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IN THIS ISSUE

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MRSA comes home with more patients, primarily with multiple hospitalizations

HHAs look for ways to prevent transmission

Methicillin-resistant *Staphylococcus aureus* (MRSA) is common in most hospitals, but a recent study shows that almost 13% of patients discharged from the hospital to home health care are infected with MRSA.[1]

"There has been an increase in the number of patients coming to home health with MRSA," says **Marcia R. Patrick**, RN, MSN, CIC, director of infection control for Multicare Health Systems in Tacoma, WA. "In 2000, we typically saw about 7% of patients admitted from hospitals to home health colonized with MRSA; now we see 12%," she says. The most common patients to have MRSA are patients with multiple hospital visits, she points out. "Patients with a lot of hospital admissions are more likely to be exposed to MRSA and are more likely to have medical conditions that put them at risk for infection," she explains. **(For information on risks, see p. 123.)**

In general, home health agencies are not screening new admissions

EXECUTIVE SUMMARY

Methicillin-resistant *Staphylococcus aureus* (MRSA) and other multidrug-resistant organisms (MDROs) are not new to home health, but according to a study published in the *Archives of Internal Medicine*, almost 13% of patients discharged from the hospital to home health have MRSA.

- One agency has seen an increase from 7% to 12% of home health patients with MRSA since 2000.
- Most home health agencies do not screen for MRSA upon admission but will use extra precautions if the patient was diagnosed with MRSA in the hospital or has had MRSA in the past.
- All staff members should use good infection control practices, even if the patient is not identified as having MRSA or has no symptoms.

for MRSA or other MDROs, says Patrick. "At our hospital system, patients discharged from the intensive care unit are screened, as are other high-risk patients, so we do know if they have MRSA when admitted," she says. "Other patients who don't receive screening in the hospital are not screened unless we have a problem, such as a wound that does not heal," she explains. The difficulty in selecting which patients might require screening at admission is that about half of patients who are colonized with MRSA do not have any symptoms or risk factors, she says.

Although some hospitals do have MRSA screening programs, they don't address all patients, just patients in high-risk areas such as intensive care, says **Irena L. Kenneley**, PhD, APRN-BC, CIC, professor at Case Western University in Cleveland.

The Association for Professionals in Infection Control (APIC) Scientific Research Council funded a study to find out the national prevalence of MRSA at U.S. health care facilities in the form of a survey sent to infection control professionals across the country.[2] "The APIC MRSA inpatient survey found that the MRSA colonization and infection prevalence in U.S. health care facilities is 46.3 per 1,000 inpatients, which is 8-12 times higher than previous estimates," points out Kenneley. "What has important implications for home health care is that it was also found that 67% of MRSA identified were on medical services, suggesting that MRSA is not focused just in ICU or surgical patients. As for active surveillance cultures, only 28% of the respondents performed them," she adds.

"We really can't do a thorough risk assessment for MRSA unless we screen, but implementing a screening program in home health presents some challenges," admits Patrick. Not only is reimbursement for the cost of the test an issue, but also additional training would be required to ensure that the screening test is conducted properly, she says. "The most commonly used method, swabbing the nose, still requires proper technique to obtain accurate results," she explains.

Although her home health agency does not conduct routine screenings for MRSA or other MDROs upon admission, **Judie Truelsen**, RN, BSN, interim co-director of Northwest Community Home Care in Arlington Heights, IL, will contact physicians for orders to culture wounds that are not healing to check for MRSA and other organisms, she says.

In the absence of thorough MRSA screening programs for both hospitals and home health agencies, the best way to protect patients, family members, and staff members from transmission of MRSA is to assume that everyone is potentially infected, suggests Truelsen. "We teach our staff members to use standard precautions in all patients' homes to prevent the spread of MRSA and any other infection," she says. Rather than single out MRSA in infection control practices, it works best to expect standard precautions to be followed all of the time, she says. "This is the best way to develop good habits and practices and makes it much easier to remember what should

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be done to prevent the spread of any infection," she adds. **(For specific precautions taught to staff members, see p. 124.)**

Although MRSA patients can be decolonized after initial exposure, they are at risk for contracting MRSA again, Patrick points out. "Once MRSA, always MRSA" is the rule followed by Patrick's staff. "A patient with MRSA contaminates his or her home, so some areas can't be disinfected," she says. "A kitchen and bathroom are easy to disinfect, but sofas, chairs and rugs can't be disinfected to remove all traces of MRSA," she says. This is another reason that Patrick stresses the use of standard precautions in all homes, she adds.

