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IN THIS ISSUE

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Turning your HHA into a 'green one': How home health can help the environment

Going 'green' can save money, involves staff

Although patient care is the No. 1 priority for home care managers and staff, a growing number of health care employees are recognizing that their workday activities can affect more than a patient's health — they can affect the environment.

"Many of us recycle and conserve resources in our homes because it is easy to see how to do these things in our personal life, and it is harder to see how to carry this philosophy into our professional lives," says **Gary Laustsen,** PhD, APRN, BC, assistant professor of nursing at the Oregon Health and Science University in La Grande.

Home care programs provide a wide range of opportunities to decrease waste, conserve resources, and recycle, he says. "We can't solve all of the environmental problems of the world but we can start with small things and the effects add up to a bigger impact," he says.

Boulder Community Hospital in Boulder, CO, established a statement of environmental principles to guide the organization in efforts to minimize the negative impact that a health care facility has on the environment. "We recognize that the health of our community is affected by the health of our environment and we need to do our part to protect the environment," says **Kai Abelkis,** sustainability coordinator for the hospital. "Our home care agency follows the same principles, and employees are encouraged to identify ways to improve efforts to recycle or minimize use of resources," he says.

Transportation has a great impact on the environment, and home care more than any other hospital department has employees in their cars all day long, Abelkis points out. "One home care employee has been encouraging other employees to purchase hybrid cars to reduce the amount of fuel needed for day-to-day work," he says. Purchasing a specific car is a significant commitment for any employee so this is not a change that will occur quickly, he admits.

"I am taking a look at what it would cost for the hospital to purchase cars for home care use compared to reimbursement for mileage," he says. "Another option that might be considered for all employees is an arrangement for a favorable-interest car loan for employees who pur-

chase cars that get high mileage per gallon," he adds. Although both of these approaches are attractive, Abelkis points out that he is in the very early steps of evaluating their feasibility.

The first step a home care agency can make to reduce staff members' effect on the environment while making visits is to carefully plan visits to minimize each staff member's mileage to and between patient homes, suggests Abelkis. "Of course, this is something that most agencies do anyway to improve efficiency," he says.

He points out that choosing an environmentally friendly approach is often the most efficient or most cost-effective approach for many activities, besides being advantageous to the home care organization in many ways.

Coming up with out-of-the-box ideas, such as purchasing hybrid cars or partnering with a local bank for favorable car loans, is an important part of a successful environmental program, says Abelkis. In order to generate a good number of ideas, you need the involvement of everyone in the organization, he adds.

"Start with a commitment to an environmentally friendly value system and put your principles in writing," he says. Because the hospital board of directors and administrators support this effort, employees are enthusiastic in their own support, he adds. **(To see a copy of the principles adopted by the Boulder Community Hospital board, go to www.bch.org, select "about BCH" and choose "environmental programs in the drop-down menu.")**

Reduce waste before it arrives

Recycling aluminum cans and bottles in the break room and using blank sides of used paper for notepads are two ways staff in the home care office can reduce waste, says Abelkis. Another way is to work with the purchasing department and vendors to minimize packaging, he adds. Reducing waste is not only good for the environment but also good for the bottom line because the cost of waste removal is often based on weight, he points out. "The fewer pounds of waste to be removed from your health care facility, the lower the cost."

"The biggest culprit of inappropriate disposal of waste is red bag waste vs. regular trash," admits Laustsen. Not only can red bag trash be up to 10 times more expensive to dispose, but the incineration of items such as IV bags and tubing can release dioxin into the atmosphere if the incinerator's temperature is not high enough, Laustsen points out. "The less inappropriate trash that we put into the red bags, the less chance that dangerous chemicals will be released into the atmosphere," he adds.

