

HOME INFUSION THERAPY MANAGEMENT™

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Solution sought for the best way to keep catheters from clogging

Providers look to TPA to replace Urokinase

With the future availability of Urokinase still in doubt, providers across the country are well on their way to finding a replacement. Now there seem to be two leading candidates. This month, in the first of a two-part series, *Home Infusion Therapy Management* looks at one option — Alteplase (TPA). Next month, we will feature a provider who chose another path: Streptokinase.

The Food and Drug Administration has yet to allow Abbott to release further lots of Urokinase to market, and neither the federal government nor Abbott have any timetable as to when it may be released.

Cathy Parker, an RN with the Vascular Access Device Consult Service, National Institutes of Health (NIH) in Bethesda, MD, notes that the NIH has chosen TPA to declot catheters.

“When the Urokinase shortage occurred, we talked with the pharmacy and interventional radiology to discuss what we were going to do,” says Parker. “We talked about other drugs, and it was quickly decided that Streptokinase was not appropriate because of its history of allergic reactions. TPA was a much better alternative.”

TPA was first considered, based on a published study comparing Urokinase and TPA.¹ After reading that study, conducting a literature search, and having NIH pharmacists call oncology centers nationwide to find out what they were doing, TPA became the clear choice, according to Parker.

Through collaborative efforts of the Vascular Access Device Consult Service and the pharmacy, the NIH developed a new procedure for declotting catheters using 2 mg TPA/2 ml based on the Haire study. (See p. 98 for the full NIH procedure.)

Thus far, the NIH has used TPA on nine patients.

“I haven’t heard of any adverse reactions,” says Parker. “On a couple of occasions it hasn’t worked, but after a cathetergram in each situation we found that there was usually something else going on — the catheter was malpositioned, the catheter was broken, or the TPA wasn’t even

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Procedure for Restoring Patency to Occluded Venous Access Devices Using rtPA (recombinant tissue Plasminogen Activator)

Essential Information:

- Review the VAD occlusion verification decision tree.
- Obtain MD order for rtPA once you have determined catheter to be occluded.
- Pharmacy will be dispensing 2 mg rtPA in 2 cc vials. Pharmacy keeps rtPA frozen. Be sure that the vial is completely thawed, before drawing the medication into a 10 cc syringe. Because rtPA is a protein, remember not to shake the vial, just roll it in your palms. Shaking or excessive pressure degrades the protein.
- Pharmacy will send only one rtPA vial per lumen. Use reorder screen if you need a second dose of rtPA.
- Portacath occlusions are special cases; please consult the VAD service.

Equipment

- 3 10 cc syringes
- 1 three-way stop cock
- 1 injection cap
- Alcohol prep pads

Procedure steps

1. Using clean technique, remove catheter injection cap and attach stopcock directly to occluded lumen. Make sure catheter lumen is clamped (prevents air embolus).
2. Attach empty 10 ml syringe to most distal port on stopcock.
Attach rtPA to most proximal port of stopcock.
Attach 10 ml NS to medial port of stopcock. See illustration next page.
3. Turn stopcock off to syringe with rtPA and open to empty syringe. Gently pull plunger back to 8 cc mark. When plunger @ 8 cc mark, turn stopcock off to empty syringe and on to rtPA. This process creates negative pressure inside the catheter, thus creating a vacuum. Opening the stopcock to rtPA allows the medication to be gently pulled into the catheter. If medication does not flow in, you may apply gentle pressure to the syringe to instill the full 2 cc.
Because of the geography of the occlusion, the full 2 cc may not flow in. DO NOT FORCE THE rtPA. rtPA should be infused slowly for approximately 1 minute, since this will coat the walls of the catheter and prevent denature.
4. Document the volume and time that rtPA that was infused on the monitor sheet.
Note the volume infused for most catheters will be approximately 1+cc. It is okay that a little rtPA will stream past the tip of the catheter.
5. Turn stopcock off to rtPA and allow the rtPA to dwell UNDISTURBED for 2 hours. Then, open stopcock to empty syringe and attempt to aspirate. If blood return is noted, aspirate 5 ml of waste, turn off stopcock to empty syringe, open stopcock to NS syringe, and flush with 10cc NS.
6. If lumen remains occluded, reorder 2nd dose rtPA. Infuse the second dose of rtPA, using the same techniques as the first rtPa infusion.
7. If catheter remains occluded after 2 doses of rtPA, then notify MD to consult with the VAD service to arrange for a diagnostic study of the catheter. A catheter-gram may be performed to determine the cause of the occlusion.
8. Once catheter patency has been restored, remove the stopcock system and attach new injection cap to the catheter.
9. Documentation as per in/out patient standards. Send the rtPA monitor form to the VAD Service 12D35.
10. Patients receiving rtPA should remain in the clinical center (2-4 hours); however they do not have to be confined to bed. Instruct caregiver/patient to report any signs of allergic reaction, bleeding, fever, SOB, and catheter migration/dislodgment. The stopcock system is the recommended standard; if the patient needs to be out of the unit, or is likely to fiddle with the system (esp. Peds), one can remove the syringes and cap the stopcock.

