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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-202945

APRIL 27, 1981


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The Honorable Rufus H. Wilson
Acting Administrator of
Veterans Affairs

Dear Mr. Wilson:

Subject: VA Home Care Program Is a Cost-Beneficial Alternative to Institutional Care and Should Be Expanded but Program Management Needs Improvement (HRD-81-72)

We completed a review of the Veterans Administration's (VA's) Hospital-Based Home Care program at eight VA medical centers. Our review was directed toward evaluating the program's effectiveness as an alternative to institutional medical care and its potential for expansion.

Home health care is generally recognized as a beneficial and cost-effective alternative to prolonged hospital and nursing home care. However, as of April 1981, only 30 of the 172 VA medical centers had home health care programs, and VA had not activated any new programs since 1974. There are individuals in VA medical centers who could benefit from this program, but VA has neither identified the number of potential candidates nor attempted to expand the program. VA officials attributed limited program growth to higher priorities and funding limitations.

Clearly defined objectives have not been established for the home care program. VA's Central Office has allowed medical centers considerable flexibility in implementing their programs while providing little guidance and monitoring. As a result, wide variations existed in the home care programs implemented by the eight VA medical centers we visited. (See enc. I for more information.)

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We are recommending that you direct the Chief Medical Director to:

--Clearly define the objectives of VA's home care program, emphasizing the cost benefits as a primary goal, and convey the objectives to all medical centers.

--Develop guidelines that assure more uniformity and consistency among the medical centers' home care programs.

--Conduct periodic program evaluations to assure that individual home care programs are carried out in accordance with agency policy and program objectives.

--Identify the number of veterans in VA medical facilities who are suitable for home care placement.

--Provide the program with adequate funding so that it can be expanded.

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being sent to the Chairmen of the four above-mentioned Committees and the House and Senate Committees on Veterans' Affairs and to the Director, Office of Management and Budget.

We would appreciate being informed of any actions taken or planned on the matters discussed in this report.

Sincerely yours,

Gregory J. Ahart
Director

Enclosures - 2

ENCLOSURE I

VA'S HOME CARE PROGRAM IS A COST-BENEFICIAL ALTERNATIVE TO INSTITUTIONAL CARE AND SHOULD BE EXPANDED, BUT PROGRAM MANAGEMENT NEEDS IMPROVEMENT

Home health care is generally recognized as a beneficial and cost-effective alternative to prolonged hospital and nursing home care. Although there are suitable candidates for home care placement in Veterans Administration (VA) medical centers, VA has not taken steps to (1) identify the number of potential candidates and (2) expand its home care program since 1974.

BACKGROUND

Home health care is generally recognized as a beneficial and cost-effective alternative to prolonged institutionalization in a hospital or a nursing home. Since 1968, VA has administered a hospital-based home care program in which previously hospitalized veterans are returned to the home setting where a caretaker (family member and/or friends) provides personal care under the supervision of a VA hospital-based multidisciplinary medical team.

The program was started--as a pilot project--at six VA medical centers because of VA's concern with the increasing number of elderly veterans and their need for more frequent and longer hospital stays than their younger counterparts. VA's current program objectives are to (1) supplement inpatient care, (2) obtain faster patient recuperation through development of a suitable home environment, and (3) establish a proper climate in the home for continued and preventive care.

As of April 1981, VA had established home care programs at 30 of the 172 VA medical centers.

OBJECTIVES, METHODOLOGY, AND SCOPE

The objectives of our review were to:

--Evaluate the effectiveness of the management and administration of VA's home care program.

--Determine whether the potential existed for expanding the program and to identify any obstacles, if any, that may hinder expansion.

To evaluate the effectiveness of the management and administration of VA's home care program, we performed detailed audit work at 8 of the 30 VA centers with such programs. In addition, we reviewed eight VA centers without home care programs to determine whether the potential existed for establishing programs at these centers. All of the centers in our review were located in urban areas and were general medical and surgical facilities. (See enc. II for list of centers reviewed.)

Because each of VA's home care programs differed in staff size, number of participating patients, and composition of the hospital-based medical team, we selected programs that were fairly representative with regard to these characteristics. We obtained program and cost data, and patient profile information on the 454 patients in, or recently discharged from, the eight programs at the time of our fieldwork. With the assistance of VA center officials, we also surveyed 78 hospital and nursing home wards at the 16 centers reviewed to determine if any of the 3,152 patients they contained at the time of our fieldwork were suitable candidates for home care placement.