"We will not fix the problem of increasing rates of infection and colonization caused by MDROs overnight," points out Kenneley. The solutions are not simple given the complex health care delivery system, she says. "Solutions will require increased support for ownership of infection control and prevention not only in home health, but also throughout the entire health care delivery system."

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SOURCES

For more information about Methicillin-resistant *Staphylococcus aureus* (MRSA) in home care, contact:

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CDC answers questions about MDROs

Definitions, precautions, and risks identified

Some key questions related to multidrug resistant organisms (MDROs) that are most likely to be seen in non-hospital healthcare settings are answered by the Centers for Disease Control and Prevention in Atlanta. This information, along with other guidance provided by the CDC, can be used to develop or enhance staff education material.

A few of the questions and answers are:

What are "non-hospital health care settings"?

They refer to residential settings (e.g., long-term care and skilled nursing homes), home care, hemodialysis centers, and physicians' offices.

What are multidrug-resistant organisms?

They are bacteria and other microorganisms that have developed resistance to antimicrobial drugs. Common examples of these organisms include:

• **MRSA** - methicillin/oxacillin-resistant *Staphylococcus aureus*

• **VRE** - vancomycin-resistant *enterococci*

• **ESBLs** - extended-spectrum beta-lactamases (which are resistant to cephalosporins and monobactams)

• **PRSP** - penicillin-resistant *Streptococcus pneumoniae*

Which multidrug-resistant organisms are most commonly seen in non-hospital settings?

MRSA and VRE are the most commonly encountered multidrug-resistant organisms in patients residing in non-hospital health care facilities, such as nursing homes and other long-term care facilities. PRSP are more common in patients seeking care in outpatient settings such as physicians' offices and clinics, especially in pediatric settings.

What is the difference between colonization and infection?

Colonization means that the organism is present in or on the body but is not causing illness. Infection means that the organism is present and is causing illness.

What conditions increase the risk of acquiring these organisms?

There are several risk factors for both colonization and infection:

• severity of illness;
• previous exposure to antimicrobial agents;
• underlying diseases or conditions, particularly:

- chronic renal disease
- insulin-dependent diabetes mellitus
- peripheral vascular disease
- dermatitis or skin lesions;

• invasive procedures, such as:
- dialysis
- presence of invasive devices
- urinary catheterization;

• repeated contact with the health care system;
• previous colonization by a multidrug-resistant organism;
• advanced age.

What can be done to prevent or control transmission of these pathogens in my facility?

CDC's recommendations for preventing transmission of MRSA/VRE in hospitals consist of standard precautions, which *should be used for all patient care*. In addition, CDC recommends *contact precautions* when the facility (based on national or local regulations) deems the multidrug-resistant microorganism to be of special clinical and epidemiologic significance.

The components of contact precautions may be adapted for use in non-hospital health care facilities, especially if the patient has draining wounds or difficulty controlling body fluids.

The following are recommended for prevention of VRE / MRSA in hospitals and may be adapted for use in non-hospital health care facilities:

• Obtain stool cultures or rectal swab cultures of roommates of patients newly found to be infected or colonized with VRE, and nasal swabs for MRSA.

• Adopt a policy for deciding when patients can be removed from isolation, e.g., VRE-negative results on at least three consecutive occasions, one or more weeks apart.

• Consult health departments regarding discharge requirements for patients with MRSA or VRE.

What precautions should family caregivers take for infected persons in their homes?

