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First-year results are here: P4P demonstration shows savings

HHAs report positive feedback, improvement in quality

More than $15 million in savings was shared with 166 home health agencies throughout the country as a result of performance in the first year of the Centers for Medicare & Medicaid Services' Home Health Pay for Performance (P4P) demonstration.

The demonstration project, which started in 2007 and ended in December 2009, was designed to show the impact of financial incentives on the quality of care provided to patients in traditional fee-for-service Medicare and the overall Medicare costs. A total of 570 agencies volunteered to participate in the program and were randomly assigned to either a treatment group or control group. Savings in the program are shared with treatment group agencies that either maintained high levels of quality or made significant improvements in quality of care. Performance was measured using seven home health quality measures computed from the Outcome-Based Quality Improvement data set and publicly reported on the Home Health Compare website. (*For more information on the P4P demonstration project, see page 99.*)

After evaluation of the first year's data, three of the four regions of the country showed a decrease in Medicare cost of care, says **Henry**

EXECUTIVE SUMMARY

Evaluation of the first-year data for the Centers for Medicare & Medicaid Services' two-year demonstration to test the effectiveness of pay-for-performance (P4P) for home health shows positive results in terms of cost savings and improvement in patient care.

- More than $15 million in savings was distributed to 166 home health agencies participating in the project as a result of improvement in seven quality measure categories.
- A survey of agencies shows low-cost impact to implement activities to improve quality.
- Agencies used a variety of strategies to improve quality and reduce costs, including use of multidisciplinary teams, incorporation of technology, improved communication between staff and physicians, and changes in visit patterns.

Goldberg, BA, principal associate of health policy for Cambridge, MA-based Abt Associates and director of the pay-for-performance demonstration project. "Top performers in the treatment group in the three regions that showed a savings shared the $15 million," he explains. These incentive payments are based on savings in the first year of the project, he points out. "Claims data for the second year savings analysis were not available until August, so I hope to have the report and savings calculation completed in the fall," he adds.

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Each agency's results in the quality measures are compared to results of other agencies in the treatment group within the region to identify recipients of the bonuses, explains Goldberg. "Incentive payments do seem to have an impact, even though the savings represented in this demonstration project is slightly less than 1%," he says. Even a 1% savings throughout all of home health Medicare spending can be significant, so Goldberg believes that the project is showing positive results for P4P. "We'll know more once the data for year two is evaluated, because we will see if agencies continue to find ways to reduce the cost of care and improve quality," he points out.

While Abt Associates is evaluating cost savings and identifying high performers within the treatment group, a group at University of Colorado, Denver, is comparing the treatment group results to the control group to identify best practices and to clarify the effect on staffing and agency costs as a result of P4P.

"There were no huge differences in the outcomes or the approach to care between the treatment and the control group, but this is not a classic treatment vs. control group study," explains **Eugene Nuccio**, PhD, senior instructor in the division of healthcare policy and research at the University of Colorado, Denver. "All of the agencies participating in the project volunteered and were most likely high-performing agencies with an emphasis on quality improvement before the project," he says.

Agencies were randomly assigned to the control or the treatment groups, and the treatment group of agencies did not receive any additional information throughout the project than the control group. "We told the treatment group agencies that they would receive a bonus payment if their region reduced costs to Medicare, and if they were high performers in the quality categories," Nuccio says. "We did not maintain continuous contact with agencies in the treatment group to let them know how they were doing, and we did not share best practice ideas with them," he adds. Feedback from agencies does indicate a desire for regular communication throughout the process, so they have an opportunity to identify areas in which they need to improve in a timely manner, he says.

Low-cost impact on agencies

In surveys of 41% of the treatment group agencies and 36% of the control group agencies,

Nuccio discovered that concerns about the burden that P4P will place on agencies are largely unfounded. *(See page 100 for more survey results.)* "Cost impact of P4P implementation for agencies in the project [was] minimal," says Nuccio. More than 53% of the agencies reported cost increases of less than 1%, and slightly more than 22% reported increases between 1% and 5%, he says. Staffing also was not an issue, with the increase in staffing similar between the two groups. "One negative issue identified by agencies is the availability of physical and occupational therapists in their areas," he says. Because the early involvement of therapists in a home health patient's care can lead to better outcomes, home health managers want to add therapists to their staffs but have difficulty finding them, he explains.

