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HOME INFUSION THERAPY MANAGEMENT™

INSIDE

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Late flurry on Capitol Hill holds hopes for IV providers

Legislation proposes Medicare reimbursement for IV therapy

Before Congress closed up shop in 1998, HR 4753 was introduced in the House of Representatives, which could have a huge impact on Medicare's reimbursement — or current lack thereof — of home infusion therapy.

Section 6 of the Medicare Prescription Drug Coverage Act of 1998 deals specifically with coverage of home infusion drug therapy services. The bill proposes to provide reimbursement for "such nursing, pharmacy and related services (including medical supplies, intravenous fluids, delivery and equipment) as are necessary to conduct safely and effectively a drug regimen through use of a covered home infusion drug."

The bill also proposes general standards for what would be required of a "qualified home infusion drug therapy provider."

The proposed criteria are:

A) The entity is capable of providing or arranging for the items and services described [in the above-quoted skills and products] and covered home infusion drugs.

B) The entity maintains clinical records on all patients.

C) The entity adheres to written protocols and policies with respect to the provision of items and services.

D) The entity makes services available (as needed) seven days a week on a 24-hour basis.

E) The entity coordinates all service with the patient's physician.

F) The entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care.

G) The entity assures that only trained personnel provide covered home infusion drugs (and any other service for which training is required to provide the service safely).

H) The entity assumes responsibility for the quality of services provided by others under arrangements with the entity.

I) In the case of an entity in any State in which State or applicable local law provides for the licensing of entities of this nature, the entity (i) is licensed pursuant to such law, or (ii) is approved, by the agency of

such State or locality responsible for licensing entities of this nature, as meeting the standards established for such licensing.

J) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home infusion drug therapy services and the efficient administration of the home infusion drug therapy.

Why so late?

HR 4753 was introduced in the waning days of the 1998 session with good reason, according to **Alan Parver**, JD, president of the Washington, DC-based National Alliance for Infusion Therapy (NAIT).

"It was clearly done to set the table for consideration in 1999," says Parver. "The thinking probably is that the National Bipartisan Commission on the Future of Medicare will be issuing a report that might well address expanded coverage of prescription drugs, and infusion would be part of that, or at least potentially part of that — and should be part of that, I might add."

HR 4753 would require home infusion providers to become Medicare-certified before being able to receive reimbursement, however.

"As it is now, agencies and organizations that provide enteral nutrition are considered to be suppliers, not providers," says Parver. "To be a provider, you must be certified as meeting Medicare conditions of participation, so you would be changed to provider status and have to meet quality standards, be surveyed, and have to be certified before you could be paid for treating Medicare beneficiaries."

While it is clearly too early to make any forecasts about the bill, **Lorrie Kline Kaplan**, executive director of the Alexandria, VA-based National Home Infusion Association (NHIA), says it's a step in the right direction.

"This would deal with a lot of the problems we have had in the past," she says. "We have quite a bit of time to wait, but it is an exciting development. This lays the groundwork for payment for professional services, and also appears to open the door for potential expansion of coverage, but obviously they'll have to find savings to pay for this."

HR 4753 clearly will have to overcome hurdles before becoming law. Parver agrees that the cost of the program is a primary issue.

"This is part of a broader bill that would cover outpatient drugs generally," he says. "That would be quite costly, or at least would add to the cost of the system. The question is, if Congress is not prepared to adopt the broad coverage proposal, would Congress be prepared to look at infusion therapy separately? If you look at how hard it was to fund the IPS [interim payment system] fix, you know that funding such proposals is not that easy."

The news isn't all positive, though. The Durable Medical Equipment Regional Carriers (DMERCs) picked eight items for which they intend to change Medicare reimbursement, using the "inherent reasonableness" rule. Included in the reductions is a 16.39% reduction in the reimbursement for enteral formula, category one.

"There are a lot of serious flaws in the methodology on how those cuts have been justified," says Kaplan. "This is anywhere from 15% to 17% of the business for most of our members, and 80% of that business is category one enteral, which these cuts would specifically address."

Parver notes that any cuts invoked through inherent reasonableness are limited to 15% in one year. Although there was a comment period through the end of November, Parver says the DMERCs are well within their authority in issuing such cuts.

