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INSIDE

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What are the latest legislative actions from the 106th Congress?

Who's minding your business on the Hill?

By no means have the ill effects of the Balanced Budget Act of 1997 been rolled back for home health care, but the industry has made some significant strides in the House and Senate during the 106th Congress.

"Congress has come to the realization that it cut too much," says **Eric Sokol**, deputy director for government affairs for the National Association for Home Care (NAHC) in Washington, DC. "So I think there is currently an appetite to provide home care with some type of relief. [But] in what facet? That remains the question."

At the beginning of this year, he explains, the home care industry received a message from Congress that it "wanted to see home health working together." The result, Sokol says, has been a list of five or six key provisions that would be necessary for a comprehensive home health relief bill.

"Now we have a lot of bills that encompass one or two or even three of the provisions that the industry has identified. Each bill brings its own piece to the puzzle," he continues, "and we want to give the Senate Finance and Ways and Means [Committee] the raw pieces with which to cobble together a comprehensive bill."

> *"Whenever you start fooling around with per-beneficiary limits for old agencies that are above the per-beneficiary limits, I get nervous because you don't know what they will come up with next."*

The Home Health Access Preservation Act of 1999 (HR 1917), sponsored by Reps. Jim McGovern (D-MA), Tom Coburn (R-OK), and Robert Weygand (D-RI), is one such example, says **Ann Howard**, executive director for the American Federation of Home Health Agencies in Silver Spring, MD. "This bill moves in the right direction," she says, referring to its provisions allowing providers three years in which to make interest-free overpayment repayments and providing home care with $250 million in outlier payments over three years.

Even so, Howard expresses concern about the overall uncertainty of

outlier funding. "Agencies won't know if they'll get paid up front or how much they will get paid. What's more, this bill doesn't focus on agencies that, without these payments, wouldn't be able to care for these patients."

Rep. Bill Coyne's (D-PA) bill, HR 2240, the Medicare Home Health Access Restoration Act of 1999, also scores high marks with both Howard and Sokol.

Yet Howard, who admits to liking this bill "a lot," would prefer that "[Coyne] not tinker around with the upper per-beneficiary limits. It increases the lid for agencies under the national average to 90% in 1999 and up to 100% in 2002. But the problem I have with this is that new home health agencies have problems that are just as serious, and in some states, more serious than older home health agencies. I think if you're increasing the per-beneficiary limits for older agencies, you should also do it for the newer ones.

> *"Ultimately, whatever they [Congress] do won't be enough to solve all our problems, but I think we are in line to receive at least some consideration."*

"They [home health agencies] need relief, and this provision isn't it. Whenever you start fooling around with per-beneficiary limits for old agencies that are above the per-beneficiary limits I get nervous because you don't know what they will come up with next," she adds.

The best bill in the House, according to Howard, is Rep. Bernie Sanders' (I-VT) HR 2361, the Medicare Home Health Care Restoration Act of 1999. "It eliminates the whole interim payment system [IPS]," says Howard. "But is it politically feasible? No, but we like it anyway."

On the other side of the congressional floor, the Senate has been hard at work drafting pro-home care legislation. S 1310, the Home Health Equity Act of 1999 sponsored by Sens. Kit Bond (R-MO) and Susan Collins (R-ME), seems the best offering to date.

"What's not to like about it?" asks Howard. "I hope it has a good chance of passing, but it's up to us to increase those chances."

Sens. James Jeffords (R-VT) and Jack Reed (D-RI) have also made some significant strides with the introduction of S 1358, the Preserve Access to Care in the Home Act of 1999 (PATCH). Reps. Bob Riley (R-AL) and Bob Etheridge (D-NC) recently introduced the companion bill HR 2546, which is identical in language to that of S 1358.

This bill would establish a waiver of per-beneficiary limits for individual outlier patients based on criteria established by the secretary of Health and Human Services, among other provisions. The problem with that, Howard points out, is that "the secretary would get to define the terms and what those terms would be are vague."