While the idea of reducing waste may seem overwhelming, the first step is to conduct a waste assessment, suggests Laustsen. The assessment will give you a good idea of how your program is handling waste, what waste you generate, and how the waste disposal affects your program financially, he says. After the assessment, you can identify which areas you want to address first, he adds. **(For a waste assessment tool, see resource box, pg. 15.)**

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Environmentally preferred purchasing is one direction that many health care facilities are taking to reduce wasteful packaging as well as to reduce the type of toxins included in packaging and supplies, says Laustsen. "More vendors are offering environmentally safe options for supplies and more vendors are willing to alter packaging to reduce waste," he adds. **(For more information on environmentally preferred purchasing, see box pg. 16.)**

Finding ways to recycle materials is another way to reduce the amount of waste that must be disposed of by incineration or by burial in a landfill, says Laustsen. Some expired supplies or bandages that have been opened but unused and are clean but not sterile can be used by local veterinarians, he suggests. Boxes can be placed in a central area for employees to take home for use or clean plastic trays or containers used to package supplies can be used by local elementary schools for art classes.

In addition to donating items to local organizations, Abelkis also recommends donating medical supplies or equipment to organizations that distribute items to medical missions in other countries. "I collect items from all areas, including home care, and donate them to our local Project C.U.R.E.," he says **(see resources box, right)**.

Dispose of drugs safely

Improper pharmaceutical disposal is another threat to the community, points out Abelkis. "There are not a lot of options for disposal of medications in the home," he admits. "We teach our home care patients to use glue or cat litter for disposal of medications," he says. By filling a prescription bottle of unused medications with glue or by emptying unused pills into soiled cat litter that is being thrown out, you can be sure that no one will be able to get the medication out of the trash, he says. This is preferable to flushing pills down the toilet, he adds. **(See article pg. 16 for summary of federal guidelines for disposal of medications at home.)**

Overall, health care employees are very receptive to opportunities to have a positive effect on the environment, says Laustsen. People are usually not resistant, just ignorant of the opportunities that exist, he says. "The key is to explore alternative ways to approach conservation and waste reduction, and to take baby steps as people get accustomed to the new approach." ■

SOURCES/RESOURCES

For information about environmentally friendly policies, contact:

• **Gary Laustsen**, PhD, APRN, BC, assistant professor of nursing, Oregon Health and Science University, La Grande, OR. Phone: (541) 962-3132. Fax: (541) 962-2727. E-mail: laustsen@ohsu.edu.
• **Kai Abelkis,** sustainability coordinator, Boulder Community Foothills Hospital, Boulder, CO. Phone: (303) 440-2273. E-mail: kabelkis@bch.org.

For information about environmental policies, programs, and tools for health care, see:
• Department of Environmental Services' New Hampshire Pollution Prevention Program has a section on their web site specific to home care. Information addresses disposal of pharmaceuticals and personal care items, reduction of mercury, recommendations for disposal of household-generated sharps, and environmentally preferred purchasing. Go to http://www.des.state.nh.us/nhppp/Healthcare_p2/index.asp.
• Hospitals for a Healthy Environment (H2E). Web: www.h2e-online.org. This web site contains tools, resources, and information about waste reduction in health care. Information includes definitions of regulated medical waste and hazardous waste, and links to state regulations. A waste assessment tool can be found by going to the main page, selecting "waste reduction" from the top navigational bar, and scrolling down to "getting started."
• Healthcare without Harm, www.noharm.org. Web site contains information on waste reduction, environmentally preferable purchasing, and design of a healthy building.
• Web: www.cleanmed.org. This web site lists conferences that focus on waste reduction, environmentally preferable purchasing, and recycling. Free downloads of presentations and information from previous conferences are available on the web site.

The following organizations collect equipment and supplies for distribution to other countries in need of medical supplies:
• Recovered Medical Equipment for the Developing World (REMEDY), New Haven, CT. Phone: (203) 737-5356 or (203) 785-6750. Fax: (203) 785-5241. E-mail: remedy@yale.edu. Web site: www.remedyinc.org.
• Project C.U.R.E., Centennial, CO. Phone: (303) 792-0729. Fax: (303) 792-0744. E-mail: projectcureinfo@projectcure.org. Web site: www.projectcure.org.

Tips for safe disposal of pharmaceuticals at home

The following guidelines are recommended by the Federal Drug and Food Administration (FDA) for disposal of medications.

• Take unused, unneeded, or expired prescription drugs out of their original containers and throw them in the trash.

• Mixing prescription drugs with an undesirable substance, such as used coffee grounds or kitty litter, and putting them in impermeable, non-descript containers, such as empty cans or sealable bags, will further ensure the drugs are not diverted.

