

Medical Management *of the* Home Care Patient

Guidelines for Physicians



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Preface

The American Medical Association convened the first Home Care Advisory Panel in 1987 with the goal of increasing the involvement of physicians in home care. That panel produced the first edition of the *Guidelines for the Medical Management of the Home Care Patient*, which was published in 1992 in collaboration with the U.S. Administration on Aging. A second panel, convened in 1997, led to the revised second edition of the *Guidelines*, published in 1998.

This third edition, *Medical Management of the Home Care Patient: Guidelines for Physicians*, has been made possible by the collaboration between the AMA and the American Academy of Home Care Physicians and is primarily the work of AAHCP Board Members, assisted by others. We gratefully acknowledge the following:

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The American Academy of Home Care Physicians received an educational grant from Ross Products Division, Abbott Laboratories, to support the work of its Board of Directors in revising these *Guidelines*.

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ISBN-13: 978-1-57947-865-0
ISBN-10: 1-57947-865-4
OP 221201

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SEE:06-0225:2.5M:11/06

Home care: The first option

Home care is a critical concern for an increasing number of patients with both chronic and acute diseases. New technologies, pharmaceutical advances, changing reimbursement policies, and the continuing desire of patients and their families to remain in their homes have combined to drastically change the treatment of acute and chronic illness. Patients with chronic illness are living longer, and patients with acute illness are discharged from hospitals earlier, increasing the need for complex and often less costly care in the home.¹ This has resulted in a paradigm shift in medical care delivery from hospital-based care back to home-based care. In an increasing number of situations, home care can be considered the “first option,” preferred over hospitals, emergency departments, or nursing homes whenever care needs can safely be met at home.

What is home care?

Home care is “the provision of equipment and services to the patient in the home for the purpose of restoring and maintaining his or her maximal level of comfort, function, and health.”² Home care is able to address a wide spectrum of patient care needs.³ By integrating physician house calls into the home care paradigm, this definition can be broadened to encompass nearly all aspects of medical care. In any case, effective home-based care requires a collaborative effort of patient, family, and professionals.⁴

Who needs home care?

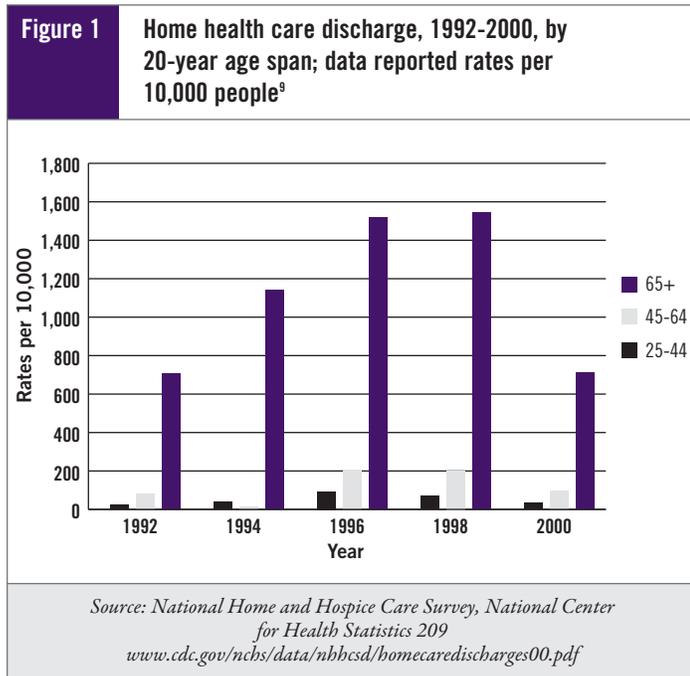
Home care is appropriate for consenting patients whose medical needs can be safely managed at home when required time, financial, physical, and emotional resources have been considered. More than 18,000 organizations deliver home care services to more than 7 million individuals of all ages with acute illnesses, long-term health conditions, permanent disabilities, or terminal illnesses.⁵ Their patients include 44% of all patients discharged from the hospital who require post-hospital medical or nursing care (nursing home or home care) that cannot be provided by family or friends alone.⁶ Home care also plays a critical role in the management of rapidly increasing numbers of HIV/AIDS, hospice, and pediatric patients, and patients at a distance from medical facilities who receive the benefits of telemedicine.¹ Between 5% and 10% of all patients in a primary care medical practice receive home care, but evidence suggests the need is much greater.⁴ For every patient over age 65 years in a nursing home, there are three more similarly impaired patients cared for in their own homes.⁷ An estimated 20% of patients over age 65 years have functional impairments with related home care needs that are often unrecognized during the typical office visit.⁸

Home health care utilization, expenditures, and reimbursement sources

While the predominate users of home care are elderly, home care had grown steadily for patients of all ages

Table 1	The goals of home care
	Improve the health and quality of life of the patient through comprehensive primary medical care and nursing and rehabilitative services
	Reduce the need for hospitalization and nursing home and other institutional placement
	Provide support for the informal caregiver
	Reduce emergency department visits
	Reduce hospital length of stay and the risk of hospital readmission
	Allow terminal patients to die at home in comfort if that is their wish
	Enhance optimal growth and development of infants and children
	Enhance functional potential of patients on life-sustaining devices

until changes in federal funding as a result of the 1997 Balanced Budget Act, which led to a reduction in the number of home care recipients (Figure 1).



Among the elderly, the largest growth in the home care services financed by Medicare has been in those patients aged 85 years or more (Figure 2).

Prior to 1997, home health agencies (HHAs) were reimbursed on a fee-for-service basis and had incentives to provide more services. The 1997 Balanced Budget Act reduced payments for home care services and resulted in a 22% decrease in the number of beneficiaries served by home care agencies and a decrease in the number of agencies (Figure 3).⁹ The average home health length of stay declined from 98 days in 1998 to 58 days in 1999. This decrease was particularly notable among those receiving care from for-profit HHAs.¹¹

There are a variety of home care services and reimbursement sources, including Medicare, Medicaid, private insurance health plans, long-term-care insurance, and out-of-pocket expenses paid by the patient or family (Table 2). Third-party payers, such as managed care organizations and commercial insurers, also fund a significant amount of home care. These organizations may vary in eligibility requirements, benefits, and limitations; many use some or all of Medicare's guidelines.

