AMERICAN HEALTH CONSULTANTS®

Hospital Home Health.

the monthly update for executives and health care professionals

INSIDE

NOVEMBER 1998

VOL. 15, NO. 11 (pages 161-176)

American Health Consultants® is A Medical Economics Company

Uncertainty over home care's future marks NAHC's 17th annual meeting

Pessimism over Medicare reductions is obvious

This year's annual meeting in Atlanta of the Washington, DC-based National Association for Home Care (NAHC) attracted home care providers hungry for information about what the future holds for their industry. However, despite such keen interest, fewer people attended the 17th Annual Meeting and HomecareExpo than in recent years.

The Expo counted approximately 4,000 attendees and 520 booths. Last year in Boston, there were 8,000 attendees at the annual meeting and 600 exhibitors, according to NAHC. But NAHC vice president for communications **Ron Kolanowski** reports that last year's number was significantly higher because NAHC also hosted the World Homecare Congress, which brought home care representatives from 60 countries around the globe.

"This year, we didn't see a significant drop in the number of agencies present, but the agencies brought fewer people," he says. "We felt like the heart of the home care community was there. We really had the decision makers there this year, and people were serious about learning."

Kolanowski says the thirst for information was evident among the attendees through the level of attendance at the educational sessions.

'An indication of unsettled times'

"The educational sessions were very well attended. That shows how hungry people are for information," he notes. "There are two ways we usually measure the success of a meeting. One is, 'Did the exhibitors get the attendees in the exhibit hall?' and we think yes. People were really looking to the exhibitors.

"The other [indicator] is 'Were the educational and general sessions well attended?' People were very responsive in the general sessions and really liked what they heard. We look at those as seeing how people are responding to what NAHC is saying about things."

Kolanowski says that, in general, there was an energy, "despite the doom and gloom people are going through." But he says NAHC had the overall feeling that the attendees think the federal government's crackdown will make them leaner and stronger. "People are looking toward the future already."

Rob Laufer, the business development manager of Staff Builders'

Lake Success, NY, medical staffing division, adds, "You don't have to speak to anyone long before the future of industry comes up, and that is an indication of unsettled times."

He says that it became clear to him at the meeting that people are becoming interested in diversifying. "No one wants all of their eggs in the government reimbursement basket."

At a *Hospital Home Health*-sponsored roundtable discussion, which was held on the first night of the Expo, **Charlotte Hughes**, the director of healthcare regulatory affairs for Melville, NY-based Olsten Health Services, says the burden of the government's changes on the industry is not only affecting new or inexperienced agencies.

"It isn't new providers who don't know what they're doing who are closing," she says. "They are good agencies who unfortunately weren't very cost-efficient."

And the agencies' closings are not that far away, adds **Susan Schulmerich**, executive director of Montefiore Medical Center Home Health in Bronx, NY, at the roundtable, which included some of the industry's top managers.

"I think it's going to be a lot sooner than the first three months of 1999 because anyone who knows what their year-end is going to look like, they're not going to stay in business the first three months of 1999." ■

GAO report tells only one side of IPS story

Is the government dishonest or just in denial?

In September, when the Office of the Inspector General's General Accounting Office (GAO) released its study, *Medicare Home Health Benefit: Impact of Interim Payment System and Agency Closures on Access to Services*, the findings came as no surprise to either the Baltimore-based Health Care Financing Administration (HCFA) or home health care professionals.

On one hand, there is HCFA, which agreed with the report's conclusion that it's difficult to single out just how much effect any one factor — such as the interim payment system (IPS) — had on agency closings. The findings, says **Thomas Hoyer**, director of the Chronic Care Purchasing Policy Group for the organization's Center for Health Plans and Providers, "certainly reflected the understanding that I have derived. The primary reports are that the distress is being felt primarily by agencies and not customers."

On the other hand are home health care industry professionals who weren't shocked by the GAO's findings, not because they agree with them, but rather because "you can always create a report to come up with a consensus on your existing position," says **Michael Sullivan**, executive director of the Indiana Association for Home and Hospice Care in Indianapolis.

Presentation counts

Sullivan says he isn't putting much stock in the GAO's findings because he doesn't have any faith in the survey itself. "This is about the poorest tool I've ever seen. The GAO should be embarrassed," he says.

"The questionnaire was so poorly done that [the GAO] had to go through and add in percentage signs and 'yes' and 'no' check boxes by hand on every page. It was a joke. If this was a ninth-grade report, they would have failed," he adds.

It wasn't only the form that Sullivan says gave him second thoughts about the report's veracity. Also troubling to him was that the GAO faxed the form to hospital discharge planners and also to local agencies on aging. "[Those local agencies on aging] have nothing to do with placing a Medicare patient with a home health agency," he says.