We interviewed VA Central Office and medical center officials who were primarily responsible for managing and administering the home care program. We reviewed pertinent legislation, regulations, and policies and procedures pertaining to the program. In addition, we researched studies by VA and others on the benefits and uses of home care.

POTENTIAL EXISTS FOR VA HOME CARE EXPANSION

According to VA guidelines, individuals are suitable candidates for home care placement when:

--Inpatient care is no longer required.

--Followup professional care is required and the return on a recurring outpatient basis to a VA hospital is not feasible.

--The individual is generally nonambulatory.

--Adequate daily care can be provided by a caretaker and the individual will respond to such care.

--The individual and the caretaker completely agree with the proposed placement.

In addition, VA's Central Office requires that a patient (1) reside within 30 minutes driving time from a VA medical center and (2) need the services of a multidisciplinary medical center-based home care team.

To determine if there were enough suitable candidates to justify expansion of VA's home care program, we reviewed home care patient profiles and VA long-range veteran population projections and evaluated patients in VA hospital and nursing home wards at the 16 centers visited. Our review showed that a significant number of institutionalized patients were qualified for VA's home care program. With the assistance of VA personnel at each center, we identified 329 (15 percent) of the 2,152 patients in 78 hospital and nursing home wards who were potential candidates for home care placement.

In determining those patients suitable for home care placement, we first considered the patient's medical condition, using the level of patient care categories identified in an October 1977 VA report. 1/ The level of patient care categories ranged from level 0 (no disability) to level 8 (severe acute disability). Patients at levels 3 to 5 were classified by VA as suitable candidates for home care placement. The results of our ward surveys at the 16 centers reviewed are shown below.

Results of Ward Surveys at Centers Reviewed

		Number of patients	Percent of total
Total number of cases reviewed (note a)		2,152	
Less: Patients not medically suited:			
Will be too severely disabled	357		
No medical need upon discharge	924	1,281	60
Total patients medically suited		871	
Less: Patients not meeting other home care criteria:			
No caretaker available	218		
Caretaker available, but not willing or able to care for patient	18		
Patients live more than a 30-minute ride from medical center	198		
Other reasons or unknown	108	542	25
Total number of candidates for home care placement		329	15
			100

a/Total reflects number of patients in 78 hospital and nursing home wards as of July 1980.

1/"The Aging Veteran: Present and Future Medical Needs."

During our ward surveys at medical centers without home care programs, VA center officials identified patients who qualified for home care placement, such as:

--A 60-year-old man with a lung disability who had been hospitalized for extended periods on a number of occasions. The VA staff estimated that home care could have reduced the patient's period of hospitalization by 1 to 2 months.

--A 31-year-old cancer patient who had been hospitalized for 2 months to receive medications that he could have otherwise received at home from a trained caretaker.

--An amputee recovering from surgery while waiting to be fitted with a prosthetic device. Center officials believed that this patient could have been sent home earlier if a home care program were available.

With few exceptions, VA medical center officials we talked to believed that the home care program could be expanded. At one medical center with a home care program, center officials told us that patients were not placed in the home care program because the center's program had achieved an average daily census (ADC) of 50 patients--VA's maximum standard for program participation. The officials said that, of the center's 800 estimated referrals to community nursing agencies each year, about 75 to 100 could have been referred to a home care program if openings were available. At another medical center, we were told that, if all qualified home care patients were considered, the program's ADC could exceed the program's capacity. For example, the center's home care program coordinator identified 10 patients who commuted by ambulance to the VA outpatient clinic who were suitable for home care.

NO VA PROJECTIONS IDENTIFYING POTENTIAL HOME CARE PATIENTS

The Veterans Omnibus Health Care Act of 1976, Public Law 94-581, required that VA study the short-range and long-range direction of its hospital and medical programs for eligible veterans with reference to the increasing elderly veteran population. The study was to include specific plans "for expanding alternatives to institutional care, including provision of home health [including homemaker and special nutrition] services."

VA's October 1977 report on the aging veteran included a demography of the veteran population, descriptions of available and planned programs, and estimates of the potential demand for given services. The report concluded that home care should be continued and proposed that a systematic and intensive program

be developed to assess and implement the appropriate placement of all potential long-term patients. As of April 1981, an evaluation on home care had not been made.

LIMITED FUNDING AND LOW PRIORITY HINDERS PROGRAM EXPANSION

Over the years VA has acknowledged the need to better serve aging veterans, such as targeting services to veterans making the transition from hospital care to their homes. However, since 1974 no new home care programs have been established at VA medical centers even though many centers have expressed interest in starting such a program. VA Central Office officials told us that, because of funding limitations, available resources have been used on higher priority programs.

