

# What's So Special About Home Care?

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Since 1965, when the Medicare benefit was passed into law, home care has evolved from a public health paradigm to an acute care model. With health-care reform targeting the need to contain hospitalization and emergency costs, the home is catapulting to the forefront of discussion as a preferred site of care. Multiple articles have been published about models of care that center in the home. In programs with labels such as “hospital at home,” the “patient-centered home,” the “medical home,” or “telehealth chronic disease management,” outcomes are confirming success in providing cost-effective, excellent care outside the acute care hospital. This migration of care from institutions to homes has significant ramifications for managers and leaders.

A major implication of the growth of home care is the increasing need for nurses with the specialized clinical and management skill sets of this specialty. Traditional approaches for orienting, training, supervising, and supporting clinical and support staff are not as effective when staff are not contained within the same four walls. Managing a patient's episode of care differs from managing a patient's condition during a short-stay hospitalization. As a long-time home health executive, I have frequently heard from nurses making the transition from hospital positions that “if I had known what people were going home to when I gave discharge instructions, I would have done so many things differently.”



## DEFINING HOME CARE

There are two models of home care: private duty and skilled intermittent care. Private duty is usually paid by patients and/or their families for 2- to 24-hour care coverage. (In some instances, third-party payers cover this type of care for short periods.) This article refers only to intermittent skilled home care, which is covered 100% by Medicare Part A and most commercial insurance companies.

There are over 17,000 certified home health agencies in this country. The ownership models for these agencies include sole proprietorships; local, regional, and national free-standing entities; and healthcare-affiliated (hospital or long-term care) organizations. These entities can be for profit or nonprofit. Approximately 15% are publicly traded on Wall Street. Regardless of organizational affiliation, agencies are paid by Medicare for providing reimbursable skilled

intermittent services, but only if certain criteria are met. Patients must have an acute condition for which skilled care is required. Care must be reasonable and necessary. Patients must be homebound, and a physician must order the services. Homebound is defined as meaning a patient exhibits “considerable and taxing effort to ambulate.”

The services covered by this benefit include nursing, physical therapy, occupational therapy, speech and language pathology, medical social work, and certified nursing assistants (CNAs). Patients must have at least one skilled service to be eligible for CNAs. Care is ordered for a 60-day certification period, and if the patient has not reached goals by the 60th day, recertification can occur. Visits by professionals are usually scheduled one to three times per week for 45 to 60 minutes. Care comprises assessments, evaluations, simple to complex wound care, intravenous (IV) drug administrations, central-line site maintenance, and patient education. At Centura Health At Home, part of the largest healthcare system in Colorado, we receive direct discharges from intensive care units (ICUs). Highly skilled and competent home care staff are essential.

### HOME CARE REGULATORY ENVIRONMENT

To maintain the privilege to provide services and be reimbursed by Medicare, agencies are subject to surveys conducted by their state health department as a contractor of the Center for Medicare and Medicaid Services (CMS). Conditions of participation include specific standards that each agency must meet to maintain certification. Surveys are conducted every 1 to 3 years. In addition, many home care agencies choose to be accredited by the Joint Commission (TJC). TJC has a separate unit that has developed rigorous and copious standards similar to those used to accredit hospitals. These standards are consistent with patient safety goals but customized for home care practice.

An example of this customization is the requirement for home care clinicians to have clean and dirty designated areas in their cars. Clinicians must be able to demonstrate these areas at random audits and during surveys. They must also be able to state the agency policy regarding these clean and dirty areas. Another area of intense investigation by surveyors is Health Insurance Portability and Accountability Act (HIPAA) compliance. Clinicians must be able to explain how their charts or laptops are managed at patients' homes in such a manner as to protect patient information. Additionally, since many clinicians have “homework” (finishing documentation at night in their own homes), they must be able to explain how they protect patient privacy from their friends and family. Home care leaders must demonstrate how they orient, train, and oversee compliance with this standard in such an uncontrolled setting.

Separate site surveys to check compliance with specific laws occur in many states. Home care managers and leaders must have expert acumen with all of these regulations in order to train and supervise staff while ensuring standards are met.

### MANAGING A SUCCESSFUL HOME CARE AGENCY

Home care agencies operate in a capitated setting, with payment determined by home health diagnostic related groups

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(HHDRGs). Medicare pays a lump sum for an episode of care based on a score calculated from admission data called the OASIS (Outcome and Assessment Information Set), a mandatory document that takes into consideration the patient's diagnosis, functional abilities, and social situation. Initial reimbursement is calculated from the OASIS. Sixty percent of the payment can be collected within the first 30 days of care. A final bill at discharge either bills for the 40% of the original calculated reimbursement rate or seeks adjusted payment based on the patient's actual care. The complexity of this process requires enormous clinical and financial competence.

Given the independence inherent to practicing in the home, clinicians need to be creative, seasoned, competent, and excellent at critical thinking. Few home care agencies hire new graduates for this very reason. In addition, there is minimal opportunity for the collegial support that often facilitates new graduates' learning. However, home care leaders know it is essential to set up support systems for even their experienced staff.

