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## Rethinking Home Health Care: Fiscal Contingencies and Future Needs

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RETHINKING HOME HEALTH CARE:  
FISCAL CONTINGENCIES AND FUTURE NEEDS

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Abstract: The authors examine the historical origins and actual circumstances of home health care and its delivery in the United States, focusing on the major beneficiaries of the system--the elderly. Cost containment policies applied in hospital settings and the residual effects of these policies in the home health care arena are discussed in anticipation of a prospective payment system for home health care. A data-based study of acutely ill recipients of home health care revealed that the severity of illness of patients receiving home health care increased after the implementation of the hospital-based prospective payment system, but the level of home care remained in a steady-state.

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Home health visits constituted part of the services provided by public health nurses by the late 1800s in the United States. Home care was administered to the indigent sick in eastern cities and other areas of New England. While the visiting nurse associations (VNAs) concentrated their efforts on adults, public health nursing was primarily involved in maternal and child care. A home health program for Metropolitan Life Insurance policyholders was begun in New York City in 1909. This health maintenance program involved some 850 VNAs, and employed 700 nurses before its termination in the early 1950s (Rabin & Stockton, 1987).

Initial federal funding for home health care in the United States was authorized by the Kerr-Mills legislation--Medical Assistance to the Aged (MAA)--of 1960. This program was intended to provide health care for those who could not qualify for welfare; the "medically indigent." The demeaning means test associated with the program, and its failure to provide sufficient assistance in states where the need was greatest, contributed to the program's eventual demise in 1966 (Mundinger, 1983).

Home care model in England. An extensive home care model evolved as part of the national health service in England after World War II. The employment of home helps, or homemakers and home health aides (rather than health care professionals) indicated the government's interpretation of the nature of services provided. An integral relationship with the overall social security system contributed to a predominantly social focus in home care. Today, most recipients of home care in England continue to be elderly or disabled. The number of paraprofessionals in relation to the population has been estimated to be four times greater than in the United States (Mundinger, 1983).

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### New Programs and New Funding Approaches

The entry of Medicare and Medicaid into the home health care sector in the United States in 1966 introduced new funding sources, and offered the potential for a wider range of services for homebound individuals. A decidedly medical orientation has consistently dominated developments in Medicare, while Medicaid provisions have permitted more broadly-based services subject to the discretion of individual states (Rabin & Stockton, 1987).

Prior to Medicare, most home care for the sick was provided by voluntary VNAS; few proprietary and public agencies were involved with homebound clients. Subsequent to the passage of Medicare, individuals eligible for Parts A (primarily an inpatient hospital benefit part of the insurance) and B (supplementary medical insurance largely devoted to physicians' service reimbursements) also were entitled to a limited range of health services provided for the purpose of maintaining an individual at home who otherwise would be hospitalized or placed in a nursing facility. Care recipients were eligible because they suffered from acute conditions and were homebound.

Research has suggested that between 25 and 50% of nursing home residents could be maintained in their own homes, if some household maintenance services (meals, laundry, shopping) were available to them (Hammond, 1979; **Vladeck**, 1980). Individuals who have serious disabilities, equivalent to those of institutionalized patients, more often remain at home if they have familial assistance. Over 70% of the care provided to the disabled and ill elderly is provided by family and/or friends, and 20% of the elderly with severe functional limitations may remain in their own homes, if family care could be made available (Rabin & Stockton, 1987). Studies have suggested that

An estimated 5.7 million elderly community residents needed long-term care, and 3 million needed extensive services (Developments in Aging, 3, 1987).

Characteristics of formal home health care services. Some of the demographic/familial characteristics associated with increased utilization of formal home health care services include: the availability of a family support network, being a member of a minority group, being female, having numerous physical limitations, and being among the oldest of the aged cohorts. With respect to this last characteristic, it has been estimated that the needs of the elderly who are over 75 are three times as great as the needs of the elderly who are between the ages of 65 and 74 (Rabin & Stockton, 1987). "Current Medicare beneficiaries over 85 are nearly five times more likely to receive home care services than Medicare beneficiaries aged 65-69" (Developments in Aging, 1, 1988, p. 185).

