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IN THIS ISSUE

■ **To pay or not to pay:** Per-visit pay combined with hourly pay does not exempt nurse . . . . . cover

■ **Choose from different pay plans:** Do you know your options? 39

■ **Cut lost workdays with weight limits:** Guidelines cut down on injuries 40

■ **Plug in and sign on:** Are you ready to automate?. 41

■ **Vendor list:** Software companies that offer home health products. 42

■ **Employee teams chose vendors:** Group evaluation can smooth process 43

■ **Think you're doing a good job?** Ask your patients 44

■ ***LegalEase***: Documentation must reflect OASIS. 46

■ **News Briefs** 47

■ **Inserted in this issue**:
— RFP for software vendor
— *Home Health Business Quarterly*
— 2002 *HHH* Readers Survey

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To pay or not to pay: Appeals court rules on overtime payment regulations

Per-visit pay combined with hourly pay does not exempt nurse

In January 2002, the U.S. District Court for the Northern District of Ohio at Cleveland ruled that a home health nurse who received a combination of per-visit pay to see patients and hourly wages to complete paperwork or attend inservices is not exempt from overtime pay, according to the Fair Labor Standards Act (FLSA).

"The FLSA states that a professional can be exempt from overtime if he or she is paid on a fee-only basis or a salaried basis," says **John C. Gilliland II**, Esq., an attorney in Indianapolis who specializes in home health and employee law. In *Elwell v. University Hospital Home Health Care Services*, the court ruled that Wendy Elwell, a home health nurse who was paid a combination of per-visit fees and hourly wages for on-call time, longer-than-normal patient visits, and mandatory meetings, was not an exempt employee because the fee-basis part of the FLSA's professional exemption description does not allow for extra pay for extra work,[1] he explains.

Although the findings of this Appeals Court only are binding in the states of Ohio, Michigan, Kentucky, and Tennessee, Gilliland points out that this is a precedent that other courts will notice. "Even if you're not within this jurisdiction, this is a good time to review pay policies and make sure they fit the FLSA's descriptions," he suggests.

"This decision doesn't affect us at all," says **Kay Sykes**, director of human resources for Alacare Home Health & Hospice in Birmingham, AL. "We have always gone against industry norms in this area and chosen to take the conservative approach," she says. "We pay our professional staff on a salary basis so they qualify as exempt employees," she explains.

Because a salaried staff member is exempt from overtime, this is a good option for some agencies, Gilliland says. It might be difficult to move to a salaried staff for some agencies because it is a nontraditional approach to pay in home health, he says. "Per-visit payments make it easy to tie productivity to pay," he explains. "Some home health managers are not used to managing salaried employees and worry that productivity will drop because it will be harder to manage the employees."

There are a number of options for wage payments, with straight salary being only one, according to Gilliland. **(For more on pay options, see box, p. 39.)** If an agency manager is not comfortable with a salaried staff, he or she can develop a hybrid that pays a small salary along with bonuses for each patient visit, he says. A salaried employee can receive bonuses for extra work without jeopardizing the exempt status according to the FLSA, he explains.

Another benefit of this approach is that you do reward your more motivated employees for productivity and you still compensate everyone for on-call, inservices, and mandatory meetings, he adds.

There is a warning if you choose this option, Gilliland adds. There are salary requirements for the professional exemption, so choose your salary levels carefully or your employees still won't qualify, he says. "The basic amount is $170 per week or $150 per week in Puerto Rico, the Virgin Islands, or American Samoa. If the weekly salary is at least $250, a shorter test is used to determine eligibility," he explains.

The choice of paying employees on a salary basis means that Sykes does not have to worry about the *Elwell* decision, but she says that staff morale is another benefit. "Knowing that their paycheck is not going to change from pay period to pay period gives our staff an added sense of security," Sykes says. This is an advantage when recruiting new nurses and retaining experienced nurses, she adds.

Happy employees might keep your agency from finding itself sued by employees who are not pleased with denial of overtime, Gilliland says.

Elwell was awarded $25,478 in damages as a result of overtime pay she did not receive and $49,884.85 in attorneys' fees and costs. "This was only one nurse suing, and the award was relatively small," he points out. "The real danger is for an agency that has a group of nurses sue and win." If a large enough group of nurses sues one agency and wins, it might mean bankruptcy for the home health agency, he adds.

Make changes with care

You still are liable for past violations, but if you handle your review of your pay policy and implementation of any changes with care, you may not find yourself served with a notice of suit, Gilliland points out.

CE questions

Please save your monthly issues with the CE questions in order to take the two semester tests in the March and September issues. A Scantron sheet will be inserted in those issues, but the questions will not be repeated.

1. Although the *Elwell* decision by the 6th Circuit Court of Appeals is only binding in Ohio, Michigan, Kentucky, and Tennessee, home health agencies in other states should pay attention to it for what reason, according to John C. Gilliland II, Esq., an attorney in Indianapolis?
   A. The damage award was very high.
   B. The ruling will affect definitions of the Fair Labor Standards Act.
   C. This ruling will serve as a precedent for other courts.

2. According to the Client Safety Classification guidelines developed at Southern Ohio Medical Center Home Health Services in Portsmouth, OH, what class of client requires two employees for transfer?
   A. Class 1
   B. Class 2
   C. Class 3
   D. Class 4

3. Joseph T. Cortese, director of health information management and information technology for Montefiore Medical Center Home Health Agency in Bronx, NY, recommends that home health managers plan to address issues that are a by-product of automation. One of these issues is:
   A. dealing with some "personal" issues related to employee's home
   B. reimbursement of overhead costs
   C. publicity within the community
   D. physician education

4. One of the key benefits to using a patient satisfaction survey that is coordinated by an outside firm according to Rita Holley, RN, MS, BSN, director of Shore Home Care Services in Easton, MD, is:
   A. a nicer looking survey form
   B. lower cost than a homegrown survey
   C. the ability to benchmark performance against other agencies
   D. consistently higher rating

Paying home health pros: Do you know your options?

Fee-per-visit pay is a win-win situation for home health nurses, therapists, and their agencies, says **John C. Gilliland II**, an attorney in Indianapolis who specializes in home health and employee law. The motivated nurse who wants to earn as much as possible can take on extra visits, cover for vacationing colleagues, and be compensated for each visit, he says. The agency can be sure that nurses or therapists are paid only for their productive time, he adds.

