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IN THIS ISSUE

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Addressing incontinence: Agency's outcomes improve more than 24%

Education, better assessments help agency, patients

With "improvement in urinary incontinence" identified as one of the pay-for-performance measures for the upcoming Centers for Medicare & Medicaid Services' demonstration project, it is essential that home health managers take a closer look at how they identify and treat incontinence. **(See "Why doesn't your agency volunteer for the P4P demonstration project?," *Hospital Home Health*, May 2007, p. 49.)**

"Incontinence is an important issue for home health patients because it can lead to other problems," says **Theresa Gates**, PT, director of rehabilitation services at Home Care Advantage in Jacksonville, FL. Incontinence can lead to skin integrity issues and can be a cause of falls in the home, she explains. Proper assessment of incontinence and identification of the type of incontinence the patient is experiencing is necessary to provide the right treatment, she adds.

"A lot of patients don't want to talk about incontinence," says **Diane Tiberg**, RN, CHCE, director of nurses at Keweenaw Home Nursing and Hospice in Calumet, MI. "We even have staff members who are not comfortable asking patients about incontinence or did not know how to ask without embarrassing the patient," she says.

In 2002, when Tiberg's agency first addressed incontinence, the agency's rate of "improvement in incontinence" jumped to 62.3% from 37.7% in 2001. "The national reference in 2002 was 52.4% so we were not only able to improve our own rate, but we reached a level above the national average," says Tiberg. The rates have continued to stay above the national reference rate but they have fluctuated between 64% and 54%, she says. "Some of the change is due to new staff and a need to re-educate existing staff to remind everyone that although we're focused on other performance improvement areas, incontinence is still important," she adds.

The first step to improving success with incontinence was a comprehensive education program, says Tiberg. "We invited a urologist to talk about how to recognize symptoms of incontinence, how to assess the cause of incontinence, and different techniques to treat incontinence,"

she says. An assessment card with questions to ask and clues to notice in the home helped nurses better identify the patient's incontinence at the start of care, she says.

"One of the reasons for a low improvement rate for incontinence is recognition of the problem later in the patient's care rather than earlier," points out Tiberg. When patients' incontinence is identified after care has started or at or near discharge, the agency has no time to improve the patient's condition, she says. "If nurses identify the problem early, we can document more accurately and we have time to address the issue," she adds.

Because incontinence is almost never the primary reason for a patient's admission, patients don't think it is important because they don't realize that incontinence can lead to other problems related to skin integrity and falls, says Gates. "When a patient is going to the bathroom four or five times every night, there is a real risk for falls," she explains. "We need to address incontinence to make sure that we improve outcomes in all categories," she adds.

Word questions carefully

When asking patients about incontinence, it is best not to use the word "incontinence," suggests Gates. "Many patients don't understand the word or they don't want to admit to another medical condition," she says. When asking a patient about incontinence, Gates suggests asking, "Are there any times when you can't make it to the bathroom in time?" This question is not threatening and it is specific and simple to answer, she says. If you get a positive response to this question, you can continue with other specific questions about accidents during the night, accidents during the day, and more details about what the patient is doing when the accidents occur, she adds.

Even if the patient does not admit to a problem, nurses need to be aware of any signs, says Tiberg. Odor, a package of pads in the bathroom, or the patient's defensive reaction to questions related to incontinence are all reasons to follow up with other questions, she says. Point out that many of your patients have told you about problems and that usually it is very simple to find ways to address the problem, she adds.

There are two types of incontinence, says Gates. "Urge incontinence can be treated with a variety of urge-suppression techniques and exercises to strengthen pelvic floor muscles," she points out. "We can also teach the patient to be proactive and use a voiding schedule so that the patient can urinate before the urge is so strong that it cannot be controlled."

Stress incontinence requires more assessment to determine the trigger, says Gates. "Does the patient lose control when sitting down or standing from a sitting position, or is the loss of control related to coughing or laughing?" she asks. Once you've identified the cause, you can teach patients to use their pelvic floor muscles to prevent accidents, she says.

