

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OPERATING PRACTICES OF LOW-COST
HOME HEALTH AGENCIES**

Seven Case Studies



**JUNE GIBBS BROWN
Inspector General**

**FEBRUARY 1997
OEI-04-93-00263**

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452 is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, settlements, and fraud alerts. The Inspector General informs the Secretary of program and management problems, and recommends legislative, regulatory, and operational approaches to correct them.

Office Of Evaluation And Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The inspection reports provide findings and recommendations on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's Atlanta Regional Office prepared this report under the direction of Jesse J. Flowers, Regional Inspector General, and Christopher Koehler, Deputy Regional Inspector General. Principal OEI staff included:

Atlanta Region

Paula Bowker, Project Leader
Ron Kalil, Team Leader
Christopher H. Koehler, DRIG
Peggy Daniel, Program Analyst
Tammy Hipple, Statistician
James Green, Contractor

Headquarters

Jennifer Antico, Program Specialist
Brian Ritchie, Program Analyst
Linda Moscoe, Program Analyst

To obtain a copy of this report, call the Atlanta Regional Office at (404) 331-4108.

EXECUTIVE SUMMARY

PURPOSE

To describe practices used by selected home health agencies which help them to provide low-cost care to Medicare beneficiaries.

BACKGROUND

Medicare expenditures for home health services have increased from \$3.3 billion in 1990 to \$15.1 billion in 1995 -- a nearly 5 fold increase in just 5 years. The average number of visits per beneficiary for all Medicare-certified home health agencies increased from 50 in 1993 to 58 in 1994. Expenditures vary significantly among home health agencies, as do average number of visits per beneficiary. In 1993, two thirds of home health agencies provided an average of 33 visits per beneficiary. The other one third provided 81 visits.

In previous studies, we determined that characteristics of the agencies, characteristics of patients, diagnoses, and quality of care did not explain this wide variation.

METHODOLOGY

We recently analyzed the operating practices of home health agencies to see if that could help explain the difference. As part of that study we conducted in-depth case studies of how low-cost agencies work.

We selected seven home health agencies for review. Our selection criteria included location in one of the five States with the highest Medicare expenditures, an average number of visits per beneficiary that was lower than the national average in 1993, and no record of investigation or negative audit findings or adverse actions, and an assortment of ownership types.

We interviewed management and key staff using a standardized discussion guide, and reviewed literature, computer and manually-generated data, and policies and procedures.

FINDINGS

We could not determine if the operating practices of the seven agencies we studied cause lower numbers of visits and lower costs. However, the case studies do illustrate what some home health agencies are doing to control costs while still being conscientious about quality of care.

- ▶ **The Seven Home Health Agencies We Reviewed Use Well-Trained Staff In An Effort To Foster Quality Care And Early Termination Of Services.** All seven, for example, required their aides to be State-certified, and in some cases went beyond

Medicare's minimum conditions of participation requirements regarding training and orientation.

- ▶ **All Seven Emphasize Discharge Planning.** Discharge planning is required by Medicare's conditions of participation. The seven selected agencies, however, took discharge planning extremely seriously and made an effort to ensure that it began at the very beginning of services. They also stressed informing both patients and caregivers that the goal of home health care was independence as soon as possible.
- ▶ **They Closely Monitor Patient Progress To Control Excessive Visits.** The monitoring included close attention of staff to each patient's condition, supervisory reviews, quality reviews, data analyses, and satisfaction surveys of both beneficiaries and referral sources.
- ▶ **Six Of The Seven Pay Staff A Salary Or Hourly Wage Rather Than By The Visit.** Six of the seven said paying a salary or by the hour is a way to help minimize unnecessary visits. Management believed that paying by the visit can provide an inducement to perform unnecessary visits, and can possibly compromise the quality of care. The seventh home health agency, which paid their aide staff by the visit did successfully keep the number of visits low. They did this by closely monitoring patients and by requiring that each staff member document the homebound status of patients during each visit.

The findings suggest that operating practices similar to those described above could help keep costs down without jeopardizing quality of care. More detailed descriptions of the operating practices of these seven home health agencies, along with data comparing them to others, can be found in the appendices.

TABLE OF CONTENTS

	PAGE
EXECUTIVE SUMMARY	
INTRODUCTION	1
FINDINGS	5
• Staff Training	5
• Discharge Planning	6
• Monitoring Patient Progress	6
• Paying Staff By Salary	9
APPENDICES	
Selected Home Health Agencies	A-1
Characteristics Of The Agencies	B-1
Site Visit Summaries	C-1

INTRODUCTION

PURPOSE

To describe practices used by selected home health agencies which help them to provide low-cost care to Medicare beneficiaries.

BACKGROUND

Home health care is nursing, therapeutic, medical social, and aide services provided in a person's home. Home health care allows people with limited mobility to live independently while still receiving professional health care services. All home health services must be specified in a plan of care certified by a physician.

Title XVIII, Section 1861, of the Social Security Act authorized Medicare Part A payments for home health care. For beneficiaries who do not have Part A entitlement, home health services may be covered by Medicare Part B. To receive Medicare reimbursement, home health agencies must provide a skilled care service to a homebound beneficiary on a part-time or intermittent basis.

Growth of Home Health Care

Medicare expenditures for home health care increased dramatically in recent years. To illustrate, between 1990 and 1995 Medicare expenditures for home health care grew from \$3.3 billion to \$15.1 billion -- a nearly 5 fold increase in just 5 years.

Between 1992 and 1993, Medicare expenditures for home health care increased by 78 percent. During this period, expenditures for home health care by all insurance sources in the United States increased by 23.8 percent. In contrast, the Health Care Financing Administration's (HCFA's) Office of the Actuary estimated that the cost of hospital care increased by 6.7 percent between 1992 and 1993. Likewise, expenditures for physician care increased by 5.8 percent between 1992 and 1993.

Variation in Cost of Care Among Home Health Agencies

Medicare expenditures for home health care per beneficiary varied significantly among home health agencies¹ in recent years. Importantly, the variation in reimbursement was not explained by differences in diagnosis, cost per visit, quality of care, or beneficiary characteristics such as age, gender, and race.

¹Variations Among Home Health Agencies In Medicare Payments For Home Health Services: OEI-04-93-00260

Most of the variation in reimbursement was explained by variations in the number of home health visits per beneficiary among home health agencies. Medicare regulations allow beneficiaries to receive an unlimited number of home health visits, and some home health agencies provide five times more visits per beneficiary on average than others.

On average, about two thirds of 6803 home health agencies provided home health care with 33 visits per beneficiary in 1993. The remaining one third averaged 81 visits per beneficiary. The high-visit home health agencies were more likely to be proprietary, for-profit and unaffiliated.

Concern About High-Cost Home Health Agencies

The wide variation in number of visits per beneficiary raised serious questions about possible differences in operating policies and practices of high and low-cost home health agencies. In our previous inspection, we looked at quality of care, among other things, of low-cost and high-cost home health agencies. We used the only available proxies for quality which were and are available from HCFA and other reliable sources -- complaints against a home health agency, survey deficiencies, and accreditation status. With respect to these measures, we found that low-cost agencies provided care that was comparable in quality to that provided by high-cost home health agencies, but they did so with fewer visits per beneficiary.

This suggested that operating practices used by low-cost home health agencies might provide examples that high-cost home health agencies could follow to keep cost down without adversely affecting quality of care. This report describes some of those practices.

METHODOLOGY

Selection of Home Health Agencies For Case Study

We selected seven home health agencies for this inspection. They are listed in Appendix A.

To select the home health agencies, we first identified and listed all home health agencies to whom HCFA had paid Medicare claims for home health service in 1993. We used HCFA's National Claims History Repository (NCHR) to identify the home health agencies. The NCHR shows both Medicare claims for home health services paid by HCFA, and provider numbers that identify States in which a home health agency is located.

From the listing of home health agencies that received Medicare reimbursement for home health service in 1993, we used the following criteria to select seven home health agencies.

