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INSIDE

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Mergers, mergers everywhere: Is one in your company's future?

Make it a reality with clear mission, strong communications

Aetna and U.S. Healthcare did it. Chrysler and Mercedes Benz did it. So did Citicorp and Travelers. With global competition, industrial consolidations, and technological advances, mergers make good business sense for many organizations. The home care sector is no exception. Medicare-certified providers are joining forces to stave off interim payment system-induced insolvency.

With good growth prospects, private duty companies are merging to enter new markets, offer new services, access capital, and improve organizational infrastructure. The promise of a being a competitive powerhouse, however, may not outweigh the loss of identity or control or the possibility of a failed union following huge resource expenditures.

"You need to be pretty convinced that one and one make five to merge. If one and one make three, it may not be enough of an incentive, because there are a lot of tradeoffs in a merger," says **Jeffrey Blumengold**, FHFMA, CPA, partner-in-charge of health care services at M.R. Weiser & Co., an accounting and consulting firm in Edison, NJ.

Those contemplating mergers can successfully merge with other organizations by undertaking the following actions, sources advise:

• **Do a strategic assessment.**

Understanding both your current and desired positions within your market is crucial to the success of any merger. "You must have a clear vision of why you're doing it and what your mission is," says Blumengold.

What are you getting out of it?

"The organizations have to know that together they can do more. It affords a greater opportunity to do something and they can get something they want out of it," says **Peggy Gilmour**, RN, MS, president and chief executive officer of Nashua, NH-based Home Health and Hospice Care.

A veteran of two mergers — one a sterling success and the other a

stunning failure — Gilmour had good reasons for entering both. The first, in 1989, involved two visiting nurse associations and a hospice that became Home Health and Hospice Care.

"There were economies of scale, and the health care environment was changing. With more regionalization, our communities were becoming blurred and our original separateness was going away. The hospice did the only fundraising. It seemed to make sense," she says.

"Although it was a difficult and painful process, it was successful. The people who needed to leave left, and we went forward with confidence. It helped us approach the second one without trepidation," she adds.

An unsuccessful merger

In merger No. 2 in 1996, Home Health and Hospice Care joined a local hospital as it entered a large multistate system.

"With the advance of managed care, both real and projected, we assumed there would be a capitated world and that capitated systems would push down to their system [affiliates]," Gilmour explains. At the same time, two local hospitals, including the one Home Health and Hospice Care eventually merged with, were going through a "make or buy" decision process regarding home care services and entered talks with Gilmour.

In the end, "part of it was their approach, which was not, 'We're going to take you over,' but, 'we want to work with you.' It was the vulnerability of being out there on your own and needing a solid referral base, combined with the local environment choosing partners. When at the same time [this] hospital was negotiating with the multihospital system. We could stay on our own, be a hospital department or contract with the hospital, but they were wholly owned, so why not join?" she says.

Despite its promise, this merger proved unsuccessful and dissolved just one year after its formation when the system board voted to disband. Given the option of joining with a part of the dismembered system, Home Health and Hospice Care instead chose independence, as did its local hospital counterpart. "Although we did due diligence, we didn't understand the fragility of unlike entities coming together," Gilmour says.

Even the first merger that created Home Health and Hospice Care took two years to mesh cultures despite common missions and a new CEO with no ties to any of the combining entities, Gilmour notes.

Find common ground

Issues surrounding mission and culture, in fact, often scuttle otherwise promising mergers. "I've seen a fair number of deals fall apart because of cultural clashes," says **Larri Short**, an attorney with Arent, Fox, Kintner, Plotkin, and Kahn, in Washington, DC.

• **Identify threshold issues.**

To minimize the risk of failure, identify the threshold or non-negotiable issues before engaging in any merger talks, Blumengold advises.

"You have to be quite clear and cautious with whomever you deal with. I'm surprised that people give short shrift to things they say are no big deal, and they turn out to be a deal-breaker. They run the gamut from the mission to support for individual programs that may be unprofitable to how the new company will be governed," he says.