"The problem is that Congress gave HCFA [the Health Care Financing Administration] very broad authority to make payment adjustments like that, and HCFA delegated that authority to the DMERCs," says Parver. "There are very few statutory and regulatory hoops they have to jump through to get this done." ■

Ambulatory infusion: The key to success

Why reimbursement is the name of the game

Every industry has its buzzwords and hot trends. For home infusion providers, one of the latest trends is following the ambulatory infusion center down the road to riches. But not every road leads to a pot of gold. There are dead ends and potholes along the way.

All the research in the world may be for naught if you fail to analyze your reimbursement sources carefully and overlook the various ambulatory infusion center models.

"It's important to find out who will pay for the service before you provide it," explains **Michael Tortorici**, RPh, MS, president of Dayton, OH-based national health care consulting firm Alternacare of America. "There are people out there promoting ambulatory infusion as a panacea, and I want to caution people that if they plan on getting into this endeavor, they first need to find out if they will get paid and who will use it."

How are different models reimbursed?

First, you need to be aware of the three models of ambulatory infusion centers and the nature of each model's relationship to reimbursement, says **Alison Cherney**, principal of Cherney & Associates in Brentwood, TN. If you understand these relationships, you're well on your way to successfully evaluating whether an ambulatory infusion center is for you.

The three models are:

1. Outpatient center.

Cherney notes that this model is a hospital-based model and can bill for all reimbursement classes.

"You can also set up a freestanding outpatient center, but you may need to meet Certificate of Need requirements in your state," she says.

Or you can consider having a local hospital outsource work to you. "If you have an independent infusion pharmacy, you can contract with a hospital to provide the compounded medication and the final product to the hospital's infusion center," says **Gary Collins**, president of Professional Reimbursement in Orlando, FL. "I'm finding that hospitals are understaffed, or else their pharmacists are trying to jockey for position under the hood."

2. Physician office-based center.

"If your biggest referral source is a physician, and he wants you to take care of his Medicare population, it makes sense to set up the center where the patients come into the physician's office and Medicare will pay for it," according to Cherney. "It's the whole concept of joint marketing, much like McDonald's and Disney. There is a mutual gain to be had there."

However, if you receive referrals from numerous physicians, that could be a different story. "Technically, the physician referring the patient would have to turn the patient over to the physician for the infusion," she says.

She adds that there also may be some education involved should you work with a physician, regardless of the model.

"If you ask Dr. Brown how many patients he can refer to you, he automatically thinks to send you just the home care patients," says Cherney. "It's much like home care was in the early '80s. We have to educate and work with physicians."

3. Freestanding center.

These centers are few and far between for one simple reason: reimbursement.

"We don't have very many for the simple reason that Medicare will not pay for it, although there are some states where Medicaid will pay for it," says Cherney. "If someone has a Medicare-based patient population, they are going to have to set up either a physician-based center or an outpatient-based center. Those are the only two options you have. It is that cut and dried."

However, if you have enough managed care business, you may be able to succeed with a freestanding center. But you'll still have to do plenty of upfront work to guarantee success.

"The best case scenario would be to get an exclusive contract with managed care," says Tortorici. "Some organizations have signed nonexclusive managed care contracts, and the business they receive is marginal because the managed care organization has signed multiple contracts. If you are going to spend the money up front for an ambulatory infusion center, you need a certain commitment from managed care to support it."

Be creative when looking for an exclusive contract. Tortorici notes that you can carve out geographic exclusivity or an exclusive niche contract such as pediatrics or HIV.

Medicare, Medicaid prove tight-fisted

Once you're familiar with the various ambulatory infusion center models, it's time to play mix-and-match between your own reimbursement and the model that best suits your payer sources.

Tortorici sums it up best: "It is very difficult for a freestanding ambulatory infusion center to get reimbursement from Medicare and Medicaid," he says, adding the managed care isn't necessarily a cash cow, either. "Many managed care contracts do not include ambulatory infusion center services."

To prevent this problem, Tortorici recommends meeting with your managed care providers to negotiate a rate for therapies provided in your ambulatory infusion center. Although the rate will be less than the one for home care, you should be able to make up the difference by having the

nurse in the center treat more patients in a day than in the home. Keep in mind that some costs will increase, such as liability insurance.

In the end, the agreement should benefit both sides of the equation.

"An ambulatory infusion center must be profitable for the provider, and the payer must save money," says Tortorici.

Along those same lines, it's important for your center to bring in new patients rather than simply changing therapy locations for patients.