Medicare home health expenditures increased from \$4.7 billion to \$17.6 billion from 1991 to 1997. This was due to an increase in the number of beneficiaries

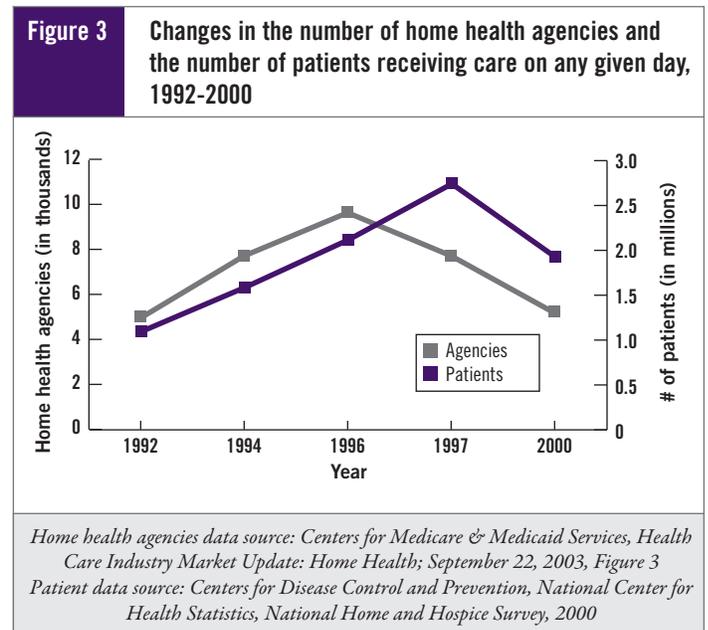
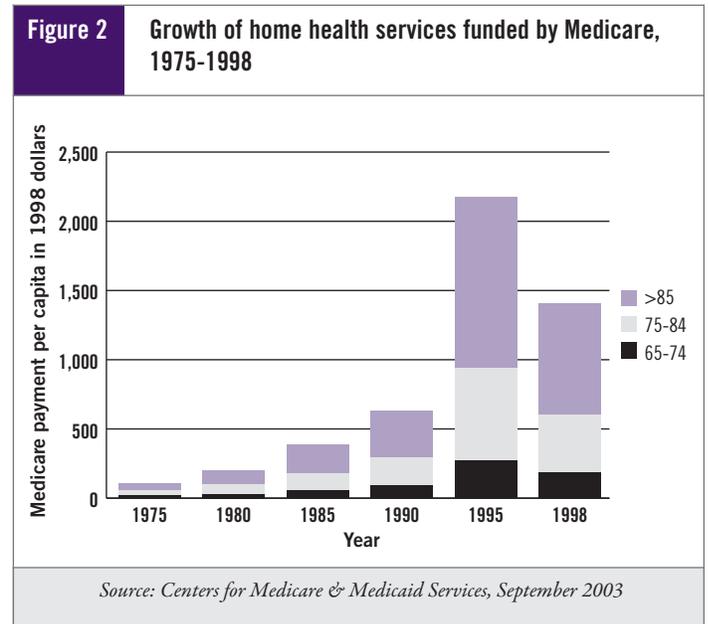


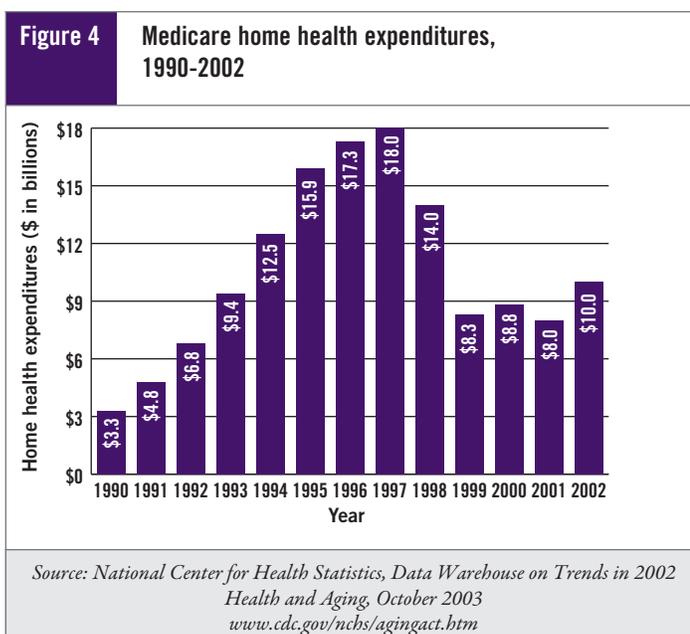
Table 2 2004 payer segmentation—HHA industry (free-standing facilities only)¹²

	Funds expended (\$ billions)	Percent of total
Private health insurance	5.0	10.4%
Out-of-pocket & other private	5.5	10.4%
Total private funds	10.0	20.8%
Medicare (federal)	16.4	34.2%
Medicaid (federal & state)	13.7	28.5%
Other public	7.9	16.5%
Total public funds	38.0	79.2%
Total public & private funds	48.0	100.0%

*Source: National Health Expenditures. Centers for Medicare & Medicaid Services, 2004
www.cms.hhs.gov/NationalHealthExpendData*

receiving home health care and the number of visits they received. In 1998, spending on home health care began to decrease, and in 1999, spending for HHAs was about \$8.7 billion. Several factors contributed to the decrease in Medicare home health spending, including the prospective payment limits created by the Balanced Budget Act of 1997 as well as several initiatives to address concerns about fraud and abuse.