Late entrants

Sen. Connie Mack (R-FL) has joined the fray with his Medicare Home Health Beneficiary Equity and Payment Simplification Act of 1999 (S 1414).

This proposed piece of legislation takes a new look at the old problem by creating four patient categories each with a specific payment. "The home health agency would then receive one payment up front according to whatever category the admitted patient is in," explains Howard. "That's it for the year, and that is a great cause for concern. What happens when a person's status changes?"

Those categories are:

1. **Post-hospital short-stay beneficiaries.**

These are people who have had one hospitalization in the two weeks prior to admittance to

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the home health agency and have had at least one illness or injury which is postoperative or post-trauma. The patient must have a prognosis of prompt and substantial recovery, says Howard, who notes that the wage-adjusted reimbursement level for this is $2,603.

2. **Medically stable, long-stay beneficiaries.** These patients haven't been in the hospital within the six months prior to admittance to a home health agency and have one or more illnesses or injuries requiring medical treatment and have one or more activities of daily living (ADL) deficiencies, says Howard. The reimbursement is $3,335 (wage-adjusted).

3. **Medically complex, long-stay beneficiaries.** Patient has had two or more hospital admissions within a year prior to admission, one or more illness or injury that required acute medical treatment, and one or more ADL deficiencies. Wage-adjusted reimbursement is $4,228.

4. **Medically unstable and complex high-use beneficiaries.** These people, says Howard, have had two or more hospitalizations within the six months prior to admission, at least one illness or injury requiring acute care, and two or more ADL impairments. Wage-adjustment payment for such patients is $21,864.

"It's a rather crude division of categories," Howard points out, noting the gap between the third and fourth levels. "I'm not criticizing the bill, it's just that we'd like to see it attached to the Collins/Bond and Jeffords bills with the best of all three."

The latest entrant in the legislative race to save home care is HR 2628, the Medicare Home Health Services Equity Act of 1999, which was introduced by two Republican congressmen from Oklahoma: J.C. Watts and Wes Watkins. This proposed legislation would eliminate the 15% reduction and would offer home health agencies retroactive relief from IPS overpayments. The bill would specifically prevent the Health Care Financing Administration (HCFA) from demanding reimbursement of any overpayment accrued prior to the fiscal year in which the agency received actual notice from HCFA as to its per-beneficiary limit.

The Watts bill also provides several redresses for per-beneficiary limits whereby exceptions would be granted for agencies that can prove they provide care in medically undeserved areas or act as the sole community provider.

Agencies able to prove that they have incurred reasonable costs above the approved per-beneficiary limits would also be granted exceptions provided they are able to show that these additional costs were attributable to additional regulatory burdens established after FY 1994. Per-visit limits would be increased to 108% of the median, and patients would be allowed to choose their own home health care provider by forcing HCFA to develop a means of prorating the per-beneficiary limit should the patient choose another agency.

Future prospects

According to Howard, there seems to be more ground for consensus on the Senate than in the House. No matter the location for consensus, Sokol stresses that each bill has its merits and "all help home care to varying degrees. We want to embrace all of them in hope that they provide the raw materials for a comprehensive bill."

Rolling back the tide of anti-home care legislation must be looked at as an evolving process, says Sokol. "Ultimately, whatever they [Congress] do won't be enough or solve all our problems, but I think we are in line to receive at least some consideration.

At this point, the squeaky wheel gets the grease, and so I would encourage agencies to contact their members of Congress and present anecdotal evidence as to access problems and beneficiaries who haven't been receiving the same level of care to which they are accustomed.

"We need to make this as beneficiary-centric as possible and put a human face on the issue," he says. "Whoever shows the most pain will be farther up in the receiving line." ■

SOURCES

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- **Erik Sokol**, Deputy Director for Government Affairs, National Association for Home Care, 228 Seventh St. S.E., Washington, DC 20003. Telephone: (202) 547-7424.