At the same time, most agency directors contend that they do need to offer other pay incentives to make sure field employees attend inservices, complete paperwork in a timely manner, and attend staff meetings, Gilliland points out. This is how a home health agency stumbled into the losing side of a lawsuit in *Elwell v. University Hospitals Home Care Services*.[1]

How can you compensate nurses and therapists for patient visits but still assure that they meet other responsibilities such as inservice education without risking violation of the Fair Labor Standards Act? Gilliland suggests the following options:[2]

- **Continue per-visit pay without payment of overtime pay and with no additional compensation for time spent in inservices, on-call service, and staff meetings.** This is supported by the *Fazekas*[3] decision, but there are two risks:
  1. Courts outside the 6th Circuit may not follow the *Fazekas* decision.
  2. Even if they do, you will need to establish that the nurses' visits are unique and not the same thing over and over.
- **Continue per-visit pay without paying overtime pay but manage schedules to avoid the nurses working more than 40 hours in a workweek.** This approach manages the risk by avoiding overtime in the first place.
- **Continue per-visit pay but pay overtime pay for all hours worked more than 40 in a workweek.** Under this option, the nurse simply would be treated as being entitled to overtime pay. Provided the overtime pay is properly calculated, no additional liability would result.
- **Continue per-visit pay with hourly payment for time not included in the per-visit payment.** This, of course, is what the 6th Circuit held in *Elwell* results in the nurse being entitled to minimum wage and overtime pay. If you are in Ohio, Michigan, Kentucky, or Tennessee, you are bound by the 6th Circuit's decision and your registered nurses will be held to be entitled to overtime pay if paid this way. If you are located in another state, you will have to convince your courts to not follow the *Elwell* decision — an uphill battle, at best. For these reasons, this option is not recommended.
- **Continue per-visit pay with lump-sum payments for time not included in the per-visit payment.** This avoids the hourly pay problem that led the 6th Circuit in *Elwell* to say the nurse was nonexempt, but it is still risky. The fee basis of payment regulations does not expressly permit extra pay in addition to the per-visit pay. Consequently, a court could hold the extra lump-sum payments are incompatible with the fee basis concept.
- **Pay a salary plus a per-visit bonus.** This avoids the fee basis of payment issue entirely by changing the compensation arrangement to be a salary with a per-visit bonus for each visit made over a stated minimum. For example, paying the nurse $400 per week with a per-visit bonus made for every visit more than 10 in the workweek. (This is just an example; adjust the numbers as you want, but keep the salary above $250 per week.)

If you do pay per-visit pay, as opposed to the salary plus per-visit bonus, you must still keep records of the hours worked by the registered nurse each workweek, Gilliland adds.

References

1. *Wendy Elwell v. University Hospitals Home Care Services*, No. 98-02472, U.S. Court of Appeals for the Sixth Circuit (Jan. 11, 2002).

2. Gilliland JC. *Legal Ramifications of Per Visit Pay.* Indianapolis. Web site: www.gilliland.com. 2002. Reprinted with permission.

3. *Fazekas v. Cleveland Clinic Health Care Ventures* Inc., No. 99-3059, U.S. Court of Appeals for the Sixth Circuit (2000). ■

Whichever option you choose to use, be sure you have a fair pay policy and present the final decision in a positive manner, he recommends. "If you do change your pay structure, be sure that your nurses' compensation is comparable to what it was under the old system." If you present the change as a positive way to stay competitive, and the employee does not suffer a loss in pay, it should be received well, he says.

Of course, how changes are presented differs from agency to agency depending on the corporate culture, Gilliland says. "Some agencies are very upfront with their employees, others bury the change in a small paragraph deep in the

employee handbook," he explains.

"Make sure you also pay attention to the laws of your state," Gilliland suggests. "There are some instances in which state laws and the FLSA conflict."

Even if you can't decide whether you want to stay fee-based, salaried, or a combination, remember that there is another option to classifying your professional employees as exempt, Gilliland says. "Although it requires careful managing, you can always pay overtime."

[For more information about the issue of overtime pay, contact:

• ***John C. Gilliland II**, Attorney-at-Law, Gilliland & Caudill, LLP, 6650 Telecom Drive, Suite 100, Indianapolis, IN 46278. Telephone and fax: (317) 616-3647. E-mail: jcg@gilliland.com. Web site: www.gilliland.com.*

• ***Kay Sykes**, Director of Human Resources, Alacare Home Health & Hospice, 4752 Highway 280 E., Birmingham, AL 35242. Telephone: (205) 981-8000.]*

Reference

1. *Wendy Elwell v. University Hospitals Home Care Services*, No. 98-02472, U.S. Court of Appeals for the Sixth Circuit (Jan. 11, 2002). ■

Patient weight guidelines reduce workers' comp

Cut work-related injuries with safety policy

When staff at Southern Ohio Medical Center Home Health Services in Portsmouth reported a total of 777 days lost due to work-related injuries in one year, managers knew that something had to change.

By tapping into the expertise of an occupational therapist and developing a well-defined policy that limits employees' risk of injury due to transferring patients, the number of lost work-days due to injury dropped to just 80 the following year.

"We are self-insured for workers' compensation injuries, so finding a way to decrease injuries was a real financial incentive," says **Karen L. Marshall**, MS, RN, administrator of the home health agency.

"We asked for help from a staff occupational therapist with a focus on work hardening and return-to-work patients," she says.

Along with continuing the agency's inservices on injury prevention, proper transfer of patients, and proper lifting techniques, the occupational therapist developed a set of guidelines to determine which patients require extra assistance, she explains.

"We titled the policy 'Client Safety Classification' since weight classification is a sensitive term," Marshall says. There are four classifications that are defined by patient description and type of assistance needed for transfer.

The classifications are:

• **Class 1 clients** are independent with all movement and transfers, and do not require any assistance from the visiting home care personnel to move from one posture to another.

• **Class 2 clients** weigh less than 300 pounds and require minimal assistance for transfer from one posture to another. Once in a standing position, patients are able to ambulate independently.

• **Class 3 clients** weigh less than 300 pounds, need moderate assistance to move from one posture to another, and require a walking device or assistance from the worker to ambulate.

• **Class 4 clients** weigh more than 300 pounds and require moderate assistance or weigh more than 50 pounds and require maximum assistance in transfers. These patients require a minimum of two people for transfers.

