AMERICAN HEALTH CONSULTANTS®

Providing the highest quality information for 18 years

Hospital Home Health®

the monthly update for executives and health care professionals

IN THIS ISSUE

JULY 2001

VOL. 18, NO. 7 (pages 73-84)

Getting patient verification of visits: Is there a right way to get it done?

Here's why it may be in your best interest to verify visits

Depending on the state in which you work and a patient's point-of-care plan, you may not require a patient verification of visit. Some home care professionals see patient verification as time-consuming and one more step in what is already miles of paperwork. Others contend that by not requiring some form of verification by the patient that a home care visit was made, administrators are leaving their agencies open to allegations of fraud.

So who's right? Well, they both are. In a regulation-filled industry, it's often difficult to walk the fine line between protecting your agency and overworking your staff. *Hospital Home Health* spoke with a few home health care professionals on the issue and found that there are as many answers to the question of patient verification as there are questions.

If you don't require patient verification of visits, you're not alone. Plenty of agencies take the documentation in the computer as verification that a visit was made. Others don't require verification from their professional staff, but ask their aides to have their activity sheets signed by either the patient or the patient's family on a regular basis.

> *"This is the new reality. You must be prepared to show evidence that you didn't commit fraud, and remember, you are guilty until proven innocent. Sometimes, we just have to make the best of the hand we are dealt."*

Julie Van Vleet, RN, BSN, interim director of St. Agnes Hospital Home Care in Fond du Lac, WI, says signatures are simply one more needless administrative task, and that in the end, it really comes down to the patient's word against that of the home care professional.

"If the clinician has entered the information in the visit note, is that not proof enough that the visit was made?" she asks. "Why must we overdo things? I'm not in favor of adding one more thing for the clinicians to have signed and bring back to the office. They have enough already. The patients can say they never signed the note, and that it's

not their signature. Who will [inspectors] believe then?"

In the argument against signatures, there is another point to be made. Does the patient actually understand what he or she is signing? As **Mark Baff**, vice president of sales at Sandata Inc. in Port Washington, NY, notes, this is especially true with senior citizens.

As an example, he tells of his grandfather, who received home care and "was so happy that someone was there he didn't even look at what he was signing. In these cases, signatures by clients don't really mean a lot."

In spite of her opposition to the signatures, Van Vleet explains that as of Jan. 1, 2001, Wisconsin requires patient signatures on patient visit notes. To avoid confusing paraprofessionals with when to get a signature, she says her agency now requires all home health aide notes to be signed. However, she still views the entire signature verification issue as "a no-win situation, so why keep adding fuel to the fire?"

Lorraine Waters, CHCE, director for Southern Home Care in Jeffersonville, IN, agrees up to a point. "I think it is almost obscene for a professional to have to prove he or she made a visit."

Their word over yours

For a time, Waters' agency didn't ask that patients sign a verification form. "[Then] several years ago, we had a request from our field investigator to produce evidence that the employee actually made the home visit [that was] billed. Having a surveyor investigate a complaint that staff never made any visits, as a confused patient stated, will soon change your opinion.

"Do you think your investigator will believe you or the patient?" she asks. " Since then, and with a careful nod to fraud issues, we always have the patient confirm every visit. It's part of our corporate compliance plan.

"This is the new reality. You must be prepared to show evidence that you didn't commit fraud, and remember, you are guilty until proven innocent. Sometimes we just have to make the best of the hand we are dealt," she says. Waters also points out that signatures can help unveil instances of fraud where "staff actually did not make the visits that were billed."

As simple as it sounds, getting a signature on the right document isn't always easy. At Arkansas (Paragould) Methodist Hospital Home Health, patient verification signatures are required. **Dinah Greer**, RN, BSN, director of home health for the agency, says the agency has always had patients sign a nurse's note, but when it switched to a point-of-care system, procedures changed too. The agency still needed signatures, but this time on a form that was printed out after the visit was made.

"We racked our brains trying to figure out a way to get our patient's signature on a note that

CE questions

13. One of the greatest hindrances to a national implementation of telephonic systems is that not all state Medicaid programs accept it.
    A. true
    B. false

14. In home health care, gaming the system refers to:
    A. instances where agency employees are caught gambling in a patient's home
    B. an agency's refusal to provide care to patients whose cost of care exceeds a 60-day episodic payment
    C. an agency's refusal to treat a patient because of a patient's particular ailment
    D. none of the above

15. Among features of telephonic programs are that they:
    A. help maintain the accuracy of records
    B. require a single, substantial capital investment
    C. are user-friendly
    D. A and C
    E. B and C

16. When it comes to communicating with others, what percentage of a message is carried by body language?
    A. 7%
    B. 27%
    C. 38%
    D. 55%
    E. 59%

was printed out later in the office," she says. "The only thing that we could come up with, and it seems to be working fine, is to print address labels out that have a place for the patients to sign and place for the date of the visit to be filled in with a statement that a skilled nursing visit or physical therapy visit was made on that day. When the clinicians review and sign their note, they stick the label on the note."

Certainly, back office systems can affect how you document a patient's visit, and therefore, how you obtain verification. At Lodi (CA) Memorial Hospital Home Health Agency, Rose **Mary Radotic**, BSN, PHN, director, found that charting was not proof enough that a patient had received care. Lodi Health now utilizes a fill-in-the-dot system that is then scanned into the computer. The questions and descriptions are written clearly on the visit sheet, which the patient can see and the answer. "[Patients] review the completed form and also can have a copy if they request," she says. "There is also space for written documentation to cover exceptions, the chart-to-the-care plan, and a plan for future visits."

"I have been preparing the nurses for the eventuality that when our hospital purchases a new fully integrated system, we will undoubtedly return to laptops [which her nurses disliked], says Radotic. "For now, our system is not without flaws, but it is so simplistic, everyone loves it, and we have less paper than we did with the previous system."

Verification without a pen

For every reason to go with a signature there are reasons not to. And accordingly, there are reasons to go the extra mile. Telephony is becoming increasing popular in the home health care industry. **(See related story, p. 76.)** The primary hindrance to widespread use is lack of acceptance by state Medicaid systems, many of which still rely on computer systems that are not compatible with today's technology and won't accept telephonically submitted reports. Not surprisingly, proponents of telephonic services, such as Baff — whose company makes and markets Santrax, a fully automated time, attendance, and data collection system for off-site locations — is leading the charge to gain national acceptance of what he says is a win-win situation for everyone.