SMG surveys hospital, home health alignments

Are more agencies looking to hospitals for help?

Are more home health agencies looking to align themselves with hospitals and integrated health care networks? That was the question posed by Chicago-based SMG Marketing Group in a recent survey of home health care agencies. According to the group's findings, the number of affiliations between agencies and either hospitals or integrated health networks is up 29%, from 777 in April 1998 to 1,097 a year later.

SMG's premise is that more agencies are looking to larger health care systems as a means of staying afloat in increasingly unfriendly waters. Yet **Dexter Braff**, president of The Braff Group in Pittsburgh, a post-acute health care merger and acquisition firm, says there could be another explanation.

"At first I found it strange that they were saying the numbers were up. But then I realized that it's probably not so much that the home health agencies suddenly want to align with hospitals. They always have wanted to because they are always looking for affiliations with referral sources.

"I think what's different about it in 1999 and the end of 1998 is that we are seeing hospitals questioning their own ownership in their relationships with home health agencies," he explains. "When you start talking about what comes first, the chicken or the egg — in this situation, I think what came first is that hospitals are having less of a commitment to home health and that has allowed for a different type of expanding relationship between the institution and agency.

"We've had a few calls from hospitals wanting to get out of home care, and it's been my experience that that is usually just the tip of the iceberg," Braff says.

Home Health Affiliations with IHNs

Date	Number of Affiliations
April 1998	777
July 1998	993
Oct. 1998	1,101
Jan. 1999	1,148
April 1999	1,097

Source: SMG Marketing Group Inc., Chicago. 1999.

Different places, different voices

Depending on where in the country you look, you might see a completely different picture of home health care. North Carolina, for instance, has seen a lot of home heath care agencies either merge or be involved in acquisitions, notes **Dottie Moseley**, RN, BS, MPH, director of the home care program for HomeCare Providers of Alamance Regional Medical Center in Burlington.

"There is a lot happening in the state," she says. "We have seen a lot of consolidation in home care. They have aligned themselves with hospitals in a sense that there has been a reduction in the number of branches that were out there, and that over the course of the past three to four years, all the hospitals in North Carolina have acquired a home health care agency."

Sherrie Thomas, director of clinical and regulatory services with the North Carolina Association for Home and Hospice Care in Raleigh, notes that "up until the interim payment system, we did have a good number of health department-based agencies become hospital-based through either partnerships or cases where the hospital would purchase the agencies. That lasted until probably sometime in the fall of 1997. And since then, in the last year anyway, we haven't had so many hospital acquisitions."

Thomas points out that as North Carolina is a "certificate of need" state, largely the only way for them to break into home care was through an affiliation with a pre-existing agency.

Certificates of need, she explains, are defined by the state, and in North Carolina's case, "it mandates that before any type of health care facility is developed, its organizers must prove that, based on usage data, that this entity is needed. It goes from there that if a facility is developed based on need, what happens to those patients when the agency closes? It's naive to assume other facilities in the area can pick them up."

SOURCES

- **Paul Bishop**, FACHE, President, Wellmont Lonesome Pine Hospital, 1990 Holton Ave., P.O. Drawer I, Big Stone Gap, VA 24219. Telephone: (540) 523-3111.
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Elsewhere in the state, home health agencies are trying to offer themselves for sale to hospitals, says **Karen Rowe**, RN, BSN, director of home care for Roanoke-Chowan Hospital in Ahoskie. "We have seen more hospitals that want to be in home care because they want to provide that full continuum of care," she explains. "It's been my experience that hospitals are buying Medicare-certified agencies, and despite the Medicare cuts, they seem to think it makes good sense when working with patients in the hospital that are going to need ongoing care."