- They must be located in one of the five Project Operation Restore Trust (ORT) States. At least one agency must be selected from each of the five ORT States.
- They must average fewer than 50.4 visits per beneficiary during calendar year 1993. The national average for home health agency visits per beneficiary in 1993 was 50.4.
- They must provide quality care. We based our quality care determination on number of complaints and deficiencies recorded in HCFA's On-line Survey and Certification Reporting System. Complaints and deficiencies are commonly used by HCFA as proxies for quality care.
- They must represent various types of ownership, including government, proprietary, for-profit, and not-for-profit. We determined type of ownership for selected agencies by using HCFA's On-line Survey and Certification Reporting System.
- They must not be under investigation, or have a record of negative audit findings or adverse actions. We made this determination by coordinating with the OIG Offices of Audit and Investigations, and with appropriate Regional Home Health Intermediaries (RHHI).

A summary on the extent of home health services provided by selected home health agencies is contained in Appendix B.

Data Collection and Analyses

At each selected home health agency we interviewed appropriate officials and staff using a standardized discussion guide. We also reviewed operating policies, procedures, and practices to corroborate and document responses provided to our standardized interview questions.

We compared data collected at site visits, and identified common practices which had been successfully implemented by two or more of the home health agencies. We profiled the practices as the basic analysis of our report. We also identified successful practices that were unique to one agency, but which might be useful if practiced more widely. Finally, we analyzed practices which were markedly different in the home health agencies to determine whether such practices had differential impact on the number of visits. We integrated this information into the body of the report and included brief individual case studies in Appendix C.

Our case studies of seven low-cost home health agencies supplement a survey we conducted of 300 randomly-selected high and low-cost home health agencies. In that study we describe similarities and differences in operating practices of these agencies. Our survey results are contained in an OIG report titled "Operating Practices of High-

Cost And Low-Cost Home Health Agencies," OEI-04-93-00261. As we discuss in that report, the mere existence of formalized operating procedures does not explain why some agencies incur higher costs while others incur lower costs. The case studies described in this report show how some of the lower-cost agencies are trying to keep their costs down while remaining conscientious about quality of care.

OPERATION RESTORE TRUST

This inspection was part of the President's Operation Restore Trust initiative. The purpose of Operation Restore Trust (ORT) is to identify and prevent fraud, waste and abuse in the Medicare and Medicaid programs. This is a joint initiative involving the Health Care Financing Administration, Administration on Aging, Office of Inspector General, and various State agencies. In 1995, Project ORT began targeting home health agencies, nursing homes, hospices, and durable medical equipment suppliers in five States for evaluations, audits, and investigations. The five States are Florida, New York, Texas, Illinois, and California. These States account for about 40 percent of the nation's Medicare and Medicaid beneficiaries and program expenditures.

— — —

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Generally, the philosophy of all seven home health agencies we inspected was to provide quality care to patients while simultaneously moving patients to a point of independent living. Regardless of how loftily or how simply an agency stated its philosophy, the overriding theme was to teach patients to care for themselves, to teach caregivers to care for the patient, and to help patients function independently. Each emphasized quality care as a precursor to patients gaining independent living status and early discharges from home care. Accordingly, they attempted to assure quality care by using well trained staffs, focusing on discharging patients, assuring that care provided was consistent with patient needs, and eliminating incentives for staff to make unnecessary home health care visits.

We could not determine if these operating practices cause lower numbers of visits and lower costs. However, the case studies do illustrate what some home health agencies are doing to control costs while still being conscientious about quality of care.

The Seven Home Health Agencies We Reviewed Use Well Trained Staff In An Effort To Foster Quality Care And Early Termination Of Home Health Service

Each of the seven selected agencies required their staffs to be well qualified for their jobs. To illustrate, all seven required home health aides to be State-certified. As required by the Medicare program conditions of participation, all seven required aides to attend at least 12 hours of in-service training. However, two went beyond the minimum requirements. One, for example, required an additional 40 hours of training for newly hired aides. Another required home health aides to complete 48 hours of continuing education every 2 years.

Likewise, the seven selected agencies required skilled staffs to undergo extensive orientation and training. One, for example, required registered nurses to undergo a 3 month orientation. At another, the orientation was customized to the individual needs of skilled staff members. One required RNs to go through an orientation followed by a 12-week mentoring program. Another required the nurses to attend at least ten in-service training programs yearly.

To assure that staff are well qualified, five of the agencies required all new hires to pass a competency and skills evaluation. One only hired experienced staff, hiring skilled staff from other agencies, and aides from a State registry. Additionally, most of them checked references of new hires. Some even required that staff have a current immunization record and liability insurance.

All Seven Emphasize Discharge Planning Starting When A Patient Is Admitted For Home Health Care

All seven home health agencies said they begin discharge planning during the first visit with a new patient. Such planning is required by HCFA's Conditions of Participation for Medicare home health agencies. The agencies' staffs emphasized that home health care should be tailored to a patient's needs, and it should be terminated when a patient is capable of independent living. Typically, when commencing service, selected staffs evaluated a patient's condition, and estimated duration and number of home health care visits to be made. Staffs at the home health agencies we reviewed emphasized that the focus is on moving a patient to a point of independent living.

Patients and family members who are involved in caring for patients, are advised when home health care commences that it is temporary care. Patients are never allowed to believe that home health care is permanent. This helps avoid any misunderstandings and pressure to continue care after a patient is no longer homebound. Staff at all seven home health agencies included in our study, advised us that they strictly follow the Medicare homebound criteria when deciding whether or not to initiate, continue, or terminate home health care.

As a patient's condition changes, the plan of care is adjusted. If a patient progresses faster than expected to a point of independent living, care is terminated and the patient is discharged.

The home health agencies we reviewed told us that the orientation toward ending home health services provides a framework for preventing unnecessary visits. For example, one manager told us that staff see discharge planning as a contract. The staff provide estimates to patients and their families on what care to expect, length of care, and number of visits. Such discharge planning sets a tone within the agency that unnecessary visits will not be made. It also establishes an understanding with patients that home health care services are time-limited, and it helps focus patients toward reaching independence.

They Closely Monitor Patient Progress To Control Excessive Visits

Each of the home health agencies we inspected had written procedures and operating practices for evaluating and monitoring patient condition, and determining that patients were progressing toward independent living as planned. The home health agencies used a variety of evaluation and monitoring practices, including staff monitoring of patient condition, supervisory reviews, quality reviews, and analyses of types and number of patient visits. Usually, individual agencies used a combination of the various techniques.

Staff Monitoring: The seven home health agencies we inspected required all staff to constantly evaluate and monitor beneficiaries to determine that home health services are reasonable and necessary. The evaluation and monitoring started immediately after a patient was referred for home health care and continued until a patient was discharged.

For each patient, the agencies performed an initial patient evaluation². Generally, a registered nurse did the initial evaluation. Typically, the RN contacted a patient's physician for medical orders and did a physical examination of the patient to determine homebound status, types of home care needed, frequency of home care visits, and duration of visits. This information was then incorporated into a plan of care for the patient.

According to staffs we interviewed, the initial patient evaluation is vitally important to assuring that care is reasonable and necessary for each patient. It helps avoid unnecessary home health care visits. One director, for example, said the initial evaluation assures appropriate service and controls use. Another said the most important question answered by the initial evaluation is whether home health care will benefit a patient by restoring or improving ability to function independently. Another agency devoted an entire section of the procedures manual to the initial evaluation. The focus of the procedures was on determining eligibility for home care, and the types and frequency of service needed. Procedures at another agency required staff to contact a patient's physician within 48 hours of referral to ascertain, among other things, appropriate types, frequency, and duration of home health services.

After starting home health care, each of the seven home health agencies required staffs to continuously evaluate a patient's progress. For this purpose, most of the home health agencies assigned each patient to a case manager. The case manager was always a registered nurse. The objective was to assure that services provided are consistent with patient needs, and that patients progress as rapidly as possible to a point where they can function independently.