"I've seen organizations that have cannibalized their home care business, so do the appropriate homework," says Tortorici.

Billing goes hand in hand with reimbursement, so it only makes sense that you consider potential billing problems as well. But you don't need a specialist — just a willingness to train your current billing staff. According to Tortorici, training would likely be necessary for any new pricing schedule, special coding required by payer sources, or new formats when submitting bills.

One of the best ways to take care of potential problems is to meet with the payer up front.

"There is no substitute for meeting with the payer to determine what is necessary," says Tortorici. "And bring billing staff to subsequent meetings to avoid initial problems. The last thing anyone wants is to start a program that causes a distraction." ■

Evaluate productivity of your whole staff

Measuring team visits rather then individuals

Productivity standards are a necessary evil for home infusion providers. Many providers find it's more effective to tally the productivity of each home infusion nurse, but only to find an aggregate number of visits per day for nurses. One provider using such a system is the Visiting Nurse Association (VNA) of Greater Philadelphia.

"We measure each individual's productivity and aggregate that into team productivity," says **Stephen Thompson**, RN, BA, CRNI, CNSN, director of infusion services division for VNA of Greater Philadelphia. "It is the responsibility of the managers who do the scheduling to have their whole team net out at what our goal is. We shoot for gross productivity of four cases per day."

Gordon Mann, RPh, team leader of home infusion therapy at Elkhart (IN) General Home Care, also is using the team approach to productivity.

"We have standards per visit and per activity and data is collected on an individual basis, but we measure it as a team," he says. "The purpose for that is one nurse might drive a lot of miles to see a patient, and another nurse might drive fewer miles and see lots of patients."

Too many factors influence productivity

Thompson says expecting individuals to meet a daily goal is nearly impossible because of the wide variety of home infusion visits.

"We evaluate the department's productivity by the aggregate rather than by the individual because there are too many factors that can influence individual productivity, such as the number of miles that have to be driven in order to see your cases, whether it's a new case or a revisit, and other factors that affect a nurse's ability to effectively route themselves from one location to another," says Thompson. "Treatments can be time-specific, so they may have to travel in an inefficient fashion to meet the time requirements and care needs of the patients."

VNA of Greater Philadelphia's home infusion staff is broken into two teams, with seven on one team and eight on the other.

"The teams are divided geographically in respect to our coverage area," says Thompson. "On a yearly basis, we analyze what zip codes our referrals have fallen into to get a sense of caseload volume by geographic location and make up dividing lines for these particular teams."

Thompson adds that just as important as providing a fair geographic coverage area for a team is matching individuals with the strengths and weaknesses of other members of the team.

"For each specific team, we try to balance off their specific individual skills, so, for instance, you have the same number of chemotherapy-certified nurses on each team," he says.

For Elkhart General Home Care, a total of 35 RNs are broken down into five teams: a north team, a south team, a complex team, an OB/infant care team, and a home infusion team.

(Continued on page 6)

HOME DIVISION of Employee ☐ TSD ☐ MDC ☐ CCD ☐ HSD ☐ HLD ☐ IPD

☐ **SHARED SERVICE** (List at Bottom) Indicate Division Worked in Column (4) ☐ **UNKNOWN FEE/MA PENDING** (Use separate sheet)

EMPLOYEE NAME_____ EMPLOYEE NUMBER ☐☐☐☐☐ TEAM NUMBER ☐☐☐☐☐ ☐☐ ☐☐ ☐☐

☐ PER VISIT ☐ PER HOUR MONTH DAY YEAR

PATIENT NAME	PATIENT STAT NUMBER	(1) TOTAL VISIT TIME (quarters)	(2) TRAVEL TIME (quarters)	(3) NON CHRG	(4) A/D
				NC	
				NC	
				NC	
				NC	
				NC	
				NC	
				NC	
				NC	
				NC	
				NC	
				NC	
TOTALS					DIVISION WORKED:

NON VISIT TIME	(6) TIME (quarters)		
COMMITTEE/TM MTG			
HOLIDAY			
PERSONAL LEAVE			
FUNERAL LEAVE			
EDUCATIONAL LEAVE			
INSERVICE			
JURY DUTY			
SHIFT DAY			
ORIENTATION			
SICK LEAVE			
VACATION			
OFFICE TIME/SPEC. PROJ.			
TOTAL NON VISIT TIME			