Gates' agency has a group of physical and occupational therapists who have undergone extra training to address incontinence. In addition to the advanced clinical training for rehabilita-

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tion staff, agency nurses received four hours of general education to help identify incontinence upon admission or early in the patient's care and to distinguish between stress and urge incontinence, says Gates.

In addition to teaching Kegel exercises to patients to strengthen their pelvic floor muscles, Gates' therapists use behavior modification techniques that include biofeedback, electrical stimulation, and voiding schedules to help patients learn to control their incontinence. "Because fluid intake can affect a patient's ability to control their bladder, we have patients keep a three-day diary to measure their fluid intake, their voiding schedule, and the occurrence of leaks," she says.

After reviewing the diary, the therapist will suggest changes in behavior, she explains. "For example, a patient who is going to the bathroom frequently during the night might routinely drink a 24-ounce Pepsi at 8 p.m. every night." Eliminating drinks that stimulate the bladder, reducing amounts of fluid taken just before bedtime, and changing the time that larger amounts of fluid are drunk can reduce the number of trips to the bathroom, she adds.

The multidisciplinary approach with nurses identifying incontinence and therapists offering different treatments geared toward the patient's needs has resulted in some wonderful outcomes, says Gates. "We have some patients who have gone from using five pads per day to only one per day, and we have patients who would have 10 leaks per day improving to one leak per day," she says.

Even if your nurses and therapists accurately diagnose incontinence, your efforts won't be successful unless the patient wants to address the issue, warns Gates. She explains, "Even though you know you can help, some patients are quite comfortable wearing pads and they don't consider their incontinence a quality-of-life issue. In these cases, you let them know you can help when they are ready and you respect their decision." ■

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Effective job descriptions are specific, detailed

Recognize interdependence between jobs in agency

Every home health manager understands the importance of clearly written job descriptions and competency assessments, but how effective are your job descriptions and do they really help you evaluate your employees' performance?

"The real challenge for home health agencies is the time and effort it takes to develop job descriptions that are specific to the agency's services and the employee's actual job," says **Sherry Taylor**, CHCE, director of home care operations for Quorum Health Resources in Brentwood, TN. "If the agency is affiliated with, or owned by a hospital, it is even tougher because the job descriptions may come from a template used throughout the hospital," she adds.

It is important to make sure your agency's job descriptions accurately reflect the employee's responsibilities as well as your expectations so that everyone knows what standards have been set for the evaluation, says Taylor. "Unfortunately, I see job descriptions that don't vary much from nurse to clerk," she says.

"Obviously, these two employees have very different jobs, so they should have different job descriptions with different competencies identified," she says.

Job descriptions and the accompanying competency assessments that are used in the employee performance evaluation should be based on specific criteria. If your job descriptions are too general, it will be hard to accurately evaluate the employee, says Taylor. "If the job description says that the employee must arrive on time to work, you need to define 'on time,'" she says. For example, a business office employee should be required to be "on time for regular office hours that are 8:30 to 5:00 p.m., Monday through Friday," while a field clinician might have "on time" defined as "arrive at patient's home at the scheduled time" or "no instances of patient complaints about not knowing

what time the nurse will arrive."

When setting specific standards, include a time frame, suggests Taylor. "If you conduct annual performance evaluations, say 'for a 12-month period' in the competency assessment or job description," she says. "You also can't say that documentation should be completed in a timely manner without defining timely," she says. "Say that documentation must be complete within 24 hours or 48 hours of the visit to make sure that you can measure compliance," she adds.

Another issue that many home health agencies overlook when developing job descriptions is the impact that one person's job has on the ability of another person to do his or her job, points out Taylor. "The accounting manager may be held accountable for keeping accounts receivable days below 60, but if you are not requiring nurses to submit documentation within a specific time frame, you are asking the accounting manager to meet a standard without any control over when the documentation comes to her," she says.

When dealing with financial issues, the most successful agencies make all employees responsible for financial performance, says Taylor. "These agencies educate all employees to show how portions of their job responsibility flow to other departments that are filing claims and collecting payments," she says. Once your entire staff understand how they all interact, some of the requirements of their jobs make more sense, she adds.

