

## PRESIDENT'S MESSAGE



On behalf of the entire Board of Directors, it is my pleasure to introduce *NALTH News* - the official newsletter of the National Association of Long Term Hospitals. Our association connects leaders and associated professional staff committed to advancing the health, well-being and understanding of patients who require complex care after an acute hospital stay. *NALTH News* will update its members on new and exciting programs, public policy and government affairs, research and best practices, as well as initiatives and new developments in the post-acute care community. We plan to "spotlight" a NALTH member hospital in each issue. I am proud that Hospital for Special Care, the LTCH where I work, is the first of our member hospitals to be profiled.

As a member-driven organization, it is member participation that makes NALTH a leader in the industry. NALTH has adopted a collegial management process which focuses on advocacy, education, research and networking goals important to our members. NALTH fosters open and ongoing dialogue with governmental policy makers. Member support and input is critical for the success of NALTH.

Most of the integrated hospital systems which operate long-term acute care hospitals in the United States are members of NALTH. As such, NALTH is vitally interested in fostering discussions between policy makers and its members on the evolution of healthcare policies.

At this important point in our nation's history, NALTH is at the forefront of discussions related to emerging healthcare concerns and provides critical leadership and education to its members, patients and decision-makers. In this year when healthcare reform will be debated and possibly passed, NALTH will be a vital resource to its members in understanding the legislation and designing strategies to successfully navigate the future in healthcare.

NALTH is proud of our achievements over the past year. These achievements listed below, fueled by member support and collaboration, led to a stronger industry and higher standard of care:

1. Timely membership legal advisories, reports and research on significant industry issues.
2. Benchmarking – via the only national LTCH database, the NHIS, which measures not only operations but helps define best practices.
3. Unified voice in Washington to address public policy and reimbursement issues.
4. Ongoing development of patient criteria, the NALTH criteria for admission, continued stay and discharge.
5. Planned and developed research to define LTCH value and criteria.
6. Fostered collaboration with the LTCH industry, AHA, ALTHA and the Federation.
7. Lobbied for MMSEA extension from 2010 to 2012.
8. Pursue universal recognition of LTCH outcome measures.
9. The NALTH Board focused on initiating a formal succession planning process for the NALTH President and Vice President positions. The Nominations and Bylaws Committee also developed a policy that formalizes the board positions, estimates time commitments, roles and a succession process.
10. Creating a President's Cabinet for weekly updates and action planning with current President, Vice Presidents and the General Counsel.
11. Retained a management company to handle many administrative association tasks.
12. Successful annual clinical education program held in Dallas, TX.

On behalf of the entire Board of Directors, thank you again for your support of NALTH and we look forward to working with you as we grow together.

Sincerely,  
 John Votto, D.O., FCCP  
 NALTH President

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**NALTH** encourages the submission of articles for publication. For more information, please contact

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## NALTH CALENDAR

### February 17, 2010

Goldberg Innovation Award – Informational Conference Call • 2pm ET/1pm CT Please email GoldbergAward@nalth.org for more information and to join this call.

### March 5, 2010

Goldberg Innovation Award – Submission Deadline

### April 28-30, 2010

NALTH 21st Annual Meeting • Omni Shoreham Hotel • Washington, DC

### October 21-22, 2010

NALTH Education Conference • Las Vegas, NV

## Community Benefit in an LTCH

Hospital for Special Care (HSC) is a private, not-for-profit, 228-bed long-term, acute-care (LTCH) hospital licensed by the State of Connecticut as a chronic disease hospital. The hospital is renowned for its expertise in physical rehabilitation, respiratory care and medically-complex pediatrics. We employ a multispecialty medical staff. In addition, special programs are available in the treatment of spinal cord injuries and illness, acquired-brain injuries, strokes and breathing disorders ranging from complex pulmonary disease to ventilator weaning and management. An important regional resource for the physically disabled, HSC is tri-accredited by The Joint Commission (TJC); the Commission on Accreditation of Rehabilitation Facilities (CARF) for comprehensive integrated inpatient rehabilitation programs, acquired brain-injury, outpatient medical rehabilitation and spinal cord system of care for both inpatient and outpatient rehabilitation; and is certified by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). Hospital for Special Care is affiliated with over 100 clinical and academic institutions throughout the nation, including the University of Connecticut School of Medicine, Yale University School of Nursing, Dartmouth Medical School and Yale University School of Medicine.