In contrast to expenditures for HHAs, expenditures for hospice have continued to grow (Figure 5).¹³



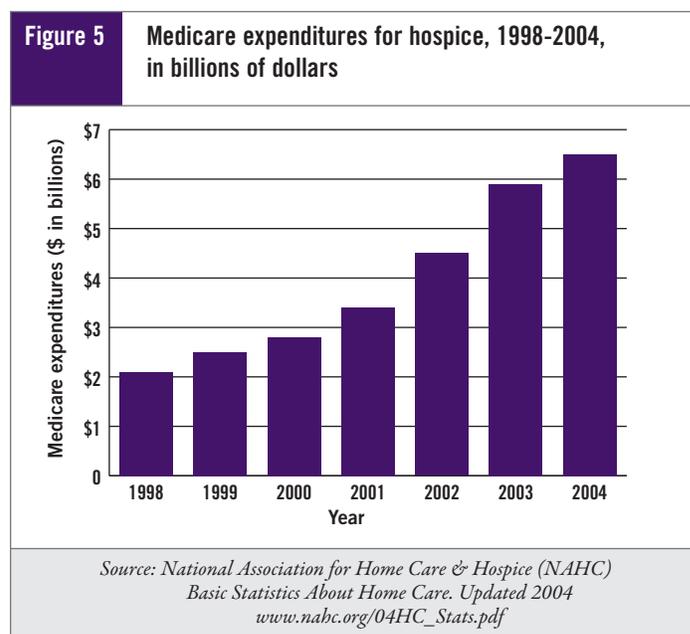
Effectiveness of home care

Good medical and fiscal management should focus on measurable patient outcomes. This is true for home care as well as for other aspects of medical care.^{14,15}

Table 3 Examples of measurable home care outcomes

Improvement and/or stabilization in patient functions
Improvement and/or stabilization in health status
Improvement in patient/caregiver management of medications and other treatments
Improvement in patient/caregiver ability to manage equipment
Improvement in knowledge of disease process and signs and symptoms to report
Improvement in knowledge of safety and provision of safe environment
Decrease in utilization of emergency departments, ambulances, and acute/subacute hospitalizations
Decrease in institutional/nursing home placement

Demonstrating effectiveness in home care is complicated by the diversity of home care programs and the various outcomes measured. Perhaps the most impressive demonstration of the usefulness of home care is the finding of improvement in rates of hospitalization and targeted clinical improvement in standard Medicare home services systems.¹⁶ Home care as a part of hospital discharge and follow-up can reduce readmissions, lengthen the time



between discharge and readmission, and decrease the costs of providing health care for hospitalized elders at high risk for rehospitalization.^{17,18} Home care is effective in monitoring patient response to plan of treatment and has been shown to identify new problems not found in the office setting¹⁹⁻²¹ and to prevent or retard disability and other health problems.²² Home care programs are effective in all aspects of care, including preventive care (e.g., prenatal visits for high-risk mothers²³⁻²⁵), as an alternative to hospitalization in the management of acute problems (e.g., venous thrombosis,²⁶ exacerbations of chronic obstructive pulmonary disease,²⁷ early discharge for low-birth-weight babies²⁸), chronic disease management (e.g., congestive heart failure²⁹), and rehabilitation (e.g., stroke³⁰ and general conditioning³¹). New technology and pharmaceuticals have made the home treatment of infectious disease possible and practical.³²

In summary, home-based care has emerged as a reasonable and important alternative to acute hospitalization or a skilled nursing facility for many patients with acute or chronic illness. Physicians in all specialties make use of home care. Changes in technology and reimbursement continually influence the scope and practice of home care. Physicians need to understand these issues in order to participate in home-based care in an informed fashion when medical necessity and/or patient wishes dictate.

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Chapter 2

The physician's role in home care

Home care starts with a physician's recognition that the patient's condition and resources are appropriate for care in the home. The physician, in consultation with the patient, family, and other members of the home care team, then develops and prescribes a home care plan of treatment that may involve a home health agency (HHA) and other resources.¹ Thereafter, the physician is legally responsible for continuing supervision of that care and determining the medical necessity of that care.² A physician arranging home care should discuss with the patient his or her role in that patient's care (i.e., provider of primary care versus specialist care only), the physician's availability for house calls, and arrangements for coordination of care with an HHA and other community resources.

Table 1 The physician's role in home care

Management of medical problems
Identification of home care needs of the patient
Establishment/approval of a plan of treatment with identification of both short- and long-term goals
Evaluation of new, acute, or emergent medical problems based on information supplied by other team members
Provision for continuity of care to and from all settings (institution, home, and community)
Communication with the patient and other team members and with physician consultants
Support for other team members
Participation, as needed, in home care/family conferences
Reassessments of care plan, outcomes of care
Evaluation of quality of care
Documentation in appropriate medical records
Certification of medical necessity when required
Making house calls as appropriate
Provision for 24-hour on-call coverage by a physician

House calls

There are a number of circumstances when a home visit by the physician is appropriate, whether or not home health services are being provided (Table 2). A house call may be the first step in developing a home-based management plan in many situations. While there are important exceptions to this generalization (e.g., pre-operative patient training and evaluation, post-operative follow-up, post-hospital discharge, etc.), house calls can provide information that may be useful or even critical for some acute and most chronic home care situations. Medicare and most other payers recognize the value of house calls and will reimburse for services at a rate comparable to office visits.

Following the initial evaluation, the home care plan may be carried out by the patient alone, but more often it involves family or other caregivers with support from a variety of health care professionals. The physician's direct, physical presence by way of house calls is often critical in convincing family caregivers that care in the home is possible and acceptable. Sometimes, the mere contingency of having a physician available to make home visits relieves the family's anxiety to the point of avoidance of institutional care.