Medicare expenditures. Although Medicare expenditures for the home health care population represented only a small fraction of the overall costs, some 3.3% or \$2.5 billion in 1987, home health care was the most rapidly increasing service area in the Medicare program (Developments in Aging, 1, 1988; Home Care at the Crossroads, 1988). Expansion in the home health care sector may be attributed, in part, to earlier hospital discharges of patients subsequent to the implementation of the Prospective Payment System (**PPS**), and to increased utilization because of service availability. The most significant factor in the course of sector growth, however, was the preference on the part of most Americans--some 72%--for home health

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care over institutionally provided services for themselves or their families (Cetron, 1986-87).

Several program requisites designed to curtail costs have contributed to increases in expenditures. The acute-care focus necessitated the provision of the most costly care, because it must be provided by trained professionals. The introduction of physician oversight in determining and approving treatment plans, although they rarely were involved in actual health care delivery, also contributed to rising costs. The retrospective payment approach for reimbursing agencies for care reflected the open-ended funding mechanism operative in other sectors of the Medicare program prior to the institution of prospective measures in 1983. The determination of Medicare reimbursement for health services based on usual or reasonable costs determined by physicians also had no precedent in home health care cost calculations. Options for providing home health care services under Medicare, Medicaid, and Title XX programs resulted in some service duplication, and permitted the transfer of clients from one program to another in order to extend eligibility (Mundinger, 1983).

An apparent paradox of home care policy in the United States is that those very services provided through federal programs designed to prevent costly institutionalization represent the most expensive form of home care--generally skilled nursing care. Rather than substituting for institutional care, home care has been a frequent addendum to hospital care (Mundinger, 1983). A continuing legislative reluctance to provide for maintenance assistance in home raises questions about commitment to the prevention of inappropriate institutional placement of the disabled or elderly ill who could be assisted in their homes, or

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to the delay of placements of the seriously impaired in nursing  
facilities.

Growth of provider agencies. The growth of provider agencies subsequent to Medicare coverage of home health care has been remarkable, given its brief history. In 1966 there were 1,850 home health agencies (HHAs). By 1988, there were over 5,700 HHAs providing care to homebound patients (Older Americans Report, January 8, 1988). These agencies continue to be largely dependent on public funding. In 1984, some 80% of the reimbursements for home health costs were derived from federal programs with Medicare payments constituting some 67% of agency support (Building a Long-Term Care Policy: Home Care Data and Implications, 1984).

Variations in Medicaid benefits. Because of state-determined client eligibility and coverage determinations for Medicaid home health benefits, variations among state programs are considerable. Some three-quarters of the states curtail utilization by means of prior authorization requisites, physician oversight, or visit limitations (Rabin & Stockton, 1987). Problems related to the home health benefit for Medicaid eligibles reflect difficulties associated with other aspects of the program including provider reluctance to accept Medicaid clients, and problems with reimbursement mechanisms.

The liberalization of benefits for Medicaid beneficiaries (Section 2176 of the Omnibus Budget Reconciliation Act [OBRA] of 1981), enabled clients to receive services beyond exclusively medical or **medically-**related care for the **purpose** of delaying or preventing institutionalization. This option, referred to as Section 2176 Medicaid waivers, has been utilized in 46 states. The Health Care Financing Administration's (HCFA), concerned that the waiver programs

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might escalate Medicaid costs by increasing services to clients not in jeopardy of **imminent** institutionalization, led to the imposition of benefit restrictions on the states in 1984. The popularity of the waiver option among the states, and their growing need to curtail the growth of the nursing facility population, however, resulted in provisions in the 1985 OBRA targeted to ensure continuation of the waiver option. In subsequent provisions of the 1987 **OBRA**, some dimensions of this waiver were expanded for home and community based services (Developments in Aging, **3**, 1987). As late as 1987, however, the waiver beneficiaries constituted only 3% of individuals classified as "at risk," or as individuals who could not remain in the community setting without home care (pp. 42; 52). The concentration of some 56% of waiver recipients in only five states further revealed the failure of most states to provide non-medically related services to Medicaid clients (**Burwell**, 1987).

Total Medicaid expenditures for home health care in 1986 amounted to only \$1.35 billion, a sum representing less than 3% of total costs (Developments in Aging, **1**, 1988). By the following year, some \$2.1 billion Medicaid dollars were expended on services for the homebound disabled and sick elderly. Limited fiscal commitments to home health care seem inconsistent with public policy designed to limit the Medicaid nursing home population through alternative strategies.

Cost containment strategies have been increasingly applied in home health care as beneficiary populations and provider agencies have expanded. The prominence of cost containment in home health care was notable subsequent to the implementation of the prospective payment system (**PPS**) in the hospital setting in 1983; particularly as the benefit was applied to the largest recipient group--Medicare clients.