References:

- 1 Vanscoy G, Rihn T. *University of Pittsburgh Clinical Trial 1998-2001*. 1999.
2. St. Jude Children's Research Hospital Pharmacy Information Sheet. *Clearing Occluded Central Venous Catheters*. Memphis, TN: April 1999.
3. Haire W, Atkinson J, Stephens L, et al. Urokinase vs. recombinant tissue plasminogen activator in thrombosed central venous catheters: A double-blinded, randomized trial. *Thromb Haemost* 1994; 72:543-547.

able to get into the catheter. I'm not aware of a situation in which TPA didn't work that there wasn't some other mitigating factor."

As a result, the NIH has not yet altered its procedure. Parker adds that the TPA tracking forms are still coming in, so further evaluation is needed. (See NIH TPA tracking form, p. 100.)

Making adjustments

Deaconess Home Medical Equipment and Infusion, in Evansville, IN, is also using TPA to declot catheters with slightly different success.

"We had talked about TPA here, but we never really looked into it until recently," says **Ann Williams**, RN, CRNI, an infusion educator nurse for Deaconess and an IV nurse consultant.

With Urokinase unavailable, Williams notes that Deaconess has lost some lines. "We've lost lines that we had to replace," she says. "We've tried to open them using the larger syringes and heparin the same way we used Urokinase, but it was few and far between that it worked."

Much like the NIH, Deaconess also considered Streptokinase but eventually looked elsewhere.

"The hospital [Deaconess Medical Center] was using Streptokinase, and they had a series of adverse reactions from it. That really prompted us to look for something else," says **Mark Roy**, PharmD, an infusion pharmacist for Deaconess. "To the best of my knowledge, they were considered serious adverse reactions. They had only used Streptokinase three or four times to unlock the lines, and I think in three of the four cases they had adverse reactions."

Once Streptokinase was ruled out, Deaconess found itself on the same track as NIH in that it turned to TPA. Williams used the NIH's procedure as a basis for Deaconess' procedure.

"I adapted our procedure from the NIH's, and basically catered it more or less to our own needs without making any major changes," she says.

Because TPA is currently available only in 50 mg vials, mixing syringes became an issue.

"We pulled a couple of articles, and the biggest thing for us was mixing up a large vial of TPA and then perhaps not using it all," says Roy. "Now, we mix up a 50 mg vial and go with 1 mg/ml, so there are 50 syringes we mixed up and froze."

He adds that TPA, when frozen, is good for 90 days. When mixing this way, the cost of TPA is almost identical to what Deaconess was paying for Urokinase.

"When we mixed up the 50 mg vial of Alteplase,

each mg ran \$27.50," he says. "The Urokinase was \$56 per 5,000 unit vial, which was one dose. But some people are using TPA in 2 mg/ml concentration, and then it is about the same."

The 1 mg/ml concentration was based on European studies that Roy found after conducting a literature search on TPA. However, Roy and Williams point out that an alteration in their procedure could be on the horizon.

"We are going to document our success rate; if we have a problem, we will increase the concentration up to 2 mg/ml," says Williams.