"Right now, the burden is really on Medicaid to allow the use of electronic records in reporting. The stumbling block is that the regulations were written 20 years ago, and we didn't have computers then.

"No one ever imagined it would be like it is today. For the world of 20 years ago, they were perfectly good regulations, but the business environment has galloped past the old regs," Baff says. "It's my belief that for the benefit of everyone, Medicaid should allow the use of electronic reporting — the benefits are clear to everybody," he says. "Several states already have agreed to accept telephony, and we believe we are about to have some success in Texas."

Electronic advantages

There are distinct advantages to going electronic, Baff says. "These systems collect the actual arrival and departure time from workers from the actual visit sight. They record the tasks they accomplish and other traditional data elements, particularly in terms of paraprofessionals. Any data that are necessary for billing and payroll services, including mileage travel, if an agency reimburses for mileage, are recorded."

Telephonic systems, he says, can be customized to interface with an agency's payroll system so that "with a click of the mouse, the billing export files go to the billing system and then to payroll. It's all streamlined. No more hassles collecting paper or doing manual data entry and dealing with the errors and delays that occur. You're getting precise and accurate information into the system and with a permanent, comprehensive audit trail," he says.

The audit trail is perhaps one of the strongest arguments in favor or using telephony, says **Thomas P. Gordon**, JD, senior account executive with Sandata.

"I tend to look at this way. An electronic verification of the visit using telephony, which can timestamp the location and phone number, definitely protects the agency from allegations of fraud and abuse," he says.

"In an audit situation, there is nothing better than having this information in an electronic format where you can search and query your visits by client or supervisor or worker. It's much harder and more time-consuming to gather the same information with paper," Gordon explains.

Meri Shaffer, RN, program manager for HomeAdvantage in Fairfax, VA, says using "a telephony system to track your staff in and out of patients' homes will give you a caller ID, which to me is primary proof that the clinician

was there and for how long.

"I know that we like to think our colleagues are honest professional health care workers, and most of them are, but unfortunately during my 20 years in home health, I have seen several professionals commit fraud and have had to investigate my share of questionable visits," she says.

"I agree that we are mired in paperwork; that is why I am a strong proponent of automation, but I also cannot condone fraud. . . . It makes us all look bad," Shaffer adds.

HomeAdvantage markets a telephony system and specializes in software development, computer telephony integration, Internet/intranet development, and project management with a special focus on health care, hospitality, and telecommunications.

Lawbreakers usually find a way

Gordon acknowledges that if "someone is interested in breaking the law, then a way always can be found to do so." To dissuade those who are less than honest, he recommends that agencies taking the telephony route, "stick with automatic number identification [ANI]-based systems and technology rather than caller ID-based systems, as caller ID can be blocked." ANI, he explains, "is the same technology the telephone companies use to switch calls between the different carriers and is unblockable."

Elisa Hinken, a nurse consultant and president and CEO of MedMal Nursing Consultant Services (a division of MedMal Consultants Inc.) in Lawrence, NY, says, "Telephony works great if the patient isn't participating with the worker in committing fraud. Some patients put in their workers' ID numbers into the phone service and then split the pay so both parties benefit from it. I have seen this with paraprofessional agencies that have cases in excess of 400."

Still she agrees that telephony has cut down on certain types of fraud and that at least on a paraprofessional level, supervision is minimal.

"Telephony is not 100%," adds Baff, "but if someone wants to collude, then the truth is [he or she] could find ways about it. This is not big brother, but all in all, it's better than the traditional way of doing things."

[For more information, contact:

*• **Mark Baff**, Vice President, Sales, Sandata Inc., 26 Harbor Park Drive, Port Washington, NY 11050. Telephone: (516) 484-4400.*

*• **Thomas P. Gordon**, JD, Senior Account Executive, Sandata Inc., 26 Harbor Park Drive, Port Washington, NY 11050. Telephone: (516) 484-4400.*

*• **Dinah Greer**, RN, BSN, Director of Home Health, Arkansas Methodist Hospital Home Health, 900 W. Kingshighway, Paragould, AR 72450. Telephone: (870) 239-7101.*

*• **Elisa B. Hinken**, Nurse Consultant, President and CEO, MedMal Nursing Consultant Services, P.O. Box 302, Lawrence, NY 11559. E-mail: medmalnursing@msn.com.*

*• **Rose Mary Radotic**, BSN, PHN, Director, Lodi Memorial Hospital Home Health Agency, P.O. Box 3004, Lodi, CA 95241. Telephone (209) 333-3131.*

*• **Meri Shaffer**, RN, Program Manager, HomeAdvantage, 10875 Main St., Suite 212, Fairfax, VA, 22030. Telephone: (703) 352-1830, ext. 8213.*

*• **Julie Van Vleet**, RN BSN, Interim Director, St. Agnes Hospital Home Care, 239 Trowbridge Drive, Fond du Lac, WI 54935. Telephone: (920) 923-7950.*

*• **Lorraine Waters**, BSN, MA, CHCE, Director, Southern Home Care, 1806 E. 10th St., Jeffersonville, IN 47130. Telephone: (812) 283-2602.]* ■

Telephony: What can it do for your agency?

Could be a boon, could be a bust

While not all state Medicaid programs will accept telephony, reports show that in those states that do, it's a major boon to the home health industry.

Mark Baff, vice president of sales for Sandata Inc. in Port Washington, NY, says that he and his company have been hard at work trying to gain nationwide acceptance for the program.

He says telephony is the way to go when it comes to documentation.

Meri Shaffer, a program manager with Fairfax, VA-based HomeAdvantage, which also offers telephonic services to home care agencies, agrees. Even those who don't work for telephonic service providers see it as a win.

Elisa Hinken, a nurse consultant and president and CEO of MedMal Nursing Consultant Services in Lawrence, NY, says that as a home care consultant, she is very familiar with telephony. Hinken says the agencies she works with are very happy with the telephonic service

programs they use.

