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INSIDE

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SPECIAL REPORT: Needlestick Prevention

The personal side to needlestick prevention: One nurse's story

New law requiring agencies to change will save lives

Once every 39 seconds, a nurse in this country sustains a needlestick injury. While most needlestick injuries result in nothing more than a good scare, far too many of them result in serious, life-altering (and in some cases, life-ending) diseases.

Most nurses accept accidental needlesticks as part and parcel of the job. Others are optimistic that it won't ever happen to them. **Lisa Black**, RN, a nurse living in Reno, NV, once thought the same thing. Then, it happened to her.

Today, Black can no longer practice bedside nursing, a job which she loved and still misses. She has spent countless hours and days in the hospital and is on a strict regimen of medications. And her young children may one day find themselves without her. That kind of accident, as she is quick to remind people, is not a situation that affects one person. It affects entire families; and while she admits that hers is an extreme example, the fact that it happens at all is one family too many that is affected.

"Most cases might be low-risk, but that doesn't negate the fact that [affected nurses] have families that are then frightened," she says. "The psychological impact is still huge."

A mission of education

Black, who contracted HIV and hepatitis C three years ago when she was accidentally stuck, has a warning for other health care professionals. "Nurses need to realize that needlesticks can happen to them and that they do happen to nurses every day. The statistics are unbelievable. When I started looking at the issue, all I could think was, 'This is unreal. How can it be happening this much in this country?' The reality is that it does happen, and people need to realize that it is preventable and it is not an acceptable risk."

Black is on a mission to educate others: "When you figure that as an industry, nurses and other health care workers sustain in the area of 800,000 needlestick injuries every year — and not because people aren't careful, but because it just happens — ethically and morally if you know it's within your power to prevent something like what happened to me from happening, then how do you justify not doing it?"

Strong arm of the law

Preventing accidental needlesticks from happening was the impetus behind HR 5178, the Needlestick Safety and Prevention Act, which was enacted into law late last year. With the legislative portion of the battle to enact needlestick safety programs behind them, activists for the issue now face the tough road of regulation.

"This is where the true meat of the matter comes in," says Black. "The legislation sets forth guidelines, but how they will be implemented will be done on the state level. States that already have an individual OSHA [Occupational Safety and Health Administration] program will need to amend their bloodborne pathogen standards to be at least as restrictive as federal OSHA.

"This process is only going to be really successful if nurses and other health care workers get involved. My message to them is that if they want to see legislation that is most beneficial to them, then they need to take it upon themselves to see that it gets done."

As part of HR 5178, she explains, in cases where a health care facility has a choice between traditional devices and safety devices, the safety device must replace the traditional unless you can show that it is either not in the best interest of the patient or that it poses an additional hazard to the user.

Federal legislation also has emphasized that not only must the safety devices be used whenever possible, but bedside nurses should be included in the decision and selection process.

"It's important that the decisions on what devices to use aren't being made in a vacuum by administrators with a rubber arm who are looking only at the bottom line," Black asserts. "The fact that nurses have a say in this process is a very important component."

In addition to selecting safety devices, the new federal law mandates that health care facilities adopt a record-keeping program that will allow them to track the incidences of needlesticks among their employees. Employers will be required to maintain a sharps injury log, which must cover, at the bare minimum, the type and brand of device involved in the incident; the department or work area where the exposure incident occurred; and an explanation of how the incident occurred.

The information will be recorded and maintained in a way that will protect the confidentiality of the injured employees, and the log will be an important source of data for researchers to determine the relative effectiveness and safety of devices now on the market and those that may be developed in the future.

Black notes that 17 states have already independently enacted needlestick prevention safety regulations, but the federal law will take them to a new level.

"With the status quo, you can look at the numbers of accidental needlesticks, but reporting is sketchy at best," she explains. This legislation requires that every exposure that occurs be recorded in one place and logged by exposure,

Cost Savings from Needlestick Prevention

- Hospitals and health care employers in California are expected to save over $100 million per year after implementing the California Occupational Safety and Health Administration's requirement for safe needle devices.
- According to the American Hospital Association in Washington, DC, one case of serious infection by bloodborne pathogens can soon add up to $1 million or more in expenditures for testing follow-up, lost time, and disability payments.
- The cost of follow-up for a high-risk exposure is almost $3,000 per needlestick injury even when no infection occurs.
- Safe needle devices cost only 28 cents more than standard devices.

the type and brand of device that was used, how it was used, if it has a safety feature, and if not, why. Many states already have taken this to a higher level and included a statement from the employee as to whether there's a device that could have prevented this from occurring."

While the government has made certain that needlestick prevention programs will be in place in every health care facility, it can't mandate that health care professionals follow those instructions.

"People hate change," Black points out. "You can't just put out the new devices and leave it at that. You need to get buy-in from your employees, otherwise you'll have people saying, 'Well, I did it this way before, and it worked fine. Why do I need to change?' So giving people new devices is only half the battle; you want to get them to use them, and that might take teaching them slightly new techniques." **(See box, p. 4, for information on where to get educational materials.)**

At Home Health Care Management in Wyomissing, PA, **Romayne Keener**, RN, has seen that change in action. Her agency has been using a needleless injection device for flu vaccinations for eight years now, and they're beginning to test other devices for use with other injections. She agrees that people sometimes react initially with negative attitudes.

"Change is difficult for everyone," she notes. "It's a very different feel to use the new device than to use a needle, and hard-core nurses like myself, who have been doing this for a long time, pride themselves on their technique. These new things can rob you a little bit of that in the beginning. But you can have good technique with these devices, and you will if you keep plugging away."

Needlestick prevention is like the age of computers, Keener explains. "Technology is coming whether you want it to or not." And unlike the computer revolution, jumping on the needle safety bandwagon is not optional.

