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IN THIS ISSUE

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Medicare denials are a way to start communication, not a sign of failure

Hospice medical directors offer tips

Hospices often make two mistakes with regard to Medicare denials: First, they try too hard to avoid receiving denials, and, secondly, they do not appeal out of fear of reprisal.

These are precisely the wrong strategies to take, experts say.

"The biggest mistake a hospice program can make is to try to never have a denial because then they'll miss caring for people who need hospice care," says **Laurel H. Herbst**, MD, vice president of medical affairs and chief medical officer at San Diego Hospice & Palliative Care in San Diego, CA.

"You need to take the attitude of like it's a surgeon's appendectomy rates, where you need about 5 percent of the appendix coming out healthy to know that you've done the right number of necessary appendectomies," Herbst says.

"If you have no Medicare denials, then you're turning away people who need your care," she adds.

It's a common fear among hospice medical directors and others that if they appeal a Medicare decision then they'll make the reviewers angry and the Medicare intermediary then will spend more time looking at their hospice, says **Charles F. von Gunten**, MD, PhD, FAHHPM, provost and vice president, Center for Palliative Studies at San Diego Hospice & Palliative Care. Von Gunten also is the editor-in-chief of the *Journal of Palliative Medicine*. von Gunten and Herbst spoke about handling Medicare denials at the American Academy of Hospice & Palliative Medicine (AAHPM) conference, held Feb. 14-17, 2007, in Salt Lake City, UT.

"So, they believe it's better not to appeal because an appeal will stimulate the intermediary's interest in you," von Gunten adds.

"That's a common fear, and it's not true," he says. "When you appropriately appeal cases, in our actual experience, the overall number of reviews goes down."

This is because the Medicare intermediary quickly learns that a particular hospice cannot be intimidated and it has high standards of medical care that the hospice medical director is willing to defend, von Gunten says.

Herbst and von Gunten offer these tips on how to handle Medicare denials:

1. Review the denial for misunderstandings or documentation issues that can easily be explained in an appeal.

"Many hospice directors, when they receive a denial, will react emotionally, thinking they did something wrong, and they'll try to prevent it from ever happening again," von Gunten says.

"Instead of reacting like that, you need to say, 'We did the right thing, and we'll appeal this,'" Gunten says. "If hospice medical directors take on that role, then patients are going to get the right care, and hospices will improve."

There are many good reasons to appeal the denials because the Medicare reviewers are not necessarily expert reviewers, and they have their own biases, Herbst says.

For example, Herbst once received a denial on a patient who had heart failure.

The denial said that the patient clearly was not terminal because she was gaining weight instead of losing weight, Herbst recalls.

"In heart failure, gaining weight means your feet are swelling, and that's not a good sign," she explains. "In a heart failure patient, the feet are swelling up because the person's heart is worse than it ever was."

Herbst used the patient's medical data and interpreted it medically to provide the Medicare reviewer with the proper context, which was missing in the denial.

"Medicare reviewers are looking only at isolated facts, and they're not sophisticated in interpreting the data," von Gunten says.

These kinds of medical misunderstandings are common, Herbst says.

She's also had patients with pulmonary fibrosis who were treated by the Medicare reviewer the same as patients with chronic obstructive pulmonary disease, although the symptoms are different and, therefore, the hospice care is different, Herbst says.

"I had a patient with a critical aorta stenosis, which is a condition where the patient is likely to die suddenly because of a lack of blood flow to the brain," Herbst says. "These patients are classed by Medicare with congestive heart failure (CHF) patients, although they don't have CHF."

Since they're classified the same as CHF, Medicare reviewers will deny hospice care because they lack CHF signs and symptoms, oblivious to the fact that these patients will die much faster than CHF patients, Herbst adds.

"Hospice medical directors need to be very good physicians who have a broad understanding of medicine," von Gunten says. "They need to help Medicare reviewers understand the nuances of medicine."

2. Respond immediately.

The key is to send the Medicare intermediary a clear, informative letter that explains why the patient's care was necessary and met all the criteria, Herbst says.

These letters take about 20 minutes on average, depending on the medical chart, Herbst notes.

Herbst repeats in her appeal letter the exact language used in the denial, putting it in quotation marks.

The letter then summarizes the physical information briefly and draws a clear picture of a very sick patient, listing the patient's condition, as

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well as specific elements that indicate the patient is terminally ill. The letter also will refute any inaccurate data stated in the Medicare denial, and it will request Medicare to reverse its denial, Herbst explains.

"If you don't ask for the reversal of denial, then they will not do it," she adds.

One recent trend Herbst has noticed involves letters from Medicare intermediaries in which the intermediary has suspended the decision to approve the claim until more information is obtained from the hospice.

