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IN THIS ISSUE

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Why doesn't your agency volunteer for the P4P demonstration project?

Abt, CMS in the final design stages for the project

You've read the headlines. You've seen the advertisements for the conferences. You're bombarded daily with articles and seminars that promise to tell you how to prepare for the Centers for Medicare and Medicaid Services' Pay-for-Performance (P4P) program.

While all of this information is helpful, there is one way to absolutely find out if your agency is ready for pay for performance, says **Henry Goldberg**, project director for Cambridge, MA-based Abt Associates and director of the pay-for-performance demonstration project. "Volunteer to participate in the demonstration project," he says.

There are no risks to participants in the demonstration project and there are definitely rewards, points out Goldberg. Although some pay for performance models do have a mechanism for withholding portions of payments from lower performers and using that money to reward higher performers, the CMS P4P demonstration project is self-funded, he says. The financial incentives distributed to high performers will be generated by the amount of money saved in costs to CMS through improved efficiency and better outcomes, he says.

The benefits to agencies include the potential for monetary rewards for high levels of performance and improvement in different outcome categories over time, Goldberg says. "There is also a marketing advantage to agencies that participate in the project because they are proving that they are forward thinking and outcome oriented," he says.

"There is no burden or cost to agencies participating in the demonstration project," points out Goldberg. "The data that will be used in the project is data that agencies are already collecting and the outcomes are outcomes that agencies are already working," he says. **(For list of outcomes, see box, p. 50)**

Abt Associates and CMS are in the final design stages for the project, says Goldberg. "I expect the design to be completed and approved in late May or June of 2007, then we will accept applications for participants," he says. "I expect operation of the demonstration project to start on October 1, 2007," he says. The two-year study will be run as a formal scientific study, which means that participants will be assigned to a P4P group or to

a control group. While participants have no choice as to which group they are assigned, it is important to get as many agencies involved in the demonstration project as possible, even if the agency is part of the control group, he says. The higher the number of agencies in the project, the better the information that will be used to make changes to the final design that will apply to all home health agencies after the demonstration, he explains.

The most appropriate agencies for the project are those agencies that have systems and programs in place to perform well in the different outcome areas or to show improvement in these areas over time, says Goldberg. At this time there are no geographic restrictions but when the final participants are chosen, the project will probably include groups of agencies in certain states or regions, he explains. ■

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RESOURCE

For updates and information on the CMS Pay For Performance Demonstration Project, go to www.hhp4p.info.

Outcomes for P4P project already measured

Agencies don't have to collect additional data

The proposed performance measures presented in December 2006 will be the outcomes used in the Pay for Performance Demonstration Project, with the possibility of an additional outcome or two, says **Henry Goldberg**, project director for Cambridge, MA-based Abt Associates and director of the pay for performance demonstration project.

Performance measures are:
- Incidence of acute care hospitalization;
- Incidence of any emergent care;
- Improvement in bathing;
- Improvement in ambulation/locomotion;
- Improvement in transferring;
- Improvement in urinary incontinence;
- Improvement in management of oral medications;
- Improvement in status of surgical wounds.

Address legal and ethical issues related to P4P

Inappropriateness and non-compliance

The Centers for Medicaid and Medicare Services' Pay For Performance Demonstration Project will test and identify data collection and measurement, and financial incentive approaches for a home health pay for performance system but it may emphasize some legal and ethical issues as well.

"We don't have details on the pay-for-performance program's final design or what legal and

ethical issues will be raised but it is important that agency managers be prepared to address two issues now," says **Elizabeth E. Hogue** Esq., a Burtonsville, MD attorney. The most critical legal or ethical issues are appropriateness for home care services and the non-compliant patient, she says.

Advances in technology and increased skills and education of nurses and therapists have expanded the services that can be offered to patients in the home, but not all referral sources understand the limitations that may exist within the patient's home or family, points out Hogue. She says that patients who are referred to home care must meet the following criteria:

- Patients' clinical needs must be able to be met in their homes.
- Patients must either be able to care for themselves or they must have a paid or voluntary caregiver available to meet their needs between visits from professional staff.
- Patients' home environments must support home health services.