So what can it do for you? Here's a starting point:

❒ **Accurate records.**

Home health aides and nurses don't have to rely on memory or scribbled notes to fill out a patient record. When aides arrive at a patient's house, they call to check in and again when they are getting ready to leave.

Upon departure, the system will take the aides through a series of basic questions regarding the type of care that was provided. "If you're depending on your memory and you have a lot of patients, things can get muddled," says Schaffer.

Interactive systems code responses

Some systems, explains Baff, use an interactive voice response system. It means the system, much like the phone system you might find at your local bank, will ask a simple question such as, "Did you bathe the patient?" The nurse or aide can then answer yes or no, accordingly. Others, like Sandata, have each task coded so that workers are asked to punch in the codes that correspond to a particular task. For example, "23" would be the code for bathing.

"If you ask whether the patient was bathed," he says, "everyone will say yes. Smart technology asks what you did and then takes in the information that way."

Home health aides have a set of codes that are specific to their agency, usually no more than 150 possible tasks but, he notes, aides tend to use only about 20 on a regular basis.

❒ **Little to no upfront investment.**

"We're web-based, so agencies don't have to spend $25,000 on software or hardware," Baff notes. "They don't need to create a mini-, automated call center in their agency. All they need to get going is a Pentium-class computer and a web browser and you pay as you go. Home care has a tough enough time to expect agencies to run call centers. We give our customer toll-free numbers so there's no cost to the patient either." HomeAdvantage is also web-based.

❒ **User-friendly technology.**

"Training is a piece of cake," he says, "and just about everyone has a telephone."

❒ **Lower demands on supervisors.**

With a telephonic system supervisors don't have to spend nearly as much time badgering employees to complete their paperwork.

❒ **Easier payroll.**

Both Santrax and HomeAdvantage are web-based programs, which allows them to interface with an agency's outside payroll company, if needed.

❒ **Real-time collection and quicker billing time.**

Rather than waiting to collect paperwork from a week's worth of work, with a web-based telephony system, agencies can bill Medicare even a day after a visit was made. "If it takes two weeks to get the paperwork processed and edited, it may be three weeks before a capitated payment shows up," says Baff.

"It provides, with PPS collection, actual arrival and departure times so in that in a capitated agency, where you pay only for the service time used, you get to keep the rest of the money. These systems can really work toward mitigating the cash-flow pressures inherent in an agency. If an agency is using the system properly, it has a cost cutting impact and a positive revenue impact."

❒ **Matching plan of care.**

Some telephony programs, such as Santrax, also offer care plan match programs, "so when we collect the data that include the tasks they [home health aides] did, we are matching [the data] to the care plan to see if it was followed and if it was underserved or overserved," Baff says.

For every positive there is a negative, and there are to be sure a few downsides to telephony. As Shaffer points out, one is certainly its lack of widespread acceptance. "Wisconsin has the most sophisticated web pages for health and human services for the state and yet won't accept a caller ID as proof that aide was in the home," she says. Nor is it the best for taking in OASIS data. That aside, telephony seems to be where the industry is headed. To be sure, there will be bumps on the road, but maybe the ride will be smoother.

[For more information, contact:

• ***Mark Baff**, Vice President, Sales, Sandata Inc., 26 Harbor Park Drive, Port Washington, NY 11050. Telephone: (516) 484-4400. Web: www.sandata.com.*

• ***Elisa B. Hinken**, Nurse-Consultant, President and CEO, MedMal Nursing Consultant Services (a division of MedMal Consultants, Inc.), P.O. Box 302, Lawrence, NY 11559. E-mail: medmalnursing@msn.com.*

• ***Meri Shaffer**, RN, Program Manager, HomeAdvantage, 10875 Main St., Suite 212, Fairfax, VA, 22030. Telephone: (703) 352-1830, ext. 8213. Web site: www.loginsoft.com.]* ■

LegalEase

Understanding Laws, Rules, Regulations

Gaming and appropriate behavior have their place

By **Elizabeth E. Hogue**, Esq.
Elizabeth Hogue, Chartered
Burtonsville, MD

[Editor's note: This is part of an ongoing series on legal and ethical issues related to implementation of the prospective payment system (PPS) for home health agencies.]

The implementation of PPS has some home health agency staff concerned. One reason is they worry that other agencies will refuse to provide care to patients whose cost of care exceeds a 60-day episodic payment. These refusals are known within the industry as gaming the system, and as you might expect, they are characterized as both illegal and unethical.

Gaming the PPS reimbursement system surely goes against the rules. Examples include supplying information that results in placement of patients in home health resource groups (HHRGs) or payment categories that pay a higher rate than the HHRG for which the patient is appropriately qualified. When taken in this context, gaming may also be characterized as fraudulent.

Although it might seem similar, managing an agency's mix of patients under PPS is not illegal or unethical. In fact, the Health Care Financing Administration (HCFA) has built incentives into reimbursement systems, including PPS, that are intended to modify the behavior of providers. In other words, HCFA wants agencies to develop new skills under PPS, if they did not already develop them under the interim payment system (IPS).

Specifically, PPS is designed to force agencies to learn to manage their patient mix.

The goal is to achieve a balance between patients whose cost of care is less than the 60-day episodic payment agencies receive with those whose cost of care exceeds amounts received for a 60-day episode of care. In order to achieve this balance, agencies may have to refuse to admit and/or discontinue services to some patients.

This particular incentive of PPS may reflect statements by HCFA officials in which they have repeatedly indicated that the Medicare home health benefit is not intended to care for patients who need chronic care.

Although it may presently be unclear where on the continuum of care HCFA believes such patients should receive care or even whether chronic care should be covered under the Medicare program at all, it is neither illegal nor unethical for agencies to modify their behavior in appropriate response to the incentives of a new reimbursement system.

A note of caution is needed at this point. When IPS was implemented, there was a general hue and cry from some providers that IPS meant that they would be unable to care for chronically ill patients. Some agencies discharged these patients and/or discontinued services to others consistent with appropriate regulatory requirements. At the end of their first year under IPS, however, some agencies, at least anecdotally, were under their aggregate per beneficiary limits but well over their cost caps.