One director advised us that constant evaluation of a patient's condition is the key to assuring appropriate services and number of visits. As a patient's condition changes, the plan of care is updated, and when the patient is no longer homebound care is terminated. As part of its case management, one agency, for example, conducted daily reviews of patient progress and services provided. Another encouraged staff who contact patients to advise the nurse manager of any change in patient condition. Another required staff to contact the case manager within 24 hours of providing home care to a patient. Finally, another agency required staff to document and certify a patient's homebound status after each visit.

Supervisory Reviews: In addition to constant evaluation of each patient's condition by field staff, each home health agency required supervisory review of patient services. The method of supervision varied among the seven home health agencies. However, to assure that home care was appropriate and reasonable to patient needs, supervisory nurses typically reviewed progress notes and followed-up as appropriate, compared patient progress to plans of care, and evaluated patients personally. One agency required supervisory nurses to visit patients at least every 14 days. Such visits may be

² The HHAs used various terms to refer to the initial evaluations. For example, they used such terms as initial assessment, initial screening, and start of care visit.

made jointly with or independently of the aides and nurses actually providing care. One director said the goal of such supervisory review is to move a patient out of service as quickly as feasible. Another director said the skill of supervisory nurses leads to more appropriate patient care which results in fewer home care visits.

One of the home health agencies we inspected told us nurse supervisors are responsible for questioning any deviation in service, and apparent failure of patients to respond appropriately. Another agency said that if the supervisory nurse observes a discrepancy between a patient's condition and plan of care, the nurse may initiate action to replace aides and nurses, and to terminate or increase the frequency of home care visits.

Likewise, each of the seven home health agencies we inspected had specific procedures for recording, investigating, and resolving complaints. Such procedures for complaints are required by the Medicare program conditions of participation. When a patient complains about care, it is recorded and brought to the attention of the supervisory nurse. One agency required that supervisory nurses investigate any complaint within 24 hours after it is received. Equally important, however, is the practice of some home health agencies of analyzing and summarizing complaints. The purpose is to identify systemic problems that might adversely impact patient progress toward achieving independent living status. The resolution of such systemic weaknesses clearly results in earlier discharges and fewer visits per beneficiary than would otherwise be possible.

Quality Reviews: All seven home health agencies we inspected performed some type of quality review on patient services. The agencies typically used a combination of techniques, including quality assurance teams, peer reviews, staff conferences, and utilization review committees.

One home health agency described the quality assurance policy as to systematically and objectively evaluate the quality and appropriateness of patient care. To this end, a utilization review committee met quarterly to assure appropriate delivery and use of services. Another agency used a quality management team to identify problems and trends in care, and to intervene when needed to improve patient care. Another agency convened a utilization review committee which included agency members and members of the community. The committee met quarterly to review beneficiary records of home health care. Another agency used a quality improvement audit to regularly evaluate beneficiary records to determine that home health care was appropriate for patient needs. One agency conducted quarterly peer reviews of patient care. Finally, most of the home health agencies used monthly conferences or quarterly conferences to help assure that appropriate care was provided, and to control excessive visits.

Satisfaction Surveys: Six of the seven home health agencies included in our inspection conducted patient satisfaction surveys to monitor appropriateness of care. For example, one agency verbally surveyed all patients at the beginning of service and immediately after discharge. Additionally, this agency conducted a monthly mail survey of a random sample of patients who are currently receiving services. Each quarter, another agency surveyed a 5 percent sample of its patients by telephone, and another 10 percent sample

by mail. One agency that surveyed its patients used an outside organization to analyze the results, and to compare the agency's performance to that of other agencies who used the same outside organization. Patients included in the survey were those that had been admitted for home health care 12 months, 6 months, and 1 month earlier than the survey date.

Likewise, six of our selected home health agencies regularly conducted satisfaction surveys of physicians and others who referred patients to them for home health care. For example, twice a year one agency surveyed about 80 percent of the physicians and others who referred patients to the agency.

Data Analyses: Four of the seven home health agencies we inspected collected and analyzed statistical data on services provided to identify trends and monitor use--e.g., number of visits. When such analyses showed an unusually large number of visits per beneficiary over time, it might trigger other more penetrating types of analyses, such as a supervisory review or quality analyses. One agency maintained an automated data base for tracking and analyzing home health use over time.

Six Of The Seven Home Health Agencies Pay Staff A Salary Or Hourly Wage Rather Than By Visit To Help Minimize Unnecessary Visits

Six of the seven home health agencies we inspected paid home health aides a salary or hourly wage rather than compensating based on number of visits they made. The remaining agency paid home health aides by the visit. Likewise, five of the seven home health agencies paid their nursing staff by the hour or a salary. One paid nurses by the visit. The remaining agency compensated some nurses by the hour and others by the visit.

According to some agency directors, compensating by the salary or hourly wage eliminates an incentive for staff to make unnecessary visits. For example, the manager at one agency which paid home health aides by the hour said the aides understand that there are no quotas for numbers of visits per beneficiary, and no advantage in making as many as possible. According to the Aide Coordinator, each home health aide visits five to six patients per day, on average. The Coordinator stressed that service quality would be diminished if an aide made more than five or six home health care visits per day. Similarly, the manager at another agency said that paying staff by the hour, rather than by the visit, helps ensure quality service. At this agency, staff are instructed to deliver as many skilled services in one visit as are appropriate, based on each patients' individualized plan of care.

Some agency managers we interviewed stated that paying staff by the visit offers an incentive for staff to provide unnecessary visits. However, the agency that paid home health aide staff by the visit did successfully keep the number of visits per beneficiary low. According to the Director and staff, they kept the number of visits low by closely monitoring patients, and by requiring that the staff document the homebound status of

each patient during each visit. Such monitoring enabled the agency to timely terminate home health visits based on patient condition.

APPENDIX A

SELECTED HOME HEALTH AGENCIES (HHAs)

- Mid-Florida Home Health Services, Winter Haven, Florida
not-for-profit, private, hospital-based
- Premier Health Connection, Walnut Creek, California
proprietary, nonaffiliated
- Holy Cross Home Health Services, Chicago, Illinois
not-for-profit, religious-affiliated
- American Care, Inc., Newburgh, New York
proprietary, non-affiliated
- Westchester County Department of Health, Hawthorne, New York
government-operated Official Health Agency
- Spohn Home Health, Corpus Christi, Texas
not-for-profit, religious-affiliated, hospital-based
- Linden Municipal Hospital Home Health Systems, Linden, Texas
not-for-profit, hospital-based

APPENDIX B

CHARACTERISTICS OF THE SELECTED HOME HEALTH AGENCIES

Average Number Of Visits Per Beneficiary By Selected Home Health Agencies Was Lower Than The National Average

Nationwide, the average home health agency made 50.4 visits per beneficiary in 1993 and 58.4 visits in 1994. Table 1 shows that in 1993 and 1994 the seven home health agencies we selected for our case study averaged 25.1 and 27.0 visits per beneficiary -- about half the national average.

The average number of visits per beneficiary by our seven selected home health agencies ranged from 19 to 31 in 1993, and from 23 to 33 in 1994.

TABLE 1		
Comparison Of Visits By Selected HHAs To The National Average		
	1993 Average Visits	1994 Average Visits
Premier Health Connection	24	23
Mid-Florida Home Health Services	27	28
Holy Cross Home Health Services	20	24
Westchester County Dept. of Health	20	25
American Care, Inc.	31	31
Spohn Home Health Care	25	32
Linden Municipal Hospital Home Health Systems	19	33
NATIONAL AVERAGE	50	58
Source of Data: HCFA's National Claims History File		

Average Number of Visits Per Beneficiary By Selected Home Health Agencies Was Lower Than The State Average For All Home Health Agencies Located In The State

In both 1993 and 1994, each of the seven home health agencies we selected for case study averaged fewer visits per beneficiary than did the average home health agency in the State where they were located. Table 2 compares the number of visits per beneficiary by our selected agencies to the average number of visits by all home health agencies located in their respective States.

