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The definition of 'homebound' keeps evolving with new clarifications

HCFA weighs in

Some six months after a government-set deadline, the Health Care Financing Administration (HCFA) has given Congress a report concerning the definition of homebound eligibility for recipients of Medicare-funded home health care.

The report recommended that current policy remain unchanged but went on to suggest that some clarification was needed to improve the term's uniform application.

Initially, HCFA suggested the definition be changed to accommodate a bright-line test (using standards for the number and duration of absences), whereby someone would be considered homebound if the patient's total absences from home were fewer than 16 hours a month with no more than five absences of three hours each per month — something that the home care industry and organizations representing Medicare beneficiaries opposed.

In its analysis, HCFA examined the possibility of applying a standard based on a person's functional capacity and measured by the person's ability to carry out the activities of daily living. HCFA pointed out that individuals with vision and hearing problems, for example, who are homebound but are able to carry out daily living activities would not be eligible. Lastly, and perhaps most importantly, HCFA recommended against expanding the definition because of the additional costs it would incur.

As for the bright-line test, HCFA ruled that its disadvantages far outweighed any benefits.

Instead HCFA decided that retaining the current definition with some elucidation would improve the determination process while avoiding the further complications that a new definition would bring. As for the bright-line test, HCFA ruled that its disadvantages far outweighed any benefits and pointed out that a person could simply modify the frequency and duration of absences in order to comply with the new definition.

It's expected that the chances of Congress formulating legislation to change the homebound definition are slim, in part because of the additional costs predicted by HCFA and because of the risk of excluding those currently eligible from coverage should the definition change. ■

Are you taking full advantage of the Internet?

Getting the most from your Web page

With the growing popularity of the Internet, more home health agencies are going on-line. There are myriad uses for the Web, and whether you use it as a means of simplifying the transmission of data between your multi-branch agency or providing a health care resource for the community, today's Web pages have become part marketing tool and part public service. To make the most of your Web page, it's important not only to understand how you want it to work for your agency, but how it will serve the public.

"The Web is not a replacement for sound judgment or human intervention," explains **Tom Burke**, director of communications for net.Genesis of Cambridge, MA. "It's a way of streamlining your business processes and making them more efficient."

Why the Web? Why not?

Larry Leahy, MHA, CHCE, is the director of programming integrity for Beaumont Home Health Service in Victoria, TX. He says that like so many other organizations his agency started using its Web site as a means of getting its basic agency information package out to the public.

"We got a lot of hits," he says about the initial site. "We actually had a nurse in Russia who accessed our site and wanted more information. It's nice, sure, but you aren't getting any referrals from it so we started asking how we could make our site more beneficial."

Now, three years after its incipience, Beaumont Home Health wants to take its Web page a step further.

"We're looking at how we can make it an information source for our own staff and patients as well as for outside referral sources, physicians, and hospitals," he says. Beaumont Home Health is considering using its Web site as an interactive site where people could write in their questions and a staff member (in this case, the director of administration who is currently working on her nurse practitioner certification) would provide answers.

"We want to be more than just a promotional site," explains Leahy. "We're also interested in making it an easier way for referral sources to send patients to us whereby they could fill out the documentation on-line. Another issue we're examining is using our Web page as a means of anonymously reporting compliance-related issues."

In either case, security is an important issue. For people to use a Web page for handling sensitive material, they have to trust that it is a secure mechanism for reporting. For this reason, Leahy has contracted with an outside vendor to develop a secure site.

> *"It's a new territory for people, and there really are no rules of the road on the information superhighway."*

The ability to use the Internet as more than a reference tool is part of what makes it so powerful, Burke explains, "but it becomes an issue when you start talking about the traditional thoughts and practices concerning liability and regulations. So far, it's a highly unregulated medium. It's a new territory for people, and there really are no rules of the road on the information superhighway."