"Patients are assigned a classification based upon their ability during their initial assessment," Marshall says.

Home health employees who have weight restrictions on lifting following a previous injury only are assigned to patients that are consistent with their restrictions, she adds.

If the patient is a Class 4 client, he or she cannot be transferred without the assistance of two people. This need can be addressed in different ways, Marshall says.

"Family members can help with the transfer, or we can evaluate the feasibility of sending a second staff member who might be in the area," she says.

If these options are not viable, Marshall sends a physical therapist to the patient's home to assess the feasibility of a hoyer lift.

"We conduct this evaluation whether or not it will be reimbursed because it is an important part of protecting our employees," she adds.

The assessment of patients and employees'

ability to transfer them is conducted by RNs at Helping Hands Home Care in Jackson, MI, says **Judy Cappell**, RN, CCM, clinical manager of the home health agency. "We conduct the initial assessment and perform a transfer to make sure an employee can do it safely," she says.

While her agency's guidelines are not as detailed as Marshall's, every job description limits lifts to 40 pounds, Cappell says. If a transfer requires more lifting, two employees are assigned to the patient or a family member assists, she says. "We do evaluate the family member's ability to help, and sometimes, there is no one who can safely assist us."

Cappell's agency will request a physical therapy evaluation to see if there is other assistance, such as a Hoyer lift, that will work only if the family can cover the expense of the evaluation. "We also require the family to cover the cost of the lift or other equipment, but we do have a relationship with an equipment supplier who offers discounts," she adds.

Sometimes, Hoyer lifts are not feasible due to space limitations in the patient's home, Marshall says. If the equipment is not feasible and there is no possibility that someone can help with the transfer, the patient is referred to another agency, she says.

"We also refer patients to other agencies after explaining to the families that this is a safety issue," Cappell says. "We will provide names of other home health agencies, but we also try to introduce the idea that it might be the right time to consider long-term care."

"If a family insists on keeping the patient at home, we tell them that the only way we can provide care is if the patient is bed-bound," she says.

"We have referred patients to other agencies as a result of this policy, but the numbers have been so few that it is not a concern," Marshall says. "The cost of losing a few patients is far less than the cost of lost workdays and workers' compensation payments for our injured employees."

[For more information about designing weight limitations, contact:

• ***Karen L. Marshall**, MS, RN, Administrator, Southern Ohio Medical Center Home Health Services, 727 Eight St., Portsmouth, OH 45662. Telephone: (740) 356-4663. E-mail: MarshallK@somc.org.*

• ***Judy Cappell,** RN, CCM, Clinical Manager, Helping Hands Home Care, Foote Health Agency, One Jackson Square, Jackson, MI 49201. Telephone: (517) 841-6962.]* ■

Plug in and sign on: Are you ready to automate?

Higher productivity follows careful purchase

People in all types of industries use the term "mountains of paperwork," but people who work in home health agencies contend they are the only ones who truly have to climb those mountains, make sense of them, and use the information within them to bill accurately.

Rather than let this mountain of paperwork crush them, the staff at Haywood Regional Medical Center Home Care Services in Clyde, NC, automated all of its activities and saved more than $326,000 in one year.

With the introduction of programs such as the Outcome and Assessment Information Set, ORYX, and the prospective payment system, as well as all of the expanded forms required for each, **Shannon Clark**, RN, BSN, MBA, assistant vice president of Haywood Regional Medical Center, told the board of directors that it needed to automate all areas of the home health agency or get out of the business.

"Financially, we could not handle the required paperwork manually and still make money on the reimbursements that were originally published," Clark explains. "My nurses would have to see fewer patients each day to allow enough time to complete the paperwork."

The board of directors approved her plan to automate all functions of the agency from admissions to charting to billing, Clark says.

Starting from scratch

"We had used an automated billing system for several years, but that system was not compatible with anything else on the market that allowed us to automate other systems, so we started looking for vendors that could provide everything from the ground up," she explains.

A team composed of staff members representing different areas of the home health agency, as well as representatives from the hospital's management information systems department, worked together to develop a request for proposal (RFP) to send to vendors, Clark says.

"The RFP was very detailed and very specific about what we wanted," she explains. **(See copy of RFP, inserted in this issue.)** Her goal was to

work with one vendor who could provide everything the agency needed to automate its functions and to integrate with the hospital's system, she adds.

The team not only was an important part of choosing the vendor, but it also helped communicate to other staff what was happening, Clark says. **(For information how team was set up, see article, p. 43.)**

Laptop not always convenient

In addition to choosing software that met their needs, the team members also evaluated different hardware choices, Clark says. The choice of consumer electronic (CE) devices for the field clinicians rather than laptop computers was made for several reasons, she says.

"They are less expensive and more durable than laptops, and their touch-screen controls rather than a keypad make it easier for clinicians to use," she explains.

The staff at Montefiore Medical Center Home Health Agency in Bronx, NY, also are looking at devices other than laptops as a result of a failed attempt to use laptops in the field several years ago, says **Joseph T. Cortese**, director of health information management and information technology for the home health agency.

"Four years ago, we provided laptops to our field nurses only to run into unplanned costs, higher than expected expenses to maintain the equipment, and technical problems," he says. "We cancelled the project and spent the last three years being deluged by paper."

The agency is in the process of purchasing a system that will automate all functions but is looking at devices such as pen tablet units rather than laptops, Cortese explains. "Laptop computers are not designed to be turned on and off a dozen times a day or be thrown into the car after each visit," he says.

"We also have field staff visiting buildings with no elevators, and having to carry supplies, briefcase, and a laptop computer up multiple sets of stairs," he points out. This wear and tear meant that Cortese had to maintain a supply of backup laptops, which required storage space and extra expense, as well as technical support available at all times.

He suggests that anyone who is evaluating vendors to provide any type of automation should remember to ask about hidden costs such as those he discovered in the laptop project.

"Find out if you will need to add extra telephone lines, including a toll-free line, to enable your field nurses to check in at night or from home. Also, if you do need to add a toll-free number, remember that the calls are free to the

Software vendors offer home health products

While there are many software vendors available, both **Shannon Clark**, RN, BSN, MBA, assistant vice president of Haywood Regional Medical Center in Clyde, NC, and **Joseph T. Cortese**, director of health information management and information technology for Montefiore Medical Center Home Health Agency in Bronx, NY, suggest that you make sure vendors offer programs that are designed for home health agencies.