Variations on a theme

Thus far, Deaconess has used its TPA procedure on four occasions — twice each on two patients.

"We're less than convinced at this point," says Roy. "We saw no adverse reactions. But the very first patient we used it on, the TPA opened the line but the line closed off again in three days. We were not able to aspirate blood from a Portacath. We were still able to infuse but we couldn't aspirate."

For the second patient it took two applications; although there was some blood return, it didn't work as well as hoped. But much like the NIH, it appears there may have been an outside factor with both patients.

"They brought that patient in for a dye study, and the radiologist sent her back home because he was meeting some resistance also, but the dye study was negative," says Williams. "We may be looking at a precipitate or something like that."

For the first patient, in which the line closed off after three days, Williams says a dye study showed a fibrin sheath in the catheter itself, beyond the port.

"We opted to use the 1 mg/ml, but we used a larger volume," she says. "We also let it dwell longer. We made some changes in our variables and on that particular occasion, it opened the line on a Friday, and on Monday they were still getting blood flow for lab work. It's just a matter of determining which variable made the difference."

As a result of the infusion provider's experiences, the medical center is also switching to TPA.

"I think the literature really supports the use of TPA, and some of the literature says it could be considered more effective than Urokinase," says Roy. "We're hoping that in the long run we will get more lines open."

Williams echoes those comments, and adds

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TPA Tracking Form

Date _____

Patient Name _____

MRN _____

Unit _____

Catheter Type and #Lumens occluded _____

Occlusion type	Lumen #1	Lumen #2	Lumen #3
S= Sluggish P= Partial F= Full			
Time of instillation of 1st dose tPA			
Amount of rtPA instilled			
2hr check- state catheter status C= Clear or occlusion type= S,P, or F			
Time of instillation of 2nd dose tPA			
Amount of tPA instilled			
2hr check- catheter status C= Clear or occlusion type= S,P, or F			
Consult VAD Service Yes/No			

Source: Vascular Access Device Consult Service, National Institutes of Health, Bethesda, MD.

that it's simply a change that providers will have to consider.

"[Using something other than Urokinase] is something that nursing has to get beyond," she says. "TPA is as safe or safer than Urokinase from everything we read about it. And we're using much smaller doses than are used for heart attack patients."

Reference

1. Haire W, Atkinson J, Stephens L, et. al. Urokinase vs. recombinant tissue plasminogen activator in thrombosed central venous catheters: A double-blinded, randomized trial. *Thromb Haemost* 1994; 72:543-547. ■

A sound way to insertions

Ultrasound provides visual aid for tough access

Home infusion providers and nurses face a difficulty unlike their peers with inpatients. In the home, it's often just you and a patient. If you cannot gain vascular access in the home, who can you turn to for hands-on assistance?

Joan Ralph Webber, BN, CRNI, a clinical nurse specialist and PICC educational clinician at Good Samaritan Regional Medical Center in Phoenix, says ultrasound equipment may be just the thing for home infusion providers. Webber has been using the technology for several months and is now a proponent.

"There are not that many nurses using it yet, but the more they hear about it, the more popular it is becoming," says Webber. "The advantage is you can do everything at the bedside. Especially for patients where traveling to radiology for an insertion is a problem. When patients cannot be moved or moving the patient would make it critical, you can see a vein and access an area that you would never be able to feel. This eliminates the guesswork of where a vessel is."

For obvious reasons, Webber says that ultrasound could help a home infusion provider who frequently sees patients with poor venous access.

"Quite often, if a home infusion patient doesn't have a vein, the only alternative is to admit them back to a hospital to have a central line placed on an outpatient basis," she says.

Webber is quick to note that using an ultrasound for catheter insertion requires a bit of a paradigm shift.

"It is just a different way of accessing the vein than we have ever done," she says. "Usually, it is a tactile thing where you feel for the vein and access it on a more parallel level. But with this, it is almost perpendicular, as it allows the vessel to be seen sharper."

How it works

When looking at vessels through an ultrasound, veins and arteries look the same. Both show up on the screen as a dark, circular area, according to Webber. However, there's an easy way to tell the difference.