TABLE 2				
Comparison Of Average Visits By Selected HHAs To The State Averages				
	1993		1994	
	Average Visits By		Average Visits By	
HHA	HHA	STATE	HHA	STATE
Premier Health Connection	24	36	23	39
Mid-Florida Home Health Services	27	57	28	60
Holy Cross Home Health Services	20	40	24	45
Westchester County Dept. of Health	20	42	25	39
American Care, Inc.	31	42	31	39
Spohn Home Health Care	25	63	32	83
Linden Municipal Hospital Home Health Systems	19	63	33	83

Average Number Of Aide Visits By Selected Home Health Agencies Was Lower Than The National Average

In a prior inspection (OEI-04-93-00260) on variation in average Medicare reimbursement per beneficiary for home health care, we found that some agencies averaged seven times more aide visits than others. Table 3 shows that all seven home health agencies we inspected averaged below the national average in aide visits per beneficiary in 1993 and 1994. Our seven selected home health agencies averaged less than half the national average in 1993, and only one averaged more than half the national average in 1994.

TABLE 3		
Average Number Of Home Health Aide Visits Per Beneficiary By Selected Home Health Agencies Compared To The National Average		
	1993 Average Visits	1994 Average Visits
Premier Health Connection	4.5	4.0
Mid-Florida Home Health Services	8.8	8.4
Holy Cross Home Health Services	5.3	7.0
Westchester County Dept. of Health	5.1	7.5
American Care, Inc.	10.7	11.6
Spohn Home Health Care	9.0	11.0
Linden Municipal Hospital Home Health Systems	7.9	16.9
NATIONAL AVERAGE	23.6	27.6

Average Number Of Skilled Nursing Visits By Selected Home Health Agencies Was Lower Than the National Average

In both 1993 and 1994, skilled nursing visits per beneficiary by selected home health agencies averaged well below the national averages (See table 4).

TABLE 4		
Average Number Of Skilled Nursing Visits Per Beneficiary By Selected Home Health Agencies Compared To The National Average		
	1993 Average Visits	1994 Average Visits
Westchester County Dept. of Health	9.3	10.9
Holy Cross Home Health Services	10.4	11.4
Spohn Home Health	10.5	14.4
Linden Municipal Hospital Home Health System	10.6	15.7
Mid-Florida Home Health Services	12.5	14.0
Premier Health Connection	14.5	14.4
American Care, Inc.	16.7	15.8
NATIONAL AVERAGE	21.5	25.1

APPENDIX C

SITE VISIT SUMMARIES

<u>HOME HEALTH AGENCY</u>	<u>PAGE</u>
Mid-Florida Home Health Services	C-2
Premier Health Connection	C-5
Holy Cross Home Health Services	C-8
American Care, Inc.	C-11
Westchester County Department of Health	C-14
Spohn Home Health	C-17
Linden Municipal Hospital Home Health Systems	C-20

MID-FLORIDA HOME HEALTH SERVICES WINTER HAVEN, FLORIDA

General and Background

This home health agency is a not-for-profit, hospital-based home health agency which is a division of Mid-Florida Medical Services. They have one branch and serve the population of 2,000-square-mile Polk County, Florida. Polk County has a population of approximately one half million people who live in both urban and rural areas.

Mid-Florida Home Health Services first received JCAHO accreditation in 1991. They are also members of the National Association for Home Care, the Associated Home Health Industries of Florida, and the Florida Hospital Association Home Care Section. Their policies, budget, financial status, quality improvement process, program development and program evaluation are overseen by a volunteer board of trustees who are appointed by the Parent Board of Mid-Florida Medical Services.

The agency's average reimbursement per beneficiary in 1993 was \$1448 and the average number of visits per beneficiary was 27. In 1993, the majority of their Medicare beneficiaries were between the ages of 65 and 79 (59 percent), and most were white (90 percent). The majority of their work in 1993 and 1994 (83 percent and 86 percent respectively) was done for Medicare beneficiaries. In 1993 they had 100 FTEs. In addition to FTEs, they use approximately 24 contract employees who are therapists or medical social workers.

How does the Home Health Agency ensure that the people they are serving are qualified for Medicare home health care and the appropriate number and types of services are provided?

This home health agency's Medicare beneficiaries usually come from a hospital into home care. Typically patients are referred by a discharge planner or social worker; however, a patient, patient's family, or attending physician will occasionally suggest home care. Once a referral is received by the agency, they send an RN out to perform a "start of care" (SOC) visit. An entire section of their procedures manual is devoted to ensuring eligibility and determining types of services and frequency of visits during an SOC visit.

The agency has a precise, written definition of homebound. If a person is non-ambulatory, needs assistance to leave home or leaves home infrequently, or uses a device to assist in moving around, the person is probably homebound. More precisely, the procedures manual points out that documentation of a person's homebound status is important on the very first visit, and that such documentation needs to include such things as shortness of breath; weakness; use of assistance devices such as walker, cane, wheelchair, bedside commode, shower chair; need for assistance from care giver; or other indicators of limited mobility.

Because of the agency's emphasis on patient independence, discharge planning is part of the very first visit to a new patient. If a person has consistently met the goals in the assessment file and on his/her plan of care, and if s/he remains unchanged for 2 to 3 weeks at that level of performance, then the home health agency staff are to discontinue home care services.

The key to insuring that only necessary services and an appropriate number of visits are given is constant reevaluation of the beneficiary. As a person's condition changes, the goals in his or her file are updated. If a person has a record of a large number of visits over a long period of time, a case review conference may be held and a supervisor sent out to evaluate that person's condition.

This agency maintains data bases for tracking numbers of visits by type and contrasting those figures to the previous year or years. The Quality Control (QC) staff are continually reviewing patient records, counting visits and matching visits to notes in each patient's file. If no notes are found to substantiate a visit, that visit is never submitted to Medicare for reimbursement.

How does the Home Health Agency attempt to assure quality of services?

This home health agency is extremely active in quality assurance. They have an entire section in their manual on total quality management and a formal quality improvement plan. The plan includes quality improvement teams which identify problems and trends and intervene to improve patient outcomes. The teams report their activities to the quality improvement (QI) committee, which meets quarterly. The QI committee also monitors satisfaction surveys completed by patients, physicians, and referral sources. The committee issues quarterly reports on the results of satisfaction surveys, non-admits, patient incident reports, and employee reports to the Board of Trustees.

The policy on quality improvement is to "systematically and objectively monitor and evaluate the quality and appropriateness of patient care by empowering all staff to be part of the problem-finding and decision-making process on an ongoing basis." While the governing body assumes overall legal authority and responsibility for quality improvement planning and implementation, the Administrator is responsible for the overall program, and the Quality Management Supervisor is responsible for the actual operations of the program. In addition, a Utilization and Clinical Records Review Committee meets quarterly to assure that services are delivered appropriately as needed and to identify inappropriate utilization. The Patient Care Service Director is responsible for taking action to address problems or improve care.

Concern for giving quality care is further reflected in the agency's commitment to training and orientation. RNs are in orientation for three months. One year of case management experience is required prior to an RN being considered for a position in quality assurance. The agency has an orientation manual for all new staff, who are required to rotate through all sections of the organization, to attend a skills lab, and to have a preceptor accompany them in the field. RN staff are assigned to a geographic

area; however, within each area an attempt is always made to make the best match between a patient's condition and care needs and the particular skills and experience of an RN.

Home health aides are also trained to play a continuous role in ensuring quality care. Aides are required to have CNA certification, which is supplemented with 40 hours of in-house training by the agency, field evaluations and frequent competency testing. Every two weeks an RN makes a supervisory visit to check on the performance of an aide. Aides are paid by the hour rather than by the visit, and their records regarding charges and mileage are closely monitored to ensure accurate reporting.

What is the philosophy of the Home Health Agency?

This agency has developed a comprehensive manual which contains, among other things, a formal, written philosophy. An important facet of the agency's philosophy is to teach another caregiver or the patient to perform the tasks that agency staff are performing so that they can decrease and eventually cease services. The written philosophy statement says that the primary goal of the agency is to provide the highest quality of health care to the patient while using well qualified staff, preserving the patient in the home, and meeting the needs, including the spiritual needs, of each patient. The philosophy acknowledges each person's right to be treated with dignity and respect.