Since all health care facilities also are mandated by law to provide employees with annual training on preventing bloodborne pathogens, Black suggests merging the two subjects and providing employees with training on how to use the new devices (such as syringes with retractable needles), and how to use them most effectively.

While the need to enact needlestick prevention legislation is rooted in the moral and ethical issues of "if a tragedy can be prevented, why not do it?" there is, of course, another side of the equation — money.

"Cost is the argument against it," Black explains. "The argument goes that it just costs too much money to enact such a program on the off-chance that a worker may sustain an injury that may or may not cause them to become infected. And it does cost more money, but when you look at the cost of follow-up health care, it pales." **(See box on cost savings, p. 2.)**

For a needlestick injury that doesn't lead to infection, the cost of treatment is somewhere in the neighborhood of $3,000. "That covers lab work, follow-up prophylactic medications, and if it was a high-risk stick, that person will be taking some very costly medication that may or may not work," Black points out. And, she adds, when you extrapolate that to every high-risk needlestick, "you're talking about a lot of money."

Take that one step further to someone who does become infected, and you're talking about a huge monthly sum for medications and Medicare

Prevention Starts with You

What can you do to make the work environment safer for yourself and others in the health care industry? Here are a few tips from the American Nurses Association.

- Request ANA's Safe Needles Save Lives kit, which contains the information and tools you need to educate your colleagues and promote the use of safer needles.
- Educate your colleagues about needlestick risks and prevention strategies. Encourage your colleagues to report all needlesticks to ensure appropriate follow-up, worker's compensation, and accurate needlestick data.
- Work with your state nurses association (SNA) to institute safer needles at your workplace and other facilities throughout the state.
- Support state and federal legislation by writing letters to your elected representatives.

disability payments. Black, for example, says her HIV medication costs between $2,000 and $3,000 a month, while her hepatitis C medication is another $2,000 a month. Add to that several thousand dollars in disability, and it costs about $7,500 a month to keep her alive . . . and that's provided she remains "healthy." She recently suffered from a severe infection that put her in intensive care. The cost: $80,000 for one week.

"When you look at that, the cost of one conversion [infection] in a 30-year-old health care worker is fully estimated to exceed $1 million from time of conversion to the end of that person's life. So I see not implementing a needlestick prevention program as a game of Russian roulette," she states.

The cost of human suffering

Keener agrees. "It's like my daddy used to tell me: If you want something, and you really need it, go buy it. And buy top of the line." Instead of only considering the cost of the device and the cost of implementing it, she stresses, "look at the cost of what it is for just one needlestick injury," especially in a company like hers, which is a conglomeration of five different health care organizations. The risk far outweighs the cost of change.

Regardless of whether an institution wants to implement a needlestick prevention program, they now must. Black encourages health care facilities not to reinvent the wheel and to do some research into other similar agencies in states where needlestick prevention regulations have already been in effect and then see if they can't share information.

But even the best-laid plans can go astray, especially when there is no one watching to see that they don't. Black points out that OSHA currently has enough funding to spontaneously inspect every health care facility in the country once every 75 years.

"OSHA doesn't plan on stepping up its enforcement efforts," she notes, "so the odds of being caught if you don't have a strong program in place are slim. If a facility is not in compliance, it's up to the employees to call and report it and ask for an investigation. If that's done, OSHA is obligated to comply, and the facility can be cited."

Citations have a greater effect than a slap on the hand, she notes, pointing out that in California "some substantial fines were levied

Where to Go for More Info

Plenty of resources about bloodborne pathogens and needle safety are available for health care professionals:

PRINTED MATERIALS

- **American Nursing Association's** bloodborne pathogen brochure (WP-2). To order, call (800) 274-4262.
- **Occupational Safety and Health Administration's** *Safer Needle Devices: Protecting Health Care Workers* (available on www.osha.org or contact your state nurses association).
- **National Institute for Occupational Safety and Health,** *Guidelines for Selecting, Evaluating, and Using Sharps Disposal Containers.* Pub. #97-111, 1998. To order, call (800) 35NIOSH.
- **American Hospital Association.** *Sharps Injury Prevention Program: A Step-By-Step Guide*, by Pugliese G, Salahuddin M. Chicago: 1999.

WEB SITES

- **American Nurses Association:** www.needlestick.org.
- **Centers for Disease Control and Prevention:** www.cdc.gov.
- **Frontline Healthcare Workers Safety Foundation:** www.frontlinefoundation.org.
- **National Institute for Occupational Safety and Health:** www.cdc.gov/niosh/homepage.html.
- **Occupational Safety and Health Administration:** www.osha.gov.
- **University of Virginia International Health Care Worker Safety Center:** www.med.Virginia.edu/~epinet.

Source: American Nurses Association, Washington, DC.

on some facilities and after that, statewide compliance shot way up."

By and large, facilities are going to comply, she says, but to get true compliance and the highest level of protection, "people need to understand that they have the power to anonymously report these offenders to OSHA.

"My own bias is that I think it's sad that we've had to legislate this issue. Ideally and ethically those in administrative positions would recognize this threat. They see the numbers; they know it's preventable; and in an ideal world, people would take precautions to protect their people and take whatever steps they needed to protect them.

"They think if it happens to one person, those risks don't matter. But when it happens to you, it's 100%, and it matters," Black adds.

[For more information, contact:

• ***Lisa Black**, E-mail: lisa.rn@worldnet.att.net, Web site: www.needlestick.net.*

• ***Romayne Keener**, RN, Community Health Educator, Home Health Care Management, 1170 Berkshire Blvd., Wyomissing, PA 19610. Telephone: (610) 378-0481.]* ■

LegalEase

Understanding Laws, Rules, Regulations

New needle standards must be 'practicable'

By **Virginia Wright Simone**
Locke Reynolds LLP
Indianapolis

Healthcare providers, take note: Nov. 6, 2000, President Clinton signed into law HR 5178, known as the Needlestick Safety and Prevention Act. This act implements changes in the bloodborne pathogens standard that was put into place in 1991 under the Occupational Safety and Health Act, and is intended to reduce the number of needlestick and other percutaneous injuries experienced by health care workers, presently occurring at a rate of 600,000 to 800,000 incidents a year.