Although outcomes for both groups were not significantly different, there were some differences in approach, says Nuccio. Survey results show that agencies in the treatment group emphasized:

- enhanced communications among patients, physicians, and staff;
- prevention and screening program;
- telehealth;
- changes in visit patterns.

Agencies in the control group emphasized:

- staff productivity;
- changes in patient visit mix;
- wound care protocols;
- electronic communications with discharge planners.

In addition to surveying almost 220 participating agencies, Nuccio's group also conducted focus groups with management and clinical staff of two highly performing agencies in each of the four regions for a total of eight agencies or 92 individuals. The focus group interviews were designed to identify the specific quality activities that high-performing agencies use to achieve superior outcomes, explains Nuccio. The agencies involved in the focus groups had a number of strategies in common, he says. These included:

- strong, effective, purposeful leadership;
- single, integrated system approach;
- strong quality culture;
- multidisciplinary teams with a patient-centric perspective.

Technology was often mentioned as a factor in improving cost-effectiveness and outcomes, but the decision to purchase technology was made with the goal of improving patient care, says Nuccio. For example, wound care is one area of technology that has far-reaching effects, he points out. Although the number of patients with wounds for any agency may not be high, a wound care patient requires intensive care and frequent visits, he explains. Any dressings, or wound care systems or protocols that reduce the number of visits or enable a nurse to care for complex wounds, can produce better outcomes for the patient and reduce costs, he says. (*See another example of technology use on page 101.*) "Several agencies mentioned that they control the costs of educating staff members on new wound care protocols by having the manufacturer's representative conduct the training," he says. "This is a cost-effective way to obtain training, and you know you are getting a qualified trainer," he adds.

Although the bonus payments were an incentive for agencies to perform well, Nuccio points out that not all agencies stressed the bonus to their employees. "There are some high-performing agencies that have not told their employees that they are in the treatment group and eligible for the incentive bonus," says Nuccio. "At these agencies, and many others in the demonstration project, it is just business as usual, with a continuous effort to provide good patient care," he says. "In general, most of the agency managers have the attitude that doing the right thing for the patient from the start of care not only improves outcomes, but is more cost-efficient anyway."

SOURCES

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P4P project looks at quality and savings

OASIS measures used for evaluation

The Centers for Medicare & Medicaid Services' Home Health Pay for Performance (P4P) demonstration started in January 2008 and concluded December 2009. States included in the demonstration were: Connecticut, Massachusetts, Illinois, Alabama, Georgia, Tennessee, and California. The

states were divided into four regions. The 570 agencies that volunteered to participate were randomly assigned to either the treatment group or the control group of the demonstration.

An incentive pool generated by savings accrued from the reduction in the use of more costly Medicare services was used to pay bonuses to agencies that produced the highest patient care ratings or produced the greatest improvements in patient care as measured by seven OASIS [Outcome and Assessment Information Set] measures. Only agencies in the treatment group were eligible for incentive payments, says **Bill Buczko**, PhD, CMS project officer for the evaluation of the P4P project. The OASIS measures used for the demonstration are:

- incidence of acute care hospitalization;
- incidence of any emergent care;
- improvement in bathing;
- improvement in ambulation/locomotion;
- improvement in transferring;
- improvement in status of surgical wounds;
- improvement in management of oral medications.

Home health agencies are already collecting the information used to evaluate quality of outcomes through OASIS, so there was no need to collect data that is not already being collected. "Results of the study show that there were no significant increased costs or need for increased staff to participate in the P4P demonstration," says Buczko. The caveat of this result is that participating agencies volunteered for the demonstration, so there may be agencies who did not want to participate that might require more staff or incur higher costs to implement strategies that will produce cost-effective care and improved quality, he adds.