Although 71,000 more individuals received home health services in 1985 than in 1984--1,587,000 compared to 1,516,000-- , some 1 million fewer home health visits were reimbursed by Medicare in 1985 than in 1984 (p. 184 ) .

The' standardization of home health care benefits by the Health Care Finance Administration (HCFA) in 1984 contributed to a significant increase in service utilization denials. The Medicare payment denial rate increased from 2% in 1983 to 7.9% in 1987. The Congressional Budget Office (CBO) projections for home health care expenditures for 1992 were adjusted downward from \$5.9 billion to \$3.5 billion. The rationale for projection decreases was related to the "standardization of benefit" and to anticipated utilization denials. The following scenario is exemplary:

. . . prior to standardization, if a physician certified that a homebound beneficiary needed vital signs checked for six weeks and the norm in that area was three visits per week, the home health agency could have checked and had approved three visits for each of the six weeks. After standardization activities, if the beneficiary's vital signs were normal for the first three weeks, the home health agency might be told that only one or two visits per week would be approved for the last three weeks. Although most of the downturn appears to be attributed to these factors, it also appears there was slight increase in the denial of coverage for individuals (Older American Report, February 12, 1988, p. 63).

HCFA reported to Congress that the increases in denials were attributable to medically inappropriate claims--those deemed medically unnecessary by an intermediary (usually an insurance company)-- , to beneficiary failure to satisfy the homebound or intermittent care

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requisites for coverage, or to the submission of claims which did not include sufficient patient information for reimbursement. The lack of specificity in agency response to medical denials has resulted in provider charges that intermediaries were operating as unlicensed medical practitioners (Seifer, 1987). Technical denials based on failure to meet the homebound or intermittent care criteria posed serious problems for beneficiaries. Prior to changes in the 1987 OBRA, an individual was declared ineligible for home health care Medicare benefits if he/she could visit a physician's office or a medical facility for treatment. This stringent regulation resulted in the exclusion of benefits for many individuals who required **hemodialysis** or radiation therapies.

The "intermittent care" criterion led to differential treatment of Medicare patients. Patients have had to seek additional support through other programs, including Medicaid, because of limited benefits. If they paid for additional private care, benefits also have been terminated. Intermediaries declared benefits to be inappropriate for individuals who needed more "intermittent care" (Home Care at the Crossroads, 1988).

The most recent HCFA report to Congress regarding home health care benefit denials revealed that half of such rejections were attributable to medical and technically-related criteria. In addition, officials noted that HHAs often failed to complete all required paperwork prior to claim submission to fiscal intermediaries. Omissions on forms constituted the basis for a considerable number of reimbursement denials. It was acknowledged, however, that reimbursement forms were poorly designed, and may have contributed to HHA paperwork compliance

failures. The use of new forms should rectify this problem (Older Americans Report, October 21, 1988, p. 413).  
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While regulatory compliance must be taken into account in implementing any public policy, the denial of benefits to those who are medically in need and legally entitled to health services is difficult to justify on procedural grounds. Using such rationales for health benefit denials would appear to contravene the basic goal of home health care; to maintain disabled and ill elderly in the community setting rather than in institutions.

#### Rationale for the Study

Increases in reimbursement denials for home health care might be less problematic, if the realities of institutional acute care were different. Given the existing PPS and related average institutional stays associated with diagnosis related group (DRG) determinations, patients are being discharged from hospital care sooner than they would have been in past years for the same kinds of medical conditions. Some critics contend that patients return to their homes quicker, but in a less recovered state than in previous years. Since the adoption of the PPS, there has been a 40% increase in the number of patients released from hospitals to either skilled nursing facilities (SNFs) or home care (Developments in Aging, 1, 1988). Neither fiscal efficacy arguments promoting the utility of the PPS, nor a lack of consensus regarding the appropriate duration of hospital stays, address the outcome of policy; specifically, a growing need to provide treatment following hospital discharge. While promoted as a prudent cost containment approach, the real cost of the PPS in human terms is yet to be determined.

A recent survey of 35 home health agencies nationwide reported that 83% of these agencies encountered increasing severity of illness

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levels among the clients they served subsequent to the implementation of the PPS. Respondents also indicated that they were providing home health care for an increasing number of post-surgery patients whose wounds were not yet healed, and for individuals recently released from intensive care units (Seifer, 1987).