The new standards apply to all employers who are regulated by Occupational Safety and Health Administration (OSHA) bloodborne pathogen standards, and requires the identification, evaluation, and use of safer medical devices. Further, in meeting these new standards, employers must now actively consult with nonmanagement employees.

Relying on statistics from the Centers for Disease Control and Prevention, the act emphasizes the use of training, education, improved medical devices, and safer work practices, estimating that an employer who meets the new requirements may reduce the rate of contaminated sharps injuries by up to 88%.

While much of the act merely encourages employers to take a closer look at safety-oriented sharps technology, a number of requirements were put into place to ensure better monitoring of injuries and the ability of those health care workers who are at greatest risk for injury to request specific safety-oriented devices.

Complete documentation will be the key to establishing an employer's compliance. An employer must now:

❒ Consider (and document that consideration) "safer medical devices, such as sharps with engineered sharps injury protections and needleless systems" when establishing engineering controls.

❒ Amend its exposure control plan to adequately reflect changes in technology that reduce or eliminate exposure to bloodborne pathogens.

❒ Document annually how it reviews, evaluates, and considers this new technology.

❒ Document its solicitation of nonmanagerial employees regarding identification, evaluation, and selection of effective engineering and work practice controls.

❒ Create and maintain an injury log for all sharps injuries. The log must contain certain required information and kept confidential.

As a final point, while it's true that frontline health care workers now have a greater voice in the selection and use of medical devices, it's important to note that the act only requires an employer to use the cutting-edge technology to the extent "practicable."

What that means is that although an employer

will be required to ask an employee his or her opinion on new technology, and use that technology if possible, if it is prohibitively expensive, experimental, or otherwise impracticable, the employer does not violate OSHA standards by refusing to use it. ■

Bloodborne pathogens: Proof is in the checklist

How safe are you from exposure?

How far has your hospital or home care agency progressed in preventing on-the-job exposure to bloodborne pathogens? Are you safe? The National Institute for Occupational Safety and Health (NIOSH), a Washington, DC-based research branch of the Centers for Disease Control and Prevention, recently issued an alert that emphasizes using needle safety devices to prevent needlesticks, particularly those with the highest risk of transmitting bloodborne infection to health care workers.[1]

"Identify priorities based on assessments of how needlestick injuries are occurring, patterns of device use in the institution, and local and national data on injury and disease transmission trends," the NIOSH alert states. "Give the highest priority to needle devices with safety features that will have the greatest impact on preventing occupational infection [e.g., hollow-bore needles used in veins and arteries]."

As safer devices are introduced, worker training is essential to ensure proper use, NIOSH emphasizes. Other highlights of the alert are summarized in the following checklist. Use it to determine if your organization is taking the right steps toward better needle safety:

1. Desirable needle device characteristics.

Such characteristics include:

- The safety feature is integral to the device.
- The device works passively (i.e., it requires no activation by the user). If user activation is necessary, the safety feature can be engaged with a single-handed technique and allows the worker's hands to remain behind the exposed sharp.
- The user can easily tell whether the safety feature is activated.
- The safety feature cannot be deactivated and remains protective through disposal. The device performs reliably and is easy to use and practical.

2. Device examples.

These include:

- needleless connectors for IV delivery systems (e.g., blunt cannula for use with prepierced ports and valved connectors that accept tapered ends of IV tubing);
- protected needle IV connectors (e.g., the IV connector needle permanently recessed in a rigid plastic housing that fits over IV ports);
- needles that retract into a syringe or vacuum tube holder;
- hinged or sliding shields attached to phlebotomy needles, winged-steel needles, and blood gas needles;
- protective encasements to receive an IV stylet as it is withdrawn from the catheter;
- sliding needle shields attached to disposable syringes and vacuum tube holders;
- self-blunting phlebotomy and winged-steel needles (a blunt cannula seated inside the phlebotomy needle advanced beyond the needle tip before the needle is withdrawn from the vein);
- retractable finger / heel-stick lancets.

Check whether your hospital or home health agency has a needlestick prevention program or committee — a good indicator of its commitment to safety. The major task of such a committee should be collecting and reviewing needlestick and blood exposure surveillance data, including types of exposures, job classifications of exposed workers, procedures involved, complete descriptions of devices involved, and whether devices were safety or conventional designs.

The needlestick prevention program should include a component for selecting and evaluating safer products, and ought to have a role in the facility's product evaluation committee.

3. Evaluation strategies.

When selecting a safer device, identify its intended scope of use in the health care facility and any special technique or design factors that will influence its safety and acceptability. Conduct a product evaluation, making sure that the participants represent the scope of eventual product users.

These steps will contribute to a successful product evaluation:

• Establish clear criteria and measures to evaluate the device with regard to both health care workers safety and patient care.

• Conduct on-site follow-up to obtain feedback, identify problems, and provide guidance.

• Monitor the use of a new device after implementation to determine the need for additional training. Solicit feedback on health care workers' experience with the device, and identify possible adverse effects of the device on patient care. Ongoing review of current devices and options will be necessary.

As with any evolving technology, the process will be dynamic, and with experience, improved devices with safety features will emerge.

Reference

1. National Institute for Occupational Safety and Health. *NIOSH Alert: Preventing Needlestick Injuries in Health Care Settings.* DHHS NIOSH Publication No. 2000-108. Washington, DC: November 1999. ■

Give blood pressure its due with accuracy

Getting it right the first time

Today, it's not uncommon for people to get their blood pressure readings at the grocery store while they're waiting to get a pound of shaved ham, or at the local pharmacy while waiting for a prescription refill. It seems a few quarters and a few minutes are all it takes.