Outside of health care settings, there is little risk of transmitting organisms to persons at risk of disease from MRSA/VRE; therefore, healthy people are at low risk of getting infected. In the home, the following precautions should be followed:

• Caregivers should wash their hands with soap and water after physical contact with the infected or colonized person and before leaving the home.

• Towels used for drying hands after contact should be used only once.

• Disposable gloves should be worn if contact with body fluids is expected, and hands should be washed after removing the gloves.

• Linens should be changed and washed if they are soiled and on a routine basis.

• The patient's environment should be cleaned routinely and when soiled with body fluids.

• Notify doctors and other healthcare personnel who provide care for the patient that the patient is colonized/infected with a multidrug-resistant organism.

RESOURCES

For more information about multi-drug resistant organisms in community settings, go to: http://www.cdc.gov/ncidod/dhqp/ar_mrsa.html.

For more information about standard precautions, go to: http://www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html.

Reference

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Strict protocols prevent spread of MRSA

Infection control training should be ongoing

Although standard precautions are taught to home health employees, the importance of precautions rises with the increasing number of patients coming to home care with multidrug-resistant organisms (MDROs), such as methicillin-resistant *Staphylococcus aureus* (MRSA).

To combat the spread of MRSA or any other infection from one patient home to another, or from a patient to a staff member's family, the employees at Northwest Community Home Care in Arlington Heights, IL, follow very specific infection control protocols, says **Judie Truelsen**, RN, BSN, interim co-director of the agency. "Each

clinician has a personal protection pack that includes gowns, gloves, masks, an eye shield, and booties," she says. "If an employee knows that the patient requires this level of infection control precautions, they are all prepared," she explains.

Even with patients who may not require employees to wear gowns and masks, nurses always follow a specific protocol to prevent transmission of infection from one patient to another through contact with shared equipment, points out Truelsen. "Nurses carry a non-permeable barrier, a piece of plastic, to place on the surface on which they are placing their nurses' bags," she says. "They also place a barrier on the surface [where] they might place their stethoscope or other equipment to prevent picking up an organism from the table or other surface," she explains.

Before the nurse removes an item from the bag, hands are cleaned with an antibacterial wipe, and any time the nurse reaches back into the bag, hands are cleaned with a wipe, says Truelsen. Before any item such as a stethoscope is placed back into the bag, it is wiped with an antibacterial wipe as well, she adds.

Nurses' bags can be a source of transmission, so it is important to pay attention to infection control protocols related to the bags, says **Irena L. Kenneley**, PhD, APRN-BC, CIC, professor at Case Western University in Cleveland, and lead investigator of a study that examined the role of home health nurses' bags in infection control **(See "Nurses bags play key role in infection control," *Hospital Home Health*, June 2008, p. 64.)** Even with good infection control precautions, MDROs present additional challenges that require extra precautionary steps, she suggests. "Enhanced environmental cleaning is vital, stressing the use of dedicated equipment, and leaving the nurses' bag out of the patients' homes," she says.

When identifying what equipment you will leave in the home, don't just focus on items such as pulse oximeters or stethoscopes, suggests **Marcia R. Patrick**, RN, MSN, CIC, director of infection control for Multicare Health Systems in Tacoma, WA. "The gait belt used by a physical therapist can transmit organisms that live on clothing or other surfaces the belt may touch," she explains. If it is not possible to leave some equipment in the patient's home, develop a process to disinfect the equipment before using it with another patient, she suggests. "MRSA can live on the surface of the skin, so even blood pressure cuffs might transmit the organism," she adds.

"Don't forget items such as rolls of bandage tape, bandage scissors, and other supplies that many nurses will just throw back into their bags," says Patrick. "Whenever possible, leave supplies in the patient's home to be used only for that patient."

"[Communicating] the clinical importance of MRSA, and in fact all multidrug resistant organisms, to clinical staff, patients, informal caregivers, and families is a high priority," says Kenneley. She suggests that educational emphasis should begin with the following facts:

- Options for treatment are limited.
- MDROs have been associated with increased lengths of stay, increased cost, and increased morbidity and mortality.
- Outcomes are worse for patients with resistant organisms that include not only MRSA, but also vancomycin-resistant *Enterococcus* (VRE), *Pseudomonas*, *Acinetobacter*, *Enterobacter*, *E. coli*, and *Klebsiella pneumoniae*.

