Occupational Therapy in Home Health: Rapid Changes Need Proactive Planning

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Home health has been expanding in the number of both agencies and beneficiaries and in the scope of service delivery. In 1961, there were 200 home health agencies in the United States. Now, there are more than 8,000 agencies—with 90% being Medicare certified—providing services to approximately 1.2 million clients (Jette, Smith, & McDermott, 1996). Home health is one of the fastest growing categories of Medicare expenditures, increasing from $2 billion in 1988 to $12.7 billion in 1994 (Halamandaris, 1995).

What factors have generated this rapid growth, and what will continue to challenge occupational therapy practitioners who specialize in home health practice? Like the industry, occupational therapy practitioners are vulnerable to potential shifts in home care policy, particularly those policies that affect inclusion and reimbursement of home-based rehabilitation.

Factors Generating Home Health Expansion

Major changes in policy and demographic factors have fueled home health growth. Before 1980, Medicare regulations required that a beneficiary had to be hospitalized before receiving home care. The Omnibus Reconciliation Act (OBRA) of 1980 (Public Law 96-499), however, eliminated this stipulation, resulting in an expansion of home care use (Helbring, Sangl, & Siletman, 1992). In addition, the implementation of the Medicare hospital prospective payment system in 1983, which mandated expediency of inpatient care and subsequent early discharge, had a major impact on the growth of home care (Caterinicchio, 1984). At the end of the 1980s, a critical change in policy was the revision in the Medicare guidelines that broadened the scope of coverage to include beneficiaries with chronic diseases who were previously denied home care services (Welch, Wennberg, & Welch, 1996). To deny care to these patients, who often demonstrated an exacerbation of the condition resulting in compromised medical and functional stability, was seen as discriminatory. Before this policy revision, coverage was limited to beneficiaries with acute medical conditions. This broadened Medicare coverage enabled the expansion of occupational therapy services from a focus on a specific diagnosis to a broader focus on functional impairment regardless of the diagnosis.

In addition to these key policy changes, there are other reasons for growth. First, the number of Medicare beneficiaries has increased with the growing aging population (Medicare Hearings, 1995). By 2025, there will be an estimated 92 million people over the age of 65 compared with 53 million in 1995. Currently, an estimated 60% of persons aged 65 have functional limitations, with half of these classified as severe (U.S. Bureau of the Census, 1984). Many of these persons are potential recipients of home care services.

Second, technology has enabled an increase in life expectancy. In addition, with advancements in technology, procedures and regimens that were traditionally provided only by outpatient or inpatient services can now be delivered in the home. Some examples include interventions such as intravenous therapies, phlebotomies, and kidney dialysis.

Third, HCFA reimburses physicians for care plan oversight (Medicare Hearings, 1995). This oversight fosters a more supportive interest in initiating as well as favorably responding to recommendations for home care. Previously, physicians had voiced concerns about the considerable and uncompensated time re-
required to oversee their patient's home care plan. In many cases, this may have led to a reluctance to authorize services. Today, because of the HCFA decision, physicians are more conscious of the fact that they, not the nurse or the therapy practitioner, are the professionals who authorize and are responsible for plan oversight. Consequently, they may scrutinize more closely the efficacy as well as the quality of the care being provided.

Occupational Therapy in Home Care

In my discussions with occupational therapy colleagues in home care, including administrators and field staff members, several critical issues consistently appear. These issues are not necessarily unique to occupational therapy, but each has major implications for our practice. The issues are quality of care, service utilization, family-centered care, teaching as a primary role, the power of documentation, fraud, and cost-effectiveness.

Quality of Care

The acceleration of growth of individual home health agencies leads to concerns about their ability to meet the increased demands for health care without sacrificing quality. There have been negative reports about the quality of home care, yet few empirical studies are available that provide actual measures of quality (Leader, 1986; Sabatino, 1986). Jette et al. (1996) reviewed 4,324 Medicare-reimbursed episodes of care provided by 47 home health agencies and found that although overall quality of care was adequate, there was considerable need for improvement. The quality problems they identified included documentation issues, problems delivering nursing and therapy services, and lack of response to emerging health problems.