When it comes to using a Web site beyond its more traditional function, Burke points to a start-up company that is looking to make some interesting changes in the recovery-care arena. Their thought, he says, is that if used properly, they can harness the untapped resources of the Internet to their advantage. "Namely, if they can use it [the Internet] to demonstrate a reduced-cost advantage, then they will become very attractive to third-party payment systems," he explains.

"And, because of the importance of continuity of care, if they can maintain patients' histories so that patients know that as they move from provider to provider their health information travels with them, then the health care provider knows it will be providing global coverage," he notes.

The Internet as an employee

Good help is hard to find. Your Web page can't replace the skills of a talented home care nurse or aide, but it can provide you with the opportunity to reallocate your resources allowing your staff to get up from behind the desk and go into the field and do what they are trained for.

"It's almost impossible for the health care provider to be an expert in everything," Burke notes, "so by providing links to other health care sites, you can free up your staff." Burke cautions, however, that while the Internet is still a relatively free-form information vehicle, it has become an unwritten rule that any company whose link you might consider providing be notified of your intentions.

Although increasingly the Web is being used to challenge the traditional boundaries of how health care information is dispensed, the use of the Internet to replace everyday office tasks is still quite commonplace, says Burke.

"Rather than it being a one-way reliance on the provider for information it [the Internet] becomes a point of information exchange. If someone, for example, is in recovery or, generally speaking, homebound, it gives them the ability at 3 a.m. to consult a Web-based resource. It takes a lot of burden off having a person at the end of an 800-number 24 hours a day, seven days a week," he explains.

In a similar vein, Burke notes that the Web also can be used for "logistical things such as, 'The handle on my crutch broke. Where can I get a replacement at a place that's open 24 hours?'"

A paperless future

People are also using it for help that approaches pre-diagnostic tasks that might otherwise be performed by a person, he continues. "With it you have the ability to go on-line and conduct a physical exam by answering questions to the point where you could get a prescription."

Leahy foresees that at some point in the future, his agency's Web site will be as much a part of agency operations as it is a patient-care service. "One day," he says, "we want to take all our policies and procedures and just be able to alert our branch offices that policy XX has been updated and they can go on-line and download it. Now [policies] are all on the computer, but whenever we update them, we have to make 13 copies and send them out. We're heading to a more paperless structure."

And at some point in the future, he hopes to use the Internet to perform other internal functions, such as providing employees access to their 401(k) plans.

For all its possibilities, you still may not be using your Web page to its fullest potential, Burke explains, unless you have a means of tracking how many people are accessing it and the ways in which they are using it. Web tracking programs **(see *Hospital Home Health*, June 1999, p. 68)** not only allow you to see how many people use your site in a given time period, but exactly where they are going.

Less sophisticated programs will only tell you from what page a person exited your site, but should that page have a host of health care-related links, you would have no way of knowing whether people were moving on to the Red Cross's site or one providing tips for a heart-healthy diet.

By using a technique called redirect, explains Burke, you are "putting an invisible page between your Web page and the link so that when you go back to do an analysis, you can see that of the 100 people who visited your page, 60 of them went to the Red Cross site."

With this information, agencies can "make better-informed decisions about what will go into their sites," he continues. "If you have a lot of people leaving your site in favor of the Red Cross, then you might consider providing more of that kind of information so they will stay on your site.

"You want them to stay on your site longer and to rely on your site as a primary source of information. It's referred to as 'stickiness' and means how often people return to your page and how long they stay." he explains. The assumption, states Burke, is that the longer a person stays, the more helpful your information is.

But unless the visitor is a potential source of referral, why would you care how long a person visits your Web page? "Well, if you can keep people on your site, and they keep returning because the information you provide is valuable to them, they will start to identify you vs. a competitor because you are providing them with better value." ■

SOURCES

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LegalEase

Understanding Laws, Rules, Regulations

Employment issues: Home care vs. hospital

Different situations require different policies

By **John C. Gilliland II**
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Dealing with employment and other human resource issues constitutes a significant portion of any company's operations. Certainly, home care is no different. One only has to look at the percentage of a home health agency's budget that is devoted to wages and benefits to see how important employment-related issues are to the agency's operation.