TIME SUMMARY

HOURLY EMPLOYEE
- VISIT TIME (1) _____
- TRAVEL TIME (2) _____
- PREP & POST (5) _____
- NON VISIT TIME (6) _____
- TOTAL TIME _____

PER VISIT EMPLOYEE
- TOTAL # VISITS _____

(3) NON CHARGEABLE VISIT CODES
NC1 - ADM EVAL/ASSESSMENT
NC2 - NOT HOME/NOT FOUND
NC3 - NO SKILLED CARE/HHA SUP ONLY
NC6 - H.H. AIDE CARE NOT PROVIDED

QUARTERS OF AN HOUR
15 MIN = .25 HOUR
30 MIN = .50 HOUR
45 MIN = .75 HOUR
60 MIN = 1.00 HOUR

SUPERVISOR'S SIGNATURE _____

(4) A - ADMISSION
D - DISCHARGE

DAILY TIME SHEET

DATE KEYED: _____ DE/CLERK:_____

White - Data Entry Yellow - Payroll (II Per Visit) Pink - (Supervisor)

Source: VNA of Greater Philadelphia.

Mann's home infusion team consists of three nurses. Each nurse covers a separate geographic region. Mileage averages 23 miles per visit and has been as high as 200 miles in one day, according to Mann.

Thompson says he looks at productivity numbers once per month. He says reviewing numbers any more frequently is nothing more than micromanaging the natural fluctuations of any business.

"It takes a few months of below-expected productivity before I would make a decision to cut staff, or if productivity numbers were through the ceiling and the numbers told me I was overworking my staff it would take a couple of months to identify a trend," he notes. "This business has ebbs and flows and you have to account for them."

The four-visits-per-day aggregate number of visits per nurse is a result of years of evaluating expectations and intangibles that can effect the duration of a visit.

"It was through a lot of years of trial and error," he says. "Initially we tried to identify different factors and find an average time per visit."

The data are collected using daily route sheets developed in-house. **(See productivity chart on p. 5.)** Staff turn in daily route sheets that list visit times and what visits were made. The data are then compiled by support staff and turned into aggregate data for each team.

Elkhart's aggregate is also four visits per day, based on standards of six hours for an admission, two hours for a visit, and a "therapy day" standard (consisting of monitoring patients and preparing supplies) of 15 minutes per therapy day. Mann says new standards of 4.5 hours for an admission and 30 minutes for a delivery are planned to better track actual costs to potentially justify delivery personnel.

"We only look at the aggregate, not at individuals," says Mann of the four-visit-per-day productivity expectation. "We take the total number of admissions, visits, and therapy days and multiply that by the standards and get a total number of hours that should have been worked. We then compare this to the actual payroll for the same time period."

VNA of Greater Philadelphia could simply compile the total number of visits made for each team to come up with an aggregate per-nurse visit number. However, that wouldn't allow for closer analysis, according to Thompson.

"If we see a quarterly trend that shows decreased productivity on one specific team, through individual productivity analysis you may be able to narrow it down to one particular person," he says. "Then we decide if that person needs some additional training and support. Most of the time it is a matter of retraining and a refocus of the nurse's energy on the concept of productivity and how important that is to our overall business plan."

Other times a careful analysis of an individual nurse's caseload will show there is an individual factor causing lower productivity. For example, if a therapy requires the nurse to stay in a home for six hours during a therapy and that patient is on the nurse's caseload for two or three months, the productivity number would be low, but Thompson would be able to account for the change and write it off.

Like Thompson, Mann collects individual data but looks at them intermittently and waits for several review periods before attributing a change in productivity to a trend rather than a spike or drop.

"We look at it on a pay-period basis, which is every two weeks, but normally I let numbers even out throughout the year," says Mann. "Our nurses are very good at taking vacation time when they don't have visits, and because we're part of a larger home health agency, they will do home health visits if we're low on home infusion visits."

Give a little to staff to get something back

Mann notes that such a system averts micromanagement and allows for the variables in home infusion that can affect an individual's productivity.

"What it comes down to is, what is the value of your nursing staff?" he says. "My nurses have children and families at home, and they need to work five days a week, eight hours a day to feed their families. I could tell them to take half a day off because we don't have visits, but I'm less likely to keep quality staff. I'm going to have to give a little to them in order for them to give back to me."

Thompson agrees that looking at aggregate numbers has a great benefit for staff.