While home care nurses and therapists can usually meet the clinical needs of patients, not all patients have the home environment or the caregiver support necessary for home care, explains Hogue. Referral sources should make every effort to determine if patients can care for themselves or if there is another caregiver available, she says. There are times, however, when referral sources may realize that home care may not meet all of the patient's needs but if the patient refuses nursing home admission, the referral source may decide some care is better than none, she says.

The challenge for home care nurses comes at the time of the initial assessment, says Hogue. "Conditions of Participation for Medicare state that the first visit to a patient's home must be an assessment visit that evaluates not only the type of care needed by the patient but also the appropriateness of home care for the patient," she says. "Failure to assess patients during the initial visit and acceptance of all patients based on referrals regardless of other factors may violate national standards of care," she adds.

Not only may home care providers be liable for injuries that occur when inappropriate patients are admitted for home, but referral sources may be liable as well, says Hogue. Additionally, home care agencies that must expend an inordinate amount of staff time and other resources for inappropriate patients are potentially reducing care to appropriate patients and that presents both a financial and an ethical dilemma, she adds.

Make sure that staff members as well as referral sources understand that the patient is not accepted for home care until after the initial assessment, suggests Hogue. If the patient is not appropriate for home care, contact the initial referral source so that other arrangements can be made for the patient. "If the problem is a lack of a family caregiver, the home health agency may be able to provide private duty staff to serve as caregivers," she suggests. In any case, the referral source needs to know that the patient is not appropriate for home care or needs other assistance, she adds.

Non-compliant patients pose problems

One of the keys to successful outcomes and success within a pay-for-performance system is a compliant patient. "The non-compliance of wound care patients is legendary," says Hogue. "Diabetic patients do not stick to their diets, family caregivers do not follow instructions for dressing wounds, and bed bound patients do not regularly change positions," she explains.

While it is easier to overlook non-compliance, it is imperative that home care staff members take action to bring caregivers and patients into compliance, or discontinue services, says Hogue. Not only are financial outcomes related to pay for performance affected by non-compliant patients, but also agencies are at risk for legal liability because it is difficult to separate substandard care from non-compliance by caregivers and patients, she points out. Home care agencies cannot afford either the legal risk or the reduction in reimbursement that non-compliance can cause, she adds.

Although documentation is important in all aspects of patient care, it is especially critical for non-compliant patients and steps taken by staff members to address non-compliance, says Hogue.

- Document every non-compliant action.

Staff must document every instance of non-compliance by both patients and/or their primary caregivers regardless of the risk associated with the non-compliant behavior.

- Documentation must be very specific.

Hogue points out that it is not sufficient to document as follows: "Patient (or primary caregiver) non-compliant." She says that providers, for example, may document the failure to change the diapers of a bed-bound patient who is incontinent of both bowel and bladder as follows: "RN

discovered patient with urine and feces in diaper. RN removed diaper, cleaned patient and placed clean diaper on patient. RN marked the right tab of the clean diaper with a red X. When the RN visited the following day, the patient was again lying in urine and feces. When the RN removed the diaper, she observed a red X on the right tab of the diaper the patient was wearing when she arrived."

• **Counsel patients and caregivers.**

Staff must counsel patients or primary caregivers regarding each instance of non-compliance and document that they have done so, says Hogue.

"The number of times practitioners are willing to repeat this protocol depends on the risk of injury/damage to patients associated with the non-compliance," says Hogue. She warns, "If patients are likely to be injured or damaged, providers should not tolerate additional instances of non-compliance after taking the above steps." ■

SOURCE

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Cover pediatric underfunding with new services

Staff responsible for verifying insurance info

Not only do home health agencies with pediatric services face the daunting task of finding staff members qualified for pediatric patients (See "Keep pediatric skills high with competencies and education," *Hospital Home Health*, March 2007, p. 25), but agency managers also deal with reimbursement problems that don't exist for adult populations.

"Our biggest challenge is the fact that reimbursement amounts set by Medicaid, Medicare, and most private insurers, are based on adult care," says **Wanda Stackpole**, RN, vice president of Children's Homecare in Columbus, OH. Pediatric patients are not just smaller versions of adult patients, so home care staff members spend a lot of time justifying the costs for everything needed for patients, she says.