Ask for employee input

At CareSouth in Winchester, TN, staff members also participate in updating job descriptions and competency assessments when needed. "I make site visits with employees as part of their evaluations **[see story on p. 65 for more on conducting effective performance evaluations]** so if I notice any areas that may need improvement among the staff, we put together a focus group of staff members to discuss the problems and come up with ideas on how to address them," says **Darlene Stewart**, RN, director of the agency. In addition to identifying additional inservice education, the group also develops additional competencies that should be added to make sure that expectations are clearly defined, she adds. "Working within the group enables all staff members to see how other clinicians are handling different situations and we are able to share ideas," she says.

"The most difficult competencies relate to wound care and medication compliance," says Stewart. "Our wound care competencies specify that nurses will measure the wound one time per week and will describe the wound in the documentation at each visit," she says. By including this level of specificity, job performance evaluations are much easier, she adds.

Ensuring the patient's compliance with medication administration is a little tougher, admits Stewart. "So many patients forget to tell nurses if their doctor has changed their prescription medication, added an over-the-counter medication, or asked them to start taking vitamins," she says. "Even if the nurse asks if there have been any changes, patients may say no because they've forgotten about the change or they assume the nurse already knows," she adds.

Stewart's nurses are expected to ask about a change in medication, vitamins, or over-the-counter medications at every visit. "We also expect nurses to look at the medications once every week to see if there are any bottles that weren't in the house the week before," she says. If there is a new medication, the patient is asked about it, and the nurse makes sure that the patient understands what it is prescribed for and how it should be taken, she adds.

"We also check for proficiency in the use of glucose monitors, pulse oximeters, and lab draws," says Stewart. If the nurse performs any of these tasks on the patient visit that Stewart attends, the skills are checked off at that time. Otherwise, nurses can demonstrate their skills at the office, she adds.

Although her agency doesn't care for pediatric patients, nurses do have to distinguish the different needs of younger adults as compared to elderly patients, says Stewart. "The most obvious difference is in the patient's ability to understand the educational information and comply with care

SOURCES

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instructions," she says. She adds, "Even with younger adults, nurses can't assume that they understand and they do have to demonstrate that they understand what they've been told." ■

CMS proposes HHA payment changes

Market basket update, 60-day episode

An additional $140 million in payments to home health agencies will be made in 2008 if the rule proposed by the Centers for Medicare & Medicaid Services (CMS) is approved. The proposed rule includes a requirement to report quality data and a reduction in the 60-episode payment rate.

The proposed rule contains the first refinements to the Medicare home health prospective payment system (HH PPS) since 2000 and also contains the annual update to the Medicare HH PPS payment rates.

"The proposed home health prospective payment system for calendar year 2008 furthers Medicare's commitment toward making accurate payments in all of its payment systems. For home health agencies, the proposed rule seeks to improve the appropriateness and performance of care for Medicare beneficiaries," said

Motivate employees with meaningful evaluations

Recognize outstanding effort with praise

You know that your job descriptions and competency assessments are thorough, specific to employee's job, and clearly define performance expectations, but how do you make sure that your performance evaluation is conducted in such as way that it provides good feedback to the employee and reflects the employee's contribution to the agency?

For a clinicians' performance evaluation, accompanying them on actual visits to patients is essential, says **Darlene Stewart**, RN, director of CareSouth in Winchester, TN.

"I choose one visit for each employee," she says. She never chooses a new admission; instead, she focuses on a patient that the nurse has visited before. "I can better judge what the nurse's normal practice is by watching to see if the patient acts as if the nurse has never checked the patient's ability to grasp or performed other physical assessments that might be appropriate for the patient," she says. Because a nurse will conduct a patient visit "by the book" when a supervisor is there, the patient's reaction is the best indicator of any surprises, she explains. "If they act like or say that they've never had this checked before, I know that the nurse doesn't always follow protocol," she adds.