• Flush prescription drugs down the toilet only if the label or accompanying patient information specifically instructs doing so.

• Take advantage of community pharmaceutical take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Some communities have pharmaceutical take-back programs or community solid-waste programs that allow the public to bring unused drugs to a central location for proper disposal. Where these exist, they are a good way to dispose of unused pharmaceuticals.

The FDA advises that the following drugs be flushed down the toilet instead of thrown in the trash:

• Actiq (fentanyl citrate);

• Daytrana transdermal patch (methylphenidate);

• Duragesic transdermal system (fentanyl);

• OxyContin tablets (oxycodone);

• Avinza capsules (morphine sulfate);

EPP protects environment by reducing waste

Environmentally preferable purchasing (EPP), also known as green purchasing, means buying products that have a reduced environmental impact while maintaining the same quality and performance. EPP also includes the gradual and ongoing process in which a health care provider refines and expands the scope of its efforts to select environmentally safe products and services. EPP may be as simple as buying recycled paper or as complex as considering the environmental impact of a product at each stage of its life, from when it is manufactured to when it is disposed of as waste.

Environmentally friendly products have some of the following attributes:

• mercury-free;
• non- or less toxic;
• recycled post-consumer content;
• minimal packaging;
• re-useable and/or recyclable;
• energy efficient;
• safer for patients, workers, and the environment.

Implementation of an EPP

Procurement of most products and services go through the purchasing department. This makes it an effective point to apply actions to improve environmental performance because it is at this stage of money transfer and contract development that vendors can best be influenced.

1. Request support for EPP goals from top management in the form of a policy statement.
2. Create a list of preferred products and vendors and/or a list of chemicals and products to avoid purchasing.
3. Incorporate environmental language in requests for proposals (RFPs) and purchasing contracts. For example, request a minimum of 30% post-consumer recycled content for copy and writing papers and envelopes.
4. Continually ask vendors and group purchasing organizations for products that are environmentally preferable, such as non-vinyl IV bags and tubing.
5. Implement modest, measurable goals for EPP and monitor progress toward achieving them. Examples:
• Reduce packaging waste or total solid waste by 20% in 12 months.
• Eliminate purchasing of mercury-added products by next year.
6. Promote EPP achievements to workers, patients, and the community.

More Internet resources are available to identify EPP opportunities, such as latex-free gloves, non-vinyl binders, reusable sharp containers, and other medical and offices supplies. Check out Sustainable Hospitals Project at University of Massachusetts at Lowell at http://www.sustainablehospitals.org/cgi-bin/DB_Index.cgi and Hospitals for a Healthy Environment at www.h2e-online.org.

Source: Adapted from: "Environmentally Preferable Purchasing for Home Care, Nursing Homes and Mental Health Clinics," Department of Environmental Services, New Hampshire Pollution Prevention Program, Concord, New Hampshire.

- Baraclude tablets (entecavir);
- Reyataz capsules (atazanavir sulfate);
- Tequin tablets (gatifloxacin);
- Zerit for oral solution (stavudine);
- Meperidine HCl tablets;
- Percocet (oxycodone and acetaminophen);
- Xyrem (sodium oxybate);
- Fentora (fentanyl buccal tablet). ■

Non-hospital RNs at risk for needlestick injuries

In one of the largest studies of its kind, researchers from the Columbia University Mailman School of Public Health assessed the risk of exposure to bloodborne pathogens among non-hospital based registered nurses (RNs), and found that nearly one out of 10 of the more than 1,100 nurse participants reported at least one needle stick injury in the previous 12 months. Findings of the study are published in the December issue of *Industrial Health.*

"These rates of exposure are surprising since they are similar to rates reported for hospital-based nurses, even though hospitalized patients generally have high levels of acuity of patient care (i.e., more procedures including more invasive procedures), than are typically performed in community health care settings," says **Robyn Gershon,** DrPH, principal investigator and professor of sociomedical sciences at the Mailman School of Public Health.

These findings are not completely unexpected since patient care, including more complex types of care, is increasingly delivered at non-hospital-based health care facilities, including patients' homes, points out Gershon.