"Our patients are constantly growing and as they grow, their needs change," explains Stackpole. Equipment and supply sizes change as the child grows, so there is a need to acquire new equipment and supplies during the course of care, she says. Because adults don't change as frequently as children, it is important to document the reasons for changes thoroughly, she says.

Overhead costs for pediatric services are typically higher because you are providing a higher level of nursing care for most patients, says Stackpole. Infusion nurses must be able to calculate doses based on weight that will change from visit to visit, she points out. "We also have to be able to evaluate patients who cannot tell us how they are feeling," she adds.

The good news is that some states do have home health care waivers for medically fragile children, says Stackpole. It is important for a home health manager to thoroughly understand his or her state's standard home health benefit as well as any additional benefits that may be available to children, she adds.

It is also important to participate in negotiations with managed care companies, especially if your agency is part of a hospital or health system, and is typically included in the blanket contract, points out Stackpole. "Be ready to explain that you cannot safely save money by infusing a pediatric patient with a drip infusion as opposed to a pump, and that your nurses do need to use a variety of blood pressure cuffs because one size does not fit all," she says.

Evaluate new services

One way to cover the costs of care that is underfunded is to develop new services that generate revenue. "We have looked at a variety of services that can bring in money to underwrite unfunded care," says Stackpole. While she did evaluate the possibility of providing some adult care, that approach to new services was not taken, she says. "We decided that our expertise is in pediatrics and we needed to stick with what we know best," she says.

An example of adult care that her agency chose not to pursue was the antepartum care in a new mom and baby program, explains Stackpole. "While we were comfortable providing some of

the postpartum assessments along with the newborn assessments, antepartum care was not part of our core competencies because it is adult care," she explains.

"For many years we've had a contract with the child protective services department in our area to provide an after hours nurse to conduct medical screenings for children that come into their custody in the evening," explains Stackpole. "This is a low cost service for us to provide because we already have nurses who are on call in the evenings, the screenings are not complicated, and the services are in line with our expertise," she adds.

Stackpole has also evaluated wellness programs such as assessment programs for high-risk infants. "It is important to know what is going on in the cities and counties in your service area," she suggests. There may be a health department that either wants to offer or is offering such a program but could use a community partner in the venture, she says. Identification of these opportunities is easier if the administrator and managers of the home health agency are involved in community organizations that relate to pediatric services, she points out.

Foundations and community grants do offer another source of funding but sometimes the grants are designed to address the needs of large populations, points out Stackpole. To find grants that may support efforts to address smaller, narrower niches of patients, look in your own community and within organizations for which your employees volunteer, she suggests. "Check out county, city, and state health department websites and state home health associations," she adds.

Evaluate your own data collection

In addition to looking for new ways to bring in revenue, it is also important to evaluate current practices to make sure you're collecting everything you should be collecting, points out Stackpole. "A couple of years ago we were losing a lot of money so we looked at every aspect of our operation," she says. Although as much information as possible was collected at the front-end of an admission, Stackpole's nursing staff was not involved in verifying information as visits were made. "Now, all nurses verify information as visits are made to make sure that we know about insurance changes," she explains. "This is very important in our state as families move from traditional Medicare to managed care," she adds.

At first nurses and other clinicians were not comfortable addressing financial issues but ongoing education and explanations of what the accurate information meant to the agency in terms of collecting proper reimbursement have eliminated the resistance, admits Stackpole. "The pharmacists in our infusion service were most resistant because they believed their focus should be on patient safety, proper dosing, and verifying prescriptions," she says.

Educational sessions for staff members addressed the importance of verifying information beyond the initial assessment visit, says Stackpole. "Long-term patients are at highest risk of changing insurance and it is not uncommon for us to have some patients in our service for years," she adds.

The importance of accurate documentation, especially for long-term patients who undergo many changes in equipment and medication needs, was another point covered in staff education, says Stackpole. "It is essential that the medical necessity for the change be clearly described in the documentation to ensure a clean claim," she explains.

Telling employees about the need to verify coverage and document accurately was not the only step Stackpole's agency took to underscore the importance of these jobs being undertaken by all staff. "We incorporated these activities in our job descriptions and job competencies," she says.

