Child Neurology Society: www.childneurology society.org
- ✔ Epilepsy Foundation: www.Epilepsy Foundation.org
- ✔ Michael J. Fox Foundation for Parkinson's Research: www.MichaelJFox.org
- ✔ Movement Disorder Society: www.movement disorders.org
- ✔ Multiple Sclerosis Association of America: www.msaa.com
- ✔ Muscular Dystrophy Association: www.mdausa.org
- ✔ National Brain Tumor Foundation: www.braintumor.org
- ✔ National Chronic Care Consortium: www.nccconline.org
- ✔ National Family Caregivers Association: www.nfcacares.org
- ✔ National Headache Foundation: www.headaches.org
- ✔ National Institute of Neurological Disorders and Stroke: www.ninds.nih.gov
- ✔ National Multiple Sclerosis Society: www.nmss.org
- ✔ National Organization for Rare Disorders: www.rarediseases.org
- ✔ National Parkinson Foundation, Inc.: www.Parkinson.org
- ✔ National Stroke Association: www.stroke.org
- ✔ Parkinson's Disease Foundation: www.pdf.org
- ✔ Society for Neuroscience: www.sfn.org
- ✔ Worldwide Education and Awareness for Movement Disorders: www.wemove.org ■

HCIA-Sachs names 2000 cream of the hospital crop

100 hospitals honored as national benchmarks

The results of the eighth annual 100 Top Hospitals National Benchmarks for Success study are out. The study conducted by the HCIA-Sachs Institute in Evanston, IL, examined hospitals around the country on the basis of their performance in the areas of quality of care, efficiency of operations, and sustainability of overall performance.

While a great honor for the hospitals that are awarded this designation, what exactly does this annual survey mean for health care professionals and consumers? "For consumers this means that there are hospitals scattered all over the country that are performing at a sustainably high rate that assure high quality care at lower costs," explains **Jean Chenoweth**, executive director of the HCIA-Sachs Institute. "These are institutions that haven't traded quality as they have found ways to reduce costs and make patients get well quicker."

The 2000 study was applied to five classes of hospitals: major teaching, teaching with less than 400 beds, large community with more than 250 beds, medium community with between 100 and 250 beds, and small community with between 25 and 99 beds. **(See list, p. 32.)**

Winners lowered cost, not quality

Empirical data were gathered from the Medicare Provider Analysis and Review (MedPAR) aggregated claims database, and a variety of other publicly available information sources with a specific eye toward risk-adjusted mortality index, risk-adjusted complications index, severity-adjusted average length of stay, expense per adjusted discharge, profitability, proportion of outpatient revenue, and productivity (total asset turnover ratio).

For selecting the hospitals, Chenoweth says, HCIA-Sachs has developed a management scorecard. "Just as in industry, we looked at not only financial results but also at the questions of whether the quality of product deteriorated through failure to update or poor process," she explains.

Such failures would show up in industry as reduced sales, lower productivity, and higher scrap and rework. "In the hospital environment, when the demand of customers is to become more efficient and reduce the rate of rising costs, we were looking for CEOs and their management teams who were able to reduce costs but not at the expense of the product they were delivering. That's what this balanced scorecard delivers to those who are looking for excellence in health care institutions," Chenoweth adds.

Each hospital in the study group was assigned to one of five comparison groups according to its size (number of beds in service) and teaching status. Within the comparison groups, they were ranked on the basis of their performance on each of seven performance measures. Each hospital's performance-measure rankings were then summed to arrive at a total ranking for the hospital.

Industrywide, the study found that hospitals experienced the largest drop in profits during 2000 than in any other year in the study's history, but despite this, the top 100 hospitals were able to maintain significantly higher profits and achieve, overall, better outcomes than their peers.

Among the study highlights are:

• The 100 top benchmark hospitals were found to have fewer complications and inpatient deaths than other hospitals. Quality of care as measured by mortality and complications indices was an average of 14% better at the 100 top benchmark hospitals.

• Despite an increasingly acute patient population, use of more expensive services, and lower Medicare reimbursement rates paid to all hospitals under the Balanced Budget Act, benchmark hospitals exhibited more than three times the profitability of all other hospitals studied.