The authors note that increasingly complex procedures, many of which involve needles and other sharp instruments, are being performed, primarily by well-trained registered nurses, in these non-hospital settings, thereby increasing the potential risk of exposure. The population at risk is large, since non-hospital-based nurses represent a substantial portion of the overall nursing workforce; approximately 40% of the 2.3 million RNs in the United States are employed in non-hospital settings. Extrapolated to the entire non-hospital-based RN workforce in the United States, the authors estimate that the annual number of needle sticks in the non-hospital RN workforce may be in excess of 145,000 per year. They also found that 70% of the exposed nurses were never seen by a health care provider, even though appropriate and timely follow-up of these incidents can reduce the risk of infection.

Findings from the study also suggest that many of the exposed nurses may be at increased risk of infection of serious bloodborne pathogens, such as HIV, hepatitis C virus, and hepatitis B virus, as only 65% of these serious exposures were ever formally reported to the nurse's administrator. Fear of getting into trouble, not having enough time to report, and not knowing how to report an exposure were the three most common reasons given for not reporting.

"These exposures place them at risk of potential infection; therefore, efforts to facilitate adequate post-exposure care must be made by administrators. Fortunately, rapid access to post-exposure care may significantly help reduce the risk of infection," says Gershon.

The study also provided information regarding the risk factors associated with these exposures, which have been well categorized for the hospital-based workforce. The researchers found similar risk factors in the non-hospital-based nurses, including heavy patient loads, long working hours, poor safety climate, inadequate training, and lack of safety devices.

"While the risk factors may be similar for both hospital-based and non-hospita-based registered nurses, there are numerous barriers to effective infection control and safety programs in non-hospital settings," remarks Gershon.

A large proportion (approximately one-third) of non-hospital RNs work in establishments with fewer than 100 employees, and a sizable percentage (16%) work in establishments with fewer than five employees. "As a result, many of these facilities lack on-site infection control and employee health programs," she observes. "With nearly 900,000 registered nurses employed in a wide range of non-hospital settings, and patient prevalence rates for certain bloodborne pathogens similar or even higher in non-hospital based settings, it is important to develop and implement targeted risk reduction strategies that are tailored to these unique non-hospital settings."

As the authors note, "Clearly it is best to eliminate these types of exposures in the first place. In fact, participatory action teams, which were formed as part of the study, identified several risk reduction strategies, with an emphasis

on improved availability of safety devices to help eliminate or reduce the risk of injury." ■

In-home monitoring helps VAs manage their health

Program reduces ED visits, hospitalization

Remote monitoring by trained telehealth care coordinators has improved the outcomes and saved costs for high-risk chronically ill patients in the VA Connecticut Healthcare System.

The telehealth program is an adjunct to the VA Connecticut's case management program in which the same nurses and social worker case managers follow the patients through the continuum, from the hospital to the community and back again.

"Telehealth is a tool that we use to augment primary, specialty, and mental health care services. Home telehealth allows for close monitoring and timely intervention based on data sent by patients from their homes. It has reduced the need to return to clinics for routine follow-up monitoring, has reduced the number of skilled home care visits, and has reduced emergency department visits and hospitalizations," says **Donna Vogel**, MSN, CCM, program director, care coordination and case management.

Patients who will benefit from telehealth

The telehealth program targets patients who are most at risk for decline, including those who may live alone, lack caregiver support, or those who are having trouble with self management and want to be more involved with their own health care.

Patients who are appropriate for telehealth may be failing at home, have out-of-control blood sugar or blood pressure, or other conditions that put them at high risk for emergency department visits or hospitalization.

"Not all patients would qualify for telehealth and some want nothing to do with having a device in their home," Vogel says.

Patients eligible for home health must have a home with a working telephone line.

The technology used at VA Connecticut's telehealth is user-friendly. Some of the devices allow for peripherals to plug into the unit to collect data to monitor blood pressure, pulse, weight, temperature, pulse oximetry, and finger-stick glucose.

"Some technology delivers patient education and allows the case managers to schedule reminders for a patient to take his or her medication or to perform a measurement," Vogel says.

Videophone technology helps veterans, nurses

Veterans who are home bound and have few interactions with the outside world can use videophone technology to communicate face to face with the RN telehealth care coordinator.