> *Agencies affiliated with hospitals that have a mission and vision to assist the poor and sick may elect to care for patients regardless of changes in reimbursement. Agencies that make this choice should be respected and even applauded. By the same token, however, it is not appropriate to vilify agency managers who are unable and/or unwilling to make the same choice.*

Dispensing justice to patients

The lack of sufficient volume of visits was, at least in part, responsible for these results. So IPS, and now PPS, is all about achieving a balance in the mix of patients served. It may be that nonadmissions and/or discontinuation of services may not be as essential under PPS as some agencies fear.

With regard to the ethics of managing patient mix under PPS, the ethical principle of justice

seems to be applicable. This principle requires providers to give each patient his or her due. Among other things, it also requires that patients receive appropriate care, including home health services.

Everyone is entitled to appropriate care

But this principle also requires providers to address issues of distributive justice. This means that everyone in the community is also entitled to his or her due, including appropriate care.

Some home care providers have legitimate concerns about access to care under IPS and now PPS. It is, therefore, appropriate for providers to be concerned about violation of this ethical imperative if failure to manage patient mix impairs the ability of agencies to make services available to the community.

Some agencies may, of course, choose to ignore patient mix and continue to care for all patients at an expense that is greater than the reimbursement they receive.

Agencies affiliated with hospitals that have a mission and vision to assist the poor and sick may elect to care for patients regardless of changes in reimbursement.

Agencies that make this choice should be respected and even applauded. By the same token, however, it is not appropriate to vilify agency managers who are unable and/or unwilling to make the same choice.

The bottom line is that there are several responses that are appropriate, both legally and ethically, to PPS. When agencies make different choices and square off against each other, patients are likely to be hurt, a result that is simply unacceptable. ■

Please ask; don't issue staff your commands

Ensure employees understand you the first time

Do you ever get the feeling you're talking but you're not actually being heard? If you're the parent of a teenager, the feeling should be a familiar one, but in the workplace, you expect it to be a different story.

Situations are seldom that simple as any home care agency administrator or manager knows. You think you've given a clear picture of what needs to be done, by whom and by when, but you still find yourself having to repeat yourself later, and even with your efforts, you find that the job just isn't getting done the way you had hoped.

Should you give up and do it yourself because, after all, you know what you want and how it should be done, or should you consider a new approach?

Regis Smolko, an instructor with the Fred Pryor Seminars, says that rule No. 1 in giving instructions is, "You ask; you don't command." He says that too many people shy away from making a request of their employees for fear of coming across as weak or lacking in leadership.

The opposite is true, in fact, and that by asking, you encourage employees to view the task as working toward a common goal. "People make 98% of their decisions based on emotions and in the first 11 seconds will decide whether they will work with your or test you and work against you. If you come across in a way that they like, they are more likely to cooperate with you," Smolko explains.

A second guideline to follow is to take a positive approach. By that, Smolko means giving your request a positive spin, emphasizing what employees should do rather than what they shouldn't, he adds.

The exception to this rule, he says, is in instances where the potential for making a mistake is high or where you really want to emphasize potential pitfalls. Then, too, he says, employees should have a clear-cut idea from their boss as to why a given task or project is important and how it relates to the big picture. "Sometimes explaining why something needs to be done is the most beneficial thing you can do," Smolko points out.

Follow up with your employees

Lastly, requests should leave room for employees to apply their personal work style. You don't need to give them a project and a step-by-step plan for getting it accomplished, he says.

"You want to delegate results, not methods," Smolko explains. Everyone works a little differently so you need to allow for that and resist the urge to comment, he notes.

Even if you've followed these rules, that doesn't mean you don't need to follow up with employees to chart their progress and to learn if they have any questions or have encountered any

problems. "To make sure your instructions took," he says, "you need to get feedback as quickly as possible."

While this may appear obvious, too many supervisors fail to do so. There are several reasons, for this, says Smolko. Today's managers are under a great deal of pressure and frequently just don't have — or don't think they have — time to revisit a subject. "You're in a hurry to get something done, and you don't want to take time out to get your employees' feedback on what you discussed," he says.

A second reason many supervisors fail to follow through is because of complacency. "We just don't do it, for a number of reasons," he notes.

Perhaps one of the greatest reasons for a lack of follow-though, he says, is that people like to think they did a good job explaining the task at hand.

"We assume the person got it," he says, "and are reluctant to revisit the subject for fear of appearing condescending." Managers, he notes, should keep in mind that people interpret different words in different ways. "Soon" as a deadline could mean the next day to you and next week to your employee. Further, he says, don't assume your employee has the same frame of reference as you do.

"When we think of things, we think of them from our perspective not the other person's. To make headway with people, you need to change your attitude and behavior to match them," he says. "But to make big leaps with people, you need to change your frame of reference." Use words they might use so that you can talk with your employees more effectively, he suggests.

Getting the feedback you need

Even the best-laid plans can go wrong, he points out, and one of the most common reasons behind this is stereotyping. "You think you know, for example, how something should be done, but in not being open to new ideas, you are limiting yourself," Smolko says.

He encourages managers to solicit ideas from their employees on how a task could best be accomplished. Another problem that can lead to communication breakdown is when managers view the process as a one-way street. "If you don't share with people, they won't follow you," he says.

If you really want to get feedback, he says, you need to be aware of nonverbal cues. Seven percent of a message is carried by words, he explains. Thirty-eight percent has to do with your tone, and 55% comes across through body language.

"We can't always interpret nonverbal cues," he says, "but you can use them to encourage us toward a given direction. Whenever you ask a question, there will be body responses. Let people's body language speak to you." Try as people may, it's very difficult to hide nonverbal signs, he says, especially those that indicate doubt.

When giving instructions or, equally as important, when negotiating on important matters, it's important to be seated, he says. "You want to assume and mirror that person's body language if you want to get the greatest compliance. After a time, change positions and see if they mirror you, and when they do, that's the time to ask for their input."

Ask open-ended questions

Another way to encourage staff feedback is through open-ended questions such as "What do you think of all of this?" or "How did that come across?" At all costs, he says, avoid such close-ended questions as, "Is that clear?" Employees, Smolko says, don't want to be the ones to say they didn't understand.