"A review of standard precautions and contact precautions is also important, along with stressing appropriate handwashing," she adds. Patients and all family members should be included in the education, she suggests.

"We include infection control practices in orientation, but we also have supervisors go on visits with the field staff to observe their techniques," says Patrick. The review of infection control practices is part of every employee's annual assessment, she adds. ■

Journal Reviews

Study: Tips to reduce risk of fracture in older patients

Up to 90% of older adults in nursing homes have osteoporosis, which increases the risk of fractures. More than 2 million fractures occur in the United States, and 75% of older patients who sustain a hip fracture require nursing home and home health care. In fact, over 2 million home health care visits are made as a result of followup care following hospitalization for fracture.

A study of literature and existing guidelines

that can improve the bone strength of older patients who have experienced a previous fracture identifies useful tools and treatment regimens than can be implemented following a fracture and diagnosis of osteoporosis.[1]

Osteoporosis medications reduce the risk of fracture in senior adults, but therapy is given to only 10%-20% of nursing home residents with osteoporosis or a recent fracture. The use of calcium and vitamin D in this population is higher, but the doses provided may not be sufficient based on current recommendations.

The authors identify the gap between treatment guidelines and current quality of care and provide an algorithm for the assessment and care of nursing home and home health care patients with a prior fracture.

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CHF patients have better outcomes at home

Although inpatient hospital care is common for elderly patients with worsening chronic heart failure (CHF), recent research supports home care over hospital care to avoid complications such as depression and functional decline.[1]

In a study conducted in Torino, Italy, patients age 75 or older with acute decompensation of chronic heart failure were assigned to either a general medical unit or a physician-supervised home care program. Six months after the start of the study, 15% of the patients in the study group had died, with no significant differences between the two groups.

Although both groups of patients required re-hospitalization or transfer to a different unit for specialized care, the average time before the first re-hospitalization was 84.3 days for the home care group compared to 69.8 days for the inpatient group. The most significant difference between outcomes for the two groups was the improvement in depression, nutritional status, and quality-of-life scores for the home care group, according to the authors.

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Type 2 diabetes guidelines offered

Although diabetes is rarely the primary diagnosis for a home health admission, management of a patient's diabetes does play a key role in the patient's outcome. Type 2 diabetes mellitus is on the rise in the United States. National statistics show that 6.3% of the population currently has diabetes, and this percentage is expected to grow. A study by researchers at Mount Marty College in South Dakota looks at the correlation between cardiovascular risk factors and diabetes.

The combination of cardiovascular disease and diabetes makes it difficult for the home health clinician to provide comprehensive care to patients with Type 2 diabetes mellitus. The authors provide tools and protocols that can help home health clinicians provide evidence-based quality care to patients with diabetes.

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Health plan, physicians collaborate on care

Pilot project focuses on coordinating care

A unique partnership between a health plan and a physician practice is helping patients with diabetes get the care and resources they need to manage their disease.

The patient-centered medical home pilot project focuses on people with diabetes who are members of BlueCross BlueShield of South Carolina, BlueChoice Health Plan of South Carolina, the State Health Plan, or BlueCross Blue Shield Federal and who are patients of Palmetto Primary Care

Physicians in the Charleston, SC, area.

The pilot project began in April using a model that integrates quality improvement, coordinated care management, and patient educational services into primary care practices.

Case managers located in the physician practice corporate business office act as liaisons between individual physicians and their patients between visits. They collaborate with the health plan's disease management nurses and certified diabetes educators to help patients comply with their treatment plan, receive the recommended tests and procedures, and reduce gaps in care. The physician office-based case managers contact the patients by telephone to help them schedule appointments with specialists and access community resources when necessary.