Although the demonstration ended in December 2009, it will take time to develop the final report, says Buczko. "In the next year, we will evaluate data from the second year and finalize the Year 2 payout, surveys of the agencies will take place, and we should have the evaluation of the demonstration finalized in around September 2011," he says. ■

Treatment vs. control groups in P4P

A survey of 219 home health agencies participating in the Centers for Medicare & Medicaid Services' Home Health Pay for Performance (P4P) demonstration doesn't show dramatic differences between treatment group agencies and control group agencies in the approaches taken to improve quality of care, but it does give a good picture of the range of strategies used by HHAs.[1]

• Staffing

Control home health agencies were more likely to add staff functions than treatment group agencies, with 45.6% of the control group adding RNs, compared to 35.3% of treatment group.

• External support

More than half of all agencies (50% of treatment group and 55.3% of control group) received help from Quality Improvement Organizations to reduce acute care hospitalizations, and more than half (58.6% of treatment group and 54.4% of control group) of agencies that are part of a larger corporate organization received corporate help to reduce acute care hospitalizations.

• Policy

Treatment group agencies are more likely than control group agencies to implement new policies related to falls prevention programs (56% vs. 48.5%).

Treatment home health agencies are more likely than control home health agencies (50.9% vs. 40.8%) to have implemented a policy to increase the quantity or quality of communication with patients.

Treatment group agencies are more likely to implement the use of care pathways or standardized treatment plans than control agencies (29.3% vs. 20.4%).

Control home health agencies are more likely than treatment agencies (31.1% vs. 18.1%) to have changed policies regarding productivity requirements for staff members.

• Clinical Practice

More than half of both groups reported that they have implemented performance improvement programs.

Treatment group agencies report implementation of additional review activities — 55.2% compared to 45.6% of the control group.

Treatment home health agencies are more likely to introduce new staff education programs (42.2% vs. 32%) than control group agencies.

• Cost of P4P

More than half of all agencies (53.4%) reported less than a 1% change in costs for participation in the demonstration, and 22.4% reported a 1% to 5% increase in cost.

• P4P Impact

Home health agencies believed that the demonstration would have the greatest impact on acute care hospitalizations (69%) and management of oral medications (72.4%).

REFERENCE

1. Nuccio E, Richard A, Hittle D, et al. June 2010. Comparison of Treatment Versus Control Home Health P4P Demonstration Participants: Survey Findings. Poster session presented at the AcademyHealth Annual Research Meeting, Boston, MA. ■

Bulky laptops give way to smart phones

Ease of use increases popularity

Increased efficiency is the name of the game for home health agencies as regulatory and financial changes occur in the next few years as part of health care reform. One way to improve efficiency is to make sure your field staff members have the tools they need to perform their job in a cost-effective manner.

While point-of-care technology for documentation and communication has become more popular over the years, most people think of laptop computers as the technology of choice. "I recommend personal data devices or smart phones," says **Tom Maxwell**, chief operating officer of Homecare Homebase, a home care software development company in Dallas. More of his home care clients are choosing smart phones over laptops, because they are versatile, easy to carry, and simple to use, he says.

"Most people are familiar with the use of cell phones, so learning to use a smart phone requires less education than learning to use a laptop," explains Maxwell. A smart phone can be easily carried in a pocket, which frees up the nurse's hands to carry other supplies or materials, and it is easier to clean than a laptop, he points out. Many of his clients also make the smart phones available to home health aides as well as nurses, which improves record keeping and communication among aides and other members of the care team, he adds.

"Transferring information is also easier from a smart phone," says Maxwell. "A smart phone can store data while the nurse or aide is making notes, then forward the data after each visit in about 2 minutes," he says. This compares to an average of 30-minute data transfer when laptops are used, and synchronized at the end of each day, he adds. "The ability to quickly synchronize and send data after each visit not only saves time for the nurse or aide, but also speeds up the billing process," he says.

Because the back-office staff are getting information throughout the day, billing doesn't get delayed, says Maxwell. "Most of my clients who have switched to smart phones are sending their RAPs [Request for Anticipated Payment] within two days of admitting a patient," he says. Because many home health agencies don't provide laptops for aides, a smart phone enables the aide to avoid office visits to pick up schedules or submit paperwork, points out Maxwell. "Smart phones offer home health agencies a viable, cost-effective alternative to laptops."

SOURCE

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Oncology CMs guide patients through treatment

Program helps with symptom management

Capital BlueCross members who have been diagnosed with cancer are getting support during all phases of treatment through a new oncology case management program launched in the spring of 2010 by the Harrisburg, PA-based health plan.