The best ways to check out which vendors are reliable and offer good products is to read professional publications and ask your peers in other agencies, Clark and Cortese recommend.

The following are some of the many vendors that offer home health-specific software:

- **3M Home Health Systems**, 977 Oaklawn Ave., Elmhurst, IL 60126. Telephone: (800) 367-2447 or (630) 832-1011. Web site: www.3m.com/market/healthcare/hhs.
- **BeyondNow Technologies**, 5750 W. 95th St., Suite 310, Overland Park, KS 66207. Telephone: (913) 385-0803. Fax: (913) 385-0212. E-mail: info@beyondnow.com. Web site: www.beyondnow.com.
- **Misys Healthcare Systems**, Homecare Systems Business Unit (formerly Home Care Information Systems), 106 Apple St., Tinton Falls, NJ 07724-2669. Telephone: (732) 936-3000. Fax: (732) 936-9400. Web site: www.misyshealthcare.com.
- **McKessonHBOC**, 5995 Windward Parkway, Alpharetta, GA 30005. Telephone: (800) 981-8601 or (404) 338-6000. E-mail: webreg@mckesson.com. Web site: www.mckesson.com.
- **Patient Care Technologies**, Two Executive Park W., Suite 220, Atlanta, GA 30329. Telephone: (404) 235-7828. Fax: (404) 235-7839. Web site: www.ptct.com.

For a list of other vendors, visit www.providerconsult.com and click on directories, then click on resources for home care providers. ■

caller but you have to pay for each call. These calls add up," he adds.

"Also, make sure that the software you purchase will coordinate the information needs of all federal, state, local, or accreditation programs in which you participate," Cortese suggests.

More importantly, be realistic about the amount of information you'll be gathering and make sure the system can not only handle what you have today but will allow you to expand, he adds.

Because field clinicians no longer need desks at which to complete their paperwork, Clark's organization no longer needed 1,200 square feet of space formerly used for the nurse's desks.

"We added an ambulatory infusion service in the area that had been used for paperwork and added a new stream of revenue," Clark points out.

Relationship changes

Nurses now complete their patient visits and connect their CE to the telephone line in their own homes to send everything back to the agency, Clark says.

If you do plan to give your field clinicians access by modem to enable them to transmit their data or check in for the next day's schedule, realize that you are changing your agency's traditional employer-employee relationship, Cortese explains.

"If you tell a clinician to check in between certain hours to transmit data or receive messages, you also have to be ready for your employees to bring up logistical issues that you've never handled," he says.

For example, if an employee lives in an area in which the telephone lines have too much static to transmit data, who works with the telephone company to solve the problem — the agency or the employee? Or if an employee's son regularly is on line during the same time frame, does the agency pay for the second telephone line?

"These are issues that need to be addressed or considered upfront because as employers, we are moving into the personal or home life of the employee," Cortese says.

How an organization deals with these issues will differ from agency to agency, but he suggests that you know ahead of time how you will deal with different situations.

Even with the problems and glitches encountered during the automation, Clark says she has no regrets about going through the process. "It has been a successful project in terms of productivity, employee morale, and financial success. If we had not automated when we did, we would be bankrupt."

[For more information, contact:

• ***Shannon Clark**, RN, BSN, MBA, Assistant Vice President, Haywood Regional Medical Center, 262 Leroy George Drive, Clyde, NC 28721. Telephone: (828) 456-7311. E-mail: shannon.clark@haymed.org.*

• ***Joseph T. Cortese**, Director of Health Information Management and Information Technology, Montefiore Home Health Agency, One Fordham Plaza, Suite 1100, Bronx, NY 10458. Telephone: (718) 405-4403. E-mail: jcortese@montefiore.org.]* ■

Team evaluates products, communicates with others

When the staff of Haywood Regional Medical Center's Home Health Services in Clyde, NC, recognized the need to automate their agency in order to handle the paperwork generated by the Outcome and Assessment Information Set, ORYX, and the prospective payment system, the first step was to put together a team of employees representing different areas of the agency, says **Shannon Clark**, RN, BSN, MBA, assistant vice president of Haywood Regional Medical Center.

The team members identified the agency's needs and came up with a list of activities the system would need to perform, Clark explains. A list of vendors was developed, and a request for proposal (RFP) was designed, she adds. **(See RFP, inserted in this issue.)**

Out of the 26 vendors identified by the team to receive the RFP, 18 returned the forms, Clark says. "The members of the team assigned points for the responses and came up with the top three vendors." These vendors were invited to make presentations and conduct site visits of their facilities or other agencies that were using their products, she adds.

Throughout the process, the team members posted notes in the office to update other employees on the progress, Clark says. "We wanted all of our employees to feel like they were part of the process and to be as excited as we were about the benefits of automation. We knew that everyone had to buy in to the new system in order for it to be effective," she adds.

In addition to looking at specific products the companies offered, Clark's team evaluated the type of technical and educational support the companies offered, how well the system integrated with the hospital's system, and how long the companies had worked in the home health field. "We also wanted to make sure we went with a financially sound vendor so we looked at how long they had been in business and at the parent company when applicable," Clark says.

Although the agency implemented all parts of the system at the same time, a core group of field clinicians tested the field devices before they were introduced to the remaining employees, Clark says.

"We choose a group of clinicians who were enthusiastic about automation, had a positive attitude, and were open to new ideas," she says. "We also looked for people who would be good trainers because we saw them as the group that would train other employees."

Surprisingly, the employees who were most reluctant to make the change to the new system were the members of the billing staff, Clark says.

These employees had been using an automated billing system for years and were not enthusiastic about learning a new system, she says.

Once everything was up and running, they quickly saw the benefits of an integrated system that combined data from all areas, she adds. ■

Find out how you're doing by asking your patients

Patient satisfaction surveys are improvement tools

How effective is your patient satisfaction survey? You can point to it and tell your accreditation agency that you measure patient satisfaction as part of your quality improvement program, but are you really getting good information from it?

"We used to send our own homegrown surveys to our patients," says **Rita Holley**, RN, MS, BSN, director of Shore Home Care Services in Easton, MD. "The return rate was miserable, but every survey that we did receive was positive."

