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IN THIS ISSUE

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Hospice and long-term partnerships work well with attention to details

Identify responsibilities and concerns up front

(Editor's note: This month we begin a two-month look at partnerships between hospice agencies and long-term care providers. This issue contains stories related to key issues to address in developing and maintaining relationships between hospice agencies and long-term care facilities, including potential legal risks as well as tips to strengthen relationships. Next month, we look at a hospice agency that has developed an inpatient hospice unit within a long-term care facility.)

Research indicates that 22% of nursing home clients who die in a long-term care facility receive hospice services, but approximately one-third of those patients are enrolled in hospice one to two weeks before death, which greatly reduces the benefits that they and their families received.[1]

Collaboration between hospice agencies and long-term care facilities can mean significant new growth opportunities for the hospice agency, as well as impressive enhancement of services and resources for the long-term care facility's clients and their families. To take advantage of the opportunities offered by collaboration, you must plan and manage these business relationships carefully, sources say.

While there is no federal requirement that nursing homes or assisted living facilities allow hospice agencies access to patients, there may be some states that define "resident rights" as including access to hospice, says **Meg S.L. Pekarske**, JD, an attorney with Reinhart Boerner Van Deuren in Madison, WI. Even in those states, a relationship with a hospice agency is elective, so developing a good relationship is important to a long-lasting collaboration, she adds. **(For more information about regulatory and legal issues, see p. 27.)**

"We have had a nursing home service line for over four years and an assisted living facility service line for three years," says **Margo Post**, administrative director for long-term care services at Tidewell Hospice

and Palliative Care in Sarasota, FL. The hospice contracts with three nursing homes in four counties in the area and several assisted-living facilities, she says. "Our contracts are reviewed and renewed every two years or whenever there is a change in ownership of the long-term care facility," she adds.

The contract is very important, Post says. "It describes each facility's responsibilities for the patient's care as well as the procedure for referral to hospice," she says. A physician order is needed for referral to hospice, and then the patient is evaluated by a hospice case manager to determine if the patient meets the criteria for hospice, she explains. The contract also should spell out who provides certain supplies, equipment, and services to the hospice patient, she adds. **(For specific items included in a contract, see p. 29.)**

The difference between offering hospice services to a nursing home patient and a patient in a private home is the presence of the nursing home staff, says Post. "In a patient's home, we are teaching family members how to provide some care to the patient, but in the nursing home, we contract with the nursing home to provide some services," she says. "We have occupational and physical therapists on staff that can work with patients, but we try to use the nursing home's therapists whenever possible."

Demonstrate your confidence in the nursing home staff's ability to provide care, Post says. "We're in the nursing home to enhance services, not to take over the care of their patients," she adds.

State surveys of nursing homes have serious implications, and hospice staff members can help nursing homes with surveys that include hospice patients, says Pekarske. Hospice staff members can ensure that the care plan and documentation of patient care show that some issues, such as weight loss, are expected for a hospice patient, she explains. "Patient weight loss is a common reason for a citation, but if the documentation supports the weight loss as a normal progression for this particular patient, the nursing home is not cited," Pekarske says.

Post says her staff are present at all surveys. "Documentation of a hospice patient is very detailed, and surveyors typically review 100% of the chart for our patients," she says. Hospice staff can answer questions and provide information to the surveyor that can help the nursing home's survey go more smoothly, Post adds.

Respect facility culture

Showing respect for the long-term care facility's staff and culture is an important part of a good relationship, says **Kelly Fischer**, RN, SHPN, director of long-term partners at Hospice Care in Madison, WI.

"Each facility has a different personality or culture," she says. "I am constantly asking the director of nursing for feedback on our services and our staff who come into their facilities."

When a staff member who has not previously worked at a particular nursing home starts seeing patients at that facility, Fischer makes a point of calling the director of nursing after a few days to make sure that there are no concerns. "Some nursing homes are very elegant and formal, while other may be homey and laid back, so we try to match our staff members' personalities and demeanors to the facility," she explains. "I call the director of nursing to show our commitment to providing staff that reflects the same attributes of her staff."