Other areas of the country haven't seen quite as rosy a picture, says **Paul Bishop**, president of Wellmont Lonesome Pine Hospital in Big Stone Gap, VA, part of a large three-hospital system. In the past, he says "going back a number of years there has been some consolidation, but in most recent times, we're not finding smaller agencies approaching us. It just so happens now that it's been a rather quiet period for organizations approaching us." Bishop says he's been a little surprised by this because "it would make sense for agencies to want to affiliate now."

Still he recognizes that some of the more modest-sized home health operations in the area are probably finding it difficult to even stay afloat, "what with the turn down in reimbursement."

Somerville (MA) Hospital Home Care is seeing even quieter days, explains agency administrator **Laureen Mazzone**. "We are closing our doors. The majority of the decision can be traced to the Balanced Budget Act of 1997. Reimbursement has gone down in all aspects, and home care is not the primary business of our hospital. Pouring money into the home health care agency wasn't something they could do," she continues, adding that OASIS acted as the final nail in the coffin. "When they saw the investment we would have to make for that and JCAHO regulations and how labor-intensive it would be, the hospital had to make a tough fiscal decision and in trying to save their primary business, it was decided we would close."

She adds that in her area, most home health care agencies "are barely hanging on. They all want to be preferred providers, but they can't really do that in these days of referral regulations."

On a somewhat brighter side, Braff says that just because hospitals may no longer be interested in owning home health care agencies, that doesn't spell the end of the hospital-home health care relationship. "Rather than wanting to own an agency, they just want to affiliate. The upswing in numbers of affiliations may not be a function of more agencies seeking these affiliations just that now hospitals are more open to it." ■

Do you know how to cope with stress on the job?

What it means, how to mitigate it

Everyone experiences it at some time or another. For some people, it crops up infrequently and goes away quickly, while for others it's around so often that they wouldn't know life without it. The problem, of course, is stress, and in today's home care field, that problem may seem to be around for the long haul.

Whether originating from personal reasons or factors in the workplace, there is no doubt that

Does your job make you sick?

It's believed that anywhere from 50% to 80% of all illnesses are stress-related. So if you find yourself wondering why you seem to get sick more than anyone you know, examine these signs of job stress before heading for the pharmacy counter:

- ✎ resistance to going to work every day
- ✎ lackluster job performance
- ✎ putting off minor tasks
- ✎ avoiding discussion of work with co-workers
- ✎ preoccupation with job's petty details
- ✎ feelings of guilt and inadequacy
- ✎ often working long hours
- ✎ frequent illnesses

Source: AAM, July 1995, p. 56.

stress on the job can lead to a host of problems. In the short term, those suffering from its effects can find difficulty in concentrating on the tasks at hand and may find themselves easily agitated and suffering from mood swings, sleeping problems, and changes in appetite.

Prolonged periods of stress can lead to physical illness, poor job performance — and eventually burnout — and even serious depression, says Washington, DC-based clinical psychologist **Judith A. Graser**, EdD. **(For warning signs, see box, above. For some advice on relieving stress, see tips, p. 103.)**

Is it stress or burnout?

To be sure, there is a difference between burnout and stress although they are frequently used interchangeably. Burnout, explains Graser, is caused by a variety of factors with stress among them. Stress is brought about by work-related events, unobtainable goals, and even an employee's excessive and unrealistic drive.

The less control people have over their situations, the more likely they are to experience stress, Graser notes. Hence, those in middle management positions may find themselves bearing the greatest load, for often they are the ones saddled with large amounts of responsibility but with little or no say in final decisions. Upper management may have weightier decisions and even more of them, but says Graser, "they typically can delegate some of the workload and free themselves to concentrate on the more important matters."

Interestingly enough, some studies have shown that women are more susceptible to stress. A study conducted by Murray Research Center at Radcliffe College in Cambridge, MA, found that women bear the brunt more frequently than men, not because they are weaker, but because they are more likely to be in stress-producing jobs. On top of that, despite the vast numbers of women in the workplace, it is still the woman who is more likely to be assigned the role of family caregiver, no mean feat for someone who is already in the care-giving profession.