• **Work out board and management leadership issues.**

Good communication between board members and management staff, as well as a clear understanding of who is guiding merger discussions are essential, according to Blumengold. "You have to make sure management is listening to the board. The board may have a different vision of what they want to get out of it."

Such an intra-organizational understanding is important because of the difficulty of gaining

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consensus between boards of the merging companies, Short notes. "Mergers are more difficult to orchestrate with community boards. The two boards can agree philosophically on a new service, but a total philosophy may not be completely compatible, especially if both organizations have been in the community a long time."

Home Health and Hospice Care used board task groups to facilitate a better understanding of merger issues from both management and board perspectives, according to Gilmour. "It was partly to get the work done and also to get to know each other," she says.

The composition of the board also influences the overall merger dialogue. "Who your board members are is very important. You can't have board members holding on to the past. You have to know who will let go," Gilmour advises.

"It is extremely important to have good outside independent facilitation. They can put the tough issues on the table, and help participants work through threshold topics."

• **Be willing to let go.**

"Private duty companies are lead by well-intentioned people who now face a whole new set of business circumstances and are forced to look at no longer controlling their companies. Psychologically alone, that's very difficult. It's few and far between, the CEO who can say, 'I'm willing to work for an organization and not just myself,'" Blumengold explains.

Non-owner senior managers also face the harsh reality that what is best for the company and for themselves may be diametrically opposed.

"They need to be strong enough not to be threatened by fairly important issues that can affect their career. The No. 2 issue [in consummating mergers] is that people look at them personally, not with eyes for the business. But they should look at non-personal survivability, and secondarily consider, 'What's in this for me?'" Blumengold adds.

• **Conduct due diligence on your potential partner.**

It is important to verify the credibility of a potential partner before beginning discussions, Blumengold advises. "You need to pick people you'd really like to work with."

• **Maintain confidentiality.**

Keeping discussions under wraps allows participants to fully explore a potential relationship, and present their positions honestly and openly.

• **Use advisors.**

"It is extremely important to have good outside independent facilitation. They can put the tough issues on the table and help participants work through threshold topics," Blumengold notes.

Involving legal counsel early on is also important. While the Department of Justice increased its health care antitrust enforcement efforts in recent years, it is more likely to focus on large organizations.

"The government is not likely to look at two small, private duty agencies merging in the same city. [However], some states are beginning to look more closely at any nonprofit merger, especially nonprofits merging with for-profits, but also with other nonprofits. You need to determine whether the state attorney general has supervisory review over nonprofits," Short says.

• **Keep discussions moving.**

Inertia is the enemy of closed merger talks. Use a timeline to keep parties focused and force discussion about critical issues, Blumengold advises.

• **Consider a strategic alliance.**

If the prospect of ceding organizational control seems too daunting, then consider a strategic alliance with potential partners. "You can court before you get married. Each party can throw in a little money and see how the program works," Short suggests.

Despite best efforts, some mergers never make it across the goal line. Philosophical issues are often the culprit.

"It's either individual egos or key trustees having differing views of what the organizations bring together," says Blumengold. Communication gaps, from either not clearly articulating one's vision or needs or not listening to those of others, also cause failure. "Professionals get involved, and it doesn't look like it started out. They should have input, but they need guidance from management and the board."

Some providers, fearful of losing organizational control or a valued name or program, delay engaging in merger discussions until it is too late. "I've seen an enormous spurt in Chapter 11 and 7 workouts. People wait too long to get together. The single most important thing is to lead, follow,

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or get out of the way. If you see danger ahead and have a need to act, the worst thing is to have paralysis," says Blumengold.

Fears of giving away the best parts of your organizations may be unwarranted at any rate. While economics and size often determine post-merger control, "the surviving entity may be the one with better relations with regulators, or a high profile nonprofit Medicare entity may survive," says Short.