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For more resources on collaboration between hospice and long-term care, go to the National Hospice and Palliative Care Organization web site for a report on the Nursing Home/Hospice Partnership. The free report contains examples of different types of collaboration and components of successful relationships. Go to www.nhpco.org and select "professional resources" then choose "Access, outreach and marketing" then select "Long term care."

As part of her follow-up with some facilities a few years ago, Fischer learned that one concern was the attire of the certified nursing assistants (CNA). "We now provide polo-type shirts with our company logo to our CNAs to wear on their visits," she says. This change improved the professional appearance of the CNAs and made it much easier for nursing home personnel to recognize them as hospice employees, she says. Even though all hospice staff members wear name badges, the "uniform" look simplifies identification, she adds.

Communication is also an issue that contributes to the success of the collaboration, says Fischer. "Because the nursing home or assisted living staff is providing personal services as part of their care of the patient, we wanted to make sure that everyone knew who did what and when," she says. A communications binder that has a calendar and room for notes about the patient is left in each hospice patient's room or in a location that the director of nursing specifies.

"The hospice staff member checks in with the front desk so the nursing home knows that he or she is there, then the staff member writes his or her name and discipline in the calendar in the patient's room," she says. In addition to listing a name, the hospice staff member also will describe what services were provided, she says. "This is very important for the CNAs so that the hospice and nursing home staffs don't duplicate services," she explains. For example, if a hospice CNA changes the patient's bed linens on Monday, the nursing home CNA who comes into the patient's room later on Monday will know that the bed linens don't need changing, she explains. Nursing home employees also use the communications binder to let hospice employees know what they did so that everyone's time is better used, she adds.

Hospice participation in the care plan meetings is also important, says Post. "We use one care plan that incorporates long-term care and hospice services," she says. Having one plan to drive the care is helpful because long-term care and hospice services are provided parallel to each other, not in isolation, Post says.

It was not easy to introduce a single care plan, but staff education for both staffs on the services that are designed to help the patient and the family increases acceptance, Post says. "It is also important to understand the conditions of participation for both organizations and reflect those requirements in the plan, and to design the plan on evidence-based practices that provide a high standard of care," she says.

Reference

1. Dobbs DJ, Hanson L, Zimmerman S, et al. Hospice attitudes among assisted living and nursing home administrators, and the long-term care hospice attitudes scale. *J Palliat Med* 2006; 9:1,388-1,400. ■

Carefully select long-term care partners

Look at reputation, reg compliance

Any contract with another organization requires careful attention to details, regulations, and legal issues, but hospice agencies need to pay special attention when contracting with a long-term care facility to provide services, says **Meg S.L. Pekarske**, JD, an attorney with Reinhart Boerner in Madison, WI.

"There are many advantages to a relationship between a long-term care facility and a hospice agency, but because each organization is governed

by different regulations and has a different focus on patient care, a contract needs to address the differences," explains Pekarske. The contract can specify which services are provided by each organization so that regulatory requirements are met, she adds.

Before establishing a contracted relationship, hospice managers need to understand the potential risks of collaboration, says Pekarske. "The hospice is responsible for compliance issues, so it is important that contracts and protocols reinforce the need for nursing home personnel to report a change of condition to the hospice," she says. A hospice visit to the patient due to a change in condition can reduce hospitalizations or trips to the emergency department, Pekarske says. This service is important because most hospice patients don't want to go back to the hospital, she adds.

Because nursing homes have RNs and LPNs on staff, there is someone to observe the patient and report a change, Pekarske says. "It is more of a challenge in assisted living facilities because there are different levels of assisted level care with different regulations, and there is not always a nurse on site," she explains. With assisted living facilities, the hospice and the assisted living provider need to work out a protocol to address this issue, Pekarske says.

Liability insurance is another key point to address in a contract, says Pekarske. "Assisted living facilities are typically small providers who may not carry the level of insurance coverage required for hospice care," she says. With the level set at $1 million per incident and $3 million aggregate, small assisted living facilities won't buy the coverage, Pekarske adds. "In this case, the hospice manager needs to make a business decision as to whether or not the agency will enter into an agreement with the facility," she says. "The risk is that if there is an incident, the hospice becomes the deep pocket for any lawsuit related to the patient."