Access to, and the adequacy of post-hospital care are problems in home health care. Difficulties in addressing these problems are often exacerbated by prevailing conditions in community environments. Community based care may be unavailable or deficient in many settings, and Medicare and Medicaid eligibles continue to experience illegal discrimination. Since the implementation of the PPS, patients have been released from the hospital after shorter stays and in greater need of follow-up care. "At the same time HCFA has targeted the home health benefit for continual cutbacks, lower payment levels, and narrower interpretation of the scope of the benefit" (Development in Aging, 1, 1988, p. 220).

Provisions in the 1987 OBRA, however, suggest that policymakers are aware of some of the problems facing home health care. Measures targeted to address current deficiencies include patient rights provisions which entitle beneficiaries to access to an investigative unit in order to pursue complaints about agencies, a number of quality control features in HCFA home health certification revisions such as surprise monitoring of HHAs, requirements for training for home health aides, and sanctions for inferior HHA standards.

### Purpose of the Study

The purposes of this study were to explore specific interrelationships between selected DRG classifications, patients' (Ss) severity of illness, and nursing services used by Ss during periods of

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home care covered by Medicare. Four hypotheses were formulated and tested:

- H<sub>1</sub>: There will be no significant difference between the severity of illness level of Ss served by home health care nurses before and after the hospital-based PPS was implemented;
- H<sub>2</sub>: There will be no significant correlation between elements on Ss' Plans of Treatment and Ss' severity of illness levels;
- H<sub>3</sub>: There will be no significant correlation between Ss' age or sex and severity of illness level;
- H<sub>4</sub>: There will be no significant difference in resource unit (nursing visit) utilization by Ss before and after the implementation of the hospital-based PPS.

#### Methodology

##### Study Sample

The study sample was composed of elderly Ss (N = 457). Sample data were derived from closed records of Ss who had received home nursing services from selected VNAs between 1983 and 1986. All Ss who had primary diagnoses of congestive heart failure (CHF/DRG 121; N = 183), chronic obstructive pulmonary disease (COPD/DRG 139-145; N = 127), or cerebral vascular accident (CVA/DRG 169-180; N = 147), who were Medicare eligible, and who had been served by visiting nurses working for VNAs located in three urban areas of the same state were included in the study sample. A majority of Ss' records (63%) listed a secondary chronic diagnosis, and a small minority (14%) had an acute illness specified as a secondary diagnosis. The prevalence of chronic secondary diagnoses in this sample may be assessed in the context of similar elderly populations where some 80% of those over 65 years of age suffer from at least one chronic condition (Aging America: Trends

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and Reflections, 1987-88, p. 97). One Plan of Treatment was sufficient to address Ss' conditions in a large minority (N = 219/48% of cases). The remaining Ss required multiple Plans of Treatment as their health conditions changed. A total of 1305 Plans of Treatment were written for the sample. The distribution of Ss by VNA location was proportionally consistent with population differentials between the geographical areas served by the agencies. More than 97% of the sample Ss were over 65 years old; 73% of the Ss were between 70 and 89. The female to male ratio exceeded 2 to 1; a distribution representative, in general, of the elderly population in the age cohorts included in this study (p. 20).

### Instrumentation: Patient Record Inventory

An inventory was developed to enable data formalization. Inventory design was based on a construct suggested by Horn (1983). The inventory was composed of 11 data categories that encompassed available information on patient charts. The categorization of data facilitated the assignment of severity of illness levels. Preliminary reviews of the inventory were conducted. Health professionals (physician [N = 3], quality assurance nurses [N = 3], and staff nurses [N = 31]) reviewed and used the inventory independently, and reviewed charts to determine a severity of illness level for 18 randomly selected patients. Inter-rater reliability (Ebel, 1951) was established, and additional tests revealed a high correlation between patient prognosis and severity of illness scores determined by using the study inventory (Chi-square = 135.5, D.F. = 9, p < .0001). Comparisons of Ss by prognoses on all Plans of Treatment indicated that only minor changes occurred in terms of professional judgments regarding patients' conditions overall. Severity of illness levels for

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the study population were assigned by a registered nurse with 10 years  
of experience in home health care delivery.

#### Data Analysis

Data were aggregated and analyzed in a review proceeding retrospectively from 1986 in order to establish severity of illness levels, and to test associated study hypotheses. Descriptive and inferential statistics were used in the analyses of data. **Chi-square** and ANOVA statistics were computed in analyses related to  $H_1$ ,  $H_3$ , and  $H_4$ . A stepwise multiple linear regression was computed to determine the correlations between each of the elements on Plans of Treatment and severity of illness levels in response to  $H_2$ .