It's also important to encourage questions from your staff as you go along, and although it sounds obvious, never put down a question,

Taking Employees to a Task

When giving instructions, it's best to:

- ✔ Tell employees what you need them to do.
- ✔ Show them what needs to be done.
- ✔ Have them tell you what they understood you to have said.
- ✔ Have them show you what needs to be done.
- ✔ Have them write it down.
- ✔ Schedule periodic status meetings.

Source: Fred Pryor Seminars, Overland Park, KS.

no matter what it is or what you think of it. Questions show employees are listening.

Lastly, Smolko says, it's important for managers to take responsibility for poor communication. It's always a good idea to preface your closing with something like, "I know I'm not always the clearest, so could you run it back by me so that I can be sure I explained myself properly?" As a manager, he notes, you bear ultimate responsibility, so make sure everyone understands where you are coming from.

[For more information, contact:

• ***Regis Smolko**, Instructor, Fred Pryor Seminars, 9757 Metcalf Ave., Overland Park, KS 66212. Telephone: (800) 905-8442.]* ■

NEWS BRIEFS

ND, AK, KY discipline the most doctors

According to a report recently released by the Public Citizen's Health Research Group, North Dakota, Alaska, and Kentucky have the best record for disciplinary action (which includes revocations, surrenders, suspensions,

Where to go on the Internet for the latest health info

The following web sites offer a bit of everything but are worth more than a casual look. Whether you're looking for a position paper on drug testing for health care workers or the proper dosage of a medication, the sites below are a great place to start looking:

Nursing World/Nursing Insider (www.nursingworld.org).
This web site offers a bit of everything from job listings to nursing news, from information on needlestick prevention to the home page of the Ethnic Minority Fellowship Program, which offers fellowship funding to qualified nurses looking to enter the fields of psychiatric and mental health care.

Allnurses.com (http://allnurses.com).
Whether you're looking to join a discussion group or interested in receiving monthly updates via e-mail, this is the site for you. Allnurses.com offers nursing news from around the world and links to health care equipment suppliers and providers.

RxMed (http://www.rxmed.com/index.html).
RxMed might be geared to family physicians but there is plenty there for everyone in the health care industry. The site offers drug monographs for all medications, information on health resources, medical supplies, employment opportunities, travel health, and patient handouts on a variety of subjects.

MDchoice.com. (http://www.mdchoice.com).
MDchoice offers information for both industry professionals and consumers. On the professional side, visitors can find a variety of information sources ranging from full-text journals to on-line textbooks and selected readings. Visitors can also test their skills with the site's award-winning ACLS and PALS critical care simulators. Other tools include clinical calculators and links to sites dealing with cancer, allergies and prescription medications. Consumers, meanwhile, can find information on hundreds of diseases thanks to an easy-to-use search function, plunge into one of several medical databases, including AIDSline, and test their own CPR skills using the home emergency simulator.

Intelihealth.com (www.intelihealth.com).
Whether it's information on such issues as stress reduction, weight management, workplace health, or asthma, caring for babies, or getting enough sleep, Intelihealth has 23 health topics from which to choose. Consumers might find the news items informative as well as the Ask the Doc feature; professionals will want to visit the medical dictionary, and tracking tools for asthma, diabetes, blood pressure, and bladder control.

and probation / restrictions) against physicians.

The report, *Ranking of State Medical Board Disciplinary Actions in 2000*, examined statistics from the Federation of State Medical Boards on the number of disciplinary actions taken in 2000 against doctors.

The study found that while nationally there were 2,746 serious disciplinary actions taken by state medical boards in 2000 (up slightly from the 2,696 serious actions taken in 1999), there were more physicians practicing in 2000, and the rate, per 1,000 physicians, was essentially the same in the two years: 3.5 serious actions per 1,000 physicians in 1999 and 3.49 in 2000.

The top 10 states, or those with the highest rate of serious disciplinary actions per 1,000 physicians are:

- North Dakota (12.43 per 1,000 physicians);
- Alaska (11.47);
- Kentucky (8.51);
- Wyoming (8.10);
- Oklahoma (6.68);
- Utah (6.27);
- Arizona (6.18);
- Ohio (5.89);
- Georgia (5.35);
- New York (5.08).

Four of these states (Alaska, Oklahoma, Wyoming, and Ohio) also were in the top 10 in 1998 and 1999, and one state, Alaska, has been in the top 10 for 10 straight years. Oklahoma has been in the top 10 states for nine of the last 10 years, while Wyoming has been in the top 10 for eight of the last 10 years, and Ohio has been in the top 10 for six of the last 10 years.

The bottom 15 states, those with the lowest serious disciplinary rates in 2000, were, starting with the lowest:

- Idaho (0.85 per 1,000 physicians);
- South Carolina (1.24);
- Hawaii (1.33);
- Delaware (1.39);
- Minnesota (1.53);
- Maine (1.58);
- Illinois (1.67);
- Washington (1.78);
- Montana (1.91);
- New Mexico (2.13);
- Maryland (2.21);
- Nebraska (2.39);
- Texas (2.42);
- Kansas (2.53);
- West Virginia (2.54).

Of the 15 states with the worst serious disciplinary records, eight of the states, Massachusetts, Illinois, Maryland, Washington, Minnesota, Kansas, Hawaii, and Delaware were also in the bottom 15 states in 1999 and 1998.

The study's results raised concerns that patients in the bottom 15 states are receiving subquality care from doctors who might otherwise be barred in another state but are allowed to practice there.

Factors for poor disciplinary records include: inadequate funding / staffing for the state medical boards; lack of proactive investigations; failure to utilize Medicare, Medicaid and other sources for information; dependence on state medical societies; and poor statutory framework for disciplining doctors.

For more information on the report, go to www.citizen.org. ▼

JCAHO to rework hospital standards

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) announced its decision to rework outdated hospital standards, after the results of an American Hospital Association study found that in some hospital departments an hour of patient care translated into an hour of paperwork.

Up to 85% of the standards that hospitals must meet in order to be accredited have not been revamped in seven years.