"We believe that if patients become more educated and better able to self-manage their disease and physicians are enabled to deliver evidence-based care, patients will experience fewer hospitalizations and emergency room visits and enjoy a better quality of life," says **Laura Long**, MD, MPH, vice president of clinical quality and health management for BlueCross BlueShield of South Carolina.

The program should reult in overall lower costs for employers and less absenteeism as well, she adds.

"Our employers are interested in patients being healthier and at work. They're looking beyond lowering their costs for health care. They want their employees to feel good on the job so they can be more productive in the workplace," she says.

Palmetto Primary Care Physicians receives the traditional fee-for-service reimbursement for the care they provide patients, as well as an additional fee per participant, per month that allows them to fund the case management program.

In addition, through BlueCross BlueShield of South Carolina's pay-for-performance program, the physician practice receives quality-based bonuses, which reward the practice for improving quality and outcomes.

"Before we began this project, case management wasn't a reimbursable service so it wasn't practical for the physician practices to have case managers. By realigning reimbursement, it allows them to provide a different type of service to support their patients and to take a more proactive approach to care. It helps the physicians focus on delivering evidence-based care and quality outcomes," Long says.

The program takes a proactive approach to care and reaches out to all patients who have been identified with Type 1 or Type 2 diabetes, Long says.

"In the past, programs focused on the most complex patients. All patients are eligible for this program. Rather than just treating the patients who walk in the door, the program also reaches out to the patients who are not coming in for services and helps them overcome the obstacles to seeking care," Long says.

Once patients are identified for the program, they receive a welcome letter from the physician practice and the health plan. The introductory packet includes information on the physician practice's extended care hours, an offer for a free glucometer from the insurer, and a blood sugar tracking booklet.

The case manager follows up with a telephone call to ascertain the patient's willingness to participate. Interested patients receive another packet with information on diabetes and tips for better nutrition, diet, and exercise.

The program is an opt-out program to which most have responded favorably when the case managers call to explain the project, says **Amber Winkler**, MHA, case manager with Palmetto Primary Care Physicians.

After the initial call, case management outreach is customized based on the needs and requests of the patients.

The physician-based case managers are non-clinical staff who provide support and resources for the patients and work with the BlueCross BlueShield clinical disease managers to ensure that patients get the clinical information they need.

Each physician-based case manager works with about 500 patients.

"We strictly avoid giving patients clinical advice. We concentrate on giving the patient the resources they need to follow their treatment plan," Winkler says.

For instance, the physician-based case managers make sure that the patients keep their appointments to see their doctor, facilitate referrals when needed, make sure that the patients' test results get back in the chart, and help patients overcome obstacles to adherence.

They provide additional resources to the patients, including free week passes and discounts to local gyms; cookbooks; American Diabetes Association-approved nutrition materials such as meal plans; diabetic education classes; free glucometers; discounts on prescriptions or free samples of medication; and patient assistance

programs.

Patients have access to the case managers at the corporate office and their physician offices through a secure web-based portal.

"We look at information like their last appointment date, gaps in care, and their most recent laboratory values. We assess what they are willing to learn about and do to manage their condition. When patients need clinical advice, we help them interface with the BlueCross clinical diabetes educator and their physician's office," Winkler says.

The improved communication, coordination, and interaction between the physician offices and the health plan are unprecedented and are a key component of the program, Long says.

In the past, the two organizations tended to work in silos. Now they work together to make sure that the gaps in care are covered, she adds.

"Before we started this program, case managers and disease managers at the health plan level communicated with members and occasionally talked to someone in the physician offices. Under this model, we're tightly interfaced with the case manager in the physician office through an electronic link into the electronic medical record in the doctor's office," Long says.

"It's been a great arrangement for both of us. It's opened up a lot of communication between the physician practice and the insurer. Having direct contact with the insurer is a big help," Winkler adds.

For instance, the arrangement allows the health plan's diabetes educators to access patients' medical record and care plan as they work with them.

"The ability to follow through and the level of communication are significantly enhanced. The diabetes educators can add an electronic sticky note for the case manager or physician based on the conversation they've had with the member and vice versa," Long says.