"As pediatric providers, it is easy for all of our staff members to get caught up in the emotional side of caring for little ones," admits Stackpole. She adds, "Our emphasis on everyone taking responsibility for making sure we were reimbursed properly helped all patients because it ensures that we have funds for patients who may not have coverage." ■

SOURCE

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First hospice PACE program opens doors

Hospice director lists benefits to program

The hospice mission shares many of the goals and features of the mission of the Programs of All-inclusive Care for the Elderly (PACE), and so for hospices with enough resources, initiating a PACE program is a natural fit.

"PACE is about palliative care — trying to help people stay comfortable in the end of their days," says **Karren Weichert**, president and chief executive officer of Midland Hospice Care of Midland Care Corp. in Topeka, KS. Midland became a PACE provider on February 1, 2007, making it the first hospice to open a PACE program.

"I think PACE fits in with what hospices are doing, and needing to become, to serve a greater population," Weichert says.

PACE also provides hospices with an avenue for growth to maintain a competitive edge, she says.

"I think most hospices today are looking at the competition and their own viability, and even though we're hearing about how hospice is growing, it's growing with some growing pains," Weichert says.

Hospices that need to stay competitive should look at the strategic plan and think as far ahead as 2020, she suggests.

"If you are looking at palliative care at all, then I think that looking at a PACE program would be a good fit," Weichert adds.

"PACE is a new model of care and a culture change," Weichert says. "It's a nursing home without the walls, and the reason this is such an easy transition for a hospice to make is because there are so many similarities between hospices and PACE — even in the regulations."

Hospice care and PACE are similar models, and PACE is a natural outgrowth of hospice care and could have a symbiotic relationship with hospices, says **Shawn Bloom**, chief executive officer of the National PACE Association in Alexandria, VA.

PACE programs are a model of care that provide all preventive, primary, acute, and long-term care services to people who are ages 55 years and older and who are certified by their state to need nursing home care so they can live as independently as possible.

PACE programs receive Medicare and Medicaid capitation payments to assume full financial risk for enrollees' care. So far, there are 38 PACE programs in 20 states, with another 20 programs expected to be opened in 2007, Bloom says.

"We are looking at the doubling of PACE in the next few years," he adds.

The focus point of PACE services is an adult day center where PACE enrollees receive a multitude of health care and support services from dental care to physical therapy. And this is augmented with home care and common sense approaches to whatever services are needed to keep enrollees out of nursing homes and hospitals, Bloom explains.

Midland Hospice Care has had an adult day center since 1992. It was started to complement hospice services, Weichert says.

"It was a safe place for hospice patients to go during the day, and it gives caregivers a break," Weichert says.

In recent years, as the length of stay among hospice patients declined, interest in adult day centers increased among families of chronically-ill older adults, Weichert notes.

"We'd have people call us to see if family members who had strokes or Alzheimer's disease could come to the day program," she says. "Pretty soon, it became a community program for frail elderly adults in the community, completely separate from hospice, although we still had some hospice patients."

The National Hospice and Palliative Care Organization (NHPCO) contacted Midland Hospice to see if the hospice would be interested in becoming a PACE site, as the National PACE Association was looking for more health care providers and others to open PACE programs, Weichert recalls.

"So in 2002 we began to explore that opportunity and what it might involve," she says.

Weichert visited existing PACE sites, and the hospice decided PACE would be a natural fit with the existing adult day program and the hospice's existing expertise.

The next steps were to complete a lengthy application form, and hospice officials asked the Kansas state legislature for PACE funding, Weichert says.

The PACE program finally opened this year, with an adult day program that can enroll up to 75 people and a day center that can serve 51 people at any given time.

The hospice had existing space in which to open a clinic within the day center, and there

were facilities with therapy space and men's and women's shower rooms for assisted bathing, so necessary infrastructure was in place, Weichert says.

"We had an advantage where we didn't have all of the upfront costs some sites might have if they were starting from scratch," Weichert says.

PACE sites have to bear the burden of implementing the program, so some organizations will collaborate with health care systems in their community, or they'll seek grants to pay for start-up costs, she notes.

