

# the management report

an update for home care providers produced by the home care association of colorado

SPRING 2001

## \$10.8 MILLION IN ADDITIONAL REIMBURSEMENT EXPECTED FOR HOME CARE BEGINNING JULY 1

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**50a** \fif-t a \n **1** : Footnote in HB 00-1451, the bill that funded Colorado state government from July 1, 2000 to June 30, 2001 and called for a study of rate disparity and rate shortfalls within Medicaid's long term continuum of care. **2** : Direct result of Home Care Association of Colorado and Colorado Association for Homes and Services for the Aging lobbying efforts to allocate money for rate increases for community based care providers. **3** : Task Force that met eight times in the summer of 2000 and recommended substantial rate increases for HCBS, Home Health and Alternative Care Facilities.

**50** \fif-t \n **1** : Direct result of 50a. **2** : Footnote in SB 01-212, the bill that will fund Colorado state government from July 1, 2001 to June 30, 2002, that calls for \$10.8 million in base rate increases for HCBS and Home Health beginning July 1 to be directed to the greatest degree toward care giver salaries.

**HCAC started the discussion. The 50a Task Force recommended it after much study and deliberation. The Joint Budget Committee concurred with the recommendation after juggling expenditures for prisons, highways and schools to come in with a balanced budget under tight spending limits. A majority of the Colorado Senate and House have agreed. Now it is up to the Governor to sign his name to a bill that will authorize \$10.8 million in base rate increases to Colorado's home and community based services and home health providers.**

According to Sue Brown, chair of HCAC's Legislative/Advocacy Council,  
Continued...

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*www.hcaconline.org*

\*\*See photos of state legislators receiving HCAC awards

\*\*Browse through exhibits from Annual Convention 2000

\*\*Read article on "The Miracles of Homecare" by Dan Nicholson,  
HCAC President

\*\*Make use of PR and media templates

\*\*Browse updated member information (please let us know if your organization has a website and we will link to it through the member section)

\*\*Get updated dates and place of HCAC's 2001 education programs

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#### **Editor/Executive Director:**

Ellen Caruso

a group that has worked on this initiative for an entire year, **this proposed rate increase is nearly four times greater than the home care industry has ever received in any one year.** Brown said the rate increases target HCBS personal care provider and Home Health certified nurse aide services because this was where home care agencies had reported the most difficulty in recruiting and retaining staff. The legislature has mandated that a substantial part of the increase be used for direct caregiver salaries and salary related costs and HCAC has worked closely with the Dept. of Health Care Policy and Financing on developing a rule detailing this requirement. The rule will be fine-tuned in the next several months before being heard by the Board of Medical Services.

**The rate increase, if approved by the governor, will result in the following rates, effective July 1, 2001:**

**HCBS Homemaker/Personal Care Provider - \$12.56/hour (up 11.6% or \$1.31 over current rate)**

**Home Health Aide - \$31.67/first hour (up 3% or 93 cents over current rate)**

**Home Health Aide - \$9.46/succeeding half-hour (up 3% or 28 cents over current rate)**

**Skilled Nursing, PT, OT, ST, Private Duty Nursing - up 1% over current rates**

**Many thanks to HCAC members who worked diligently on this project** in concert with the association's lobbying team of **Betsy Clark Murray** and **Ellen Caruso: Sue Brown**, Argus of Colorado Home Health, Denver, and **Dan Nicholson**, Caring Plus, Inc., Pueblo, co-chairs of the Legislative/Advocacy Council; **Sue Birch**, Northwest Colorado VNA, Steamboat Springs, and **Judi DeVore**, Heartland and Hospice Home Health, Greeley, who represented home care on the 50a Task Force; Council members **Martha deUlibarri**, Visiting Nurse Corp. of Colorado, Denver; **Jackie Donnelly**, Sterling MedCare, Sterling; **Bob Page**, Adult Home Care Services, Delta, and **Susan Grayson**, Centura Home Care & Hospice, Denver; and members of a special HCAC task force that developed recommendations for reporting requirements: **Marlene Davis**, Visiting Nurse Corp. of Colorado; **Kimberly McKay**, CPA, Baird Kurtz and Dobson, Colorado Springs; and **Suzanne Hamilton**, Adult Home Care Services, Delta.

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**PRIOR  
AUTHORIZATIONS TO  
GO INTO EFFECT  
ON JULY 1**

**A hotly debated and heavily amended rule calling for prior authorization of all Medicaid long term home health services passed the Colorado Board of Medical Services in March and will take effect on July 1, 2001.**

“Even though the Home Care Association strongly opposed the rule on the grounds that it will be cumbersome, administratively burdensome, costly to administer, and a complication to the admissions process,” says Ellen Caruso, “it is now the law of the land and the association will work to assist the department in implementing the new regulations.”

To that end, the association sponsored an audio conference seminar on the new rule on March 29. More than 260 people from 46 agencies and single entry points participated. Tapes of the conference are available and more information was scheduled to be provided during the Regulatory/ Intermediary panel discussion held on Friday, May 4 during the association’s annual convention in Denver.

**OLMSTEAD  
COMMITTEE  
LISTS BARRIERS**

**As reported in the Winter 2001 issue of *the management report*, Colorado's Medicaid program has formed a committee to respond to the recent U.S. Supreme Court’s decision which held that no person should have to live in a nursing home or other institution if he or she can live in a home or community-based setting.**

Representing home care on Colorado’s committee is HCAC President Dan Nicholson, Caring Plus, Inc., Pueblo. On its way to developing suggestions on how to ensure that the intent of Olmstead is met, the committee has listed the following barriers to home care services:

Eligibility

- Determination is slow
- Log jam at the county level
- Inconsistent interpretation of eligibility requirements

Challenges for community based providers

- Providers at capacity
- Lack of workers
- Instability of existing work force
- Limited range of services
- HH providers afraid to take high users as may exceed cap
- Insufficient capacity

Funding

- Complexity of funding streams
- Imbalance between funding for institutional services & community-based services

*The Mission  
of the  
Home Care  
Association  
of Colorado  
is to  
strengthen the prominence  
of the home care industry  
as a core component  
of the integrated  
health care system.*

Continued...

**HCFA PUBLISHES  
SUMMARY OF  
UTILIZATION  
PATTERNS  
BY STATE  
FOR 1997 to 1999**

Colorado followed the rest of the nation in an alarming reduction in total payments and reimbursement per Medicare patient in 1998 and 1999, compared to previous years.