Even more disturbing was that the GAO wanted a one-day turnaround on the response. "They were asking for information on how many Medicare patients the hospital discharged last year, what percentage was discharged to home health care, how many Medicare-certified home health agencies were in the area, and for a list of all of them to be faxed in with the response. They were asking for information that you just don't have sitting around on your desk," he says.

GAO defends report

Hoyer defends the report. "This is one of those times when everyone wants to know today what they will know next year. I think the GAO did the best with the time it had, and I think it made a good contribution. [The agency] was asked to do a study in a hurry, and it acknowledged its limitations and reported it with full disclosure. I

think the quality of the report is laid out in the context."

Sullivan says he isn't buying it. Nor is he the only one irritated by how the GAO report came to its conclusions.

> *"The questionnaire was so poorly done that [the GAO] had to go through and add in percentage signs and 'yes' and 'no' check boxes by hand on every page. It was a joke. If this was a ninth-grade report, they would have failed."*

Anita Bradberry, executive director with the Austin-based Texas Home Care Association, says she was surprised that "they didn't interview any physicians." More than that, she says she believes the report's timing was way off. "They certainly didn't take into consideration that the agencies haven't received any demand letters yet," she says, adding that she believes once Texas agencies have received them, along with their new per-beneficiary and per-visit rates, "there will be a drastic reduction in the number of agencies as well as patient access."

Home Care Association of New York State (Albany) executive director Carol Rodat agrees. As she sees it, "the GAO took a snapshot at a point in time that was too early. Agencies aren't feeling the effects yet. I think we're really going to see them [at the end of the year]; people are waiting until Congress recesses to make the big changes. When agencies have field-cost reports and start receiving feedback on how much they owe, that's when you may really see the doors close."

John C. Gilliland, a health care attorney based in Crestview Hills, KY, agrees with the report's findings — up to a point. "The sickest patients aren't being treated now," he says, adding the clarification "because agencies can't afford to treat them."

Similarly, Rodat has found that patient access to home care has become increasingly problematic. However, she believes the issue lies not so much with how many agencies have closed, but rather how many are left open and accepting new cases.

The latest figures from the National Association for Home Care in Washington, DC, and other trade groups such as the American Federation of Home Health Agencies in Silver Spring, MD, and the Home Care Association of America in Washington, DC, show that approximately 1,200 agencies nationwide have shut their doors.

"In truth, I think agency growth had gotten out of hand, but I don't think we have data that definitively answer the GAO questions. I don't believe that numbers alone are [proof] of whether there is an access problem. You could have a rural area, for example, with two providers but neither is taking wound cases. That's an access problem in my belief," she says. "I think that without question there are access problems for patients."

Where did these numbers come from?

As for Sullivan, he says he wonders where the GAO came up with its findings on agency closures. "I don't know if it was the OSCAR file or what, but they didn't even call the Indiana Department of Health to get the official list of agency closures. [OSCAR, a HCFA database, is an acronym for Online Survey, Certification and Reporting System.] They're the ones that are responsible for licensing and certifying agencies in the state, and they count 35 as having closed. The GAO went to another source and came up with 11."

No one in the home health industry would argue that agencies are the ones bearing the brunt of the IPS burden, and there's a strong belief that as agencies suffer so do the beneficiaries. Perhaps an even stronger sentiment is that as IPS settles in, the problem posed to both agencies and Medicare beneficiaries will only grow. ■

What the GAO found

The Office of the Inspector General's General Accounting Office's (GAO) study, which surveyed discharge planners from 82 hospitals and representatives from 21 local aging organizations in seven states, concluded that "neither agency closures nor the interim payment system [IPS], with less than a year's implementation experience, has significantly affected the capacity of the home health industry to provide services or beneficiary access to care."

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Medicare-Certified Home Health Agencies, 1994 to 1997, and Voluntary Closures, Fiscal Year 1998

State	HHAs as of Oct. 1, 1994	HHAs as of Oct. 1, 1997	Percentage change (1994-97)	Voluntary closures,* Oct. 1, 1997-Jun. 30, 1998	HHAs as of Aug. 1, 1998
Alabama	173	183	5.8	0	183
Alaska	19	27	42.1	7	20
Arizona	100	131	31.0	13	114
Arkansas	200	206	3.0	2	202
California	617	861	39.5	74	768
Colorado	150	201	34.0	21	174
Connecticut	115	116	0.9	7	104
District of Columbia	18	22	22.2	1	21
Delaware	19	21	10.5	2	19
Florida	305	398	30.5	20	378
Georgia	81	96	18.5	0	97
Hawaii	26	28	7.7	5	22
Idaho	56	78	39.3	4	73
Illinois	314	392	24.8	17	369
Indiana	214	299	39.7	11	282
Iowa	172	211	22.7	5	205
Kansas	163	221	35.6	16	202
Kentucky	107	111	3.7	0	112
Louisiana	432	519	20.1	37	466
Maine	29	51	75.9	4	47
Maryland	74	81	9.5	3	78
Massachusetts	175	198	13.1	5	192
Michigan	179	234	30.7	3	230
Minnesota	232	265	14.2	2	261
Mississippi	76	70	-7.9	1	69
Missouri	229	272	18.8	20	247
Montana	48	62	29.2	0	61
Nebraska	65	83	27.7	0	83
Nevada	41	54	31.7	8	44
New Hampshire	39	46	17.9	0	46
New Jersey	53	57	7.5	0	58
New Mexico	80	117	46.3	11	102
New York	214	227	6.1	1	226
North Carolina	149	162	8.7	3	166
North Dakota	33	35	6.1	1	34
Ohio	352	472	34.1	21	452