The health plan added oncology case management to its specialty case management program after determining that 20% of the patients receiving case management services have a diagnosis of cancer, says **Jennifer Chambers**, MD, MBA, FACP, medical director at Capital BlueCross.

"Patients with a diagnosis of cancer have a unique set of issues. When they hear the word 'cancer,' they tend to shut down, and when they come out of the doctor's office, all they remember is that they have cancer. We created this program to support them during this challenging time," she adds.

The case managers who work with cancer

patients are nurses with extensive case management, home care, and/or oncology experience. They work with Chambers, who is board-certified in internal medicine and palliative medicine, to coordinate care for patients who have been identified through hospital admissions, referrals from physicians, and self-referrals.

The purpose of the program is to help members and families work through difficult issues such as treatment options, symptom management, and life-care planning, Chambers says. Case managers are trained to help patients understand their disease and their treatment options. They help them access educational resources such as the American Cancer Society and the National Cancer Institute and assist them in compiling a list of questions they should ask their doctor at their next appointment.

"We know from evidence-based data that there are five domains where case managers can make a difference: empowerment, adherence and compliance, coordination of care, knowledge, and safety," Chambers says.

Empowerment is the portal to all the other domains, Chambers says.

"When members are educated and understand their treatment plan, they start to feel a sense of control. They may not be able to control the cancer, but they can control when and where they receive treatment, when to make the decision about palliative care, and who to see for a second opinion. We want members to feel educated and informed," she adds.

Patients undergoing cancer treatment often are treated by multiple physicians, including a surgical oncologist, a medical oncologist, and a radiation oncologist, as well as their primary care physician, Chambers says.

Case managers often coordinate with the various treating physicians to make sure they are fully informed about other treatments the patient is receiving, and attempt to coordinate times and arrangements for numerous medical appointments.

They also may consult with treating physicians to advise them of concerns or challenges voiced by patients.

"A primary goal for case managers is to help patients navigate through the health care system and feel more comfortable in making decisions with their doctors. We don't make treatment decisions for the members; we help the members with questions they need to ask to make the best decision for them," Chambers says.

They address safety issues with patients, such as whether they have someone to provide transportation or assist with care at home. They advise them on how to prevent infection and suggest overall ways they can improve safety in the home.

Once patients say they are interested in participating in the program, the nurse case manager completes an assessment to identify the patient's needs and helps him or her develop individual goals and plans.

The case managers base their interventions and frequency of follow-up on the needs each member identifies.

They make periodic calls to check on the patients' progress and work closely with the patient and the treatment team to address any concerns or questions.

"We find these phone calls are very helpful because they provide a sense of confidence and empowerment for the member. They ask the patients about their goals and what they need to accomplish them. The case managers listen to the patients and offer their support and encouragement," she says.

The case manager closes the case when the plan of care developed by the member and case manager is completed and no further needs are identified. If patients need further treatment or support, they may become actively involved in case management again.

During their interventions with the patients, the case managers encourage them to have advance directives in place.

When a patient's cancer progresses to the point that he or she needs palliative and/or hospice care, the case manager helps facilitate a discussion with the physician and gives the patient information about palliative care and hospice options and providers.

"Some patients never want hospice care. They want to continue treatment, even if the cancer can't be cured. But they do want help with pain and nausea. What happens is always the choice of the member. If people are making a conscious decision not to have hospice care, the case managers help facilitate management of symptoms," Chambers adds.

The oncology nurses meet with their supervisor on a routine basis to discuss their feelings and experiences in dealing with patients with a life-threatening disease.

"The case managers are either experienced hospice nurses or oncology nurses, but they often need support in coping with caring for terminally ill

patients. They talk about when they are feeling sad and when they need to take a break and do self-care," she says.

The health plan team spent about nine months developing the program and ensuring that everything the participants would need was in place.

"We like to start working with these patients as early as possible or as soon as they're ready to participate," she says.

The health plan mines its claims data to identify patients who have been hospitalized with a primary or secondary diagnosis of cancer and makes an outreach call after the patients are discharged, following up with a letter asking if the patient would like to participate in the program.