In addition to Stewart's site visit and review of personnel documentation to evaluate the employee's performance, the employee's self-evaluation is included in the performance review. "I have employees go through the evaluation form, which is based on competencies and criteria established in the job description, and rate themselves as being able to perform the skill, not sure about performing the skill, or not able to perform the skill," says Stewart. Nurses know that there is no punitive action if they admit to not knowing how to perform a skill so they are willing to mark this category so that they can discuss with Stewart how to get the needed training.

"We encourage our clinicians to always ask for help if they are performing a service or using equipment that they've not used before," says Stewart. "Even if a nurse becomes proficient with a Wound VAC because she has a number of patients with wounds requiring this treatment at one time. If she goes months without using the equipment, she may want assistance the first time she uses it again," she explains. Clinicians know that asking for help is not a negative in her agency, so they help each other maintain a high level of skills, she adds.

Once you've completed the performance evaluation, look carefully at how you administer salary increases, suggests **Sherry Taylor**, CHCE, director of home care operations for Quorum Health Resources in Brentwood, TN. "Too many agencies still have the 'across the board' mentality when it comes to raises," she says. By giving all employees a 3% raise, regardless of the performance evaluation, you send a message that everyone is valued at the same level, she explains.

"I like the idea of telling a manager that he or she has a certain amount of money or a certain total percentage to grant to employees, then let the manager divide it up as appropriate," says Taylor. "While money is not a major reason for job satisfaction for home health nurses, recognition of their effort to do a good job is a contributor to job satisfaction," she says. "If a nurse knows that she will receive a higher raise if she exceeds the minimum requirements for the job than the nurse who meets minimum requirements, then she'll be motivated to strive to be a better employee."

CMS Acting Administrator **Leslie V. Norwalk**.

The proposed rule includes a provision to continue to adjust payment for reporting of quality data. HHAs that submit the required quality data would receive payments based on the proposed full home health market basket update of 2.9% for calendar year 2008. If a HHA does not submit quality data, the home health market basket percentage increase would be reduced by two percentage points to 0.9% for 2008.

The proposed rule adds two National Quality Forum-endorsed measures to the 10 that are currently reported: emergent care for wound infections deteriorating wound status and improvement in status of surgical wound.

Episode payment to be reduced in 2008

CMS analysis of the latest available home health claims data indicates a significant increase in the observed case mix since 2000 and that the case mix increase is due to changes in coding practices and documentation rather than treatment of more resource-intensive patients, according to CMS representatives. To account for the changes in case-mix that are not related to a home health patient's actual clinical condition, this rule proposes to reduce the national standardized 60-day episode payment rate by 2.75% per year for three years beginning in 2008.

The proposed case mix model includes a proposal to replace the current therapy threshold at 10 visits per episode with three new therapy thresholds at six, 14, and 20 therapy visits. The new levels would have graduated payment levels between the proposed therapy thresholds to reduce incentives to inappropriately target higher thresholds. These proposed changes would significantly increase the case mix model's ability to more appropriately reflect HHA costs and consequently provide more accurate payments to HHAs.

Changes to the low utilization payment adjustment and payment for non-routine medical supplies are also addressed by the proposed rule.

The proposed rule is available on the CMS web site at www.cms.hhs.gov/HomeHealthPPS/downloads/CMS1541Pdisplay.pdf and background information on the differences between the current HH PPS and the proposed refinements and updates of this rule can be found at www.cms.hhs.gov/HomeHealthPPS/downloads/1541PBackground.pdf. ■

Hospice as continuation of care not just end of the road

Open access could help patients avoid 'terrible choice'

Hospice evolved from the need to provide medical and social support to terminally ill patients in the last weeks of their lives. But while the benefits hospice can provide have expanded, the perception that hospice is where patients go to die has, until recently, stayed the same.

According to **Richard Payne,** MD, director of the Duke Institute on Care at the End of Life at Duke University Divinity School in Durham, NC, patients at end of life who might benefit from what hospice has to offer — medical, social, and spiritual support — have been faced with what has come to be known as the "terrible choice:" To qualify for Medicare hospice benefits, most patients have had to resign themselves to giving up advanced medical treatments such as chemotherapy and dialysis.