(continued)

Medicare-Certified Home Health Agencies, 1994 to 1997, and Voluntary Closures, Fiscal Year 1998 continued

State	HHAs as of Oct. 1, 1994	HHAs as of Oct. 1, 1997	Percentage change (1994-97)	Voluntary closures,* Oct. 1, 1997-Jun. 30, 1998	HHAs as of Aug. 1, 1998
Oklahoma	232	389	67.7	36	336
Oregon	81	90	11.1	6	80
Pennsylvania	312	381	22.1	4	375
Rhode Island	19	30	57.9	3	28
South Carolina	66	82	24.2	1	80
South Dakota	36	56	55.6	3	52
Tennessee	234	232	–0.9	8	222
Texas	961	1,949	102.8	134	1,758
Utah	65	89	36.9	12	75
Vermont	13	13	0	0	13
Virginia	197	233	18.3	8	226
Washington	59	68	15.3	2	67
West Virginia	67	92	37.3	3	88
Wisconsin	172	181	5.2	4	176
Wyoming	57	65	14.0	5	59
United States	7,920	10,557	33.3	554	9,842

Note: HHA = home health agency.

*This does not include the 206 closures that were involuntary because the agencies were out of compliance with Medicare's conditions of participation.

Source: HCFA's On-Line Survey, Certification, and Reporting System data.

Medicare Per-Beneficiary Limits for "New" and "Established" Home Health Agencies

State	Median aggregate per-beneficiary limit for "established" agencies[a]	Illustrative aggregate per-beneficiary limit for "new" agencies, state averages[b]	Ratio of "new" provider limits to "established" provider limits
Alabama	$4,484	$2,744	0.612
Alaska	$3,674	$3,957	1.077
Arizona	$3,529	$3,171	0.899
Arkansas	$3,715	$2,620	0.705
California	$3,160	$3,942	1.247
Colorado	$3,072	$3,187	1.037
Connecticut	$3,589	$4,037	1.125
Delaware	$3,015	$3,336	1.106
District of Columbia	$3,300	$3,595	1.089
Florida	$3,630	$3,188	0.878
Georgia	$4,070	$3,311	0.814
Hawaii	$3,304	$3,417	1.034
Idaho	$3,020	$2,921	0.967
Illinois	$2,826	$3,151	1.115
Indiana	$3,364	$3,151	0.937
Iowa	$2,047	$2,850	1.392
Kansas	$2,513	$2,966	1.180
Kentucky	$3,613	$3,109	0.861
Louisiana	$5,764	$2,978	0.517
Maine	$3,059	$3,192	1.043
Maryland	$2,900	$3,435	1.184
Massachusetts	$3,676	$3,803	1.035
Michigan	$2,868	$3,497	1.219
Minnesota	$2,186	$3,332	1.524
Mississippi	$4,977	$2,989	0.601
Missouri	$2,742	$2,976	1.085
Montana	$2,690	$3,140	1.167
Nebraska	$2,248	$3,131	1.393
Nevada	$3,988	$3,523	0.883
New Hampshire	$2,688	$3,594	1.337
New Jersey	$2,556	$3,919	1.533
New Mexico	$3,190	$2,993	0.938
New York	$2,605	$3,850	1.478
North Carolina	$3,005	$3,080	1.025

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Medicare Per-Beneficiary Limits for "New" and "Established" Home Health Agencies continued

State	Median aggregate per-beneficiary limit for "established" agencies[a]	Illustrative aggregate per-beneficiary limit for "new" agencies, state averages[b]	Ratio of "new" provider limits to "established" provider limits
North Dakota	$2,156	$2,669	1.238
Ohio	$2,615	$3,204	1.225
Oklahoma	$4,885	$2,711	0.555
Oregon	$3,025	$3,449	1.140
Pennsylvania	$2,505	$3,451	1.378
Rhode Island	$3,711	$3,631	0.978
South Carolina	$3,591	$3,089	0.860
South Dakota	$2,197	$2,749	1.251
Tennessee	$5,521	$2,979	0.540
Texas	$4,822	$3,072	0.637
Utah	$4,064	$3,282	0.808
Vermont	$2,762	Not applicable	0.000
Virginia	$3,008	$3,129	1.040
Washington	$2,888	$3,581	1.240
West Virginia	$2,755	$2,926	1.062
Wisconsin	$2,554	$3,193	1.250
Wyoming	$3,302	$2,840	0.860

Note: An established agency is one that opened before October 1, 1993; all others are new agencies.