• The study revealed a regional disparity in performance, most notably in the number of top hospitals in the South (37) vs. the Northeast (15). However, the number of top hospitals in the Northeast increased by the highest percentage of any region, nearly doubling since last year's study. The results show there is variability in the levels of hospital performance caused by competition, managed care, and regulation.

• Benchmark hospitals paid higher wages but employed fewer staff than peer hospitals.

• Benchmark hospitals had a median total profit margin of 8.71% and a median cash flow margin of 16.44%, compared with only 1.88% and 9.69% respectively for peer hospitals. These findings are the weakest since the study was first conducted in 1993.

(Continued on page 33)

100 Top Benchmark Hospitals of 2000

Small Benchmark Hospitals (25-99 Beds)
Thomasville (AL) Infirmary
WellStar Douglas Hospital, Douglasville, GA
St. Mary's Hospital, Cottonwood, ID
Shelby Memorial Hospital, Shelbyville, IL
Memorial Hospital, Manchester, KY
Hubbard Regional Hospital, Webster, MA
United Memorial Health Center, Greenville, MI
Otsego Memorial Hospital, Gaylord, MI
Itasca Medical Center, Grand Rapids, MN
Austin (MN) Medical Center
St. John's Mercy Hospital, Washington, MO
St. Joseph Hospital-West, Lake St. Louis, MO
Titusville Area Hospital, Titusville, PA
Baptist DeKalb Hospital, Smithville, TN
Hendersonville (TN) Medical Center
Valley View Medical Center, Cedar City, UT
Castleview Hospital, Price, UT
Enumclaw (WA) Community Hospital
New London (WI) Family Medical Center
Sauk Prairie Memorial Hospital and Medical Center, Prairie Du Sac, WI

Medium Benchmark Hospitals (100-249 Beds)
Medical Center Enterprise (AL)
Tempe (AZ) St. Luke's Hospital
Paradise Valley Hospital, Phoenix
Brandon (FL) Regional Hospital
Largo (FL) Medical Center
Mease Countryside Hospital, Safety Harbor, FL
Palms West Hospital, Loxahatchee, FL
Fairview Park Hospital, Dublin, GA
Terre Haute (IN) Regional Hospital
Milford-Whitinsville Regional Hospital, Milford, MA
Mercy Hospital Anderson, Cincinnati
St. Joseph Health Center, Warren, OH
Licking Memorial Hospital, Newark, OH
Medical Center of Southeastern Oklahoma, Durant
Cottonwood Hospital Medical Center, Murray, UT
Logan (UT) Regional Hospital
Martha Jefferson Hospital, Charlottesville, VA
St. Francis Hospital, Federal Way, WA
Theda Clark Medical Center, Neenah, WI
Appleton (WI) Medical Center

Large Community Benchmark Hospitals (250+ Beds)
JFK Medical Center, Atlantis, FL
Leesburg (FL) Regional Medical Center
Palms of Pasadena Hospital, St. Petersburg, FL
Aventura Hospital & Medial Center, Aventura, FL
Memorial Hospital Jacksonville (FL)
Community Hospital of New Port Richey (FL)
North Florida Regional Medical Center, Gainesville
Florida Medical Center, Fort Lauderdale
Blake Medical Center, Bradenton, FL
Cape Coral (FL) Hospital
Regional Medical Center-Bayonet Point, Hudson, FL
WellStar Kennestone Hospital, Marietta, GA
Doctors Hospital, Augusta, GA
Washington County Hospital Association, Hagerstown, MD
EMH Regional Medical Center, Elyria, OH
UPMC Passavant, Pittsburgh
Westmoreland Regional Hospital, Greensburg, PA
Baptist Hospital of East Tennessee, Knoxville, TN
Houston Northwest Medical Center
St. Joseph's Hospital, Parkersburg, WV