However, CMS recently announced $7.5 million in competitive grants that are being awarded to 15 rural health care provider organizations for the purpose of developing PACE sites. The organizations that will receive a $500,000 grant to support development of a rural PACE program include the Hospice of Siouxland in Sioux City, IA.

Midland's PACE staffing needs were supplemented with contracts, although the hospice did hire staff to coordinate the PACE data, as well as monitor performance improvement.

"We have contracts with therapists, and we use them when we need to, but it is our hope to have our own physical therapist on staff, and we're searching right now," Weichert says.

Demonstration projects from the 1990s showed that a PACE approach can save states Medicare money. PACE provides a variety of services, including transportation, meals, social interaction, and health care to keep frail and older adults from entering nursing homes or from becoming frequent fliers at hospitals. When these patients need end-of-life services, PACE can contract with hospices to provide hospice care, as well, Bloom says.

"The rule of thumb, according to a government study, is that PACE saves Medicare 40%," Bloom says.

The mean Medicaid payment per PACE enrollee who is Medicaid eligible is about $3,000 per month, and the mean Medicare payment per PACE enrollee who is Medicare eligible is about $2,000 per month, Bloom says.

For enrollees who are dual eligible, as are enrollees at PACE providers, the monthly capitation payment of roughly $5,000 per patient covers all drugs, hospitalizations, specialty visits, therapy, transportation, meals, day care services, etc., Bloom says.

Some providers are pre-PACE providers who operate solely under Medicaid contracts for long-term care services only, and these sites are expected to become PACE providers in the near future.

Hospices can contract with PACE sites, but when Bloom speaks before national hospice , he outlines the benefits to hospices that decide to become PACE providers. Bloom is next expected to discuss PACE at the 22nd Management and Leadership Conference, sponsored by NHPCO, April 19 - 21, 2007, in Washington, DC.

"I think hospices that have approached us have generally approached us with an interest in PACE," Bloom says.

Hospices have a lot of competencies that are a good starting point for PACE, so there's a natural fit, he adds.

"We routinely provide end-of-life care to individuals in PACE," Bloom says. "And if you look at the place of death among PACE patients, you will see that our place of death statistics are on par with hospice, in terms of giving people the opportunity to die at home, as opposed to in an institution."

The Centers for Medicare & Medicaid Services memorandum clarifies that PACE organizations can contract with hospices for providing end-of-life care and palliative care to PACE enrollees, Bloom says.

So far, maybe five to 10 PACE sites contract with hospices, and the others provide in-house palliative care services, since many of the medical directors are board-certified in palliative care, he adds.

"Most of our folks have comorbidities, and the average enrollee is in the program for 2.5 to three years," Bloom says. "They form very strong relationships with the PACE staff."

In the case of Midland Care Connection's PACE, there will be a natural relationship between the hospice and PACE.

"We have an interagency agreement to provide hospice services to our PACE participants," Weichert says. "PACE patients can't be transferred to the hospice benefit, but we contract with our-

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selves to provide a hospice team, when necessary, and so that becomes a part of the review we do in PACE, and the hospice team becomes part of the interdisciplinary team." ■

Kansas hospice describes how PACE program works

Participants receive day-long help

The first hospice to implement services under Medicare/Medicaid's Programs of All-inclusive Care for the Elderly (PACE) has made the philosophical skip to expanding its care to the frail and elderly who are not hospice-eligible.

"PACE is about helping people maintain the highest cognitive and physical levels possible, and it's about wellness, coordinating, and managing care, and it's more palliative in nature than aggressive," says **Karren Weichert**, president and chief executive officer of Midland Hospice Care of Midland Care Corp. in Topeka, KS.

"It's aggressive to the point that you want to help people maintain their independence," Weichert says. "There are some aggressive components in terms of how much physical therapy and occupational therapy a person needs, but our goal is to keep people healthy as long as possible so they can focus on their quality of life."

When the Midland Care Corporation's PACE program officially opened February 1, 2007, it consisted of an adult day center in which 51 frail, elderly people could receive services on any given day. It also has a clinic, showers, and a therapy room.

The PACE team is interdisciplinary and consists of a nurse, social worker, home care coordinator, clinic nurse representative, a transportation coordinator, adult day center site director, an occupational therapist, a physical therapist, a dietitian/nutritionist, and a physician. A speech therapist is called in when deemed necessary, Weichert says.