In addition to a philosophy statement, the manual contains a mission statement, a definition of a patient, and a clear statement of the agency's objectives. It contains a detailed description of each job in the agency, lines of authority, procedures for performing jobs, time card completion, Medicare and Medicaid regulations, safety guidelines, procedures for supplies, charges and mileage, and a multitude of other details.

PREMIER HEALTH CONNECTION WALNUT CREEK, CA

General and Background

Premier Health Connection, previously known as the Premier Health Services of the Bay Area, is a proprietary, for-profit, non-affiliated home health agency headquartered in Walnut Creek, California. It was established in 1977, and serves the entire San Francisco Bay area, including the mainly urban counties of Alameda, Contra Costa, Solano, Napa, Sonoma, San Francisco, San Mateo, and Marin. In addition to Medicare patients, they also serve private pay, third-party pay, Medicaid (Medi-Cal), and HMO patients of Kaiser-Permanente.

The agency is divided into two divisions, the Intermittent Care Division, which provides home health services, and the Continuous Care Division, which serves people who need around-the-clock, custodial care in their homes. The agency is run by a governing body of officers, and receives guidance from an Advisory Board which consists of professional and community people who review the organization's policies and recommend improvements. The Advisory Board is comprised of at least one physician and an RN, one of whom is neither an owner nor an employee of Premier, and representatives of consumers, hospitals, medical and other health-related entities in their market area.

Premier has been accredited by JCAHO since 1991. They received a commendation from JCAHO after their most recent review in 1994. In addition, they belong to the CAHSAH (California Association for Health Services at Home), the NAHC (National Association of Home Care), the Bay Area Regional Council (an offshoot of the CAHSAH), and the Continuity of Care Council.

In 1994, slightly more than half (51.7 percent) of their visits were made to Medicare beneficiaries, 45.4 percent to "other/third party," 1.8 percent to Medi-Cal, and 1 percent to private/self pay.

How does the Home Health Agency ensure that the people they are serving are qualified for Medicare home health care and that the appropriate number and type of services are provided?

The agency's policy and procedures manual (PPM) contains several sections which address eligibility. Those sections include a policy and procedures on verifying the Medicare status of newly-referred patients, on acceptance and assignment of referrals and initial assessment of new patients, and on the admission criteria and protocol for Medicare beneficiaries. Those procedures are so detailed that they require the staff person who opens a case to see a Medicare beneficiary's Medicare card.

Agency personnel are required to verify and document for each visit that a Medicare beneficiary is still homebound. Ascertaining that a person is in need of skilled services is accomplished through a combination of the orders received from his/her attending

physician and an evaluation of the person's condition by the staff person who opens the case. If a person does not meet all criteria for admission, agency personnel will notify the referral source and provide information on alternate care sources.

Several levels of personnel monitor a case to ensure the appropriateness of the number and types of visits. As soon as a patient is evaluated, a case goes to the Utilization Review Nurse, who develops a Plan of Care specifying the frequency, duration, and types of services to be provided. The completed Plan of Care is sent to the attending physician who must verify his/her orders and sign the plan. In addition the Nursing Supervisor, Utilization Review Nurse, and staff hold monthly team meetings and patient care conferences in which they discuss the progress of a patient and any appropriate changes to a Plan of Care. Any employee involved in a patient's care is empowered to call a supervisor or any other discipline to discuss a patient's progress.

Agency staff are required to document and certify as to the condition of a patient after each visit. Each plan of care is reviewed every 60 days and revised as necessary before being sent to the certifying physician for signature. The PPM requires that the frequency, duration, and type of services be part of this review.

How does the Home Health Agency attempt to assure quality of services?

The results of patient evaluations are fed into the Quality Assessment and Improvement Audit Program. The Continuous Utilization Review/Quality Improvement Audit Program ensures that services are appropriate; that patients' needs are met both quantitatively and qualitatively; that each patient's records reflect needs, conditions, problems, goals, services, diagnoses, and evidence of medical necessity; that each discipline's role is clearly delineated; and that field staff receive ongoing guidance and feedback. Patient care evaluations and clinical records are audited to monitor quality and to address problems or complaints.

The agency also operate a Performance Improvement Plan. The plan is intended to achieve the best possible patient service and is designed to monitor and evaluate the quality of services, pursue opportunities to improve services, and resolve problems. Included in this plan are patient and client satisfaction surveys. Each quarter the agency selects 5 percent of their patients to survey by telephone and another 10 percent to survey by postcard. Twice a year they survey about 80 percent of physicians and other referral sources by mail.

To ensure technical skills and competency, the agency performs a competency and skills evaluation of all new staff and provides an orientation. RNs participate in a 12-week mentoring program following orientation. The agency's standards for hiring aides are higher than the Medicare conditions of participation. Aides are also required to take 48 hours of continuing education every two years.

Two other processes which relate to quality assurance are the "ethics forum" and a service code of ethics. The ethics forum provides support and advice in dealing with

ethical dilemmas, particularly in more complex situations and in cases which are more problematic for the staff. The service code of ethics is a pledge which agency personnel take in recognition of the importance of providing quality services. The pledge includes such principles as consistently providing quality service in accordance with the highest professional and ethical standards possible; abiding by all Federal, State, and local laws, rules and regulations; not discriminating on the basis of age, race, sex, creed, color, national origin or handicap; and carefully matching skills and abilities of the staff to the needs of the clients.

What is the philosophy of the Home Health Agency?

Their policies and procedures manual contains a written mission and philosophy statement. It says that their mission is to provide high-quality, cost-effective multi-disciplinary health services to patients and clients.

Their philosophy statement says that home care plays an integral part in the complete health care system, supplying patients and families with a cost-effective alternative in the privacy and dignity of their place of residence. It goes on to say that they believe that each patient has the right to considerate and respectful care, including the right to live and die with all the dignity and respect that human life contains, and the right to know his/her diagnosis.

The agency's emphasis is on teaching the patient or a caregiver to provide all the care that agency staff are providing, and to, thereby, make the patient as independent as possible, as soon as possible.

HOLY CROSS HOME HEALTH SERVICES CHICAGO, IL

General and Background

Holy Cross Home Health Services (HCHHS) is a department of Holy Cross Hospital, which was founded by the Sisters of Saint Casimir. Home health services were started in 1990. HCHHS is a volunteer, not-for-profit agency which serves patients in metropolitan Chicago. The agency has been accredited by JCAHO since 1990, and was last surveyed by the Commission in 1995.

The agency's governing body is the Board of Trustees of the Holy Cross Hospital. The Board is legally responsible for the home health agency operations. Responsibilities outlined for the Board in the policy and procedures manual (PPM) include annually reviewing, revising, and adopting policies, procedures and objectives of the Department, reviewing the Department's operations, and appointing the Professional Advisory Committee. This Committee participates in evaluating the home health services program. A Professional Advisory Committee, which helps guide the agency, is comprised of the VP of the hospital, the Director of HCHHS, the Supervisor of Patient Care Services, one physician, the fiscal manager and human resources director of the hospital, selected representatives from the professional services offered, a communication/data processing representative, and a community representative who is not a hospital or agency employee.

The agency's patient population is approximately 83 percent Medicare beneficiaries, 9 percent Medicaid recipients, and 8 percent "other payers."

The agency belongs to the Illinois Hospital Association, the Illinois Home Care Association, and the NAHC.

How does the Home Health Agency ensure that the people they are serving are qualified for Medicare home health care and that the appropriate number and type of services are provided?

According to their PPM, referrals may be accepted via telephone, facsimile, or in person, and a referral form is completed at that time. Following the initial contact, the Home Health Coordinator, Supervisor of Patient Care Services, or the Director may contact the patient or family for additional information. All referrals are reviewed and approved by the Home Health Coordinator, Supervisor of Patient Care Services, or Director for appropriateness. This verification process includes contacting a patient's attending physician, if the referral source was a non-physician, to verify the person's homebound status and to obtain care orders. The review also includes ensuring that the services are necessary and reasonable. If a patient does not meet all admission criteria, the agency will recommend another source of care to the patient, family, or referral source. If the patient has been discharged from Holy Cross Hospital, an interview and chart review are also performed to ensure appropriateness.