JCAHO's best intentions may be difficult to implement, however, as roughly half of its

COMING IN FUTURE MONTHS

- Coping with verbal abuse
- Electronic records: Should you keep them?
- Getting workers' comp coverage
- Ideas for recruiting new employees
- Utilizing home health aides

standards were written to comply with Medicare's condition of participation, and accordingly, JCAHO standards will have limited room for reworking and require government approval for substantial change. ▼

Few home care patients have advance directives

A study conducted and sponsored by the Rochester (NY) Individual Practice Association and Blue Cross found that less than 10% of home care patients with chronic diseases such as heart failure have advance directives, and that in general, people are not be referred to hospice care early enough. Results showed that 40% of referred patients died within one week of admission.

The survey also found that the majority of institutions ask patients at the onset of care about advance directives. The Rochester Community End-of-Life survey sampled 72 area hospitals, home care agencies, hospices, diseases management programs and skilled nursing facilities on such matters as advance directives, hospital referrals, and pain management. ▼

Hospitals forcing medical costs up

Thanks to hospitals' demands for dramatically higher payments from insurers, Americans are seeing some of the most rapid

Hospital Home Health® (ISSN# 0884-8521) is published monthly by American Health Consultants®, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Home Health®**, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: customerservice@ahcpub.com. World Wide Web: http://www.ahcpub.com. Hours: 8:30-6 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $427. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $342 per year; 10 to 20 copies, $256 per year. For more than 20 copies, call customer service for special arrangements. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $71 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Kristina Rundquist**, (703) 836-2266.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Senior Production Editor: **Ann Duncan**.

Editorial Questions
For questions or comments, call **Lee Landenberger** at (404) 262-5483.

AMERICAN HEALTH CONSULTANTS™
THOMSON HEALTHCARE

surges in medical costs in recent years.

In the first quarter of last year, consumers saw a 10% to 15% increase in medical costs as insurance companies attempt to pass along their costs to consumers.

Up until recently, the average annual increase over the past 10 years averaged between 5% and 6%. As more hospitals are becoming increasing powerful within a region, thanks to an industry-wide pattern of mergers and acquisitions, they are using their newfound power to demand higher payments from insurance companies and dropping those who refuse to pay.

Some NY hospitals have won double-digit increases in payments, while those in certain part of WI have asked for 40% to 60% payment increases for some services.

Meanwhile, hospitals in Chicago, Portland, OR, and Orange County, CA, have severed ties with insurance carriers that refused to meet the new price scale.

Hospitals are blaming a payment hike freezes for their now-sudden increases. Escalating the problem is a rising cost in prescription medications that rose nearly 19% last year, and more widespread use of costly diagnostic treatment and equipment. ▼

Check caller ID, advises JCAHO

Several home care organizations have received calls from an individual falsely claiming to be affiliated with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The individual is asking organizations for information on hourly rates, productivity levels, and the number of revisits and admissions. Please be advised that the caller is not affiliated with JCAHO. ▼

ME, MA leave ANA

The Maine and Massachusetts nurses' associations have voted to leave the American Nurses Association (ANA), saying that the national group is too moderate.

They are the first two state nurses associations to leave the ANA since 1995, when the California Nurses Association left. Both votes occurred in April, with the Maine group voting 259-31 to leave and the Massachusetts Nurses Association voting 3,105-656 to split.

The result of the two departures will mean more than $1.1 million lost in dues. ■

CE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

THE EXECUTIVE'S SUPPLEMENT TO *HOSPITAL HOME HEALTH*

HOME HEALTH BUSINESS QUARTERLY

JCAHO developing way to assess staffing effectiveness

The Joint Commission on Accreditation of Health care Organizations (JCAHO) is developing a new approach to assessing the effectiveness of staffing in health care organizations. The process, to be pilot tested this year, will use performance indicators to screen for potential staffing issues.

The approach will emphasize the relationship between human resources — such as staff who provide health care services, including direct patient caregivers and clinical support professionals — and clinical outcomes. It will use two types of measures, one identified by JCAHO and the other self-selected by each health care organization.

Current JCAHO standards require accredited health care organizations to determine and provide the right number of qualified staff to meet patients' needs. The determinations usually are based on internal formulae that reflect the number of patients and how sick they are. ■

Web-based system connects remote patients, professionals

Panasonic of Secaucus, NJ, has created a web-based tele-homecare system linking patients and their doctors or other health care professionals by telephone service over the Internet. The system allows remotely located patients to measure their vital signs and other physiological information — including blood pressure, pulse rate, blood sugar, oxygen saturation, and weight — and quickly transmit the data to a health care professional.

The tele-homecare system includes a patient terminal, network server software, and doctor terminal software. The patient terminal measures patient vital signs using a thermometer, blood pressure / pulse cuff, blood sugar machine, oxygen saturation sensors, a stethoscope, an electrocardiograph device, and a scale, and it reminds patients of their schedule to measure vital signs and other activities. It automatically notifies the health care practitioner if the patient's pre-set maximum or minimum level has been exceeded.

The network server informs the patient which sensor to use to monitor which vital sign at a particular time, based on the individual plan drawn up by the health care professional. The doctor terminal software enables a health care professional to browse and observe patient data stored on the server and transmit medical advice and information to the patient via e-mail or videophone.

Panasonic has tested the system with Focused Health Solutions Inc. of Northbrook, IL, a provider of customized health services for the self-insured employer market, and with the VA Connecticut Healthcare System, a division of the integrated health care delivery system that serves the veterans of Connecticut and southern New England. ■

COMPANIES IN THE NEWS

In Home Health completes merger

In Home Health Inc. (IHHI) has completed its merger with Manor Care Inc. of Toledo, OH, and is now a wholly owned subsidiary of Manor Care, which paid $3.70 per share for 39% of IHHI, representing an 88% premium over IHHI's closing price the day before the transaction. ■

McKessonHBOC goes virtual

McKessonHBOC of San Francisco, a supply management and health care information technology company, has launched Supply Management On-line to offer real-time ordering, tracking, and management of pharmaceutical and medical-surgical products.