Blumengold agrees. "Not everything is dollars and cents. There is a lot of intrinsic value in the market place in a reputation and good operating history," he notes. ■

Legal issues evolve case management area

Manage risk with thorough assessments

We normally associate case managers with payers, but the function, if not the name, can also apply to the employees of private duty companies. Those who provide services for patients such as assessments, problem identification, planning, monitoring, and evaluating may be considered case managers. In the evolving health delivery system, they may also face legal issues regarding their case management activities, according to **Elizabeth Hogue**, an attorney specializing in health care in Burtonsville, MD.

"Medicare Conditions of Participation [require] that home care agencies . . . manage the care of their patients, and non-certified agencies routinely enter contracts with managed care organizations that include case management services. But case management is an emerging discipline, and it's time that all home care providers who are performing case management prepare for legal issues," Hogue explains.

No shingle needed

The Case Management Society of America (CMSA) defines case management as a "collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communications and available resources to promote quality, cost effective outcomes."[1]

In 1995, CMSA also published *The Standards of Practice for Case Management* as a guideline for practice excellence and recognition of the changing concept of case management.

With such broad definitions, employees don't have to hang a shingle to be looked upon as a case manager. "Whether or not they're certified by the CMSA . . . or they call themselves a case manager, if they're the traffic cop and coordinate care with physicians or decide when a patient needs acute care, etc., they may be considered a case manager. They may not be the only one [involved with a patient]; there may also be the insurance company case manager. Still, this places an enormous burden of case management and sets very high, broad standards," Hogue says.

"I applaud the CMSA for publishing the standards early on, but we should look at them with an understanding that they'll be refined and redefined several times. We should also recognize that these are not pie in the sky. Attorneys go into court with these," she continues.

Other groups, including the National Association for Social Workers and the National Association for Professional Geriatric Care Managers, have also published standards.

Some of the potential legal and ethical issues that home care case managers face include:

- With such broadly defined standards, can case managers be held liable for nearly any patient care problem?
- If the treatment team, including the patient and case manager, cannot reach agreement, whose wishes will govern, especially when the case manager's recommendations are contrary to the payer's?
- Do continuous monitoring and evaluation requirements mean that case managers are responsible for the quality of care of all providers serving patients in their caseload?

• When patients do not achieve expected outcomes, have case managers violated care standards?

These issues mostly impact case management responsibilities for assessing patient needs, obtaining consent for case management services, and advocating for patient care, according to Hogue. Although they are currently being debated and considered, providers and case managers can manage their risk now in the following areas:

• **Assessing patient needs.**

Case managers are at risk for overlooking or misevaluating patient problems and needs. "It's especially hard to do a comprehensive assessment because you don't have access to crucial records and you're dependent on patients and families. But if you're not there 24 hours a day, how do you really assess every time?" Hogue asks.

Make every effort to obtain as much information as possible from patients, family members, and other providers so you will have all you need to fully assess patient needs, Hogue advises.

This may seem obvious, but "I can't tell you the number of times I get calls, and when I start asking questions, we find all kinds of information that should have been available but isn't," she says. For example, providers often fail to gather proper information about patients' mental status.

• **Obtaining consent for case management services.**

Home care providers obtain informed consent from patients every time they open a case. Case management standards suggest patients must also consent to case management services. Providers can simply amend their consent for treatment forms to include case management services. However, Hogue wonders how this will impact the few patients who won't consent to case management.

"Some patients may say, 'I don't want this. I'm tired of this harassment, all these people calling me and coming to my house.' If they don't consent, then have they forfeited access to other services? Because the managed care company may say, 'If you can't case manage, then why should we provide services? The way that we provide appropriate services is through case management.' I'm not quite sure what it means," she says.

• **Advocating for patient needs.**

The CMSA practice standards also include guidelines for patient advocacy. Case managers are to represent their client's best interest in such areas as appropriate funding, treatment alternatives, the timeliness and coordination of health services, and frequent re-evaluation of progress and goals. In today's complicated operating environment, however, home care case managers can be placed between the best interest of their patients and employer, according to Hogue. For example, if a provider has a capitated contract, decisions that benefit a patient may harm the agency financially.

"Many case managers feel that it's noteworthy that they don't carry any decision-making role, and that because they're not making decisions, they don't have to worry about liability. But payers and providers force decisions," she says.