Hospital for Special Care provides a full range of outpatient services, including physical, occupational and speech therapy, rehabilitation evaluation, neuropsychology and pulmonary rehabilitation programs. The hospital also includes a 27,000 square-foot Aquatic Rehabilitation Center, which completes the full spectrum of rehabilitation and community fitness activities offered.

At Hospital for Special Care, being responsive to the changing needs of the communities it serves is an everyday occurrence. The hospital reaches out to the members of these communities by establishing, supporting or sponsoring a variety of programs that complement the high quality medical care it delivers to its patients each day. Those programs include sponsoring twelve support groups, numerous adaptive sports programs, participating in area events and hosting educational conferences.

## Community Support Groups

Community Support Groups are integral to our mission and we are vigilant to be responsive and accountable to our communities, for whose benefit we exist. Among our support groups, Hospital for Special Care believes we facilitate the largest pulmonary support group in the world, with over 260 active members, called Special Care Breath-Takers. Other support groups include two others with a pulmonary focus, the Fit for Life Exercise (FLEX) group and the CPAP group. Additionally, the hospital facilitates groups for patients and families who have survived brain injuries, spinal cord injuries, are living with ALS, muscular dystrophy, Guillain-Barre Syndrome, Parkinson's disease, stroke, and Alpha One Antitrypsin deficiency. There is also a group that works on communication enrichment for people living with aphasia.

## Aquatics and Fitness

Hospital for Special Care's Aquatics Rehab Center (ARC) has continued to draw inpatients and outpatients to HSC for the opportunity to receive aquatic therapy. It also provides aquatic therapy for patients with spinal cord injury, arthritis and other chronic debilitating conditions.

## Academic and Clinical Research

Research remains an essential component of our mission at HSC. We have clinical research grants and conduct clinical trials in the areas of Spina Bifida, oral health, pulmonary disease and Sickle Cell disease. We are taking advantage of current funding opportunities to expand our studies from hospital-based research to include community-based programs.

Under the direction of Dr. John Votto, President and CEO, and Roger S. Thrall, Ph.D., Director of Research, HSC will expand its focus to new pharmaceutical interventions, medical home models and oral health initiatives.

Our academic research partners include: University of Connecticut Health Center, Connecticut Children's Medical Center, Yale University, and Columbia University. The State of Connecticut Department of Public Health (DPH) remains a valuable supporter/partner of all of our community-based research initiatives.

Working in collaboration with acute care hospitals and community-based organizations, the HSC research department has established a statewide consortium of Sickle Cell Disease (SCD) vested stakeholders. The Research Department has taken the lead in applying and administering SCD research grants in Connecticut. This consortium has been the recipient of over \$1.2 M, over the last 4 years, in grant awards from both state (DPH) and federal (Health Resources and Services Administration) programs.

## Educational Conferences

HSC serves as a clinical resource and regularly hosts a myriad of educational conferences that include a "Care of the Child with Complex Medical Needs," an A.S.P.E.N. (American Society for Parenteral and Enteral Nutrition) teleconference, a Second Annual Trends in Care of the Respiratory Patient, a School Nurse Education Program, a Clinical Resources Youth Program, the Gossling Lecture Series which focuses on rehabilitation advances, and annual Neuromuscular/Neurology day-long conferences which target a multi-state audience. HSC is CME accredited by the Connecticut State Medical Society.

## Sports Programs

At Hospital for Special Care, we believe that people living with disabilities should have every opportunity to pursue their dreams. Through our sports programs, we give both children and adults the opportunity to achieve their goals and lead independent lives. Sports programs, both competitive and recreational, teach life skills, promote confidence, and develop leadership. In addition, friendships are built, accomplishments are recognized and people push themselves to levels they never thought they could achieve. All of these attributes combined, promote healthy lifestyles for individuals living with



## Community Benefit in an LTCH (con'td)



disabilities. Our adaptive sports teams and activities include: Cruisers junior wheelchair track & field, Spokebenders basketball, Chargers soccer, Skiers' Unlimited, Wave swim teams and HSC's Ivan Lendl Junior Wheelchair Tennis Training and Sports Camp.