Since implementation of the Balanced Budget Act of 1997, the total Medicare home health payments in Colorado have decreased by 58 percent. However, in the same time period, the total number of patients decreased by only 27 percent.

In 1999, Colorado providers billed Medicare less per patient than the national average. Average reimbursement per patient in Colorado was \$2,708 in 1999 compared to \$2,949 in 1998 and \$4,739 in 1997. The national average was \$2,892 in 1999, \$3,412 in 1998 and \$4,705 in 1997.

More Nursing Facility (NF) beds available than community beds  
Lack of funding for community programs  
Bundled rate for NFs but not for community-based programs  
Rate for NFs includes room and board but not for community-based programs

**Case Management**

Lack of timely planning before institutional services are discontinued or changed  
Family/persons' fear  
Lack of information / Misinformation  
Not utilizing rules/incentives that already exist  
Inappropriate discharge placements  
Insufficient utilization of DI mechanism  
Insufficient use of diversion from institutional placement  
ULTC-100 applied less stringently in nursing facilities  
Counties do not inform consumers of 300% rule  
No way to access immediate HCBS  
People still following homebound rule  
People encouraged to act sick and dependent to get what they need  
SEP case managers mostly geared towards elderly services  
No case management for people with straight Medicaid  
Hospital "fast-track" discharges on Friday afternoons  
Home health agencies not being ready/willing to accept clients on Friday at 4 PM  
No SEP screen required before nursing home placement  
Lack of info about alternative placements  
Delays while awaiting MINS screen and PAR  
Inadequate, inefficient and inappropriate use of screens  
Poorly trained/informed case workers  
Too many "players" between funder and consumer  
Re-evaluations to confirm appropriateness of placements not done  
Bias against those labeled as perpetrators

**Continuum of Care**

Inability of systems to work together  
Lack of Transitional Settings  
Insufficient community-based respite services  
Lack of social/natural supports  
Restrictions on assistive technology needed for community living  
NF offers "One-Stop Shopping"  
Some NFs actively marketing for residents with mental illness  
No system responsible for developing new MH resources  
Lack of crisis intervention services  
Insufficient MH services re LTC

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## HOME HEALTH PPS QUESTION & ANSWERS

Check out this web site for the latest answers to frequently asked questions:

<http://www.hcfa.gov/medlearn/refhha.htm>

Scroll about half way down the page and click on:

**HHPPSQUESTIONS**

Open it or save it to a disk

Non-medical transportation not allowed for integrated settings  
Problems getting / repairing equipment  
HCA too limited  
CDAS not implemented  
People in NF cannot save SSI/SSDI for move out costs  
HCBS closed in 30 days  
NF resistance to transferring Medicaid  
Belief that some people cannot live independently  
Limits in Nurse Practice Act  
Some consumers need more extensive or complex care than system will fund  
Detrimental records prevent consideration for D I

### Politics & Regulations

Imbalance in political clout  
Complex, confusing and redundant rules and regs  
No incentive to use or develop alternatives to NFs.  
Additional MINS screen for home health

### Quality

Insufficient monitoring of providers for service quality  
Instances of clients going without needed services not quantified or documented  
Poor quality institutional care

### Data

Lack of reliable info on MI clients in nursing homes

### Challenges for Nursing Facilities

Residential facilities have no capacity for even low level medical/physical problems  
Residential facilities are more short-term  
Lack of support in NFs for person in post-medical crisis

### Challenges for Alternative Care Facilities

ACFs unwilling to take MH clients.

### Client Rights

Medical paternalism among providers  
Lack of consumer control  
Providers "dump" undesirable clients  
Clients not fully informed of rights  
Real consumer choice not honored

### Infrastructure

Lack of appropriate housing

### Long Term Care Insurance

Lack of LTC insurance particularly covering home care  
Lack of attorneys specializing in LTC planning

**MESSAGE FROM THE  
PRESIDENT**

**"Is the PAR Rule Good  
for Business?"**

by Dan Nicholson  
Caring Plus, Inc., Pueblo

***A Vision  
for the  
Home Care Association  
of Colorado***

*By the year 2000,  
home care will be  
the primary choice  
in the integrated  
health care system.*

**This regulation and new rule sounds good on the surface. It is good bureaucracy. It is good rule making. If you like rules and you like bureaucracy, then you should love this set of rules. This rule is not good for business. This rule amounts to an unfunded mandate and is another attempt to balance the Medicaid budget on the backs of providers.** To quote Larry Wall, executive director of the state's hospital association, "The state is going to have to quit doing that at some point."

Recently there was an article in a national magazine about a process specialist who was a medical doctor and studied health care delivery and made the "discovery" that up to 50 percent of a health care provider's time is spent doing non-patient related work. This rule adds to that burden, and it does nothing to improve patient outcome or care.

**The department says there is no cost to this rule. This is ludicrous! It will require more time, paperwork and supervision by the home care agency. Time is precious and is a disappearing commodity in the lives of home care workers. Time is money - money that is coming directly from the home care agency's pocket and money that can't be used for client care. This rule impacts care for the frailest, eldest and weakest.**

**This rule pits two different models of care against each other.** The single entry point is a social model, whereas home care is a medical model. A home care agency is a hospital without walls and the department is requesting that a long-term care organization control the acute care organization without walls. It is one more instance of treating home care agencies as wards of the state, instead of business entities. Even agencies that are not free-standing or small businesses, are part of a larger company operating very much like a small business.

**There is a better way to manage this type of care.** One thought would be to create clear expectations of outcomes, build it into a survey process and existing systems and create a medical/functional model of monitoring that is focused on the legitimate needs of individuals. A focus like this would make more sense than blaming the entire industry for perceived, but maybe not real, abuse.

**This rule is a meat cleaver where a scalpel would work.** The criterion for defining utilization is unclear. The goals and outcomes are vague and it sets a bad precedence of the wrong people managing the wrong type of care. This is another burden to home health care staff, is anti-business and micro manages home care. This will not save the state money. It may make this portion of the Medicaid budget temporarily look better but the care needs will go somewhere else. If you take the fully loaded cost of imple

Continued...