The best course of action in such situations depends on the circumstances. "They may need to consult with legal counsel or take the dilemma before the agency's ethics committee," Hogue advises.

Although the concept of case management is evolving, patients will increasingly use professional association practice standards to bolster both liability claims and complaints against professionals' licenses, Hogue warns. The best protection for both providers and case managers is to be knowledgeable of and responsive to the standards, she advises.

"Regardless of the future of managed care, the future includes case management. Some analysts are beginning to develop a model of community-based health care that puts home care at the center of the delivery system, so it's appropriate for home care case managers to wonder about their roles and responsibilities from both functional and legal points of view."

SOURCE

• **Elizabeth Hogue**, attorney, 15118 Liberty Grove Drive, Burtonsville, MD 20866. Telephone: (301) 421-0143.

Reference

1. Center for Case Management Accountability. *A Framework for Case Management Accountability*. Little Rock, AR; 1997.

[Editor's note: Copies of The Standards of Practice for Case Management *are available from the Case Management Society of America (CMSA) at (501) 225-2229. The document costs $10 for CMSA members; $12 for non-members.]* ■

Loving live-in services: A provider's success story

It's easy once you have the staffing

Clients reportedly love live-in caregiver services, but they can be the bane of private duty companies' existence. Finding and keeping caregivers willing to live in a client's home for several days or even weeks at a time can drain resources and frustrate customers and staff alike. After many years of operation, however, one provider finds live-in services an important and successful product line.

"Once you get the staffing in place, it's actually the easiest to do," says **Ann Short**, RN, director of extended care for Preferred Health Care, a private duty company in St. Louis.

Good help is hard to find

The company's live-in workers, all employees, are mostly home health aides, including certified nursing assistants (CNAs) and companions. They perform personal care, light housekeeping, and errands for up to 16 hours a day and sleep in the client's home the remaining eight.

Finding them is the difficult part, Short says. Although the company advertises, it recruits most live-ins through word-of-mouth referrals from other caregivers and clients. Preferred's caregivers are predominantly middle-aged women with grown children and no day-to-day family commitments.

"We've had a little more success with those who live in rural areas. They're OK to come in the city if they're there for several days and don't have to worry about driving in and out. Some of our existing caregivers also tried it and found they liked it," she says.

Preferred's companions are exempt from Federal Fair Labor Standards wage-and-hour restrictions. The typical caregiver earns about $76 per day and receives overtime only on holidays. The rates are based on minimum wage for 12 hours. "If you don't use companions and have to pay overtime, you can't afford the service," Short explains. **(See related story on companion services, p. 19.)**

Clients, though still independent, need assistance with activities of daily living and no longer feel safe staying at home without support. They usually live alone, although some also have a spouse, Short says.

The company charges a $150 daily rate, prorated in 2-hour increments beginning at 9 a.m. Most clients directly pay for their care, although some have long term care insurance that usually reimburses up to $50 per day, according to Short.

Nighttime is different

Clients usually refer themselves to the service. Preferred runs a Yellow Pages ad under nursing services, and other business comes through word-of-mouth referrals. Some referrals also come from hospitals.

"We're known as a live-in provider. There's not that many, so we do get calls from hospitals. We can't compete with a lot of hospital-based services, but this is one where we can," Short explains.

The company's intake staff is trained to work with potential clients when they call about the service. "There's usually a little exploration during intake. People know they need 24-hour care, but may not be aware of the options available," Short says. Staff emphasize the service's advantages over shift care, including its cost effectiveness and more consistent and fewer caregivers. They also discuss the downside: Clients are responsible for themselves at night.

In addition to an initial exploration over the telephone, Preferred offers a free assessment, conducted by a supervising RN or LPN, to all potential clients. "They have to be OK at night. For example, they must get to the bathroom or commode by themselves at night. If they need help once in a while, we can do it, and if a client fell we would respond. But if they go the bathroom every two hours at night and need help to do it, they probably need some other service," Short explains.