Table 2 Reasons for making a house call

Patient unable to travel to the physician's office due to immobility, cognitive impairment, or psychiatric condition
Request for home visit made by other home health team member, patient, or family member
Need to meet with patient and caregivers to make important decisions
Need for direct observation of patient's environment, patient's functional abilities, or caregiver activities to understand medical issues (e.g., failure of treatments, unexplained symptoms)
Need to meet on-site with community-based providers
Need for direct observation in the home to verify eligibility for third-party reimbursement for services (e.g., homebound status for Medicare Home Health)

Table 3 Areas of potential importance for initial home care evaluation

Type of assessment	Specific assessment	Elements to be observed and evaluated
Patient assessments	<i>Functional assessments</i> Against the backdrop of the disease process, the physician must assess the patient's ability to perform activities of daily living (ADL) and the more complex instrumental activities of daily living (IADL)	ADL <ul style="list-style-type: none"> • Ambulating • Feeding • Toileting • Continence • Transferring • Dressing • Bathing IADL <ul style="list-style-type: none"> • Taking medications appropriately • Arranging transportation • Doing housework • Handling finances • Preparing meals • Using the telephone • Shopping Gait and balance assessment/fall prevention Sensory assessment <ul style="list-style-type: none"> • Vision • Hearing
	<i>Mental/cognitive assessment</i> Assesses the ability of the patient to follow/implement the directed care plan	<ul style="list-style-type: none"> • Alcohol or drug use • Recent changes in cognition • Health literacy • Cognitive ability and educational development • Decision-making capacity • Use of medications that affect cognition
	<i>Psychosocial assessment</i> Interventions must be individualized to be effective	<ul style="list-style-type: none"> • Nature and quality of interactions with others • Cultural, ethnic, or religious influences on health care behavior, beliefs, preferences, and expectations • Affect and mood
	<i>Nutritional assessment</i> There is potential for malnutrition in the socially isolated or disabled population	<ul style="list-style-type: none"> • Eating habits: preferences, frequency, and content of meals • Access to shopping assistance and the ability to purchase and prepare food • Fluid intake • Changes in body weight • Ability to swallow • Oral health/dental needs
	<i>Medication use and compliance</i> A structured approach based on thorough assessment and patient education can reduce adverse drug events	<ul style="list-style-type: none"> • All medications (prescription, over-the-counter, herbal and other remedies, and substances of abuse, such as alcohol) present in the home • Patient's understanding of the function of medications, desired outcomes, and potential side effects • History of allergies and adverse drug events • Numbers/names of prescribing physicians • Patient's understanding of how to handle medication errors • Written instructions • Patient's current regimen and compliance
	Advanced care planning	<ul style="list-style-type: none"> • Resuscitation wishes • Health care agents/durable powers of attorney and guardianship
Caregiver assessments	Assessment of burden of caregiving	<ul style="list-style-type: none"> • Caregiving responsibilities (i.e., spouse with Alzheimer's, grandchild, disabled child) • Number of hours of caregiving work per day • Nature of tasks to be completed • Physical and psychological stress related to nature of illness and necessary care • Caregiver's perception of the need for respite
	Assessment of the caregiver	<ul style="list-style-type: none"> • Acceptance of the responsibility • Emotional competence, stability • Caregiver's availability • History of abusive behaviors • Number of available caregivers • Willingness and ability to learn and apply knowledge • Willingness and ability to implement care plan • Physical capacity to meet caregiving needs • Willingness and ability to work with the care team • History of family relationships and traditions
Environmental assessment	<ul style="list-style-type: none"> • Safety of the area for patient care activities (barriers, hazards, cleanliness, overcrowding) • Access to emergency services; emergency response/alert systems • Alternative source of electricity if life-supporting equipment is needed • Adaptations needed in terms of special equipment, furniture arrangement, remodeling • Telephone availability and accessibility • Adequate fire safety plan • Adequate space for caregivers • Stability of housing situation • Access to toilet, food, water, medication • Adequate storage space for supplies and equipment • Transportation accessibility 	
Community assessment	<ul style="list-style-type: none"> • Safety of neighborhood for patient care • Communication as needed with local police, fire, utilities, highway departments, and emergency medical services • Community resources—Eldercare services; legal, mental health, social services available at home 	
Financial assessment	<ul style="list-style-type: none"> • Eligibility for patient to receive services under Medicare/Medicaid/Veterans Administration or other public programs • Resources for private funding for necessary care, including insurance • Impact on family resources from inadequate coverage • Ability of patient and/or caregivers to manage finances 	

The booklet *Making House Calls a Part of Your Practice*, published by the American Academy of Home Care Physicians (revised January 2006), is a useful resource for efficiently incorporating house calls into a primary care (or specialty) practice, (contact AAHCP: [410] 676-7966 or www.aahcp.org).

Initial evaluation for home care

The success of the care plan depends on the patient's or caregiver's ability to carry it out.³ The physician's support and encouragement are essential factors in patient compliance with the care plan. **Appropriate medical management in the home is a function of the physician's skills in optimizing the patient's independence while utilizing medical and social resources to minimize the effects of illness and disability in the patient's daily life.** A subtle but critical distinction between medical management in the home and medical management in the hospital, clinic, or office is the emphasis on the patient's functional abilities, family assistance, and environmental factors. An array of assessments are generally required to evaluate the patient's and/or family caregiver's ability to implement the care plan, including the risk of caregiver burnout. These assessments have proven valuable in both the identification of new medical and psychosocial factors not evident in the office^{4,5} and the prevention of further disability.^{6,7}

As is the case in any health care venue, the evaluation begins with a traditional history and physical examination and appropriate laboratory tests. This should include a careful assessment of nutritional risk, especially in older patients and patients with chronic illness.⁸ The availability of sophisticated testing equipment for in-home use has increased the scope of laboratory tests, but the use of this technology should be tempered by the patient's treatment goals. Beyond the medical evaluation, the areas indicated in Table 3 should be the targets of careful screening as part of the initial evaluation.