"With the ultrasound probe pressed down, a vein will compress, as will the artery, although the artery will pulsate on compression," explains Webber. "On the screen, you can see the pulsation of the artery; whereas, when you press down on a vein you can't see it anymore. That's why you have to be very gentle with the ultrasound probe because when you scan, it will flatten out the vessel and you won't see it."

She adds that it is critical that you know upper-arm vasculature. For example, you should be aware that an artery usually has a vein lying next to it, and that an artery is typically larger than the accompanying vein. The basilic vein is usually 1 cm to the side of the artery, although that isn't always the case. And, with ultrasound, you can see if a vein is thrombosed as it will appear to grow narrower or look smaller than expected.

Once you learn how to distinguish veins from arteries onscreen, it's a matter of learning how to use the ultrasound and its attachments. Webber uses the Site Rite II ultrasound by Dymax of Pittsburgh with a depth finder on the screen marked off in 0.5-cm increments that tells you how far down from the surface the vessel is. But once again, being gentle with the probe is critical.

"If you are compressing hard with the probe, that will alter the depth reading," notes Webber.

Webber has used both the freehand technique for insertion, as well as an attachment called a Needle Guide. The latter holds the needle firmly in place during the process at an angle so the needle will intersect with the ultrasound beam at predetermined depths to reach the desired vessel. The angle is often almost vertical compared to the more horizontal angle most nurses are comfortable with. While helpful, Webber says there is a time and a place for freehand.

"[On some patients,] I have to level out the

angle of the needle going in, because the wire may not make the right angle turn and quite often gets caught on the needle bevel on removal," she explains. "That's why with the free hand I feel a little better because I can tunnel it a bit. "

See how you're doing

Also, if you use specially designed needles that allow the tip to show up on ultrasound, you can watch the tip of the needle enter the vessel upon insertion. That's not to say you can't tell when you insert the needle into the vessel without such needles.

"As you poke the vessel, I liken it to putting a dull needle into a balloon," says Webber. "It pushes it down a little and then springs back [once the needle enters]."

If you use needles that show up on ultrasound, Webber's most recent attachment is the Navigator.

"This allows you to scan over the patient, identify the tip and confirm the tip placement," she says. "It doesn't eliminate the need for a chest X-ray, but it allows you to reposition the tip with the site is still sterile."

Webber points out that there is a big difference between being capable and being proficient.

"To get really good, I would give yourself at least a couple of months. But to just use it would take less than a week."

A sales rep gave Webber her initial training, as well as a pretend vein to practice on. From there, she was on her own.

Gaining proficiency

"I had it for two months to see if I liked it, but once you start accessing more challenging veins you run into more problems," she says. "If you are not trained and don't know what you are doing and what to look for, you can do some serious damage. You need to know what you are looking at and where you're going. To get your accuracy really good, it would take a couple of months."

The cost may be prohibitive for some, starting at \$11,000 and going up from there with attachments. However, for a provider with a high percentage of problematic access patients, such as end stage renal disease patients, oncology patients, or IV drug users, the machine could prove invaluable and a cost savings over the long haul.

"It helps find a vein where you normally wouldn't be able to find one," says Webber. ■

PharmaThera takes steps to become cream of crop

How one provider rose to the top

When Monterey Capital combed the Midwest and Southeast for the top privately owned home health care providers, it carefully examined more than 200 companies. In the end, only eight made the grade to form a new health care company, Auxi Health. One of the eight was PharmaThera, a Memphis, TN-based home infusion provider.

Monterey Capital began looking in the home care sector for purposes of consolidation, and considered only providers that were:

- **not publicly owned;**
- **privately held;**
- **dominant players;**
- **had a balanced referral base;**
- **minimized Medicare Part A.**

What was it that PharmaThera did — or had been doing — that made it stand out from the crowd? According to **Larry Robinson**, COO of Auxi and PharmaThera's president, it's little more than making a series of smart business decisions and having the courage and confidence to stand by those decisions.

First, Robinson notes that PharmaThera is a diverse provider by offering a variety of services and working with a diverse range of payer sources.

"We don't put all our eggs in one basket," he says. "We have Medicare, Medicaid, managed care, and non-managed care referral sources, and we provide adult and pediatric services."