#### Results

Severity of illness levels was assigned. A majority of the Ss received a rating of 2 on a scale of 1 to 4, where 1 indicated the most severely ill (Table 1). Eighty-seven percent of the study Ss received fewer than 10 home visits covered by the first Plan of Treatment. Stability was notable in the distribution of visits made for initial Plans, and for all Plans of Treatment (Table 2).

The sample was divided into a before PPS group (G 1, N = 221) and after PPS group (G 2, N = 236). The date (August 31, 1985) that the PPS was implemented in the study setting, was used as the criterion for dividing the population. There was a significant difference between the two groups in terms of severity of illness. Severity of illness of Ss increased after the implementation of the PPS (**Chi-square** = 8.33; **D.F.** = 3;  $p < .05$ ). Analyses of variance were performed to examine the severity of illness variable by VNA (location). The trend toward higher levels of severity of illness after the implementation of the PPS (Table 3) was indicated. Given these findings,  $H_1$  was rejected.

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Table 1

Severity of Illness

Severity of Illness	Number of First Plan of Treatment	%	Number of All Plans of Treatment	%
1. Most	83	18	316	24
2.	242	53	647	50
3.	117	26	302	23
4. Least	15	3	<b>40</b>	3
Total	457	100	1305	100

Table 2

Frequency of Visit (Resource Units)

Visits	Frequency for First Plan of Treatment	%	Frequency for All Plans of Treatment	%
1	41	9	128	10
2	49	11	208	16
3	61	13	179	14
4	58	13	201	15
5	59	13	142	11
6	48	10	137	10
7	35	8	82	6
8	21	5	48	4
9	23	5	52	4
10	23	5	43	3
11	7	1	20	1
12	7	<b>1</b>	10	<b>1</b>
13	5	1	<b>11</b>	1
14	5	1	5	<1
15	4	<b>1</b>	9	1
16	3	<b>1</b>	6	<1
17	0	0	3	<1
18	<b>0</b>	0	3	<1
19	2	<1	4	<1
20	3	1	5	<1
21	3	<b>1</b>	3	<1
22	0	<b>0</b>	6	<1
Total	457	100	1305	100

Severity of Illness by PPS

Source	df	SS	F	P
PPS	1	4.26	7.855	.005*
Error	455	246.78		
Total	456	251.04		

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PPS	Before	After
Severity	2.24	2.05
N	221	236

A step-wise linear regression analysis of severity of illness by elements on the Plan of Treatment was computed (Table 4). All elements were significantly correlated ( $p = < .0001$ ) with the dependent variable, severity of illness. Results led to the rejection of  $H_0$ .

Severity of illness and S age were considered. A highly significant relationship was found between severity of illness and age (Chi-square = 74.32; D.F. = 12;  $p < .0001$ ). The progression of severity of illness with age was indicated. Ss over the age of 75 constituted 80% of the most severely ill segment of the sample. No relationship was found between severity of illness and sex using the initial Plan of Treatment in analysis (Chi-square = 4.58; D.F. = 3;  $p = < .20$ , ns).  $H_0$  was rejected for one demographic variable (age), and confirmed for the other (sex).

$H_4$  was tested in analyses of relationships between nursing resource units (visits) and Ss' severity of illness before and after the implementation of the PPS (Tables 4 and 5). It was found that the number of visits was not dependent on Ss' severity of illness level.

