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American Health Consultants® is A Medical Economics Company

Collaborate with competitors to recruit home health aides

Alliance boosts local paraprofessional supply

Is the phrase "I can't find enough home health aides!" a familiar refrain in your community? Then consider joining with other providers to create a home health aide recruitment and training program.

A group of home care companies and nonprofit agencies in Madison, WI, has done so and increased the local supply of certified nursing assistants (CNAs), according to those involved.

The YWCA, a Hispanic service organization, and three home health agencies founded the CNA Career Alliance in 1997. The program trains welfare-to-work mothers and other low-skilled, working poor individuals to become CNAs. The Urban League of Greater Madison has since replaced the Hispanic service organization and a fourth home care company has become an Alliance partner.

Demand exceeds supply

The collaboration resulted from brainstorming among home health and community-based organization executives, according to **Rita Giovannoni**, MS, executive director of Independent Living, one of the founding organizations. The greater Madison area unemployment rate has been below 3% since 1988, but many people are marginally employed in low-paying jobs with few or no benefits, she explains. At the same time, the demand for paraprofessional home care workers far exceeds the supply. These factors, combined with Wisconsin's welfare reform initiative, says Giovannoni, lead CNA Career Alliance founders to believe they were on to something.

"We represented the supply and demand sides [of certified nursing assistant care], were established and respected in the community, and knew enough to get program funding,"she says.

Their initiative paid off; today, the CNA Career Alliance receives grant support from the United Way, a City of Madison block grant, and two private foundations, says Giovannoni. It is now seeking long-term funding for other activities such as additional training for program graduates. Home care sponsoring organizations do not fund the

program, but they provide valuable training and hire program graduates.

The program costs about $85,000 annually, including the director and instructor's salaries and student support, explains **Kay McGee**, program director. Start-up expenses, including staff time to develop curriculum, policies, and procedures and applications, were about $50,000, she estimates.

This does not include time spent by executives of affiliated home health and community-based organizations, Giovannoni adds. Career Alliance organizers did not consider funding the program themselves. Like Independent Living, many could not continue their existing recruitment activities and also support the Alliance, she explains.

While acknowledging the unique collaboration among competitors, Giovannoni says, "Ultimately, we all have the same problem of recruiting a good work force, and when the other methods aren't working, [this is] a way to do [it] differently and create a more focused response to this problem. Hopefully, our ship [will] rise collectively."

Problem solving is a key training component

Since its inception last year, 25 people have completed CNA Career Alliance training, out of 34 people accepted in the program, says McGee. Up to seven students enroll in each eight-week session. The program's 200 hours of training cover clinical, workplace, and life skills topics. It also includes a 40-hour practicum in which students accompany CNAs employed by sponsoring home health organizations as they perform their jobs.

In addition to clinical subjects such as infection control, nutrition, bathing, and transferring, students learn equally important lessons about problem solving and conflict resolution — both on the job and in their personal lives, she says.

For example, participants discuss how to deal with the prejudice among the elderly who will largely make up their case loads. Many commonly refer to their African American caregivers as "colored girls," McGee explains.

Students' complicated lives also create various workplace dilemmas, so they discuss responses to punctuality and attendance challenges such as missing the bus, having a sick child, or quarreling most of the night with one's partner.

The Alliance recruits students from the Dane County (Madison, WI) Job Center, Dane County Head Start program, and other community-based organizations. It also advertises in a local minority newspaper and the Urban League of Greater Madison's newsletter.

McGee extensively screens applicants with personal interviews and criminal background and driver's checks. Those accepted must also have high school diplomas or GEDs. These requirements eliminate about 60% of applicants, according to McGee.

Caregiving experience — formal or informal — is also valued. "We will accept people without formal work experience who've cared for someone," says McGee. Applicants also take the CurryScreen Nursing Assistant and Home Health Aide screening test. **(See *Private Duty Homecare*, December 1997, p. 138, and August 1997, p. 90, for more on the CurryScreen.)** Although the screen predicts job performance, attendance, and longevity, McGee does not use it as a program entrance hurdle. "I use it as a test of honesty and integrity [and] as a tool to [see whether they can] follow instructions," she explains.