"It recognizes the difficulties and individual circumstances they face in their daily job," he says. "Because there are so many factors that can affect productivity, this seems more fair. The staff perceives that and it tends to create a better team environment." ■

Learn the ABCs of activity-based costing

Follow these steps to lift the bottom line

It's not good enough to simply want to cut waste out of your business; it's a necessity. To get the biggest bang for the reimbursement dollar, home infusion providers — like the rest of the health care industry — are being forced to operate with minimal costs without adversely affecting patient care. **Tom Pryor**, president of ICMS (Integrated Cost Management Systems), a health care consulting firm in Arlington, TX, says there's a way to streamline your costs using activity-based costing (ABC) and activity-based management (ABM).

"Activity-based costing and management is simply looking at the labor and overhead of an organization by activity instead of by type of resource, salaries, fringe benefits, travel, etc.," says Pryor. ABM focuses on measuring work, while traditional accounting focuses on measuring workers. Here are the basic steps required in doing an activity-based costing analysis of your operations.

1. Spread it out.

"The basic format we use is a spreadsheet with columns and rows," says Pryor. "First, we define the significant activities of a group of employees and place these activities at the top of each column."

He notes that "significant activities" are those that consume more than 5% of an employee's time or resources.

Each row of the spreadsheet is then allotted a resource needed to perform an activity, measured in dollars, such as salaries, fringe benefits, supplies, telephones, computers, etc.

2. Fill it in.

"At the bottom of the spreadsheet, after you determine how much resource is consumed by each activity, you measure the output and what is the workload of each activity," notes Pryor.

To fill out the activity accounting spreadsheet, ask employees, "How much time do you spend performing your activities?" Pryor recommends you have employees estimate their time in 5% increments. The same method is used for all the other resources.

To complete such a chart takes approximately 90 days, according to Pryor. The key is to use a representative sample to avoid measuring costs during a peak or valley of expenditures.

"For a pilot project, we recommend looking at a year's worth of data to make sure there is no seasonality in costs," says Pryor. "We also recommend making sure the pilot project is sized so it can be completed in 90 days or less. Otherwise you lose momentum and focus."

Pryor adds that the time required will vary according to the size of the organization and the staff the organization commits to the project.

"The general recipe is that if a business has 10 cost centers, groups of employees, or activity centers [such as administrative staff, billing staff, clinical staff, etc.], and if someone can spend 25% of their time asking employees about their activities and collecting cost information for workload measures, the analysis could be completed in less than 45 days," he says. The 45-day timetable will fluctuate from one organization to the next depending on variables, such as there being fewer or more than 10 cost centers or the analysis taking more or less than 25% of one employee's time.

Software, consultants, colleges can help

Pryor says the cost for such an initial pilot project can vary widely. Near the low end, ICMS sells self-implementation tools that cost $995.

"It is PC-based software along with a case study and ABM dictionary for anyone who wants to implement this themselves but needs tools to assist them," says Pryor.

He adds that even with such a starter kit, you're not necessarily on your own.

"If you don't have the time or skills, call your local college," says Pryor. "There are professors and students actively looking to get hands-on experience implementing ABM or ABC. That would be a low-cost way for a business owner that doesn't have the staff, time or money."

If you're willing to spend a little — or a lot — more time and money, you can attend a workshop or even hire a consultant to come in and get the work done for you. According to Pryor, the price tag on the latter option can run anywhere from $10,000 to $50,000, depending on size of organization.

3. Put it to use.

Having compiled the activity and cost center information isn't enough. You've got to put it to good use. Pryor says there are two basic categories of uses for the information.

• **Cut the fat.**

"You can use the activity information to identify continuous improvement opportunities, meaning you'll be able to define which activities are high cost [in relation to output of work and value-added benefit to clients]," says Pryor. "If you were to do common-sense benchmarking, these activities would be areas that would enable you to improve your bottom line through basic cost reduction."

In his experience implementing ABM, Pryor typically sees a minimum amount of non-value-added cost of 20%.

"It would be very common for a home infusion provider to find that 20% of their business and overhead costs are non-value added waste that doesn't add customer value."

Velma Goertzen, RN, and the general manager of Health-E-Quip, a home medical equipment (HME) and oxygen provider in Hutchinson, KS, has seen such dramatic improvement first hand.

"There are not many home infusion or HME providers who have implemented this, but we were hit with a 25% cut Jan. 1 for oxygen reimbursement, so I started looking at where we could cut costs without cutting quality, because we were 60% oxygen."