The videophone technology has allowed the care coordinators to identify patients whose condition has declined and to arrange for them to come into the hospital or clinic for care, Vogel adds.

The technology also can be used to monitor spinal cord injury patients for decubitus ulcers and other problems.

To identify patients eligible for the program, the case management department mines its data for high-cost, high-utilization patients with chronic diseases. Clients can be referred by primary care providers, specialist providers, or other clinicians.

Because it has received so much national attention, patients read about the VA and its telehealth programs and feel they could benefit from more frequent monitoring, Vogel says.

When someone is referred to the program, the case manager conducts an assessment of their health care needs. When the care coordination office gets a referral, a case manager conducts an assessment to determine what services the VA can offer and that the patient can benefit from receiving.

If the assessment shows that monitoring the patient's health more frequently can keep him or her out of the hospital and that the patient and/or caregiver are willing to use home health technology, the case manager refers the case to the telehealth coordinator.

The telehealth coordinator identifies what technology is most appropriate for each patient and configures the devices to make sure that the right dialogues are set up.

The telehealth coordinators enroll the eligible veterans in the program, get their consent, and educate the patient and caregiver on the equipment and how to use it. The education may take place on the hospital unit, at the case manage-

ment office, or in the primary care clinic.

"We get the equipment configured, educate the patient on how to use it, and the patient can take it home with them that day," Vogel says.

The patients have instructions on how to install the equipment but if they have difficulty, the VA calls in a durable medical equipment contractor to help.

The telehealth care coordinators are all registered nurses who have completed an intensive web-based training program offered by the Office of Care Coordination Services in the VA Central office. They must complete competencies in telehealth coordination and undergo annual training.

They collaborate with the patient's interdisciplinary team to monitor the patient's condition and make sure his or her needs are being met.

If a patient who is being telemonitored is hospitalized and needs additional case management services such as a skilled nursing visit to the home for wound care or home infusion services, the telehealth care coordinator hands the patient off to the case management department to avoid duplication of services.

Back and forth communication

Each day, the patients use the telehealth unit to check their vital signs and send data on weight, blood pressure, blood oxygen, temperature, or other data needed to a secure web site monitored by the telehealth care coordinator.

If the data indicate that the patient's condition has worsened or his or her health is at risk, the telehealth care coordinator will call the patient and confirm that the data sent were obtained correctly and that any out-of-range responses to disease-specific survey questions were entered correctly. Depending on the data received, the telehealth coordinator will provide patient education, discuss the findings with the patient's primary care clinician, or recommend that he or she go to the emergency room or be seen at the clinic.

If the patient fails to enter the data, the telehealth care coordinator calls to remind him or her to send data and to make sure everything is OK.

The telehealth care coordinators monitor the site every business day to identify potential problems in real-time. They remind patients that data they send from home isn't viewed on weekends and holidays and reinforce the importance of self-management and knowing when it's critical for them to seek urgent or emergent care.

"We dedicated staff to watching the telehealth web site so they can see the data when they come in. When the patients' case managers were responsible for watching their own patients who were on telehealth, there was frequently a delay in viewing and intervening on data sent from the patient's home because the case manager was often busy seeing patients in the clinic or on the inpatient unit," Vogel says.

Where CMs come in

At VA Connecticut, part of the VA New England Healthcare System, case managers are specially trained RNs and social workers assigned to care lines as well as to a panel of providers where the patient receives primary care. The providers may be a physician, an advanced practice registered nurse, or a physician assistant in the VA health system.

Services provided by the case managers include assessment, care planning and implementation, education, referral, coordination, advocacy, monitoring, and periodic reassessment to meet an individual's health care needs.

The case managers see the patients in the clinic, hospital, or may need to follow them in a skilled nursing facility if the patient requires skilled nursing care. They may need to coordinate with hospice care or work with any other VA and non-VA providers to ensure seamless coordination of care.

"The constants in the patients' health care continuum are the nurses and the social worker case managers. Wherever that patient is, the care is coordinated by the same RN/social worker case management team to promote continuity. It's an efficient way to coordinate care and the patient always knows who is handling his or her care," Vogel says.