"These women really feel caught in the middle between what they are responsible for in the workplace and what they need to do at home," notes Graser. "It's important that they realize they cannot do everything and do it perfectly." Perfectionists then are doubly cursed and feel that they must continue working until everything is done and done right. A good idea? Wrong, she says. "The idea that working long hours produces better work is flawed. In reality, it squashes creativity and makes it more likely that mistakes will happen."

These days, perhaps no one is as caught in the middle as home health care professionals. Here are some pointers from the people in the trenches on keeping calm, cool, and collected:

✔ Sandra Smith, RN, MPH, administrator, Angel Home Health and Hospice, Franklin, NC.

"The greatest stressor comes in trying to provide quality care in an environment where Medicare makes that almost impossible. That, combined with staff cuts, is probably the biggest cause of stress.

"Before there was a freeze put on educational programming, we could train people and bring people into the agency to talk to staff on different issues. Now, our master social worker is also a licensed therapist, and she usually does something once a year on dealing with stress.

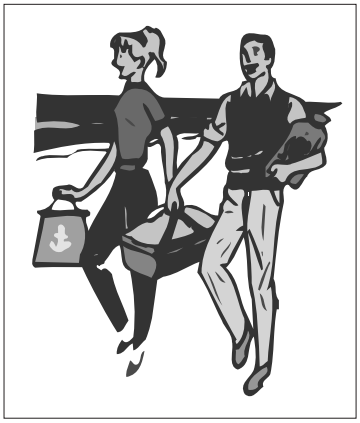
"We have staff meetings and give employees the opportunity to talk about stressors, and we have social workers on the hospital staff who are available for counseling if an employee needs it. The hospital with which we are affiliated has a

(Continued on page 104)

Tips for Keeping Stress at Bay

Whether it's your professional life or your personal life — or both — that has you in knots, the long-term effects of stress can be debilitating.

A recent issue of *Newsweek* noted that increased levels of stress experienced over a period of time have been linked to immune deficiency, heart disease, and even memory loss. While single, high-stress incidents don't seem to share the same link, knowing how to cope can go a long way toward your physical, not to mention your mental, health.



Try the following stress-busters. They won't eliminate stress. But you'll be calmer:

- **Emulate those who seem impervious to stress**

Everyone has a friend or neighbor who seems permanently unruffled in the face of stress. Are they? Or are they just copying someone else's behavior?

Either way, studies have shown that people who focus on the immediate issue — the crisis before you — rather than the global picture — such as the perceived injustice done to home care — are less affected by stress. The perpetually calm also have found ways to rationalize stress-causing factors: "If I couldn't take it, it wouldn't have happened to me," for example.

Moreover, people adept at coping with stress take an "explanatory approach" toward life whereby they assume their troubles are temporary rather than permanent and view them as specific as opposed to universal. In other words, having a bad day is just that. It doesn't mean your entire life is cursed or ruined. Finally, when using this approach, people internalize their success rather than externalize it.

You don't have to be a Zen master to be calm. It's a technique you can learn. By acting as though you hold these beliefs, you will be perceived as calm, and with a little practice, you may even come to believe it yourself.

- **Take a holistic approach**

Meditation and massage have both been shown to help people reduce their levels of stress. Both trigger physical responses that help the body cope. Meditation, for example, lowers a person's blood pressure and heart rate, as well as the flow of stress hormones.

No one knows exactly why massage works, but studies on premature babies have shown that those receiving it gain weight faster (47% more in 10 days) than their nursery mates.

- **Work it out**

It's the old standby — exercise. Everyone knows it's good for combating stress, but unfortunately, many of us are too stressed and have too little time to even consider it. Scientists have conducted studies whose results show that after 30 minutes on a treadmill, young men scored 25% lower on anxiety tests and showed favorable changes in brain activity. The best advice is if you're feeling that you don't have enough time, exercise is one thing you should make time to do.