The average student is a 30-year-old single mother, according to McGee. About 40% of program graduates are African American; 32% are Caucasian, with the remainder mostly Hispanic. Nearly two-thirds are public assistance recipients; the remainder are working poor individuals with no aid.

The Alliance's grant funding pays students a $4 per hour stipend during training. It also covers their $500 tuition and book expense, child care, and transportation needs during the eight-week program. The Alliance also has six cars that graduates may use in their first home health jobs.

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Child care support continues until graduates qualify for state-funded assistance. It costs from $1,000 to $3,000 per trainee, depending on the individual's need, McGee estimates.

Trainees must sign a contract that requires them to reimburse half of their training costs if they stop working within six months after graduating. "I realize you can't collect money from people who don't have it. [I ask for this] for its psychological value as a commitment. I tell the students, 'Stay with me. I know your life is complicated, but it will get better,'" she says.

Sticking with the program is one of the main lessons McGee tries to impart. Difficult life circumstances make it easier for program graduates to bolt rather than resolve conflicts. "[I educate students that] they can stay and work out problems. They have this 'all or nothing' mentality, and if they have one disagreement [with an employer], they say 'I'm outta here!' But I try to tell them, 'This is your career,'" she explains.

While the CNA Career Alliance is successful — it has hired six CNAs that Independent Living would not have located through its normal recruitment efforts — program graduates require special attention and resources, says Giovannoni. Many have ongoing difficulties juggling their personal and work lives that other employees are experienced at handling, such as making it to work even though they missed the bus or their child has a doctor's appointment. Not uncommonly, sometimes program graduates deal with such issues by not showing up for work and not phoning in to report a problem. This requires much intervention from both McGee and the home health providers. "Most employers don't have time for it, but you have to help with skill building and problem solving to make them successful," Giovannoni explains.

To improve the retention and job performance of both CNA Career Alliance graduates and other CNAs, Independent Living recently created two CNA mentor positions, says Giovannoni. The mentors, taken from the ranks of Independent Living's experienced CNAs, help fellow CNAs with day-to-day problem solving. They closely monitor peers with co-visits and phone calls. "It really helps to have someone to talk to and for the organization to take the initiative [to reach out] rather than relying on staff to call in with questions," she says.

Steady work schedules also influence program graduates' longevity, says McGee. Although there is a huge demand for paraprofessional services in home care, providers have difficulty stringing four- and six-hour work assignments together to make a forty hour work week, she explains.

The Independent Living scheduler "works very closely with CNAs to get them at full-time activity. We know we stand a good chance of losing employees if we don't keep them at or near 40 hours," says Giovannoni. The company also keeps benefit funding constant even with flexible hours, and it guarantees hours for certain employees, she adds.

Despite the special challenges of working with graduates, the CNA Career Alliance is a success, say McGee and Giovannoni. The combined concentrated recruitment efforts, home health curricula and practicum, ongoing mentorship, and daily living support appear to bring in people more interested in and committed to home care, they note.

"It really is a good program. It's wonderful; it's giving people a chance," says McGee.

SOURCES

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Expand business with field staff marketing

Subtle sales efforts increase community awareness

Increasing and diversifying revenue in today's challenging operating environment is a real necessity. Owners and managers often go the extra mile to bring in more business, selling the company to hospitals, physicians, and payers, but field staff can play a role too, according to **Mark Deutsch**, vice president at Homecare Resource Center, a management and marketing consulting firm in Mechanicsville, VA.

"Marketing is not just market share; it's also share of customer. [We encourage people] to maximize the services you can get from them," he says.

Field staff, with day-in, day-out patient contact and a highly visible community presence, can be an important link in your overall marketing effort. Harnessing their marketing potential, however, "is a challenge. Sales is seen as dirty, but the best sales people are clinicians. They can build rapport with physicians and families [that others can't]," Deutsch notes.

He advises helping field staff overcome their sales aversion and lead them down the business development path with several simple measures, as follows:

❒ **Communicate with staff.**

"Get staff involved. Communicate [with them] about your services and let them talk about what's happening in the community," Deutsch suggests. Diversified providers may find that field staff lack knowledge about the full range of your company's services. Likewise, "staff may work for other companies, and they can tell you lots [about your competitors] if given the opportunity," he says.

Harness employees' competitive information and increase their understanding of your operations with regular staff meetings, Deutsch suggests. Present information about different company services and ask every staff member to bring up one sales-related idea each meeting.