The screening assessments should include subjective reports from the patient (and/or family) and the physician's observations during the physical examination. When limitations in daily functioning are identified, the patient should undergo more detailed assessments (Table 4).

Table 4	More extensive evaluations are indicated when screening suggests a potential problem in the following areas:
Determine level of functional disability	
<ul style="list-style-type: none"> • Patient is independent • Patient needs minimal assistance • Patient needs moderate assistance • Patient is dependent 	
Determine the cause of the impairment	
<ul style="list-style-type: none"> • Temporary or permanent physical limitation • Uncontrolled pathophysiologic process • Pain • Lack of motivation 	
Determine the method to overcome the disability	
<ul style="list-style-type: none"> • Potential for change with rehabilitation • Potential for improvement through pharmacotherapy • Use of assistive devices • Necessity of reliance on others • Skills training for caregivers 	

The evaluation process should be sensitive to cultural and racial issues that can influence outcomes.⁹

The physician and the home care team

Home care is a team endeavor, and physicians have a number of distinct and important roles on the interdisciplinary home health team. These roles can be challenging for physicians who are used to face-to-face contact with team members, as occurs in the hospital, or when the physician has limited direct contact with the patient during an episode of home care. Understanding clearly the roles and responsibilities can improve the ability of the physician to participate effectively in the home care process. A high level of involvement by the physician in oversight of the care plan, either directly or indirectly, has proven beneficial to the patient's overall health.¹⁰⁻¹²

In addition to making house calls as appropriate (Table 2), the physician's basic responsibilities can be summarized in two broad categories:

Knowing when and which HHAs are working with your patients.

It is impossible to play an active role in the home care plan unless you are aware that home care is being provided to a patient. Office-based physicians should insist that hospitalists inform them about home care referrals that occur at hospital discharge. Referrals from the office should be documented clearly in the medical chart. Some physicians place information about the HHA involved in care on the front of the office chart.

Having direct contact with patients receiving home care.

For most patients, this will be in the office setting. Home health nursing visits supplement physician care, but should not be considered a perfect substitute for it. Patients receiving home health services should be seen at a frequency comparable to other patients with similar conditions and severity of disease. Some health insurance programs and other regulations require a minimum frequency of physician visits; e.g., the Medicare Part B outpatient rehabilitation benefit (which can be provided at home) requires visits every 30 days.

Communication and coordination of services

Physicians have the responsibility for coordinating medical care for patients receiving home care. The attending physician who is overseeing home care must also serve as a liaison between the multiple physicians who may be involved and the home health care providers. An organized system for communication with HHAs can facilitate effective patient care, care plan oversight, and certification or recertification of medical necessity of the home care services, thereby reducing the stress of directing care from afar.¹³

Critical communication and coordination activities for physicians in home care include:

- Providing or arranging for continuous, knowledgeable physician coverage: Home care patients and the home health professionals serving them need 24-hour telephone access to a physician. When home care involves high-technology equipment, home infusion therapy, or hospice services, it is critical that covering physicians be knowledgeable of the situation to avoid unnecessary emergency room visits and hospitalizations for problems that can be addressed at home.
- Maintaining organized records of home care services: Office charts should include copies of all signed orders, evaluations and reports from home health team members, notes from telephone conversations, and names of all organizations, personnel, and consulting physicians involved in the patient's care.
- Prompt response to telephone calls from HHA staff: Telephone calls should be returned the same day they are received. When a home health provider requests an urgent response, a system should be available just as it is for calls from an intensive care unit nurse or another physician.
- Timely response to written communications: The paperwork sent to physicians for review and signature is important for communication regarding ongoing care, for billing by the HHA, and for compliance with state, federal, and accreditation agency requirements. Laboratory reports sent from HHAs (e.g., prothrombin times) should generally be reviewed within a day of when they are received. Physicians should have a system to sign and return routine correspondence at least weekly.

- Communication of changes in patient condition and care plan to the HHA: Home health agencies must know of all changes in the patient’s overall care plan, including changes in medications, upcoming medical appointments and tests, and new diagnoses. Changes in patient condition should also be communicated, especially if they might affect eligibility for reimbursement for home care (e.g., changes in a patient’s ability to leave the home). After an office visit by a home health patient, such information can be communicated to the HHA via a phone call or by sending progress notes to the agency.
- Advocate on behalf of the patient for provision of all needed services: Many health insurers require authorization for home health services. Physicians may need to communicate directly with the staff involved when the HHA’s efforts to obtain such authorization fail. Under Medicare Prospective Payment for home health services, agencies receive a fixed payment for all services provided. Therefore, physicians must represent the patient’s interest to receive all services needed for as long as they are needed (subject to eligibility rules).

The site of care

Perhaps the most critical role for the physician is determining if home care is suitable for an individual patient. Care in the home may be medically appropriate for almost any acute or chronic problem; however, situations exist where medical care is necessary, but home-based care may not be appropriate. The patient’s unique home, social, and family/caregiver situations play a paramount role in decisions regarding medical necessity for home care. For example, when diagnostic tests or therapies are considered necessary but are not available in a timely manner, patients should be referred to other settings. Factors to consider in this determination are listed in Table 5.