- **Write it down**

No one likes to be micromanaged, but when it comes to handling stress, making a list and checking it twice can do wonders. Experts advise making a to-do list at the start of each day. Prioritize the list, and note which items are and aren't within your control. Then start chipping away at it. Distractions will happen but having the big picture before you can help keep you focused and help keep you calm.

- **Let's do lunch**

Whether it's taking a walk with your spouse, heading for the confessional, or simply chatting about your life over lunch with a friend, studies have shown that talking about what makes you stressed can ease your mind. Not only does the act of talking force you to put some order to your thoughts, but you might even get some sound advice. ■

mental health contract that employees can use if needed.

"We also encourage people to do some fun things. We occasionally hold staff meetings at the recreational park and have a staff picnic with team-building games. Through the hospital, they also have a program called HealthQuest, where you get a full work-up done and it includes a section devoted to stress management. If you score high on that section, they offer classes and tips on reducing stress. You get points for completing the courses and can redeem them for some fun prizes."

✔ Jean Arias, RN, MS, CHCE, administrator, Baptist-South Miami Home Care.

"We went through a merger at the first part of this year. All the employees from both agencies had to re-interview for their jobs, so no one felt secure. For those people who were affected, the hospital found positions in the system that were open and people had several choices. So that made it less stressful, but, nevertheless, it was a highly stressful situation overall.

"I brought in a master social worker who gave us stress management workshops. I had staff meetings twice a week, and we sat and talked about the systems merging. We gave continuing orientation sessions to people who weren't acquainted with the new way of doing things. I tried to lighten the mood and brought in baked goods and cookies, and we tried to laugh a lot. Humor is probably one of the greatest stress relievers that we have. If we can face our problems with a little more humor than we're used to, I think it would really help.

A supportive system is needed

"We were lucky in that we had the support of a system that's listed as one of the top 100 employers in the country. They had experts on hand to listen to staff and hold sessions with management and staff and hear their problems. Employees were excused from their jobs and were allowed to go and talk.

"I think it helped that these sessions were with people in human resources or the executives of the hospitals because staff knew these people took the time to listen to them. Employees felt valued and felt that their word counted.

"Personally, I exercise and watch my caffeine, and no matter how tired I am, I try to listen to what my body is telling me as far as rest. For just stress in general, I think it's important to deal with problems head on and not to procrastinate because sometimes those problems will just get worse. If it's causing you stress, it's best to face the problem head on and get it over with."

✔ Rick Collett, administrator, Hutcheson Home Care, Fort Oglethorpe, GA.

"We're part of a medical system, so we do have some stress management classes that are done in-house by our personnel. All these classes are available for all employees to attend. For me it's external factors like reimbursement issues that cause the most stress, but for the field staff it's having to comply with all the changes in regulations that we're going through such as with OASIS. We're Joint Commission-certified, and having to deal with all these regulations creates the most stress for us. . . . For the clerical staff, too, because they have to learn how to deal with all the changes in paperwork and submission.

"My philosophy is that I exercise a lot. I think that's always been the key for me. I can always tell if I don't because my blood pressure goes up a little bit. When I'm really fed up, I'll schedule myself a mental health day. I encourage this with all my staff — supervisory and whoever. I encourage them to do the same and take time off. This goes for nurses, too. Even if they want to work seven days a week — and some people desperately need the money — we monitor that. We don't have a set level where we say. 'You can't do this any more.' But we talk with them

SOURCES

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and make sure that they're OK. If we see those signs of burnout, that they're more short-tempered or making sloppy errors on the job, we'll cut back their schedule or encourage them to take time off. That's what vacation is there for.