❒ **Educate staff.**

Clinicians tend to see themselves as healers, not marketers, but "health care is so related to sales," Deutsch notes. "Sales is building relationships, understanding customer needs, and providing products and services that fill that need," he adds.

Field staff obviously have a relationship with clients, and they conduct a clinical assessment at every visit or shift. Identifying other care and service needs is merely another type of assessment, according to Deutsch. "The only hump they have to get over is asking [clients whether they are interested in other services]. They can still generate the lead even if they don't ask [clients] themselves," he notes.

Providers can increase staff awareness with focused sales and marketing training or sales education during general staff meetings.

❒ **Create a sales plan.**

Staff can learn to at least identify, if not ask, clients about additional services. But "often if they identify a need, it either doesn't get back to someone in the office, or it isn't acted upon," says Deutsch. Creating a sales plan with specific targets and accountabilities can help provide a mechanism for staff feedback and a system to build on their efforts.

❒ **Incentivize staff.**

"Incentives are usually very cost-effective [and something that almost all employees respond to]," says Deutsch. Set up a simple incentive program to build on sales training and achieve results, he advises. You might ask field staff to identify one referral source or contact each week, as a minimum, and reward them after they provide two contacts above the minimum.

Even small incentives such as an extra hour of paid time off or a department store gift certificate can produce desired results, he says.

❒ **Provide marketing materials.**

Once you have staff headed down the marketing path, provide them with professional but subtle collateral materials, Deutsch suggests. "Get a nice brochure. It doesn't have to be a major four-color piece — that can work against you — but have it printed professionally." Staff can mention your organizations' other services and leave the brochure.

Generic business cards with a blank line for staff to write their names on are also fairly inexpensive and enhance the organization's professional image, he says.

❒ **Get out in the community.**

"Traditional marketing techniques don't work the same [in health care]. People only think of it when they need it, so you have to be in as many places as possible," Deutsch says.

Expand your share of the exploding senior care market by reaching out to baby boomers. "[They] feel badly they haven't spent as much time with [their parents]. They feel guilty and want to make it better, but don't want to spend a lot of time themselves," he explains. Encourage staff to speak out in forums with heavy baby boomer participation such as churches and Optimist and Kiwanis Club meetings, he suggests. After identifying themselves, staff can talk about a home care issue and never mention your company again, but the connection will have been made, says Deutsch.

Field staff marketing training "is intangible. You can't tie it to referrals or revenues," he

SOURCES

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acknowledges. However, in today's competitive environment, without the luxury of waiting for business to come to them, providers can use clinicians to blanket their organization over the community and get their rightful market share. ■

Pediatric providers face uphill battle

Tips for overcoming family control, staffing issues

Pediatric providers may rightfully argue they have one of the toughest private duty assignments around. Chronically ill children with intense care needs, overwhelmed families, and continually limited staff resources can create a boiling cauldron of family control issues, staff unrest, and clinical care challenges. Meeting demanding care regimens and keeping family and staff happy without overtaxing organizational resources requires continual effort, but is possible, according to providers, by applying these techniques:

1. Understand family stresses.

Success in pediatrics starts with understanding the difficulties the family faces. The burden of caring for a chronically ill child with nonstop care needs creates enormous financial, emotional, and physical stress, according to sources. The child's care dominates family life, is isolating, and often disrupts relationships both within and outside the family.

"You have to recognize that parents have difficulty dealing with [the child's] multiple disabilities. They experience chronic sorrow, anger, and frustration," says **Melody O'Neal**, RN, BHA, president and chief executive officer of Melmedica Children's Healthcare, a pediatric private duty company based in Country Club Hills, IL. Such stress exacts a toll; divorce among parents of chronically ill children is common. "For relationships that even survive, [there is] a tremendous impact," she adds.

With so many factors — their child's health, their finances, their relationships — out of their control, parents take charge where they can. They may create stringent house rules and care regimens, expect staff perfection, and demand 100% shift coverage. "It's all about control. Parents can be very, very picky — unreasonably so," says **Dana Berger**, RN, manager of Houston-based VNA Private Duty Services.

"What really is the issue is that the mom wants the kid to be well and that isn't going to happen," says **Peggy Gilmour**, RN, MS, president and chief executive officer of Home Health and Hospice Care based in Nashua, NH.