In May of 2008, Hospital for Special Care established a Veterans' Outreach Program offering screenings for the effects of Mild Traumatic Brain Injury (MTBI) and Post Traumatic Stress Disorder (PTSD) in veterans returning from service in Iraq and Afghanistan. Many veterans may be suffering symptoms of MTBI after exposure to bomb blasts and other combat-related incidents, but may not recognize the symptoms as mild brain injury. As a result, they may not be getting the treatment they need. The screenings being offered by HSC are free and will direct veterans to appropriate treatment if warranted.

### Art Program

Established in 2000, HSC's Joy of Art program has grown in service and popularity beyond expectation. The program is designed to enhance the quality of patient life by providing a diversity of artwork for our patients to experience and enjoy, and to strengthen the relationship between the hospital and the community by displaying works of local artists with art exhibitions four-to-six times each year.

### Therapeutic Horseback Riding

Manes & Motions Therapeutic Riding Center, an affiliate of HSC since 2002, provides children and adults living with neurological, neuromuscular and/or cognitive and emotional difficulties the opportunity to meet life's challenges through horseback riding, with a stable of nine horses and the active involvement of over one-hundred volunteers.

### Dental Clinic

In 1997, in response to a dire need in the community, Hospital for Special Care established the Special Care Dental Clinic to provide dental services to children on Medicaid who did not have access to dental care. In addition to activity at the dental clinic, the staff is involved in community outreach activities with other community dental care providers to aid in oral health education and access to care for this underserved population.

Through its many and diverse programs to promote the health and well-being of people living with disabilities or chronic disease, HSC fulfills its mission to be responsive and accountable to our community for whose benefit we exist.

Each NALTH newsletter will highlight a member hospital's outstanding program or community benefit. Please contact NALTH to suggest a member to spotlight.

## CAUTI Reduction in the LTCH Setting Hospital for Extended Recovery

– NALTH Quality Award Winner –

### Background

The Centers for Disease Control and Prevention (CDC) has issued a challenge to the healthcare community to reduce catheter-associated adverse events by 50%.<sup>i</sup> This is due in large part to the fact that Catheter Associated Urinary Tract Infections (CAUTIs) comprise approximately 40% of all nosocomial infections.<sup>ii</sup> Disturbingly, the presence of catheter-associated bacteriuria in a patient carries with it a 2.8 fold increased risk of death, independent of all other conditions.<sup>iii</sup> This is mostly due to the fact that in 3% of patients with CAUTIs, bacteremia will develop with its associated mortality and morbidity. CAUTIs are, in fact, the most common source of gram-negative bacteremia in hospitalized patients.<sup>iv</sup> Furthermore, CAUTIs comprise the largest reservoir of resistant organisms within healthcare facilities, which is a major risk to the patient's health and to public safety.<sup>v</sup>

According to the CDC, treating each CAUTI costs approximately \$676 and it lengthens the hospital stay 1-4 patient days. This number does not include all of the potential complications that can arise from CAUTIs, including but not limited to bacteremia and potentially patient demise. When bacteremia develops, the additional cost climbs to at least \$2,800.<sup>vi</sup> Also, with CMS' policy on hospital-acquired conditions going into effect on October 1, 2008 for other healthcare facilities, our hospital looked to where we could improve quality and potentially mitigate losing reimbursement in the future. According to a study from Thomson Reuters Corp's healthcare business, payment for hospital-acquired CAUTIs was 27% lower as a result of Medicare's plan to remove selected hospital-acquired conditions from calculations to determine payment rates.<sup>vii</sup>

### Description of Program:

Due to rising patient safety and fiscal concerns regarding CAUTI in our 35-bed Long Term Acute Care Hospital (LTCH), our Infection Control and Quality Council developed a program to reduce CAUTIs.

Interventions:

#### • Avoid Unnecessary Catheterization

- Only patients that truly needed urinary catheterization had a catheter, including but not limited to patients requiring relief of outlet obstruction, critically ill patients or post-op patients that required accurate measurement of their urine and debilitated or paralyzed patients (to prevent skin breakdown and infected pressure ulcers).
- The Infection Control Coordinator made rounds once a week to determine if the patient needed the catheter. If not, the catheter was discontinued (with permission from physician).
- Nursing staff was educated about proper use of the catheter and were encouraged to advocate for their patients to have the catheter discontinued when no longer needed.