But that's changing, as evidenced by a movement toward "open-access" hospice programs that allow patients to continue the treatments that, while not life-saving, can make the quality of the end of life much better.

"We're not talking about people like Elizabeth Edwards or Tony Snow, who have incurable conditions but who aren't likely to die in six months," says Payne, referring to the wife of presidential candidate John Edwards and the White House spokesman, both of whom recently have had recurrences of cancer.

"But what hospice can do is provide open access to people who are likely to die in six months but who can be made more comfortable through palliative chemotherapy or radiation, antiretroviral drugs — treatment that is not going to cure them, but will make the last weeks or months of their lives much more comfortable," he explains.

'Terrible choice' forced by money

Medicare's rules on hospice care do not require that hospice programs deny patients advanced medical care. But at a benefit of $130 per day for such care, the ability for a hospice program that's not backed by a larger institution to offer that kind of care to its dying patients is not likely.

To qualify for hospice benefits, a patient must be diagnosed with a condition that is likely to

result in death in six months or less. For many patients and their doctors, that requirement in and of itself is enough to delay entering hospice.

"Physicians in their training are taught to cure," points out **Roseanne Berry**, RN, chief compliance officer for VistaCare, an Arizona-based national hospice provider. "There is much more education going on now in end of life [in medical schools], but some doctors have had little or no training in how to help their patients die."

The challenge for hospice providers, Berry says, is to help patients and physicians see hospice not as the end of the road in treatment, but as another layer in the continuum of care — a natural continuation of the care the patient has had up to the point where hospice becomes a consideration.

"We're getting there, but we still have about one-third of hospice patients die within a week of admission, and while we're glad to provide that care, it certainly doesn't give us the chance to provide the best care we could for those patients," Berry adds.

In 2005, only about a third of the 2.4 million people who died in the United States were in hospice care, Payne says, perhaps half as many as could have benefited from hospice programs.

He says Medicare policy makers argued that by giving patients a choice of staying in traditional health care or opting into hospice care that would allow the government to save money and still give patients what they need to die comfortably.

"But where do you draw the line?" asks Payne, addressing advances in medicine that blur the line between palliative and curative care. "How do you decide if something is given with palliative intent vs. curative intent?"

Larger hospices can offer more in the way of palliative care because they can spread their costs over a larger population, he points out.

"If you have 1,000 patients and 900 are getting relatively low-intensity therapies that cost less than $130 a day, you can spread around the remainder to provide higher-cost care to the other 100 patients who need it," he says.

As the baby boom generation and its parents age, they are demanding more choices than just a place to die comfortably, Berry says, so hospice services are changing to meet that demand.

"I bet you have seen more changes in this area in the last two years than you've seen in the 10 years prior to that," she suggests. "But you have to have those conversations. We're great at planning parties, planning vacations, planning everything but the end of our lives; but having those conversations lets us say, 'If you're eligible for hospice care, if your doctor has certified that you are, then let's remove the barriers and look at hospice as another part of your treatment.'"

The question that remains, Payne says, is how to afford it. While Medicaid is saving money by paying only $130 per day in benefits, for many patients the costs skyrocket because of expensive trips to the emergency department or hospital admissions that could be avoided with advanced care provided within the hospice setting, experts say.

"It's a good thing to do to offer patients these options, and it does diminish the psychological barrier of the terrible choice," says Payne. "If there is a way to provide the care they need in hospice — team-oriented, physical, psychosocial, and spiritual well-being — and provide some medically oriented therapies with palliative intent, it makes a lot of sense medically, and it's a reasonable health policy."

Open access means providing these types of therapies, Payne continues. A hospice does not get paid any differently when advance treatment is provided, so open access can mean providing more care at a financial loss. And if Medicare determines that the treatment is curative, not palliative in intent, it could withhold funds for that patient completely.

Removing obstacles and fear

Patients who might be eligible for hospice often are kept away by fear and lack of understanding, Berry and Payne agree.