[a]The per-beneficiary limit for established agencies is a blend of 75 percent of an agency's own per-beneficiary payment and 25 percent of the average payment in the region. When the limits are compared with an agency's costs, the regional component is adjusted for area wage differences. In this table, the regional component has not been adjusted.

[b]New agencies are given a national per-beneficiary limit based on the median of such limits for all established agencies. In this table, the national limit is adjusted for differences in wages based on the location of the agency. In calculating payments, the wage index adjustment will be based on the place of service. These numbers do not reflect all new agencies.

Source: HCFA.

Source: Health Care Financing Administration, Baltimore.

(Continued from page 163)

(See tables for survey findings, pp. 164-167.)

Further, the report did not substantiate the home health care industry's belief that more agencies were closing their doors as a direct result of IPS. Instead, the GAO study found that agencies were going out of business for a variety of reasons, and that despite 554 voluntary and 206 involuntary agency closings between October 1997 and June 30, 1998, the total number of agencies nationwide had increased during that period.

Some patients hard to place

The GAO reported no substantial problems in access to home health care, but acknowledged that overall, even though discharge planners reported no significant change in agencies' behavior, these same people had found those beneficiaries requiring expensive, long-term care were more difficult "to place in home health services." ■

SOURCES

Anita Bradberry, Executive Director, Texas Association for Home Care, 3737 Executive Center Dr., Suite 151, Austin, TX 78731. Telephone: (512) 338-9293.
John C. Gilliland, JD, Law Office of John C. Gilliland II, 2670 Chancellor Dr., Suite 290, Crestview Hills, KY 41014. Telephone: (312) 850-7500.
Thomas Hoyer, Director, Chronic Care Purchasing Policy Group, Center for Health Plans and Providers, Health Care Financing Administration, 7500 Security Blvd., Baltimore, MD 21244. Telephone: (410) 786-3000.
Carol Rodat, Executive Director, Home Care Association of New York State Inc., 21 Elk St., Albany, NY 12207. Telephone: (518) 426-8764.
Michael Sullivan, Executive Director, Indiana Association for Home and Hospice Care Inc., 8888 Keystone Crossing, Suite 1000, Indianapolis IN 46240. Telephone: (317) 844-6630.

Screening tool predicts job performance

Better hiring decisions improve bottom line

Recruiting home health aides is hard enough, but retaining them can be even more challenging. Despite their scarcity in relation to the demand for their services, home health aide turnover nationwide averaged more than 21% in 1997, according to research from the National Association for Home Care in Washington, DC. Repeated absenteeism and poor job performance cause employers to terminate services, while home health aides often leave over seemingly minor differences, providers say.

At the same time, recruitment costs remain high. Experts estimate the hard dollar cost of advertising, criminal background checks, drivers tests, TB tests, and physicals, combined with staff interviewing and orientation time, can add up to over $1,000 per home health aide. With such a large investment, identifying candidates with staying power is vital to home care human resource managers.

Help is on the way, according to one person who operates a home health aide training program that supports four Madison, WI-based home health agencies. **Kay McGee**, director of the CNA Career Alliance, uses a written test that predicts attendance, job longevity, and job performance in her overall screening process. McGee combines the CurryScreen Nursing Assistant and Home Health Aide test with thorough interviews, criminal background checks, and drivers tests to select participants in the CNA Career Alliance's eight week home health aide training program. "I don't use it to determine whether they're in or out, [but] as a tool to [see whether] they follow instructions," says McGee.

'It's really a test of honesty and integrity'

But the test's reliability and validity would enable a provider to use it as a hiring disqualifier, according to its developer, **Michael McDaniel**, PhD, principal of Curry Business Systems in Glen Allen, VA.

"Those who score low on the survey have only a 25% chance of staying on the job five years, a 44% chance of having excellent attendance, and a 38% chance of [performing excellently]," he says.

Questions on the six-page test deal with such topics as reasonable reasons for skipping work,

SOURCES

Michael McDaniel, PhD, Principal, Curry Business Systems, 12401 Linwood Dr., Glen Allen, VA 23060-7121. Telephone: (804) 364-8474. Web site: www.curryinc.com.
Kay McGee, Director, CNA Career Alliance, YWCA of Madison, 101 East Mifflin St., Madison, WI 53703. Telephone: (608) 257-1436.

how long applicants usually stay on a job, how well they follow instructions, and general cognitive and math skills. Most applicants complete the survey in about 30 minutes, according to McDaniel.