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## ► The longest a urinary catheter could remain is 28 days.

- Due to the uniqueness of LTCHs, in that we receive many of our patients' from other acute care facilities, it is imperative for patient safety that we know insertidates of indwelling catheters.
- If an insertion date is unknown or if the catheter has been indwelling for longer than 28 days, the urinary catheter was replaced upon admission, if the urinary catheter was deemed necessary (for the reasons listed above).
- The Admission Order Set at our hospital was changed to reflect this as an order from the admitting physician.

## ► Staff Education

- Staff was provided with continuing education regarding insertion of catheters using an aseptic technique, continuous peri and foley care, ensuring dependent drainage and uncompromising maintenance of closed drainage (i.e. the red seal keeping the catheter closed is not to be broken and not contaminating the collection bag drain during bag emptying).

## ► When catheterization is necessary, we stock and use only the BARDEX® Infection Control Foley Catheter

- This catheter is coated with hydrogel and silver alloy with a closed drainage system and bacteriostatic drainage tubing, collection bag and a microbicidal outlet tube.
- This catheter has been shown to reduce the incidence of CAUTIs on average by 47%.<sup>viii</sup>

## ► All catheters are secured using a device manufactured for this use (not tape).

### Measurement Indicators

To define a CAUTI, our hospital used the CDC's National Healthcare Safety Network (NHSN) definition of a CAUTI.

Each morning (Monday-Friday), the Infection Control Coordinator would review the microbiological reports to assess for CAUTIs.

Prior to the interventions, the CAUTI rate per 1,000 foley days was 5.22 for FY 2007 (June 1, 2006 – May 31, 2007). The raw data rate was 24 CAUTIs. The catheter usage rate was 51% of all patient days for FY 2007.

After the above interventions, the CAUTI rate per 1,000 foley days was 3.44 for FY 2008 (June 1, 2007 – May 31, 2008). The raw data rate was 15 CAUTIs. The catheter usage rate was 44% of all patient days for FY 2008.

The above data indicates a 37.5% reduction in CAUTIs (a total of 9 CAUTIs) and a 7% reduction in catheter usage amongst our LTCH patient population. Per the NALTH Health Information System managed by the Lewin Group, the benchmark group data indicates a rate of 4.47 CAUTI per 1,000 foley days for calendar year 2007 amongst all LTCH hospital types and hospital sizes.

### Financial Impact

For our facility, the cost of one Bardex® IC foley is \$12.29/kit as opposed to \$7.51/kit for a non-infection control foley. This is a price difference of \$4.78 per foley kit. In FY 2008, we used approximately 195 foley kits; an increase in cost of \$932.10. This cost is far less than the cost of treating nine additional CAUTIs, which according to the CDC would be approximately \$6,084. However, this number does not take into account the additional patient days (1-4 days per patient) and the additional cost due to

complications from CAUTIs. This savings could potentially reach over \$60,000 (this includes patient days for the nine CAUTIs that were prevented). However the biggest savings of all is the potential life saved from preventing urosepsis and bacteremia.

### Lessons Learned

We learned several valuable lessons from this program (which is still ongoing). We realized that follow-up and reinforcement with the staff needs to be ongoing and not a one-time inservice; the weekly rounds really helped in this process. This was a true team effort. We relied on the information we received from the nursing team, the ET nurse, the PT/OT team and the respiratory therapy team in knowing when it was appropriate to discontinue a catheter. We improved our physician relationships and built a very trusting relationship with most of our attending physicians, who they trust the Infection Control Coordinator to know when a catheter is no longer appropriate.

We are currently looking at different securement devices for a catheter in order to increase patient comfort while they have a catheter and to prevent non-infectious adverse events with a catheter.

Following this experience, we are looking at other infection control initiatives we can implement with our staff, including increasing hand hygiene compliance amongst our entire staff (including medical staff), because as we learned with this experience, when the entire team is involved, patient safety and financial outcomes improve.

### One year later...

A year after the implementation of the program, our CAUTI reduction program has become standard at the Hospital for Extended Recovery. Some tweaks to the program have included an increase in the removal of foley catheters; we rarely change the catheters anymore. We have found an excellent securement device that has helped to alleviate non-infectious adverse events with a catheter.