Evaluation of quality depends on context. Therefore, in home health, methods for evaluating quality of care need to be unique to the home care setting and not based on the hospital setting. For example, the need for home care is not based solely on the patient's medical problems, but also on their functional, cognitive, and socioeconomic status. Additionally, the location of care is the patient's home where the needs are met by informal services in addition to formal services delivered by the agency.

OBRA of 1987 (Public Law 100-203) mandated that the Medicare certification process and surveys shift the emphasis of quality evaluation from agency structure—or capacity to provide care—to quality of process and outcome. In response, home care agencies have instituted quality assurance teams to develop outcome-oriented measures of quality of care specific to home care practice. In addition to developing these outcomes measures, there is interest in developing process measures, particularly among those home health agencies that seek accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), whose standards require a plan for continuous quality improvement (Williams, 1995). Agencies are embracing concepts of Total Quality Management (TQM), which emphasize the evaluation and improvement of the processes that created the poor outcomes. Examples of these processes include the appropriateness of care prescribed for the problem, whether care ordered was provided, the extent to which the care provided was given according to accepted standards of practice, and the adequacy of management and coordination of services (Williams, 1995). TQM principles suggest that because every person in an organization can influence quality, they should be included in the evaluation and improvement process. These ethos create an important opportunity for occupational therapy practitioners to take leadership roles in quality improvement initiatives not only for therapy services, but also for the overall agency.

Service Utilization

Reports of service utilization in home care indicate that occupational therapy, speech–language pathology, and medical social services combined account for only 3% of industry visit totals as opposed to 8% for physical therapy (Ellenbecker, 1995; Welch et al., 1996). Overall, the majority of visits include skilled nursing services (42%) and home health aide services (44%). These data reflect underuse of occupational therapy services particularly because the majority of diagnoses reported in home care claims include chronic conditions (Welch et al., 1996). Working with intake personnel to allow screening of all agency referrals will likely indicate many cases where a referral to occupational therapy may be appropriate. It becomes clear that occupational therapists need to be consistently assertive to assure that all necessary referrals for occupational therapy services occur. It is also important to participate in staff development by presenting in-services on not only the nature and scope of occupational therapy services, but also on generic topics, such as functional limitations of various conditions.

One cannot assume that all agency staff members know about occupational therapy services. Similarly, not all persons who influence the decision regarding referral for occupational therapy and have an impact on the process and outcome of intervention are familiar with the nature and scope of occupational therapy services. These persons include physicians, nurses, administrators, clinical managers, other home care personnel, caregivers, and family members. Formal in-service education about the occupational therapy process in home care as well as development of checklists and printed material about services can be effective in increasing the use of occupational therapy services.

Family-Centered Care

Adopting a family-centered orientation is both valuable and necessary in the home care setting. A catastrophic illness or disabling condition within the family system affects all family members. Educating caregivers about home safety is a primary goal addressed by all home care staff members. It is of particular concern to the occupational therapist because of the emphasis on acquiring self-care skills and the rise of injury due to impaired sensorimotor, psychological, and cognitive functions. The emotional response to caregiving stress, particularly of elderly spouses, is evaluated to determine whether maladaptive behaviors begin to emerge. Advocating a plan for the primary caregiver to seek regular respite from the daily demands of patient care provides necessary rest as well as demonstrates a concern for the caregiver's well-being. It is a requirement of JCAHO accreditation that discharge planning
include an evaluation and plan of the caregiver's ability to continue to meet the needs of the patient as identified by the home care personnel (CAHO, 1993).

Teaching as a Primary Role
Teaching is a natural component skill of the occupational therapy practitioner working in home care. Because of the intermittent nature of home visits, the patient and family members must be given formal instructions for home program follow-up. Documentation of instruction outcomes, including the patient and caregiver’s ability to replicate them verbally and by demonstration, is needed to ensure that procedures are understood. The caregiver is always included in the teaching-learning process to ensure accurate and consistent follow-through of prescribed activities. Home care personnel must be conscious of the temporary nature of their services and to share that reality with the patient and caregivers. A determination of the impact of discharge begins early in the intervention program, which enables appropriate, collaborative planning and action.