"It's really a test of honesty and integrity. [Some applicants] are real honest and take time to write explanations [even though the exam doesn't require it]," says McGee. "[I don't see it as] an intellectual skills test but more of an emotional balance [indicator]."

About 40 CNA Career Alliance applicants have taken the exam since McGee began using it more than a year ago. She has not yet correlated their exam scores with program or subsequent job success. Of the 35 people who have entered the Alliance training program since its inception about 18 months ago, 25 have completed it, she says.

Some applicants eliminate themselves

Some applicants screen themselves out of the process after learning of the exam in the initial interview, McGee says. "To you and me it sounds like a wonderful opportunity, but to someone living on the edge, it may not seem worth it."

She reassures those who return to take the test that it is not the sole determinant of their continuing in the program. "I observe the applicants to see how they approach the paper. Some people don't read well or process information quickly, [but that doesn't mean they won't make good home health aides]. A lot of them freeze up on the math, and while I hope they can add 2 and 2, I look at it as a test of honesty," McGee explains.

Providers who use the exam as an employment screen can score it in about five minutes, according to McDaniel. Their efforts will lead to a better hiring decision. "Unlike other screening tools, which don't have empirical data, I can prove on average that this [predicts attendance, job longevity, and performance], he adds.

Editor's note: The home health aide screening tools are available from Curry Business Systems. A starter kit with four surveys and an administration and technical manual costs $100. Subsequent surveys are $12 each for less than 50, and $10 each in quantities of more than 50. ■

Could your aides be at risk for violence?

Safe working conditions can help you retain staff

No matter how superior your home health aides are, nothing will ruin an employer-employee relationship quicker than a patient or family caregivers who are prone to violence. As director of a hospital-affiliated home health agency, your staff looks to you for protection. Are you prepared to help?

Judy Jacobs, RN, MA, president of Professional Healthcare Systems in Troy, MI, tells the story of a home health aide who had recently become engaged. When the aide arrived at her patient's house, she slipped off her engagement ring and placed it in the pocket of her jacket — a commonplace action in what seemed an ordinary day. But here the story takes a tragic turn.

During the time she was in the home, a relative of the patient came in and tried to steal the ring, says Jacobs. Unfortunately for the aide, she caught the would-be thief red-handed, and says Jacobs, "The thief beat her so badly that she has been in a vegetative state for years."

A frightening story for anyone, especially home health aides whose jobs require them to enter other people's homes alone. What went wrong? And perhaps just as importantly, what can home health agencies do to prevent tragedies like this from ever happening again?

Take a good look around

Jacobs, who with her partner **Wayne D. Porter**, MS, a special agent and criminal investigative analyst with the Florida Department of Law Enforcement in Tampa and co-author of the book *Workplace Violence in Healthcare Toolkit*, says there are quite a few things that agencies should be doing but all too often aren't. Porter also is a senior vice president with Professional

Healthcare Systems consultants in Troy, MI.

First, an agency "needs to teach its employees to recognize and assess the patient and the environment for potential signs of violence. This needs to be done on the initial visit," she says, "and at every subsequent trip to the home."

Much of the initial assessment and information gathering (such as whether the patient has a criminal record or a history of past abuse) should be done by the nurse during the initial patient assessment visit, before an agency has even agreed to take on a patient. Also, check to see if there have been sudden and multiple changes in caregivers, recommends Jacobs. "If a caregiver says he or she is afraid of a patient, you know you have a problem."

Assessing for violence can get complicated

Trying to evaluate an individual's potential for violence can get a little complicated, Jacobs admits. Just about anyone would agree that a patient who is pacing the room, fists clenched and face flushed, as he swears loudly is angry. However, the signs aren't always so easy to read, "because it's not always something as overt as someone screaming," says Jacobs. Still, there are some significant clues to be had if only the aide knows where to look.

Among the more obvious are "weapons in the caregiving area and any drug paraphernalia that might be out," says Jacobs. Should either of those items be found — at any stage in the case — the agency should require the patient to sign a contract agreeing to remove the items from the home and lock them up elsewhere while the aide is there. Oftentimes, the items in question don't belong to the patient but to a family member. That, says Jacobs, poses just as much of a threat to the aide as if they were the patient's personal property.

Some less apparent threats to an aide's safety are blocked egresses, she says. "Any time that ways out of the home are blocked, the agency can ask to have them cleared. If the patient refuses, the agency has the right to determine the place as unsafe and not admit the patient," Jacobs explains.