Holley and her staff experienced a shock the second quarter after they had changed to an outside research firm to handle their patient surveys and provide reports that compared Shore Home Care's results against other home health agencies' results.

"We dropped to the first percentile in overall satisfaction ratings when compared against other home care agencies," Holley admits.

The low ranking was a real wake-up call to her and all employees of the agency who had believed they were providing good service, she adds. "We realized that our homegrown survey was giving us a false sense of security."

While larger agencies may have the resources to develop a scientifically sound survey, distribute it, and produce reports, Holley suggests that most home health agencies benefit from outside companies that enable them to benchmark against other agencies.

"You must also have a method to identify the causes of your low scores and develop solutions to your problems," she says.

Teams address problems

A multidisciplinary committee that was set up to identify the areas in which the agency had opportunities to improve found several areas on which to focus, says **Kay Satchell,** RN, quality improvement specialist for the agency.

Scheduling was one area that received very negative scores, she adds. Smaller work groups were set up to address specific issues and make recommendations for changes, she explains.

"We just assumed that because our patients are homebound, we can schedule visits at our convenience, but our patients wanted us to show them more respect for their schedules," Satchell says.

The work group that focused on scheduling found that a major obstacle to meeting the patients' needs was the exclusive use of the hospital's rehabilitation therapy staff to provide services to home care patients, she says.

Because the hospital staff's priority was their own patients, home care patients were just fit in when possible, she adds.

As a result of the work group's recommendations, the home care agency hired six independent rehab contractors who work out of the agency's office.

"Having our own therapists gives us more control over the scheduling and lets us work more easily with our patients' schedules," Satchell explains.

After addressing areas that involved scheduling, the patients' desire to be more aware of the plan of care, the method for handling emergencies,

and other areas, Shore Home Care staff saw their rankings increase, Satchell says. From March 2000 to December 2001, the mean percentile rose from 76.8% to 93% for the scheduling issue, and the overall patient satisfaction rose from a percentile ranking of 1% to 95%, she adds.

While Shore Home Care contracted with additional staff to address one of their concerns, **Sylvia Fournier**, RN, MSN, director of Wentworth-Douglas Home Care & Hospice in Dover, NH, did not change her staff size, but did increase staff education to improve her agency's patient satisfaction rankings.

"Our patients complained that they had trouble reaching us by telephone and were often transferred several times before they were able to speak with someone," Fournier says. "We learned that our employees needed additional training on the telephone system so they could use voicemail, paging, call forwarding, and other features appropriately."

Because her patients also were unhappy with explanations of billing procedures, more training was provided to help clinicians and office staff answer financial questions, Fournier says.

"After the prospective payment system was implemented, we not only present training sessions, but we also conduct a pre- and post-class test to make sure employees are getting the information they need," she adds.

The efforts at her agency to improve communication with patients have been successful, Fournier says. "We've improved from the 35th percentile in this area when compared to other agencies in early 2001 to the 92nd percentile at the end of 2002," she explains.

Let staff see results

You must share data from the patient survey with staff members if you want changes to occur, says **Patrice A. Cruise**, RN, PhD, corporate vice president for clinical development and research for the home care division of Adventist Health System in Port Charlotte, FL.

Although Adventist distributes the surveys and results are returned to the corporate office, the original, completed surveys are sent back to the individual agencies in addition to the quarterly reports, she says. "This enables the directors to share written patient comments with staff members and give kudos to the staff or identify areas in which they need to improve."

Benchmarking is a big benefit to choosing an outside, national, or regional firm to handle your satisfaction surveys, Fournier says.

"We collect a lot of data from different sources, but you don't know how you are doing as compared to others if you only look at your results," she says.

Sometimes, the patient satisfaction results reinforce what you already may know, Cruise says. "One of our agencies had more than its share of complaints. We knew the agency suffered from staffing shortages, but the patient survey results pointed out that the shortages were affecting the patients' perception of our service," she adds.

The survey results added impetus to an effort to look at the market rates for salaries, benefits, and other issues to increase the agency's ability to attract and retain nurses, she adds.

Most importantly, pay attention to the results, Satchell says.

"Have a staff member designated to read and understand the reports, share the results with the staff, and oversee efforts to address performance improvement issues," she says.

Holley agrees. "If you see a downward trend in an area, don't wait too long to react. Set up a team to address the problems before they affect other areas of your agency's service."

[For information about the use of patient satisfaction survey results, contact:

• ***Patrice A. Cruise**, RN, PhD, Corporate Vice President for Clinical Development and Research, Adventist Health System, Home Care Division, 1600 Tamiama Trail, Suite 400, Port Charlotte, FL 33948. Telephone: (941) 255-9296. E-mail: pcruise@ahss.org.*

• ***Sylvia Fournier**, RN, MSN, Director of Wentworth-Douglass Home Care & Hospice, 113 New Rochester Road, Suite 4, Dover, NH 03820. Telephone: (603) 742-7921. E-mail: sqsf@wdhospital.com.*

• ***Kay Satchell**, RN, Quality Improvement Specialist, Shore Home Care, 29515 Canvasback Drive, Easton, MD 21601. Telephone: (410) 763-7282, ext. 8713. E-mail: ksatchell@shorehealth.org.*

For information about patient satisfaction survey tools that are available for home care, contact:

• ***Fazzi & Associates**, 243 King St., Suite 246, Northampton, MA 01060. Telephone: (413) 584-5300. Fax: (413) 584-0220. E-mail: mwelch@fazzi.com. Web site: www.fazzi.com.*

• ***Press, Ganey Associates**, 404 Columbia Place, South Bend, IN 46601. Telephone: (800) 232-8032 or (574) 232-3387. Fax: (574) 232-3485. Web site: www.pressganey.com.]* ■

LegalEase
Understanding Laws, Rules, Regulations

Base documentation on OASIS assessment

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

Most home care staff members now understand the importance of accurate completion of the Outcome and Assessment Information Set (OASIS) in terms of reimbursement to agencies. But OASIS assessments do not exist in a vacuum. Subsequent documentation of care rendered must include all of the needs of patients identified on OASIS assessments or explanations for the lack of care provided.

What are possible consequences of failure to provide these types of documentation?

• Agencies and staff members may face legal liability for substandard care. Home health agencies have operated "under the radar" of attorneys who represent patients and their families against health care providers for many years. The cat is now out of the bag.