Making good business decisions

But more important than being diverse is PharmaThera's willingness to accept good contracts while saying no to some business opportunities, a lesson many providers would be wise to learn.

"Every managed care contract we look at has to be good for us, good for the patient, and good for the payer," notes Robinson. "We have to make money doing this. When a contract comes across my desk and the reimbursement level is below the acquisition cost of the drug, it is not hard to tell that that would not be good business for us."

Robinson notes that PharmaThera has never made decisions on whether to accept

contracts based on what competitors are doing. That in itself allows Robinson to concentrate on PharmaThera's success and which contracts will add to that success.

"There are contracts that we have turned down that others have taken, and I know of contracts we have turned down that nobody has taken," he says. "Don't try to figure out what the competitor is going to do. Figure out what you want to do, make sound business decisions, and live by those decisions."

Robinson says that for any home infusion provider to be successful, it must keep several basic concepts in mind:

- 1) You must run an efficient and effective operation.**
- 2) Be aware of all the issues relating to providing quality care.**
- 3) For-profit businesses can only accept business that is profitable.**

"You can't make a profit-taking business that is not profitable on face evidence," he says. "Nobody can, truthfully."

By knowing the exact costs it takes to do business — something Robinson says comes with being in the home infusion business with the same company for 15 years — it often is fairly evident what is good business and bad business.

"Some of this really comes down to, 'Don't make stupid decisions,'" he says. "For example, don't get into a network thinking that after you get in you can renegotiate and surely the payer will give some concessions when it realizes that the provider can't do something for cost."

In addition to experience and an in-depth knowledge of the industry, Robinson says another key factor lies in being privately held.

"A lot of this comes from running your own business," he notes. "You look at things in a different light when you are the owner and operator than when you are the operator but it's owned by somebody else, or vice versa. And none of the companies [in Auxil Health] were chasing quarterly earnings or doing anything other than making good day-to-day business decisions."

Why combine?

If things were going so well for PharmaThera, why was there a need to join other home care providers to form Auxil Health? Robinson says it comes down to a free exchange of expertise and ideas.

"A lot of it was to simply improve our

resources," he says. "Within any company, resources reach a limit depending on how big you are. Auxil allows us to have more resources than we had before, and each company has its own expertise. One of the things we saw was the opportunity to cross-pollinate between companies and take business lines from one company to another. If someone within the organization has developed a business line or a product that they are very successful with, I have instant access to their expertise. The key to it is what opportunities do I see in my marketplace, and who else is in Auxil already doing that somewhere else?"

Robinson adds that one of the ideas behind Auxil Health was for the back office support functions to come from the founding companies. This will allow Auxil to remain a lean operation and for the founding companies to focus on what they do best.

Still PharmaThera

PharmaThera still remains a regional provider — with locations in Arkansas, Georgia, Mississippi, Tennessee, and Texas — and has only slightly changed its marketing approach. Because the other seven companies (Always Care, Missouri Home Care, First Home Health, Hawkeye Health Services, Home Medicare, Jackson Healthcare, and Procure Home Health Services) are also in the South and Midwest, PharmaThera has not expanded its geographic coverage area, but can now offer services through its Auxil Health colleagues.

"We continue to market in our regional area, so we haven't pushed that up to a different level," Robinson explains. "What we are able to do is go back to our referral sources and introduce these services. We think that enhances our value because it is the same person they called before for infusion therapy coming in and saying, 'Look what else I can do.'"

Again, Robinson has a very specific business approach in mind as to what kind of new business he will be able to capture through his alignment with Auxil Health.

"We are not asking referral sources to do anything differently," he explains. "A referral source may use us for infusion therapy and make other referrals for respiratory therapy. But if there is an infusion therapy patient who needs respiratory, are we not a better choice than splitting it between two companies?"