We have also been able to continue to reduce our CAUTI rate. FY 2009 reported a rate of 3.20; this is compared to FY 2008 with a rate of 3.44. Our catheter usage rate has also decreased to 42% of all patient days.

Currently for year ending 2010, which ends the end of May, we are at 2.39. So you can see we have continued to reduce the catheter associated UTI's based on our program.

### For more information, contact NALTH member:

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CEO/Administrator  
Hospital for Extended Recovery  
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## Health Reform: What Next?

By Edward D. Kalman, NALTH, General Counsel  
Behar & Kalman, LLP, Boston, MA.

At the time of the writing of this article, the prospects of comprehensive health reform legislation mandating that most Americans obtain health insurance are in doubt. Legislative initiatives to achieve this goal have engendered divisive debate and, for its proponents, universal health care insurance coverage remains an elusive goal. Health care providers, however, should not equate the near term prospects of universal health insurance coverage with the potential for implementation of policies which have emerged as part of the health reform debate, especially policies which are directed at reducing the rate of growth of health care expenditures. There is little or no political discord over an array of provisions contained in health reform legislation which would impose new controls on Medicare payments, and would experiment with ways to integrate providers in a quest to achieve greater payment efficiencies while enhancing the quality of patient care. It may well be that in the near term, attempts to achieve comprehensive health reform are transformed into less ambitious targeted insurance and Medicare payment reforms. Since there is at least a chance that reform legislation of some type may emerge this year, this article examines some key Congressional proposals which would affect LTCH payments and operations.

### What is a Pilot Project?

As a threshold matter, it is important to understand that current Congressional proposals include a number of “pilot” projects whose objective is to develop new post-acute care payment and delivery policies. Current legislative proposals would allow the Secretary of HHS to expand the scope and duration of most of the proposed pilot programs without further authorization by Congress. Thus, in a real sense, a “pilot” program has the potential of supplanting, in the geographic area, the, both Medicare Part A and Part B fee for service payment systems for an indefinite period of time. It is also noteworthy that even if there were no legislation, the Secretary of HHS could institute under the agency’s current “demonstration project” authority, programs similar to those in current legislative proposals. Demonstration projects, however, are usually limited in duration.

### LTCH Pay for Performance Pilot

Under one proposed pilot project, the Secretary of HHS would be required to conduct, no later than 2016, separate pay for performance pilot projects for LTCHs as well as IRFs and other classes of post acute hospitals. The objective of these pilot projects appears to be to test the value to the Medicare program of each PAC provider type through the implementation of a value based purchasing system specific to LTCHs, IRFs, and other post-acute providers. In order to implement this pilot project the Secretary would need to identify quality measures. It is noteworthy that the legislation would give the Secretary authority to waive existing Medicare requirements. Thus, the Secretary could waive the LTCH 25 day Medicare ALOS requirement as well as 25% rule and make new payment arrangements. Under this same authority the Secretary could waive the so-call 60% rule for IRFs. It is important to note that this year, Medpac has indicated it intends to develop quality indicators for both LTCHs and IRFs. NALTH has used quality indicators in the context of the national LTCH data base it has established. One possibility is that this pilot project could be refined to experiment with LTCH management of patients, throughout their post-acute care episode (e.g. after discharge from and acute care hospital or LTCH) with the objective of increasing quality of care and reducing readmissions to acute care hospitals. During the legislative process NALTH provided to the Senate Finance and the House Ways and Means



## NALTH Repository of Medical Necessity Review Appeals Data

To assist its members in addressing medical necessity reviews, NALTH has created a repository of medical necessity review appeals data. Providing data to the repository is voluntary and all data remains confidential (i.e., an overview of the data, but not any specific data, is available to NALTH’s Medical Necessity Review Committee and its General Counsel, and may be made available to its Members from time to time). NALTH thanks those members who have submitted data to the repository and encourages other members to participate. The overview of the repository data is vital in assisting NALTH in making policy decisions and in understanding the medical necessity review environment.

To date, 25 NALTH member hospitals have submitted data to the repository and the repository will be overviewed during a NALTH Annual Meeting. For more information, please contact Patricia Stimac of Spartanburg Hospital for Restorative Care at [pstimac@srhs.com](mailto:pstimac@srhs.com).