The insurance coverage may be an issue for some nursing homes as well, she adds.

Be aware of fraud, kickback potential

Hospice agency managers also need to look out for any kickback or fraud issues, suggests Pekarske.

"Nursing homes don't deal with fraud statutes as much as hospice agencies do, so they don't recognize the potential for fraud in many cases," she says.

Be careful not to guarantee a certain number of certified nursing assistant days for all hospice patients, she points out. Guaranteeing a number of days without producing an individual care plan and documenting appropriateness of service will raise a red flag, she says.

Although hospice agencies can purchase services from nursing homes or assisted living facilities that are related to the hospice care of the patient, these services must be priced at fair market value, points out Pekarske. "A hospice cannot pay a nursing home for services that are covered by the nursing home's room and board rate because a facility cannot be paid twice for the same service," she adds. "Be sure to check your state's laws as well as federal laws to make sure that you understand what is allowed."

Hospice agencies need to select their relationships carefully, suggests Pekarske. Look at the reputation of the provider in the community, study Nursing Home Compare, ask the provider how they have addressed any compliance issues identified in their surveys, ask about the acuity of their population to see if they have potential hospice patients, and evaluate the staffing of the facility, she says. *(Editor's note: To access Nursing Home Compare, go to www.medicare.gov, then under "Search Tools," select "Compare nursing homes in your area.")* You want to make sure the long-term care facility is staffed appropriately to handle day-to-day care of all patients and is not looking for a hospice to supplement staff to handle non-hospice duties, Pekarske explains. Be sure to choose a partner that provides the same quality of care that your organization provides, she adds.

Agencies also should plan their entry in long-term care partnerships carefully as well, warns Pekarske. "There are many problems with establishing as many contracts as possible when you start a long-term care program," she says. A lot of contracts may generate a lot of referrals, but if you are not prepared for the extra patients at a large number of facilities, you won't provide good service and you won't help your own reputation, she explains. "It is better to contract with a few facilities at first as you develop the infrastructure to handle growth," she suggests.

The issue of long-term care and hospice partnerships is an extremely important issue that will only become more important in the future, says Pekarske. "We have an increasing geriatric population with no easy answers as to how to best provide care, but partnerships between long-term care and hospice will grow because it is one way to provide care to patients and their families in a setting of their choice," she says. ■

Address specifics of patient care up front

Checklist ensures no details missed

Four years of a program focused on partnerships with long-term care facilities and contracts with 88 different facilities has taught the staff at Hospice Care in Madison, WI, a few tricks on how best to manage multiple relationships in different areas.

"It has been a challenge to manage the relationships as the program has grown, but we've focused on improved communications, and we've developed a template to make sure we address all of the issues we need to address as we admit each patient," says **Kelly Fischer**, RN, SHPN, director of long-term partners at Hospice Care in Madison, WI. "The contracts are renewed annually and we have one person in charge of tracking them."

While the overall contracts are the same, the form that describes specific responsibilities for each patient differs from facility to facility, she adds.

Before a patient is admitted to hospice and the care plan is developed, a checklist is used to assign responsibilities and collect information. The list includes:

- Who is responsible for obtaining the "do not resuscitate" order?
- Who makes sure the power of attorney for health care forms are in the chart?
- What is the patient's name, diagnosis, and ICD-9 code?
- Who will obtain the physician order for hospice medications?
- What nonpharmaceutical treatments are available for the patient, and who will provide them? (Examples include whirlpool, massage, volunteers to visit, and pet or music therapy.)

"We also discuss items such as how to handle falls, laboratory tests, and X-rays, and document our agreement," says Fischer. "In many nursing homes, the policy for a patient that has fallen may require a trip to the emergency room."

Her agency prefers that a hospice nurse evaluate the patient first to avoid an unnecessary trip to the hospital, Fischer says. "Not only is it stressful for the patient and family, but our patients have usually said that they never want to return to the hospital," she says. Asking the nursing home to wait until the hospice nurse has evaluated the patient is respecting the patient's wishes even if they conflict with nursing home policy, Fischer adds.