More attorneys now perceive that agencies are another pocket that they can pursue to obtain larger damage awards for their patients. As a routine matter, attorneys will be able to gain access to patients' records in order to support malpractice cases against agencies and their staff members. When an attorney's review shows that agencies identified clinical needs on OASIS assessments that were not appropriately addressed, and the patient suffered injury or damage as a result, such discrepancies will support patient lawsuits. Consequently, inconsistencies between OASIS assessments and subsequent documentation of care provided will increase the risk of legal liability for agencies and staff members.

• Agencies also may face possible decertification from participation in Medicare and Medicaid as a result of discrepancies between OASIS data and care rendered. Identification of clinical needs of patients on OASIS assessments that are never addressed during the same episode of care may mean that patients are at risk of harm. Serious issues related to substandard care likely are to result in condition-level deficiencies on statements of deficiencies that support a decision by the Centers for Medicare & Medicaid Services (CMS) to deny agencies participation in the Medicare / Medicaid programs.

• Inconsistencies between OASIS assessment and care provided to patients also raises the possibility that agencies and staff members may be perceived to engage in fraudulent conduct. Specifically, the False Claims Act has been interpreted to mean that agencies submit claims only for medically necessary and appropriate care. If claims are submitted for what appears to be substandard care because care rendered does not meet the needs of patients as identified on OASIS assessments, regulators may conclude that agency staff members engaged in fraudulent conduct.

• Individual practitioners involved in instances of discrepancies between OASIS assessments and subsequent care also risk disciplinary action by state licensure boards, including loss of their licenses to practice.

What should agency managers do to avoid these possible consequences?

• Agency managers should conduct an in-service program to share this information so field staff members understand the importance of consistency between OASIS assessments and documentation of care provided. This point should be reinforced periodically using a variety of mechanisms that might include articles in in-house publications and reminders included in envelopes with staff members' payroll checks.

• Agency managers also should make certain that staff members responsible for quality of care evaluate whether OASIS assessments are reflected in both plans of care and documentation of care that actually was rendered. Specifically, staff must make certain that every clinical need identified in

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OASIS assessments is accounted for in plans of care and in documentation of care provided, such as visit notes. This review ideally should occur before a final claim is submitted. Careful review will go a long way toward avoiding the consequences described above.

The prospective payment system continues to require radical change in the home care industry. Regulators now have the tools to make more accurate evaluations of the care provided by agencies. Agency staff members must, therefore, be more vigilant than ever with regard to inconsistencies in patients' records.

[For a complete list of Hogue's publications contact:
*• **Elizabeth E. Hogue**, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Telephone: (301) 421-0143. Fax: (301) 421-1699. E-mail: ehogue5@comcast.net.]* ■

Physicians don't know all needed Medicare rules

According to the Office of the Inspector General's report, *The Physician's Role in Medicare Home Health 2001*, 50% of physicians surveyed say they are not clear about the definition to apply when certifying medical necessity for a patient, and 3% say they are unclear on the Medicare criteria for "homebound."

Many physicians also say that they are not able to provide the level of oversight expected of them

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Editor: **Sheryl Jackson**.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Associate Managing Editor: **Christopher Delporte**, (404) 262-5545, (christopher.delporte@ahcpub.com).
Senior Production Editor: **Ann Duncan**.

Editorial Questions

For questions or comments, call **Christopher Delporte** at (404) 262-5545.

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for Medicare home health patients: 83% of the respondents understand that Medicare expects them to make sure that only medically necessary services are on the plan of care, but only 48% say that they are able to ensure that this is the case.

Although home health staffs are struggling to understand the rules for the home health prospective payment system (PPS), physicians are even less aware of the requirements. In fact, 60% of the physicians surveyed said they had never heard of PPS.

To view full report, go to http://oig.hhs.gov/oei/reports/oei-02-00-00620.pdf. ▼

Medicare and Medicaid answers available on line

The Centers for Medicare & Medicaid Services created an electronic mailbox in December 2000 to accept questions related to billing and other issues related to the home health prospective payment system. Questions were accepted until October 2001, and new batches of answers are periodically posted on the Medlearn web site.

Four new groups of answers to questions posted in the last few months of the mailbox have been posted on the web site. To see the newest answers, go to www.hcfa.gov/medlearn/refhha.htm and scroll down to the section on frequently asked questions to link to the set of questions of greatest interest to you. ▼

JCAHO surveys in CA affected by state rules

An unlicensed person may deliver home medical devices in California, but according to the Respiratory Care Board in the state, equipment delivery does not include instruction in equipment use or its application to a patient. These services must be performed by a licensed respiratory care practitioner or other licensed persons authorized by their licensing statutes to provide respiratory care. The Oakbrook Terrace, IL-based Joint Commission on the Accreditation of Healthcare Organizations has announced that its surveys in California will include this interpretation since a particular standard that has a state or federal requirement is surveyed to the strictest interpretation.

For more about the California regulation, contact the California Department of Health Services, Food and Drug Division at (916) 445-5224. ■

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

Senators take stock of accounting for corporate options

"The stock-option double standard has been a long festering problem in corporate America," according to Sen. **Carl M. Levin** (D-MI), author of a bipartisan bill that would change how companies account for stock options.

In the wake of the Enron collapse, accounting practices have come under scrutiny, and Levin has found new support for an effort first begun in 1993. The Ending the Double Standard for Options Act (S. 1490), introduced Feb. 13, 2002, aims to amend the Internal Revenue Code so that companies must record stock options as an expense if they also count them as tax deductions.

The bill — cosponsored by Sens. John McCain (R-AZ), Peter Fitzgerald (R-IL), Dick Durbin (D-IL), and Mark Dayton, (D-MN) — doesn't aim to change accounting standards, just to require companies that take a tax deduction for stock-option compensation as a business expense also show it as an expense on financial statements.

If passed, the Levin-McCain bill could reduce companies' reported earnings by millions of dollars, in some cases changing profit to loss.

Currently, only two of the 500 companies listed by Standard & Poor record stock-option expenses on both financial statements and tax returns. An analysis by brokerage firm Bear Stearns found that in 2000, the aggregate operating income of those 500 companies dropped about 8% when adjusted for stock-option compensation.

In 1993, when Levin urged the Financial Accounting Standards Board (FASB) to require options to be listed on company financial statements, the FASB merely recommended that they be reported on the bottom line. It still allowed companies to list outstanding options in just a footnote on financial reports.