Experience is needed

Other considerations include whether the client requires an extreme amount of care every day, and the amount of physical work involved, for example, with obese clients. The service does work with Alzheimer's disease patients as long as they do not wander at night.

Live-in employees must have prior caregiving experience, in either formal or informal care settings. Preferred also requires two previous work references, conducts criminal background checks, verifies driver's license and car insurance, and certification of CNA caregivers. The company's

Making companion services exempt

In-home companion services may be exempt from minimum wage and overtime pay laws, depending on whether a provider meets Federal Fair Labor Standard Act (FLSA) conditions, and the state in which the organization operates, according to **John Gilliland**, an attorney practicing in Crestview Hills, KY.

To be considered exempt under the FLSA, companion services must meet five conditions:

1. The services must be companionship personal care for clients who, through age or infirmity, cannot care for themselves.
2. Not more than 20% of the caregiver's total work week hours can involve general household work.
3. The duties performed may not require RN- or LPN-level training.
4. The services must be provided in a patient's home.
5. The patient or the patient's family must jointly employ the caregiver, along with the personal care company.

Usually, providers can meet the joint employment condition by allowing clients to participate in setting the caregiver's schedule and selecting caregivers. However, many organizations have difficulty substantiating that the caregiver devotes no more than 20% of her time to household work. Providers also trip up by caring for clients who enter assisted living centers, hospitals, or nursing homes, according to Gilliland. Even if an organization meets FLSA standards, its companion services may not be exempt under state law, he cautions. ■

office-based orientation covers policies, procedures, reviews transfer techniques, infection control, and observation skills. Caregivers also receive an in-home orientation conducted by the field supervisor.

Caregivers spending so much time in clients homes may raise the specter of theft or out-of-bounds relationships, but Short reports that Preferred has not experienced such problems. The company bonds caregivers, but it also counsels clients to secure valuables. And it prohibits caregivers from handling any financial transactions without prior approval. Supervisors conduct patient evaluations every 60 days and the staffing coordinator is in constant phone contact just to check that everything is OK, Short explains.

Outline responsibilities

In most homes, Preferred also limits each caregiver's schedule. This not only helps them maintain therapeutic relationships with clients, but also helps with overall case coverage, according to Short. "We try to have at least two caregivers per client. Most work four or five days with two or three off, although some work three weeks on, one week off. We prefer this to avoid problems of becoming too involved, [caregiver] burnout, and resentment that they can't see their own family," she explains.

Short also clearly outlines caregivers' responsibilities upon hire and when assigning them to a case. This is especially important in keeping open communications about any changes in work load or problems in the home.

"We tell them, 'If you're tired during the day and not getting sleep, you need to let us know,'" she explains.

Preferred does not guarantee coverage, but "we always find a way to staff cases, even if we have to eat the cost of hourly care in the meantime," she says. Companies offering live-in services can run into problems by taking on too many cases without sufficient staffing. "You can't just call and get another caregiver everyday. You can't contract with other agencies like other home care services," Short says.

Although operating a live-in service can be challenging, "patients love it because it allows them to continue living at home and it's a great cost effective way to provide care," says Short. ■

SOURCES

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Riding the consumer directed care wave

Agencies' model may work for you

Consumer-directed care is riding a wave of popularity that shows no sign of declining. At least 30 states have introduced some form of consumer choice for disabled and elderly citizens whose care is reimbursed through state funds. **(See *Private Duty Homecare*, January 1999, p. 1.)** As more states enact these initiatives, private duty providers are exploring ways to make their services more attractive to clients who might otherwise directly employ caregivers. Two agencies in Illinois have joined forces to do just that.

Under an Independent Choices Project grant from the Robert Wood Johnson Foundation, the Forest Park-based Progress Center for Independent Living, and Salem House, a Lutheran Social Service program in Chicago, are collaborating to introduce consumer choice to clients receiving services through the Illinois Department of Aging Community Care Program (CCP).