"Some patients aren't ready to participate just after diagnosis. It's an individual decision. Our case managers are there to help them whenever they are ready for assistance," Chambers says.

Initial participants in the program range from patients who have just had surgery for cancer to those who are entering hospice, Chamber says.

"As the program progresses, we anticipate that we will be enrolling the majority of patients in the program much sooner in their cancer treatment regimen," she says. ■

Initiatives reduce readmission rates

Health plan partners with hospitals, PCPs

After two successful pilot projects aimed at reducing readmission rates, Capital District Physicians' Health Plan Inc. (CDPHP) has implemented a program aimed at ensuring that its Medicare Advantage members get the care they need after discharge to avoid a return trip to the hospital.

The pilot projects produced significantly improved readmission rates, dropping from an average of 13% to 14% for members in CDPHP's Medicare Choices plan to an average of 6% to 8% for patients in the pilot, according to **Kirk Panneton**, MD, medical director of senior services at the Albany, NY-based health plan.

"When our Medicare members are admitted to the hospital, we partner with the hospitals and the primary care physicians and follow the patient to their home to make sure their medication is reconciled and that they get back to see their primary care physician in less than seven days," he says.

The readmission rate nationwide for beneficiaries with fee-for-service Medicare is 20%, while it's 15% on average for people who are in Medicare Advantage programs, Panneton points out.

"Right off the bat, Medicare Advantage plans touch people more effectively to keep them out of the hospital. At CDPHP, we offer more than most Medicare Advantage programs and provide more support and education to help prevent readmissions," he says.

The health plan's readmission prevention program, which began in July, "takes the best elements of both pilot programs," Panneton says.

In one pilot, the health plan placed RNs, called inpatient care coordinators, in local hospitals to assist the hospital-based case managers in coordinating care for all CDPHP members.

When a Medicare Choice member in the pilot project was going home, the inpatient care coordinator alerted the health plan's case managers, who called the primary care physician to arrange a follow-up appointment within seven days.

In the other pilot project, the health plan arranged for visiting nurses to see patients in the hospital and introduce themselves, then followed up within 24 hours after the patient was discharged. When the nurse visited these patients after discharge, he or she examined all the medications the patient was taking, evaluated the patient for care needs, and helped set up a follow-up appointment with a primary care physician.

For the pilot projects, the health plan focused on patients who received primary care at several big medical groups in the area with no regard to diagnosis.

"In the pilots, every Medicare Choice member who was chosen to participate received the services regardless of diagnosis. Going forward, we're going to provide the follow-up services for patients who can most benefit," he says.

The vast majority of Medicare members who are hospitalized have heart failure, chronic obstructive pulmonary disease, or coronary artery disease, Panneton points out.

The program focuses on patients with those three diagnoses and any others who the health plan's onsite inpatient care coordinators feel could benefit from the program.

For instance, a patient with a fractured hip may not need follow-up care unless he or she has limited support at home, has several chronic diseases,

or is taking multiple medications.

The new program combines the best approaches from the two pilot programs, Panneton says.

While the new program will cover all lines of business that CDPHP serves, the majority of members served will be within its Medicare population.

Members identified for the program will be seen by a nurse in the hospital, then receive a home visit from a nurse within 24 hours of discharge.

The home visit part of the program strives to reconcile medications, ensure that care needs are being met, and schedule a follow-up appointment with the patient's primary care physician. The nurse will then conduct a follow-up call seven days later to ensure that these processes, and the patient's recovery, remain on track.

Before the pilot projects began, representatives from CDPHP met with representatives of the hospitals in their area, the visiting nurse organizations, and primary care group practices to educate them about the project's goals and to get their buy-in.

"Everybody in health care is trying to reduce readmissions, but those who are the most successful are those that are collaborating with other organizations. When the payer, the hospital, and the primary care provider come together, they are able to make a program happen," he says.

It's a win-win situation for everyone, Panneton says.

"Hospitals have an interest in reducing readmissions because they aren't going to get paid. The visiting nurse agencies are anxious to get more business. The providers are willing to participate because we are giving them extra reimbursement for seeing patients within seven days of discharge," he says.