Table 5	Considerations for initiating in-home care
Service can be provided in the home	
<ul style="list-style-type: none"> • Personal, financial, and family/community resources available • Severity of illness is such that care needs can be met • Technology exists • Physicians, and other home health staff, can be accessible in a timely manner • Meets growth and development needs 	
Safety	
<ul style="list-style-type: none"> • The service can be provided safely in the home • Difficulty in receiving proper care in event of complication • Risk to the providers in making house calls 	
Patient autonomy	
<ul style="list-style-type: none"> • Patient’s desire to remain in the home • Elimination of need for more restrictive environment (hospital, nursing home, etc.) 	
Transportation barriers	
<ul style="list-style-type: none"> • Patient stressed by need for transportation to other settings • Patient unable to leave home for functional reasons 	
Expected outcomes	
<ul style="list-style-type: none"> • Improved function, compliance, and quality of life as a result of intervention • Better chance of achieving expected outcomes in home than in other settings • Enhance family health, socialization 	
Cost-effectiveness	

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Chapter 3

The physician-patient-caregiver relationship

Regardless of the venue, successful doctor-patient relationships are built on effective communication with specific information relevant to diagnosis, treatments, and prognosis, as well as general health education.¹ This is especially true for home care patients. The patient in need of home care usually has multiple, complex medical problems that require increased assistance from his or her physician in understanding the illness and the requirements of home-based care to manage it. **In addition to medical oversight of the frequently fluctuating pathophysiological condition(s), physicians involved in effective home care advise, encourage, and support the home care patient's efforts in self-care.** House calls may be a source of both professional satisfaction and maintenance of trust in a doctor-patient relationship.

Table 1	Topics for effective doctor-patient communication in home care
	Effects of disease and treatment on the patient's daily functioning and lifestyle
	Expected course of the illness, both short- and long-term
	Tasks that the patient and/or caregiver will be expected to perform
	Capacity of home caregiver(s) relative to the care needs
	Stress and burdens arising from chronic illness and methods to relieve such stress for both the patient and caregiver(s)
	Potential for rehabilitation
	Preventive care and counseling
	Special nutritional considerations
	Psychosocial needs
	Importance of monitoring the condition(s) by the patient and/or caregiver
	Early signs of instability or deterioration that should be reported to the physician
	Improvements in function or condition that should be reported to the physician

In all of these discussions, it is imperative that the physician and others involved in home care assure themselves that the patient and all caregivers understand the issues and aims of the home care plans.

Table 2	Topics of special importance to pediatric home care patients
	Optimal nutrition and feeding
	Therapy options for rehabilitation
	Modification of technology support (for high-technology home care) for optimal function
	Educational and socialization needs
	Issues related to promotion of optimal growth and development
	Effects of chronic illness/disability on social development/sibling and/or family relations
	Family/marital stress due to parenting a child with special needs

Caregiver issues

Family caregivers provide at least 80% of the care received by individuals in the community.² Nearly three-fourths of the frail elderly cared for by family members live in the same household, and most family caregivers are women, either spouses or daughters.² Female caregivers are more likely to be 65 years of age or older, black, married, better educated, unemployed, and primary (rather than secondary) caregivers, and provide more intensive and more complex care compared to male caregivers.³ The difficulties of care provision and balancing caregiving with other family and employment responsibilities results in poorer emotional health secondary to caregiving for women, and compared to men, women tend to cope with caregiving responsibilities by forgoing respite participation and engaging in increased religious activities.³

As might be expected, the stress of caregiving can prove burdensome. Caregiving requires from four to eight hours per day, and generally, this responsibility lasts from one to four years.^{4,5} There are direct and indirect financial costs (e.g., reduced employment), and these have the greatest impact on ethnic minorities.⁶ For example, the additional yearly cost of informal care per case for patients with chronic lung disease was \$2,200, or a national annual cost of more than \$2 billion in 2001.⁵ There are also personal costs; approximately half of caregivers experience symptoms of depression and stress and suffer an increased susceptibility to their own health problems.⁷ These costs have been described for caregivers of patients with various physical (e.g., ventilator dependent⁸) and mental/psychological disorders.⁹

This sense of burden stems from a complex interaction of factors. Patient-specific factors include behavioral problems, the skills required in providing the treatment and maintenance regimens, and the ability or willingness of the patient to assist in care. The caregiver's health, perceived competence, and commitment are important factors in the caregiving role. Finally, the nature of the relationship and the ability of both parties to compromise and adjust to one another's needs are essential.¹⁰

A self-assessment of caregiver burden is available through the American Medical Association that may help uncover the full effects of caregiving and prompt interventions on their behalf (www.ama-assn.org/ama/upload/mm/36/caregivertooleng.pdf).

The patient/caregiver unit

The patient and caregiver form a unit with the dependencies of the patient matched by the capabilities and the willingness of the caregiver to provide assistance and support. A comprehensive home-based approach to care should provide the full range of treatments and service resources necessary to support the patient/caregiver unit. Formal supports through public and private agencies may complement those skills and abilities that the caregiver cannot provide.

A systematic approach to identifying the strengths and weaknesses of the patient/caregiver functional relationship is central to developing the medical care plan and provides a measurable set of goals for its success. Those functions most likely to respond to clinical improvements or rehabilitative efforts can be identified by matching the dependencies noted in the initial patient functional assessment to the underlying co-morbidities. This also helps identify areas of training to target to enhance the caregiver's skills.

Ideally, responsibility for each part of the care plan should be assigned to either the patient or the caregiver. If neither is capable in certain areas, or the caregiver is unwilling to assume certain responsibilities, then secondary caregivers may be needed. These services may be acquired through referral to a home care, social service or legal agency, or the family may wish to hire the necessary personnel directly. Periodic reassessment, especially with significant changes in clinical status (of either the patient or the caregiver), helps to maintain stability of the home care program. Alternatively, this approach will also make clear the need to consider institutionalization.

The physician and caregiver relationship

The physician's role in support of the caregivers is critical and multi-factorial.¹¹ Caregivers often feel a sense of isolation and are very dependent on their relationship with the patient's physician. They see the physician as a de facto case manager who provides appropriate connections with health, social service agency, and specialty referrals to assist in clinical management. The physician should validate the caregiving role by affirming the work of caregiving and acknowledging the stress, loneliness, and burden. Caregivers and patients must be frequently assessed and reassessed to identify behavioral, functional, and physiologic problems that may threaten the patient/caregiver unit. A home visit provides significant emotional support to the caregiver as well as a means for continuing medical management.