If a patient needs specialized case management, such as the telehealth monitoring, surgery, specialty care, or inpatient services, he or she may be handed off to another case manager. The primary case manager will be kept informed about the patient's condition and changes in the patient's health care needs. After the specialty or episodic case management needs are met, the specialty case manager will hand back the patient to the primary case manager.

The care of veterans who are receiving intensive mental health treatment may be coordinated by a mental health case manager.

"We may hand off our patients when there are specialized case managers and services that can

help meet the patient's needs with the understanding that the patient will be referred back to the primary case manager once he or she no longer needs or is benefiting from specialized case management services. We don't want to duplicate services and we want to get the best trained case managers for that specific event or care need," Vogel says.

Case managers are assigned to clients who are at high risk for utilization including those who have been hospitalized for a crisis episode or those who have recent or repeated hospitalizations, as well as those with chronic illnesses. Chronic conditions include diabetes, congestive heart failure, chronic obstructive pulmonary disorder, chronic pain, spinal cord injury, hypertension, and end-stage renal disease.

VA Connecticut has an elaborate computerized patient record system that allows for the case manager to access information at whatever point the patient is in the continuum. When there is a change in patient status or an event that requires case management, it's easy for the case manager to access the information. ■

Health plan targets the medically underserved

Programs engage community providers, civic leaders

By collaborating with hospitals, schools, and members of the community, UPMC Health Plan is providing health care services to a population that has traditionally been underserved.

The Pittsburgh-based health plan has been awarded the Recognizing Innovation in Multicultural Health Care Award by the National Committee for Quality Assurance for providing culturally and linguistically appropriate health care services for its members in Western Pennsylvania.

The health plan provides commercial benefit plans, Medicare, and Medicaid through the Pennsylvania Medical Assistance Program.

The health plan studied the outcomes for members covered by the medical assistance program and identified areas in the community where access to medical care as well as medical care outcomes are poor compared to the commercial population.

"We concentrated on members in areas with the lowest access to health care and the lowest HEDIS scores and targeted a program to improve the delivery of health care services and subsequently the outcomes to this population," says **Michael Culyba**, MD, vice president of medical affairs, health disparity.

The health plan has developed three programs in the economically depressed and medically underserved areas. UPMC for You, the health plan's medical assistance program has partnered with hospitals to provide support for pregnant women and their children. Through a partnership with a community school, the health plan is ensuring that children receive preventive care, recommended vaccinations, and dental care. The third program partners with a hospital to recruit community leaders who educate residents about the health plan's disease management programs for childhood asthma and adult diabetes and cardiac disease.

The maternity program targets the Braddock area, formerly a steel workers neighborhood that is now a low income area with scarce health care services.

"Poor birth outcomes, particularly low-birthweight infants, were significantly higher in this community than in the medical assistance population as a whole. We partnered with community hospitals and physicians in the area to improve prenatal care for women in this area," Culyba says.

Prenatal care provided

The insurer collaborated with representatives from UPMC Braddock community and McGee Women's Hospital of UPMC, physician practices that are a part of UPMC, and federally qualified health centers to improve access to prenatal care for women living in the area.

"This was accomplished by creating community awareness by engaging hospitals and practicing physicians, community agencies, and community civic leaders; by developing communication tools to inform the community of maternity programs and the value of appropriate prenatal care; and by coordinating the identification of at-risk pregnant members and referring them to appropriate clinical services, including a doula program we developed," Culyba says.

Members eligible for the program are identified primarily through an obstetrical needs assessment form that physicians are required to fill out for patients who are covered by

Pennsylvania's medical assistance plans.

Women in the neighborhood are largely transient without regular access to telephone and have tremendous psycho-social needs.

"One of the issues we recognized is that telephonic disease management is not effective with this particular population. Peer-to-peer support is much more effective than someone from a corporate office calling them," Culyba says.

Working with East Liberty Family Practice, a large physician practice group, and the federally qualified health centers, UPMC Health Plan has created a doula program to provide support during pregnancy, labor and delivery, and beyond.

"Doula" is a Greek word that means a specially trained women who "mothers the mother" and assists her through pregnancy and delivery and helps her understand her role as a parent.

The health plan recruited women from the Braddock community and put them through a training and educational program that includes motivational interviewing and meets the requirements for a doula certification program.