But when you take the time to consider that some of the very qualities that make the home care profession so appealing to some can become a headache for the home care human resource professional, you might think the industry has more than its share of employment-related issues and the headaches that follow.

Hospital connections won't make it easier

Whether it concerns minimum wage, overtime pay, unlawful discrimination, negligent hiring, or wrongful discharge, failure to comply with legal requirements can lead to significant liability for back wages, damages, and possibly the employee's attorney fees.

It's tempting to imagine that the backing of a hospital's human resource department would make dealing with employment-related issues easier for a hospital-based or affiliated agency. Unfortunately, that's rarely the case.

For many such agencies, the problem is quite often the hospital itself: The agency is expected to operate according to hospital policies and procedures that typically have little relevance to the reality of how a home health agency functions.

Hospital policies that inaccurately reflect the working environment of home care employees and the subsequent differences between hospital and home care employment create a vicious cycle of problems for the home health agency. First, recruiting new employees is significantly more difficult when it becomes clear that the hospital lacks a true understanding of how its own home care agency functions.

Without adequate and properly trained staff, Medicare and Medicaid reimbursement may be compromised as a result of poor or incomplete documentation, putting the agency at risk of failure to comply with legal requirements. The end result? An agency's ability to succeed may be jeopardized.

Most commonly, the misconceptions are created when hospital management is either unaware or refuses to recognize the striking differences between employment in a hospital and in a home health agency. Such differences include:

1. **The types of employees.**

By their very nature, home health agencies use a variety of employees, the types of which are simply nonexistent within an inpatient hospital setting, such as home health aides, sitters, and companions. But more than just the type of employee, it's the ways in which they are scheduled that differ so sharply with that of hospital staff. It's not surprising then that employment policies devised to work in a hospital setting will not be 100% applicable to a home health agency.

2. **Compensation arrangements.**

In home care, staff compensation arrangements can be quite different from what prevails in a hospital. In a hospital, there are both salaried and hourly employees, whereas a home care agency additionally will compensate a percentage of its employees in a variety of nonstandard ways — per-visit pay, per-diem pay, salary plus bonus arrangements, daily instant pay, and bonuses for timely and complete documentation.

Rarely do hospital policies allow for the types of compensation arrangements a home care agency must be able to offer its employees, making the agency less attractive to employees and seriously jeopardizing its ability to attract and retain employees.

Even when home care compensation models are permitted by the hospital, its payroll department may not know how to properly calculate hours worked and overtime pay under those pay arrangements. Moreover, application of the wage

and hour laws to home care can involve issues that simply never arise for hospital employees.

3. Employee benefits.

Most hospitals provide a comprehensive array of employee benefits. In contrast, due to today's reimbursement environment, home health agencies have or are becoming quite lean in the benefits department. In more traditional work sectors that is seen as a large drawback. However this tends to work well for the home care employee who is, more often than not, more cash-oriented than benefits-oriented.

No hospital would think of taking the employment policies and practices of a home health agency and imposing them on the inpatient hospital environment: It wouldn't work.

If a hospital-based home health agency is required to provide the same employee benefits as the hospital, rather than adapting to what is relevant to the home care operation, the additional costs of doing so may make it virtually impossible for the agency to remain competitive and profitable.

4. Autonomous employees.

Typically, a hospital employee works directly for a supervisor. In contrast, a home care employee functions autonomously in the field with little or no direct supervision. To address these differences in work environments, the hospital must adapt its employment policies to match the needs of the home care agency. Among the topics to be considered are scheduling, timekeeping, documentation, travel time, meal periods, and telephone use — to name only a few.

5. Employee-dependent reimbursement.

Unlike a hospital, a home health agency is reimbursed for services based upon the adequacy of documentation produced by an employee working in the field with little to no supervision.

Thus, if the employee fails to correctly document the work, not only may reimbursement be denied, but the agency might become subject to various government investigations into fraudulent activity.