Capital District Physicians' Health Plan was started 26 years ago by a community of physicians in the greater Albany area, according to **Kevin Mowll**, vice president of Medicare products.

The health plan has about 25,500 members enrolled in its Medicare Choice program, a Medicare Advantage plan. The figure includes about 8,000 retirees who are part of an employer group, Mowll says.

CDPHP expanded its Medicare case management program when Panneton, a physician with years of experience in geriatric medicine, came on board in June 2008.

"At the time, we had only one case manager dedicated to our Medicare population. As the membership has grown, we have expanded the program and now have six case managers dedicated to Medicare beneficiaries," Panneton says.

The health plan created the CDPHP Health Ally program, a voluntary case management program for the health plan's Medicare Choice members and their caregivers, Panneton says.

The program was developed specifically for the Medicare population and takes into account the unique needs of that population and provides support, education, access to the health plan's benefits, and community-based services, he adds.

The health plan makes three outreach calls to Medicare Choice members shortly after their enrollment.

When members enroll in Medicare Choice, they receive a verification call from the health plan's outreach staff to make sure they understand the plan. When they become eligible, the outreach staff call again to walk them through the benefits and ensure that they understand what benefits are available to them, Mowll says.

The third welcome call is from a case manager who completes an assessment that stratifies the members into three groups based on their likelihood of using health care services, Panneton adds.

"Our Health Ally program is designed to touch all new Medicare members by the telephone and to conduct a brief health survey," Panneton says.

Based on their response to the health survey and probability of needing health care resources, the members are referred to health plan programs that can meet their needs.

Members who are fairly healthy are referred to the health plan's SeniorFit program, a free health, exercise, and wellness program for older adults.

Seniors with one or two chronic diseases, such as a diabetic with hypertension, are referred to disease management, where they receive education on their chronic condition and how to keep it under control and are encouraged to see their physician regularly.

About 5% to 10% of beneficiaries in the program are among the most frail and sick members and are assigned a case manager, who contacts them regularly and offers support and counseling and helps them find resources to meet their needs.

"Our case management program has grown significantly, and our Health Ally program has helped us stratify the members and help them get the services they need," Panneton says.

The advantage of the Health Ally program is that CDPHP is able to identify the needs of members without waiting for claims data, Panneton point out.

"If we wait for claims to come in, we are always three to four months behind. Our program helps us find out more about the membership when they enroll and start working with them to help them avoid unnecessary hospitalizations and emergency room visits. Our case managers work with our members to help them keep their conditions under control and educate them so they can make informed decisions," he says.

"The Health Ally program was a big strategic move to meet the challenge of finding out more about the membership so we can take a proactive approach to help them manage their health care," he says. ■

Depression increases risk of dementia

People who experience depression have more than a 50% increased risk of developing dementia or Alzheimer's disease later in life, according to a study published in *Neurology*, the medical journal of the American Academy of Neurology.[1]

Researchers examined data on 949 people with an average age of 79 from the Framingham Heart Study. At the start of the study, participants were free of dementia and were tested for depressive symptoms, based on questions about general depression, sleep complaints, social relationships, and other factors. A total of 125 people, or 13%, were classified as having depression at the start of the study.

The participants were followed for up to 17 years. At the end of the study, 164 people had developed dementia, with 136 specifically diagnosed with Alzheimer's disease. Nearly 22% of people who were depressed at the start of the study developed dementia compared to about 17% of those who were not depressed, a 70% increased risk in those who were depressed. The 10-year absolute risk for dementia was 0.21 in people without depressive symptoms and 0.34 in people with depressive symptoms. The results were the same regardless of a person's age, sex, education and whether they had the APOE gene that increases a person's risk of Alzheimer's disease.

Researchers point out that it is unclear if depression causes dementia, but there are ways that depression can impact the risk of dementia. Inflammation of the brain tissue, along with an increase in certain proteins in the brain that occurs in depression, might contribute to dementia, the authors suggest. Lifestyle factors affected by long-term depression, such as quality of diet and amount of exercise and social interaction, might also affect the risk of developing dementia, they point out.