Teaching Benchmark Hospitals (250+ Beds)
Scripps Mercy Hospital, San Diego
Pomona (CA) Valley Hospital Medical Center
Morton Plant Hospital, Clearwater, FL
Palmetto General Hospital, Hialeah, FL
Ball Memorial Hospital, Muncie, IN
Downtown Worcester Hospital (MA)
Beverly (MA) Hospital
Munson Medical Center, Traverse City, MI
McLaren Regional Medical Center, Flint, MI
Methodist Hospital, St. Louis Park, MN
St. John's Mercy Medical Center, St. Louis
St. Luke's Hospital, Chesterfield, MO
Good Samaritan Hospital, Dayton, OH
Kettering (OH) Medical Center, Kettering
Aultman Hospital, Canton, OH
The Christ Hospital, Cincinnati
Hillcrest Hospital, Mayfield Heights, OH
Providence St. Vincent Medical Center, Portland, OR
Providence Portland Medical Center, Portland, OR
York (PA) Hospital
Hermit Medical Center, Erie, PA
Lancaster (PA) General Hospital
Senator Virginia Beach (VA) General Hospital
Inova Fairfax Hospital, Falls Church, VA
Southwest Washington Medical Center, Vancouver

Major Teaching Benchmark Hospitals (400+ Beds)
St. Francis Hospital and Medical Center, Hartford, CT
Hartford (CT) Hospital
Christiana Care Health Services, Wilmington, DE
Evanston (IL) Northwestern Healthcare
Advocate Christ Hospital and Medical Center, Oak Lawn, IL
Lutheran General Hospital, Park Ridge, IL
Brigham & Women's Hospital, Boston
Spectrum Health Downtown Campus, Grand Rapids, MI
William Beaumont Hospital-Royal Oak (MI)
Kennedy Memorial Hospital, Cherry Hill, NJ
The Ohio State University Hospitals, Columbus, OH
Cleveland Clinic Foundation
Thomas Jefferson University Hospital, Philadelphia
Vanderbilt University Hospital, Nashville, TN
Parkland Health and Hospital Systems, Dallas

Source: www.100TopHospitals.com. *Note:* Order does not reflect performance ranking. Hospitals are ordered by Medicare ID.

• If all U.S. acute hospitals performed at the level of the 100 top benchmark hospitals, health care expenses would decline an estimated $12 billion.

Clinically, these benchmark hospitals also operated under different procedures, notes Chenoweth.

• For angioplasties, the 100 top benchmark hospitals tend statistically to use more stints and more drugs such as Intergalin, and they have lower rates of performing the procedure a second time over a three-year period.

• For Medicare patients with breast cancer, the hospitals do more breast-conserving surgery than do nonaward winners.

"When they do perform total mastectomies," notes Chenoweth, "they combine that procedure with plastic reconstruction thereby avoiding a second hospitalization. Other studies completely separate from ours show that patients' outcomes are better from both a mental and physical standpoint when you combine the two procedures."

• 100 top hospitals are more selective in their use of antibiotics to prevent post-op wound infections, Chenoweth says, noting that while some hospitals may use two or more doses of third- and fourth-generation antibiotics, 100 top hospitals use "single doses of single generation antibiotics thereby not overexposing the patient and reducing sensitivity, and they get the same results."

In summary, says Chenoweth, "These hospitals tend to be doing things differently clinically. We are trying to identify places that are doing things differently and make that information available across the country. They tend to be adopting new techniques more quickly than the rest of the hospital population."

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Be resourceful! Here are tools you can use

There are several new seminars, conferences, books, and Web sites that can benefit your agency and keep you up-to-date on the latest issues and developments in the field. Here is a representative selection:

Education for all

Baxter Healthcare Corp. in Deerfield, IL, is launching three new Internet-based continuing education programs. These on-line home study programs provide nurses with 1.2 contact hours and pharmacists with 1 contact hour of continuing education credit and cover the following areas: Initiation of Parenteral Nutrition in the Adult; Peripheral Parenteral Nutrition and Hydration Therapies in Long-Term Care; and Introduction to Home Parenteral Nutrition. Baxter also offers courses in IV therapy, basic pain management, and preventing medication errors. Baxter's courses are accredited by the American College of Pharmaceutical Education and the American Nurses Credentialing Center. *(For more information, contact Baxter Healthcare Corp. at (847) 948-2000.)*

