QUALITY CARE IN HOME HEALTH:

Improving Patient Outcomes and Agency Scores

J'non Griffin, RN, MHA, WCC, HCS-D, COS-C

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HCPro
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Quality Care in Home Health: Improving Patient Outcomes and Agency Scores is published by HCPro, a division of BLR.

ISBN: 978-1-55645-719-7

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About the Author

J'non Griffin, RN, MHA, WCC, HCS-D, COS-C

J'non Griffin, RN, MHA, WCC, HCS-D, COS-C, is a 24-year veteran of homecare. She received her master's degree in Health Care Administration in 2005. She has experience as a field nurse, director, and executive with home health and hospice agencies, both large and small. She has served as director of Staff Development and Appeals for home health and hospice agencies. Griffin has taken part in mock surveys for agencies as well as prepared agencies for accreditation. She has been involved in accreditation surveys, acquisitions, and many regulatory crises with state survey agencies and the intermediary.

Chapter 1

Understanding Payment and Quality

Historically, the majority of medical care was provided in the home in the United States by physicians and nurses. As early as the 1790s, visiting nurse associations and other charitable organizations provided nursing care to the poor, primarily mothers and children. In the early 1900s, concerns about protecting public health and preventing spread of disease prompted many community organizations, such as women's clubs, churches, hospitals, charitable organizations, health departments, and settlement houses, to send visiting nurses to homes. Many regarded visiting nurses as the solution to urban threats of poverty, industrialization, and infectious disease. Brief nurse visits occurred to treat the sick, train family members in care techniques, and protect the public from the spread of disease through better hygiene. People were treated at home versus in the hospital. Many additional nurses worked freelance as private duty caregivers.

Advances in medicine, new technology, and required space and maintenance then shifted the care of the patient into hospitals. Physicians started to specialize and offer their services in a centralized location. In addition, the increased use of care and public transportation allowed patients to travel to hospitals, rather than receiving care at home.

The Rise and Fall of Home Health

By the 1930s, most care of acutely ill patients had transitioned to the hospital. Visiting nurses now provided long-term care in the home to chronically ill patients. Home health care services began to shift in the 1950s to focus on convalescence in the home after discharge from the hospital, with services that included nursing, social work, and rehabilitation. Home health agencies were funded by charitable and public contributions.

By midcentury, "[t]here was a growing recognition . . . of the need for federal action to help meet the high cost of health care for the Nation's elderly."[1] In 1965, Congress passed the Medicare Act of 1965, and Lyndon B. Johnson signed into law HR 6675 for people over the age of 65 who found it virtually impossible to obtain health insurance coverage. President Harry S. Truman was issued the first Medicare card. A staggering 19 million individuals enrolled in the first year.[2]

Medicare covered care for acute conditions under Part A after a three-day hospital stay. This care coverage was limited to 100 home visits per calendar year for nonprofit agencies and public health departments. Medicare also covered, under Part B, chronic care conditions and limited that care to 100 home visits per calendar year as well. Congress passed the Older Americans Act in 1965, which was designed to help older persons stay in their homes by helping to fund home care. This act provided assistance to the development of new or improved programs that help older people. It also established the Administration on Aging within the Department of Health, Education, and Welfare. Home care as an industry began to grow rapidly.

Expansion of the Medicare home health benefit continued in the 1980s. The Omnibus Reconciliation Act of 1980 removed the limits for the number of home care visits and the prior hospitalization requirements. At this time, participation in Medicare home care was extended to for-profit home care agencies. More than half of the patients receiving home health care did not have immediate prior hospitalization, and many people received services for more than six months. During the 1980s, the hospital inpatient prospective payment system was

implemented, which resulted in faster discharges from hospitals and the need for posthospitalization home care services. Because of the removal of the requirement for a recent hospitalization, services increased to the chronically ill, who needed more long-term care. From 1989 to 1996, Medicare home health care payments increased an average of 33% per year.

Throughout the 1990s, home health care services continued to expand due to earlier hospital discharges, declines in nursing home beds, increased numbers of frail adults and elders, and cost-based financing of home care. In the early 1990s, Medicare reimbursement for home visits also increased, and the majority of home health episodes extended past six months. During the late 1980s and 1990s, Medicare paid for home health services on a fee-for-service basis. Between 1990 and 1997, home health care was 9% of the Medicare budget. In 1997, there were 10,444 Medicare-certified home health care agencies in the United States. The Balanced Budget Act (BBA) of 1997 was an omnibus legislative package enacted by Congress designed to balance the federal budget by 2002. The legislation set limits on Medicare spending, refocused home health care to postacute care spending, and cut the increased services made available in the 1980s and early 1990s. The legislation also set new requirements for homebound status and refocused home health on episodic care, as well as reduced the benefit for chronically ill patients.

The BBA also created a home health prospective payment system. It proposed that home health agencies would be paid a set amount for each episode, regardless of the number of visits provided.Additionally, the BBA created a requirement for agencies to report patient outcome data on all Medicare and Medicaid patients using the Outcome and Assessment Information Set (OASIS), beginning in 1999. OASIS data are collected at various time points during an episode of care, such as admission, recertification, transfer to an inpatient facility, resumption of care, and discharge. The data are electronically transmitted to the Centers for Medicare & Medicaid Services (CMS) to provide evidence of the need for skilled care. The OASIS serves several purposes. Its compilation determines the amount agencies will be paid during a 60-day period. In addition, the OASIS tool drives outcomes by showing improvement, stabilization, or decline during various time points.