Strength in collaboration

The Progress Center for Independent Living is a non-residential self-help and advocacy organization established in 1988 by and for people with disabilities. Salem House is a Medicare-certified home health agency that provides personal care services to elderly clients who qualify for the CCP. The CCP actually does not have a formal consumer-directed component, so the two organizations are including elements of choice used in the state's waiver program for disabled adults.

Although advocates for the disabled and elderly have clashed elsewhere on the consumer-directed care front, the directors of the Progress Center and Salem House see strength in collaboration.

"Most elderly see themselves as old, not disabled. With our attitude and their numbers, we can be formidable in influencing the industry," says **Diane Coleman**, JD, Progress Center executive director.

Coleman hopes to duplicate the Progress Center-Salem House collaboration in adjacent counties and ultimately make it a national model. The agencies' collaboration involves several elements:

- additional training for Salem House employees on client choice and rights, ethics, and the use of assistive technology;
- in-home training of clients on interviewing and selecting caregivers, establishing schedules, and directing care tasks;
- development of a training video featuring both disabled adults and Salem House clients demonstrating ways to participate in their care;
- establishment of a Project Advisory Committee, composed of staff and clients of both organizations;
- a program evaluation conducted by the University of Illinois Institute on Disability and Human Development.

Find client preferences

The collaboration started with training for Salem House administrative staff and members of the Project Advisory Committee, immediately followed by Salem House caregivers. In the caregiver training sessions, Progress Center staff, who are themselves disabled, covered such topics as independent living, disability awareness, myths and stereotypes about the elderly, and assistive technologies that staff personally use. The sessions added about five hours to caregiver orientation time.

The first half of caregiver training focuses on incorporating clients in their own care regimen. Caregivers learn to jointly establish care plans, including the times and days of service (most clients are eligible for 20 hours of care each week). They also work with clients to facilitate transfers and other personal assistance according to clients' preferences.

"The correct way is not always the best way. The client may have done it 20 years [a certain way] and know how to do it safely. We encourage staff to help them as long as they stay within safety guidelines," Cobb says.

Although staff know clients have also received training, they learn techniques to promote more consumer direction. "Some clients think the home health worker comes in and just starts working. And if you've lived 77 years without help and you now have to ask, you don't want to. Aides are instructed to help clients direct them by asking such things as how they want their bed made and how they want their laundry folded," Cobb explains.

The second half of caregiver training addresses assistive technologies. Most think of common assistive devices as wheelchairs, walkers, and bath chairs, but they either aren't aware of or

SOURCES

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don't know how other technologies can help their clients, according to Coleman. For example, most people associate text telephones (TTY) for use by the deaf, but the technology also benefits those who are speech-impaired.

Trainers make a visit

Progress Center staff also work with Salem House clients. A Progress Center trainer visits newly referred clients before Salem House opens the case. The trainer first reviews materials already presented by the state CCP case manager such as the client's determination of need and disclosure of waivers documents. The trainer also communicates clients' rights and responsibilities, and gives examples of how clients can direct their care. The trainer then talks with the client about his or her care needs and preferences, and shows a video that portrays how a client collaborated with a caregiver to get the services she wanted.

The stars of the video are the disabled and elderly clients of both the Progress Center and Salem House. Seeing actual clients not only emboldens the elderly to ask for what they want, but also gives them a new perspective about their own condition, Coleman says.

"It can change an elder's attitude if they see a younger person with more significant disabilities. When people are losing functional abilities they often don't think of tools, but seeing disabled trainers gives reality to assistive devices, and they think, 'So what if I'm doing it differently?'" she explains.

Ideally, the collaboration will also enable clients to interview up to three caregivers and choose the one they most want to care for them. Interviewing and selection techniques are part of client training. However, Salem House, like many other private duty providers, does not have enough personal care workers to facilitate such freedom of choice.

Researchers from the University of Illinois Institute on Disability and Human Development conducted pre- and post-training surveys and are still tabulating the results. However, caregivers report they like it, Cobb says.

"It makes them feel like specialists in a way. They like the plan of care development and joint planning. Some are not as comfortable working on their own and like a little more structure," she explains.