The Healthcare Financial Management Association (HFMA) has unveiled its Spring 2001 seminar series. The 21-seminar series will focus on such topics as: Supervisory Management for Healthcare Financial Managers; Medicare Reimbursement Strategies for Healthcare Executives; Understanding and Evaluating Managed Care Contracts; Healthcare Compliance Plans; Preparing Financially for HIPAA; and Collections, Billing & Receivables Management. The courses will be offered in Chicago (March 19-22), Boston (March 26-27), Hilton Head, SC (April 2-5) and Las Vegas (May 7-10). *(For more information on course offerings and prices, visit HFMA's Web site at www.hfma.org.)*

Need an interpreter?

In light of the 14 new "culturally and linguistically appropriate standards" for health care providers that was published by the Department of Health and Human Services in the Dec. 22, 2000 *Federal Register*, interpreters are going to be increasingly familiar faces in the home care world. **(See *LegalEase*, p. 28.)** You might want to check out the following Web sites as a starting point for making your facility culturally and linguistically compliant:

• Center for Multicultural and Multilingual Mental Health Services: www.mc-mlmhs.org

• Establishing Interpreter Services in Healthcare Setting: www.diversityresources.com/vinddahc.html

• Directory of Health Care Interpreter Training Programs in the U.S. and Canada: www.ahschc.org/traindir2.htm

• Language Line Services: www.languageline.com/

• Multicultural Best Practices Overview: www.diversityrx.org/best/

Books and manuscripts

• *The Home Care Information Technology Council's Fall 2000 Resource Guide* is now available at no charge from Stony Hill. This guide covers a wealth of information on the prospective payment system (PPS) (1,000 pages in all), including the training manual and the more than 700 pages of the Health Care Financing Administration's PPS resource site. Developed by 20 leading home care software vendors, the guide includes more than 4,500 pages of reference material, Medicare manuals, and instructions for the Outcomes and Assessment Information Set. To obtain a free CD, contact stony hill@prodigy.net.

The Healthcare Intelligence Network has several publications geared to home care and the Internet:

• T*he 2000 Guide to Disease Management on the Internet* provides readers with information about on-line organizations and disease management technologies. Among the features are: state of the art technology developments and what they mean for you; company profiles of organizations already utilizing the Internet for their disease management programs; the future of on-line disease management, and interviews with industry experts. Cost is $99.

• *e-Healthcare: Harness the Power of Internet e-Commerce & e-Care* gives home care professionals practical advice for planning and launching e-services. Covered in the book are topics such as Web services that can build consumer and patient relationships as well as time and money-saving options for home care agencies looking to offer more e-services. Cost is $85.72.

• *e-Health Business Strategies, Second Edition,* is filled with articles on health organizations' Internet strategies, the ways in which health plans are using the Internet to save money and improve patient relationships, and how medical groups are using the Internet to improve relationships with not only their patients but their vendors as well. Cost is $50.

• *e-Healthcare Market Reporter* is a semimonthly, electronic newsletter that delivers news on the emerging trends that are taking place in the medical community with respect to the Internet. Subscribers also are given access to a free, keyword search of the newsletter's archives. Cost is $477 for a year. (Choose between HTML or PDF formats.)

(To order, contact Healthcare Intelligence Network on-line at www.hin.com.) ■

NEWS BRIEFS

What's the latest in acquisitions and closings?

According to *The New York Times*, St. Luke's-Roosevelt Hospital Center in New York City will phase out its "Continuum Home Care Services." The home health agency will transfer its more than 1,200 patients to other area home care agencies over the next six months. The hospital reportedly wants to focus on inpatient and outpatient programs.

CarePoint Health Services Inc., a home medical equipment company, has been purchased by Glendale, CA-based Continental Home Healthcare Ltd., for $2.3 million. According to Continental, it is the largest acquisition the company has made to date.

Minnetonka, MN-based home care company In Home Health Inc., has been bought out by Manor Care of Toledo, OH. The nursing home operator paid $7.9 million for the remaining 39% of the stock the company did not already own.