The truth is far from it, however, and as those in the home care field are well aware, there are myriad variables that can affect a reading's accuracy.

A recent article in the the *Journal of Clinical Hypertension* written by **Raymond R. Townsend**, MD, director of the renal-electrolyte and hypertension division at the University of Pennsylvania Medical Center in Philadelphia, cited his finding that it's not only laypeople who are taking false readings.

"I have been impressed with how often a home blood pressure is poorly done, even by very intelligent people whom I had assumed knew better," Townsend writes.

As such, he shares these tips for getting the best and most accurate blood pressure readings possible:

✔ **Take five.**

A "quick" blood pressure read with virtually no time of rest, he says, won't yield accurate data. Instead, he reminds health care practitioners that patients need to sit for at least five minutes with their back and feet supported. He recommends reminding patients who take their own blood pressure at home that their blood pressure will reflect their most recent activity unless the body is given at least five minutes to properly rest.

✔ **Third time's the charm.**

Townsend says when it comes to frequency, he recommends that patients take their blood pressure three times a week (once in the morning, once in the evening, and once in the afternoon) for the best overview.

✔ **Write it down.**

"Patients with atrial fibrillation or other rhythm problems may not tell their physician that it took a dozen tries to get a single reading other than 'error,' which makes the obtained data questionable at best," Townsend writes.

To help verify the quality of the data, he advises his patients to use a spiral notebook and enter their readings and other vital statistics (date, time, positions: sitting, standing, etc.) at the time they take their blood pressure. He also requests that they separate the heart rate from the diastolic value. "It is worth the few minutes it takes during a visit to ask the patient to tell you exactly how they take their blood pressures at home. Correcting faults in technique early on, and periodically checking the home monitors against a mercury-based cuff to ensure proper calibration can result in a well-trained patient who takes an active part in their blood pressure management," Townsend notes.

[For more information, contact:

• ***Raymond Townsend**, MD, Renal-Electrolyte and Hypertension Division, 210 White Building, University of Pennsylvania Medical Center, 3400 Spruce St., Philadelphia, PA 19104. Telephone: (800) 789-PENN.]*

Recommended reading

• Townsend R. *Journal of Clinical Hypertension* 2000; 2(4):288-289. ■

Marketing success costs less than you think

Tips to get you started

One of the biggest mistakes small business owners and managers make is not marketing. They may be afraid that marketing will be too costly, too complicated, or worse — both. But in neglecting a marketing plan, they are overlooking a vital part of any successful business plan.

Today, with Internet and on-line search capabilities, home health agencies have the advantage in that they can market themselves aggressively without spending the entire annual budget. "There are a number of things a home health care agency can do," says **Don Cooper**, a partner in The Guerrilla Group, a Boulder, CO-based international training and consulting company.

"One of the most important things for those in the home care field to do is develop a personal relationship with area discharge planners. The No. 1 buying and referral factor is confidence. People will refer to people in whom they have confidence, and that comes from their past experience with a company, its reputation, and a personal relationship they have," he explains. "Luckily, there are a number of weapons you have in your arsenal to further this relationship."

To get the most bang for your buck, try following some of these Guerrilla marketing guidelines:

• **No money? No problem.**

"Marketing" and "inexpensive" are not mutually exclusive terms. Notes Cooper, "Some of the easiest things to do have the greatest impact." There are a wide variety of marketing strategies that cost little to nothing and with some common sense and creativity can reap big results. **(See box, p. 9.)** A great resource guide for small businesses is *Guerrilla Marketing Attack* by Jay Conrad Levinson, of The Guerilla Group Inc. This book lists 100 marketing tools, including 50 that cost nothing. **(For contact information, see note, p. 10.)**

• **Get them talking.**

Use patients' testimonials. This might not be the most cutting-edge idea, but it is one of the more effective means of getting your agency known. Cooper suggests getting patient testimonials, which can be used in brochures, fliers, and newsletters which are sent out to community organizations, patients, and hospital discharge planners. Direct-mail pieces are a great way of keeping everyone updated on your agencies goings-on, specialties, and new branch offices.

• **What do you say?**

Always thank someone for a referral, says Cooper. No matter if it's a hospital discharge planner or a family member of a former patient, it's a good business practice to say "thank you." And while you might be tempted to cut corners and shoot off an e-mail, take the time to write a brief note. "The personal touch really packs a big wallop," notes Cooper. "It can just be two lines on a plain note card, but it's sincere and it shows you took the time. It carries tremendous impact."

• **Aim for a bull's eye.**

Connect with your target group. That means unless you have a clear idea of who your target market is (community's residents, hospital discharge planners, etc.), you will end up with no market at all and all your efforts will be wasted. Before you get started, ask yourself these questions: Who are your customers? What does your agency offer that no other home health agency can?

• **Who are you?**

Promote your identity and turn your business card into a brochure, says Cooper. "Use both sides of the card. Put your company motto or mission statement on the back of your business card. Put your address, phone, fax, e-mail address, and Web site on it. And if you have any specialties, list them as well as your branch office locations."

And, he adds, "put your picture on your business cards. The part of your brain that remembers faces is 10 times the size of the part that remembers names. It costs nothing to add a black-and-white photo and only a few cents extra per card for a color picture."

Once you've gone to all this trouble, don't just keep your cards in your desk drawer — pass them out. Hand them out at local business meetings, conventions, and church and school functions. A good way to promote your company identity is to turn your voice mail on-hold message into a radio-style commercial. Write a short commercial expressing who you are, what makes you unique, and why people should consider using your home health care services.