"Essentially, PACE provides everything a participant needs in terms of health support services, from the primary care to cardiologists, to eyeglasses, to a podiatrist, to a wheelchair and lifeline in case the person falls," Weichert explains. "We even provide meals if the person needs them, we help to keep the person's diabetes under control, and we provide all pharmaceutical needs."

PACE enrollees typically meet eligibility requirements for both Medicaid and Medicare, as well as for these 4 criteria:

- they are age 55 or older;
- they live in the service area of the PACE site;
- they meet the threshold score set by their state to be eligible for long-term care services; and
- they have the ability to live safely in the community with supports in place.

If the potential enrollee is already on Medicaid, the enrollment could be concluded in as little as 10 days, Weichert says.

"If someone is filling out the Medicaid application, too, it could take 45 to 50 days," she says. "From the time we get our information into the state for their assessment in determining the frailty score, the state will take about 48 hours to turn it around, so the process can be quick if the other components are in place."

A typical PACE enrollee may be 85 years-old with congestive heart failure. He will have had a stroke and is wheelchair bound. PACE staff will encourage him to attend the day center as much as possible after first bringing him to the center on a trial basis, Weichert says.

Once enrolled, the man is assessed by a nurse, a physician, a dietician, occupational/physical therapists, and an activities coordinator.

"They talk to the patient about what his goals are, and we develop a plan of care around the goals," Weichert says.

Goals might be as simple as these:

- "I want to be able to transfer myself to go to the bathroom."
- "I want to get out of this wheelchair."

"These people want to live as fully as possible, so we develop a plan of care around that idea," Weichert says.

The recommended course of action might be to have the person come to the day center three days a week. PACE will send someone to the person's home to get him ready and to pick him up. Once at the center, the person will be given physical therapy by a physical therapist or physical therapy assistant, Weichert says.

The person will receive a consultation with the dietitian, as well as see the nurse practitioner once a week. The physician will see the person once a month unless the health needs are complicated, she adds.

"We will involve the person with a product called 'It's never too late,'" Weichert says. "It's an interactive computer system that's great to utilize to improve cognitive and physical ability."

The PACE enrollee also will have lunch while at the day center, and he'll receive a teeth cleaning from a dental hygienist. If the person has an appointment with a cardiologist or another specialist, PACE staff will transport him to the appointment, stay with him during the doctor's visit, and then escort him back to the day center, Weichert says.

"Then we'll take him home in the evening, and we'll send out a home health aide to get him ready for bed, prepare his evening meal, and let the dog out before he settles in for the night," she adds. ■

MRSA rampant among patients on dialysis

Emerging vancomycin resistance also linked

The rate of invasive methicillin-resistant *Staphylococcus aureus* (MRSA) infection in dialysis patients is higher than for any other known patient population and is 100 times higher than for the general population, the Centers for Disease Control and Prevention reports.[1]

In 2005, the incidence of invasive MRSA infection among dialysis patients was 45.2 cases per 1,000 population. People receiving dialysis are at high risk for infection with invasive MRSA compared with the general population, in which rates of invasive MRSA have ranged from 0.2 to 0.4 infections per 1,000 population. The findings "underscore the need for continued surveillance and infection-control strategies aimed at reducing infection rates and preventing additional antimicrobial resistance among persons receiving dialysis," the CDC emphasized. The CDC report refers ICPs to 2001 infection control guidelines for dialysis, which emphasize that standard precautions – as opposed to more rigorous contact isolation measures — are generally adequate for dialysis settings. However, the emerging data on MRSA raise the question of whether lack of compliance with infection control measures is a part of the problem. In a nutshell, could dialysis settings be amplifying the problem?

"We know that adherence to infection control guidelines is a challenge in many settings," says **Cynthia A. Lucero**, MD, an epidemic intelligence service officer in the CDC's division of healthcare quality promotion. "This [dialysis] study did not attempt to assess adherence to infection control guidelines by physicians or dialysis center personnel or the effect of treatment in a dialysis center setting on the risk of infection. I am not aware of any U.S. study that has specifically done that. Hopefully, this report will serve to inform or remind individuals providing care to dialysis patients that recommendations for preventing transmission of infections and antimicrobial resistance among dialysis patients have been published by CDC and are available for reference. Care providers may wish to review these recommendations to make sure that risks of infection are minimized where possible."