The majority of the home care referrals come from the hospital and physicians' offices. At the time of referral, information regarding the patient's eligibility for Medicare home health services is obtained, including the Medicare number, skilled care needs, physician's orders, and homebound status. Prior to discharge, the home care coordinator/hospital liaison visits as many hospital referrals as possible to confirm needs and eligibility, set expectations and review the medical chart to facilitate smooth hospital to home transition. The appropriateness of home care for a patient is reconfirmed during the initial assessment visit performed by an RN.

All referrals are reviewed and approved by the Home Health Coordinator, Supervisor of Patient Care Services, or Director to ensure appropriateness. This verification process includes contacting a patient's attending physician, if the referral source was a non-physician, to verify the person's homebound status and to obtain care orders. The review also includes ensuring that the services are necessary and reasonable. If a patient does not meet all admission criteria, the agency will recommend another source of care to the patient, family, or referral source.

Monthly meetings are held among the various disciplines to discuss the progress of each patient and to adjust the type and frequency of visits accordingly. In addition, the Supervisor of Patient Care Services has case conferences with staff to discuss each patient. She also reviews notes in each case file and accompanies all RNs into the field on problem cases.

Their PPM also requires that the physician be contacted within 24-48 hours of the initial visit to confirm his/her orders, medications, services, frequency of visits, frequency of communication, parameters, and outcome expectations. When recertification is required, the physician is contacted by telephone again. When agency staff believe the patient should be discharged, the physician is once again contacted approximately one to two visits or no less than one week prior to discharge to obtain orders to continue care or authorization to discharge.

How does the Home Health Agency attempt to assure quality of services?

The agency employs a variety of mechanisms to ensure quality. Their PPM requires that they perform case management "to ensure quality patient care and effective coordination of multi-disciplinary care." Case management requires RNs to assess patients, submit appropriate documentation, follow-up with physicians, and maintain the frequency of visits in accordance with the Plan of Care. In addition, RNs are required to make supervisory visits at least every 14 days, either alone or in tandem, to oversee the work of home health aides.

The PPM also requires that staff supervision be provided at all times. This includes daily discussions on an informal basis regarding patient care and organizing workloads, formal case conferences, reviews of documentation, observation visits, and chart reviews.

The agency uses the Holy Cross Nursing Service Quality Management Report as a quality assurance monitoring device. This report is part of their ongoing Quality Assurance Review and includes infection surveillance, home health aide compliance, reviewing documentation, measuring patient satisfaction and physician satisfaction, and gathering and analyzing statistical data to identify trends and monitor utilization (including average number of visits) by service and by discipline. They also evaluate case files and charts of patients who are readmitted to the hospital within 30 days of having been discharged from the hospital and placed in home health care. Peer reviews of cases are conducted on a quarterly basis.

Any complaints by a patient or family member are followed up within 24 hours of receipt, as are any negative responses on patient or physician satisfaction surveys. A corrective action plan must be developed and executed for any complaints received. The agency must respond to recommendations made by either body.

All new employees must go through an orientation period. The length of the orientation is tailored to fit the needs of each person, based on that person's job classification, knowledge level, and experience. In addition, an in-service education program is offered each month. RNs are required to attend at least ten in-service/competency programs per year, and home health aides are required to have twelve hours of in-service training per year, three hours per quarter. RNs who are on the hospital registry and are not full time employees of the agency are encouraged to attend as many in-service training sessions as possible. Staff are also encouraged to attend in-service training programs offered at Holy Cross Hospital.

What is the philosophy of the Home Health Agency?

Their policies and procedures manual contains written statements of their mission, philosophy and agency objectives. Their mission is to provide quality, professional, and support services to patients in their homes to return patients to their maximum level of health and independent function.

The philosophy which bolsters their mission is that home health services should minimize negative patient illness and disability outcomes; maximize potential client level-of-independence outcomes; restore, maintain, and promote patient health; and meet each patient's needs to assist them in finding the meaning of their experience and to promote self-actualization. Their philosophy includes a commitment to educating the patient, the patient's family, and the community.

**AMERICAN CARE, INC.
NEWBURGH, NY**

General and Background

This home health agency is a proprietary, non-affiliated, organization. It opened in June, 1988 and was certified, at that time, to serve Medicare beneficiaries. It serves a two-County area, one of which is suburban and one of which is rural. The Newburgh office serves beneficiaries in Orange County. In adjoining Ulster County they operate a branch office in New Paltz and a new branch opening soon in Kingston. Ulster County is considered rural.

The agency is in the process of obtaining accreditation from the JCAHO. They consider accreditation an asset for marketing purposes. In addition, the agency belongs to the New York State Association of Health Care Providers and the National Association for Home Care.

Seventy-five percent of the agency's patients are Medicare beneficiaries. The remaining twenty-five percent are Medicaid (15 percent) and managed care (10 percent). In 1993, their average reimbursement per beneficiary was \$1917. That figure rose slightly to \$2022 in 1994, but the average number of visits remained the same for both years, 31 visits per beneficiary.

How does the Home Health Agency ensure the people they are serving are qualified for Medicare home health care and that the appropriate number and type of services are provided?

Every referral to the agency is processed within 24 hours or less. A registered nurse is sent to the home of a patient to perform an initial assessment. If the RN determines that the payer is Medicare, she follows Medicare policies to determine what services to authorize. The RN develops a Plan of Care after this initial patient assessment is completed, and the attending physician signs the plan. The extent of involvement of the physician in developing the Plan of Care varies.

The requirement that a Medicare beneficiary be homebound is strictly adhered to. RNs continuously evaluate a patient's progress, and when the patient is no longer homebound, s/he is discharged. The agency only provides services to Medicare patients who have an acute condition, that is, those whose condition will improve. The agency discharges a patient as soon as he or she is stabilized. Chronic care patients, that is, those whose condition will not or cannot improve, are not provided home health services reimbursed by Medicare.

The home health agency believes that their servicing RHHI and their State Department of Health play an important role in adherence to the conditions of participation. The RHHI has a good working relationship with the agency. Claims for inappropriate services or for patients who are not homebound are denied. The agency controls

appropriate utilization of home health aide visits by using the New York State "Guide to Home Health Aide Training and Competency Evaluation" and "Matrix of Permissible and Non-permissible Activities: Home Health Aide Services."

The agency has an easy-to-read, large-print brochure which contains guidelines for determining if a patient may be eligible for Medicare home health care services. This brochure makes it clear at the onset of services what the Medicare home health benefit includes. It clearly states for what services Medicare will pay and for what it will not pay. For example, it states that Medicare will not pay for services which are considered custodial or housekeeping. The brochure also states that Medicare provides only intermittent or part-time skilled services generally for a short duration and that the patient must be confined to his or her home. Examples of what constitutes homebound are also clearly illustrated in the brochure.

How does the Home Health Agency attempt to assure quality of services?

The agency believes the relationship between a caregiver and patient is important in assuring that the services are of high quality. When a patient or a patient's family complains about a staff member, that person is replaced immediately. The agency does not force a caregiver on a patient. The agency believes that working together as a unit affects the quality of the services. They, therefore, work hard to ensure that the (1) patient, (2) family member(s), (3) caregiver, and (4) attending physician are in agreement as to what is needed and appropriate.

The agency employs a variety of techniques to assess and ensure quality. Plans of Care are reviewed by an RN on a regular basis. A Utilization Review Committee made up of staff members and professional people from the community meets quarterly. Since the agency also regards the relationship between a caregiver and a patient as the key to the quality of the services, they are very interested in measuring patient satisfaction. All patients are surveyed verbally when services begin and immediately following discharge. In addition, a mail survey is sent monthly to a random sample of patients.

Patient complaints are handled formally and promptly. A complaint file is opened and the complaint investigated. Upon completion of the investigation, the agency meets with the complainant and tries to resolve the problem. Most complaints, it turns out, are misunderstandings regarding what the client was to receive from the agency.

All professional caregivers and aides receive an agency orientation and periodic in-house training. All staff are credentialed according to their position and references are checked prior to hiring.