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Table 4

Severity of Illness by Elements on the Plans of Treatment

Elements	Beta	R <sup>2</sup>	F	P
(1) Prognosis	-.389	.233	1098.107	.0001*
(2) Complete Bedrest	-.289	.265	933.962	.0001*
(3) Ambulation	-.147	.328	554.503	.0001*
(4) Incontinent Bladder	-.138	.339	499.943	.0001*
(5) Respiration	-.116	.352	450.871	.0001*
(6) Oriented	<b>+.119</b>	.361	417.737	.0001*
(7) Transfers from Bed to Chair	-.101	.367	385.552	.0001*
(8) Paralysis	-.082	<b>.372</b>	355.991	.0001*
(9) Lethargy	-.078	.337	331.567	.0001*
(10) Partial Bedrest	-.072	.381	309.888	.0001*
(11) Disoriented	+.077	.387	274.258	.0001*
(12) Bowel Incontinence	-.062	.392	244.751	.0001*
(13) Patient Sex	+.054	.394	323.949	.0001*
(14) Agitated	-.064	.398	211.857	.0001*
(15) <b>Contractures</b>	<b>+.047</b>	.399	202.676	.0001*
(16) Start of Care Year	<b>+.036</b>	.400	193.903	.0001*
(17) Hearing	-.035	.401	185.911	.0001*
(18) Uses Wheelchair	<b>+.038</b>	.402	175.529	.0001*
(19) Prescribed Exercise Program	-.035	.403	171.766	.0001*
(20) Uses Cane	+.034	.405	159.916	.0001*
(21) Vision Problem	-.031	.406	154.493	.0001*
(22) Uses Crutches	-.033	.406	149.487	.0001*
(23) Uses Walker	+.024	.407	144.577	.0001*
(24) <b>Patrial Weight Bearing</b>	-.028	.407	140.074	.0001*

Despite changes in Ss' severity of illness, additional analysis (Table 6) indicated that there were no significant differences in the number visits made before and after the hospital-based PPS was implemented. H<sub>4</sub> was accepted.

Discussion

Data revealed that the severity of illness levels of Ss who received home health care benefits appeared to increase subsequent to the implementation of the hospital-based PPS. There was a significant

Visits by Severity (All Plans of Treatment)

Visits	Group 1 (Before PPS)					Group 2 (After PPS)						
	Severity Level					Severity Level						
	1	2	3	4	Total	%	1	2	3	4	Total	%
1-5	70	187	102	16	375	66	138	222	109	18	487	65
6-10	31	85	37	1	154	27	49	118	36	5	208	28
11-15	8	12	6	0	26	5	9	10	9	0	28	4
16-22+	6	2	2	0	10	2	9	10	2	0	21	3
Total	115	286	147	17	565	100	205	360	156	23	744	100
	20	51	26	3		100	27	49	21	3		100

Chi-Square = 18.57  
 D.F. = 9.0  
 Significance = 0.03\*

Chi-Square = 15.34  
 D.F. = 9.0  
 Significance = 0.08

\*p < .05

Table 6

Visits by Group (All Plans of Treatment)

	1 - 5	6 - 10	11 - 15	16 - 22+	Total
Before (G1)	375	154	26	10	565
After (G2)	483	208	29	20	740
Total	858	362	55	30	1305

Chi-Square = 2.16; D.F. = 3.0; Significance = 0.61

correlation between the elements of Ss' Plans of Treatments and Ss' severity of illness levels. Analyses revealed a significant positive

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relationship between the age of these Ss and increased incidence of serious illnesses.

The number of visits by home health nursing personnel was not significantly different after the implementation of the hospital-based PPS, given the incidence of visitation prior to PPS implementation. Several explanations may be offered to elucidate these findings, and study related implications may be suggested.

### Severity Levels

The finding that the severity of illness levels of home health care beneficiaries increased after the implementation of the PPS is consistent with informal contentions of some home health nurses. They have suggested that patients are more seriously ill since the implementation of the PPS than they were before the system was implemented. 'This finding supports related assertions (Fischer, **Phillys**, & **Scattergood**, 1986; Seifer, 1987) that today's homebound patients are more impaired than homebound patients prior to the implementation of the PPS. A trend toward a higher percentage of patients classifiable as more severely ill was confirmed in this population, while fewer Ss were categorized as less severely ill. What has happened, and may happen to patients who generally received home health care before the PPS? Are the patients identified as "less severely ill" **simply** abandoned to an inferior level of health care in their communities as a consequence of current cost-containment measures emanating from the hospital setting, and subsequently applied to home health reimbursements? The findings of other inquiries suggest that this may have occurred (Developments in **Aging**, 1, 1988; Older Americans Report, February 12, 1988; Seifer, 1987).

These data suggest that some administrators of home health agencies may not sanction visits to homebound patients unless it can be demonstrated that the cost is clearly reimbursable. A conservative approach to home health visit approval is in keeping with strictures imposed by HCFA regulations and implemented through **fiscal** intermediaries. **An** alternative explanation may focus on the stringency of eligibility standards for Medicare reimbursement. **It** has been documented that narrowly interpreted standards impose limitations on the number of visits made to patients, even though those same patients might require more visitation (Older Americans Report, February 12, 1988; Seifer, 1987). If patients receiving home health care visits are more seriously ill and reimbursement guidelines are more narrowly interpreted, another possibility may arise. Nurses constrained from making more frequent visits to patients because of fiscal policy directives may decide, in some cases, to spend more time with patients when agencies allow visits. In this way, nurses may be **able** to address what they consider to be professional obligations for quality of care even though patient visitation is restricted. Respondents in Seifer's (1987) study indicated that the time spent with more seriously ill homebound patients was increased subsequent to the implementation of the **PPS**.