2. Put parents in the driver's seat as much as possible.

Providers can still be effective by accommodating parental control needs as much as possible and acknowledging parents' care knowledge and skills. "Parents are probably the most skilled in providing chronic care, but they may be doing some things not quite by the book. You need to evaluate the outlook and potential for harm and be realistic. If the parents are doing it their way 16 hours [a day] and you're only there for eight, [then] unless they're asking you to do something that's a safety issue or blatantly illegal, [you should adopt their care regimen]. Put [them] in control of the care plan as much as possible," Gilmour advises.

"Don't go in and tell the family [how to care for the child]," O'Neal adds. "They are the experts; they know [their child] better than anyone and [they] live it day in and day out. There's no way you can be the expert. But you do have a lot of knowledge and expertise and can offer experiences and share your insight, [so that you and the family] can share and work together."

3. Clearly designate parent-provider responsibilities.

While emphasizing a collaborative relationship, forestall misunderstandings and help manage control issues by carefully delineating both parties' responsibilities at case opening. Have parents sign a responsibility statement, advises **Marilyn Lynch**, RN, CNCU, director of the Pediatric Services of America's Nashville and Knoxville, TN branches. "Parents must understand that the child is their responsibility. [That means] if I send someone that you're unhappy with, that's your choice, but you're responsible until I find someone who can staff the case," she explains.

4. Communicate extensively.

Continue the thorough and honest start of care communication as long as you provide services, sources advise. "You should have constant communication with the family. Urge them to call if they have a problem," says Berger. When problems arise, "keep them updated, even minute to minute if necessary," Lynch suggests.

5. Consistently involve managers.

While the entire care team, including administrative staff such as schedulers and billers, should do their part to promote good communication, clinical managers in particular should keep their finger on the case pulse. "Managers must have more involvement. [They should] call often and go by. [They shouldn't] just rely on the clinical staff," Berger recommends.

Consistent relationships are also important. It helps to have "one person that tries to sort through issues. The biggest mistake is to try to send 18 people to fix it," says Gilmour.

6. Be prepared for challenging staffing issues.

Chronic pediatric cases present special staffing challenges. Parents seeking control in a world in which they often otherwise feel powerless may quickly run through an agency's limited pediatric staff resources. Qualified professionals may not meet parents' exacting care, conduct, and appearance standards. Staff may also remove themselves from the case because of tensions within the home. Combating parents' uncompromising position, as well as the rapid-fire pediatric private duty grapevine that quickly broadcasts "problem cases," can present real challenges for providers.

7. Determine family staffing preferences.

Make your way through this obstacle course by first meeting with parents to understand their needs and perception of what it takes to make a good relationship, O'Neal suggests. For example, while they may highly value clinical expertise, they may also feel strongly about having staff who are very personable and interact well with the patient and siblings. Or, they may emphasize neatness and punctuality over personality.

8. Be honest with staff.

When recruiting staff for a case, "bring out the positives of the situation," but don't sugarcoat the challenges, O'Neal advises. Talk about the child first, and then discuss the case dynamics.

Hire only nurses with pediatric experience, assess their competency and inservice them in front of the parents, Lynch suggests. Maturity and experience are particularly important, according to Gilmour. "A seasoned home care nurse has a large repertoire of responses. [They] don't know what [they're] walking into when they open the door. Some people need you to be in control; others, you are absolutely under their control and [seasoned nurses can] recognize the difference and react to it," she adds.

9. Maintain professional relationships.

Counsel staff nurses, both before they start on a case and in the midst of any conflicts, not to take criticisms personally, sources advise. Remind staff, as well, about maintaining professional boundaries. "If a nurse goes beyond [her] limitations and becomes 'part of the family,' and starts commenting on things that don't have anything to do with care, you're headed for trouble," Lynch cautions.

"Don't become unprofessional or [forget you're] a guest," O'Neal concurs. "Ask where to put things — you can't take over their home or space — and be as considerate as possible when utilizing supplies, electricity, paper towels, and toilet paper," she adds.