## Congressional Addresses

**Sen. Ben Nighthorse Campbell**  
380 Russell Senate Office Building  
Washington, DC 20510  
(202) 224-5852; Fax (202) 224-1933

**Sen. Wayne Allard**  
513 Hart Senate Office Building  
Washington, DC 20510  
(202) 224-5941; Fax (202) 224-6471

**Congresswoman Diana DeGette**  
(1st Congressional District)  
1339 Longworth House Office Bldg.  
Washington, DC 20515  
(202) 225-4431; Fax: (202) 225-5657

**Congressman Mark Udall**  
(2nd Congressional District)  
128 Cannon House Office Building  
Washington, DC 20515  
(202) 225-2161; Fax (202) 226-7840

**Congressman Scott McInnis**  
(3rd Congressional District)  
320 Cannon House Office Bldg.  
Washington, DC 20515  
(202) 225-4761; Fax: (202) 226-0622

**Congressman Bob Schaffer**  
(4th Congressional District)  
212 Cannon House Office Building  
Washington, DC 20515  
(202) 225-4676; Fax (202) 225-5870

**Congressman Joel Hefley**  
(5th Congressional District)  
2230 Rayburn House Office Bldg.  
Washington, DC 20515  
(202) 225-4422; Fax (202) 225-1942

**Congressman Tom Tancredo**  
(6th Congressional District)  
1123 Longworth House Office Bldg.  
Washington, DC 20515  
(202) 225-7882; Fax (202) 226-4623

menting and monitoring these laws, it will take a very long time, if ever, to create a net gain for the State of Colorado. It is like a balloon: you can squeeze it in one place and make it skinny, but it will always bulge outward in another place.

Department officials have stated they do not know any other way or have any other tool to control the costs on a patient basis. **I do not think that the state should be in the business of regulating and determining individual care. This rule is an attempt to ration care on the back of the frailest and most needy. They are the ones who will be impacted. Yes, it does cost money to take care of the frailest and most needy, but the decision to ration care should be made in a public discussion with elected officials, not by a regulatory agency that is unaccountable to the public.**

Furthermore, the model of using dollars to control care has not yet been proven. The phenomenon of squeezing the balloon cannot go on forever. We have used PARs in the past to control costs and they have failed. They will fail again. There seems to be an attempt to drag up rules out of the past that have previously failed to control costs without consideration of the biggest elements that drive the cost. Things such as the benefit itself, the authorization process, the medical conditions, the complex social conditions, and changes in society. Simple, short-term solutions, such as this rule, do not solve complex problems. Our association has offered to work with the department on alternatives and has met with them to explore new ways.

In summary, as a small business owner, representing a business that cares deeply for the community it cares for, this seems to be a step backwards for the State of Colorado and for home care providers that are sincerely trying to provide care in the most efficient way possible.

*(Ed. Note: Dan Nicholson presented this testimony on the Home Health PARS rule at the February 9, 2001 meeting of the Colorado Board of Medical Services. It is re-printed here because of its relevancy to the operation of a home care agency in today's environment. Other testimony provided by HCAC was printed in the Winter 2001 issue of **the management report**.)*

**CONGRESSIONAL  
NEWS**

**As a new member of the Senate Budget Committee, Colorado's U.S. Senator Wayne Allard was instrumental in the vote by 99 of 100 senators to allocate funding within the Senate Budget Resolution for the elimination of the additional 15 percent cut to home care reimbursement scheduled for October 1, 2002.** This vote sets aside the entire \$13.7 billion over ten years that the Congressional Budget Office says would be required to fund the elimination of the 15 percent cut. According to the National Association for Home Care, this move will make it much easier to get the legislation passed by Congress.

HCAC members are encouraged to call Sen. Allard and Sen. Ben Nighthorse Campbell to thank them for their support of home care. (see page 7 for phone numbers)

\* \* \*

**The House Committee on Energy and Commerce is conducting a thorough review of the Medicare program in an effort to improve delivery of quality health care to patients.** To facilitate its information gathering, the committee has developed a survey of health care providers. Home care providers are encouraged to visit [www.house.gov/commerce/hcfasurvey.htm](http://www.house.gov/commerce/hcfasurvey.htm) and complete the survey and make your concerns known.

**HCFA ASKS  
AGENCIES TO  
RE-BILL TRAUMA  
CODES**

**The Health Care Financing Administration (HCFA) recently reported an increase in the number of injury codes on home health claims and stated that this increase could represent a misunderstanding in the proper use of these codes when the patient has a surgical wound.**

**According to the National Association for Home Care, HCFA said it suspects that providers are incorrectly coding uncomplicated surgical wounds using 800-level ICD-9-CM "trauma" codes, which should be limited to wounds that are caused by accidents or injury.** Rather than using the 800-level trauma codes for uncomplicated wounds, home health agencies should use the diagnosis code that describes the underlying reason for the surgery. However, when beneficiaries have uncomplicated surgical wounds, providers may use appropriate injury codes for "complications of surgical and medical care" (ICD-9 codes 996-999). On the other hand, diagnoses such as hip fracture or other fractures are, in most cases, correctly coded with a trauma code, using one of the codes for fracture (860-869).

HCFA advised agencies that have erroneously coded disease related post-surgical cases with a trauma code to submit corrected claims to ensure accurate payment and data collection.

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**RURAL ADD-ON  
IMPLEMENTED**

**On January 16, 2001, the Health Care Financing Administration (HCFA) issued full instructions to implement the rural add-on and the market basket inflation increase that was approved by Congress before adjourning in December.** The methodology increases the base episodic rate of \$2,378.02 for all non-MSA episodes that end on or after April 1. This base rate is then adjusted for the HHRG and wage index in the normal fashion. The per visit LUPA rates are also adjusted and the Fiscal Intermediary pricer module makes the changes.

**OSHA'S NEW REG  
TOUGHENS  
STANDARDS**

**Beginning April 18th, home care agencies are required to keep precise logs of clinical accidental needle sticks from contaminated sharps, no matter how slight the puncture.** Agencies will have to maintain a sharps injury log that contains, at a minimum 1) the type and brand of device involved in the incident; 2) the department or work area where the exposure incident occurred, and 3) an explanation of how the incident occurred. There is no specified format for the sharps injury log, however, the log must protect the privacy of injured workers.

In January 2002, agencies must begin using the OSHA 300 series logs which will replace the OSHA 200 logs.

