

Home Care

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The transition from the acute care setting to home is a critically important time. Health care providers play an essential role in coordinating this care along with case management. In 1990, practicing internists and family physicians were found to make at least three home health agency referrals per month and spend a significant amount of time in home care phone management and paperwork.¹ Importantly, 44% of patients discharged from the hospital by primary care physicians need post-hospitalization medical services or nursing care that cannot be provided by family or friends alone.² Since the 1980s, there has been a marked increase in the use of these services, including skilled nursing facilities and home health services³ Laws initiated in 1997 heralded regulatory and payment legislation that severely affected Medicare reimbursement for these services. Despite this, many patients and families continued to prefer the services that home health care offered.

Home Care as a Medicare Benefit

Home health care is a legally defined Medicare benefit. The required elements for home health⁴ are as follows:

- the patient is under the care of a physician
- the patient requires skilled nursing, occupational, physical, or speech therapy
- the patient's needs can be met by intermittent services
- patient home care is medically necessary
- the patient is homebound
- the patient resides in a home/facility that does not provide skilled care
- the plan of care is supervised by a physician.

Homebound means that the patient is normally unable to leave home, or that leaving home requires a "considerable and taxing effort."⁵ Services covered under the Medicare home health benefit include skilled nursing, physical therapy, occupational therapy, speech therapy, nutritional guidance, and medical social services. While skilled nursing services are covered, the cost of medications, including home infusion therapy, are not. These costs can be very high. Under Medicare Part B, durable medical equipment (i.e.: wheelchair, hospital bed) is covered if it allows an impaired person to

remain at home. Medicare requires a physician prescription, a specific diagnosis for why the equipment is needed and projected duration of use. Medicare will pay 80% of the cost (purchased or leased, whichever is less) of the equipment.⁵ Tube feedings are covered only when they are the main or sole source of calories.

Medicare reimbursement for home health agencies is based on the Prospective Payment System (PPS). This means the agency has a fixed payment for each 60-day period of care, which is adjusted for case complexity. Strangely, low reimbursement cases include those patients with heavy care requirements and those needing only a few visits to "check" on the patient. The payment rate to the agency generally increases when referrals for therapies (PT, OT) are made.

Medicaid coverage varies from state to state; with all states providing some coverage for skilled and personal care services for those who meet income and medical need criteria. In Virginia, there is an annual limit of 32 skilled visits. After that, special permission is needed to extend Medicaid skilled home care. Importantly, Medicaid will pay for "personal care," which provides the patient with assistance with daily activities (i.e.: bathing, dressing, feeding). Personal care aides cannot administer medications, give tube feedings, or perform wound or respiratory care.

Selection of Patients for Home Care

Proper selection of patients for home care is essential. The following must be considered:

- **Clinical stability:** the complications of illness need to be anticipated and arrangements made for proper assessment and treatment of these complications.
- **Caregiver support:** prior to patient discharge, support systems at home must be evaluated. Sources of information include family, friends or neighbors, former health care providers, home health nurses, social workers or adult protective services caseworkers.
- **Appropriate environment:** home must be adaptable to the new needs of the patient, without unreasonable hazards.
- **Availability of appropriate services:** patients, families and home health staff must have the skills and knowledge needed for

complex home care (for example: ventilator care).

- Financial resources: Medicare and other insurance coverage, plus out-of-pocket costs must be assessed. Hospital discharge planners can provide information about regulatory complexities and changes.
- Rehabilitation and education needs: patients who will benefit from continued rehabilitation or education are very appropriate for home health referral.

Role of the Physician in Home Care

The role and responsibility of the physician in home care includes: identifying and referring patients who need home care; management of medical problems; assessment of the home environment as an appropriate site of care; specifying clearly what initial services are desired; approval of the plan of care with short and long-term goals; being available to support other home health team members throughout the episode of care; evaluation of new medical problems based on information provided by in-home personnel; participation in family conferences when necessary; evaluation of the quality and suitability of the home care provided; arrangement for 24-hour physician coverage; and timely completion of paperwork.