10. Give families space.

Also, encourage nurses, whenever possible, to carry out their nursing regimen flexibly, allowing family members to interact with the patient, O'Neal suggests. For example, if the family is together when a noncritical treatment or feeding is scheduled, nurses can postpone that intervention, she explains. O'Neal also recommends not passing judgment on different parenting styles and beliefs that do not impact care.

SOURCES

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Remember your 'case' is a child

Despite providers' best efforts, conflicts are bound to arise. When facing a difficult staffing situation, "speak in terms of the child," Lynch suggests. "Instead of saying 'we're trying to staff the case as best we can,' say 'we're doing everything for Joey we can do,'" she explains.

If staffing difficulties or other conflicts persist, "sit down with the family. Get both parents together and be honest with the family. [Let them know] the stress they encounter flows over to the

staff. Outline a plan so that [you] can continue working together," O'Neal advises. Include a deadline in the plan and make it clear that if the situation does not improve, you will not be able to continue providing services, Lynch adds.

11. Terminate when you can't make it better.

Cases go through cycles, and there's no pat answer about when case dynamics irrevocably change for the worse. Time and human resources are factors, explains Lynch. "When you're spending a certain amount of time on this case and it's way out of proportion with your case load — for example, the care coordinator [devotes] 20 hours per week on the case — [then termination is probably justified]," she explains.

"When issues continue to surface and it doesn't matter what you try, it just doesn't work, and every day or week there are new challenges and you are tense with the family," you probably need to remove yourself from the case, O'Neal advises. "You need to be honest with the family and say 'I'm not able to meet your needs,'" she adds.

Once it terminates services, Melmedica allows nurses who have a good relationship with parents to continue working with the successor home care company, says O'Neal. However, most nurses choose to leave "because it's the support of the agency that allows them to stay," she adds.

Providers working through such thorny issues may find some days easier than others. "It's a delicate situation," Berger acknowledges. "You have to work hard to please these moms and go the extra mile," she adds. Satisfaction, not to mention praise, from overwrought family members may be scarce at best. Rewards often come from making a difference in the life of a chronically ill child. "Most of the time nurses stay in because they really care about the child," she says. ■

Getting what you want out of managed care

Don't accept unfavorable contract terms

You finally got the managed care company's attention. They are willing to contract with you. However, as excited as you are, don't let your enthusiasm over the promised relationship lead you to negotiate a bad contract, sources warn. Consider their suggestions to get the best deal for your organization:

• **Understand the contract.**

Providers should understand what they are agreeing to above all else, says **Robert Stewart**, RN, MSN, CHC, CHE, administrator of Durham (NC) Regional Homecare. Contracts are often "couched in subtle legalese, and they're difficult to understand," he says. Having your attorneys as well as several home care staff members review proposed agreements helps bring clarity, he adds.

Carefully review service definitions, advises **Tim Bosse**, director of private duty services at Home Care 24 in Baltimore. For example, the managed care organization may define a RN visit as two hours or less. Providers should negotiate an "extended" definition and rate for those situations where visits go longer, he explains.

Providers should also determine what overall services the contract covers, sources advise. For example, general home care agreements may exclude special populations such as maternal/child or congestive heart failure; both are potentially large service opportunities for providers.

It is also important to know where your potential patients are located, Bosse advises. Determine how much the payer's membership and your service area overlap. If you only serve fringe areas and can't reasonably expect a large patient volume, then you may have no compelling reason to enter a contract. "Is it a fit? What's the reason for entering it? Is it just because it's prestigious?" he asks.

• **Know your costs.**

Before signing on the dotted line, providers should know how they will fare financially with a contract. Involve the staff responsible for the areas the contract covers, Stewart advises. They should know their cost of care and whether they can deliver the proposed services within the agreement's reimbursement, he says.

"With straight fee-for-service, they should be able to determine their costs and know whether they can make money," says **Elizabeth Hogue**, a Burtonsville, MD-based attorney who specializes in home care. She notes, however, that capitated contracts are trickier. The managed care organization should be able to provide current membership and home care utilization figures, but such information is often hard to come by.

• **Watch payment terms.**

Most providers can relay horror stories about

slow payments from managed care organizations. Do what you can contractually to facilitate prompt payment, sources advise. "You should look at your [account receivables] and cash flow situation. If you don't have the luxury of floating 180 days [account receivables], then you need fixed reimbursement dates [in the contract]," Stewart advises.