"We want to remove the obstacles. We tell patients you don't have to have a caregiver in your home. You don't have to have a [do not resuscitate] order, you don't have to have advance directives to come into hospice," explains Berry. "Medicare allows hospices to have their own philosophies, so we do what we can to remove as many of the obstacles as we can, get them into hospice, and then work with them to plan how they want their end of life to be."

Payne says the psychological barrier of looking at hospice as a place to go to die is one of the biggest obstacles.

By not choosing hospice, or by choosing it only in the last days of life, Berry says, many people are giving up a valuable system of care and support.

"Most of our services are provided in the patient's own home," she points out, often with providers the patient has come to know and trust.

"One big concern among patients at the end of life is abandonment. They don't want to be aban-

doned by their primary care or oncology provider," she says. "In hospice, we can tell them that we will work with their providers, and we are just another layer of care and another set of providers who are here to enhance the care their doctors say they should have."

Payne advocates educating patients and their health care providers and support systems (family, clergy) about hospice, so that the decision to choose hospice is made ahead of time as a part of continued care, not as a last resort.

"The No. 1 complaint I hear from patients is, 'Why didn't we get this sooner?'" says **Ronald J. Crossno**, MD, medical director for VistaCare Hospice in Temple, TX. "Thirty-five percent of eligible U.S. patients receive hospice care. Twenty-five percent of these patients get hospice care for less than seven days [before they die].

"An earlier referral means the patient can still go see the grandchildren and it improves the transition. If you're hurting or in pain, you can't deal with the other issues relative to dying."

Berry says that patients who enter hospice shouldn't think they have to give up hope.

"But you have to have the prognosis [of death likely in six months], and those prognoses are very hard for physicians because they want to be optimistic," she explains.

Palliative care physicians can be a good resource if a patient — or his or her physician — is having a difficult time concluding that hospice is an option.

"Palliative care specialists deal with all of the issues that terminally ill patients face. The specialist makes arrangements and goes beyond the social worker," Crossno explains. He says 25% of U.S. hospitals had palliative care specialists in 2005, but expects that number to jump by 2010. ■

Home visits help members avoid preterm births

Program saves $2.80 for every $1 spent

A combination of telephonic case management and home visits has helped Optima Health decrease preterm births and low-birth-weight infants.

Optima Health estimates that it has saved $2.80 for every dollar spent on its award-winning Partners in Pregnancy program and has avoided nearly 3,000 days in the neonatal intensive care unit since the program began in 2002.

Optima Health, the health plan division of Norfolk, VA-based Sentara Healthcare, established the program to promote healthy pregnancies and reduce premature births for both its Medicaid and commercially insured populations.

The high-risk population includes both Medicaid and commercial members, often for different reasons, says **Karen Bray**, PhD, RN, CDE, vice president, clinical care services.

"The Medicaid members often have financial and social issues. In our area, we have a renowned in vitro fertilization program and we are managing the care of a number of older women in the commercial population who are carrying multiple babies," she adds.

The health plan partners with Virginia's Comprehensive Health Investment Project (CHIP) to conduct home visits to assess the needs of hard-to-reach members and to follow them through the pregnancy if needed.

'We rarely miss a pregnancy'

The majority of members in the program are identified when their physicians send in authorization forms for obstetrical services. Members can self refer or physicians can directly refer them. In addition, the health plan scans its claims database regularly to identify members who have had positive pregnancy tests.

"We rarely miss a pregnancy," Bray says.

As soon as the plan identifies a member who is pregnant, the information is automatically transmitted to the Partners in Pregnancy team.

Women who are likely to be at risk for problems during the pregnancy, such as very young women, older women, and women with a history of problems in pregnancy automatically are assigned to a case manager who calls them and conducts a detailed risk assessment over the telephone.

Low-risk pregnant members are assigned to patient service coordinators, who contact the member, conduct the risk assessment, and determine whether the woman should be referred to a case manager.

The patient service coordinators and case managers make monthly telephone calls to the women throughout the pregnancy, talking to them about how things are going, and conduct serial risk assessments to screen the members for problems with the pregnancy.