• **Use a full-court press.**

It has been said that there is no such thing as bad publicity. Whether this is true is questionable, but the theory behind it is correct — even (especially) bad publicity gets your company's name out in front of the public eye. To make certain your publicity is friend rather than foe, make friends with the local media. By making

Get Your Agency Noticed with These Marketing Ideas

Can't think of any good ways to get your home health agency's name out in the public eye? Consider trying a few of these low-cost, high-impact ideas.

✔ **Try tagging your agency's name and motto/ slogan to ads on:**
- Local cable television
- Local newspapers
- Local yellow pages
- Company newsletter
- Web site banner ads

✔ **Personalize administrative supplies**
Sending correspondence is a necessity. Why not make the most of it? Make sure your agency name and information are displayed prominently on the following:
- Stationery/envelopes
- Fax cover sheets
- Business cards
- Note pads
- Mailing labels

✔ **Give promos a purpose**
Everyone loves freebies. Next time you attend a regional health fair or other community event, consider giving away the following, prominently stamped with your agency's name, of course:
- Pens
- Mugs
- Water bottles
- Tote bags
- Balloons
- Phone message pads
- Car sun shades
- Plastic pill caddies

✔ **Be creative**
There are numerous avenues for getting your home health agency in the public consciousness. Here are a few more ways you can get the word out:
- Create a slogan and add the slogan to your corporate logo and your on-hold message.
- End communications to both clients and suppliers with the slogan.
- Become a spokesperson and use the slogan when speaking to media, clients, suppliers, and employees.

Source: The Guerilla Group, Boulder, CO.

connections with local press, small businesses receive enormous free publicity with low costs and minimal effort.

Package your home health agency's events and happenings into press releases. Send out a press release to your local paper's business section whenever someone new is hired or promoted. Hosting an informational seminar? Let someone know about it through a press release.

If you're unsure as to where to begin, consider checking out books from your local library on marketing and public relations. **(For more information on marketing your agency, see *Hospital Home Health*, June 2000, pp. 61-67.)**

• **Avoid information overload.**

While many mediocre marketers believe "short is sweet," marketing moguls coin the phrase "more means more." The truth is that readership does fall off after the first 50 words, so keep this in mind if you're preparing a brochure or "white paper." And be sure not to overlook the five Ws: Who, What, Where, When, and Why.

• **Talk it up.**

Volunteer to speak at a local community club or church meeting. "They are always looking for speakers," says Cooper. He suggests calling the group's president or activities chairperson and telling him or her you would like to give a talk. Make sure you have a specific subject in mind, maybe something on how the elderly can prevent falls, what you need to do to prepare for a stay in the hospital, or how to speed recovery from surgery.

The key to this approach, he warns, is to "share your experiences and stories. Give them information and advice, but don't try to sell your agency. It will come off as a spiel, and the more you try to sell, the worse the results will be. Give them information that is useful to them, and you will get a better response. Now is the time to be selfless."

• **Use fusion.**

Fusion marketing, explains Cooper, is when two or more organizations work together for mutual benefit. An example of this would be a home health care agency partnering with the local library and having employees volunteer to read to the elderly, or to work with an area animal shelter and bring (well-screened) pets onto hospital wards to meet and greet the patients.

"You'll be right up front with your target market," he points out, "and you'll be splitting whatever costs are involved with another organization."

• **Remember that patience is a virtue.**

Once you start a marketing campaign, stick with it. You may be sick and tired of your current campaign, but your prospects may just be beginning to take notice and to recognize your identity. Rather than updating your advertising, be repetitive. Allot money for reiterating the same message over and over and over again. Remember, once is never enough.

[For more information, contact:

• ***Don Cooper**, Partner, The Guerrilla Group, 1002 Walnut St., Suite 101, Boulder CO 80302. Telephone: (800) 247-9145. Web site: www.guerrillagroup.com.]* ■

Tips on how to manage a successful SDS program

In the current regulatory and reimbursement environment, managing an outpatient surgery program can be overwhelming. For help on costing surgical procedures, containing costs, and surviving reimbursement changes, among other topics, attend the Seventh Annual Same-Day Surgery Conference March 4-6 in Orlando, FL. The conference is sponsored by American Health Consultants, publisher of *Hospital Home Health.*

Topics include advice on reprocessing, antibiotic resistance, hazards in the workplace, achievement of excellence, surgical trends and new technologies, accreditation, risk management, medical errors, the nursing shortage, the outpatient prospective payment system, and employee motivation.

The conference includes opportunities to network with your peers at lunches and a reception, as well as a Downtown Disney excursion.

For more information or to register, contact American Health Consultants, Customer Service, P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. ■

Pressure ulcers in 9% of new home care patients

A national chain of home care agencies found through a quality assurance report that one in 11 new home care patients enters the system with pressure ulcers. The report, published in the September issue of the *Journal of the American Geriatrics Society*, raises concerns about the quality of routine skin care measures for older adults in hospitals and nursing homes and points out the need for better wound care.

More than 3,000 home care patients from 14 states — 65% of whom had been discharged from a hospital or nursing home — were examined as part of the study. About 9% already had pressure ulcers at the time of their first home care visit, and of those, roughly a third had two or more pressure ulcers, while three-fourths had advanced-stage ulcers.

The report also revealed that patients who began home care after being released from a nursing home or hospital were more likely to have pressure ulcers than other patients. Fifty-four percent of those with pressure ulcers received pressure-reducing mattresses or other devices on admission to the facility, and only 18% of those at risk received pressure reduction. Other risk factors for pressure ulcers included functional impairment, incontinence, and previous ulcers.

Most ulcers were being managed by wound care products, including dry or wet-to-dry gauze dressings. The researchers recommended educational and quality improvement efforts to ensure that home care providers have the knowledge and skill to assess and manage these potentially dangerous wounds.