6. Differences in working time.

In the hospital setting, it's usually quite clear what constitutes an employee's workday and how much time the employee has worked. In home care, though, there is no such thing as a "standard" workday, a situation that would be considered highly atypical in the hospital setting. For example, in home care, issues arise with regard to travel time, sleeping time, and work at home, which do not arise in a hospital. Even on-call time, which may exist in both a hospital and a home health agency, typically has different legal issues in a hospital than in home care, for example, exactly when the time counts as working time, how time spent on the phone is to be treated, travel time, and how to calculate overtime pay in light of on-call payments.

7. Differing applications of laws.

Even when the same law applies to both the hospital and the home health agency, it can differ significantly in its application and thus its ramifications for hospital and home care employees. For example, various occupational safety and health requirements require different responses, such as universal precautions, infectious waste, and respiratory protection.

8. Off-site employees.

In a hospital, most of the employee's working time is spent on the hospital premises. But in home care, most of a field staff employee's time is spent at patients' homes and not the office.

Copies of policies and resources, which are available only at the office, are not particularly helpful to a home care employee who needs to have reference materials — including personnel policies — readily available for use and consultation in the field.

9. Competition by former employees.

It's very easy for a home care employee to go to work for another agency only to have patients follow. From the patient's perspective, the nurse or home health aide is the home health agency, so whatever company employs the aide is of little consequence. In contrast, although hospital patients can be just as attached to hospital employees, it would be very unusual for a patient to follow that nurse to another hospital.

10. Criminal history checks.

Background checks — especially into criminal

activity — are becoming quite common in home care and are required by law in an increasing number of states. Such checks are especially important in home care because employees are usually alone with patients in their homes. In contrast, criminal history checks are not nearly as common in a hospital environment.

11. **Corporate compliance programs.** The specific issues to be addressed in a hospital's corporate compliance program are in many respects different than for a home health agency. For example, in home care, matters such as homebound status, medical necessity, and the assurance that falsified visits do not occur are critical. Such risks don't exist in a hospital setting.

This listing of specific differences between hospital employment and home care employment is not exhaustive, nor will each of the stated difference exist in all circumstances.

What is true in most situations, however, is that many employment policies and practices, including employee handbooks, developed for use in a hospital setting may not be appropriate for home care employees and have little, if any, relevance to them. Home care is a different kind of business and provider than a hospital.

Attempting to use hospital policies, practices, and employee handbooks in home care without at least adapting them to the home care environment not only increases the risk of legal liability but can very well lead to an agency closing its doors.

Consider this: No hospital would think of taking the employment policies and practices of a home health agency and imposing them on the inpatient hospital environment: It wouldn't work. Why do so many hospitals do the reverse to their home health agencies? ■

What have you got to learn?

Lots, if it's with on-line education

Riddle: What part of your business has been cut by an average of 75% and yet is required by 100% of your staff? Answer: Employee training. It's not much of an answer though. It just creates another host of questions:

✔ **Where do I get the money for training?**

✔ **How can I keep my agency running if I can't even afford to train my employees?**

And therein lies the problem, says **Bert Rawald**, vice president of Dallas-based m3 The Healthcare Learning Co. "While we still expect employees to be skillful and to arrive at their place of employment with the necessary skill sets . . . training has taken a real setback in funding, especially in home care." No surprise then that computer-based training (CBT) — or on-line training — is growing in popularity.

An increasing number of companies are discovering they can little afford the combined cost of classroom training and lost employee time yet even the most basic jobs require a fair amount of technical know-how.

Enter on-line education. It may be the wave of the future, but at this time, not many companies are offering classes held over the Internet. However, notes **Luther Cale**, director of marketing for HealthStream, a Nashville-based on-line education company, given the option, "we're seeing more and more customers run to the Web as fast as they can." Instead, what is becoming increasingly popular is the use of CD-ROMs and customized courses offered over a company's internal network.