Payers often propose paying clean claims within a specified period of time. This exposes the provider to the payer's interpretation of clean. Hogue suggests requiring payment of all claims within a specified period of time, while withholding a small percentage of overall claim value to cover problem bills. Some states have prompt payment laws that require payment within a certain time period.

Stand behind your contract's conditions

The best contract language is only good when it is enforced. Providers should do their part to hold payers accountable, sources advise. "You almost have to put them on a program, constantly niggling them about [payment]," says Hogue. One of her clients routinely calls a slow payer and says "We're coming to pick up a check tomorrow. Please have one ready." The provider's presence usually springs people into action, and she does not leave the office empty-handed, Hogue reports.

"You have to be very proactive about collecting the money. Tell the company 'if you don't pay me on time, I won't [provide] service,'" Hogue advises. While some providers may feel uncomfortable making such a comment, they really shouldn't, according to Hogue. "Don't state it as a threat; just a matter of fact. Explain that 'this is a labor-intensive [service]; we have to pay people; we don't have capital [to] float these expenses over and over again,'" she adds.

Providers also have to do their part internally to facilitate prompt payment. "You need [your] front-end process to [meet] the payers' requirements. A sloppy front end leads to payment problems, and you have an obligation to clean up your internal systems to make your reimbursement as quick as possible," Stewart advises.

Bosse agrees. "Make sure you understand what data are required on claims [so that your billing practices facilitate payment]."

• **Avoid evergreen clauses.**

Many managed care agreements have automatic renewal or "evergreen" terms. These can cause serious problems for providers who find themselves in unprofitable contracts. Hogue recommends one-year contracts that terminate unless the parties renew the agreement prior to the termination date.

• **Terminate without cause.**

Many payers propose contracts that may only be terminated with cause. While this protects providers from being dropped for no reason and facing a sudden loss of business, it can also work against them, says Hogue. A provider that wants to terminate a contract for cause may find itself in conflict with a payer that insists there is no cause. For example, after continuing to experience long payment delays, a provider may serve termination notice. The payer may then argue that it has only experienced some temporary difficulties due to a computer glitch and that there is no cause for termination, she explains.

Hogue also advises against language requiring a cure period prior to contract termination. "If a contract is on the verge of termination, you should already be talking about problems. Cure clauses work when you're ready to terminate but no one is ready to say what the problem is. If you're passive-aggressive and [don't] readily discuss problems, [they] may give structure [to facilitate dialogue]," she says.

To prevent payers from immediately transferring patients to another provider once either party gives termination notice, include language that allows you to continue caring for patients on service at the contract's end, Hogue advises. This not only gives clients important continuity of care, it also enables providers to more smoothly adjust their operations to the loss of business, she says.

• **Choose mediation over arbitration.**

Providers and payers sometimes become locked in head-to-head battle over payment, service denials and other contractual issues. Carefully evaluate proposed grievance procedures to resolve these disputes, Hogue recommends.

"Grievance procedures [should be] quick, neutral, and require no waiver of other rights by providers and patients," yet most managed care contract language and actions are diametrically opposed to those concepts, she says.

Aim for such goals and seek mediation over arbitration, Hogue advises.

In arbitration, a third-party decision maker hears evidence from both parties and makes a binding decision. "Mediation is more like shuttle diplomacy. [The mediator] finds common ground [between the parties]. A solution should emerge that's acceptable to all," she explains.

Regardless of your desire to work with a payer, contract negotiations can be difficult and draining. And while you should strive to have the most advantageous language possible, the only real deal-breaker is price, according to Hogue. "Why would anyone need a money-loser?" she asks.

But many providers do enter financially poor contracts. "Home care [companies] usually underestimate the financial impact [of contracts or knowingly enter bad ones] because they are so anxious to spread their Medicare business they will sign anything," says Stewart.

Managed care is not the only game in town

You should not feel compelled to enter a disadvantageous contract, sources advise. "Help your competitors sign as many managed care contracts as possible and don't sign any yourself," advises **H.C. Sonny Covington**, of Lafayette, LA-based I CAN! America. Covington helps clients find alternative funding sources. "Managed care [in home care] hasn't worked, especially in emerging markets. It will guarantee business, but you'll go broke in the process," he explains.