"I think we're starting to have a more wellness-oriented workplace in our culture, and we're trying to get all our employees at least thinking that and hearing it from us. I, for one, strongly believe it's the way to go and include the message of 'this too shall pass' in our newsletters." ■

Mount Sinai Medical announces staff cuts

Mount Sinai Medical Center in Miami Beach, FL, has announced that as a result of cuts in Medicare reimbursements, coupled with the loss of Medicare funding for its graduate medical education, it has been forced to terminate nearly 200 of its 2,900 employees. The facility, a 553-bed, not-for-profit teaching hospital, reported a loss of $13 million in revenues last year out of a total of $509.6 million. According to hospital administrators, Medicare constitutes 62% of the hospital's total revenues. ▼

People in the news: Who's working where?

• Marsha Casey has left her position as CEO of Nashville's Vanderbilt University Medical Center to become president of St. Vincent's Health System in Indianapolis. Mark Penkhus, a former health care consultant, has been named as her replacement. Most recently he worked in Washington, DC, as director of the health care consulting practice for Ernst & Young's mid-Atlantic region.

• Cardinal Health in Dublin, OH, has announced that Robert Walter, chairman and CEO, and John Kanes, president and COO, have assumed the responsibilities of Lester Knight, vice chairman and a member of the company's board, who recently resigned. Prior to its being purchased by Cardinal, Lester had been chairman and CEO of Allegiance Corp., a manufacturer and distributor of medical products.

• Pittsburgh-based Western Pennsylvania Healthcare System has announced that it will take management control of the four remaining hospitals of the Allegheny Health, Education and Research Foundation. Acceptance of this proposal was contingent upon the release of Allegheny University Hospitals-West's top management: Anthony Sanzo, CEO, Joseph Dionisio, CFO, and Dwight Kasperbaurer, vice president of human resources.

• John Page, the executive director of Healthcare Information and Management Systems Society, has resigned his post, citing personal reasons. He had held the position since 1991. ▼

Organizations announce mergers, acquisitions

Eclipsys Corp. in Delray Beach, FL, a health care information company, and VHA in Irving, TX, a health care alliance, have formed a new company, Healthvision. This newly formed organization will combine the two companies' Internet-based product and services such as VHA's Web-based network and portal to deliver clinical, operations, and knowledge-management tools and services. Eclipsys is in the process of developing clinical products that can also be delivered via Internet.

In a sudden turn of events, Brentwood, TN-based Community Health Systems has ended an agreement to purchase the 119-bed Victor Valley Community Hospital in Victorville, CA. No reason was given for the change in plans.

Catholic Health Services of Long Island in Melville, NY, will purchase another New York health care facility, Episcopal Health Services' St. John's Episcopal Hospital in Smithtown. Included in the sale are a nursing home, home health agency, senior housing, a medical office building, and a section of land. The deal, which is expected to close in mid-September, is worth an estimated $100 million.

Blue Cross and Blue Shield of Maine will be acquired by Indianapolis-based Anthem for about $120 million, $100 million of which will be used to fund a new foundation for state residents. The program currently has some 380,000 enrollees.

In other Anthem / Blue Cross news, Colorado Blue Cross and Blue Shield is now being bid on by WellPoint Health Networks. Anthem had already established a definitive agreement to purchase the Denver-based group for $200 million.

Foundation Health Systems (FHS) in Los Angeles announced plans to sell the 180-bed Memorial Hospital of Gardena, CA, and the 127-bed East Los Angeles Doctors Hospital to Healthplus in Houston for an undisclosed amount. The announcement comes as FHS continues to focus on its core health plan and government operations. As part of this strategic initiative, FHS has sold its health plans in Utah, Louisiana, Oklahoma, and Texas.

Tenet Healthcare Corp. has signed an agreement to sell its Columbia (MO) Regional Hospital to the University of Missouri for an undisclosed sum. The hospital in question is just one of 20 the group has indicated it wanted to sell by year's end. ▼

Olsten returns to the spotlight

After months of negotiations, Olsten Corp. has signed the final civil, administrative, and criminal settlement agreements it reached with the federal government in March.