In January 1977, VA Central Office issued a circular to selected VA medical centers soliciting proposals for home care programs. The circular stated that the proposals would be considered for funding in fiscal year 1979, noting that such funding could be delayed because of other budgetary considerations. In responding to the circular, 48 medical centers submitted program proposals.

Six of the eight centers we reviewed without home care programs submitted proposals. However, because of funding limitations, none of the 48 proposals was approved by VA Central Office.

Our examination of VA's budgeting process showed that the home care program generally receives a low priority compared to other VA programs. For example, in the preliminary fiscal year 1981 VA-wide budget, the home care program was ranked 149 out of 193 VA budget items.

VA's budgetary process also appears to act as a deterrent to expansion of specialized medical programs, such as home care. The major determinant of the budget's size and character is the number of operating beds.

In its May 1977 report, 1/ the National Academy of Sciences stated that VA's budgetary process appears to suggest that the medical center director would be reluctant to identify patients for outplacement because it would reduce the hospital's occupancy rate, thereby affecting hospital funding.

1/"Health Care for American Veterans," May 1977, page 47.

VA Central Office officials told us that they do not believe patients are retained in medical centers longer than necessary to keep occupancy rates high. They also said that they plan to expand the home care program as resources permit. However, VA's budget for fiscal year 1982 does not include funding for new home care programs.

PROGRAM MANAGEMENT NEEDS IMPROVEMENT

VA Central Office has allowed medical centers a great deal of flexibility in implementing their programs while providing little guidance and monitoring. Clearly defined objectives conveying VA's home care goals have not been established. As a result, at the eight VA medical centers we visited, wide variations in program practices occurred, including the types of services provided and patients treated. Also, some medical centers have questioned the appropriateness of VA's productivity standards and may have kept patients in the home care program longer than necessary in order to meet the standard. Management information reported by the programs was inaccurate and misleading.

Limited program guidance

Over the years, VA Central Office has issued several circulars and guidelines describing the program's objectives, staff responsibilities, patient selection criteria, and reporting procedures. Originally, a VA circular issued in November 1968 listed four program objectives:

--Faster patient recuperation through development of a suitable home environment and training of family members.

--Establishment of a proper climate in the home for preventive care.

--Increased turnover rate and increased bed availability for the care of acutely ill patients.

--Reduction of length of hospital stays, number of readmissions, and cost of medical care.

In April 1973, the original circular was incorporated into the Department of Medicine and Surgery's Operations Manual, and those sections pertaining to staff responsibilities and patient selection criteria were not materially changed. However, the 1973 manual eliminated any reference to the objectives of increasing the turnover rate and reducing the length of hospital stays and the cost of medical care. Currently, the manual states that the home care program is a specialized medical service that supplements inpatient care and its objectives are "* * * to obtain faster

patient recuperation through development of a suitable home environment and to establish a proper climate in the homes for continued preventive care."

VA medical center officials told us that they are uncertain about the intent and objectives of VA's home care program. Most officials believed more direction and guidance were needed from VA Central Office. Officials at five centers with home care programs told us that further clarification and uniformity in program scope and design, personnel staff requirements, and patient suitability were needed. The chief of staff at one medical center said that additional direction and guidance would insure more uniformity among individual home care programs.

Because of the lack of direction and guidance, some VA home care program coordinators had to obtain clarification on certain administrative matters from other VA centers. For example, the program coordinator at one center contacted each of the other 29 VA home care program coordinators to resolve a problem of mileage restrictions imposed by center management on visits to home care patients. The coordinator told us that, although the Central Office should provide assistance for such problems, it was unable to help him resolve this problem.

Central Office officials agreed that more direction is warranted. They said that a committee of program team coordinators was convened in 1976 to write home care guidelines, and although these guidelines have been finalized, they have not been published. These officials stated that, although they could provide more guidance, they had little control over VA medical center operations. They said that the medical center director is responsible for allocating staff and is in the best position to direct program operations in his or her facility.

Limited program monitoring

Since the home care program was established, VA Central Office officials have visited only 11 of the 30 programs, 2 of which were included in our review. Our review of the onsite visit reports showed that the scope of the visits varied and was limited in depth.

Central Office officials stated that they rely upon reports prepared by the centers to monitor the program. The reported information is compared to VA's productivity standard requiring each program to maintain an ADC of 50 patients and to make 350 home visits each month. Documentation on the appropriateness of this standard was not available.