According to a report in the *Birmingham News*, the Visiting Nurses Association (VNA) in Birmingham, AL, has closed its doors. The VNA began operations in 1938.

The paper reported that the association

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transferred at least 400 patients to other home health agencies.

Geriatrix, a leading senior care management organization, has acquired For Health Inc. of Costa Mesa, CA, in a stock transaction valued at $7.4 million. San Diego-based Geriatrix provides specialized services to more than 10,000 elderly patients in nursing homes and has operations in Oklahoma, Michigan, Southern California, and now in Rhode Island and Arizona. ▼

Cancer patients survive longer with home care

A study in the December *Journal of the American Geriatrics Society* found that elderly cancer patients who received home care from advanced practice nurses lived an average of seven months longer than patients who received standard care.

The four-year study was conducted at the University of Pennsylvania School of Nursing from 1992 to 1996 and followed 375 elderly patients newly discharged from the hospital after cancer surgery. Some patients received standard care while an experimental group received three home visits and five telephone contacts with an advanced practice nurse, who also educated family members about caregiving. Advanced practice nurses are specially trained registered nurses, usually holding master's degrees, who can provide such highly skilled care as medication prescription and physical examinations.

The study focused on elderly patients, who are more likely to experience postoperative complications. This problem is exacerbated by a trend to discharge patients rapidly after surgery. The interventions of the advanced practice nurse served to avert or address complications rapidly. In contrast, some patients in the standard care group died prematurely from surgical complications, such as infections. The authors speculate that survival may also have been enhanced in the experimental group by the psychosocial support that nurses gave patients and families.

The findings were especially significant because the patients in the group who received the special nursing care tended to be in later stages of their cancer than the group that received standard care. The assumption would be that these later stage patients would die sooner, but the reverse happened. ▼

Lawyers threaten suit on childcare for mentally ill

Lawyers representing mentally ill children in Massachusetts say they are prepared to file suit in federal court if the state does not develop programs to remove young mentally ill patients from unnecessary and lengthy hospital stays, said a spokesperson at the Hale and Dorr law firm in Boston. The attorneys said the state is violating federal law by not providing home care to children enrolled in Medicaid, as stipulated by the program.

Despite spending millions of dollars to increase the number of psychiatric, residential beds, less restrictive care was not available for all children in the state. The lawyers are pushing the state to develop comprehensive programs for therapy and

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recreation to allow the children to stay home. In response, the state will meet with lawyers from the Center for Public Representation and the Mental Health Legal Advisors Committee. ▼

Wrong forms lead to slow PPS reviews

According to Palmetto Government Benefits Association, many home health providers aren't submitting the right OASIS (Outcomes and Assessment Information Set) documentation, which is interfering with Regional Home Health Intermediaries' ability to do medical review on prospective payment system (PPS) claims.

Three examples of common documentation problems, according to a Palmetto staff member:

1. Home health agencies (HHAs) are sending patients' discharge OASIS rather than the admission OASIS or the resumption-of-care OASIS, which Palmetto needs to determine the accuracy of the health insurance PPS code used for case-mix adjustment.

2. HHAs aren't submitting documentation to support the OASIS assessment, such as evidence that the patient actually is "bedfast."

3. Some agencies haven't submitted the multiple OASIS forms needed when billing for a significant change in condition.

Palmetto says it became aware of the documentation problems from its recent medical reviews of initial home health PPS claims. ▼

HUD offers $29.3 million to help elderly, disabled

The U.S. Department of Housing and Urban Development (HUD) recently announced the creation of $29.3 million in grants to hire "service coordinators."

The coordinators will help more than 35,000 low-income elderly and physically incapacitated residents in federally supported housing identify and receive health care, meals, and other critical support services they need to remain living independently.

The grants go to the owners of private housing developments in 39 states, Puerto Rico, and the District of Columbia that receive HUD money to house low-income individuals. In turn, the owners / management companies will either hire or enter into a contract for the service coordinators, who have backgrounds in providing social services, especially to the frail elderly and people with disabilities.

For more information, visit HUD's Web site at www.hud.gov. ■

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. ■