Just because a patient has been accepted into an agency's home care program is no reason to relax, warns Jacobs. Aides should continue to monitor the situation and patient environment on a visit-by-visit basis.

For example, "When you're changing the sheets look under the mattress. Check to see if there is alcohol beneath the bed," she advises, pointing out some of the other hiding spots for weapons. Granted, Jacobs says, if you find a 9 mm Glock under the pillow, it's a pretty good chance that you may be in danger, but the problem arises even when the threat isn't right under your nose, she adds.

Physical, psychological, and psychosocial factors can all point to a potential for harm, says Jacobs. Aides should pay attention to whether prescriptions are getting filled, and if not, why. Has the patient's power or water been cut off? "Sometimes, the patient doesn't have the money to pay bills or refill prescriptions perhaps because he lost his job," she says.

> *"In nursing, you're taught that if you can't deal with someone, then you're not good. I think the aides put the blame on themselves."*

Nor is a lack of money always the issue. Sometimes a patient's deteriorating mental health can also be the source, especially patients in the latter stages of AIDS and Alzheimer's. Added together, those factors can combine with deadly force, she explains.

At any time, if an aide determines the threat of violence exists, says Jacobs, reporting it is critical.

COMING IN FUTURE MONTHS

- Are your computer systems ready for the year 2000?
- What you need to know about advance directives
- The 1998 Salary Survey results
- Working with the elderly has its risks
- Latex allergies and how to prevent them

Tragically, all too seldom do aides follow through.

The refrain that Jacobs hears the most is "Aides aren't reporting incidents of violent behavior; therefore, no one knows what's going on." The reasons behind this are numerous, she says, but cites self-blame on the part of the aide as one of the leading factors.

Encourage aides to report incidents

"In nursing, you're taught that if you can't deal with someone, then you're not good. I think the aides put the blame on themselves," she says. "Added to that is the possibility that they have reported an incident before and were rebuffed or even written up by the management. Sometimes the administration takes it very lightly when someone comes back and says there's something wrong."

The last reason, and one of the easiest to remedy, is that few agencies have a reporting process in place.

Once managers have been educated on how to be aware of and handle reports of violence, the agency needs to set up very specific procedures for handling threats and workplace violence, she says. To do so, staff from all levels of the agency need to be involved — anyone who may come into contact with the patient in question.

"The legal department or lawyer needs to be involved, and the entire agency team, not just nurses and aides but occupational therapists and social workers, need to know what the plan is," she says.

All agencies should have incident reports on hand that allow space for the aide to "write down verbatim what was said, what happened, and who was there. You need to put it in quotes and include the report in the patient's chart because if the agency is ever sued and an attorney shows up, an agency can say, 'Hey, this is what we did. We provided reasonable accommodation, but they were noncompliant and posed a threat,'" Jacobs explains.

Formal policies are required

Once documented, the agency needs to decide how to continue. "You may decide you have to send an armed escort with the health care workers," she says. "You need to put the patient and family on notice and put in the patient's bill of rights that there must be a safe work environment for the aide, and if it doesn't happen, that the family will be notified and the place deemed unsafe. Spell out exactly what the consequences will be."

Medicare-certified agencies are required by the Americans with Disabilities Act and civil rights laws to provide care to patients without discrimination as long as the patient provides no significant risk to the third party," explains Jacobs.

"That third party is the home health aide. The agency has to provide reasonable accommodation for the patient's treatment and care, but the patients have the responsibility to comply and cooperate. If they don't, the agency can discharge the patient."

Document everything

Without documentation, an agency might have a hard time proving it had discharged a patient over a legitimate concern. Still, says Jacobs, agencies often don't want to report incidents of threats or violence because they don't want to open themselves up to investigation by the regulatory agencies.

What those agencies don't understand, she adds, is that by failing to do so they are hurting only themselves, and maybe their employees, she explains.

"Agencies need to understand that without these formal policies they haven't created a safe harbor for themselves and they can be sued by their employees," she says.

"One incident of workplace violence can put an agency out of business. A critical incident could cost as much as $250,000 in legal fees alone. If it's homicide, double it, and if it goes to trial, then triple that figure.

"You just can't afford to have something happen at your agency. What's more, could you really live with yourself if something did?" Jacobs asks. ■

SOURCES

Judy Jacobs, RN, MA, President, Professional Healthcare Systems, 3911 Rochester Road, Troy, MI 48083. Telephone: (248) 740-7888.
Wayne D. Porter, MS, Senior Vice President, Professional Healthcare Systems, 3911 Rochester Road, Troy, MI 48083. Telephone: (248) 740-7888.