During this time, many rural agencies closed due to implementation of new regulations, such as no longer allowing venipuncture as a qualifying skill. The BBA resulted in a 20% decline in home health care. The changes created by the BBA resulted in decreased use of home health care services, with fewer patients receiving home health care, fewer visits, lower payments, and shorter durations of service.

Home health care shifted to focus on postacute hospital and episodic care only usually lasting weeks to months. Fourteen percent of home health agencies closed between 1997 and 1999, and home health care comprised only 4% of the budget, compared to 9% during 1990–1997. By 2001, more than one-third of home health agencies closed. Over time, however, agencies adjusted to the prospective payment system. Home health care agencies have gradually increased in number.

In 2003, CMS posted a subset of OASIS-based quality performance information on the Medicare.gov website, known as Home Health Compare. These publicly reported measures include outcome measures obtained from the OASIS, which indicate how well home health agencies assist their patients in regaining or maintaining their ability to function, and process measures, which evaluate the rate of home health agency use of specific evidence-based processes of care.

In 2007, 9,284 Medicare certified home health care agencies existed in the United States, and Medicare spent more than $14 billion on home health care. However, the current Medicare home health care program no longer encompasses long-term chronic care of patients in their homes but instead focuses on filling in the gaps through posthospitalization short-term postacute and episodic care.

Effects of the ACA

President Obama's Affordable Care Act (ACA), commonly known as Obamacare, has had several effects on certified home health agencies and has changed senior care. It offers free preventive care for seniors, such as yearly wellness checks, lower prescription drug costs, and protections for Medicare fraud. Included in these provisions for home care are the face-to-face encounter, closer government

scrutiny of claims submitted for payment with screening, and audits to detect fraud. Estimates in 2014 of margins for Medicare certified home health agencies offered a prediction that approximately 40% of providers would have negative margins. Reduction of the annual market basket rates for home health also contributed to this.

The ACA also has provisions to establish a national Medicare pilot program to develop and evaluate a bundled payment for acute inpatient hospital services, physician services, outpatient hospital services, and postacute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. The bundled payment initiative asks providers to assume the financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications. The payments are made on the basis of expected costs for clinically defined episodes that may involve several provider "types." The CMS Bundled Payment for Care Improvement (BPCI) Initiative is piloting payments in almost 100 settings (ranging from hospitals to nursing homes) over the next two years, and the program is expanding further. Arkansas, for example, created the Arkansas Health Care Payment Improvement Initiative for both Medicaid and commercial payers for five different episodes: perinatal, ADHD, upper respiratory infection, total joint replacements for knees and hips, and congestive heart failure.

The ACA also created the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of healthcare services, and achieve patient satisfaction. The ACA also establishes a hospital value-based purchasing program in Medicare to pay hospitals based on quality measure performance and extend the Medicare physician quality reporting initiative beyond 2010. It also enacts plans to implement value-based purchasing programs for home health agencies.[3] Currently, there is legislation for the Bundling and Coordinating Post-Acute Care Act that would ensure patients have access to a range of vital postacute care services, such as home health, for

approximately three months following their hospital stay. The bill strengthens coordination of care for each setting and across the continuum of care. In addition, CMS plans to implement a five-star rating system for home health, similar to the one for skilled nursing facilities, for consumer use. In 2014, CMS also proposed a change to the *Conditions of Participation* to include a requirement for home health agencies to have a performance improvement program to monitor and improve their own performance improvement efforts.

The Future

The future of home care is ever changing, with the emphasis from the government, via the ACA, on quality improvement at a reduced price. Accountable care organizations are emerging in several areas of the country. These are groups of doctors and hospitals and other healthcare providers who come together voluntarily to give coordinated, high-quality care to their Medicare patients.

CMS has also sent out proposed changes to the *Conditions of Participation* that will drive the quality of home health care and mandate a standardized performance improvement program.

Specifics of the proposed changes will be discussed in detail later in this book.

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The future of the home health care industry is patient-centered care and quality outcomes.

The Centers for Medicare & Medicaid Services (CMS) is sharing with the world how your agency stacks up to the competition through its Patient Survey Star Ratings and Quality of Patient Care Star Ratings (formerly HHC Star Rating). These ratings come from OASIS patient outcomes data and CMS' Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Patient Experience of Care Survey. This means homecare providers need to start focusing on patient education and engagement initiatives to ensure better outcomes and compliance, sustain high ratings and a good reputation, and continue to receive referrals for post-acute care.

Quality Care in Home Health: Improving Patient Outcomes and Agency Scores provides home health agencies with the tools and tactics they need to address these measures and improve publicly reported survey results through training, systematic practices, and bedside clinical behavior. Expert **J'non Griffin, RN, MHA, WCC, HCS-D, COS-C,** provides general patient education and engagement strategies, as well as staff training tips to improve the patient experience and achieve positive HHCAHPS scores and star ratings.

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ISBN-13: 978-1-55645-719-7
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