Customers can go to www.mckessonhboc.com and perform on-line product research, order, review contract information, analyze reports, make payments, and review pharmacy claims reimbursement edits. It also integrates with handheld PDA devices. ■

Senior Care completes $70 million transaction

To expand its portfolio of diverse, age-restricted communities, Senior Care Industries Inc. of Laguna Beach, CA, has acquired a portfolio of real estate assets from Tri-National Development Corp. The value of four properties located in the Baja, CA, resort area is $70.2 million, including assumed debt of $9.6 million. The net value of the transaction is $60.5 million. The acquisition results in an increase of Senior Care's net shareholder equity from $10.2 million as reported in the company's most recent quarterly report to $70 million. The transaction increases the book value of Senior Care shares as reported at the end of the first quarter from 97 cents to $7.05 per share.

The properties acquired include approximately 650 acres of land to be developed as an age-restricted community, as well as a 16-acre oceanfront senior timeshare development site, a 112-unit condominium project under construction, and a 170,000-square-foot shopping mall under construction with an adjacent 15-acre oceanfront senior housing site. Senior Care intends to complete the construction under way and will develop the 650-acre site and the oceanfront properties. ■

YEAR-END RESULTS

Losses, gains at Almost Family

Almost Family Inc. (AFAM) of Louisville, KY, has announced earnings for the three- and 12-month periods ending March 31, 2001. Consolidated net income was $751,486 or 24 cents per share for the quarter and $2.2 million or 70 cents per share for the year. Consolidated net loss for the previous periods were $262,871 or 8 cents per share and $4.7 million or $1.52 per share, respectively. For the year, the company reported net income from continuing operations of $1.6 million or 51 cents per share on revenues of $49.7 million, compared with $175,322 or 6 cents per share on revenues of $44.7 million. As for the quarter, the higher earnings — up more than 800% for the year — resulted primarily from higher sales volumes and improved reimbursement rates.

Almost Family provides adult day health care services for seniors and special needs adults who wish to avoid nursing home placement. The company changed its name from Caretenders HealthCorp. in January 2000. ■

Medical Action shows increase

For the fiscal year ended March 31, 2001, Medical Action Industries Inc. (MDCI) of Hauppauge, NY, a supplier of medical and surgical disposable products, reported net sales of $75.4 million, compared with $70.9 million for the previous year. Net income rose 36% to $4.4 million or 48 cents per basic share (46 cents per diluted share), compared with $3.2 million or 36 cents per basic share (35 cents per diluted share). Earnings before interest, taxes, depreciation, and amortization was $9.6 million.

Net sales for the fiscal 2001 fourth quarter increased to $19 million from the $16.7 million in net sales reported for the three months ended March 31, 2000. Net income for the fourth quarter increased to $1.2 million or 14 cents per basic share (13 cents per diluted share) from the $882,000 or 10 cents per basic (9 cents per diluted share) reported in 2000. This represents the 11th consecutive quarter of record net income. ■

FIRST QUARTER RESULTS

Extendicare reports a loss

Extendicare Inc. of Marham, Ontario, reported a first quarter loss of $5.3 million (8 cents per share), compared with a loss of $11.9 million (16 cents per share) last year. Operating cash flow, before working capital changes, was $23.2 million (32 cents per share), compared with $9.7 million

(13 cents per share). Earnings before interest, taxes, depreciation, and amortization (EBITDA) was $33.3 million (8.2% of revenue), compared with $25.4 million (5.8% of revenue), an improvement of $7.9 million.

Lower U.S. resident care liability costs improved quarter-over-quarter EBITDA by $17.9 million, as a result of the disposal of Extendicare's Florida operations. Following a $20 million jury verdict against the company, it sold or leased all its Florida facilities with combined revenues of $125 million and combined losses of $44 million.

Revenue from same-facility operations improved by $31.6 million, while disposals reduced revenue by $60.8 million. Improvements in same-facility revenue resulted from several factors, including increased revenue from higher volume and rates for Canadian home health care operations, higher U.S. nursing center rates, and new management contracts. The impact of the U.S. foreign exchange rate on translation of U.S. operations added $14.4 million to revenue. In March, the company received a cash dividend of $22.6 million from Crown Life Insurance Co. The money is being used to buy back shares and reduce debt. In May, the company's U.S. operations received a tax refund of $22.5 million, which has been applied to its revolving credit facility. ■

Lincare Holdings posts gain

For the first quarter of 2001, Lincare Holdings Inc. (NCR) of Clearwater, FL, posted revenues of $191.7 million, a 20% increase over revenues of $159.5 million for the same period last year. Net income was $31.5 million, compared with $27 million. Diluted earnings per share were 60 cents, an increase of 21% over 50 cents diluted earnings per share previously. Net cash from operating activities was $62 million, and cash earning per share was 66 cents.

For the quarter, the company recorded an unrealized loss of $2.2 million (2 cents per share) as required by SFAS No. 133, which governs the change in market value of derivative financial instruments.

During the quarter, Lincare completed the acquisition of two companies with aggregate annual revenues of about $10 million and added 13 new operating centers through internal expansion, bringing the total number of locations to 523. The company provides oxygen and other respiratory therapy services to patients in the home and has over 285,000 customers in 44 states. ■

Manor Care reports gain

Manor Care Inc. (HCR) of Toledo, OH, announced diluted first-quarter earnings of 24 cents per share, a 20% increase from first-quarter results in 2000. Net revenues were $638 million, compared with $570 million, a 12% increase. Net income was $25 million, compared with a loss of $800,000.

"Over the past year, we added 12 new facilities and completed several expansions that have improved our position in growing markets. Our home health care business contributed to the strong revenue growth compared with a year ago, including significant gains in our hospice care business. We expect continued strength in this business as we complete the successful integration of In Home Health Inc., acquired in December 2000," said Paul A. Ormond, president and CEO. Manor Care Inc. owns and operates long-term care centers in the United States primarily under the Heartland, ManorCare, and Arden Courts names. ■

Pediatric Services sees drop

Pediatric Services of America Inc. of Norcross, GA, posted a 5% decline in net revenue from $48.1 million in fiscal year 2000 to $45.6 million. The decline was expected as a result of eliminating noncore services. Net income was $186,000, compared with $1.98 million previously. Net income for the quarter included a gain on the disposal of discontinued operations of $24.3 million. Diluted net income per share was 3 cents, compared with $3 previously. Pediatric Services provides comprehensive pediatric home health care services in 22 states. ■

Vencor now Kindred Healthcare

In April, Vencor Inc. of Louisville, KY, emerged from Chapter 11 and changed its name to Kindred Healthcare Inc. The company entered a $120 million senior exit facility with a lending

group led by Morgan Guaranty Trust Co. that will provide working capital for general corporate purposes. It has filed a Form 8-A with the Securities and Exchange Commission to register its common stock and will maintain its status as a public company.