What is the philosophy of the Home Health Agency?

The home health agency has its written philosophy hanging on the wall. It says

Commitment to Our Patients

Meet the Perceived Needs of Our Clients and Employees

The agency believes that honesty is the best policy. By cooperating with doctors, hospital staff, patients and their families to provide appropriate services, they will get more referrals. They believe there is too much to lose by providing unnecessary visits and services.

**WESTCHESTER COUNTY DEPARTMENT OF HEALTH
HAWTHORNE, NY**

General and Background

This home health agency is run by County government and is an official home health agency. It serves the entire County of Westchester, a suburb of New York City. The agency has been certified by HCFA to provide Medicare home health services since 1966. In addition to the main office in Hawthorne, home health services are provided from 5 district offices located throughout the County.

The agency, being part of a County public health department, provides a wide variety of public health services. In the early 1970's they received home health referrals from every hospital in the County. At that time there was very little competition. Now proprietary agencies have entered the home health market and are very aggressive in seeking Medicare home health referrals from hospitals and physicians. Medicare referrals have steadily been declining in this agency as a result of this increased competition from for-profit home health agencies.

In 1993 the agency's average reimbursement per beneficiary was \$1724, and the average number of visits was 20. In 1994 those figures increased slightly to \$2188 and 25 visits.

How does the Home Health Agency ensure the people they are serving are qualified for Medicare home health care and that the appropriate number and type of services are provided?

This home health agency has no incentive to provide unnecessary visits since they are a government-run agency. However, despite the absence of a profit motive, the agency takes definite steps to ensure appropriateness of care and to control utilization. They evaluate a patient's condition and situation, teach a patient and his/her family, whenever possible, how to perform the same services and tasks as agency personnel, and discharge the patient as soon as possible. They perform all three tasks simultaneously so that they may terminate care in the shortest possible number of visits, while providing quality care.

Discharge planning occurs at the commencement of services. Staff see discharge planning as a contract. That is, agency staff tell patients what they should expect, approximately how many visits they will likely receive, and for what period of time. They seek an understanding and agreement from both the patient and the family at the beginning regarding what they will provide. If a patient's condition and needs change during the course of care, agency personnel re-evaluate the situation with the patient and his/her family.

The agency adheres to the homebound criterion for Medicare patients. Beginning at the time of the referral, agency staff have lengthy discussions with the referring physician or hospital regarding whether a patient is homebound. In situations where a Medicare

patient is not homebound but needs home care services, the agency will find another payment source besides Medicare rather than terminate services.

The home health agency provides, with few exceptions, home care to patients with acute illnesses. When determining whether to provide home visits to chronic care patients, they follow the HCFA guidelines.

Initial screening is a key factor in assuring appropriate services and controlling utilization. A lot of information is gathered by the agency during the initial referral contact, which is typically by telephone. Referrals are always handled by professional staff rather than clerical staff. Staff obtain detailed information regarding the patient's condition, homebound status, and what should be included in the Plan of Care. This initial telephone conference helps reduce a lot of unnecessary steps and gets an attending physician more involved in the patient's Plan of Care.

The home health agency believes that the policies and procedures of their servicing RHHI help control utilization. The RHHI provides valuable training, technical assistance, and consistent and clear guidelines. The RHHI is diligent in reviewing Plans of Care against claims submitted for reimbursement, particularly with regard to the necessity for visits. Rarely does their RHHI request additional information on claims submitted.

The agency carefully controls the number of aide visits to a patient. It strictly adheres to the Plan of Care, providing what a patient needs as opposed to what a patient or his/her family wants. They regard aide services as an extension of skilled services, not a service unto itself. As a result of tight controls, only 20 percent of all their visits in a year are aide visits, as compared to an average of 47 percent nationally. Aides are paid by the hour rather than by the visit.

The patient is always assigned a case manager. The case manager is the RN who makes the initial visit to a patient's home. If it is determined that a patient needs the services of a skilled therapist, the therapist must report to the case manager. A therapist must contact the case manager within 24 hours of making a visit to discuss a patient's therapy needs and to obtain approval to continue providing services.

How does the Home Health Agency attempt to assure quality of services?

All professional caregivers and aides receive an agency orientation and periodic on-going training. All are certified and references are checked prior to hiring. Therapists under contract with the agency must provide documentation that they have at least one year of experience; are licensed to provide home care; are immunized; have been trained; and have liability insurance.

A Utilization Review Committee meets quarterly to review home health records. It is made up of people from the staff and professional people from the community. Patient

complaints are given top priority by the Main office in Hawthorne. Upon completion of an investigation, the patient or the complainant is notified of corrective actions taken.

What is the philosophy of the Home Health Agency?

They refer to themselves as "the provider of last resort." This public health agency provides home health services to anyone in need regardless of insurance status, location of neighborhood, and severity of illness.

SPOHN HOME HEALTH CORPUS CHRISTI, TX

General and Background

Spohn Hospital Home Health Agency is a hospital-based, not-for-profit agency. Spohn Hospital is a private, Catholic hospital, operated by the Sisters of the Incarnate Word. The home health agency serves the Corpus Christi metropolitan area which is largely urban with a few rural, isolated pockets.

At the time of the site visit, the agency was settling in from a very recent reorganization. Despite some small confusion with new titles and some change in roles and reporting lines of authority, this agency clearly understood its mission and was focused on delivering quality patient care. The central theme of reorganization was "total quality." However, it was apparent from discussions with staff that the agency was steeped in a tradition of quality services prior to organization changes.

The home health agency operates under the general direction of the Spohn Hospital board; however, they are physically separated from the hospital and operate quite independently. The hospital, the largest in Corpus Christi (about 500 beds) provides the agency with patients as well as a variety of other resources.

Spohn Home Health Agency is a member of the Texas Home Care Association. They are also members of the National Association of Home Care.

A variety of home health agencies accept patients who are discharged from Spohn Hospital. While patients have a choice of home health agencies upon discharge, staff at Spohn made clear that they hold a certain competitive edge when it comes to Spohn Hospital patients. These patients make up the preponderance of the agency's patient census.

Finally, the hospital serves as a teaching facility for home health employees. Spohn Hospital has an active staff development component and also offers seminars which the staff can attend. This hospital resource is an important part of the agency's in-service training program.

How does the Home Health Agency ensure that the people they are serving are qualified for Medicare home health care and the appropriate number and types of services are provided?

Eligibility is treated seriously at Spohn. When referrals come in, the supervisory nurse ensures that there is a physician's order and that the order is clear. Then a registered nurse makes an evaluation visit. This visit involves a complete physical assessment, including a judgment of whether the patient is homebound. "Homebound" is interpreted in a serious manner by employees at Spohn Home Health, and is based on written instructions from the Regional Home Health Intermediary.

The most important question in determining eligibility is whether this patient is actually a candidate for home health care. In other words, will home health care benefit this patient by restoring or improving their ability to function independently.

Discharge planning begins at the point of referral. From the assessment visit through discharge, Spohn emphasis is on moving the patient to the point of independent living. The Patient Care Coordinator (PCC) is a BSN degree nurse. The PCC carefully follows the notes on patient progress and compares them to the plan of care. Discrepancies are noted and adjustments to the plan of care are made.

There is no arbitrary limit put on the number of visits. Staff expressed some surprise that they were in the "Low Visit" category as they felt they were allowing as many visits as are consistent with the goals of the Medicare home health benefit. In fact, two respondents stressed that even when the patient has progressed as far as possible from the perspective of independent functioning, they may continue visits to stabilize other aspects of that patient's life, such as helping them to cope with an undesirable home environment.

Central to the process of managing care is the critical element of continuous communication. This includes communication between Spohn direct care staff and the patient and other caregivers, between the Spohn direct care staff and Spohn support and administrative staff, and between Spohn staff and the physician. Open and frequent communication is key to managing patient care and ensuring the best outcomes in the shortest time frame.

How does the Home Health Agency attempt to assure quality of services?