**On the net:**

[www.osha-slc.gov/recordkeeping/index.html](http://www.osha-slc.gov/recordkeeping/index.html)

**IMPROPER  
MEDICARE  
PAYMENTS DROP**

**The Dept. of Health and Human Services has reported that improper Medicare payments to doctors, hospitals and other health care providers in fiscal year 2000 continued to show sustained improvement since the department's Inspector General began tracking Medicare's payment error rate five years ago.** The error rate measures payments made by Medicare which are not properly supported by health care providers' documentation or which otherwise do not meet Medicare reimbursement requirements.

Medicare's estimated error rate was 6.8 percent in fiscal year 2000, compared with nearly 8 percent the previous year, according to the OIG's latest report. The error rate has fallen to roughly half of the 14 percent rate estimated in fiscal year 1996, the first year that the Inspector General conducted an audit to estimate Medicare's overall error rate.

According to newly appointed HHS Secretary Tommy G. Thompson, "Our challenge now is to keep improving Medicare's management and to modernize and strengthen the program to ensure that we meet the long-term needs of our seniors and people with disabilities."

Continued...

## HCFA SPEAKS OUT ON OASIS CONFIDENTIALITY

### TRY THIS SITE FOR TRANSLATIONS!

Go to [mamma.com](http://mamma.com)  
and type in [babelfish](http://babelfish.com).  
[www.translate.ru/eng/other.asp](http://www.translate.ru/eng/other.asp)  
Copy and paste English text in  
top box, select language you  
want, click translate and presto!

In a statement welcomed by health care providers across the country, Thompson said "We must not only modernize Medicare's accounting systems, but also make its rules and procedures more understandable and user-friendly. If we can make our programs and our coverage easier to understand, we'll be helping physicians and other providers to avoid unintended errors, and we'll help detect deliberate abuses as well."

**The National Association for Home Care has been involved in discussions with HCFA regarding the many concerns about patient identifiable information on the OASIS adverse event reports and patient confidentiality. During these discussions two major points became apparent:**

1. The patient identifiable information that appears in these reports is accessible to two parties only - the agency that sent the data that produced the reports and the state agency/HCFA that received this data.
2. In order to improve outcomes of care, agencies must be able to identify the patients who had adverse events and carefully evaluate the care provided, making changes if inappropriate care practices led to those adverse events.

**In response, HCFA identified the regulations and system security measures in place to ensure data security and patient confidentiality:**

The Outcome-based Quality Monitoring Reports (OBQM) and the OASIS data are confidential information and should not be released to the public or press.

In accordance with the Privacy Act of 1974, the HHA OASIS System of Records (SOR) was published June 18, 1999 in the *Federal Register*. This SOR defined the allowed uses of the Federal data and detailed in the routine use section of the Privacy Act Statement: Health Care Records certain patient rights statements which are required to be given to each Medicare or non-Medicare patient receiving home care services.

HCFA maintains that the protection of privacy of patient specific information is a key element in using OASIS. No one may release OASIS assessment information that is patient identifiable to the public. At all locations where OASIS data is held, the home health agency, the State Survey Agency, or at HCFA, whether the data is hard copy or electronic, it must be secured and controlled in compliance with the requirements for safeguarding the confidentiality of clinical records.

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### CHECK OUT THE WEB TO IDENTIFY YOUR ELECTED OFFICIALS

1. Identify your 9-digit zip code: [www.usps.com](http://www.usps.com), "find zip code," complete address, city, state and press "process."
2. Visit [www.vote-smart.org/index.phtml](http://www.vote-smart.org/index.phtml), "Candidates Issues..." Enter 9-digit zip code, "GO." You will be told your US Senator and Representative and your State Senator and Representative.
3. Then make that all important call.

#### Who "owns" the data?

There are two levels of ownership for this data.

1. At the home health agency level, the data is owned by the agency and is subject to the Conditions of Participation. Specifically, the OASIS data and reports are confidential and may be used internally to support the agency's quality improvement program. The agency is not to release any data to the public.
2. At the State Agency and HCFA level, the data are part of a system of records and are bound by rules of the Privacy Act of 1974 and the published HHA/OASIS System of Records.

#### Rules that govern confidentiality of patient data

The rules that govern confidentiality of patient data at the home health agency level are:

**484.10 (d) Standard:** Confidentiality of medical records - The patient has the right to confidentiality of the clinical record maintained by the agency. The agency must advise the patient of the agencies' policies and procedures regarding disclosure of clinical records.

#### **484.11 CoP:** Release of patient identifiable OASIS information

The agency and agent acting on behalf of the agency in accordance with a written contract must ensure the confidentiality of all patient identifiable information contained in the clinical record, including OASIS data, and may not release patient identifiable OASIS information to the public.

The Social Security Act in section 1891(a)(1)(C) establishes the patient's right to confidentiality of the clinical record. Additionally, State laws exist concerning confidentiality of medical records.

We are requiring that the home health agencies keep all information contained in the patient record confidential and maintain safeguards against the unauthorized use of a patient's clinical record information, regardless of the form or storage method.

#### The rules that govern confidentiality of patient data at the State and HCFA are:

1. The Secretary's Agreement with each State that requires that they maintain the confidentiality of all data.
2. The HHA/OASIS System of Records that governs all data held after transmission to the State /HCFA. The penalties are addressed in the SOR found on the OASIS web site. Each State agency or Regional Office surveyor authorized to access and use the OASIS data or reports derived from the OASIS data must comply with the provisions governing the privacy and security of this Federal automated information system. Each

Continued...

## **Important Phone Numbers**

### **Home Health Hotline**

(800) 842-8826 or  
(303) 692-2800

### **Dept. of Public Health & Environment, Health Facilities Division**

(303) 692-2908

### **Medicaid Home Health**

(303) 866-4654

### **Medicaid HCBS**

(303) 866-5659

### **Medicaid PARS**

(303) 866-5908

### **Home Health PDN & EPSDT**

Sharon Bren, CFMC  
(303) 695-3300, ext. 3035

### **Consultec Provider Assistance**

(800) 237-0757 or  
(303) 534-0146

### **Medicaid Billing Abuse or Fraud**

(303) 866-5879

user having authorized access to the system, records, and reports must agree to maintain appropriate administrative, technical, procedural, and physical safeguards sufficient to protect the confidentiality of the data and to prevent unauthorized access to the data. Each user is required to have an individual valid User ID and a secure password. Each user shall not disclose, release, reveal, show, sell, rent, lease, loan or otherwise grant access to the data to any person. The Privacy Act provides criminal penalties and fines for certain violations.