By having access to the health plan's data, the physician office case manager can tell if the patient actually filled his or her prescription and can discuss it with the patient on the telephone and get the patient medication assistance or a coupon for a prescription if needed.

"We work so closely with the health plan and know our patients so well that we can advise them on the best way to get prescriptions or supplies. We have access to each patient's individual coverage so we can advise the patients what is best for them," Winkler says.

For instance, the case managers have suggested that patients consider generic drugs or a different glucometer because they would be covered under their plans.

One patient was paying out of pocket for his glucometer strips. Winkler advised him that his health plan would pay for the strips if he got a prescription for them and paid the copay.

"Benefits can be so complex and so difficult for patients to understand. We try to work out the best way for the patient to get what they need and pay for it so they will keep following their treatment plan," Winkler says.

The case managers take an individualized approach to each patient's unique situation, identifying why gaps in care occur and working to overcome the barriers.

"We look at whatever we can rearrange to make the situation workable. If the patient is on a high-deductible health plan and can't afford the deductible, we see if they qualify for a patient assistance program," she says.

They assist patients who are eligible for Medicaid supplemental insurance but need help filling out the paperwork.

In some cases, the case managers work with the health plan to get an out-of-contract social worker visit authorized as an alternative treatment plan.

"Within this pilot, we have the ability to be flexible on a case-by-case basis," Long says.

In one instance, a patient who had lost his job was afraid to come into the office with a broken toe and an infection because of financial problems. The case manager at the physician practice called the health plan to get approval for an office visit and get him help with his medication needs.

"The health plan bridged a gap until the physician office case managers could get other resources in place," Winkler says.

The physician office case managers have compiled a tremendous amount of information on community resources and other programs that can help patients overcome their obstacles to getting care or complying with the treatment plan.

"Since the case managers are in the Charleston area where the patients live, they are able to identify an amazing amount of community resources that help patients overcome the barriers to care. The case managers at Palmetto Primary Care Physicians have wonderful social and organization skills, which help them connect with the patient and identify their needs. Anytime they need us, they can call us in and we'll get involved," Long says.

The physician office case managers work

closely with the patients to make their health care dollars stretch.

"Many times when we get to know the patients, we find they are spending money unnecessarily on things that are covered by insurance and are skimping on things that they really need. We utilize every resource we can find to help the patients get what they need to keep their disease under control," Winkler says.

For instance, when the case managers can help patients find transportation assistance or get help with an electric bill, it frees up money to pay for medications, or if patients can get low-cost generic drugs, they can use the money they would have spent on drugs for their copay.

"It's kind of like a shell game, a matter of arranging and maximizing the patient's available dollars. The case managers have been very adept at identifying community and health plan resources to fill the gaps in care," Long says. ■

CMs through the continuum help keep patients healthy

Organization provides seamless continuity of care

A comprehensive case management program at Desert Oasis Healthcare that provides care coordination for patients throughout the continuum keeps patients healthier and out of the hospital. And it's cost effective.

"Our belief is that excellent patient care is also the most cost-effective care. We try to fill all the gaps in the health care system and give patients the support they need to stay healthy and out of the hospital," says **LaDonna Headley**, RN, director of case management for the IPA and medical group.

The case management program at Desert Oasis Healthcare has multiple components that work hand in hand to provide continuity of care for patients along the continuum, Headley says.

"We have different programs to take care of a patient's needs throughout the continuum of care. They can go from one program to another or be in multiple programs simultaneously, if needed," Headley adds.

Desert Oasis Healthcare is a team of primary care physicians and ancillary providers. The organization has headquarters in Palm Springs, CA, with offices located throughout the Coachella Valley area. The medical group is a full-risk provider with most of the health plans.

The Desert Oasis physician group provides care for about 22,000 seniors enrolled in Medicare Advantage and a total of 78,000 patients. The 30-day readmission rate for Medicare Advantage patients enrolled in Desert Oasis is between 11% and 12%, Headley says. This compares to an average of 19.6% readmitted within 30 days for traditional Medicare beneficiaries, according to a study in the April 2, 2009, issue of the *New England Journal of Medicine*.