Selecting a Home Health Agency

The home health agency nurse will be the principle in-home professional communicating with the physician and providing case management. Aspects to consider in agency selection include: reputation of the agency, accreditation (JCAHO or CHAPS), quality improvement activities, number of nurses per supervisor, and documentation of care as evidenced by written communications. Staff should be available 24 hours a day 7 days a week. The policy related to uninsured patients should be clear. Other important information includes: time from referral to first visit, ability to make same day visits, and the range of services provided. The VCU Health System Care Coordination Department monitors agency qualifications and refers only to agencies that meet basic standards. Medicare law does require that patients and families be given a choice among all qualified agencies that ask to be listed by the hospital.

If the referral is for a chronically ill elderly patient who is nearing death, home health agency personnel may be instrumental in exploring end of life decisions and preferences of patients and caregivers.⁶ Sometimes physicians refer directly to

hospice; other times agencies transfer a patient into hospice from skilled care. Key criteria for hospice referral include an estimated life expectancy of 6 months or less and the willingness of patient and family to accept a palliative approach to care.

If appropriate services are available and patient and caregiver agree, the home health agency that has previously provided services to the patient should be contacted to maintain continuity. If in-home Medicaid personal care services are already provided by an agency that provides skilled services, using that agency for skilled care when appropriate can be more efficient.

Developing a Plan of Care

In developing the plan of care, an interdisciplinary approach is best. This requires input from physicians, nurses, discharge planners, therapists (physical and occupational), social workers and patients and families. This information should be subsequently communicated to the in-home care team. This includes current diagnoses and condition; medication regimen; reason for recent hospitalization and course; specific orders for frequency of nursing assessment, treatments to be given; goals of treatment; potential for improvement; estimate of duration of need for services; medical equipment and supplies needed. Although much of this can be anticipated at the time of discharge, some adjustments are usually needed after the initial in-home assessment. Remember that agency nurses doing the initial assessment will not have access to inpatient records.

Education of Patient and Caregiver

Informal caregivers may or may not be present in the hospital or at discharge. Regardless, the person responsible for care at home should receive sufficient instruction for procedures done in the home to ensure basic competence and confidence. After discharge, this instruction can be reinforced by home health personnel. Any changes in medications from the pre-admission regimen should be carefully reviewed and written down for the patient or caregiver to refer to in the home. The patient and caregiver should be aware of any scheduled follow-up appointments and transportation should be arranged. Contact phone numbers should be provided in case any problems arise after discharge.

Other Care Options

For some patients, returning home is ill advised. If the patient insists on leaving against medical advice, decisional capacity should be clinically assessed

(psychiatry input may be helpful) and need for guardianship determined. Referral to the appropriate social service agency, such as adult protective services, may also be needed. Other post-hospitalization sites of care include: nursing home (short or long term), licensed adult home or assisted living facility, day care, informal private caregiver, or home of a friend or family member. A discharge planner should be involved early if there is a need to consider alternatives to care at home.

Useful Resources in the VCU Health System

Home health referrals are handled through the Department of Care Coordination (828-0212), which includes social workers and nurses assigned to each nursing unit. There is also a team of Transitional-Care Geriatric Case Managers (828-4624) that focus on complex and frail adults, especially the elderly. These nurse practitioners follow the patient from discharge to their first post-hospital clinic visit, in order to maintain continuity of care.

References

1. Boling PA, Keenan JM, Schwartzberg JS, Retchin SM, Olson L, Schneiderman M. Reported home health agency referrals by internists and family physicians. *J Am Geriatr Soc* 1992;40:1241-9.
2. Department of Geriatric Health. Guidelines for the medical management of the home care patient. Chicago: American Medical Association, 1992.
3. Boling PA, Abbey LJ, Keenan JM. Home care. In: Ham RJ, Sloane PD, Warshaw GA. *Primary Care Geriatrics*. 4th ed. St. Louis: Mosby, 2002.
4. Montauk SL. Home health care. *American Family Physician* 1998;57:1609.
5. Boling PA, Abbey LJ, Keenan JM. Home care. In: Ham RJ, Sloane PD, Warshaw GA. *Primary Care Geriatrics*. 4th ed. St. Louis: Mosby, 2002.
6. Ratner E, Norlander L, McSteen K. Death at home following a targeted advance-care planning process at home: the kitchen table discussion. *J Am Geriatr Soc* 2001;49:833-4