### **What information can HCFA release to the public from these reports at this time and in the future?**

HCFA will publish public releasable reports when we have developed the report that does not identify any person or persons. This is expected in the summer. The reason the current reports cannot be released now is what we call "cell size." For example, if the Adverse Event Outcome Report relates to a particular outcome to a single patient or all of the patients, you potentially could identify that this particular characteristic applies to those person(s). We will create a report to mask those small or large numbers. When this is developed we will make this public.

### **What information can HCFA NOT release from these reports?**

1. The Adverse Event Outcome Report - Patient Listing because this is patient specific and any patient identifiable information cannot be released to the public.
2. The Adverse Event Tabular Outcome Report because of the cell size, as described earlier.
3. The All Patient's Case Mix Profile because of cell size, as described earlier.

### **What information can HHAs release on these reports?**

Home health agencies may not release any information from any outcome report to the public. The OASIS data and reports are confidential and must remain as an internal document to support the agency's quality improvement program. The agency is not to release any data to the public.

It is recommended that each agency and software vendor, as applicable, review the Federal Register Notice, noted above, and review the Program Memorandum: Transmittal No.99-2, November 1999, Section XIII Protection of the Confidentiality of OASIS data found on pages 41-42.

**REGULATORY  
UPDATE FROM NAHC****Survey and Certification**

**The Health Care Financing Administration (HCFA) released a revision to the State Operations Manual.** This revision provides updated instructions for State Agencies regarding survey of certification policy issues. Examples of revisions include: differentiating parents, branches and subunits; separate entities; and the survey process including preparing for the survey, selection of records and patients for home visits, and entrance and exit conferences.

**This information is available on the HCFA website at [www.hcfa.gov](http://www.hcfa.gov) (Transmittal 25, March 16, 2001)**

**Prospective Payment System**

During the March 15, 2001 conference call it was learned that most of the needed fixes for home health PPS have been implemented. One major fix that has not been completed is the remittance advice correction that is to be implemented in the near future through a special release. This fix will result in clearer remittances to providers. (A tape of this conference call is available for purchase through HCAC.)

**Medicare Summary Notices**

Errors in Medicare Summary Notices have been rectified. The fixes include deleting payment information from RAP notices. HCFA is considering elimination of beneficiary RAP notices all together. In addition, a correction has been put in place to eliminate the errors in total payment that reported final claim payments to home health agencies as the sum of charges and episode payment.

**Consolidated Billing**

An error resulted in Medicare B therapy and medical supply claims being rejected in cases where services or supplies were provided to discharged beneficiaries between the date of discharge and the 60<sup>th</sup> day of a home health episode. This has been corrected and the Common Working File now shows discharges accurately. However, problems persist for therapists and medical suppliers in cases where home health agencies fail to submit their final claims for discharged beneficiaries in a timely manner.

**Advance Beneficiary Notices (ABNs)**

HCFA staff are involved in a team effort to resolve the many problems that have surfaced due to implementation of the new ABN instructions of March 1, 2001, especially for beneficiaries with both Medicare and Medicaid eligibility.

Continued...

## NEW MEMBERS

### Suspended RAPs

All intermediaries have installed the fixes needed to correct software problems that caused suspension of cancelled RAPs. Providers will now be able to resubmit corrected RAPs and final claims for all suspended RAPs.

### RAP Rejection

Work is continuing on correcting a system problem that results in RAP rejections in cases whereby a readmission or transfer RAP is submitted prior to the RAP for the initial services.

### Welcome to the following new Allied members who have joined HCAC since the last publication of *the management report*:

- **Summit Consulting and Education, Inc.**, 1181 Ponderosa Way, Woodland Park, CO 80863; (719) 533-0084; cka22@ix.netcom.com
- **Sandata**, 26 Harbor Park Drive, Port Washington, NY 11050; (516) 484-4400; [dmemasters@sandata.com](mailto:dmemasters@sandata.com); [www.sandata.com](http://www.sandata.com)

## HCAC NEWS

HCAC member **Linda Gaetani**, VNA Hospice-at-Home, Denver, is serving as president of the Colorado Hospice Organization.

\* \* \*

**Betty Baker**, Alliance Healthcare, Fort Morgan, had U.S. Sen. Wayne Allard's ear for about an hour at his town hall meeting in her community. Baker told Allard of home care's increasing issues with the growing "bureaucracy." Baker encourages other home care agencies to make it a point to attend congressional town hall meetings to make personal contact with your elected officials.

\* \* \*

Many thanks to **Larry Lillo**, Interim Healthcare/Denver Branch, and **Sheryl Bellinger**, Associated Professional Home Health, Denver, for their outstanding service on the HCAC Board of Directors.

SPRING 2001

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LETTERS

**ATTENTION:  
AGENCY  
ADMINISTRATORS**

Have you ever thought of inviting your state legislator or U.S. congressman or a spouse to serve on your agency's advisory board?

If this sounds like a good idea to you, please contact Ellen Caruso at the HCAC office (303) 694-4728 ecaruso@assnoffice.com

**Olmstead Contributions**

I would like to let you know how much I appreciate the input of your association president, Dan Nicholson, in the Olmstead planning group process. He brings a thoughtful and realistic perspective to the realities of providing health care in the current system. His contributions are indeed valuable.

— Marge Block  
Member, Colorado Olmstead Committee

**Thank You**

I want to be sure you know how pleased I was to be a part of the HCAC seminar. As always, I really enjoyed the members and give you credit for developing and maintaining such a positive, constructive tone. Thanks.

— Elizabeth Hogue, Esq.  
Featured Speaker, "Using Case Management to Succeed Under PPS and Other Medicare/Private Duty Topics"  
February 21, 2001

**Keep Up the Great Work**

I have changed positions to Director of Education for our organization. Good luck and I have enjoyed knowing you. I always brag on what you and your team have done for Home Care locally, statewide and nationally...Keep up the great work. Home care will always be in my heart and we are very fortunate to entrust it to you.