The Power of Documentation
Inadequate, or missing, documentation has been identified as a major deficiency in the quality of home care (Jette et al., 1996). The old adage, “If you didn’t write it, you didn’t do it,” serves as the general rule for documentation. Agencies spend considerable time in in-service programs emphasizing the importance of documentation. Like other staff members, occupational therapy practitioners are well versed in the rules for documentation. Nonetheless, they should engage in periodic self-evaluation by asking, “Is my documentation in compliance with regulatory and agency standards and with standards of occupational therapy practice?” There is no variable other than documentation as powerful for evaluating the practitioner’s skill and delivery of quality care.

In-service training that provides both good and bad examples of compliant documentation can ensure improvement. In addition, many agencies are streamlining documentation systems as well as initiating automated documenta-

Fraud
Fraudulent practices are of concern in the home health industry. In congressional testimony presented to the U.S. Congress by the Office of Inspector General (OIG) (Medicare Hearings, 1995), several types of fraud in home health agencies were reported. These include cost report fraud, excessive services or services not rendered, use of unlicensed or untrained staff members, falsified plans of care, and forged physician signatures and kickbacks. In response to these concerns, HCFA has initiated the Medicare Home Health Initiative, which is directed at assuring that home health care is appropriate, efficient, and of high quality (Medicare Hearings, 1995). The goals of this initiative are as follows: (a) respond to the needs of the beneficiaries; (b) enhance providers’ flexibility in structuring plans of care; (c) ensure provision of high-quality care; (d) improve the efficiency of administration and operations; (e) facilitate appropriate use of home health services; and (f) ensure appropriate payments for the benefit and enhance efforts to detect fraud and abuse. The OIG announced plans to conduct provider-specific audits. The intent is to validate claims in specific regions of the country to determine the nature and extent of the inappropriate payments made under current Medicare rules. In addition, OIG will continue to explore alternatives to the current Medicare program structure and system.

In one audit of a home health agency in Florida, 75% of the $45 million in claims submitted did not meet Medicare requirements (Medicare Hearings, 1995). Claimed visits were not made, were made to persons who were not homebound, were made but not authorized by physicians, and were made to persons who did not want the service. The OIG is now conducting random audits of 200 claims by other agencies in the state of Florida to determine whether the problem uncovered in the one agency is typical of that state in general (Medicare Hearings, 1995). Additionally, OIG will initiate investigations of agencies in other regions where HCFA has determined potential problems. To combat fraud, all professionals, including occupational therapy practitioners, are ethically bound to report incidents of fraudulent practice to the intermediary organization of HCFA. Beneficiaries of services are also strongly encouraged to report fraudulent practices, and all home health agencies are required to provide a toll-free telephone “hotline” for this purpose.

Cost-Effectiveness
The Home Care Coalition, in its recent congressional testimony on the cost effectiveness of home health services (Medicare Hearings, 1995), indicated considerable cost savings; the differential ranged from 40% to 87.8% between hospital and home care costs for various diagnoses. For example, the cost variance of a hip fracture was found to be approximately $2,000 less for home treatment than for inpatient treatment. A report by the General Accounting Office in 1994 (as cited in Medicare Hearings, 1995) indicated that a shift from inpatient services to in-home and community-based care in the states of Washington, Oregon, and Wisconsin resulted in service to more Medicaid beneficiaries with the state dollars available. In addition, per user spending was found to be lower in home care than for nursing facility care (Medicare Hearings, 1995). In Oregon, the average 1993 monthly expenditure per user for elderly persons and persons with disabilities averaged $1,657 for nursing facility care compared with $420 for home care (Medicare Hearings, 1995).

Conclusion
As the U.S. Congress continues hearings and, eventually, actions on controlling health care spending, occupational therapy practitioners can expect a shift to a managed care reimbursement system in the Medicare program, which is the largest source of reimbursement in home health. In a managed care environment, occupational therapy services are part of an agency’s cost center as opposed to being revenue producing. The primary objective is to demonstrate that there is a benefit to the patient and family mem-

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bers that would not have occurred in the absence of occupational therapy services. Emphasis on prevention and education will be critical for the occupational therapy practitioner as opposed to restorative procedures, which fit less appropriately in the context of home care. We can benefit by sharing new ideas and innovative programs. In part, this special issue describes and discusses the potential of occupational therapy in home care and hopefully will facilitate new ways of thinking about and acting on the changes taking place.

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References