Case managers who are employed by Desert Oasis work in local hospitals and nursing homes to ensure that patients get the care they need in a timely manner. Intensive case managers coordinate follow-up care for patients with complex needs and multiple comorbidities. Case managers follow up with patients who have been discharged from the hospital or the emergency department.

Desert Oasis' Living and Aging Well program provides an array of services for seniors, including in-home physician visits for homebound patients, disease management for chronic diseases, and health education programs.

In addition, Desert Oasis provides case managers on call around the clock so that if a patient or a physician calls, he or she always speaks to a live person.

"We're always looking at better ways to serve our patients. We want to be the GPS for our patients to help them navigate the health care system and to provide care that is coordinated and timely," Headley says.

The case managers call any patients who made an emergency department visit and those who are discharged from the hospital within 24 hours to ensure that they get follow up.

In addition, when patients make an emergency department visit or are admitted to the hospital, the case management team analyzes each case to determine what, if anything, could have been done to give them the service and medical care they needed to prevent the admission, Headley adds.

"We are always looking for gaps in care and ways that we can eliminate them," she adds.

Desert Oasis has its own staff of case managers in four local hospitals and a regional tertiary medical center who work with the hospital case managers to coordinate care.

"Hospital case managers have numerous responsibilities, and our case managers help supplement their care coordination efforts. When a consult is ordered with a specialist, they make sure the consult is done in a timely manner that

day and doesn't fall through the cracks in the system because the cardiologist office wasn't notified," Headley says.

The Desert Oasis case managers make sure that when the physician orders a test or procedure it gets done in a timely manner and the information is in the chart.

"We make sure there aren't discharge delays because of lack of transportation or because the information the physician needed wasn't in the chart," she says.

The Desert Oasis case managers spend time with patients and family members and assess the patient's support system and the situation at home to determine if the patient may need additional care after discharge.

For instance, there may be an elderly patient whose wife doesn't drive after dark. The case manager makes sure the discharge happens early in the day so he will have transportation available.

Often the hospital-based care managers identify high-risk patients who could benefit from other case management programs.

When they leave the hospital, patients receive a Desert Oasis discharge card with a dedicated number to call 24 hours a day, seven days a week with questions about follow-up care.

"We want to know about it if the patient has problems understanding his medication regimen or home health doesn't come when expected. Those are things that can lead a patient back to the emergency department," Headley says.

Desert Oasis's outreach clerical staff call patients after discharge to make sure they have a follow-up appointment with their primary care physician.

A nurse case manager follows up the day after discharge to make sure the patients have gotten their prescriptions filled, are not experiencing any problems, and that their support system is in place.

"We work closely with the emergency departments at our four local hospitals. If they identify patients in the emergency department who are not necessarily being admitted but need follow up, they call our case manager," she says. Desert Oasis has case managers on call around the clock.

It has developed an intensive case management program, staffed by RNs with emergency department and intensive care unit experience to coordinate care for at-risk patients with complex needs that aren't being met.

Patients eligible for the program have multiple comorbidities, are frequently hospitalized, make frequent visits to the emergency department, or have been diagnosed with cancer.

Referrals come from primary care physicians, emergency department staff, skilled nursing facilities, home health providers, and the physician group's customer service line.

When a patient is referred to the program, the intensive case manager reviews the patient's chart and immediately calls the patient to determine what is going on.

When the situation indicates it, the intensive case manager and a physician see the patient in the home, often within an hour of getting the call.

"Whether we see the patient in person or handle it by telephone depends on the patient and the patient's needs," Headley says.

The intensive case managers assist cancer patients to get all of the tests, such as biopsies, ultrasounds, and positron emission tomography (PET) scans, completed before they see the oncologist so the patients avoid repeated trips to the physician.

"When people are being diagnosed and treated for cancer, it's a frightening time. Our case managers support them and coordinate their care to ensure it occurs in a timely manner," she says.