The company announced revenues for the first quarter of $752 million, compared with $715 million for the first quarter of 2000. It reported a loss from operations of $9 million or 13 cents per share, compared with a loss of $16 million or 23 cents per share previously. The reported losses included expenses connected with the company's restructuring activities. The results for the quarter do not include any adjustments that will result from the company's emergence from bankruptcy. Kindred Healthcare is a long-term health care services provider operating nursing centers and hospitals. ■

CORPORATE LADDER

Veritas Medicine of Cambridge, MA, an on-line clinical trials and treatment resource for patients and health care professionals, has appointed **Maggie Adamski** as director of sales. Adamski has more than 15 years of experience in pharmaceutical industry service sales and has also accumulated significant experience in the on-line clinical trial recruitment business at Acurian Inc., where she was director of patient recruitment and retention. She will lead the Veritas sales organization, establish new customer relationships, and expand pharmaceutical industry-sponsored clinical trials available to the public at www.veritasmedicine.com. ■

Coordinated Care Solutions Inc. of Coral Springs, FL — which provides post-acute and high-risk patient management services to more than 3.6 million members covered by HMOs, PPOs, insurance organizations, and state governments — has appointed **Eichard Austin** senior vice president of sales and business development. He will be responsible for the marketing and sales of all product lines and for development and implementation of marketing strategies. Austin has more than 17 years of experience in managed care and has served in senior management positions for national managed health care plans and start-up companies. Most recently, he founded and operated a PPO for USA Group International. ■

On Executive Vice President C.G. Johansson's retirement, **David R. Brennan** will become executive vice president for North America and president and CEO of AstraZeneca LP, in Wilmington, DE. **Tony Zook** will succeed Brennan as senior vice president of commercial operations for the U.S. business. Brennan joined AstraMerck in 1992, where he was responsible for marketing and sales planning and the gastrointestinal and cardiovascular business units. He also led the operating committee. He held similar roles at Astra Pharmaceuticals and went on to lead the commercial area for AstraZeneca LP in the United States. For the last two years, he has been senior vice president. AstraZeneca is an international health care business that researches, develops, manufactures, and markets prescription pharmaceuticals and supplies health care services worldwide. ■

Active Services Corp., of Birmingham, AL, which operates 57 licensed and certified adult day health care units in seven states, has named **John DeStefanis** president and chief operating officer. He will be responsible for managing operations and marketing the company's business units. DeStefanis has more than 25 years of experience, including 10 years in senior executive positions developing health care organizations from start-up, to high growth, to publicly traded. ■

ASSISTED LIVING UPDATE

Sunrise Assisted joins NYSE

Sunrise Assisted Living Inc. of McLean, VA, began trading May 23 on the New York Stock Exchange. Sunrise was previously listed on the Nasdaq National Market. "We believe the move will increase our exposure to a wider investor base, improve trading efficiencies in our shares, and promote our status as a leading company in the long-term care industry," said Paul Klaassen, Sunrise founder, chairman, and CEO.

The company has 199 communities in operation or under construction in 25 states and three countries, employs over 10,000 people, and has a resident capacity of more than 13,500. ■

American Health Consultants
Education and Training Fax-back Survey

We would like to learn more about training and education needs for you and your staff. Please circle the number corresponding to your level of interest in the following topics:

	No Interest		Some Interest		Much Interest
HIPAA privacy rules	1	2	3	4	5
Stark II	1	2	3	4	5
EMTALA	1	2	3	4	5
Aftermath of ergonomics	1	2	3	4	5
OSHA compliance	1	2	3	4	5
Post-exposure prophylaxis	1	2	3	4	5
Influenza update	1	2	3	4	5
Antibiotic resistance	1	2	3	4	5
Adverse drug reactions	1	2	3	4	5
Drug interactions	1	2	3	4	5
Medication errors	1	2	3	4	5
Herb-drug interactions	1	2	3	4	5
Nosocomial infections	1	2	3	4	5
Patient falls	1	2	3	4	5
Basic information for frontline workers	1	2	3	4	5
Needlesticks	1	2	3	4	5
Latex sensitivity	1	2	3	4	5
TB compliance	1	2	3	4	5
Restraints and the violent patient	1	2	3	4	5
Pain management	1	2	3	4	5

	No Interest		Some Interest		Much Interest
Palliative care	1	2	3	4	5
End-of-life care	1	2	3	4	5
Assisted suicide	1	2	3	4	5
Genetic testing	1	2	3	4	5
Organizational ethics	1	2	3	4	5
Human research protection	1	2	3	4	5
Informed consent documentation	1	2	3	4	5
New accreditation standards	1	2	3	4	5
Observation units (23-hour care or recovery beds)	1	2	3	4	5
ED diversion	1	2	3	4	5
Avoiding lawsuits: What to say when something goes wrong	1	2	3	4	5
Improving documentation for nurses and physicians	1	2	3	4	5
Nursing shortage	1	2	3	4	5
Bioterrorism	1	2	3	4	5
Disaster planning and mass casualties	1	2	3	4	5
Safety and security	1	2	3	4	5

What training format is preferred for you and your staff? Rate the following methods using the scale below:

	Least Preferred				Most Preferred
On-site speakers	1	2	3	4	5
Travel off-site to live conferences	1	2	3	4	5
Subscription-based newsletters/journals	1	2	3	4	5
Outside-sponsored teleconferences	1	2	3	4	5
Outside-sponsored videoconferences	1	2	3	4	5
Web-based conferences	1	2	3	4	5
Resource books	1	2	3	4	5
Other _____	1	2	3	4	5

What is your title?_____

To what American Health Consultants newsletter(s) do you subscribe? _____

_____

Thank you for your assistance.

Please fax your completed form to (800) 850-1232 by August 1, 2001.