The support infrastructure for staff includes manager availability via telephone for assistance with problem solving. Even so, the field staff must have independent judgment and an ability to communicate the patient's status. Individual professionals are evaluated and stratified into novice to expert tiers. Patient assignments can be made based on a clinician's level of expertise. Quality, expressed through clinical outcomes and patient satisfaction, is directly correlated to appropriate home care staff assignments.

As in acute care settings, quality outcomes are reported by CMS on a public domain; Home Care Compare is the Web site for the industry. Pay-for-performance demonstration projects have been ongoing and promise to be part of home care's reality in the very near future. Accurate documentation at admission and discharge is essential, both for quality results and for calculation of reimbursement. Managers and leaders are responsible for oversight of care and documentation needs of their staff. They must read every admission OASIS and all revisit notes to ensure that the home care supports the original assessment and is moving the patient toward goals. Be-

cause the individual who admits and the team member who discharges a patient may be from different professions, there is a need to coordinate a consistent measurement process to accurately show patients' progress.

### CHALLENGES AND BENEFITS OF LEADERSHIP IN THE HOME SETTING

Productivity is as big an issue in home care as in acute care. Compensation models influence productivity substantially. When a home care agency pays professional staff via salary or with an hourly rate, leadership is usually challenged with convincing staff that they can see at least five patients per day. (The national benchmark is 5.5 patients per day.) It is not uncommon that the average number of patients seen per professional per day is between three and four in these compensation environments. When home care agencies pay professionals by the visit, the staff is paid when the home care agency bills, and the number of patients per day per professional jumps to between five and seven. In this payment model, leaders can spend less time discussing productivity and devote their energy to exploring clinical best practice, training, and supporting staff.

Turnover is another issue in the home care environment. The average nursing turnover in this setting is 25%. Nurses new to home care, regardless of experience, find the practice can be lonely and overwhelming because of the vast amount of documentation required by the government. For the majority of clinicians, work invades evening and weekend time. Many say they would prefer to clock in and out and have their work finished at the end of a shift rather than deal with home care paperwork. Leaders are faced with the intense priority to orient and train nurses for success while simultaneously supporting their current staff. Since organizational skills for clinicians seem to be the key to their success, leaders must have fastidious organizational skills themselves to teach others.

Physician relationship building and maintenance can be very challenging. The safety of patients' environment is something only the home care professional sees, experiences, and evaluates. The physician must rely upon the home care professional to be an extension of his or her eyes and ears. One negative experience by a physician can impact volume, as he or she may thereafter refuse to refer to or work with an agency. Time is one of the most valued commodities for physicians, so calls placed to them regarding patient status and care need to be concise, appropriate, and urgent. Routine needs or changes can be transmitted by e-mail or faxes. Leaders must teach and support staff to critically think about safe care, when it is a patient's right to comply or not comply with orders, and when to communicate something to physicians.

The benefits of leading in this setting outweigh the challenges. Home care attracts autonomous independent practitioners who are engaged 100% in patient education and clinical improvement. One recent patient story illustrates the rewards of this specialty: A home care nurse cared for a 50-year-old man with a diagnosis of insulin-dependent diabetes mellitus (IDDM), adult onset, and congestive heart failure for 4 months. He was obese, depressed, and feeling like life just was not worth

living. The registered nurse (RN) and her licensed practical nurse (LPN) partner admitted the patient to home care and provided focused education to the patient about his disease process and all the ways he could affect his well being. No one had been successful in educating the patient before in a way that allowed him to see his own role and responsibility for how he felt every day. This patient was discharged from home care having lost 40 pounds and stating he had reason to live again. The RN and LPN were ecstatic with this outcome, explaining that this was the reason they love home care.

### FUTURESCAPE

Many are surprised to learn that we are currently able to provide virtual care to patients via telehealth. The use of this technology is expected to grow in the future, when reimbursement practices are changed. Whether devices are provided to patients to monitor clinical status or to actively evaluate and treat patients, clinicians and leaders must develop technical skills that are not currently taught in schools. It is already possible for a patient to have a telehealth device in the home where, through a video monitor, the patient and the nurse can see each other while conversing. The nurse can talk the patient through putting on a blood pressure cuff, an oximetry monitor, weighing him- or herself, and placing the stethoscope so the nurse can assess the heart and lungs. All these parameters are transmitted through existing telephone lines into software that produces trend graphs and documentation. This type of care is happening today, limited only by the lack of reimbursement. With the focus of reform discussions predominately centering on prevention and proactive support of chronic populations, this type of care will redefine home care and potentially become a standard rather than an exception.

### SUMMARY

No other setting offers more opportunity for impacting patients' level of wellness than their own homes. At home, patients feel they are in control of their environment, rather than experiencing the vulnerability felt in other settings. With the home becoming a new focal point for care, we need to prepare those who are interested in leadership in this setting. Historically, home care experience has been required for management and leadership positions because of the complexity of the "uncontrolled" setting and industry-specific processes and standards. An in-depth knowledge of the financial model and its interface with clinical modeling is essential for leadership success. As technology evolves and reimbursement changes, the future will mandate that home care embraces new leaders into its domain. There is an exciting future for this nursing specialty and opportunities for those who choose to lead. **NL**

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