— Joanna King, RN  
Former Director, St. Mary's Home Care, Grand Junction

**NAHC Needs to Work Medicaid Issues**

*(Following are excerpts from a letter written by HCAC Board Member Suzanne Hamilton, Adult Home Care Services, Delta, to Linda Therrien, The Children's Hospital Home Health Agency, Denver, who is a member of the Board of Directors of the National Association for Home Care.)*

As you know, many agencies in Colorado dropped their Medicare certification or went out of business altogether due to IPS/PPS and the BBA. Some of our rural agencies, especially those affiliated with health departments or small rural hospitals, either disenrolled or were able to pull through only with special supplements from county governments who were committed to home care. Only three agencies represented at a recent Southeast Forum meeting still billed Medicare.

Continued...

By the same token, as home health visits dropped due to IPS/PPS, Medicaid visits have risen, much to the chagrin of State government. Ellen Caruso fondly calls this the balloon theory – squeeze it one place and it expands in another. Without Medicaid, many at-risk patients would be without care.

Our agency provides homemaking and personal care only (no skilled care) under the Medicaid-waivered HCBS programs. Many other agencies provide these services, some as stand-alone corporations, some affiliated with skilled care agencies. Our clients depend very heavily on HCBS to keep them out of skilled nursing facilities.

HCAC does a great job lobbying state government on Medicaid issues. We believe NAHC needs to lobby just as diligently on the national level to keep home care an integral, vital part of the Medicaid delivery system.

—Suzanne Hamilton, CSA  
Certified Senior Advisor  
Co-Owner, Adult Home Care Services, Delta

## BOARD OF NURSING NEWS

**The Colorado Board of Nursing has announced that it is seeking applications for two members of the Nurse Aide Advisory Committee (NAAC), beginning July 1st.** According to Dorothy Braun, RN, Nurse Practice Consultant at the Board of Nursing, one member will represent professional associations composed of home health agencies and one member will be from a group representing the concerns of senior citizens. Interested persons should contact Braun at (303) 894-2442 or write to the Board of Nursing at 1560 Broadway, Suite 880, Denver, CO 80202.

According to the announcement, the purpose of the Nurse Aide Practice Act is the protection of the consumer, specifically in the Long Term Care and Home Health settings. The Colorado Nurse Aide Practice Act, based on federal law, is comprehensive and tailored after the Nurse Practice Act and includes education and certification requirements, grounds for discipline, sanctions, and procedures for hearings. Many facilities, other than Long Term Care and Home Health which are required to hire certified nurse aides, have chosen to utilize the certified nurse aide to ensure a level of competency to patients and residents.

Since the beginning of Colorado's statutory regulation of the nurse aide in July, 1989, the Board has had the ability to form an Advisory Committee to assist the Board in matters related to nurse aides. The Board granted this authority to the Nurse Aide Advisory Committee (NAAC) to

Continued...

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determine eligibility for certification when an applicant disclosed a history of felony, drug and/or alcohol problems, or mental and/or physical disabilities, and to determine the disposition of complaint investigations and the appropriate sanctions.

The NAAC is composed of five members 1) one certified nurse aide, 2) one member to be a member of the Board of Nursing, 3) one member representing professional associations composed of home health agencies, 4) one member from a group representing the concerns of senior citizens, and 5) one member representing professional associations composed of nursing homes. The sixth member is from the Department of Public Health and Environment and serves as an ex officio member. All positions serve a three year term and are eligible for reappointment once.

The committee meets monthly on the fourth Wednesday of the month in the afternoon. Meetings may last from two to four hours. Committee members receive their agenda packets approximately two weeks prior to the meeting to allow adequate review and preparation time. Members receive monetary compensation.

During 2000, the committee reviewed 140 non-routine applications for certification. The committee also reviewed 163 Reports of Investigation, dismissing 62 cases, issuing 15 Letters of Admonition, and suspending 38 and revoking 48 certificates. The committee has also dealt with various requests, reinstatements, and settlement matters.

\* \* \*

The State Board of Nursing has amended Chapter 10 of the rules which covers certification of Certified Nurse Aides. According to Susan Grayson, Centura Home Health & Hospice, Denver, who represented HCAC on the task force charged with studying and recommending changes in an effort to ease the aide shortage, the major changes are:

\* any one with a health care background can challenge the nurse aide training program curriculum content via testing and demonstration of competency.

\* the credentials are good forever rather than two years.

Continuing without change is the requirement of a four-month limit of work for an aide who has not yet been certified.

**On the net:**

**[www.dora.state.co.us/gov\\_dir/stateleg.html](http://www.dora.state.co.us/gov_dir/stateleg.html)**

**Scroll to Dept. of Regulatory Affairs, Board of Nursing,  
and Board Rules.**

## IMPORTANT WEB SITES (\*= new listing)

**Agency for Healthcare Research and Quality** - [www.ahrq.gov/consumer/diaginfo.htm](http://www.ahrq.gov/consumer/diaginfo.htm)

### CAHABA

[www.bcbsal.org](http://www.bcbsal.org)  
[www.cahabagba.com](http://www.cahabagba.com)  
[www.almedicare.com](http://www.almedicare.com)  
[www.gamedicare.com](http://www.gamedicare.com)

\*CHAP - [www.chapinc.org](http://www.chapinc.org)

**Colorado Medicaid HMO quality reports** - [www.state.co.us/gov\\_dir/chcpf/mcc/mccindex.html](http://www.state.co.us/gov_dir/chcpf/mcc/mccindex.html)

### Colorado Dept. of Public Health & Environment

[www.cdphe.state.co.us/cdphehom.asp](http://www.cdphe.state.co.us/cdphehom.asp)

### Colorado Dept. of Public Health & Environment Health Facilities Division & List of Providers

[www.cdphe.state.co.us/hf/hfd.asp](http://www.cdphe.state.co.us/hf/hfd.asp)

### Consultec

(new Medicaid fiscal agent)  
[www.consultec-gcro.com](http://www.consultec-gcro.com) or  
[www.consultec-gcro.com/colpage](http://www.consultec-gcro.com/colpage)

### Federal Register

[www.nara.gov](http://www.nara.gov)

### Health Care Financing Administration

[www.hcfa.gov/medicare](http://www.hcfa.gov/medicare)

### HCFA/PPS

[www.hcfa.gov/stats/pufiles.htm](http://www.hcfa.gov/stats/pufiles.htm)