"I think the premise is great. It's a good idea, but we need more homemakers. In the long run, it will be better for us, because if clients and caregivers have agreement and work as a unit, it will be better. Everyone will know up front what's expected."

With such positive initial results, the two hope to spread the model to other communities. "Our goal is that both other assisted living programs and home care providers will [adopt the model]. It is a marketing and competitive advantage to home health agencies," says Coleman. ■

Don't catch the Millennium Bug

Act now to minimize problems

"The sky is falling! The sky is falling!" It's not Chicken Little, but technology experts warn companies that do not address year 2000 (Y2K) computer problems now may face equipment malfunctions, lost records, cash flow crises, and worse come Jan. 1, 2000. The millennium may be 11 months away, but correcting the coding omissions that the so-called Millennium Bug cause may make the days go by lightning-fast, according to some prognosticators.

Y2K problems result from a quick fix first used years ago when computer memory storage was more expensive and less efficient. To save valuable processing space, programmers used two-digit instead of four-digit date codes, making 1999 into 99 for example. With no instructions to recognize a 00 date, computers may miscalculate or even crash after midnight on Jan. 1, 2000.

The bug affects any program that relies on date differences, such as age or time period calculations. Financial packages are particularly vulnerable, but any system is at risk. The problem also involves software that tells computers how to perform their processing.

With technology so pervasive, Y2K may impact every aspect of private duty operations, from patient financial records and ventilators, to office security, payroll and scheduling systems.

Fortunately, most systems can be fixed, but doing so may require lots of investigative legwork and time of already harried programmers and technicians. You can outwit the Millennium Bug, though, by taking the following actions:

• **Do it now.**

"Don't wait until the middle of the year. Make it a New Year's resolution! The people solving the problem already have a backlog, and it may take some time to find some manufacturers," advises **Jeff Bonham**, MBA, vice president of Medicare Training and Consulting, a consulting firm in Herron, IL.

• **Develop an action plan.**

If no one in your organization is formally responsible for information systems, then assign responsibility for developing a companywide action plan to the person with the most computer-related credentials, Bonham recommends.

"You need to look at every single process and every company that you're doing business with."

The plan should include a system-by-system inventory that identifies vendors and manufacturers, lists steps to correct the problem, and outlines contingency actions in the event of a malfunction.

The level of effort involved in such an undertaking depends on the number of systems your company operates, whether they are networked or standalone, as well as the number of external relationships you have, ranging from banking to equipment suppliers, according to Bonham.

If the task is too time-consuming or overwhelming, then consider using an outside company. Choose a firm that is qualified and insured to do Y2K remediation, Bonham recommends. This may offer you an extra level of liability protection in the event of any system failures. **(Some experts predict a spate of Y2K-related litigation. See *Private Duty Homecare,* December 1998, p. 166.)** Vendors that support your accounting or clinical packages may offer Y2K remediation services for your entire operation, not just their own software.

Providers that choose to develop an action plan internally can download programs that will identify Y2K glitches. **(See Internet resources, above.)**

• **Assess risk.**

Once you've identified the depth of your Y2K problem, you should assess risk and prioritize remediation efforts, Bonham advises. For example, the crash of a payer's system affecting your cash flow would be critical, whereas having the right date on the VCR you use for staff training would be a lower priority.

• **Remediate.**

Correcting Y2K problems can be free and simple, or expensive and complex. Beginning with the high priority items, develop a plan to fix the glitch and do without it in the event of a malfunction, Bonham recommends. Most home care companies are cash-poor to begin with, so forgoing payments from third-party payers would wreak havoc. Write a letter to all of the payers you have contracts with asking where their own remediation efforts stand.

"You can't do anything about a payer source, but you can plan for a short fall," he says.

Medicare-certified providers that have at least 25,000 annual visits should consider the agency's periodic interim payment (PIP) program. It was

Where to find Y2K help

The Internet is full of Y2K information. Some Web sites worth visiting include:

• **http://www.zdnet.com/pcmag/special/y2k/features/websites**
At *PC Magazine's* Y2K Resource Center, you can download free utilities to test your computer's Y2K compliance. The site also offers articles on how to assess risk and fix Y2K problems.