"The patient service coordinators and case

managers can increase the frequency of the telephone calls if the members request it or if they feel the member would benefit," Bray says.

When the case managers or patient service coordinator can't get in touch with a pregnant woman who lives in an area with a high incidence of low-birth-weight babies, Optima calls on its community partner, CHIP, to locate the members and conduct a risk assessment.

If the member is at high risk for complications of pregnancy, CHIP continues to provide home visits by nurses and other outreach workers, if appropriate.

Contracting with home health

In areas where there are no CHIP programs, Optima contracts with home health agencies to provide specific services.

The case managers can also call on CHIP if they have concerns about the situation in a pregnant member's home. "In these cases, the case manager feels that a more thorough evaluation of the home situation may help to determine the risk level," she says.

CHIP lay workers and nurses who visit the home evaluate the home condition, family's financial and social issues, and the stress level of the mother-to-be.

"We know that stress seems to be a factor in low-birth-weight infants. Some of these members are at risk of losing their home or have terrible family problems. We get them in touch with community social services and have gone so far as to intercede with landlords who were trying to evict a family," Bray says.

CHIP services include transporting women to medical appointments, connecting them with substance abuse programs, teaching them how to care for their infants, and connecting them to social services agencies that can provide assistance.

The case managers follow the members throughout their pregnancy, making sure they receive the standards of care, such as regularly seeing the physician. They help the women manage any complications or comorbidities, such as gestational diabetes or hypertension, and educate them about community services that are available if appropriate.

For instance, poor dental health can adversely affect a pregnancy.

"Many women don't realize that the condition of their teeth can affect their baby. We send them toothbrushes and toothpaste and refer them to a dental provider if needed," she says.

The health plan sends out regular packets to the mothers with information about pregnancy and a small gift. For instance, the stress management packet includes information about how to deal with stress and a bottle of lotion.

T-shirts, water bottles, diaper bags, and a book about baby's milestones are other gifts that the members receive as long as they are in the program and talk regularly to the case manager or patient service coordinators.

The Partners in Pregnancy program has won numerous awards including a national award from the Disease Management Association of America. ■

CM program keeps preterm delivery rate low

Doulas pitch in when moms-to-be need extra help

A program that targets women at risk for premature deliveries for case management has paid off for ConnectiCare, a regional HMO based in Farmington, CT.

ConnectiCare's preterm delivery rate (babies born before 37 weeks) ranges from 7.8% to 6.5% compared to national rates of 11.3% to 12.7%.

In 2006, ConnectiCare's low-birth-weight rate (less than 5.5 pounds) was 6.8% compared to a national average of 8.2%.

"It's hard to compare our statistics year by year because every nine months, there's a whole new set of people with a whole new set of risk factors. One year, we may have a preponderance of women with preterm deliveries and the next year, a large number of multiple births," **Maggie Perracchio**, RN, program manager and nurse case manager for the ConnectiCare's Birth Expectations program.

ConnectiCare's Birth Expectations program was developed in 1995 to help women identify signs and symptoms of preterm labor, the primary cause of pre-term births.

Women identified in risk assessment

Women are identified through a risk assessment form that asks for medical history, including chronic conditions, such as hypertension and diabetes that may put them at risk for a preterm

delivery. Other risk factors include an incompetent cervix, a history of preterm births, or multiple births.

When physician offices precertify pregnant women with ConnectiCare, the health plan mails the members a risk assessment to fill out and return.

"Many of the physicians fill out the risk assessment and they alert us when there are risk factors so we don't have to wait for the member to return the assessment," Maggie Perracchio says.

If a woman hasn't returned the survey by the time she's 23 weeks pregnant, ConnectiCare sends another survey. And the health plans sends another survey to pregnant members at 23 weeks to find out if anything has changed.

"Sometimes someone might find out later in the pregnancy they are carrying twins or that they are having issues with their cervix that could put them at risk for a preterm delivery," she says.

In 2006, the health pan completed a risk assessment on 91% of all women precertified for maternity benefits.

Once a member is identified as having a risk factor for a preterm delivery, Perracchio makes an outreach call.