### HCFA/Sequential Billing

[www.hcfa.gov/medicare/hhafaq.htm](http://www.hcfa.gov/medicare/hhafaq.htm)

### HCFA/15 Minute Reporting

[www.hcfa.gov/pubforms/transmit/A992960.htm](http://www.hcfa.gov/pubforms/transmit/A992960.htm)

### HCFA/Hospice Payment Rates

[www.hcfa.gov/pubforms/transmit/A993360.htm](http://www.hcfa.gov/pubforms/transmit/A993360.htm)

**Health Care Policy & Financing**  
[www.state.co.us/gov\\_dir/chcpf/index](http://www.state.co.us/gov_dir/chcpf/index)

**Health Care Policy & Financing Essential Community Providers**  
[www.state.co.us/gov\\_dir/chcpf/ecplist.html](http://www.state.co.us/gov_dir/chcpf/ecplist.html)

### Home Care Association of Colorado

[www.hcaonline.org](http://www.hcaonline.org)

### HHABN (Revised Forms) -

[www.hcfa.gov/regs/prdact95.htm](http://www.hcfa.gov/regs/prdact95.htm) or e-mail request to [Paperwork@hcfa.gov](mailto:Paperwork@hcfa.gov)

### Home Health Agency 1-5 Star Rating -

[www.healthgrades.com](http://www.healthgrades.com)

### Hospice Facts & Stats

[www.hospice-america.org](http://www.hospice-america.org)

### Hospice Providing Free Care -

[www.hhs.gov/oig/advopn/2000/ao00\\_3.htm](http://www.hhs.gov/oig/advopn/2000/ao00_3.htm)

### Hospice Survey and Certification

**Issues** - [www.hcfa.gov/medicaid/hospice/hospice.htm](http://www.hcfa.gov/medicaid/hospice/hospice.htm)

### JCAHO

[www.jcaho.org](http://www.jcaho.org)

### Managed Care Yearbook, Fourth Edition or Medicare managed care

plans exiting the risk market  
[www.themcic.com](http://www.themcic.com)

### Management and Prevention of Osteoporosis

[www.sma.org](http://www.sma.org)

**Medicaid Rules** - [www.state.co.us/gov\\_dir/chcpf/StateRules/index.html](http://www.state.co.us/gov_dir/chcpf/StateRules/index.html)

### MMIS Fiscal Agent News

[www.state.co.us/gov\\_dir/chcpf/mmis](http://www.state.co.us/gov_dir/chcpf/mmis)

### National Association for Home Care

[www.nahc.org](http://www.nahc.org)

### OASIS

[www.hcfa.gov/medicare/hsqb.oasis.oasishmp.htm](http://www.hcfa.gov/medicare/hsqb.oasis.oasishmp.htm)

**OASIS Implementation Manual**  
[www.cdphe.state.co.us/hf/orhrinfo.asp](http://www.cdphe.state.co.us/hf/orhrinfo.asp)

**OASIS User's Guide**  
[www.hcfa.gov/Medicaid/oasis/usermanu.htm#guide](http://www.hcfa.gov/Medicaid/oasis/usermanu.htm#guide)

### Occupational Safety & Health Administration

[www.osha.gov](http://www.osha.gov)

### Office of Inspector Genl/ Hospice Compliance

[www.dhhs.gov/oig](http://www.dhhs.gov/oig)

### OLMSTEAD Decision -

[www.hcfa.gov/Medicaid/olmstead/olmslink.htm](http://www.hcfa.gov/Medicaid/olmstead/olmslink.htm)

**Persons/ Entities Excluded from Medicare**- [www.dhhs.gov/progorg/oig](http://www.dhhs.gov/progorg/oig), click on Electronic Reading Room, then OIG exclusions.

### PPS Billing Questions -

[www.hcfa.gov/medicare/hhcbill.htm](http://www.hcfa.gov/medicare/hhcbill.htm)

**PPS Final Rule** - [www.hcfa.gov/Medicare/hhppsum.pdf](http://www.hcfa.gov/Medicare/hhppsum.pdf)

\*Senior HELP - [www.help4srs.org/](http://www.help4srs.org/)

### State of Colorado Agencies

[www.state.co.us/gov\\_dir](http://www.state.co.us/gov_dir)

### State of Colorado Homepage

[www.state.co.us](http://www.state.co.us)

### State Pharmacy Board

[www.dora.state.co.us/Pharmacy/PharmacyRules.htm](http://www.dora.state.co.us/Pharmacy/PharmacyRules.htm)

### Tweed-Weber, Inc.

[www.tweedweber.com](http://www.tweedweber.com)

### US Dept. of Health, Agency for Health Care Policy & Research

[www.guideline.gov](http://www.guideline.gov)

### U.S. Government Printing Office (Federal Register)

[www.access.gpo.gov/nara](http://www.access.gpo.gov/nara)

### Wellmark

[www.wellmedicare.com](http://www.wellmedicare.com)

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**LEGAL AND ETHICAL  
ISSUES RELATED TO  
IMPLEMENTATION  
OF PPS: ADVERSE  
EVENT OUTCOME  
REPORTS**

by Elizabeth E. Hogue, Esq.

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**The Health Care Financing Administration (HCFA) has issued guidelines that will govern Case Mix and Adverse Event Outcome Reports.** HCFA intends to use OASIS data transmitted by all home health agencies as a “reference sample” to compare data for individual home health agencies with regard to both case mix and adverse event outcomes.

HCFA’s development and use of Adverse Event Outcome Reports raises a number of significant legal issues for home health agencies as described below:

1. HCFA defines an adverse event as a low frequency negative or untoward event that potentially reflects a serious health problem or decline in health status of an individual patient. According to HCFA, adverse events are “markers” of quality of care provided by agencies. In other words, by definition, adverse events are similar to what many agencies often call “incidents” that may be caused by the failure of agencies to provide appropriate care that resulted in an adverse result for patients.

Many agency managers will immediately recognize that placing information regarding adverse event reports in certain individual’s hands is potentially problematic for agencies. Specifically, if patients, their families and their malpractice attorneys have access to information regarding agencies’ Adverse Event Outcome Reports, agencies could be subjected to liability for adverse events.

First, the fact that HCFA regards certain events as “adverse” events may reinforce the appropriateness or even serve as the basis for lawsuits against agencies.