X-rays and lab tests also may be ordered routinely following a fall in some nursing homes, but Fischer's agency asks that they not be performed until after the hospice nurse's evaluation.

Weighing patients is another item that Fischer's agency asks for a departure from policy in some facilities. "A hospice patient is going to lose weight as a natural progression of the condition," she points out. "We've had many of our facilities agree that we can weigh our patients on different schedules than their other patients, even though they may still require some regular timeframe."

The goal in our relationships with long-term care facilities is to put comfort care at the forefront of the care plan, says Fischer. "Our patients' needs are different from the needs of a long-term care patient, and constant communication and education between the staffs of the two facilities is ensuring the best care for them," she says. ■

Bunnies and bears help children face grief

Puppet show provides safe place for questions

"I don't want to go to no stupid funeral." These words uttered by a key character in a puppet show convinced **Penne Williams**, LCSW, an instructor at University of South Florida at Lakeland, that the puppet show used by LifePath Hospice and Palliative Care in Tampa, FL, is exactly what is needed to help many children handle their grief.

"These words are real. They are the same words used by children who have experienced the death of a parent, family member, or friend," says Williams.

The puppet show, "The Loss of Locci," was written by **Karl Knox**, LMHC, a LifePath staff member. "I wrote the show when I worked at another hospice but brought it with me when I came to Lifepath," Knox explains.

While there are many grief counselors that use puppets on a one-on-one basis with children, he has not seen another show produced specifically for children through a hospice. "It is difficult for some children to talk about their grief or put their feelings into words," he explains. "The puppet

show is designed to provide a safe place for children to ask questions that they might not normally ask."

The three-act play focuses on two bunnies and a bear cub that have to deal with grief when the bear cub's mother dies. "In the first act, the bunnies visit their bear friend and learn that Mama Bear is sick," says Knox. In the second act, the bunnies find out that Mama Bear died, and the third act follows the funeral, he says. In between each act, the narrator leads the children in a brief discussion, during which questions such as: Have you ever been sick? How do you think Locci is feeling? "We ask the children if it is OK to be sad or angry, or we ask how they think his friends should behave," he says. All of the questions are designed to give children permission to ask questions they may have thought they shouldn't ask, he adds.

Even when the questions are about the characters in the play, they often reflect the children's unasked questions, points out Knox. "We often have children ask if the bear's father is going to get married again, or if the little bear will have to move away from his friends," he says. These are questions that children may not ask about their own situation because they don't want to upset their families or appear to be selfish, he explains.

The use of animal characters is critical to the success of the puppet show, Williams says. The children relate to the puppets as peers, she says. "One counselor told me that a child came up to her after the show to tell her that 'the brown bunny said everything was OK, it wasn't my fault my mom died'," she relates. "Even though counselors and family members may have said the same thing, it meant more to the child when the brown bunny said it."

The children even talk to the puppets after the show when the puppeteers come out from behind the stage, holding the puppets, says Williams. The adult is standing there with the puppet and the child talks directly to the puppet, she says. "They want to pet them and offer them advice on how to handle their loss," Williams adds.

With six main characters and a narrator, the show requires at least five and preferably eight people to put it on, says Knox. "They don't all have to be grief counselors, but they do need to be trained on how to answer questions from the children," he says. Because children are unpredictable, there are always some questions that are hard to handle, Knox admits. "Questions about God, religion, or heaven are difficult because we are presenting to a group of children from different backgrounds," he says.

When these questions are asked, the puppet or the narrator often turns the question back around to the child by asking, "What do you think?" This technique often elicits an answer from the child that asked the question as well as others in the group, he adds.

Although volunteers can be trained, Williams prefers to use counselors. "I've had one incident when a volunteer responded inappropriately to a question by making light of the child's question," she says. In this case, a child asked about the possibility that the parent would date again, and the puppeteer made a joke about the parent finding a friend for the puppet so they could double-date, she explains. Not only did the puppeteer's response not answer the child's question, but it also trivialized the issue that might make the child avoid asking other questions because they might be silly.

"It is very important that the answer address the question without raising other issues," Williams says. "This was a good time to turn the question back to the child and ask how the parent dating would make the child feel."