(Editor's note: Next month's issue of Hospital Home Health *will provide a pressure ulcer protocol, which will detail treatment stages, care options, and useful resource information for home care professionals who deal with pressure ulcers.)* ■

COMING IN FUTURE MONTHS

- Home care education: How are agencies finding the funds?
- The story of a home care agency with a unique alcohol detox program
- Winter advisory: Get your agency ready to brave inclement weather
- Why pressure ulcers are common in new home care patients
- Pressure ulcer protocol for better treatment of these potentially dangerous wounds

NEWS BRIEFS

Study looks at patients' perception of health plans

A recent study by the nonpartisan Center for Studying Health System Change (HSC) in Washington, DC, found that beauty really is in the eye of the beholder, at least when it comes to what people think about their health plans. In other words, people rate their overall satisfaction levels with their health care programs according to what type of plan they think they have. Not surprisingly, people who think they have HMO plans ranked their overall satisfaction level as lower than that of non-HMO participants (or those who thought they were), and expressed a lesser degree of trust in their doctors. In fact, those who believed (correctly or incorrectly) that they were in an HMO rated the thoroughness of their last doctor's visit as fair to poor, and said they doubted that they would be referred to a specialist even if they needed it.

According to **James Reschovsky**, lead author of the study, people's "perception of what kind of health plan [they] are in colors [their] perception of what kind of care [they] receive and, ultimately, [their] level of satisfaction."

The study asked some 20,000 privately insured people the type of health insurance they had (which HSC later verified), as well as their feelings about their most recent medical visit, their trust in their doctors, and their overall satisfaction with the care they receive. The study found that nearly 25% of those surveyed incorrectly reported the type of plan they have; 11% believed they were in a plan other than an HMO when they really were, while 13% incorrectly believed that they were in an HMO.

The study looked at 10 criteria, and in every case, those who believed incorrectly that they were in a certain type of plan, whether HMO, point-of-service, or preferred physician organization, gave similar ratings to those who actually were in the plan. Interestingly, when researchers adjusted for those who had incorrectly identified their type of coverage, differences in health care ratings between HMO and non-HMO enrollees shrunk and in many cases, disappeared. ▼

HHS releases annual work outline

The Department of Health and Human Services inspector general's office earlier this month released its annual work plan detailing its planned audits and inspections of hospitals. The 103-page plan outlines 19 areas the office will concentrate on, most of them carried over from the prior plan. Additions include Medicare payment for satellite long-term-care units, reporting of patient restraint deaths, and follow-up on peer review organizations' complaint process. The plan also includes a greater emphasis on contractor compliance. ▼

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2001 Medicare rates announced

The Department of Health and Human Services (HHS) has announced the 2001 rates for the Medicare Part A deductible and Part B monthly premium amounts paid by beneficiaries.

Beginning in January, Medicare recipients will see their premiums rise $4.50 from the previous year to a total of $50. This is the first increase since 1999 when the premium rose $1.70. There was no increase in 1998. In fact, in the past six years, premiums have risen less than $1 when accounting for inflation. Part B premiums cover physician services, hospital outpatient care, durable medical equipment, and other services outside hospitals.

Increase reflects congressional actions

In addition to health care costs, this year's increase reflects legislative changes that increase Part B spending. The beneficiary-paid Part B premium represents 25% of total Part B spending. Although premiums are rising by more than $4, this increase is considerably less than projected. Earlier predictions following the enactment of the Balanced Budget Act of 1997 (BBA) saw premiums rising from $43.80 in 1997 to $59.40 in 2001.

The Part A deductible for inpatient hospital care will rise by $16 to $792, a 2% increase reflecting savings from reductions in Medicare hospital payments and other program changes resulting from the BBA.

Last year, the deductible rose by $8. HHS estimates that the daily cost to beneficiaries for hospital days 61 through 90 in a benefit period is rising by $4, to $198 per day, and by $8, to $396 per day, for hospital days beyond the 90th in a benefit period.

The skilled nursing facility daily coinsurance amount, which must be paid after the first 20 days of such care in a benefit period, is rising by $2, to $99 per day.

The Part A premium, paid by only a small percentage of beneficiaries, is decreasing again, this time by $1, to $300.

That amount is paid by seniors with less than 30 quarters of Medicare-covered employment (and by certain people with disabilities who are under age 65, have lost disability benefits because of work and earnings, and have less than 30 quarters of Medicare-covered employment).

Seniors with 30 to 39 quarters of Medicare-covered employment (and certain people with disabilities who are under age 65, have lost disability benefits because of work and earnings, and have at least 30 quarters of Medicare-covered employment) are entitled to a reduced monthly premium, which is falling by $1 to $165. ■

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. Cite 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

HIPAA includes home infusion therapy code

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) aimed to reduce inefficient paper claims submitted to multiple payers using different medical coding sets, such as those required for home infusion therapy. The final HIPAA regulations published in August 2000 adopted some key recommendations by the National Home Infusion Association (NHIA), and standardized electronic claims for home infusion therapy will be in place by October 2002.

"While it is now widely accepted to pay for home infusion services on a per diem basis, the lack of standardized coding sets and lack of electronic claiming increases the overall cost of home infusion services," according to a NHIA spokesperson. Home infusion therapy is estimated to be a $5 billion industry, with overall savings to the health care system estimated at more than $12 billion. The regulations require payers and providers to be able to support electronic claims transactions without requiring all claims be handled this way. In the future, however, paper claims may use the codes set as standards for electronic data interchange (EDI).

In the final regulation, the Department of Health and Human Services endorsed four national coding sets — CPT codes, used primarily for physician services; HCPCs, used primarily for medical products and equipment; ICD-9s, used for diagnoses and select medical procedures; and NDCs, which assign a unique code for each drug from each manufacturer — will replace "J" codes, which will be eliminated.

The ASC X12N 837 code will be the electronic transmission standard for professional pharmacy claims, including home infusion therapy; only retail pharmacies will use a NCPDP format.