"There is a myth in the home care world [that you must have managed care contracts]. I don't know why it was created or who perpetuates it, but [managed care business] is not as essential as many people think it is. There are lots of niche markets that people should consider," says Hogue.

Sidney Melnik, president and chief executive officer of Westmont, NJ-based Medical Homecare Associates agrees. Although his private duty company has a contract with a major insurer in his market, "we don't do any business with them," he says. Melnik found Medical Homecare Associates' nurses were often sent for money-losing assessment visits with few subsequent ongoing service authorizations. "I'll do everything I can to work with other [payer] sources such as waiver programs," he explains. Melnik does provide supplemental staffing to other agencies that work with the payer.

The managed care climate has changed enough in the past year that providers have more negotiation power than before, sources report. "The government is doing more and more intervening with managed care, and there will be more and more," says Melnik.

"There is much more skepticism about entering managed care contracts and a better understanding that [payers and providers] must negotiate not just price, but terms," Hogue notes.

SOURCES

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Contentious or unprofessional negotiations may be an important indicator about life after the contract, and a warning sign that providers should not ignore, according to Hogue. "The way contract negotiations proceed [is usually] indicative of the way the relationship will proceed. If you experience autocratic or patronizing behavior, or [find that] a lot of the staff at the managed care provider is misinformed, then your antennae should go up and you should ask yourself 'if this is so painful, do I really want to go through with it?' Don't think you're dead in the water, and don't sign unless you negotiate." ■

Minding someone else's business can pay off

Management contracts offset overhead

With so many challenges both here today and on the horizon, taking on another provider's problems in the form of a management contract may not seem very appealing, but it can be a winning strategy under the right circumstances, according to **Deborah Zients**, vice president for community operations at North Arundel Health System in Glen Burnie, MD. "I see other people's problems as my opportunities. If you're a good manager, you can take advantage that people haven't kept up with the times," she explains.

Structure agreements that meet regulatory requirements

Meeting federal anti-kickback law requirements is an obviously important consideration in designing management agreements. The Department of Health and Human Services Office of Inspector General (OIG) looks closely at arrangements that have no safeguards against overutilization or include financial incentives to increase patient referrals or abusive billing practices, according to **John Gilliland**, a health care attorney based in Crestview Hills, KY.

"The federal anti-kickback law, s. 1128B(b) of the Social Security Act, makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, one purpose of which is to induce the referral of business covered by either the Medicare or Medicaid Programs," he says. Violations carry a $25,000 maximum fine and possible imprisonment up to five years, or both, along with Medicare and Medicaid program exclusions.

In 1991, the OIG established six safe harbors that outline practices that do not violate the anti-kickback statute. Providers who do not meet safe harbors are not necessarily breaking the law, but they are at risk of OIG scrutiny, according to Gilliland.

Management agreements meet the six safe harbor requirements if they:

- ✔ are in writing and signed by the parties;
- ✔ specify the services to be performed;
- ✔ specify the schedule of any periodic, sporadic or part-time services, and their precise length and exact charge;
- ✔ are less than one year in length;
- ✔ predetermine compensation on a fair market value, arms-length transaction basis, and exclude volume- or referral-based compensation on any Medicare or Medicaid-related business;
- ✔ Do not promote any business that violates any federal or state law. ■

North Arundel Home Care, an affiliate of the North Arundel Health System, recently began managing the home care operations of a community hospital in nearby Baltimore. The arrangement is a good fit between the parties, she says. While North Arundel is large and diversified with strong information systems and quality improvement programs, its new partner provides visits only — about 15,000 annually — lacks state of the art technology, and substantial investment funds, but wants a 1998-style makeover.

The contract allows the community hospital to maintain its home care identity and crucial continuity of care connection while offloading operational "nuisance pieces" such as billing, intake, and quality improvement, Zients explains. The hospital-based program also cut administrative positions, and while the management contract was an added expense, it still realized an overall cost savings.

North Arundel, on the other hand, took on its responsibilities without adding staff, so the contract management fee directly offsets overhead expenses. By increasing geographic service area, the agreement also strengthens its contracting efforts, she notes.

Under the arrangement, North Arundel provides general management, intake, and quality improvement services, and also oversees billing and reimbursement functions. The arrangement may expand to include information system conversion and more extensive billing responsibilities in the future, according to Zients.