A wide range of offerings

"Computer-based training comes in a variety of sophistications from a simple page turner you'd do in Microsoft Word to very sophisticated, full multimedia with narration, moving graphics, color, embedded questions to create interactivity, and a database for recording the competency scores," explains Rawald.

The majority of CBT is delivered on a standard desktop PC, he says, noting that it need not be at the office, but could just as easily be the employee's home computer. For those taking the office route, he says "if they have a LAN [local area network] it can be delivered over the local network, or if the agency is part of a larger organization and has an Intranet, it can be delivered that way. Typically, the courses are loaded on the hard drives so employees don't have to keep up with CD-ROM," he says.

Whether you install the course on individual PCs or over the company network, there are still further choices, he adds. "You have static courses

where you buy the CD, install it, and you can't change it. . . . Then the other type is actually more like a software license in that the course is dynamic. For example, we upgrade them with any OSHA [Occupational Safety and Health Administration] or HCFA [Health Care Financing Administration] changes and it has an interactive database for record keeping. More people are going to the latter because they want to prove competencies and add things to courses."

Home care? Of course

On-line learning may be the next best thing since the binary system for companies looking to keep their employees up on the latest releases from software like Microsoft and Excel. But is it really applicable to fields such as health care? Both Cale and Rawald think so.

HealthStream deals exclusively with on-line medical education and at last count offers 21 programs targeted at the health care professional, some exclusively for home health. Rawald's company offers 40 courses for the medical profession, 10 of which are geared specifically to home health. Other groups — private companies as well as professional associations — are following suit. **(See related story, p. 80.)** According to Cale, on-line education, in general, is a $6 billion business with a large portion devoted to health care.

The home health care course catalog is broken down into two groups, explains Rawald. First there is continuing education for skill assessment featuring courses on such topics as "employee safety in the home or workplace environment and patient safety. Then there's ergonomics with things like working safely with your back and then there are things that are almost corporate requirements, such as corporate compliance and customer service."

Still further, he says, are mandatory education requirements, which because of the redundant and standard nature of their content, are ideal for computer-learning formats. With corporate requirements, he says, "you have the OSHA-required courses with topics such as airborne transmission precautions and fire safety. Then you have the Joint Commission courses . . . such as age-specific competencies and patient rights."

The beauty of on-line learning lies in its simplicity. The employee simply sits down in front of the computer, clicks on the icon (or pops in a disk), logs on, and starts working. Some companies have built-in customization options so that a customer may tailor a particular course to suit its needs and objectives or even customize a unique curriculum for an employee.

More complex offerings include streaming graphics or short video clips, which can demonstrate, for example, the proper procedure for changing a dressing. HealthStream recently broadcast a laparoscopic hysterectomy over the Internet from which a course was developed. Cale sees this as a "neat bellwether for the future of health care education."

Why do it?

For home care agencies, the savings from such an arrangement are clear and immediate, says Rawald. Taking the CBT route, he says, is half the cost of traditional classroom training.

With CBT, he says, "agencies can save about $25 per employee per course, so for the average agency today that's $20,000 in savings at the absolute minimum. It's hard to determine exactly the cost [of classroom training] if you include instructor's time, materials, payroll, and mileage to class, but it's easy to see the savings."

Savings aren't the only incentives for moving toward on-line learning. Management and employees alike can be well served by the format. Depending on the program and the software company, management can use a variety of options in tracking its staff's educational progress.

"The agency can pull up standard reports which show the agency's status by branch and by department and see what their compliance percentage is at any given time," Rawald says. "They can pull up student progress reports and see where the students are and who hasn't completed the program. The savings in administrative time are huge."

Most programs offer some type of transcript information whereby supervisors can determine in minutes who is deficient in what compliance courses and what scores they received in the classes they have completed.

Agencies can also determine their own competencies, he adds, based on the importance of the course. For something like preventing the transmission of bloodborne particles, he says, you would want everyone to score 100%, but with something like back safety an agency might consider those in the 80th percentile as having passed.