Some medical center officials indicated that the productivity standard may not be applicable for all programs. The chief of staff from one medical center believed the 50 ADC criteria were somewhat arbitrary and that each center should establish its own goals based upon the medical conditions and ages of the patients treated. Two team coordinators believed that the standard was too low--their program's staffing and patient structure allowed for a higher patient census and more monthly visits. One program coordinator, however, requested that the standard be reduced to 30-35 patients because he could not obtain sufficient staffing to meet the standard.

Use of a uniform productivity standard apparently caused some home care programs to keep patients in the program longer than necessary. For example, a March 1979 VA Rehabilitation Medicine Service study at one medical center concluded that many patients may have been kept in the program longer than necessary to meet the standard's required quota for visits. At two other programs the study noted that 14 out of 40 and 11 out of 55 patients, who could have been discharged from home care, were kept in the program to meet the standard's requirement for ADC.

We also noted that the team visit figures were inaccurate and misleading. At four programs, the number of multidisciplinary team visits reported included medical and nursing students' visits. For example, of 4,142 visits reported by one program, 265 were student observation visits rather than physician visits. In another program, 4,753 home visits were reported in fiscal year 1978. These visits included 864 hospital bedside visits made while patients were temporarily readmitted to the medical center. This program did not regularly meet VA's 350 monthly team visit criteria when bedside visits were excluded.

Also, the VA Central Office used medical center home care cost reports and the number of home visits to calculate the "cost per visit" figure as a measure of cost effectiveness. The cost per visit amount for each program was then compared with the other 29 programs. While this provided some measurement and comparison of program costs, VA had not developed a cost standard to measure against. The cost per visit varied between programs and ranged from $25.59 to $109.21 in fiscal year 1979.

Medical center and program officials told us that VA's cost reporting lacked credibility. For example, four of eight programs excluded costs of prosthetic equipment used by home care patients, whereas the other four included such costs. One medical center official said that the lack of uniform cost data occurred because of inadequate guidelines from the Central Office. Also, a team coordinator believed that there is a tendency to "adjust" data to reflect a lower cost per visit figure. Two program officials

stated that using a cost per visit figure to measure cost effectiveness without a reliable standard is meaningless.

In February 1980, VA issued a report in response to a congressional inquiry on the cost effectiveness of the home care program. The report contained information on the program's cost and services but did not assess cost effectiveness because VA was unable "to obtain adequate information in one year for a program with low turnover"; thus, a subsequent study was planned. However, the Central Office home care program coordinator told us that they have not obtained funds for the followup study.

Services provided home care patients were influenced by staffing patterns

Program services were often influenced by the staffing composition of the home care team. Each of the eight home care programs we reviewed provided different combinations of medical, educational, and social services. Four programs emphasized educational and social activities (i.e., advising and training patients and caretakers on health maintenance and monitoring the patients' emotional conditions), two emphasized medical activities, and two provided combinations of all three.

In 1971, VA established a staffing criterion for home care programs of 9.25 full-time equivalent employees (FTEEs). VA Central Office officials believed this to be sufficient for meeting their productivity standard of 350 visits per month. VA's suggested staffing breakdown by type of position follows:

Position	FTEE
Physician	1.00
Public health nurse	1.00
Home health technician	4.00
Therapist	1.00
Dietitian	.25
Social worker	1.00
Secretary	1.00
	9.25

Staffing at the eight programs we reviewed ranged from 6.25 to 9.5 FTEEs. Only two programs met or exceeded the 9.25 FTEE criterion. Medical center officials of the six understaffed programs stated that the home care program was considered a low priority compared to other medical center inpatient services, and therefore, sufficient staff had not been assigned to the center's home care program.

The composition of the home care team and the discipline of the team coordinator can affect the focus of program services. For example, two programs emphasizing medical services had a staff mix of only professional disciplines with no participation by nonprofessional nurse assistants. The team coordinator from one of the programs told us that the program's primary objective was to provide physician-directed medical, nursing, and related home care services, while its secondary objective was educational. Another program used nonprofessional nurse assistants as the primary personnel making home visits. Medical center officials and home care staff perceived this program essentially as educational and social.

The types of program activities were also influenced by the background and discipline of the team coordinator. This was observed in two programs. In one program, the physician team coordinator viewed the program as an alternative to nursing home care. The program provided long-term care to patients in need of services from more than one professional discipline. At another program, the team coordinator--a registered nurse--emphasized patient education and nursing services with a minimum use of individuals with other disciplines. The patient stay in the program was short term and physician care was only provided during ambulatory clinic visits.