The portable stage and puppets can be moved easily, so the show can be presented at grief camps, community groups, or school groups. "We used to present the show to children up to ages 11 or 12, but we found that they [the older children] were bored," admits Williams. "Even though the script is developmentally appropriate for 11- and 12-year-olds, these children are exposed to so much more sophisticated entertainment that it doesn't hold their interest."

There are few things Knox would change about the puppet show, but he does admit that he would

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For more information about The Loss of Locci or the use of puppets in grief counseling, contact:

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use fewer characters if he wrote another script. "Fewer characters would require fewer puppeteers. This would make the production simpler," he says.

Even with the success of the puppet show, Knox warns that it is only one tool for grief counselors to use. "The show may give children permission and a safe place to express thoughts they haven't shared before, but a counselor needs to follow up with the child to make sure all issues are addressed," he says. ■

Turning 'green': How to help the environment

You can save money, involve staff

Although patient care is the No. 1 priority for hospice managers and staff members, 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, 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 (CO) Community Hospital 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. 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 hospice has employees in their cars all day. "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," Abelkis 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, but I'm at the very beginning of the evaluation," he says. "Another option that might be considered for all employees is an arrangement for a favorable-interest car loan for employees who purchase cars that get high mileage per gallon."

The first step a hospice 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, sources suggest. "Of course, this is something that most agencies do anyway to improve efficiency," Abelkis 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 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. To generate a significant 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.")**

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 office staff 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."

Laustsen says, "The biggest culprit of

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- **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 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 then scroll down to "getting started."
- **Healthcare without Harm, www.noharm.org.** This 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.

inappropriate disposal of waste is red bag waste vs. regular trash." Disposal costs for red bag trash can be up to 10 times more expensive, and 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 waste assessment tool, see resource box, left.)**

Environmentally preferred purchasing is one direction that many health care facilities are taking to reduce wasteful packaging as well as 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 p. 33.)**

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. 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. Project Commission on Urgent Relief & Equipment (CURE) is affiliated with Benevolent Healthcare Foundation, a nonprofit relief organization that collects medical supplies and equipment for developing countries. **(See resources, left)**.

Overall, health care employees are very receptive to opportunities to have a positive effect on the environment, says Laustsen. People usually

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;
- reusable 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 nonvinyl 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 and the community.

More Internet resources are available to identify EPP opportunities, such as latex-free gloves, nonvinyl binders, reusable sharp containers, and other medical and offices supplies. Check out Sustainable Hospitals Project at the University of Massachusetts at Lowell at 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.

are 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," Laustsen says. ■

Tips for safe disposal of pharmaceuticals at home

The following guidelines are recommended by the 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, nondescript 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);
- 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). ■

Nurse admits stealing body parts, forging papers

A nurse in Philadelphia has admitted that he removed body parts from 244 corpses and then helped forge the paperwork that would allow those parts to be transplanted.

Philadelphia authorities say Lee Cruceta was involved in a group that provided more than 1,000 stolen body parts for black market transplants, Fox News reports. The 35-year-old Cruceta pleaded guilty to conspiracy, taking part in a corrupt organization, abuse of a corpse, and 244 counts each of theft and forgery. He also pleaded guilty to related charges in New York and negotiated pleas to serve concurrent sentences of 6½ to 20 years, Fox News reports.

Authorities say Cruceta is expected to testify against the other defendants, so he won't be formally sentenced until those cases are resolved. In other cases related to the theft ring, several funeral directors have pleaded guilty in New York, and a former oral surgeon, the accused ringleader Michael Mastromarino, 44, is being held in the case. Three funeral directors in Philadelphia have pleaded not guilty and are awaiting trial.

Bruce Sagel, JD, Philadelphia assistant district attorney, said in court recently that Mastromarino is expected to plead guilty. His lawyer, **Mario Gallucci**, JD, of Philadelphia, told The Associated Press that as part of his plea arrangement, Mastromarino plans to tell prosecutors about the companies that bought the stolen specimens. Once those companies are known, the scope of the case could grow exponentially, as the companies are charged and the parts are traced to individual patients who received them, who may in turn sue the companies and the health care providers.