#### Fiscal Constraints

Administrative judgments conditioned by fiscal constraints may impact the decision making latitude of professionals who deliver health care. Nurses have less control over practice--determining what care to provide--when third-party cost containment imperatives control the decision making process. The "kind" of nursing care that is Medicare

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reimbursable poses a serious problem for home health nurse. Support services such as "... monitoring of diet or medication to prevent exacerbation of existing conditions, reinforcing care routines, or identifying health problems is not covered" (Home Care at the Crossroads, 1988, p. 10). Such services enhance patient self care, and may prevent acute episodes that result in hospital readmissions.

### Plan of Treatment

Study findings revealed that all of the items on the patient's Plan of Treatment were significantly related to the severity of illness level. Prognosis was the variable most closely related to the patient's severity of illness level. Results suggest that professional judgments with regard to patient prognosis and illness severity' are closely associated. The congruency may be explained by the fact that the same data base for each patient was used in both prognosis and illness severity determinations.

When a patient was bedridden and could not move except with assistance, it was assumed that the patient was severely ill. Severity levels were closely related to being confined to bed, or to experiencing extreme difficulty in ambulation. Ambulation problems combined with chronic disease diagnosis pose critical problems. Confinement to bed or inability to ambulate normally restricts the activities of daily living. Such conditions alone **may** not be life-threatening, but they may contribute to a myriad of other conditions which may result in, or constitute life threatening events. Increased illness severity levels were related to increased duties for nursing personnel in Horn's (1983; 1985) studies.

As the age of study Ss advanced, the illness severity level rose. Study results were consistent with findings of the Select Committee of Aging which indicate that disability rates, chronic health conditions, and general health problems increase with age (Aging America: Trends and Projections, 1987-88). The findings are particularly germane to a consideration of home health care of the elderly, since the most rapidly **expanding** portion of that population are individuals age 85 and older. The majority of the oldest are female. Their advanced age and the potential for living alone in old age suggest the likelihood of nursing facility placement for women (p. 118). A growing problem of impoverishment among older women may be partially attributable to the long-term institutionalization of disabled husbands (Stone, 1988). Such familial experience, coupled with increasing longevity, makes elderly women all the more vulnerable to old age dependency. Circumstances suggest that this population may represent a larger proportion of the client population for future home health service, considered as an alternative to publicly subsidized nursing home care. Medicare beneficiaries over 85 are much more likely to receive home health care services than other old age cohorts (Stockton & Rabin, 1987) .

#### Home Health Visitation

Results of this inquiry revealed that the number of visits by home health nurses was not significantly different after the implementation of the **PPS**. Since the patients who returned home from the hospital and were referred to **VNA** caseloads were, subjectively, more **seriously ill** than homebound patients before the implementation of the **PPS**, it is

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axiomatic that more care **would** be required (Horn, 1985; Seifer, 1987; Sovie, **Tarcinale**, Vanputte, & Stunden, 1985).

The **study** findings do not indicate corresponding increases in care provided. A number of explanations may be offered. One reason for no increase in visitation may be that more seriously ill patients do not need more visits. This is an unlikely explanation, given contrary findings from hospital studies of seriously ill patients (Horn, 1985). The provision of care by relatives and friends may serve as another explanation. Home health aides, homemakers, and meal service providers are currently rendering more care for homebound clients in some communities. Such services as homemaker, home health aide, chore and personal care are provided under Title XX through Social Services Block Grants (**SSBG**). A survey conducted by the American Association of Retired Persons (**AARP**) revealed, however, that although home-based services were the most frequently provided services to the elderly in 41 states, those same states reported that the service need for in-home care far exceeded provider capacities (**Gauberlavage**, 1987). The Older Americans Act Amendment of 1987 (**P.L. 100-175**) authorized some non-medical services for frail elderly in the home (Home Care at the Crossroads, 1988).