In addition, the material HCFA published regarding these Reports does not indicate whether this information will be available to patients, their families or perhaps the general public. But there is certainly cause for concern about this issue in view of the fact that HCFA says that the information will be used by surveyors during the survey process. Home care managers can readily envision circumstances in which surveyors quote directly from agencies’ Adverse Event Outcome Reports or perhaps even attach copies to a Statement of Deficiencies. Since Statements of Deficiencies are public information and readily available to the public, not to mention to patients and their families,

Continued...

agencies have legitimate concerns about the implications for good risk management based on HCFA's use of these Reports.

2. Agencies should also be concerned about several of the specific adverse events that HCFA has indicated will be routinely included in agencies' Adverse Event Outcome Reports. Specifically, such events include:

*"Discharged to Community Needing Wound Care or Medication Assistance."*

Patient was discharged to the community without paid or resident assistance, while confused or nonresponsive, and while unable to take medications without assistance, or with either a Stage 3 or 4 pressure ulcer or a non-healing surgical wound." (Confused and/or nonresponsive patients presumably cannot dress their own wounds.)

The underlying assumption of this event is that agencies might actually admit or continue care for such patients. On the contrary, patients that fit the description of this adverse event are not appropriate for home care and should not be admitted. When agencies discover that patients whom they thought would have paid or voluntary resident assistance (a reliable primary caregiver) do not have such help, agencies should immediately discontinue services to such patients. To do otherwise will place patients, agency staff and agencies at unacceptable risks for legal liability.

*"Discharged to Community Needing Toileting Assistance."*

Patient was discharged to the community without paid or resident assistance while chairfast/bedfast and totally dependent in toileting.

Again, agencies should not admit or continue services to patients who fit this category. The fact that HCFA apparently envisions that agencies may do so is sobering indeed. When agencies fail to take action in the face of continuing adverse events, they may, in fact, jeopardize their Medicare certification.

Continued...

3. Although it is clear that agencies should not admit or continue services to the types of patients described above, agencies cannot always tell whether there is a reliable paid or voluntary resident caregiver, especially when patients are newly admitted. HCFA may also attempt to use Adverse Event Reports to prevent agencies from discharging patients after admission when circumstances make it clear that patients do not have paid or voluntary resident assistance. If such circumstances occur, agencies should always bear in mind that, if all efforts fail to find appropriate placement for patients, including a patient's refusal to accept appropriate referrals to other levels or care, agencies can discharge patients and have them transported to the local hospital emergency room.

Implementation of the Prospective Payment System (PPS) for home health agencies will continue to present new challenges for agencies. Savvy agency managers will promptly modify current practices in order to avoid pitfalls.

*(Ed. Note: Elizabeth E. Hogue is an attorney practicing healthcare law in Burtonsville, Md. She was a keynote speaker at HCAC's convention in May 1999 and at the Medicare Seminar in February 2001. This copyrighted article was published in **the management report** with permission of the author. The material has been provided to HCAC members as information only and in no way is to be inferred that HCAC recommends or endorses the contents. To obtain additional information about this subject, write to Hogue at 15118 Liberty Grove, Burtonsville, MD 20866.)*

## GROWING TRAGEDY OF ELDER ABUSE

**In an Associated Press report that elder abuse is growing and expected to rise, the American Psychological Association advises that time off for the caregiver (respite care) is essential to avoid the stress that may lead to elder abuse. APA says it is particularly important for people caring for older relatives who suffer from Alzheimer's or other forms of dementia. The organization recommends:**

- \* Social contact for the caregiver and the elder to help minimize tension and give the caretaker someone else to talk to.
- \* Being conscious of verbal abuse. Name-calling, threats, the "silent treatment" and other forms of emotional intimidation causes fear and distress that can lead to illness or aggravate existing health conditions.

Continued...

- \* Counseling for family members with behavioral problems such as drug or alcohol abuse.
- \* Researching whether it is better and safer to move the older person into a setting where there are skilled nurses or other providers.
- \* Increasing awareness among health care workers, social workers, mental health professionals and others who serve the elderly and their families.

**On the net:**

**[www.apa.org/pi/aging/eldabuse.html](http://www.apa.org/pi/aging/eldabuse.html)**

**CALENDAR**

**May 23, 2001**

Colorado Hospice Organization  
2001 Annual Spring Conference  
DoubleTree Hotel, Denver

**October 14-18, 2001**

National Association for Home Care  
20th Annual Meeting & HOMECAREXpo  
Las Vegas Hilton Hotel  
Las Vegas, Nevada

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**DIRECTOR OF CLINICAL SERVICES** - Caring Plus Home Health Care in Pueblo is seeking an RN/BSN with 4-5 years home care management experience, including PPS/OASIS. Caring Plus provides skilled/non-skilled and private duty care and an out-patient diabetes program. Seeking leader who can grow with the company and integrate clinical and business aspects of home health care. Competitive compensation package. Send resume to Caring Plus, 420 West 29th Street, Pueblo, Co 81008 or email to [CaringPlus@CNIP.net](mailto:CaringPlus@CNIP.net).

Continued...

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details."*

This is a quote from the recently completed Ground Point Zero Project. It is, however, something that **Home Care Automation Report (HCAR)** has known for quite some time. Since 1995, **HCAR** has been the only home care publication that focuses on automation. Each month, **HCAR** offers readers timely advice on how to succeed through use of information technology. One subscriber recently stated, "I enjoy **HCAR** - very timely and informative. As busy as we are during these HHS times, I always make time to read it. I can't say that about everything that crosses my desk."

Now you have an opportunity to check out **Home Care Automation Report** at no cost. **HCAR** is making a special limited time offer for a three-month **HCAR** subscription to HCAC members at no cost or obligation.

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**HCAC 1998 Salary and Employee Benefits Survey—A Membership Service!** The first Colorado-specific report on salaries and benefits paid to home care employees. If your agency responded to the survey, you've already received your copy of the report. If not, send in your request with \$75 and we'll mail you a copy. (Nonmembers will pay \$100 for the results.)

**Home Care Colorado 1999 Benchmark Survey of Client Services and Employment—Another Outstanding Membership Service!** HCAC's latest survey is full of important and valuable data on the current state of home care in Colorado. If your agency responded to the survey, you've already received your copy of the report. If not, send in your request with \$75 and we'll mail you a copy. (Nonmembers will pay \$100 for the results.)

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