Home care team members stated that their staffs' limited medical capabilities have prevented referrals of suitable patients. Officials from one program told us that hospital ward staff did not refer patients because they believed the home care staff could not provide adequate medical services. In early 1979, this program was unable to obtain additional nursing staff, even though its only licensed nurse was on extended leave and the physician spent half of his time on the program. A ward physician at another center stated that he stopped referring patients because they were in worse medical condition after program discharge. The nurse on the home care staff at this center stated that continuity of care was often jeopardized because the team physician was only assigned part time. As a result, team nurses had to go to other physicians to seek advice on appropriate patient care, and often these physicians were not familiar with the patient.

Home care as an alternative to institutionalization affected by patient selection

In spite of the criteria shown on pages 2 and 3 for selecting the home care candidates, we found that home care program officials had different perceptions of the types of patients best suited for the program. Views differed on whether patients should (1) be nonambulatory, (2) receive treatment on an outpatient basis, (3) require a caretaker, and (4) require the services of more than one professional discipline. For example, although

acknowledging VA's patient selection criteria, the team coordinator at one center believed that the criteria for patient selection were unclear. At this center, patients who were placed in home care were generally ambulatory and making clinic visits to receive medical treatment. Also, our review of 55 home care patients in this program showed that 13 (or 24 percent) had no caretaker.

Our review of 208 patient files with home care officials at the eight programs showed that, if the home care program had not been in existence, about 67 percent of the patients would have remained hospitalized or would have been placed in nursing homes. However, 28 percent of the patients would still have been discharged to their homes and would have received medical treatment at VA ambulatory clinics. For these patients, it is questionable whether they were best suited for home care and whether their care provided any cost savings to VA. We were unable to obtain this information for the remaining 5 percent.

CONCLUSIONS

Home health care is generally recognized as a beneficial and cost-effective alternative to prolonged hospital and nursing home care.

We believe that the potential for program expansion exists. Our hospital ward surveys showed that many patients in VA medical centers could have used the home care program. However, VA has not attempted to identify and project the number of veterans suitable for home care or to expand the program since 1974.

The VA Central Office has allowed medical centers a great deal of flexibility in implementing their programs while providing little guidance and monitoring. VA has not established clearly defined objectives for the program conveying VA's home care goals. This lack of guidance limits program effectiveness and has resulted in wide variations in the home care programs implemented by the eight VA medical centers we visited.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that you direct the Chief Medical Director to:

--Clearly define the objectives of VA's home care program, emphasizing the cost benefits as a primary goal, and convey the objectives to all medical centers.

--Develop guidelines that assure more uniformity and consistency among individual home care programs.

ENCLOSURE I

--Conduct periodic program evaluations to assure that individual home care programs are carried out in accordance with agency policy and program objectives.

--Identify the number of veterans in VA medical facilities who are suitable for home care placement.

--Provide the program with adequate funding so that it can be expanded.

GENERAL INFORMATION ON 16 VA MEDICAL CENTERS INCLUDED IN OUR REVIEW

(as of September 30, 1979)

Medical centers (note a)	Number of beds		Bed occupancy rate		Cost per diem		Has home care program
	Hospital	Nursing home	Hospital	Nursing home	Hospital	VA nursing home	
			(percent)				
Bay Pines, FL.	666	120	92	97	$ 91.81	$55.98	Yes
Birmingham, AL.	420	-	68	-	150.38	-	Yes
Dallas, TX.	722	-	76	-	175.26	-	Yes
Des Moines, IA.	255	-	73	-	192.32	-	No
Gainesville, FL.	480	-	80	-	180.69	-	No
Hines, IL.	1,335	-	76	-	164.18	-	Yes
Little Rock, AR.	1,365	200	79	96	114.96	51.49	Yes
Long Beach, CA.	1,269	180	76	92	176.26	66.05	Yes
Los Angeles (Wadsworth), CA.	792	-	67	-	256.82	-	No
Milwaukee (Wood), WI.	800	200	86	98	155.01	57.10	No
Minneapolis, MN.	738	-	79	-	202.24	-	Yes
San Antonio, TX.	670	-	85	-	178.74	-	No
San Diego, CA.	570	60	78	92	210.32	86.13	Yes
Sepulveda, CA.	688	200	68	78	175.76	70.26	No
Shreveport, LA.	413	-	64	-	160.93	-	No
Tampa, FL.	697	-	82	-	171.64	-	No

a/All medical centers selected are general medical and surgical.

ENCLOSURE II