Health-E-Quip implemented ABM last August and has seen a profound impact on its business.

"Instead of a negative bottom line, we've got a solid, positive bottom line, and we did that in about six months," says Goertzen.

• **Improve decision making.**

"Of the activities, you can look at how they relate to your products, services and customers," says Pryor. "Rarely in home infusion does an owner know where they are making money and where they're not, because all customers are not created equal."

With the information at hand, you can analyze what type of business is most beneficial to your bottom line, and conversely, that which may not be worth the effort. But Pryor cautions against simply looking at profitability without putting the information to use.

"I emphasize that because I see too many businesses use the activity information only to determine where their profitability is, and all it does is reallocate existing costs more accurately," says Pryor. "That will give you some insight, but most business owners want improved profitability, not just improved profit-activity costs."

4. Update.

To make sure you're always working with the latest figures, and to keep the process ongoing, Pryor recommends updating your figures on the spreadsheet.

"You should update the costs, activities, and workloads four times a year, unless you are very large, in which case you would update monthly," he says.

Pryor notes that it takes only two or three days to update ABM data if done properly.

"Involve every manager in the updating process," he says. "Spread the workload and learning."

You must obtain employee buy-in

Pryor notes that many business owners don't tell employees the consequences of improving or acting upon the findings.

"As a business owner, you need to create a positive and negative consequence. Otherwise, the employees tend to dwell on the negative and ask, 'What's in this for me?'"

Goertzen agrees that employee buy-in is a necessity.

"This cannot be done with one person," she says. "It has to be done by the whole organization." Only with the entire staff evaluating your procedures and looking for ways to cut costs will you fully realize the benefits of ABM. ■

A syringe pump that saves you money

Ending your high-priced pump woes

A nickel saved here and a dime saved there adds up in the course of a year. And all those nickels and dimes could be the difference between being profitable or becoming another casualty of the cost-savings move sweeping the health care industry.

Ken Foerster, RPh, vice president of clinical services for Ultra Care Home Medical in Chicago, has found a way to save not just change, but dollars, on every visit. His secret? The Freedom 60 Syringe Infusion System from Repro-Med Systems of Chester, NY.

"We started using the pump in December of 1997," says Foerster. "We saw our managed care contracts dramatically squeezing our margins. So

our staff began researching our options, and we decided to go with IV push to administer IV medications. We did cost studies and looked at safety, efficacy, and the number of drugs that could be administered with IV push via syringe pump."

Once Ultra Care decided to go to IV push, it found the Freedom 60 was a perfect fit for its antibiotic patients.

"Cost was one of the original factors, because we had to make money in a managed care world," says Foerster of his decision to use the Freedom 60. (When Foerster bought the pumps more than a year ago, the cost was $45 each. Now, however, the price has increased to $65.)

The savings have been tremendous. "We're saving about $4 per dose," says Foerster. With Ultra Care's average antibiotic patient staying on service for 21 days, if patients average two infusions per day, Ultra Care saves $8 per day per applicable patient.

Foerster points out that the pump is well worth its price. First, the Freedom 60 is anything but complex.

"It is a simple pump to operate," says Foerster. "We provided pharmacy and nursing staff with training and an inservice. In January during our annual nursing skills check, they were tested on the pump with a written test and return demonstrations. Adequate training is important to give staff the skills and confidence."

Patients like speed, ease of use

But lower cost and a simple pump for staff are not the only benefits.

"Another benefit has been that the patients really like it," says Foerster. "The infusion can go a little faster [than gravity systems] and it's easy to use, so that was a value-added benefit."

He adds that he has had no problems since purchasing the pumps a year ago.

"The pumps are very durable," he says. "They take the standard abuse of being cleaned or dropped. We have not had one mechanical problem."

Foerster says the Freedom 60 is a good choice for any home infusion provider like his, doing 40% to 50% or more of business in antibiotics.

The pump comes with an unconditional two-year warranty, does not require batteries or electricity to run, and is FDA approved. For more information on the pump, contact Repro-Med at (800) 624-9600. ■

Get the biggest bang for your Web buck

How to create a beneficial home page

So you've decided to take the plunge and set up a Web site for your agency, but you don't have the slightest idea where to begin. Don't worry — setting up a site is much easier than you might think.