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Saczynski JS, Beiser A, Seshadri S, et al. Depressive symptoms and risk of dementia. *Neurology* 2010;75:35-41. ■

Payment changes proposed for 2011

Payment changes proposed by the Centers for Medicare & Medicaid Services (CMS) represent a 4.75% decrease in Medicare payments to home health agencies (HHAs) for calendar year (CY) 2011. This is an estimated net decrease of $900 million compared to payments HHAs received in CY 2010. It includes the combined effects of a market basket update, a wage index update, reductions to the home health prospective payment system (HH PPS) rates to account for increases in aggregate case-mix that are unrelated to underlying changes in patients' health status, and other provisions mandated by the Affordable Care Act (ACA) of 2010.

The ACA mandates that CMS apply a 1% point reduction to the CY 2011 home health market basket amount, which equates to a proposed 1.4% update for HHAs in CY 2011. CMS also proposes to further reduce HH PPS rates in CY 2011 to account for additional growth in aggregate case-mix that is unrelated to changes in patients' health status. Based on updated data analysis, instead of the planned 2.71% reduction

for CY 2011, CMS proposes to reduce HH PPS rates by 3.79% in CY 2011 and an additional 3.79% in CY 2012.

The ACA also changes the existing home health outlier policy through a 5% reduction to HH PPS rates, with total outlier payments not to exceed 2.5% of the total payments estimated for a given year. HHAs are also permanently subject to a 10% agency-level cap on outlier payments.

The proposed rule also offers an approach to implement an ACA provision, which mandates that, prior to certifying a patient's eligibility for the Medicare home health benefit, the physician must document that the physician or a non-physician practitioner has had a face-to-face encounter with the patient. ■

Practices evaluated for pain assessment

Cancer hospice patients examined

A study published in the *Journal of Pain and Symptom Management* finds gaps in the use of evidence-based pain assessment and treatment practices for older adults with cancer in community-based hospice settings.[1]

Using a tool developed by the researchers to measure evidence-based pain management practices, patients received an average of 32% of those key evidence-based practices that were applicable to their situations. When examining individual practices, most of the patients had their pain assessed at admission using a valid pain scale (69.7%) and had primary components of a comprehensive assessment completed at admission (52.7%); most patients with admission reports of pain had an order for pain medication (83.5%).

Data did reveal a number of practice gaps, including additional components of a comprehensive assessment completed within 48 hours of admission (0%); review of the pain treatment plan at each reassessment (35.7%); reassessment of moderate or greater pain (5.3%); consecutive pain reports of 5 or greater followed by increases in pain medication (15.8%); monitoring of analgesic-induced side effects (19.3%); initiation of a bowel regimen for patients with an opioid order (32.3%); and documentation of both nonpharmacological therapies (22.5%) and written pain management plans (0.6%).

The authors conclude that although hospices are using some best practices for pain assessment and treatment, there are many areas in which hospices can improve.

REFERENCE

1. Herr K, Titler M, Fine P, et al. Assessing and treating pain in hospices: current state of evidence-based practices. *J Pain Symptom Manage* 2010; 39:803-819. ■

TJC counsel underscores privacy commitment

The Joint Commission (TJC) is underscoring its commitment to keep accreditation records confidential and its willingness to resist prosecutors' requests as far as the law will allow.

Hal Bressler, JD, general counsel to TJC in Oakbrook Terrace, IL, says that the accreditation process and quality improvement efforts depend on providers sharing sensitive information with TJC, and that the group realizes confidentiality is paramount to that exchange.

"We take this extremely seriously in terms of maintaining the confidentiality of accreditation information," Bressler says. "We have taken it extremely seriously from the beginning. In the 1980s, we accepted a contempt citation and took the question of confidentiality of these documents up to the Illinois Supreme Court. We have an Illinois Supreme Court decision from 1985 that says our documents are privileged under the Illinois Medical Studies Act and not subject to production."

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Recent concerns about records

TJC's ability to keep prying eyes out of accreditation records was questioned after a recent court case in Kansas. The Headache & Pain Center in Leawood, KS, is under investigation for alleged federal offenses, and a federal prosecutor was able to access the organization's TJC accreditation records, explains **Robert Guenthner**, JD, a partner with the law firm of Sonnenschein Nath & Rosenthal in Chicago, who has studied the case. TJC resisted the prosecutor's request, on the basis that Illinois law prohibited the release of the information.