Through Auxil, PharmaThera has, in some

locations, added medical equipment, respiratory therapy, various components of nursing and other home care services to its own infusion therapy services. And with an Auxi coverage area confined to Arkansas, Georgia, Iowa, Mississippi, Missouri, Tennessee, Texas, and West Virginia, PharmaThera will continue to do what it does best: provide regional home infusion therapy. PharmaThera does not offer home infusion in Iowa, but now members in Iowa can rely on PharmaThera's expertise to see if they may want to offer those services. Yet members who exist in PharmaThera's coverage area will send home infusion referrals PharmaThera's way. ■

Five common mistakes of automating your staff

Do it right the first time to save time, money

There is the right way to automate your field staff, and then there is the wrong way. **Michelle Boasten**, owner of FBE Service Network, a home care consulting firm in Akron, OH, has seen her share of both and describes the five most common mistakes she sees in her works with home infusion and home care providers.

Before a provider discusses technology, Boasten is quick to point out that there are two types of automation: field automation and back office automation.

"Probably 99.9% of home infusion back offices will be automated, and that can be broken into billing, payroll, and scheduling," she says. "Second is field automation, and that is the clinical side," which Boasten addresses for *Home Infusion Therapy Management* readers.

• **Mistake No. 1: Underestimating the level of commitment required to take a staff from paper to automated environment.**

Providers don't enter the process totally naive, but typically they are not near as aware as they should be.

"They think that it will be painful, but they don't anticipate just how painful," says Boasten. "To convert one clinician from paper to a laptop or handheld, which includes training, hardware, software, etc., takes approximately \$12,000 and six months."

Too many providers don't fully understand the time *and* capital investments necessary to

properly make the switch.

• **Mistake No. 2: Underestimating the total resources needed.**

Too many people don't realize the full commitment necessary to make automation and technology really work.

"Home infusion is a 24-7 business," notes Boasten. "You need IS people and good trainers, and you have to do better than a one-day training seminar."

In essence, you must hire an in-house staff to make sure your system runs well all the time.

"You don't have the luxury of a system being down very long without disrupting your daily practices, so you need to have people on hand."

• **Mistake No. 3: Underestimating and overestimating the power of information and data.**

Few people typically understand how much — or little — data can do for you. A common mistake is for providers to automate and then think the data will go to work on its own.

"Many people think that data is magically put to use once everything is automated," she says. "Is it a glorified typewriter or are you collecting the data? And once you collect the data, you've got to do something with it."

And that is when most people underestimate the full value of the data sitting in their computers.

"If you collect it, you can market and sell it and use it to make your internal practices a lot more efficient," says Boasten. "Clinical trials are always run on infusion. They need information back on drugs. All drug companies are paying for this data on clinical trials. They are paying for it on paper, so you know they would pay for it electronically."

She adds that much of your information, such as how long it takes to deliver a drug and certain care, is valuable to managed care organizations as well. Don't overlook your data as a possible profit center.

Cut your costs

• **Mistake No. 4: Underestimating the power of newer technology out there.**

"You need the right tool for the right industry," says Boasten. "Many people think that laptops and handhelds are the cream of the crop. The truth is, they're not. It is probably the worst decision someone can make for a transient field clinical person. For home infusion staff, the best type of tool is the tool that costs you the least to maintain."

That's why Boasten recommends using telemedicine whenever possible.

“By using the telephone rather than a laptop or handheld, you can cut the cost of automating by about 90%.”

Along those lines, Boasten is the vice president of Teledocument, a Cincinnati-based company that offers Dial-n-Document, a product that allows field staff to enter patient data over the phone from the field. (See related story, below.)

“It costs about \$1.25 per visit, but you can collect both visit data and clinical data, and you don’t need any IS personnel.”

• **Mistake No. 5: Underestimating the real barrier: change.**

Any time you undertake such a big change in your operations as going from paper to automation, Boasten suggests using this checklist to prepare yourself:

Use people who have already been through the process — consultants, associations, peers, e-mail lists.

“Find people who have literally been through the process, not someone who can postulate about the process,” she says.

Be committed to the process, and be aware of the resource requirements.

Be open-minded about what is best for you, not the provider down the street.

“Don’t let someone else choose your system,” warns Boasten.

Get staff to buy in. Without a willing staff, you’re doomed from the start.

Understand what Boasten calls the “robustness of service.” Realize that laptops are computers and they have a tendency to crash or break. How will you prepare for such situations?