If this is a tactic to delay payment, it will work unless the hospice director immediately answers it, Herbst says.

"They'll give you 60 days to get the information back, but if you wait, that delays your hospice from getting paid," she says. "I usually have those back in the return mail, explaining exactly why the patient got the care he or she got."

Most of the denials Herbst sees these days involve denials of levels of care, rather than the denials for length-of-stay and prognosis reasons, she notes.

"These are much easier to handle because all you need to indicate is the reason for the general inpatient care (GIP) status and why the patient was admitted," Herbst says.

3. Use the appeal process as an opportunity to improve everyone's education about hospice documentation and care.

"The other role for the physician here is to read your own staff medical records critically, using the information to teach better documentation skills to your own staff," Herbst says.

"I have had denials happen where the nurse may have documented that the patient was not having pain, when the fact was the patient was on 200 mg of morphine per hour, which controlled the pain," Herbst says. "But if the chart says the person doesn't have pain, then the reviewer doesn't go to the next step to see if the patient is on medicine, and will think the patient doesn't need any hospice care."

The correct way to document this is to say that the pain is well-controlled by the name of the patient's medicine, Herbst explains.

"This is the same with documenting other symptoms," von Gunten says. "You should write, 'The nausea is controlled by X drug; the shortness of breath is controlled by X drug.'"

These are the sort of chart nuances that can cause a claim to be denied, Herbst says.

"I've managed to win all of these types of appeals by pointing out that the patient is on 200 mg an hour of morphine," Herbst says. "But if the nurse were to chart it that way to begin with then we wouldn't even get the denial."

Hospice medical directors should see it as part of their job to handle Medicare denials, she adds.

"Medicare has an obligation to pay for needed care and nothing more than that," von Gunten says. "On the hospice side, you need to defend what you do and explain it, because if you don't, then patient care will be affected."

Handling Medicare denials and appeals is another way of educating the hospice community, Herbst says.

"I have had fewer denials now than I used to have, and I think it's because I've trained others," she adds.

Herbst says that handling Medicare denial appeals has helped to improve her own thinking, as well as her teaching skills. She educates her staff and physician trainees about Medicare documentation and reviews.

"When I first noticed a trend like the pain medication documentation problem, I started by speaking with our team of directors and sent them emails as a heads up," Herbst says.

The directors discussed her emails in team meetings, and Herbst also spoke with other hospice physicians about the problems, and they, too, spread the word.

Since hospices in different parts of the country have different Medicare intermediaries, their experiences might differ when appealing denials, Herbst notes.

"Our intermediaries are quite reasonable and easy for me to deal with," she says. "I spend a lot of time working with them to understand their process and to help them understand ours."

It's a good idea for all hospice medical directors to get to know their intermediary representatives as people rather than as letters on a page, Herbst suggests.

"I've gone to meetings with them and also had phone conversations," she says. "I often call them up to ask their opinion."

For instance, Herbst was proactive when the hospice was considering changing the way it used nurse practitioners (NPs). She called the Medicare intermediary medical director and discussed how the hospice wanted to use NPs, asking the medical director for advice on how this could best work and how the hospice would bill for the care.

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"I think it would be helpful if people had more proactive conversations with intermediaries because it helps to make sure we all understand something the same way," Herbst says.

"Medicare intermediaries loom large in your imagination as fearsome when they're just trying to do their job just like you're trying to do yours," von Gunten says. ■

Hospice care may lower end-of-life hospitalizations

Study looks thoroughly at all factors

Hospice care has a strong impact on reducing end-of-life hospitalization rates among nursing home residents, according to a recent study that examined a variety of factors that could affect hospitalization rates in this population.

The study provides solid data for hospice directors to use when promoting hospice care in nursing homes, suggests **Susan C. Miller**, PhD, an associate professor of community health (research) at Brown Medical School in Providence, RI. Miller was a co-author of the study, which was published in Health Services Research.

"I've talked with people before about studies that weren't as sophisticated as this one, and they sometimes take the information to a meeting with nursing home administrators, using it to talk about the benefits of hospice care," Miller says. "Hospice care improves the quality of a patient's end of life, so it's an issue that most nursing home administrators want to know about."

The study looked specifically at the last month of life for nursing home residents in five states, including Kansas, Maine, New York, Ohio, and South Dakota.

"It was a convenience sample of states because they had nursing home minimum data set information for residents, and we looked at those who died between 1995 and 1997," Miller explains.

"Then we combined the resident assessments with nursing home information, the claim information for Medicare, and hospitalization information," she adds.

Often, hospitalizations among nursing home patients are more about the facility's policy, a state's policy, and other factors that are not necessarily related to a specific patient, Miller notes.

For example, some studies have shown that when there are more hospital beds in a particular market, then there are more hospitalizations, Miller explains.