The North Arundel-supplied director of operations, and its quality improvement, reimbursement, and intake managers each devote part of their time to the contract. Their collective on-site time totals about one full-time employee, she says. Field staff, nonsupervisory administrative workers, and front-line clinical managers at the hospital-based agency are hospital employees. Although North Arundel is the administrator for regulatory purposes, the hospital board retains crucial legal authority.

North Arundel receives a per visit management fee. Zients' pre-contract research indicated that such fees generally range from $5 to $15 per visit depending on the services provided.

The North Arundel intake department maintains a separate referral line for the hospital-based provider, so that the arrangement is transparent to its referral sources.

Given the home care industry's current turmoil, management contracts are not for the faint-hearted. "This scenario is not for anyone who is not in risk-taking mode," Zients concedes. Provider-managers must carefully identify and closely manage their costs and negotiate financially and legally viable agreements. In addition to fraud and abuse considerations, contracts must also address antitrust concerns.

Although per-visit fee structures are common among home care management agreements, they

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- **John Gilliland**, Attorney, 2670 Chancellor Dr., Suite 290, Crestview Hills, KY 41017. Telephone: (606) 344-8515.
- **Deborah Zients**, Vice President for Community Operations, North Arundel Health System, 1708 W. Rogers Ave., Baltimore, MD 21209-4545. Telephone: (410) 578-8600.

pose some fraud and abuse violation risk, according to **John Gilliland**, a Crestview Hills, KY-based health care attorney. They fall outside safe harbors designated by the Department of Health and Human Services Office of the Inspector General (OIG). **(See related story on safe harbors, p. 150.)** Per-visit management fees "[don't] mean you're violating the law; [they] just mean you're open to [OIG] scrutiny," he says.

If you are considering a per-visit fee structure, "you want the rest of the agreement strong enough that [the relationship] would not be considered a payment for referral," Gilliland advises. Still, flat fees or those based on achieving budgetary goals are less risky, he says.

In addition to fraud and abuse regulations, provider-managers must also clear anti-competition hurdles. "It can be hard to manage a competitor. If there is a lot of [territory] overlap, you may potentially violate antitrust laws," says Gilliland. Even when not illegal, such arrangements may be a conflict of interest, he adds.

The line dividing friendly competition and adverse relationships is blurry and very dependent on individual considerations. It veers toward anti-competition when it influences either party's judgment, he says.

North Arundel and its managed partner have "almost no overlapping territories," Zients says. Also, expansion plans for the hospital-based agency involve maximizing hospital-related activity, as opposed to reaching for new business from other sources, she notes.

Providers should also clearly understand their own costs and capabilities before proposing an agreement, Zients advises. If your expertise does not match your potential partner's needs, the agreement stands less chance of success.

"Make sure you'll be properly compensated with a clear understanding of the services provided," Gilliland suggests. Consider charging an upfront fee to cover extra staff time required at the contract's onset, Zients adds.

Most management agreements have financial and operational performance targets, such as achieving certain net income levels or receiving licensure or accreditation renewals. Provider-managers should "negotiate performance parameters they can live with," she advises.

While management contracts do require additional effort during already challenging times, they also represent an excellent opportunity as many hospitals try to maintain home care programs struggling under Medicare interim payment system reductions, according to sources. "It's easier with provider-sponsored organizations," not only because smaller hospital programs in particular may have fewer competitive issues, but also because hospitals are looking for home care alternatives, Zients says. ■

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Olsten signs national contract

Olsten Health Services in Melville, NY, and First Health Group Corp., in Downers Grove, IL, recently entered a national contract that allows Olsten, through its Network Services program, to provide centralized administration, home nursing, infusion therapy, and medical equipment services to First Health's 14 million beneficiaries. Olsten will coordinate patient care through its four regional Network centers, and both Olsten and its Network Services-contracted providers will provide home care.

First Health is a national health benefits company. The contract, effective May, 1998, is being implemented on a plan-by-plan basis for First Health's workers' compensation and group health arrangements. ■

CE objectives

After reading this issue of *Private Duty Homecare*, CE participants will be able to:

- Identify three important considerations when negotiating managed care contracts.
- Name four strategies to improve pediatric case management.
- Identify regulatory requirements in management contracts.
- Identify an important component of paraprofessional training. ■