Judith Walden, RN, MHA, administrator and chief executive officer for Kokua Nurses in Honolulu, did most of the development for her agency's Web site herself (www.kokuanurses.com).

"I did the entire Web site myself with FrontPage from Microsoft," she says. "I had a couple of people helping me initially. I spent $400 on a consultant, and the software is right off the shelf. CompUSA has a whole section on setting up a Web page and people who will help you."

Even better than the ease of implementation is the cost.

"You can spend upwards of $10,000 on a Web site, but ours cost about $500, not counting my time, which was about 40 hours," she says. "Or you can hire a student majoring in computer science or programming at a local college, and if you're a nonprofit, you can get this help for free."

While setting up a site may not be difficult, setting up a useful Web site takes a bit of thought, says **Kevin Sypniewski**, president of Kailua, HI-based AssistGuide, a Web site with information and products related to long-term health care (www.assistguide.com).

For his site, Sypniewski is working with various Hawaii associations to get numerous facilities and manufacturers listed. The key is providing information not available elsewhere.

"It's critical that you provide more information than people can get out of the phone book or some list," he says. "You need to provide more information than what is on your brochure, but on the surface it needs to read somewhat like a flyer, with bulleted lists and information, and if they want the in-depth information it needs to be there."

The next step in making the site useful is ensuring the information is applicable to your market.

"There has to be a collection of information there that is useful for the community," says Sypniewski. "You need to do some proactive exchanges with other organizations in your area. For a community-based system like home infusion, address the

needs of the people you're serving and look at the customer service end of it."

The information also should be updated regularly — every month or two — to make sure you get constant traffic to your site. Sypniewski says this is best accomplished by continually adding the number of businesses participating and continually developing quality content so people have a reason to visit and return to the site.

It's also important to let others know about your Web site so they can access the information you've made available. It's useless to have a stellar Web page that no one knows about.

"Your Web address has to be on every correspondence that leaves the office, every brochure, every flyer, and even business cards," says Sypniewski.

The second way to get traffic is to make sure you submit information to Web search engines. This way, when someone looks for certain information, your site will pop up without them having to know it exists beforehand. ■

Results of IV Hectorol trials announced

Bone Care International, a pharmaceutical company in Madison, WI, recently announced results of two Phase 3 clinical studies using the intravenous (IV) formulation of Hectorol (one-alpha D2). The drug is under development as a new treatment for secondary hyperparathyroidism associated with end-stage renal disease.

The trials included 64 hemodialysis patients at 16 study centers in the United States. In these IV trials, Hectorol effectively controlled moderate to severe secondary hyperparathyroidism with no clinically important side effects, notably hypercalcemia or hyperphosphatemia. Data from these trials are consistent with results obtained from the completed Phase 3 trials for oral Hectorol supporting the Company's New Drug Application (NDA) currently under review by the Food and Drug Administration (FDA). The Company submitted an NDA for IV Hectorol to the FDA in late 1998. ▼

Amedisys acquires Columbia sites in six states

Amedisys of Baton Rouge, LA, recently signed an asset purchase agreement to acquire Columbia / HCA home care operations in Alabama, Georgia, Louisiana, North Carolina, Oklahoma, and Tennessee. This will give Amedisys more than 80 home care and infusion therapy offices.

Chairman and CEO William Borne said the acquisitions allow Amedisys to further penetrate its markets and provide additional platforms to grow its infusion therapy services. ▼

Becton Dickinson reports record revenues

Becton Dickinson of Franklin Lakes, NJ, reported record results for its operations in fiscal year 1998 of $3.117 billion, an 11% increase over 1997's revenues. Revenues from medical supplies and devices were $1.715 billion, a growth of 14% over 1997 numbers. The company reports that customer conversions to safety devices for health care

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workers remain consistent in generating underlying growth in the infusion therapy and injection systems businesses. ▼

Olsten announces third-quarter results

Melville, NY-based Olsten Corporation announced third-quarter net earnings of $13 million, compared to $25 million for the same period in 1997. The company notes that the reduced profitability was primarily the result of a loss in health services operations. This offset growth in Olsten's infusion therapy services. ▼

Baxter to distribute IV Express in U.S.

Round Lake, IL-based Baxter Healthcare Corporation's IV Systems/Medical Products group recently signed an agreement with Switzerland's Debiotech SA to distribute Debiotech's IV Express pump. The pump is an ambulatory multitherapy electronic infusion pump capable of delivering multiple infusion profiles.