"So we tried to control for all confounding factors so we could really isolate the hospice effect," Miller says. "So, we have found a causal effect."

Investigators also looked for selection bias, meaning they adjusted the study to account for people who were in hospice care because they chose to be in hospice care, and were less likely to desire being hospitalized in the first place, she adds.

"And there are different kinds of nursing homes, with some sending residents to the hospital more than others," Miller says.

"What we found is there is some bias if you don't have the sophisticated adjustment that we used," Miller says.

Adjusting for selection bias, the study found that significantly fewer nursing home residents who received hospice care had been hospitalized when compared with similar residents who did not receive hospice care.

While 44 percent of residents who received no hospice services had been hospitalized in their last 30 days of life, only 26 percent of residents who received hospice care had been hospitalized in their last month of life.[1]

"The estimate is conservative because we included anyone who had hospice care — whether it was one day or 30 days," Miller adds.

Some of the factors that impacted whether or

not a nursing home resident received hospice care were these, Miller says:

- Men were less likely to enroll in hospice;
- People with cancer were significantly more likely to choose hospice, even if they also had dementia;
- Some people with chronic illnesses, like congestive heart failure, were significantly less likely to choose hospice care; and
- Patients in a nursing home located more than 30 miles away from the nearest hospice were less likely to use hospice services than those in nursing homes less than 15 miles away.

Researchers also concluded that the increased availability of palliative care management services used by hospice was preventing end-of-life hospitalizations.

The biggest challenge for hospices will be to convince Medicare to get rid of the biggest barrier to hospice enrollment among nursing home residents, which is the skilled nursing benefit, Miller says.

Nursing home patients who are enrolled in skilled nursing care cannot simultaneously enroll in hospice care, Miller says.

"You can't be in hospice care for care of the same condition as the skilled nursing benefit, and that's a huge barrier to hospice care," Miller says.

But it's also a shortsighted policy on Medicare's part because if hospice care can reduce hospitalization rates, then allowing hospice enrollment among these patients will save, not cost, more money, she adds.

"There are a lot of people who can never get into hospice if they want to remain on the Medicare Part A benefit," Miller says.

For example, a patient who is dying of lung disease and is receiving care in the nursing home under the skilled nursing benefit would have to pay privately for the nursing home care if he or she wanted to be enrolled in hospice care, Miller explains.

"There are financial disincentives to enrolling patients in hospice care, and maybe this subject should be revisited [by policymakers] because it looks like hospice has a powerful effect and can reduce hospitalizations," Miller says.

There is too little incentive for nursing homes to change the way they classify these patients because their budgets are so tight that the skilled nursing benefit is needed, she adds. ■

[Editor's note: For more information on nursing home-hospice collaborations, visit this Web site: www.nhpco.org\nursinghomes.]

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Reference:

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Keys to success in donation program

Expert offers tips on increasing donor base

Whether a hospice's goal is to increase memorial gifts or expand the pool of donors of smaller gifts, there are a variety of ways to improve an existing donation program, according to a certified fundraising executive who works for a hospice that has a successful donation program.

The key is to know your donor base, assess your marketing program, and recognize donors as creatively as possible, says **Kathleen B. Emmett**, CFRE, director of development for the Hospice of Palm Beach County Inc. of West Palm Beach, FL.

"We raise a fair amount of money from special events," Emmett says. "But those are more friend-raisers than fundraisers."

For example, the hospice holds an annual fishing tournament, a run/walkathon, and a golf tournament, Emmett says.

"I've always viewed events as a different kind of way to roll people into the fold," Emmett says.

However, most of the hospice's focus in encouraging donations is on major and planned gifts, she adds.

Here are some of the strategies employed by the Hospice of Palm Beach County to encourage donations:

1. Understand your donor base.

"You need to understand your donors' needs and how they are connected to your organization," Emmett says. "Often, this can lead to more gifts."

The hospice stores a database of people who have given gifts, both large and small, to the hospice, and the database is capable of being analyzed for trends, Emmett says.

"When you're running a report and analyzing trends, certain people might jump off the page," she notes.

For instance, suppose a hospice donor has given $25 every three months for the past 15 years.

The key is to call that person to have a chat and learn more about him or her, Emmett suggests.

"You can say, 'You seem very dedicated to our organization, what prompts you to give to the hospice?'" Emmett says.

"It might be that the person had an important experience with the hospice's bereavement center," Emmett says. "Maybe he lost a loved one and received counseling at the bereavement center, and because of that has given regularly ever since."

This information will help the hospice development staff better target potential donors.

"So, it's important to really listen to your donor base," she adds.

2. Assess how you're marketing the giving program.

"The more you put your organization or your opportunities in front of people, the more likely they are to give," Emmett says.