The number of dialysis patients continues to increase. The dialysis population reached 335,963 at the end of 2004, triple the number from 1988 and up 16% since 2000, the CDC reports. Repeated hospitalizations and surgeries along with administration of prolonged courses of antimicrobial agents increase exposure to potential pathogens and create opportunities for antimicrobial resistance in the dialysis population.

Hemodialysis patients are especially vulnerable to vascular-access infections because they require vascular access for prolonged periods and undergo frequent puncture of their vascular-access site, the CDC noted. The primary risk factor for bacterial infections among dialysis patients is vascular-access type. Risk is highest for catheters, intermediate for grafts, and lowest for native arteriovenous fistulas. Despite higher rates of bacteremia among patients with catheters, the percentage of U.S. dialysis patients with an indwelling hemodialysis catheter is increasing. The most basic strategy to prevent catheter-related bacteremias, including invasive MRSA infections among hemodialysis patients, is minimizing the use of catheters for long-term vascular access, the CDC emphasizes.

"Where possible, alternate means of vascular access for hemodialysis treatment should be considered," Lucero says. "Arteriovenous fistulas and grafts have lower risk of infection than catheters but may not be appropriate for all patients. When catheters are necessary, health care workers should be sure to maintain good hand hygiene and infection control practices, including proper needle insertion technique."

Reference

1. Centers for Disease Control and Prevention. Invasive Methicillin-Resistant *Staphylococcus aureus* Infections Among Dialysis Patients — United States, 2005. *MMWR* 2007; 56(09): 197-199. ■

Patients discharged on Fridays likely admitted

In an article entitled "Data Analysis Exercise: Beware of 'Friday's Child,'" that appeared in "*Home Care Automation Report*" on October 31, 2006, **Tim Rowan** reported on a presentation at the most recent National Association of Home Care (NAHC) meeting by Jeff Lewis from Lewis Computer Systems in Baton Rouge, LA. Based on his research, Mr. Lewis was able to present conclusive data that patients discharged from hospitals to home care on Fridays are significantly more likely to be rehospitalized within a week than patients discharged on other days of the week.

Of course, the reasons for this disparity remain unclear. One explanation could be that hospital discharge planners/case managers are too anxious to discharge as many patients as possible before the weekend so that patients are going home who really do not belong there yet. Regardless of the explanation, this data spells potential trouble for hospital discharge planners/case managers.

Conditions of Participation (COP's) of the Medicare Program for hospitals include requirements related to discharge planning. Specifically, these COP's make it clear that hospital discharge planners/case manager must assess and evaluate patients for discharge planning purposes. They are also required to develop and implement appropriate discharge plans.

If patients whose plans of care include home health services are rehospitalized within a week, and in view of the disparities described above, patients and/or their family members may claim that hospital discharge planners/case managers were negligent. Specifically, according to national standards of care in Medicare COP's as described above, discharge planners/case managers have a duty to develop and implement appropriate discharge plans. They may be liable if they breach this duty and cause injury or damage to patients.

From a practical point of view, it is easy to imagine and cringe at the way in which attorneys for patients and their families may use data that shows that patients discharged with home care services on Fridays were more likely to require rehospitalization later. Juries are likely to conclude that discharge planners were just too eager to "clear the decks" before the weekend to the detriment of patients!

Based upon this data and potential liability, discharge planners must be very careful on Fridays with regard to referrals for home health services. At a minimum, this means that they must be certain that the following criteria of appropriateness for home care services are met:

- Patients' clinical needs can be met at home.
- Patients can either care for themselves or there is a paid or volunteer primary caregiver who can meet patients' needs between visits from professional staff.
- Patients' home environments will support home health services.

When one of more of these criteria are not met, discharge planners are on "thin ice" with regard to managing their risks of legal liability.