For companies with a more substantial education budgets than those of most home

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care agencies, highly specialized courses can be developed much like the one created by HealthStream on advances in immunotherapy. "We did a CD-ROM with hyperlinks so they could build a community around the specific topic," explains Cale.

Employees benefit as well from computer-based training. By allowing employees to work at their own pace and at times which they choose, studies have shown that retention rates have increased. Rawald says he has read of studies which said students using CBT show 56% greater learning capability overall than when compared to learning in classrooms and that retention after six months is 25% to 50% greater than that of traditional learning methods.

Computer vs. classroom

This, he agrees, contradicts conventional wisdom, which has long suggested that the give and take of a classroom environment stimulates learning and enhances retention. But the success of on-line learning makes sense, he says, "when you think about the problems of varying degrees of education and language skills encountered in a classroom. Thirty percent are bored, 30% don't get it, and for 40% it probably works. With computer-based training, those challenged by language or education can repeat sections and go back to review.

"Equally important is that it's so respectful. It's not embarrassing if you need to repeat a section, and you can take it over and over again until you pass. Or if you have had many years of experience and could almost teach the course, it's respectful of your time. This is so important in the changing philosophy of home care," says Rawald.

Despite its benefits, on-line education is not the panacea that employers would like it to be. One of it's most attractive features — the ability to study whenever you have a spare moment — is also one of its largest flaws. "In the work environment, you can't really sit down and study for three hours so you might find yourself interrupted a lot," he adds. To combat the problems consistent interruptions bring, m3 has designed 25-minute courses with lessons of five minutes each. Users can bookmark their place so if they are interrupted, they can go back to it.

Nor is computer-based training ideal for unique clinical skills training where you need the interchange of employees to build best practices, Rawald says. Cale backs this up, adding that "we don't see it as the answer to everything. It gets to the point where we have to see that this isn't a substitute for something like teaching a language where you need in-person classes."

Whether the computer-training format ever takes off in home care is something that remains to be seen. However, Rawald, who spent a good portion of his career as the founder and owner of a hospital home care management company, foresees a bright future.

He predicts that "within another year or two, once things have settled down and the survivors have figured out that they will survive, 40% of those agencies will have this education. This format efficiently answers the home health care workers' question of tell me, 'How can I do a better job and give better patient care?'" ■

Go to Home Care U

The need for continuing education is a Catch-22, says **Marcie Barnette**, RN, MSN, director of education and credentialing for Home Care University, an affiliate of the Washington, DC-based National Association for Home Care (NAHC).

"Employees won't be able to do their work unless they have the education," she continues. If companies don't have the money to educate workers, then employees won't perform as well as they could. But without the appropriate budget and hence the appropriate training and credentialing, it's not only employees who won't be working, it's the agency itself.

"You need to have a basic knowledge base to understand the concepts of PPS [prospective payment system]. Clinical staff, for example, need to know how to manage their staff with fewer visits. Manager and administrators are going to need to know how to understand and work with financial

SOURCES

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people and examine productivity and cost reports. [PPS] is going to bring about a new way of thinking," she concludes.

With this in mind, NAHC developed Home Care University, a self-described hybrid of a corporate and a virtual university. It's NAHC's first foray into the on-line education world.

"We're not a degree-granting university," Barnette is careful to point out, "but we will be offering on-line this year programs having to do with quality management in addition to the tutorials we have on HTML and software programs like Excel and Word. The quality management course will deal with the basic concepts, things like performance improvement and risk management components along with outcomes and how to use them in affecting change."

Even though Home Care University's on-line offerings are still in their incipient stages, Barnette sees a day not too far in the future when the curriculum will expand to "address the educational needs of all levels of staff from clinical to administrative to therapists, and of course, the paraprofessional. Within that range we see a potential for specialty programs such as wound care, diabetes, and infusion therapy. Our plan is to incorporate video wherever it seems appropriate, and we have loads and loads of footage."