In addition to ramped, intermittent, continuous, and patient-controlled infusion, the pump's small size (5.5 inches wide by 1.7 inches high) gives patients a convenient and discreet method of receiving their infusion. The total weight of the pump is just 13 ounces including the rechargeable battery. ▼

Alpha recalls infused plasma products

Los Angeles-based Alpha Therapeutic Corporation recently announced the recall of some of its plasma products designed for intravenous infusion for treatment of hemophilia and immune disorders. The Food and Drug Administration is inspecting Alpha's facilities and has ordered the recall as a precautionary measure.

The products being recalled are those filled in one particular area of the Alpha facility between Dec. 11, 1997, and June 25, 1998, under the trade names Alphanate Antihemophilic Factor (Human), AlphaNine SD Coagulation Factor IX (Human), Albutein Albumin (Human) — 20 ml size only, Profilate SD Antihemophilic Factor (Human), Profilnine SD Factor IX Complex, and Venoglobulin-S Immune Globulin Intravenous (Human). Specific lot numbers of the above products being recalled can be obtained on the Food and Drug Administration Web site at www.fda.gov/cber/recalls.htm or by calling Alpha at (800) 292-6118. ▼

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Editorial Questions

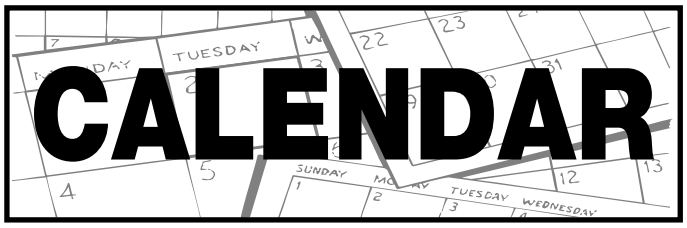
For questions or comments, call **Park Morgan** at (404) 262-5460.

INCC announces 1999 CRNI exam info

The Intravenous Nurses Certification Corporation (INCC) of Cambridge, MA, recently announced test dates of May 2 and Sept. 18, 1999, for the CRNI exam, as well as dozens of locations across the country to take the exam.

The 200-question multiple-choice test is based on nine clinical areas of IV practice: technology and clinical applications (14% of questions on the exam); fluid and electrolyte therapy (14% of questions); pharmacology (13%); infection control (12.5%); pediatrics (7.5%); transfusion therapy (10%); antineoplastic therapy (10%); parenteral nutrition (10%); and quality assurance (9%).

For more information on the CRNI exam, contact the INCC at (800) 434-4622. ■



• **The Role of Nutrition in Cancer Prevention Video Conference** — Feb. 2, 5 p.m. EST. For more information on broadcast sites, contact the American Society for Parenteral and Enteral Nutrition at (301) 587-6315.

• **Center for Healthcare Environmental Management certification seminar** — Feb. 1-5, Oakland, CA. For more information, call (610) 825-6000, ext. 145.

• **LITE 99** — Feb. 25-27, Marriott City Center, Pittsburgh. For more information, contact the League of Intravenous Therapy Education at (412) 678-5025.

• **American Society for Parenteral and Enteral Nutrition teleconference on Nutrition Support in Critical Care** — March 18. For more information, call (301) 587-6315, e-mail aspen@nutr.org, or go to ASPEN's Web site at www.clinnutr.org.

• **INS Annual Meeting and Industrial Exhibition** — May 1-6, Charlotte, NC. For more information, call INS at (800) 694-0298.

• **Center for Healthcare Environmental Management certification seminar** — May 17-21, 1999, Plymouth Meeting, PA. For more information, call (610) 825-6000, ext. 145.

• **HIDA/99 Trade Show** — Oct. 10-12, Chicago. For more information, call (703) 549-4432.

• **How to Build an Ambulatory Infusion Center** — Jan. 20th, 1999, Philadelphia; Jan. 22, Atlanta. For more information, call (800) 395-9495, or visit www.pgigpo.com. ■

CE objectives

After reading the January issue of *Home Infusion Therapy Management*, CE participants will be able to:

1. Identify the three models for ambulatory infusion centers.
2. List the benefits of tracking team rather than individual productivity.
3. List the general steps a provider must follow to use activity-based costing effectively.
4. Identify the most surprising benefit of having a Web page for home infusion providers. ■