By avoiding these mistakes, Boasten says you will save yourself plenty of time and effort. “Otherwise, the switch over will cost you much more after you’re done messing it up the first time.” ■

Telemedicine for home infusion is made easier

Data collection via telephone

If the whole purpose of computerizing your field staff is to collect clinical data, why not go with something that could be just as efficient yet cheaper and more reliable? That’s what Tele-Document, a Cincinnati-based corporation, had

in mind when it developed Dial-n-Document, a product that allows field staff to enter patient data over the phone.

The company, which was created in 1996 and followed in the summer of 1997 with the beta-testing of Dial-n-Document, now handles more than 500,000 annual visits from home care providers across the country. According to **Don O’Rourke**, Tele-Document’s president, one of the biggest benefits is ease of use.

“The training is minimal,” he says. “We are seeing that the training for aides is less than half a day. It is not much different than if you do banking by telephone. It uses voice prompts, and everyone is comfortable using the phone.”

Progress takes time

Debra Tadgett, RN, BS, director of home care services for Upper Valley Medical Center Home Care Services in Troy, OH, says the training time is miniscule compared to that typically required when moving to automation.

“We have already trained our entire staff to use the system,” she says. “It takes about an hour to train nurses’ aides and staff to use the telephone documentation. One of the big benefits is that it does not take a lot of training time to learn how to enter information through the telephone.”

However, having switched to the system from a totally paper-based documentation system is requiring some time.

“Our primary reason for using the product is that we were looking for a more cost-effective way to provide documentation and be able to build a database to use information that we needed from our patients’ records,” says Tadgett. “Being so new, we haven’t had the opportunity to glean information from the system yet. We started with a third of our patient population and started inputting all of that data. We’ve been converting new patients and recertifications into the system. I think we’ve just about gotten to the point where we have our whole caseload and demographics in the system.”

According to Tadgett, it took about four hours to train nurses and therapists how to use the system so they could enter all the necessary patient information into their computers.

O’Rourke notes that the product has a very specific use.

“This is used to collect data for home care,” he says. “It is not a time and attendance product, but it is a fairly robust clinical data collection product

that enters the information into a database.”

The process to collect data is simple. A clinician or aide can call from any phone and enter her PIN number, followed by the patient’s ID number.

“The clinician is then asked if they want to document in English or another language,” says O’Rourke. Right now, the company has two languages available and is letting users decide what languages become available in the future.

“Right now, we have English and Russian available because a provider had a high percentage of Russian-speaking patients and staff,” he says. “We may go to Vietnamese next, but we are letting the customers dictate where we go.”

The clinician then enters the mileage, supplies used, and several patient vital signs.

“Then it takes you through the processes and procedures you performed, ranging from an aide providing a bath and going grocery shopping to a nurse providing infusion therapy,” says O’Rourke. “The nurse simply enters the appropriate code.”

About \$1 a call

After the documentation phase, the nurse is allowed to dictate a message that will be transcribed into the patient’s data. After the clinician reviews the information provided, she enters the data and ends the call.

In addition to ease of use, O’Rourke adds that the upfront cost is but a fraction of the typical cost associated with computerizing staff.

“We set this up as a service rather than a licensing of software,” he says. “They pay per documented visit — what we call per ‘click,’ or hang-up.” Although a number of variables come into play in terms of cost, it averages out to just over \$1 per call.

“And the servers reside at the customer site,” he adds. “If they are of the requisite size, they don’t have to pay for that service. From then on they can view their data in any number of formats that are Windows-compatible and report it.” ■

NEWS BRIEFS

Coram, Aetna file opposing lawsuits

Coram Healthcare recently filed suit against Aetna US Healthcare alleging fraud, misrepresentation, and breach of contract. Coram charges that Aetna led Coram into an agreement to provide services to Aetna enrollees by misrepresenting and understating the utilization of home health care services by its enrollees. Coram is seeking damages in excess of \$50 million.