"So if you have a quarterly newsletter or are profiling donors, the more personal you can make it seem, the better," she adds.

Ways to do this would be to include an article on how people have arranged giving to the hospice and to ask whether a reader's company is a matching gift company, Emmett suggests.

"Include an article on the most recent special event and where the money went," she says. "Be sure to dedicate two or three pages to development-related activities, and include with it a business envelope so people can send you money."

Marketing should be continual. The Hospice of Palm Beach County has a quarterly newsletter which is considered 50 percent fund development and 50 percent community outreach.

"It's not a real heavy fundraising-driven piece," Emmett notes.

But the newsletter provides positive news about the hospice to the community and to current and potential donors.

Another great marketing tool is judicious use of email messages, she says.

"We find that email blasts are a good way to communicate with people," Emmett says. "We send out emails that are specific to events, and this drives attendance to special events."

Personal notes from directors also are great marketing strategies, Emmett says.

"You can't write enough personal notes," she says. "Anytime I visit someone or they come to our facility, I write the person that same day, whether a donor or a prospect."

3. Find creative ways to attract and recognize your donors.

This is tricky for hospices, particularly with memorial gifts, but it is a good way to enhance the donor base.

Donor walls, recognizing memorial donations, are popular, and this type of recognition can be placed anywhere.

For instance, the Hospice of Palm Beach County has a lovely meadow in the back of the building, near an inpatient unit, and donors can dedicate benches or bricks there, Emmett says.

"We have trees where donors can have a plaque placed next to the tree in memory of a loved one," Emmett says. "It's important to find creative ways to recognize your donors, and it's something we're focusing on right now."

One of the recent ideas for attracting new donations is to mail potential donors a special card in recognition of mothers, Emmett says.

The mailing was made in time for Mother's Day, and it was a pretty card with heart-shaped, biodegradable flowers, flattened and stuck to the card's front. The flowers could be planted to grow forget-me-nots, Emmett says.

The cards included this saying: "If I had a single flower for every time I think of you, I could walk forever in my garden," Emmett says.

The rest of the card's wording included a sentence about how mothers help us remember what's important in our lives, and as it's time to pay tribute to mothers, the hospice requests a gift in honor of a special mother in their lives.

Donors can send in a check and have a card that is similar to a Mother's Day card sent on their behalf to their mother, grandmother, sister, wife, or best friend. The letter would say that this person has contributed a gift to the hospice on their behalf, in honor of Mothers' Day.

4. Encourage legacy contributions.

"We've developed a legacy society, similar to what many hospices have," Emmett says. "We recognize not only the person who has passed away and left a planned gift, but it's our hope to recognize people in their lifetime for their commitment."

When a donor writes the hospice into his or her will, he or she automatically becomes a part of the hospice's legacy society, Emmett says.

"And we host special events for those kind of people," Emmett says. "We try to build on their commitment to our organization and make them feel special because they have made a sizable, long-term commitment to our organization."

The special event might involve a breakfast with the hospice's chief executive officer or medical director, which will include an overview of new and innovative programs at the hospice, Emmett says.

"We talk about how the donated dollars are being used," she says.

Again, it's helpful to look at the legacy donation database to identify trends that will help a hospice director determine who else would be a good planned-gift prospect, Emmett says.

"It relates to frequency, not to size of gift," Emmett says. "If a little old lady has sent in $25 every quarter since 1982, then she is very dedicated to the hospice organization and would make a good planned-gift contributor."

In this case, the hospice legacy director would visit with her and see if she's thought about leaving a gift to hospice in her will, she adds.

5. Say thank-you, often.

"You can never say 'Thank-you' too many times," Emmett says. "I've heard that the average number of thank-you's for one gift should be seven times."

While this might be difficult to do, there should be more than one thank-you for each gift, she notes.

For instance, once the hospice receives a gift, the donor will be sent an acknowledgement thank-you within 24 hours, Emmett says.

"We have two volunteers who spend an afternoon calling every single person who has made a gift donation," Emmett says. "They say, 'Hi, this is Betty, a volunteer with Hospice of Palm Beach County, and I just wanted to thank you for your support.'"

For larger gifts, the volunteer will call, and Emmett will write a follow-up note to that donor.

"The note asks if I can come and thank them in person for their gift," Emmett says. "I'll call and set up some kind of personal appointment to talk with them and thank them in person." ■

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Agencies 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 mecha-

nism 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.

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. ■

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 patient, 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." ■

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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, 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 at 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 has 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.

Need More Information?

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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." ■

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

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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 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."

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 (CDC). Invasive methicillin-resistant *Staphylococcus aureus* infections among dialysis patients — United States, 2005. *MMWR. Morb Mortal Wkly Rep.* 2007;56:197-199.