Training the caregiver to recognize the specific signs and symptoms of illness in the patient and to know the appropriate response ensures the caregiver's competence and the safety and well-being of the patient. Most families are highly motivated and can be successfully trained in a wide variety of therapeutic, diagnostic, and behavioral management skills. The caregiver should appreciate that new behavioral problems should be evaluated expeditiously. Often, these changes signal an acute delirium requiring prompt diagnostic and therapeutic intervention. If the aberrant behavior is not based on an acute physiologic problem, specific recommendations involving either behavioral management or psychopharmacologic therapies must be provided.

Finally, caregiver's stress or frustration are important factors associated with failure of the care plan, abuse, or premature institutionalization.¹² It is important, therefore, to recognize and develop plans to deal with caregiver stress. Caregiver well-being has been shown to be affected by patient behavioral problems, frequency of caregiving breaks, self-esteem, perceived social support, burden, and hours of informal care.¹³ Various interventions (e.g., respite and caregiver education) have been shown to be effective in improving patient outcomes¹⁴ and caregiver stress^{15,16} in caregivers of patients with dementia.

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Chapter 4

Paying for home care: Eligibility and coverage for home care services

Medicare (and most other payers) reimburse for home-based health care under multiple types of health insurance benefits. Skilled home care is generally limited to patients who are considered homebound, although non-Medicare providers waive this requirement for patients receiving home infusion services. It is not necessary to be homebound to receive home-based rehabilitation under Medicare's outpatient rehabilitation benefit, hospice under hospice benefits, or medical care in the home (provided by physicians, nurse practitioners, and physician assistants). Insurers do not require patients to be homebound to receive durable medical equipment such as wheelchairs or oxygen. In all cases, however, physicians must certify the need for the care, often subject to insurers' guidelines for medical necessity and eligibility. Co-pays and deductibles vary across these types of insurance benefits and by insurer.

Physician's responsibilities

The prescribing physician is responsible for the initiation and ongoing review of home care funded by Medicare and most other payers, and must clearly define the purpose of providing skilled home health care services in the plan of care.¹ This involves choosing the treatments and services that are appropriate and medically necessary to reach desired treatment outcomes, knowing which services can be provided by individual members of the home health staff, and projecting the frequency and duration of those services needed to reach the defined outcomes.

The amount of care a patient requires is determined by the acuity of his or her condition, the level of skilled care a patient needs, and the level of technology needed.

The Medicare home health benefit will cover skilled services when the care is such that it could only be performed safely by a skilled professional. Although home health aides, physical and occupational therapy assistants, and family caregivers can follow the treatment plan outlined and supervised by the skilled professional (e.g., registered nurse, physical therapist, occupational therapist), the development and oversight of that treatment plan is the responsibility of the prescribing physician. In particularly problematic cases, requesting a consultation from outside the specified home health agency, or HHA (e.g., a qualified rehabilitation specialist), may be appropriate to provide clarification of medical necessity.

In developing and reviewing the care plan, the prescribing physician must determine the scope and frequency of home care services. A patient's individual nursing and other home care needs depend on his/her physiologic status, as well as the ability of the patient and caregiver to learn and carry out correctly the delegated nursing tasks (such as dressing changes). Some patients with multiple complex morbidities are essentially chronically unstable and require both physician and nursing interventions on a periodic basis.

The frequency of physician home visits will also vary depending on the patient's co-morbidities, the relative risk versus benefit of aggressive therapies, need for documentation in the non-compliant caregiver situation, or instability of both social and medical factors. As is the case with physicians' services in the office, the scope, frequency, and duration of home care is highly individual and is determined by the patient's needs and resources.

Table 1	Factors determining frequency of home care services
	Acuity/instability of illness, need for observation and intervention
	Complexity of treatment prescribed
	Patient and/or caregiver need for education to learn how to safely provide the prescribed treatment
	Patient or caregiver need for psychosocial support to manage the treatment at home

The physician plays a critical role in understanding and advising patients as to options for funding home care in the face of acute or chronic illness. These may include long-term-care insurance, government programs such as In Home Support Services, and community-based services. State laws or payers' policies may require a physician's declaration of mental competence or a written evaluation of the safety of a given patient living in the community. Physicians also need to consider the risks of elder abuse, especially financial elder abuse, in supporting the final decision by a patient to stay at home. These issues become quite complex and may require several home visits with care coordination with the appropriate authorities, such as adult protective services, before a just disposition can be made.

The duration of home care services should depend on achievement of the care plan's predetermined, expected outcomes. Outcomes may be straightforward and easily documented (e.g., healing progress of a wound or improvement with physical therapy) or more difficult to quantify such as simply keeping the patient out of an institutional environment. The physician may wish to make a house call before discharging a patient from home care.

Table 2	Factors affecting the duration of home care services
	Achievement of expected goals and outcomes of care
	Overall prognosis
	Unanticipated complications from expected outcomes
	Need for continuing skilled services because of inability of patient/caregiver to evaluate and provide appropriate care independently

Medical necessity

Medical necessity is a critical element of Medicare and most other types of insurance coverage. What constitutes medically necessary care has not been determined in a scientific manner. Some aspects of medical necessity apply regardless of the site of care (Table 3). Typically, medical necessity determinations are based on a combination of acuity of the illness/injury, patient co-morbidity, and patient dependency. Other models of medical necessity emphasize prognosis and obtainable outcomes. For pediatric patients, the American Academy of Pediatrics includes in its definition of medical necessity not only the outcomes the service will have on the patient's condition, illness, or injury, but also questions of the age appropriateness of services, their effect on mental and physical growth, and the maintenance of functional capacity.²