The program provides pregnant members who chose to participate with six prenatal visits and four post-partum visits.

"When we identify a member for the program, we refer her to one of the doulas who makes personal contact and follows her through the pregnancy and delivery and helps transition her and her baby into better pediatric care," Culyba says.

The doula identifies any risks to a healthy pregnancy and points the member to services that would help. For instance, if the woman is a smoker, the doula will refer her to a smoking cessation program. If she needs transportation, housing, or food, the doula helps her access community agencies that can help with those needs.

"Our feeling is that peer-to-peer communication creates a social bond and the woman who is in need is more likely to respond," Culyba says.

The doulas communicate with UPMC's maternity program, using tools that outline their visits with the women and what headway they have made.

Magee Women's Hospital of UPMC, which performs the majority of deliveries for women in the Braddock area, allows the doulas to attend the delivery with the women and help them through the labor and delivery process.

After the baby is born, the doula makes a post-discharge follow-up visit to make sure the mother and child are doing well and that the child is getting good pediatric care.

Participants in the program have shown a significant increase in breast feeding, an increase in having a prenatal visit in the first trimester, and a decline in low-birth-weight babies.

Targeting school-age kids

In another community project, the health plan has been working for about a year with the school nurse at a community school to identify members who haven't gotten the recommended immunizations or who haven't seen a dentist. The health plan coordinates with the nurse to ensure that the children get the necessary medical care.

"UPMC Health Plan functions as a coordinating entity between the school, the child and family, and the health care practitioners," Culyba says.

If the health plan's data analysis shows that a member hasn't had a recommended immunization or isn't getting regular dental care, the health plan's care coordinator tries to get in touch with the family.

If the health plan can't contact the family and the child is a student at the school, the case manager alerts the nurse who calls the student in and talks to him or her.

"We have created a communication vehicle. If we can't contact the parent, we ask for help from the school. We know that these children have to go to school so we work with the school nurse to get in touch with the child and parent and we coordinate a visit with the primary care practitioner," he says.

The health plan has been piloting the program in one school for about a year.

The school nurse and the case manager work together to make sure the student gets the care he or she needs.

"We provide care management services for our members and work with the school nurse to improve the medical care for our members," Culyba says.

Through a partnership with UPMC Braddock, the health plan is helping people with chronic conditions who live in the Braddock community learn to manage their diseases.

With the help of the health plan, the hospital has recruited community ambassadors to educate the public about its Steps to Health program, which provides disease management for adults with diabetes and cardiac disease and children with asthma.

"We know that peer-to-peer communication is an effective way to engage members, particular those in our medical assistance programs. We want to create awareness of these disease management programs and to work with the hospital to ensure that members with these conditions are referred into our clinical program," Culyba says.

UPMC Health Plan and UPMC Braddock train the ambassadors about the health plan and hospital-based disease management programs, including how to identify people who would benefit from the program and refer them to UPMC Health Plan.

The health plan assists the hospital in developing and implementing disease management programs for people with chronic conditions who are without health insurance. The health plan has representatives on the hospital's disease management steering committee and coordinates clinical activities with the hospital to make sure that the care is consistent for all members of the community.

"The role of the hospital is changing, particularly when it is in a depressed area. Instead of just taking care of people when they're sick, the hospital's role is evolving to recognize the value of prevention and to become a leader in developing clinical programs to help prevent and manage chronic diseases," Culyba says. ■

CMS posts implementation guidance for HH PPS

The Centers for Medicare & Medicaid Services (CMS) is providing guidance to home health agencies (HHAs) on two issues related to the implementation of the refined HH PPS, which became effective Jan. 1:

1. Billing options for HHAs whose systems are not ready to bill, based on the refined HH PPS, on Jan. 1, 2008;

2. Upcoming revisions to the HH PPS Grouper, which may result in underpayments to HHAs, and the options available to HHAs on how to handle those potential underpayments.

CMS will be releasing the revised grouper, HAVEN and associated pseudo code as soon as possible in 2008.