Mastromarino paid funeral directors $1,000 per corpse, the district attorney says, and then sold the parts to tissue banks. Court documents indicate that the stolen body parts were sold to tissue banks for up to $10,000 each. The tissue banks resold them to hospitals for much more.

Prosecutors say Cruceta was part of several teams of "cutters" employed by Mastromarino. The ringleader made between $6 million and $12 million from the operation since 2001, they say. Some of the stolen body parts were diseased, and none were tested properly before being sold to tissue banks, court documents show. A grand jury in Philadelphia recently found that the body parts ring forged death certificates to hide diseases such as cancer and AIDS and lowered the ages of the deceased to make the stolen specimens more desirable.

Cruceta told the court that he was already earning more than $100,000 a year working two jobs when he agreed to work with Mastromarino. The nurse said he thought he had been hired by a legitimate tissue bank. He refused to say when he realized something was wrong. Cruceta previously had worked as a surgical nurse manager and at a tissue bank.

Court documents indicate the body parts were used in disk replacements, knee operations, dental implants, and other surgical procedures performed by unsuspecting doctors across the United States and in Canada. About 10,000 people received tissue supplied by Biomedical Tissue Services, Mastromarino's company, which sold the tissue to other tissue banks and to health providers, prosecutors say. ■

COMING IN FUTURE MONTHS

- How to turn 'info-only' calls into referrals
- Latest pain management developments
- Pediatric hospice has special focus
- Tips for community involvement to increase awareness

Nonhospital workers and bloodborne pathogens

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 nonhospital-based registered nurses (RNs), and found that nearly one out of 10 of the more than 1,100 nurse participants reported at least one needlestick injury in the previous 12 months.

"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 nonhospital-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 nonhospital settings, thereby increasing the potential risk of exposure. The population at risk is large, since nonhospital-based nurses represent a substantial portion of the overall nursing work force; approximately 40% of the 2.3 million RNs in the United States are employed in nonhospital settings. Extrapolated to the entire nonhospital-based RN work force in the United States, the authors estimate that the annual number of needlesticks in the nonhospital RN work force 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 the 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 work force. The researchers found similar risk factors in the nonhospital-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 nonhospital-based registered nurses, there are numerous barriers to effective infection control and safety programs in nonhospital settings," remarks Gershon.

A large proportion (about one-third) of nonhospital 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 nonhospital settings, and patient prevalence rates for certain bloodborne pathogens similar or even higher in nonhospital based settings, it is important to develop and implement targeted risk reduction strategies that are tailored to these unique nonhospital 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."

Findings of the study are published in the December 2007 issue of *Industrial Health.* ■

CMS publishes new fact sheet

The *Hospice Payment System Fact Sheet*, which offers providers information about the Medicare hospice benefit, is now available from the Centers for Medicare & Medicaid Services

(CMS) Medicare Learning Network.

The fact sheet includes a definition of hospice care, certification requirements, election periods, covered services, and rates. Go to www.cms.hhs.gov and select "Outreach and Education." Then under "Medicare Learning Network," select "MLN Products," then "MLN Products Catalog," and then "MLN Products Catalog, Updated January 2008." Once the catalog is downloaded, scroll down to page 8 of the catalog to find "Fact Sheets," then scroll to *Hospice Payment System Fact Sheet*. ■

Medicare issues updates, revisions

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to Transmittal 1304 (Change Request 5567) which was titled "Reporting of Additional Data to Describe Services on Hospice Claims."

This revision changes the effective date of Transmittal 1304 for additional service data on the claims only. Reporting of additional service data on hospice claims becomes mandatory on July 1, 2008. Medicare systems changes described in Transmittal 1304 were implemented on Jan. 7, 2008. This allows hospices to exercise their option to beginning reporting for January dates of service. The changes are necessary for the optional information to be received and processed correctly.

CMS also has issued an updated version of the Questions and Answers document for "CR 5567 — Reporting of Additional Data to Describe Services on Hospice Claims." The "Additional Questions and Answers" document and information on the revision to Transmittal 1304 is available at www.cms.hhs.gov. Under "Resources and Tools," select "hospice center." Under "Spotlights," choose "CR 5567." ■