One patient who received intensive case management was a Medicare Advantage patient who had made several visits to the emergency department in a short period of time because he was having prostate issues and couldn't void. The emergency department staff also noticed that the patient had a benign meningioma.

The patient needed to see a urologist but because he was an alcoholic had problems making and keeping appointments.

The urologist wouldn't operate until the patient had been cleared by a neurologist.

"There was no real likelihood that this man would be able to coordinate a visit to a neurologist, then get an appointment for prostate surgery," Headley says.

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Desert Oasis got the urological problem controlled and enrolled the patient in a recovery program. He finished the program during the holiday season, and since he had no support system at home, the intensive case manager arranged for him to go to an assisted living center for a couple of weeks.

The case manager then assisted him with the appointment to see the neurosurgeon to remove the meningioma, then supported him through prostate surgery.

Nearly a year later, he's still sober and his medical issues have been handled.

Desert Oasis Healthcare is part of The Heritage Companies, which include 25 medical facilities in California and New York. Richard Merkin, MD, COO, developed the model to manage medical groups and independent practice associations and integrate them with hospitals and ancillary care providers. ■

Joint Commission corrects accreditation manual

The Joint Commission has published corrected service applicability grids for home care services on its web site. Incorrect service applicability grids were included in the 2009 Update 1 for the *Comprehensive Accreditation Manual for Home Care* (CAMHC) published in June. To see the corrected standards, elements of performance and service applicability grids, go to www.jointcommission.org, select "Accreditation Programs," and then choose "Home Care." ■

2010 NPSGs released

The 2010 National Patient Safety Goals (NPSG) can be accessed on The Joint Commission web site. Although no new goals were established for 2010, all organizations are expected to have fully implemented the requirements related

CNE *questions*

5. What percentage of hospitalized patients with methicillin-resistant *Staphylococcus aureus* (MRSA) were located on the medical units rather than the intensive care units that are most associated with MRSA, according to Irena L. Kenneley, PhD, APRN-BC, CIC, professor at Case Western University in Cleveland?
   A. 28%
   B. 45%
   C.67%
   D.74%

6. What condition increases the risk of a patient contracting a multidrug-resistant organism (MDRO) that can be carried home from the hospital?
   A. Repeated hospitalizations
   B. Dialysis
   C. Previous colonization by an MDRO
   D. All of the above

7. At what point during care does her staff test patients for MRSA, according to Judie Truelsen, RN, BSN, interim co-director of Northwest Community Home Care in Arlington Heights, IL?
   A. Upon admission
   B. Prior to any invasive procedure
   C. When a wound does not heal properly
   D. Never

8. What is one way to prevent transmission of MRSA or another MDRO from one patient's home to another, according to Marcia R. Patrick, RN, MSN, CIC, director of infection control for Multicare Health Systems in Tacoma, WA.
   A. Leave supplies and equipment in patient's home for dedicated use
   B. Disinfect equipment once per day
   C. Use only disposable equipment
   D. Don't let patient handle nurse's bag

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

to healthcare-associated infections that were included in the 2009 NPSGs. To see the 2010 NPSGs for home care, go to www.jointcommission.org and select "patient safety" from the top navigational bar. Choose "national patient safety goals" and scroll down to "home care." ■

NAHC provides option to cut transportation costs

Last summer, transportation costs represented a significant part of home care and hospice agencies' overhead costs due to employees who drive nearly 5 billion miles each year to reach the homes of their patients, according to the National Association for Home Care & Hospice (NAHC). The association has announced a partnership that might provide a solution to help its members reduce transportation costs and protect against future price fluctuation.

NAHC has announced a partnership with Enterprise Fleet Management through which its members can receive 15% savings or more. ■

CNE objectives

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

1. Identify clinical, ethical, legal, or social issues particular to home health care.
2. Describe how the clinical, ethical, legal, or social issues particular to home health care affect nurses, patients, and the home care industry in general.
3. Integrate practical solutions to the problems faced by home health professionals 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. ■