"My goal is to educate them regarding what to expect, what to watch for, and what to report to their physician. I can't prevent anyone from going into preterm labor but I can educate women with potential risks about the early signs and encourage them to seek medical care," she says.

When a physician determines that a woman needs to be on complete bed rest in order to have a full-term delivery, the health plan may offer the services of a doula if the woman has small children at home or otherwise needs extra help.

Doulas are women who provide physical and emotional support to women before and after childbirth. ConnectiCare contracts with a doula service to provide doulas for a certain number of hours a day, depending on the needs of the mother.

"If a woman is the primary caregiver of a toddler, there's no way she can stay in bed. We live such fragmented lives that we don't have support from mothers or sisters who live nearby like we used to. That's where the doulas come into play," Perracchio says.

"We want to make sure our pregnant members have the physical and emotional support they need to have a healthy pregnancy with a good outcome," Perracchio adds.

The frequency with which Perracchio calls the members depends on what the women need. Some members in the program don't need much reinforcement. Others need to be called frequently, she adds.

She advises them on the importance of nutrition and healthful habits and encourages the diabetic members to follow their diet and take their medications in order to avoid being hospitalized for complications of pregnancy.

"My job is to make sure they know what symptoms to look for that may be a sign of problems and when they should call their physician. Women are sometimes reluctant to bother their doctor but I tell them it's better to find out they're OK than to wait until they have to be hospitalized," she says.

At 22 weeks

When the women in the program are 22 weeks along in their pregnancy, Perracchio may increase the frequency of contact, depending on what is happening with the member and the pregnancy.

"Sometimes I follow up to talk about the results of their last appointment. Sometimes when we are talking they'll bring up something that happened and I may tell them to ask the doctor or at the next visit or to call right away," she says.

The plan also covers post-partum doulas as part of its early-discharge program. If members opt to stay in the hospital for a shorter period of time than their coverage will pay for, ConnectiCare will provide a doula to help out with the children, prepare meals, do grocery shopping, or take care of other household tasks so that the mom can rest and take care of the baby.

"Some women like to leave the hospital early when they can have additional support at home," she says.

The post-partum doula program is available to all pregnant members, not just those at risk for complications of pregnancy. Members call ConnectiCare to sign up for the benefit.

"We don't do outreach for this program. All pregnant members get mailings during the course of the pregnancy with information about all the services available to them. This program is not limited to members in case management," Perracchio says. ■

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

CNE *questions*

9. What patient safety risk is associated with untreated urinary incontinence, according to **Theresa Gates**, PT, director of rehabilitation services at Home Care Advantage in Jacksonville, FL?
   A. Fire in the home
   B. Overmedication
   C. Falls
   D. High blood pressure

10. Which of the following is a good way to word a performance expectation in a job description or competency assessment, according to **Sherry Taylor**, CHCE, director of home care operations for Quorum Health Resources in Brentwood, TN?
   A. Documentation must be completed in a timely manner.
   B. Documentation must be complete and turned into the business manager 48 hours after the patient visit.
   C. The patient visit must be documented.
   D. Documentation must be completed as soon as possible.

11. The so-called "terrible choice" posed by Medicare hospice benefits refers to:
   A. Patients likely having to relinquish advanced medical treatments.
   B. Patients having to leave their homes and move into hospice facilities.
   C. Patients having to end their relationships with their primary care or oncology providers.
   D. Income requirements that deny hospice benefits to many patients.

12. Doulas provided by ConnectiCare assist mothers by:
   A. helping out with children
   B. taking care of household tasks
   C. grocery shopping
   D. all of the above

Questions in February issue should have been numbered 17-20, March 21-24, April 1-4, and May 5-8.

Answer Key: 9. C; 10. B; 11.A ; 12. D.

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 the 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."

Reference

1. Centers for Disease Control and Prevention (CDC). Invasive methicillin-resistant *Staphylococcus aureus* infections among dialysis patients — United States, 2005. *MMWR. Morb Mortal Wkly Rep.* 2007;56:197-199. ■

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