Enron is one company that took this path. Citizens for Tax Justice analyzed Enron's public filings, in which the company claimed income of $1.8 billion between 1996 and 2000, but listed options only in a footnote and not with total expenses. The group found the options awarded during those five years were worth almost $600 million, about one-third of the income reported during that time.

"Enron was not acting illegally here, nor were its actions unique," Levin says. The corporation, like many others, followed existing accounting rules in this instance.

The tide may be turning. A survey conducted in September 2001 by the Association for Investment Management and Research found that more than 80% of U.S. financial analysts support charging stock options against earnings on financial statements. **Arthur Levitt**, who chaired the SEC from 1993 to 2000, says he regrets he didn't work harder to get stock options treated as expenses. The International Accounting Standards Board, the global equivalent of the FASB, will propose international standards that require options to be expensed at its next meeting.

While critics argue that current accounting practices regarding options distort earnings, companies generally regard options as an incentive they offer employees for future performance. They argue that predicting when options will be exercised and for how much makes it impossible to accurately state outstanding options as an expense. Furthermore, options do show up in earnings per share; outstanding options result in diluted earnings, which are reported.

Many companies use options as a management tool. For example, in 2001, Baxter International Inc., a worldwide medical products and services company, granted stock options to more than 41,000 employees "to further drive alignment of Baxter team member and board of director

incentives with shareholder value." The company also changed its long-term incentive compensation program for senior managers and redesigned the compensation plan for its board of directors so that senior managers and board members will receive stock options priced at fair market value the day they're granted rather than shares of restricted stock.

According to **Harry M. Jansen Kraemer Jr.**, chairman and CEO of Baxter, "These changes serve as a strong statement about the level of excitement that our senior management team and board of directors have about Baxter's growth prospects and the commitment we all have toward our shareholders."

The FASB has yet to say whether it will set new standards that could change the use of options as compensation. ■

COMPANIES IN THE NEWS

Lincare settles Medicare reimbursement inquiry

Lincare Holdings Inc. of Clearwater, FL, has agreed to pay the government $3.15 million without admission of wrongdoing to settle a government inquiry begun in 1998. The U.S. Attorney's Office in Sacramento, CA, investigated some of the company's California operating centers' Medicare reimbursement claims for home oxygen and other therapies. As part of the settlement, the company will enter a corporate integrity agreement with the Office of Inspector General covering some centers involved in the investigation. ■

Option Care to acquire division of Mt. Sinai

Subject to approval by its board of directors and lenders, Option Care Inc. plans to acquire the home infusion and specialty pharmacy of Mount Sinai Hospital in New York City. The pharmacy serves approximately 350 infusion and 400 organ transplant patients in New York. Details of the agreement will be disclosed after the transaction is finalized. The acquisition will be Option Care's first venture in the area. ■

FINANCIAL RESULTS

Apria Healthcare Group Inc. (AHG) of Costa Mesa, CA, announced its fourth-quarter net revenue was $293 million, compared with $258 million in the 2000 fourth quarter. Net income was $20 million or 36 cents per share, compared with $15.3 million, or 28 cents per share for the 2000 quarter.

EBITDA was $67 million, compared with $62.5 million previously. Net revenue for 2001 was $1.1 billion, compared with $1 billion in 2000, a 12% increase. Net income for 2001 (including an extraordinary charge of $1.5 million) was $71.9 million or $1.29 per share. EBITDA was $261.7 million for 2001, compared with $243.5 million for 2000.

Baxter International Inc. (BAX) of Deerfield, IL, which develops biopharmaceuticals, vaccines, biosurgery products, and transfusion therapies; medication delivery systems; and renal therapy, reported fourth-quarter sales of $2.14 billion, compared with $1.93 billion in the 2000 period. Earnings for the quarter, excluding special charges, were $324 million or 53 cents per diluted share, compared with $270 million or 45 cents in the 2000 quarter. For the year, Baxter reported sales of $7.6 billion, compared with $6.9 billion in 2000. Earnings were $1.06 billion or $1.75 per diluted share, compared with $915 million or $1.53 per diluted share in 2000.

HCA Inc. (HCA) of Nashville, TN, which owns, manages, and operates hospitals and centers for ambulatory surgery, diagnostics, radiation, and oncology therapy, outpatient rehabilitation, and physical therapy, announced fourth-quarter revenues of $4.5 billion compared with $4.2 billion for the 2000 quarter.

Net income was $206 million or 39 cents per diluted share, compared with $21 million or 4 cents per diluted share in the same quarter previously. In the quarter, the company recorded an extraordinary charge of $17 million or 3 cents per diluted share related to the early elimination of debt.

For the year, revenue was $18 billion, compared with $16.7 billion for 2000. Net income (including gains, impairments, restructuring, investigation, and settlement and extraordinary charges) was $1.05 billion or $1.95 per diluted share, compared with $219 million or 39 cents per diluted share last year.

Lincare Holdings Inc. (LNCR) of Clearwater, FL, a home health provider of oxygen and other respiratory therapy services, announced 2001 fourth-quarter revenues of $215.6 million, compared with $189.3 million for the 2000 quarter. Net income for the quarter was $33.3 million or 30 cents per diluted share. Net operating income for the quarter, before special items totaling $10.3 million (6 cents per diluted share after taxes), was $39.7 million or 36 cents per diluted share, compared with $31.8 million or 30 cents per diluted share for the fourth quarter of 2000.

For the year, revenue was $812.4 million, compared with $702.5 million for 2000. Net income was $134.9 million or $1.23 per diluted share. Net operating income, before special items of $16.7 million (9 cents per diluted share) was $145.3 or $1.32 per diluted share, compared with $116.9 million or $1.08 per diluted share for the prior year.

Matria Healthcare Inc. (MATR) of Marietta, GA, which provides comprehensive disease management programs to health plans and employers for women's health, diabetes, and respiratory disorders, reported fourth-quarter revenues of $69.7 million, compared with $56.4 million for the quarter in 2000. Net earnings available to common shareholders from continuing operations were $400,000 or 4 cents per diluted common share, compared with $1.2 million or 13 cents per diluted common share in the 2000 quarter.