You may access the home health agencies guidance document at: http://www.cms.hhs.gov/HomeHealthPPS/Downloads/GuidanceforHHAs_Posting_12-18-2007.pdf. ■

CMS: Slight acceleration of health spending growth

Health care spending growth in the United States accelerated slightly in 2006, increasing 6.7% compared to 6.5% in 2005, which was the slowest rate of growth since 1999, according to data recently released by the Centers for Medicare and Medicaid Services (CMS). Health care spending, however, continues to outpace overall economic growth and general inflation, which grew 6.1% and 3.2%, respectively, in 2006.

In 2006, health care spending reached a total of $2.1 trillion, or $7,026 per person, up from $6,649 per person in 2005, according to a report by (CMS). The health spending share of the nation's Gross Domestic Product remained relatively stable in 2006 at 16%, up by only 0.1 percentage point from 2005.

Out-of-pocket spending grew 3.8% in 2006, a deceleration from 5.2% growth in 2005. This slowdown is attributable to the negative growth in out-of-pocket payments for prescription drugs, mainly due to the introduction of the Medicare Part D benefit. Out-of-pocket spending accounted

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for 12% of national health spending in 2006; this share has steadily declined since 1998, when it accounted for 15% of health spending. Out-of-pocket spending relative to overall household spending, however, has remained fairly flat since 2003.

Total Medicaid spending declined for the first time since the program's inception, falling 0.9% in 2006. The introduction of Medicare Part D, which shifted drug coverage for dual eligibles from Medicaid into Medicare, contributed to the decline in Medicaid spending growth. Other reasons for the decline include continued cost containment efforts by states and slower enrollment growth due to more restrictive eligibility criteria and a stronger economy.

Spending growth for home health services slowed. Spending growth for freestanding home health care services decelerated from 12.3% in 2005 to 9.9% in 2006, also partially due to a reduction in price growth. Despite the 2006 deceleration, home health care continues to be the fastest growing component of all personal health care spending.

The health care spending data can be found on the CMS web site at http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp. ■

NAHIT report advocates unique patient identifier

Current process called unreliable

The National Alliance for Health Information Technology has called for the creation of a voluntary patient-controlled system of unique patient identifiers to ensure privacy and accuracy when exchanging medical information through an electronic health network.

The alliance concluded that the current statistical process for matching patients to their records based on such attributes as name, address, and birth date was too unreliable.

It said a system of unique identifiers would make medical information more complete, accurate, private, and secure, and allow patients to decide who has access to their health records without worrying about incomplete information or identification mix-ups.

The alliance has been focusing on the issue of

CNE *questions*

5. What is the first step to take when developing a waste reduction program, according to **Gary Laustsen**, PhD, APRN, assistant professor of nursing at the Oregon Health and Science University?
   A. Educate employees
   B. Conduct a waste assessment
   C. Ask for money to purchase recycling bins
   D. Implement several initiatives at one time to see which works best

6. To what factor do authors of a Columbia University Mailman School of Public Health study of the risk of exposure to bloodborne pathogens attribute the similar rate of exposure between nurses in community settings and hospital settings, even though hospital-based nurses are dealing with a more acute patient?
   A. Community nurses are generally less experienced.
   B. Supervision of home care and community nurses is less stringent.
   C. Home care nurses don't have the resources to protect themselves.
   D. Home care and community nurses are performing more complicated procedures than in years past.

7. Patients who would be appropriate for VA Connecticut's telehealth program include which of the following:
   A. patients who live alone
   B. patients who have a caregiver
   C. patients at low risk for emergency department visits
   D. none of the above

8. According to Michael Culyba, MD, UPMC Health Plan concentrated on members with the lowest access to care and the lowest HEDIS scores.
   A. True
   B. False

Answer Key: 5. B; 6. D; 7. A; 8. A.

patient identification for three years, including holding forums, reviewing research, and gathering input from a range of experts, including some of its own members.

Outside of carefully controlled pilots, accuracy for the current process of ensuring patient identification is roughly 90%, based on industry estimates, says Tom Doyle, vice president for HCA and a member of the alliance's technology leadership committee. That margin of error will widen, he says, as it is applied to ever-larger populations.

As part of the consensus-building process, the alliance is soliciting comments on unique patient identifiers on its web site at www.nahit.org. ■

CNE objectives

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

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

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **March** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■