• **http://microsoft.com/technet/topics/year2k/default.htm**
Microsoft's Web site features Y2K advice for both companies and individuals. Includes information about potential hardware, operating systems, applications, and data interface problems.

• **http://www.everything2000.com**
This site also features both business system and personal computer Y2K issues.

• **http://www.year2000.com**
This site provides links to compliance data from major hardware and software companies. It also has articles about the legal, accounting and insurance aspect of Y2K, and it provides regular updates to its e-mail subscribers.

• **http://www.y2k.com**
This site features links to other sites, has information on Y2K seminars, and special areas that deal with Y2K problems of small business owners. ■

SOURCE

- **Jeff Bonham**, vice president, Medicare Training and Consulting, 4 Dogwood Lane, Herron, IL 62948. Telephone: (618) 988-8180.

to be phased out in 1999, but the Health Care Financing Administration delayed that action, Bonham says.

Be prepared

Read the fine print on contracts and seek representation from equipment vendors and manufacturers that their product is Y2K compliant. Vendors should facilitate remediation efforts on newer systems, but you may have to go directly to manufacturers for older products, Bonham advises.

Some systems may truncate patient records at the strike of midnight on Jan. 1, 2000. Prepare for this catastrophic event today by maintaining a manual patient list that includes key information, Bonham suggests.

And don't forget system interfaces. For example, those home-grown private duty scheduling and payroll databases may work fine on their own, but depending on how they interface with purchased accounting packages, they may still have problems, Bonham advises.

Despite the predicted dire consequences and tedious remediation involved, the Y2K problem is manageable. "Just being aware is half the battle, but you have to take actions," he says. ■

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NEWS BRIEFS

New consumer Web site announced

JD Power and Associates and Better Health recently announced a business alliance creating a health-related consumer web site. The

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site, *www.betterhealth.com/jdpower*, will offer consumers important information based on the results of a series of consumer surveys to be conducted on-line.

The surveys will cover such topics as consumer attitudes about managed care, patient rights, and concerns of frustrated health care consumers. The site will also provide consumers with quality rankings of health plans in 20 major metropolitan areas, identified by the MEDSTAT Quality Catalyst Program, a series of annual studies of health plan enrollees, administrators, and physicians. Additionally, using chat rooms, the site will enable consumers to discuss their experiences with other consumers and health care industry professionals.

JD Power and Associates is a global marketing information services firm specializing in market research, forecasting and customer satisfaction studies. Better Health is a major health care information Web site.

"Both of our organizations have the highest commitment to empowering consumers to be better decision makers," says **Robert Levitan**, president and co-founder of Better Health and Village. ▼

Association report shows impact of caregiving

The National Family Caregivers Association (NFCA) and Fortis Long Term Care recently issued a report indicating that those who provide intense care for family members are themselves at risk for health and emotional problems. "Caregiving Across the Lifecycle" summarizes a survey of NFCA's 2,300 nationwide members.

With a response rate of about 35%, the survey shows:

- Sixty-one percent of caregivers have experienced depression since becoming a caregiver.
- Almost 45% of caregivers feel a sense of isolation, yet 70% reported an increased inner strength as a result of their care role.
- Caregivers experience a number of health problems, including sleeplessness (51%), back pain (41%), stomach disorders (24%), and headaches (15%).

The report also includes information about the characteristics of caregiver-respondents and the family members they serve, the impact and consequences of intense caregiving (defined as more than 21 hours of care per week), and implications of caregiving on the relationship between caregivers and care recipients.

Based in Kensington, MD, NFCA is a not-for-profit organization dedicated to improving the lives of America's family caregivers. Fortis Long Term Care, in Milwaukee, is one of the largest long term care insurance companies in the United States. Copies of the report are available through NFCA at (800) 896-3650. ■

CE Objectives:

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

1. Identify impediments to successful mergers.
2. Name circumstances under which employees face case management legal issues.
3. List the challenges of operating a live-in service. ■