Committees an outline of how LTCHs could coordinate care in PAC settings with the objective of avoiding repeat acute hospital readmissions and thereby producing Medicare program savings. The waiver of current requirements such as the 25 day ALOS requirement and 25% rule would be part this type of pilot project.

### Continuing Care Hospital Pilot

Another legislative proposal would require the Secretary of HHS is to conduct a “continuing care hospital” pilot project. A continuing care hospital would be clinically responsible for an “episode of care” which includes LTCH, IRF and SNF (not HHA) services as well as Medicare covered services provided a Medicare beneficiary within 30 days following discharge from the continuing care hospital. There are a number of questions presented with respect to a continuing care hospital pilot. These questions include whether services provided within 30 days of discharge include new admissions to acute hospitals or other providers for conditions unrelated to diagnosis treated by a continuing care hospital. Another question is whether Medicare secondary payor liability would be diminished for Medicare beneficiaries who would otherwise exhaust Part A hospital and SNF covered days, but do not do so under the pilot project. This proposal does not specify a method of payment which would be developed as part of the pilot project.

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## Coding and Documentation Services

For the health of your organization, consider NALTH Coding and Documentation Specialists. NALTH is the industry leader for accurate coding and documentation requirements under the new Medicare Prospective Payment System. Our specialists provide the best solution to your long-term acute care coding and documentation problems. Our team is composed of experienced AHIMA credentialed professionals trained in the long-term acute care to the industry.

NALTH offers Coding and Documentation Specialist services for long-term acute care coding, documentation and DRG compliance. NALTH is dedicated to quality coding. We advocate the use of the American Hospital Associations Coding Clinic for ICD-9-CM and ICD-9-CM Official Guidelines For Coding and Reporting. These educational resources assure your hospital is in compliance with all the rules and regulations pertinent to coding compliance.

These NALTH specialists code on a daily basis in NALTH member hospitals, thereby offering a broad, knowledge base and experience with a varied case mix in all clinical specialties. NALTH specialists understand the long term acute care industry. They bring competence and expertise to assist you with accurate coding and DRG assignment of all long-term acute care patient stays, thus maximizing reimbursement for your facility.

NALTH specialists have thorough training and experience with compliance issues and can assist you with quality improvement initiatives for coding and documentation of long-term acute care health records. They understand documentation requirements of the Medicare Prospective Payment System in long-term acute care and can assist with physician education concerning proper documentation requirements for the industry.

NALTH specialists can assist you with training new coding employees and providing continuing education services for your existing coding staff, and offer coding seminars targeted at various levels of competence.

### **The following services are available from the NALTH Documentation and Coding Specialists:**

- Coding Audits
- DRG Validation
- Compliance Audits
- Quality Improvement Initiatives
- Documentation Audits
- Physician Documentation Education
- Coding Staff Education and Training
- Case Mix Reporting

**Pricing:** NALTH specialists audit 30 charts per day. Most audits take 1 or 2 days. On the second day, some hospitals prefer to have 15 charts audited with the auditor providing education on coding in the afternoon. NALTH requires payment in advance, with expenses reimbursed to the auditor at audit completion.

**NALTH Members:** \$2,100 per day plus the coder's expenses.

**NALTH Coding and Documentation Specialists are just an e-mail away.**  
Contact: Anna Cierocki at: [acierocki@nalth.org](mailto:acierocki@nalth.org).

## Health Reform: What Next?

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### Pilot Program on Payment Bundling

Another key proposal is a national “voluntary” initial 5-year pilot program to which would bundle payment for hospital, physician, and post-acute provider services for 1 or more of 10 “applicable conditions” designated by the Secretary. The bundled period applies to all services related to “an applicable **condition**” for an episode of care starting 3 days prior to a hospital admission and ending 30 days after discharge from the hospital. The pilot program is required to cover short-term acute care inpatient hospitalizations, physician services, outpatient hospital services as well as LTCH, IRF, SNF and HHA services. The Secretary would be directed to develop quality measures for use in the pilot program for episodes of care and for post-acute care which are site neutral. An entity comprised of providers of services and suppliers, including a hospital, a physician group, a SNF, and a home health agency, may apply to the Secretary to provide applicable services under the pilot program. The Secretary would establish a payment methodology to pay the entity which may include bundled payments and bids from entities such as, LTCHs for episodes of care.