Before filing the complaint, Coram and Aetna were involved in negotiations over the disputes. However, during the negotiations, Aetna filed suit against Coram that would in part prevent Coram from terminating the agreement. Aetna did not disclose to Coram that it was filing a suit during the negotiations. ▼

Industry experts say no need to stockpile supplies

A group of 65 senior health care executives recently took part in the Health Industry Distributors Association (HIDA) 1999 Y2K Summit. Representatives from the entire spectrum of the health care continuum, developed the “Y2K Inventory Initiative Guideline.”

In addition to creating the guideline, the participants in the summit concluded that there is no need to stockpile medical supplies — as such hoarding could cause artificial shortages that

COMING IN FUTURE MONTHS

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would degrade the quality of patient care. The best plan of action is to work closely with supply chain partners and develop a contingency plan.

The "Y2K Inventory Initiative Guidelines" is available through HIDA's Web site at www.hida.org in the Y2K Resource Center. ▼

More states follow CA's lead in needlesticks

In recent weeks, Maryland, Tennessee, and Texas have followed the lead set by California in passing needle safety legislation into law to protect health care workers. And other states aren't far behind. In New Jersey at press time, Gov. Christine Todd Whitman was expected to sign a bill that would mandate the use of safe needles within 30 days of her signing the law. And in New York, a needle safety bill unanimously passed the house and has moved on to the senate.

The California law that started it all went into effect on July 1, and requires all health care institutions provide workers with safety needles designed to prevent needlesticks. ▼



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Baxter plans to spin off cardiovascular company

Deerfield, IL-based Baxter International recently announced that it will spin off its cardiovascular business to shareholders, creating a new publicly traded company. Baxter will continue to focus on critical medical therapies for patients with life-threatening conditions. The spinoff should see shares distributed to Baxter shareholders in the first six months of 2000 and will allow both companies to have greater financial flexibility to invest and grow.

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Editorial Questions

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

As a result, Baxter will invest more resources in its blood therapies, IV systems/medical products, and renal businesses. The cardiovascular company, to be headquartered in Irvine, CA, will focus on heart-valve therapies, mechanical cardiac-assist systems, cardiac-monitoring systems, perfusion products and services. ▼

Nesiritide shows promise for some heart patients

In a recent test conducted at the University of Florida in Gainesville, intravenously administered nesiritide was shown to dramatically improve signs of heart failure in certain patients.

In the test, patients with congestive heart failure showed marked improvement in measures of heart function compared to patients who received a placebo infusion of sugar-water. The improvement lasted as long as nesiritide was infused. Once the administration of nesiritide was stopped, measures returned to their previous values within four hours. Other than low blood pressure and some nausea, there were no other adverse reactions. ■



- **NAVAN 13th Annual Conference** — Sept. 26-29, Orlando, FL. For more information, call (888) 57-NAVAN.
- **Safety of IV Drug Delivery** — Sept. 27-28, Phoenix. For more information, call (614) 292-1514.
- **Eighth Annual Nutrition Symposium** — Oct. 2, Doubletree Hotel, San Diego. For more information, call (619) 522-3784.
- **National Association for Home Care 18th Annual Meeting and Home Care Expo** — Oct. 9-13, San Diego Convention Center. For more information, contact NAHC at (202) 547-7424.
- **HIDA/99 Trade Show** — Oct. 9-11, Navy Pier Convention Center, Chicago. For more information, call (703) 549-4432.
- **CINA 1999** — Oct. 20-22, Toronto. For more information, call (416) 292-0687 or go to web.idirect.com/~csotcina.
- **Medtrade 1999** — Nov. 3-6, 1999, Ernest N.

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Morial Convention Center, New Orleans. For more information, call (770) 641-8181.

- **1999 Fall National Academy of Intravenous Therapy** — Nov. 5-7, Westin Hotel Copley Place, Boston. For more information, call (617) 441-3008.
- **Medtrade 2000**, Oct. 3-6, 2000, Orange County Convention Center, Orlando, FL. For more information, call (770) 641-8181. ■

CE objectives

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

1. Identify the benefit of TPA over Streptokinase as a clotting agent.
2. Identify the benefit of using an ultrasound for catheter insertion.
3. List the most common mistakes when automating.
4. List the first step in catching phlebitis at the first stage. ■