Home infusion is still covered under "local" payer-specific and "custom" codes, which now must be standardized to comply with HIPAA. The NHIA endorses adopting as a national standard its Home Infusion EDI Coalition (HIEC) codes, which it says have widespread industry support. The codes were developed by a coalition of providers and payers, and are used by multiple payer organizations.

"Through HIEC, the association will continue to work to advance standardized electronic claiming for home infusion, which will benefit payers and providers alike," said **Bruce E. Rodman**, the HIEC committee chair. "For the first time, this goal appears to be within reach, and the cost savings will ultimately be significant."

The association has a fact sheet available at www.nhianet.org/hiec0700.pdf.

For more information about HIPAA, go to www.hcfa.gov/hipaa/hipaahm.htm. ■

Blood thinning agent approved

For the first time, the U.S. Food & Drug Administration (FDA) has approved a blood-thinning agent for the prevention of blood clots know as deep-vein thrombosis.

Lovenox, a low-molecular weight heparin from Aventis Pharmaceuticals in Parsippany, NJ, was approved for patients with restricted mobility at risk for thromboembolic complications from illnesses such as heart failure, respiratory failure, severe infection, back pain, vertebral compression, and arthritic episodes. ■

JCAHO offers Quality Check

The Joint Commission on Accreditation of Healthcare Organizations has launched a series of public accountability initiatives to make consumer information available about

the quality of care provided in accredited health care organizations.

Quality Check, a guide to learning about the quality of organizations can be found on the Web site at www.jcaho.org. It provides information about accredited health care organizations and programs, including contact information, accreditation decision, date of accreditation, and current accreditation status.

It also includes organization performance reports showing overall performance level, performance level in key areas, areas needing improvement, and how the organization compares to other organizations nationally in each performance area. ■

COMPANIES IN THE NEWS

InSource enters insurance alliance

InSource Health Services of Chatsworth, CA, a group purchasing organization owned by MedAssets.com, has entered a strategic alliance with health care industry insurance broker InLight Risk Management Inc.

The alliance will give InSource's 9,300 member organizations access to affordable insurance programs designed for their changing needs.

The initial offering is a professional liability program accessible through InLight's Health Care Risk Purchasing Group to leverage the buying power of InSource's customer base. The insurance broker will develop a suite of insurance products to help InSource customers manage their risk more effectively and efficiently. ■

Invacare and Mallinckrodt sign deal

Invacare Corp. in Elyria, OH, which makes and distributes home medical products, and Mallinckrodt Inc. in St. Louis, a manufacturer and marketer of specialty medical products to sustain breathing and relieve pain, have formed a strategic alliance with a double aim.

Invacare will distribute Mallinckrodt's oxygen therapy products, and Mallinckrodt will stop producing its Puritan Bennett 590 series oxygen concentrators, which Invacare will still support in North America. Transitioning this business over to Invacare and making it a distribution partner was driven by Mallinckrodt's decision to refocus on developing technologically innovative products. ■

Option Care buys infusion pharmacy

Option Care Inc. in Bannockburn, IL, a provider of ancillary infusion therapy and high-tech pharmacy services, has acquired the infusion business of Peluso Investments Inc. in Hemet, CA, an Option Care franchise. The acquisition is consistent with Option Care's strategy to purchase independent and franchise pharmacies in strategic markets, and it will leverage the core infrastructure and enhance revenues and profits in southern California. ■

Children's unit signs with Cigna

Building Blocks Pediatric Home Health Services in Newport Beach, CA, a regional provider of high-tech pediatric home care, and Cigna Healthcare of California, a health benefits organization, have signed a provider agreement for the HMO product for southern California and a statewide contract for the preferred provider organization product.

Building Blocks will provide Cigna's members in California with home health services designed for children, including skilled nursing services; in-home physical, occupational, and speech therapy; medical social services; infusion therapy; and some medical equipment. ■

CARF accredits network administrators

The Addictions Resource Network of Indiana Inc. in Indianapolis, and Kent County Community Mental Health in Grand Rapids, MI, are the first two networks to receive Commission of Accreditation of Rehabilitation Facilities (CARF) accreditation in network administration. Both behavioral health organizations were awarded accreditation for three years.

The Addictions Resource Network acts as a funding and compliance link between the state and 10 organizations that provide chemical dependency and compulsive gambling treatment. Kent County Community Mental Health manages the provider network for mental health services in that county, as well as the provider network for substance abuse services for a four-county region in Western Michigan.

Any organization with a formal agreement to manage or deliver rehabilitation with one or more service providers may apply for CARF

accreditation in network administration. The providers' services first must be accredited by a nationally recognized accrediting body. ■

Omnicare Inc. (OCR) in Covington, KY, reported revenues for the quarter of $491.3 million, compared with $474 million in 1999. EBITDA totaled $56.5 million, compared with $53.4 million previously. The company earned 18 cents per diluted share — excluding the impact of restructuring and related charges of $2.7 million after taxes, or 3 cents per diluted share, from previously announced productivity and consolidation initiatives. In 1999's third quarter, Omnicare reported earning 16 cents per share, excluding restructuring charges and expenses totaling $389,000 or 1 cent per share. Net income this quarter was $16.2 million, compared with $14.3 million in the same period a year ago. ■

Option Care Inc. (OPTN) in Bannockburn, IL, announced third-quarter revenues increased 17% to $35.3 million. EBITDA rose 33% to $4.3 million. Net income grew 69% to $2.3 million or 18 cents per diluted share. ■

Lincare Holdings Inc. (LNCR) in Clearwater, FL, a home care provider of oxygen and respiratory therapy services, announced revenues for the third quarter were $186 million, a 24% increase over revenues of $150 million in 1999. Diluted earnings per share were 55 cents, an increase of 24% over the 45 cents diluted earnings per share for the previous year. Net income was $29.7 million compared with $26 million.