The prosecutor then obtained a court order from a federal court, and TJC complied. Some sensitive information, such as patient names and all communication related to sentinel events, was redacted. The order also included strict limits on the dissemination of the information, Guenthner says.

Federal law can supersede the Illinois peer review statute that TJC relies on to refuse records requests, but even then TJC requires a federal court order, not just a subpoena, Bressler says.

TJC's legal position is that the federal court is supposed to balance the federal need for the documents against the obligation to recognize the state privilege if it can, Bressler says. The federal court isn't supposed to just say that there is no federal peer review protection but rather to balance the competing needs.

That is why the position of the TJC is that the subpoena alone is not good enough, that the federal court must enter an order for the TJC to produce the documents, along with redaction, return of the documents, and other requirements, Bressler says.

"Everything we do in this regard is because we realize candid communication is critical to our mission of improving care and improving patient safety," Bressler says. "We don't do that to help anyone win a lawsuit. We're neutral in litigation, but we are not neutral on maintaining the confidentiality of our materials and communications."

Records don't yield much

In fact, Bressler points out that TJC still will not confirm or deny that the Headache & Pain center was involved in the recent Kansas dispute over

CNE QUESTIONS

21. By what amount were Medicare costs reduced in the first year of the Centers for Medicare & Medicaid Services' Home Health Pay for Performance demonstration?
A. $4 million
B. $8 million
C. $15 million
D. $18 million

22. How did participation in the Centers for Medicare & Medicaid Services' Home Health Pay for Performance demonstration affect the majority (more than 50%) of home health agencies' costs?
A. Decreased costs by 4%
B. No change in costs
C. Increased costs by less than 1%
D. Increased costs by 5%

23. Which of the following is NOT included in the quality measures evaluated for the Centers for Medicare & Medicaid Services' Home Health Pay for Performance demonstration?
A. Improvement in ambulation/locomotion
B. Improvement in bathing
C. Improvement in transferring
D. Improvement in bladder control

24. What technology does Tom Maxwell, chief operating officer of Homecare Homebase, a home care software development company in Dallas, recommend to improve efficiency and productivity for home health nurses and aides?
A. Smart phones
B. Laptops for use in home
C. Telehealth
D. Agency funded Internet service in clinician's homes

Answer Key: 21. C; 22. C, 23. D, 24. A

releasing records.

"The documents that were made public do not include the name of the organization in question, and we take this so seriously that I won't confirm or deny who that subpoena was issued under," he says.

Even in the few cases in which investigators were successful in obtaining TJC records, Bressler says prosecutors have not found much information useful to them. The most sensitive documents, such as the official accreditation report and TJC findings, take the form of confidential communication between TJC and the provider, he explains.

"That means that if the prosecutor is truly interested in obtaining those items, there are two places where it can be found: The Joint Commission and the organization," he says. "That's one reason we get so few of these requests."

SOURCES

For more information on the Joint Commission's commitment to confidentiality, contact:

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- **Robert Guenthner**, JD, Partner, Sonnenschein Nath & Rosenthal, Chicago. Telephone: (312) 876-8961. E-mail: rguenthner@sonnenschein.com. ■

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify the 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 **September** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

Hospital Home Health
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HHH090110TM

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at right.

Please make label address corrections here or PRINT address information to receive a certificate.

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CNE Evaluation: Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your certificate**.

CORRECT ● **INCORRECT** ⊘ ✓ ✗ ⋀⋀

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After participating in this program, I am able to:						
2. Identify the clinical, ethical, legal, or social issues particular to home health care.	○	○	○	○	○	○
3. Describe how the clinical, ethical, legal, or social issues particular to home health care affect nurses, patients, and the home care industry in general.	○	○	○	○	○	○
4. Integrate practical solutions to the problems faced by home health professionals into daily practices.	○	○	○	○	○	○
5. The test questions were clear and appropriate.	○	○	○	○	○	○
6. I detected no commercial bias in this activity.	○	○	○	○	○	○
7. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
8. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

9. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

10. Do you have any general comments about the effectiveness of this CNE program?

_____

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Name (printed) _____ **Signature** _____

Nursing license number (required for nurses licensed by the state of California) _____