Video streaming may be a bit further down the road she concedes, because of the problems with user compatibility. "You can create and put out a fantastic program with all the bells and whistles, but if they can't open what you're sending, it becomes a moot point. I think this will be temporary problem though as more and more organizations are getting on-line and upgrading their equipment."

Upon completion of Home Care University courses, Barnette says students will be given continuing education certificates, which will count toward their hours. So far, she says, the response has been positive and plans are in the works for teleconferences on risk management and other specialty programs.

Barnette believes that NAHC is the first home care trade association to develop an on-line education program. "I think we are on the leading edge," she says. "If there are other associations doing this, I'm not familiar with them, although I wouldn't be at all surprised if others have things in the works. I really see this as being the wave of the future." ■

HCFA names integrity program contractors

Twelve business have been selected by the Health Care Financing Administration (HCFA) as the administration's first-ever program safeguard contractors — companies hired to identify and prevent the defrauding, waste, and abuse of Medicare.

These agencies may take on all or any of the duties associated with payment safeguarding, namely medical review, cost report auditing, data analysis, and provider education. According to HCFA, these firms will "focus on the post-payment work that is beyond the baseline work our Medicare contractors are currently performing."

The companies recently chosen by HCFA are the following:

- Aspen Systems in Rockville, MD;
- Blue Cross/Blue Shield of Alabama in Birmingham;
- Computer Sciences Corp. in Falls Church, VA;
- California Medical Review in San Francisco;
- DYN Corp. in Reston, VA;
- Electronic Data Systems in Plano, TX;
- Lifecare Management Partners in Alexandria, VA;
- Reliance Safeguard Solutions in Syracuse, NY;
- Regence Blue Cross/Blue Shield of Utah in Salt Lake City;
- Science Applications International Corp. in Vienna, VA;

• Tri-Centurion LLC in Columbia, SC;
• United Government Services in Milwaukee. ▼

Beverly subsidiaries sold

Beverly Home Care, a subsidiary of Beverly Enterprises in Fort Smith, AR, has sold its middle Tennessee operations to HomeCare Solutions in Chattanooga, TN, barely a year after acquiring the company.

Under the terms of the sale, the five locations will be merged with Southern Home Health and Hospice, HomeCare's office in Madison, TN. The newly created agency will be based at Beverly's Airpark Business Center and operate under the new parent company's name. Charlotte, NC-based Capitol Health Management Group has been brought in to oversee the merger, which resulted in the loss of about 150 jobs.

Beverly Enterprises has sold its subsidiary AdviNet to Phoenix-based Managed Care Solutions, an operator of long-term health plans. AdviNet provides personalized eldercare consultations and assistance with referrals and case-management using a 100,000-name database of long-term and post-acute care providers. ▼

Hawaii agencies close their doors

In the past year four Hawaii home care agencies have been forced to close their doors. Now Straub Home Health Agency, a division of Straub Clinic and Hospital, joins those ranks. Citing decreased reimbursements — a 24% decrease not including an additional 15% reduction once the prospective payment system goes into effect — and the implementation of Outcome and Assessment Information Set, the agency feared its quality of service would suffer.

Reavis HomeCare of Round Rock, TX, closed for similar reasons, predominantly the decrease in Medicare reimbursements. At one point, Reavis counted itself as one the country's four largest home care agencies, with six branch offices and nearly 200 employees. As a result of the agency's intermediary miscalculating Reavis' reimbursements, the company was notified that it owed $1.3 million to Palmetto Blue Cross and Blue Shield, a figure that was eventually lowered to $750,000. ▼

OASIS goes to the Senate

The Senate recently held hearings examining the impact of the Health Care Financing Administration's (HCFA) Outcome and Assessment Information Set (OASIS) requirements for home care.

The hearing stemmed from complaints from home care officials, nurses, and patients who feel data set is not only time-consuming and costly, but also threatens patients' privacy. Among the particular concerns as spelled out by five national home care associations are that OASIS is too lengthy and needs to be simplified.