Medicare home health is the standard for home health care given by the agency; however, patients are treated by this standard regardless of who the insurer is. Several direct care staff reported that they are not aware of whether the patient is Medicare, Medicaid, private-pay or charity. The Spohn Home Health Agency is accredited by JCAHO.

The single most important element in providing quality services is to assure a quality staff. Spohn hires only experienced nurses and pays them by the hour. These nurses come to Spohn with excellent assessment skills and the ability to work independently. Spohn nurses understand that there is no quota for numbers of visits and no advantage in making as many as possible.

Spohn hires only experienced aides and pays them by the hour. They require that the aides be listed on the Texas Aide Registry. The agency has a very low turnover, which suggests staff satisfaction and contributes to service continuity. Aides average five to six patients per day and the Aide Coordinator stressed that more than that would diminish service quality.

The final point on quality of service is the Spohn culture of problem identification and amelioration. As soon as a problem becomes apparent or even suspected, staff begin to focus on how to solve that problem before it gets out of control. This timely intervention reduces serious problems.

What Is the philosophy of the Home Health Agency?

The Spohn Home Health Agency's philosophy is clearly embodied in its Mission Statement. "The mission of Spohn Home Health is to collaborate with professionals and others in an attempt to provide specialized care and education based on patients' human response to their illness. We perform quality care in the patient's environment with the family and primary caregivers. We promote health care and the patient is the focus of our efforts."

This mission statement goes on to emphasize four important points. These are to help the patient realize optimum potential, to be supportive, to enhance independent living and to extend a caring, Christian attitude.

The Spohn Home Health Agency, despite its low number of visits, does not focus on utilization in any of its philosophical underpinning. Rather, they accept HCFA guidelines in a literal sense, approaching each patient from a perspective of patient and caregiver education. They make it clear to all involved that this service is time-limited and goal oriented.

LINDEN MUNICIPAL HOSPITAL HOME HEALTH SYSTEM LINDEN, TX

General and Background

Linden is a small town of about 2400 people, which is the county seat of Cass County, in rural, northeastern Texas. The hospital is a small (40 bed) facility, operated by a municipal hospital authority. The agency is located in a building adjacent to the hospital and operates under the general direction of the hospital administrator.

The hospital, itself, faces many of the problems typical of small, rural facilities, such as low occupancy. Both the hospital and the home health agency have dropped JCAHO accreditation in a cost cutting exercise. The Office of Evaluation and Inspections has reported on similar problems to those observed in Linden, in detail, in its series on Hospital Closures (the latest being Hospital Closure: 1994 (OEI-95-04-00100). The hospital has maintained its membership in the Texas Hospital Association and the home health agency is a member of the Texas Hospital Home Health Association.

The home health agency serves a wide geographic area of five counties, in which an estimated 25 physicians practice. Despite the relative scarcity of trained health professionals in the area, there is no paucity of home health agencies. The nearby town of Atlanta, Texas (pop. 6100) lists six such agencies and there are others located in and or serving the geographic area. Therefore, despite the very rural nature of the area, the market is seen as extremely competitive.

How does the Home Health Agency ensure that the people they are serving are qualified for Medicare home health care and the appropriate number and type of services are provided?

Eligibility is treated seriously at Linden. Eighty (80) percent of the patients come from the Linden Hospital Clinic. Most of the remaining patients are discharged from Linden Hospital. Every Linden patient comes with a physician referral and virtually all of their patients have been seen by the referring physician.

Respondents maintain that the role of the physician is growing increasingly more active. They attribute this to two factors. The first is that physicians have become increasingly more aware of home health care over time. The second is the fact that physicians can now be paid for developing and monitoring home health plans. Despite having more knowledge of the services, physicians continue to have more problems with understanding and accepting limitations of services such as the need for skilled visits and of eligibility, such as homebound.

Linden staff carefully follow the homebound criteria, found in the Regional Home Health Intermediary manual. Respondents reported that in a small town such as Linden, it is relatively simple to determine that this provision has been met. Nevertheless, they also

reported that many of their competitors do not interpret the homebound provisions strictly.

Discharge planning begins at the time of referral. From the assessment visit, Linden is focused on moving the patient along the plan of care to discharge. The Scheduling Nurse is critical to that objective. Although respondents did not use the term, "case management," that term would perfectly describe the activities of the Scheduling Nurse. Her duties include reviewing the original nursing assessment, completed on the first visit, reviewing the plan of care that is developed following the assessment, reviewing patient progress and comparing it to the plan of care. Any discrepancies are noted and the Scheduling Nurse has authority and flexibility to make necessary changes. Such changes might include changing nursing staff or aide assignments, or convening a team to review the case.

The Scheduling Nurse ensures that the plan of care is appropriate to the specifics of the situation. She questions deviations in services and any apparent failures of patients to respond. She ensures contact with the referring physician at the first sign of a serious or unusual problem. Agency staff report that keeping a patient too long can be detrimental to that patient.

The key to the management of services at Linden is the daily review of services and progress notes. Staying on top of each case that has received service is an effective strategy for ensuring that no patient gets too far off course, in areas that the agency can control. This tight case management works well.

The goal is to move the patient out of the service as quickly as feasible. However, we observed the average number of visits per beneficiary increased by over 50 percent between 1993 and 1994. This increase could have resulted from recent pressure from the affiliated hospital for the home health agency to increase visits for economic reasons. The home health agency is considered a profit center for the hospital. According to agency staff, the hospital has suggested that appropriate visits do not justify the overall economic status of the parent organization. Agency staff advised that hospital management has suggested that the home health agency staff could benefit from in-service training with home health agencies that make considerable higher numbers of visits per beneficiary. For example, one lesson that could be learned is to never waste skilled visits by delivering more than one skilled service per visit. While the staff is loyal to the hospital, it is not clear to what extent the increase in visits per beneficiary was affected by the pressure.

How does the Home Health Agency attempt to assure quality of services?

Quality home health at Linden begins with a high quality staff. Nurses are experienced, often coming from other agencies whose practices with regard to utilization they questioned. Aides are experienced as well. They come from the Texas Aide Registry. Turnover for both nurses and aides is low, which helps ensure continuity of care.

The second element of quality is the tight case management discussed in the preceding section. The skills of the Scheduling Nurse allow Linden Home Health to develop appropriate treatment plans which have also resulted in fewer visits.

In addition to case management, two activities are focused on improving the quality of home services. First, Linden managers make supervisory home visits with nurses and independently to assure that the quality of care is up to their standard. Second, in-service training is required of all care staff. This keeps their skills current.

Recently when studying the operations of other agencies, Linden managers were struck by "standard care plans" which dictated a certain set number of visits for the first cluster of weeks, another set number of visits for the second cluster of weeks and, finally another set number of visits for a final cluster of weeks. Further, these agencies insisted on no more than one skilled service per skilled visit. These types of formulae, which are reported to be common practice in the home health industry, result in higher utilization without improved results.

Linden, by contrast, insists on individualized plans of care rather than stock formulae and considers these individual plans to be keys to quality. Linden staff deliver as many skilled services in one visit as are appropriate. Linden Home Health Agency managers also report their belief that paying staff by the hour (rather than by the visit) is a way to ensure a better quality service.

Finally, Linden conducts phone and mail surveys of discharged patients and their physicians. They use these to measure quality of service and to identify problem areas.

What Is the philosophy of the Home Health Agency?

Linden Home Health Agency has neither a formal, written philosophy nor a mission statement. However, discussions with Linden staff produced similar responses which centered around giving patients an appropriate level of care to assist them to realize their maximum level of independent functioning.

Respondents from Linden expressed some surprise that their average number of visits in 1993 placed them in the lower third of the nation. However, staff realized that many agencies in their area make many more visits to Medicare patients, and they expressed their belief that in most cases these high numbers of visits were unnecessary and unethical. Several members stated that the overriding Linden philosophy is to "do the right thing."

Linden Home Health Agency staff are likely to know how the patient is paying for home care. While they are increasingly aware, due to growing financial problems with the hospital, staff denied that they would treat a patient differently based on how a patient was paying for home care. They did state that they no longer accept any charity cases.