The agreement was made with the Department of Justice and the Office of the Inspector General of the Department of Health and Human Services following the results of an investigation into the company's dealings with Columbia / HCA and its home office cost reports. Now Olsten only needs to make the formal execution and entry in three federal district courts, and pending their approval, payment of the $61 million cash settlement.

More encouraging news from Olsten comes in the form of the company's announcement that 68 Olsten Health Services branch office locations were awarded accreditation from the Joint Commission on Accreditation of Healthcare Organizations.

The locations, by region, are:

- **Bradenton, FL**
— Bradenton
— Tampa
— Lakeland
— Sebring
— Sun City
— Clearwater
— St. Petersburg
— Dunedin
— New Port Richey
— Zephyrhills
— Bushnell
— Brooksville
— Hudson
- **Fort Myers, FL**
— Fort Myers
— Naples
— Port Charlotte
— Englewood
— Sarasota (2)
- **Lake City, FL**
— Lake City
— Live Oak
— Fort Walton Beach
— Crestview
— Panama City
— Marianna
— Tallahassee

— Jacksonville
— St. Augustine
— Gainesville
— Chiefland
— Starke
— Ocala
— Crystal River
— Pensacola
— Palataka
• **North Miami, FL**
— North Miami
— Miami
— Ft. Lauderdale
— Hollywood
— Lake Worth
• **Tampa, FL**
— Tampa
• **Winter Park, FL**
— Winter Park
— Sanford
— Kissimmee
— Daytona Beach
— Deland
— New Smyrna Beach
— Cocoa
— Melbourne
— Vero Beach
— Port St. Lucie
• **Springfield, CT**
— Cheshire
• **St. George, UT**
— Las Vegas
— Reno, NV
— Hurricane, UT
— Cedar City, UT
— Carson City, UT
• **Birmingham, AL**
— Birmingham
— Andalusia
• **Omaha, NE**
— Lenexa, KS
• **Louisville, KY**
— Louisville
• **Racine, WI**
— Racine
— Rockford, IL
— Madison, IL
— Milwaukee
— Jackson, WI
— Mequon, WI ▼

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Staff Builders spins off home care company

Staff Builders, one of the nation's largest home health care and staffing providers, has established Tender Loving Care Health Care Services, a separate, privately-held company.

This wholly owned subsidiary will acquire all the outstanding stock of those Staff Builders subsidiaries engaged in home health care. Staff Builders recently announced its earnings for the first quarter of FY 2000: $107.7, a 3.2% decrease from this time last year. ▼

What else is new with mergers and acquisitions?

Lake Success, NY-based Staff Builders has sold its Hackensack, NJ-home health agency to New York Health Care Inc. in Brooklyn for an undisclosed sum. The agency does about $300,000 in business throughout northern New Jersey.

Horizon Pharmacies Inc. in Denison, TX, which runs 13 home medical equipment (HME) locations along with five infusion operations and two home health agencies, has purchased Fulton Drug in Canton, OH, and its Internet pharmacy, Starkscripts, for $5.3 million.

Concentra Health Services and Tenet HealthSystem St. Louis have teamed up in a joint venture to provide the St. Louis area with expanded occupational health services. On May 31, Concentra, a provider of occupational medicine, acquired a 51% stake in six former HealthLine occupational health care clinics in St. Louis. This partnership makes the third such venture for the companies. The two have joined forces in southern Florida and New Orleans as well.

Dallas-based HealthCor Holdings has announced the sale of its Home Medical Equipment operations to Lincare Holdings for an undisclosed sum. Included in the transaction are the company's divisions in Texas, Arizona, Oklahoma, New Mexico, Arkansas, Missouri, and Kansas. Until a buyer is found, HealthCor will continue to run its Denver-based HME operation. ■

CE objectives

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

1. Appraise current home care legislation.
2. Define a "medically stable, long-stay beneficiary."
3. Define "certificate of need."
4. Identify the difference between stress and burnout. ■