In addition, the collection and reporting of information should apply only to Medicare patients, and home care agencies should be fully reimbursed for complying with the regulation. As it stands, home care agencies are given 3 cents per visit as reimbursement for what costs an agency between $1 and $3 per visit.

Among those testifying were Kristy Wright, RN, MBA, president and CEO of the Visiting Nurses Association, George Taler, MD, from the American Academy of Home Care Physicians, and Jeffrey Kang, MD, director of clinical standards and quality for HCFA. For more information, go to www.senate.gov/~aging/hr32.htm. ▼

COMING IN FUTURE MONTHS

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Home health's popularity grows on the Hill

As the Senate took a second look at the ramifications of the Health Care Financing Administration's (HCFA) Outcome and Assessment Information Set (OASIS) documentation, two other hearings were destined for the Senate chambers.

"What's Ailing Home Care: An Examination of the Problems Facing the Home Health Industry Today," was held June 10 before the Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs and examined the cumulative effect of the Balanced Budget Amendment (BBA) and HCFA's regulatory initiatives on home health. Among the topics covered were the interim payment system, medical review policies and procedures, and the 15-minute billing requirement.

A second hearing heard by the Senate Committee on Finance examined the BBA's impact on Medicare fee-for-service. ▼

New home care resources available

Springer Publishing Co. has added two home care-related publications to its roster. The first, a series of essays drawing on more than 20 years of experience in the field, *Geriatric Home Health Care: The Collaboration of Physicians, Nurses and Social Workers,* provides insights on creating and managing home care programs for the aged.

This 320-page volume touches on clinical subjects such as mental health and functional ability, and provides case studies on four long-term home health care programs. Chapter titles include "Services and Supports to the Homebound Elderly with Mental Health Needs," and "Learning and Training in Long Term Home Health Care." Cost for the hardcover edition is $49.95, plus shipping and handling.

The Physician's Role in Home Health Care offers insight into the problems and opportunities home health care offers to the medical profession and

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society as a whole. Among the topics addressed in this 328-page book are: physician's strengths and critical functions in collaboration with nurses, social workers, and other service providers; physicians and professional provider compensation; delivery system strategies and information management; home health care practices guidelines for physicians; and the cost effectiveness of "medical" home health care. Cost: for the book is $46.95, plus shipping and handling.

For more information, or to order, contact: Springer Publishing Co., 536 Broadway, New York, NY 10012. Telephone: (212) 431-4370. Fax: (212) 941-7842. ▼

Health care Y2K reference resource available

With the year 2000 deadline fast approaching, hospitals, other health care providers, and the medical device industry are scrambling to complete a process that in many cases was started too late.

What may have once been a logistical issue is burgeoning into an overwhelming problem, compounded by the scarcity of time, rising costs, and a lack of programming resources and expertise.

As the Y2K issue moves far beyond a mere "technological" issue, American Health Consultants, publisher of *Hospital Home Health*, has published the *Hospital Manager's Y2K Crisis Manual*, a compilation of resources for nontechnical hospital managers.

This 150-page reference manual includes information, in nontechnical language, on the problems your facility will face, the potential fixes, and the possible consequences, including:

- Will your computers and software work in 2000?
- What does Y2K mean for patient care?
- What will happen to your medical devices?
- How can you make sure your vendors are Y2K compliant?
- Are you at legal risk due to Y2K?
- Are you prepared if Y2K delays Health Care Financing Administration's payments?

Jan. 1, 2000, is not a moving target. Either your computer systems, medical devices, and suppliers can handle the date change and maintain business as usual, or they can't — in which case your entire organization may face serious problems.

The Hospital Manager's Y2K Crisis Manual is available now for $149. To order, contact American Health Consultants' customer service at (800) 688-2421. ■

CE objectives

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

1. State HCFA's recommendations on defining the term "homebound."
2. Identify at least two functions of a home health agency Web page.
3. Identify two ways companies can use computer-based training to further the education of their employees.
4. Discriminate between appropriate employment practices for hospital employees and those of a home health agency. ■