### Strains on the Social Service System

The institution of the hospital-based PPS has created problems for social service providers. Because of increases in the numbers of home health clients subsequent to the PPS, state and area agencies on aging have experienced pressures to serve the most seriously incapacitated clients. Agencies are, for example "spending most of their transportation funds to transport older persons to dialysis and

While social services supplement home health nursing, they cannot substitute for essential health care delivery to the seriously ill and impaired. Patients may be returning to hospitals or turning to nursing homes for the additional medical care they require. Another scenario suggests that patients are simply remaining at home without the level of care that they formerly received from public health nurses.

#### Provider Attitudes

An alternative explanation for the finding of a steady-state in the number of home visits before and after the implementation of the PPS may be associated with nurses' attitudes toward the meaning of illness. Since all three diagnoses used in this investigation pose acute threats to patient well being, but are chronic in nature, these patients are unlikely to experience substantial **recovery** regardless of the level of health care provided. In most instances, patient decline is inevitable. The home health nurse may be resigned to these circumstances, and elect to routinely visit such patients regardless of present severity of illness or increasing severity levels. Such resignation on the part of the home health nurse may be reinforced further by agency policy directives related to cost containment in providing services.

#### Conclusions and Recommendations

This study focused on resource use in home care within selected DRG categories in anticipation of the development of a PPS for reimbursement of home health nursing services patterned, to an extent, on the hospital-based PPS system. A cost-controlled system is designed to effectuate efficiencies.

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Provisions for the delivery of home health care remain essentially unchanged, while studies are underway to ascertain the feasibility of a PPS. Much of the home care for the disabled and ill elderly is provided to those who can satisfy acute-care medical reimbursement requisites, while increasing numbers of elderly need care because of chronic impairments.

The "intermittent care" criterion for Medicare patients continues to contribute to access problems for the home health recipient who requires additional services. If patients seek necessary support through other public programs or pay for private care, they risk losing eligibility for home health benefits through Medicare. Such provisions impede efforts to meet the needs of home health care recipients and should be eliminated.

Current limitations on home health care expenditures for the economically vulnerable are incompatible with policy formulated to curtail the growth of the Medicaid nursing home population through approaches that include increasing the utilization of home health care. The needs of this population should be a home health care priority, since their personal resources are generally inadequate for even a modest contribution toward institutional support.

Fiscal measures designed to curtail home health costs by limiting nursing visits have been initiated without sufficient consideration of the time that may be needed to administer care to more seriously ill patients. Additional studies of time periods required for home health visits should be undertaken. Another problem for the home health nurse is associated with the provision of preventative, nonreimbursable services for homebound patients. Further investigation of the total

care administered by home health nurses, including nonreimbursable assistance provided to patients, is recommended.

While there is no definitive evidence that a fiscal strategy similar to the one in place in the hospital setting will prove appropriate for home health care, alternative approaches should be assessed. By 1984, 18 states with Medicaid home health beneficiaries had implemented some type of prospective payment strategy. Existing approaches have not been attractive to home health care providers (Williams, Gaumer & Cells, 1984). Because of current limitations on reimbursements for home health care under the Medicare program, the 200 Medicare certified providers withdrew from participation in 1986 and 1987. This trend is also observed among some county health organizations (Home Care at the Crossroads, 1988). A tractable prospective strategy must be viewed as desirable by providers and private payment sources alike, if it is to deter a growing trend among agencies to limit their Medicare/Medicaid populations or to withdraw from participation altogether. Feasibility testing of alternative designs for a PPS for home health care is required.

Strategic plans for the home care of future beneficiaries should include, in addition to professionally provided care for the most seriously ill, provisions for maintenance level nursing assistance that may be delivered by health aides. A 1987 survey of hospital discharge planners revealed substantial disapproval of Medicare eligibility determinations for home health care which failed to consider patients' social circumstance (Home Care at the Crossroads, 1988). More emphasis should be placed on the social/personal needs of patients.

A medicine oriented toward the relief of suffering rather than the deliberate extension of life, or even the prolongation of death, has

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been suggested as the aim of a caring society and an enlightened medical community (Callahan, 1987). The provision of health and social care for the elderly in their own home may constitute the basis for a viable strategy, not only because this approach may provide an alternative to costly institutional care, but because of the potential it offers in terms of the social and psychological well-being of patients.

In addition to home health care demonstrations prompted by fiscal concerns, experiments based on expanded considerations of health maintenance and social need are recommended. A more holistic definition of health should guide **policy**makers in planning for tomorrow's home health needs.

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