For the nine-month period, revenues were $513 million, a 20% increase over revenues of $429 million for the same period in 1999. Diluted earnings per share were $1.57, a 24% increase over the $1.26 earnings per share in 1999. Net income was $85 million, compared with $74 million. ■

National Healthcare Corp. (NCH) in Murfreesboro, TN, a long-term health care corporation, announced third-quarter revenues of $130 million, compared with $105.6 million last year.

Earnings were $2.5 million or 22 cents per share, compared with $1.8 million or 16 cents per share for the same period in 1999.

For the nine-month period, revenues totaled $361.7 million, compared with $321 million, for the same period in 1999. Earnings per share were 64 cents, compared with 55 cents previously. Net income was $7.4 million compared with $6.3 million. After the quarter's end, NHC completed a two-year extension of its $19 million credit facility to Nov. 10, 2002. ■

New York Health Care (NYHC; BSE; NYH) in Brooklyn, NY, a licensed home health care agency, announced net revenues for the third quarter rose 20% to $7.5 million from $6.3 million the previous year.

The company reported net income for the quarter of $67.8 million or 2 cents per diluted share, more than double the $27,500 or 1 cent per share for the same period in 1999.

For the first nine months of 2000, revenues increased 29% to $21.8 million from $16.9 million the previous year. Because of a one-time, noncash charge to operations of $1.5 million taken in the second quarter, the company reported a net loss of $1.4 million or 37 cents per diluted share for the nine months, compared with last year's net loss of $223.5 million or 6 cents per diluted share. ■

Vencor Inc. (VCRIQ.OB) in Louisville, KY, a long-term healthcare services provider, announced revenues for the third quarter totaled $717 million, compared with $682 million in 1999. The company reported a net loss of $27 million or 38 cents per share, compared with a net loss of $42 million or 61 cents per share previously. The net loss included certain unusual items — the company recorded a write-off of $9 million related to an impaired investment and incurred costs of about $5 million for restructuring activities.

For the nine-month period, total revenues were about $2.1 billion. Vencor reported a net loss of $48 million or 69 cents per share, compared with a net loss of $107 million or $1.53 per share previously. The net loss included unusual transactions — a $5 million gain on the sale of a closed hospital, the investment write-off, and restructuring costs of $10 million. On Sept. 13, 1999, Vencor filed a voluntary petition for reorganization under Chapter 11 in U.S. Bankruptcy Court for the District of Delaware. It filed a plan for reorganization on Sept. 29, 2000, and a first amended plan and disclosure statement on Nov. 6. The court approved an extension for its debtor-in-possession financing until Jan. 31, 2001. ■

CORPORATE LADDER

Cara C. Bachenheimer, a home health care specialist, has joined the Washington, DC, office of **Epstein, Becker & Green** as senior counsel, working with nearly 90 lawyers who comprise the firm's National Health Law Practice. She will focus on representing home health care providers and manufacturers, distributors, and other health care industry companies. ■

Option Care Inc. in Bannockburn, IL, appointed **Carla M. Pondel** chief financial officer. Pondel spent almost 10 years at Baxter International Inc., most recently as director of global finance of the IV Systems Division, where her responsibilities included strategic and operations plans. ■

Richard Tschider, CEO of St. Alexius Medical Center, has been named chair of the **Health Industry Business Communications Council** board of directors. He has been a member of the board, representing the American Hospital Association, since 1989, serving two separate terms and on numerous key committees.

The board also elected **Frank Simone**, director of electronic commerce for Johnson & Johnson Healthcare Systems, as vice chair; **Jon Briney**, vice president and general manager for AmeriSource Corp., as treasurer; and **Robert Schuweiler**, vice president, Supply Chain Solutions Group for Premier, Inc., as secretary. ■

ASSISTED LIVING UPDATE

Ergonomics standard announced

In November, the Occupational Safety and Health Administration issued its final ergonomics standard.

The standard will cover "general industry" employers and takes effect Jan. 16, 2001. It requires all employers to provide employees with specific information about musculoskeletal disorders (MSDs) and to evaluate whether reported MSD incidents meet "action triggers."

If more than two MSDs have been reported in the preceding 18 months or the incident cannot be resolved in 90 days, the employer is required to develop and implement a full ergonomics program for the job involved.

The Assisted Living Federation of America continues to actively oppose the regulation. ■

Senior services firm reports loss

Diversified Senior Services Inc. (DSS) in Winston-Salem, NC, which creates affordable community living alternatives for seniors with fixed incomes, reported third-quarter losses of $155,737 or 4 cents per share on revenues of $1.5 million compared with earnings of $67,051 or 2 cents per share on revenues of $1.3 million in 1999's third quarter. In the first nine months of 2000, the company lost $22,556 or 1 cent per share on revenues of $4.6 million, compared with earnings of $324,469 or 10 cents per share on revenues of $4.1 million in 1999. The losses were expected, according to the manager of housing for the elderly, as DSS completes its transition from a development-based to a management-based company. Management income in the first nine months was about $845,000, compared with about $653,000 in the same 1999 period. ■

Greenbriar announces increases

Greenbriar Corp. (GBR) in Addison, TX, which operates assisted and full-service independent living communities, reported a 20% increase in operating income for the third quarter and a 31% increase in operating income for the nine-month period ending Sept. 30, 2000 (exclusive of noncash write-offs of impaired assets totaling $7.5 million).

With four fewer operating units, the company's revenues for the quarter decreased to $10.3 million, compared with $10.4 million in 1999. Revenues for the nine-month period increased to $31 million, compared with $30.9 million for the same period in 1999. ■

Marriott names preferred provider

Omnicare Inc. of Covington, KY, a geriatric pharmaceutical care company, has been named national preferred provider of pharmacy services for most Marriott Senior Living communities across the country, for about 15,000 residents. ■