In addition to the above criteria, discharge planners/case managers must be sure to communicate complete, accurate information to post-acute providers. The tendency on Fridays may be to rush to get as many patients discharged as possible to the detriment of the planning process, including communication of crucial information to post-acute providers. Home heatlh agencies, private duty agencies, hospices and home medical equipment (HME) companies should also be quite concerned about this data.

From a practical point of view, patients sent home "too quick, too sick," as the old cliché says, are risky for home health agencies to accept. When discharge plans are inappropriate and lawsuits result, post acute providers may be drawn into these lawsuits despite the fact that the basic problem was breach of duty by case managers/discharge planners.

In addition, the quality of home health service is already evaluated, in part, based on rates of rehospitalization of agencies' patients. This quality indicator is likely to become more crucial when pay for performance (P4P) is implemented because agencies' reimbursement will depend on low rates of

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rehospitalization. At least at this point, rehospitalization rates are one of the indicators which will be used to determine agencies' reimbursement from the Medicare Program. A viable strategy for agencies to use to lower rates of rehospitalization may be to decline to accept patients on Fridays.

Consequently, it is clearly in the best interests of both discharge planners and post acute providers to further consider this disparity in rehospitalization rates and to work together to reduce this rate in order to manage risks and maintain reimbursement rates that support financial viability. The real "bottom line," is that patients should not be sent home on Fridays who really do not belong there and who are more likely to experience deterioration in their conditions that puts them back in hospitals. This result is unacceptable to everyone. ■

Security breach laws

The total number of states with breach of information laws that require notification of consumers when a security breach involving consumers' personal information increased to 35 with the addition of 11 more states in 2006. **(For information on security requirements, see "As identity theft increases so does your responsibility" *Hospital Home Health*, April 2007, p. 45)**

The 35 states that now have security breach notification laws are: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Maine, Michigan, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Washington, and Wisconsin. So far in 2007 nine states have proposed similar laws or introduced bills to amend their existing notification laws. You can see the report at www.ncsl.org/programs/lis/cip/priv/breach07.htm.

CNE *questions*

17. When does **Henry Goldberg**, project director for Cambridge, MA-based Abt Associates and director of the pay for performance demonstration project expect the P4P demonstration project to begin?

A. July 2007
B. August 2007
C. September 2007
D. October 2007

18. What are two legal or ethical issues that may be critical to an agency's success in Pay for Performance, according to **Elizabeth E. Hogue,** Esq., a Burtonsville, MD attorney?

A. Appropriateness for home care services; background checks for staff
B. Insurance coverage verification; overtime pay scales
C. Compliance with care instructions; appropriateness for home care
D. Insurance coverage verification; background checks for staff

19. What is a criteria for choosing a new service for her agency to provide, according to **Wanda Stackpole**, RN, vice president of Children's Homecare in Columbus, OH?

A. Proper fit with staff's expertise.
B. Ability to improve managed care negotiations.
C. Potential to move into adult care.
D. None of the above.

20. According to **Elizabeth E. Hogue**, Esq., "Conditions of Participation for Medicare state that the first visit to a patient's home must be an assessment visit that evaluates not only the type of care needed by the patient but also the appropriateness of home care for the patient".

A. True
B. False

Answer Key: 17.D; 18. C; 19. A; 20. A.

Lawmakers eye medicare advantage for cuts

Lawmakers looking for ways to increase funding for the State Children's Health Insurance (SCHIP) Program and to repair the Medicare physician fee payment system are taking a closer look at Medicare Advantage programs. The House Ways and Means Committee, Subcommittee on Health, chaired by Rep. Pete Stark (D-CA), recently held a hearing on the structure and costs of the Medicare Advantage program, one of several hearings the chairman plans to conduct to "refine" the payment program. Stark says that of the 43 million Medicare beneficiaries, 8.3 million or 19% currently utilize Medicare Advantage plans. The chairman says "everything should be on the table" when it comes to finding the funds to expand SCHIP and to fund the physicians. Stark noted research from the Congressional Budget Office that shows on average Medicare Advantage programs are overpaid by 12% and, depending on individual plan and location, sometimes as much as 40%.

Medicare Advantage defenders says reducing payments could impact access to care for beneficiaries, particularly among minorities and low income plan participants who are more reliant on Medicare Advantage than fee for service plans. ■

CNE objectives

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

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

CNE instructions

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