### Pilot Program on Accountable Care Organizations

Under an Accountable Care Organization (ACO) pilot project physician groups would enter into agreements with other providers, including IPPS and non-IPPS hospitals to provide Medicare patients with Part A and Part B services. ACOs are predominantly physician groups but may include any model where physician groups enter into agreements with other providers, including IPPS and non-IPPS hospitals, to participate in the pilot program. If they are successful ACOs would receive a share of “savings” achieved by the Medicare program.

### Stay Tuned

It may be that initiatives such as those reviewed in this article will move forward regardless of the course of health reform legislation. NALTH intends to closely monitor the development of these issues and engage in a process of constructive consultation with its members and responsible policy makers.

## CAUTI Reduction in the LTCH Setting Hospital for Extended Recovery

– NALTH Quality Award Winner –

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- i [http://www.cdc.gov/ncidod/dhqp/about\\_challenges.html](http://www.cdc.gov/ncidod/dhqp/about_challenges.html)
- ii Salgado, CD, Karchmer, TB, Farr, BM. Prevention of catheter-associated urinary tract infections. In Wenzel RP ed. Prevention and Control of Nosocomial Infections. 4th ed. Philadelphia:Lippincott Williams and Wilkens. 2003; 297-311.
- iii Saint, S. “Prevention of Nosocomial Urinary Tract Infections,” Making Healthcare Safer: A Critical Analysis of Patient Safety Practices; Chapter 15.
- iv Orenstein, R., Wong E., “Urinary Tract Infections in Adults”; American Family Physician, March 1, 1999.
- v Maki, DG, Tambyah PA. Engineering out the risk of infection with urinary catheters. Emerging Infectious Diseases. 2001; 7:342-347.
- vi Saint S. Clinical and economic consequences of nosocomial catheter-related bacteriuria. American Journal of Infection Control 2000; 28: 68-75.
- vii Wilson, I. The Cost of Errors. Modern Healthcare supplement, June 2, 2008. 8-9.
- viii Karchmer TB, Giannetta ET, Muta CA, Strain BA, Farr BM. A randomized crossover study of silver-coated urinary catheters in hospitalized patients. Archives of Internal Medicine. 2000; 160: 3294-3298.

## NALTH Liaisons to the American Hospital Association (AHA)

NALTH Members serving on the Governing Council and Regional Policy Board of the AHA Section for Long Term Care and Rehabilitation 2010:

### James Prister, CHAIR

(NALTH Board Member)  
RML Specialty Hospital, Hinsdale, IL

### Catherine Barr

Bethesda Hospital, Saint Paul, MN

### Margaret Crane

(NALTH Board Member & Past President)  
Barlow Respiratory Hospital, Los Angeles, CA

### Eddie L. Howard

(NALTH Board Member)  
East Texas Specialty Hospital, Tyler, TX

### Linda Stones, R.N.

(NALTH Past Board Member)  
Madonna Rehabilitation Hospital, Lincoln, NE



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## NALTH 21<sup>ST</sup> ANNUAL MEETING

Health Reform and Long Term Care Hospitals (LTCHs)

April 29 - 30, 2010 ■ Omni Shoreham Hotel ■ Washington, DC

### NATIONAL ASSOCIATION OF LONG TERM HOSPITALS

#### Topics and speakers include:

- US Senator Debbie Stabenow of Michigan (US Senate Committee on Finance)
- Update from Centers for Medicare and Medicaid – Tzvi Hefter, Director of Division of Acute Care, Hospital & Ambulatory Policy Group Centers for Medicare and Medicaid
- Medical Necessity Review Policy – Latesha Walker, Director, Division of Medical Review & Education, Provider Compliance Group, Centers for Medicare and Medicaid
- Update from Medicare Payment Advisory Commission (MedPAC) – Dana K. Kelley MPH, Commission Staff Consultant Responsible for Post Acute Provider Policy, Medicare Payment Advisory Commission (MedPAC)
- Overview of LTCH Industry Sponsored Research
- NALTH Repository of Medical Necessity Review and Appeals Database
- Congressional Health Staff Invited
- Goldberg Innovation Award Winner Presentation
- Health Reform Policy and Regulatory Update – Ed Kalman, General Counsel, NALTH
- NALTH Member Business Meeting & Election of Officers

*Speakers invited; Program subject to change.*



[www.nalth.org](http://www.nalth.org)