LegalEase

Understanding Laws, Rules, Regulations

If payer is slow, try sending a 'speed letter'

Don't get caught providing services for free

By **Elizabeth Hogue**, JD
Health Care Attorney
Elizabeth Hogue Chartered
Burtonsville, MD

Has your agency ever been retroactively denied payment for services even after the payer had "preauthorized" care for a patient? Of course, this usually happens only after extensive services have been delivered for the home care patient. And you are left holding the unpaid bill while the payer takes its sweet time getting back to you.

Understandably frustrated by such tactics, many hospital-affiliated home health agency directors, nonetheless, find it difficult to remedy such unsavory situations. Is there a solution?

The best strategy for providers is to make sure they confirm in writing every verbal conversation involving payment issues with representatives of payer organizations. Because of the timing of payment decisions, immediate written confirmation is absolutely essential.

A case of 'detrimental reliance'

The best way to accomplish this is to develop a form for this purpose, similar to multi-part "speed letters" that businesses have been using for years. During each telephone conversation with a payer, your staff should fill out the form confirming the agreement reached. This confirmation may read as shown in the sample form. **(See box at right.)**

One copy of the form should be faxed immediately to the payer. Providers should also keep a copy for their files.

The language in the letter regarding reliance by providers on payers' agreements to pay is especially important because it sets up a theory of contract law often referred to as "detrimental reliance." This theory basically says that when one party, such as a payer, agrees to do something such as pay for services and the other party relies on this agreement, the party that made the promise to pay must do so. In other words, when providers rely "to their detriment" on payers' promises, agreements to pay are enforceable even though payers frequently indicate the contrary in so-called disclaimers.

A recent case, *Florence Nightingale Nursing Services v. Blue Cross/Blue Shield of Alabama*, CA 11, Nos. 93-6867, 93-6819 (January 9, 1995), illustrates the usefulness of this strategy for providers. In this case, a nursing agency provided skilled care to a patient who had a diagnosis of AIDS. The patient's insurance, which was administered by Blue Cross and Blue Shield, provided coverage for "medically necessary" nursing care, but not for "custodial care."

Nightingale received verbal assurances from Blue Cross and Blue Shield that services to be rendered to the patient were covered. The agency sent a letter to Blue Cross and Blue Shield to confirm its agreement to pay. Blue Cross and Blue Shield did not respond to the agency's correspondence.

Blue Cross subsequently refused to pay the agency for some services and paid for other services at a rate that was much lower than agreed

Confirmation Form

The purpose of our correspondence is to confirm our telephone conversation of _____ (date), regarding _____ (patient's name) in which you agreed to pay for the following at these rates:

1. _____

2. _____

3. _____

We will rely on your agreement to pay as indicated above when we provide services to this patient.
If we have misunderstood our agreement in any way, please notify us immediately in writing.

Source: Elizabeth Hogue, Burtonsville, MD.

upon. Blue Cross also refused to pay on the basis that some of the care provided was "custodial."

The court rejected those arguments and ordered Blue Cross to pay for the services rendered at the rates claimed by the provider. The court took into account the provider's written confirmation of the payer's agreement to pay. Since no response was received from the payer, the provider was entitled to rely on this agreement when it provided services to the patient.

Staff responsibilities for payment may respond to these suggestions by saying that payers frequently give so-called "disclaimers" that seem to indicate that preauthorization does not necessarily mean they will pay for services. Providers should simply ignore these disclaimers and proceed as described above. Based upon the Nightingale case, it seems likely that courts will discount such disclaimers and insist on payment.

Although time is certainly in short supply for providers, polices and procedures that require written confirmation of verbal agreements with payers will pay off handsomely. Taking the time to follow this practice may make the crucial difference in whether agencies are ultimately paid for services rendered.

Editor's note: To obtain a copy of Managed Care Contracting, *including additional information about how to handle adverse payment decisions, send a check for $25, made payable to Elizabeth E. Hogue, at 15118 Liberty Grove, Burtonsville, MD 20866.* ■

Expand your business by managing others'

These arrangements offset your 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.

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.

Hospital board retains authority

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 frontline 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

Structure agreements that meet requirements

Meeting federal anti-kickback law requirements is an important consideration in designing management agreements.

The Department of Health and Human Services Office of the 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. ■

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 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, at left.)** 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

SOURCES

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.

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. ■

Olsten signs contract with Prudential HealthCare

Olsten Health Services in Melville, NY, North America's largest home health care company and a subsidiary of Olsten Corporation, has signed an exclusive contract with Prudential HealthCare Midwest Plan to provide home care nursing and home infusion therapy to more than 200,000 HMO/POS members in Columbus, OH, and Cincinnati, as well as Indianapolis and Northern Kentucky.

Under this agreement, coordination of patient referrals are being handled through Olsten's Houston Regional Network Center, one of four such centers around the country designed to provide the managed care community with care coordination, access to a national provider network and centralized patient intake, and other administrative services.