For the year, revenue was $264 million, compared with $225.8 million for the year 2000. Net earnings available to common shareholders from continuing operations were $6.8 million or 76 cents per diluted common share, compared with $10.1 million or $1.05 per diluted common share for the previous year.

The company announced net earnings for the fourth quarter and year were lower than the company's most recent forecast because the final, annual income tax provision was higher than previously estimated. The increase resulted from finalizing differences between Matria's accounting and statutory taxable income.

New York Health Care Inc. (NYHC) of Brooklyn, a licensed home health care agency, announced for the year ended Dec. 31, 2001, net patient service revenue increased 17% to $34.3 million, compared with $29.4 million in 2000. Net income for the year was $352,886 or 7 cents per diluted share, compared with a net loss of $1.2 million or 33 cents per diluted share in 2000 (including a $1.5 million noncash charge for the write-down of intangible assets to their estimated fair value).

Respironics Inc. (RESP) of Pittsburgh, announced net sales for the fiscal year's second quarter of $117.4 million, compared with $104.5 million for the same quarter last year. Domestic revenues were $94.1 million, a 12% increase over $84.1 million in the second quarter a year ago. International sales were $23.2 million, compared with $20.4 million in the prior year's quarter.

Net income for the current quarter was $10 million or 32 cents per diluted share, compared with $8 million or 26 cents per share the same quarter previously. Earning per share for the quarter ending March 31, 2002, were predicted at 36 cents and between $1.31 and $1.32 for the fiscal year ending June 30, 2002. The company specializes in sleep disordered breathing, chronic obstructive pulmonary disease, asthma, infant care, and restrictive lung disorders for home care, hospital, and international markets.

Transworld Healthcare Inc. (TWH) of New York City, which provides nursing services, respiratory, and infusion therapies, and home medical equipment, announced consolidated revenue for the three months ended Dec. 31, 2001, was $61 million.

Operating income was $5.91 million, compared with a loss of $1,25 million in the same period previously, which included a $3.3 million in nonrecurring costs related to the wind down of the U.S. mail-order business and $745,000 related to the sale of Amcare Ltd. Net income for the quarter was $1,4 million or 8 cents per share, compared with a net loss of $2,8 million or 16 cents per share for the quarter last year. ■

CORPORATE LADDER

CEO **Philip Carter** of Apria Healthcare Group Inc. in Lake Forest, CA, which provides home infusion and respiratory therapy, is leaving the company he turned around over the last four years. Apria posted fourth-quarter income of $20 million, compared with $15.3 million in the 2000 fourth quarter.

Carter will be replaced as CEO, and on the board of directors, by **Lawrence Higby**, president and COO since November 1997. Before joining the company, Higby was president and COO of Unocal Corp.'s 76 Products Co.

Robert C. Larson is a new director on the board of ARV Assisted Living Inc. of Costa Mesa, CA. Larson is chairman and managing principal of Lazard Freres Real Estate Investors LLC and managing director of Lazard Freres & Co., as well as nonexecutive chairman of United Dominion Realty Trust Inc.

Larson also is a director of Six Continents PLC and chairman of Larson Realty Group. He is replacing Jeffrey D. Koblentz, who resigned from the board.

CEO **Patrick Kennedy** and senior vice president of operations **Chet Bradeen** will take on the management responsibilities of Steven L. Vick, who in January resigned his positions as president and COO of Alterra Healthcare Corp. of Milwaukee. Both joined Alterra in 2001. Before then, Kennedy directed the international operations of Holiday Retirement Corp., an independent living retirement facilities operator. Bradeen was CEO / managing director of Sun Healthcare Asia Pacific.

Balanced Care Corp. of Mechanicsburg, PA, appointed **Richard D. Richardson**, **John N. Beall,** and **R. Fredric Zullinger** to its board of directors. Richardson, interim CEO of Balanced Care and president of CPL Management LLC, was chairman, CEO, and president of Renaissance Healthcare Corp. from 1989 to 1999.

Beall is CEO of Bell Hearing Aid Centers Inc., and was president of the Miracle-Ear division of Dahlberg Inc. Since 1985, Zullinger has been senior vice president and CFO of Consumers Financial Corp.

Emeritus Assisted Living of Seattle has named **Thomas Stanley** as general counsel to direct risk management, government relations, and public policy activities.

A graduate of the University of Idaho, Stanley's experience includes representing senior housing providers in legal, regulatory, and legislative matters, including survey and inspection issues, administrative appeals, resident agreements, policy and procedure development, and real estate development.

Option Care Inc. of Bannockburn, IL, which provides pharmacy services to patients on behalf of managed care organizations and other third-party payers, has appointed **Paul Mastrapa** as senior vice president and CFO.

Mastrapa, the founder and CEO of AdvoLife, has worked at the senior level in financial management, business development, and operations of several health care service companies. He joined Option Care in 1991.

Stuart H. Altman, professor of national health policy at Brandeis University, in Waltham, MA, has been elected to the board of directors of Lincare Holdings Inc. of Clearwater, FL, which provide oxygen and other respiratory therapy services to patients in the home.

Altman, an economist who focuses on federal and state health care policy, is co-chair of the Governor / Legislative Health Care Task Force for Massachusetts, and was interim president of Brandeis from1990-1991 and deputy assistant secretary for planning and evaluation / health at the Department of Health Education & Welfare. ■

ASSISTED LIVING UPDATE

Genesis and Manor Care settle contract dispute

In February, an arbitrator with the American Arbitration Association awarded Genesis Health Ventures Inc. $23.4 million in compensatory damages to resolve a contract dispute with Manor Care Inc. Arbitrator Charles B. Renfrew found that Manor did not lawfully terminate its service contracts with Genesis' long-term care pharmacy subsidiary NeighborCare Pharmacy Services Inc.

In 1998, NeighborCare acquired Vitalink Pharmacy Services Inc. and long-term service contracts between Vitalink and Manor Care, which gave Vitalink the right to provide pharmacy services to all facilities owned or licensed by Manor Care and its affiliates. Manor Care tried to terminate the contracts as of June 1999, citing changes resulting from the Medicare prospective payment system and NeighborCare's alleged breach of pricing provisions in the contracts.

The parties agreed to binding arbitration, and Renfrew ruled that the contracts between NeighborCare and Manor Care will remain in force until they expire in October 2004 and reversed a prior ruling that allowed Manor Care to withhold 10% of the payments owed to NeighborCare. ■