Prudential HealthCare, with headquarters in Roseland, NJ, provides managed care benefits to over 200,000 members in Ohio and has nearly five million managed care members in 40 markets across the country.

In September, Olsten Health Services signed a contract with Sierra Military Health Services, a subsidiary of Sierra Health Services to provide home care nursing, home infusion therapy, and home medical equipment services to 600,000 current and retired military members who live in Northern Virginia, Delaware, Pennsylvania, New York, Massachusetts, Connecticut, Vermont, New Hampshire, Maine, West Virginia, and Rhode Island. In August, Olsten signed a national

Hospital Home Healthfi (ISSN# 0884-8521) is published monthly by American Health Consultantsfi, 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**fi, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: custserv@ahcpub.com. World Wide Web: http://www.ahcpub.com. Hours: 8:30-6:00 M-Th, 8:30-4:30 F, EST.

Subscription rates: U.S.A., one year (12 issues), $383. Approximately 18 nursing contact hours annually, $419; Outside U.S.A., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $192 per year; 10 or more additional copies, $115 per year. Call for more details. 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 $34 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultantsfi, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Centers Commission on Accreditation.

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Managing Editor: **Park Morgan**, (404) 262-5460, (park.morgan@medec.com).
General Manager: **Thomas J. Kelly**, (404) 262-5430, (tom.kelly@medec.com).
Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Production Editor: **Ann Duncan**, (404) 262-5463.

Editorial Questions

For questions or comments, call **Park Morgan** at (404) 262-5460.

UNITED STATES POSTAL SERVICE

Statement of Ownership, Management, and Circulation
(Required by 39 U.S.C. 3685)

1. Publication Title	2. Publication No.	3. Filing Date
Hospital Home Health	0 8 8 4 - 8 5 2 1	9/25/98
4. Issue Frequency: Monthly	5. No. of Issues Published Annually: 12	6. Annual Subscription Price: $443.00

7. Complete Mailing Address of Known Office of Publication *(Street, City, County, State, and ZIP+4) (Not Printer)*: 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305 — Contact Name: Willie Redmond

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*: 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305 — Telephone Number: 404/262-5448

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*: Don Johnston, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*: Park Morgan, same as above

Managing Editor *(Name and Complete Mailing Address)*: Park Morgan, same as above

10. Owner *(If owned by a corporation, its name and address must be stated and also immediately thereafter the names and addresses of stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Do Not Leave Blank.)*

Full Name	Complete Mailing Address
American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste. 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check here. ☐ None

Full Name	Complete Mailing Address
Medical Economics, Inc.	Five Paragon Drive
	Montvale, NJ 07645

12. For completion by nonprofit organizations authorized to mail at special rates. The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes: *(Check one)* ☐ Has Not Changed During Preceding 12 Months ☐ Has Changed During Preceding 12 Months *(If changed, publisher must submit explanation of change with this statement)*

PS Form **3526**, July 1995 *(See instructions on Reverse)*

13. Publication Name	14. Issue Date for Circulation Data Below
Hospital Home Health	September 1998

15. Extent and Nature of Circulation	Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*	844	920
b. Paid and/or Requested Circulation (1) Sales Through Dealers and Carriers, Street Vendors, and Counter Sales *(Not Mailed)*	3	3
(2) Paid or Requested Mail Subscriptions *(Include Advertisers' Proof Copies/Exchange Copies)*	635	595
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*	638	598
d. Free Distribution by Mail *(Samples, Complimentary, and Other Free)*	20	20
e. Free Distribution Outside the Mail *(Carriers or Other Means)*	0	0
f. Total Free Distribution *(Sum of 15d and 15e)*	20	20
g. Total Distribution *(Sum of 15c and 15f)*	658	618
h. Copies Not Distributed (1) Office Use, Leftovers, Spoiled	186	322
(2) Return from News Agents	0	0
i. Total *(Sum of 15g, 15h(1), and 15h(2)*	844	920
Percent Paid and/or Requested Circulation *(15c / 15g x 100)*	97	97

16. This Statement of Ownership will be printed in the November issue of this publication. ☐ Check box if not required to publish.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Donald R. Johnston, Publisher — Date: 9/25/98

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5. In item 16, indicate date of the issue in which this Statement of Ownership will be printed.
6. Item 17 must be signed.

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PS Form **3526**, July 1995

contract with First Health Group to provide home nursing, infusion therapy, and medical equipment services for the health benefits company's more than 14 million participants. Both of those fee-for-service contracts also include certain of Olsten's Network Services. ■

CE objectives

After reading this issue of *Hospital Home Health*, CE participants will be able to:

1. Identify key elements in IPS legislation.
2. Identify factors in hiring dependable home health aides.
3. List ways to recognize potential violent situations in a patient's home.
4. Identify safe harbors provided in the federal anti-kickback law ■