Table 3	Considerations for the determination of medical necessity in any setting
	Acuity/severity of illness
	<ul style="list-style-type: none"> • Physiologic abnormalities • Uncontrolled symptoms • Risk of adverse events • Frequency of clinical judgments/re-evaluations
	Co-morbidities
	<ul style="list-style-type: none"> • Interrelationships of multiple disease processes and multiple treatments • Medical complexity
	Dependency
	<ul style="list-style-type: none"> • Functional impairments caused by disease(s) may require: <ul style="list-style-type: none"> -Equipment and training in its use -Assistance of another person (skilled or unskilled) -Education for self care -Rehabilitative therapy -Prevention of excess disability/risk management

Medicare Home Health Care

Medicare Home Health Care is defined as “skilled nursing care and certain other health services provided in a person’s home to treat an illness or injury.” Medicare will pay for home health care if it is medically necessary for treating a person’s illness or injury. Medicare has specific guidelines for beneficiaries to qualify for Medicare Home Health Care and certain criteria for the services covered.³

The definition of homebound may not be an issue for patients who pay for the services themselves, but it is when considering eligibility for payment of home care services by Medicare and some other insurers. The beneficiary must be homebound to be eligible for the Medicare Home Health Care coverage. A patient is considered homebound if “leaving the home would require a considerable and taxing effort” and if the patient “has a condition due to illness or injury which restricts ability to leave the residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person, or if the patient has a condition such that leaving the home is medically contraindicated.” Homebound patients may leave the home “if absences are infrequent or for periods of relatively short duration...or for the purpose of receiving medical treatment.” Participation in adult day services is permissible under this definition of homebound.

The beneficiary must also be under a physician’s care, have a written plan of care approved by the responsible physician, and need at least one of the following intermittent services: skilled nursing care, physical therapy, speech therapy, or continued occupational therapy. Occupational therapy alone does not constitute a skilled service. However, after care has begun and other skilled services are discontinued, continued occupational therapy does qualify as a skilled need. Finally, the HHA must be Medicare-certified.

If the threshold coverage criteria are met, beneficiaries are entitled to receive clearly defined services as reviewed in Table 4. The beneficiary is not responsible for any deductibles or co-payment. Medicare pays the full approved cost of all covered home health visits and will pay 80% of the approved amount for certain pieces of medical equipment. Medicare does not limit the length of coverage. The physician’s plan of care covers a 60-day period, or what is known as a home health benefit period. If a beneficiary requires more time, a physician must recertify that the beneficiary requires the services and continues to meet Medicare’s requirements in order for Medicare to continue paying for home health care.

Medicare does, however, limit the number of hours per day and days per week a beneficiary can receive home health care. The part-time/intermittent criteria are used both as eligibility criterion and to determine the amount of services. In determining whether an individual is eligible for home care, Medicare defines “intermittent” skilled care as fewer than seven days a week or less than eight hours each day for a period of 21 days. Once the beneficiary is receiving home health care, Medicare limits the amount of skilled care and home health aide services to a combined total of less than eight hours per day and 28 or fewer hours each week.

If a beneficiary is in a private Medicare plan, such as a Medicare HMO, then he or she generally must use an HHA that has a contract with the HMO, and the HMO must approve the home health care. If the beneficiary is in the Medicare Private Fee-for-Service (PFFS) plan, then he or she can use any HHA that will take on the patient and will accept the PFFS plan’s terms of payments.

Table 4 Medicare-covered services**Skilled nursing**

Some situations that might warrant skilled nursing services are:

- Observation and assessment of the patient's condition that can be performed safely and accurately only by a skilled professional
- Procedures/services that can be performed safely and effectively only by a skilled professional
- Evaluation or management of the patient care plan (including intermittent monitoring of the physiologic status of patients requiring high-technology care)
- Patient education/teaching self-care strategies

Skilled therapy services

Medicare covers two types of therapeutic programs:

- Restorative therapy—provided with the expectation that the patient will improve (and such improvement can be measured) in a reasonable and generally predictable amount of time
- Maintenance therapy—provided with the expectation that these services are necessary for the establishment of a safe and effective maintenance program, and that the beneficiary or caregivers will be instructed and supervised in carrying it out

Specific conditions that may be amenable to therapeutic exercises, treatments, training in compensatory techniques to improve level of independence, or training in the use of assistive devices include (but are not limited to):

- Loss or restriction of mobility affecting ambulation, balance, positioning, transferring, bed mobility, generalized weakness, or fatigue
- Loss or restriction of mobility that limits performance of activities of daily living (toileting, transferring, and eating)
- Communication disabilities such as expressive or receptive aphasia, voice disorders, or limitations in reading or writing
- Swallowing difficulties
- Safety risk—fall prevention, training in awareness of hazards, and prevention of injury for those with functional impairments

Home health aide services

When a qualifying skilled service is provided, home health aides can perform part-time and intermittent services such as:

- Personal care (assistance with bathing, dressing, toileting, transferring, and eating)
- Simple dressing changes that do not require the skills of a licensed nurse
- Assistance with self-administered medications that do not require the skills of a licensed nurse
- Assistance with therapeutic exercises that do not require the presence of a skilled therapist
- Routine care of prosthetic or orthotic devices

Medical social services

When a qualifying skilled service is provided, the services of a medical social worker can be covered if those services are necessary to resolve social or emotional problems that are an “impediment to the effective treatment of the patient's medical condition or rate of recovery.”

Such medical social services include (but are not limited to):

- Assessment of pertinent psychosocial and economic factors
- Appropriate action to obtain community resources to help the patient
- Counseling services for the patient
- Short-term counseling services (two to three visits) for family caregivers

Medicaid

Eligibility for Medicaid home health programs, funded jointly by state and federal governments, varies from state to state in terms of qualifying income levels and welfare status. States also vary in their coverage of services. Most programs cover part-time nursing and aide services, medical equipment, and supplies. They may or may not cover physical, speech, or occupational therapy. Some states require preapproval before services can be provided.

In addition to traditional Medicaid skilled home health coverage, some states operate a Medicaid waiver program that enables them to provide Medicaid payments for home- and community-based services to individuals who would otherwise receive Medicaid-reimbursed care in nursing homes. States must show that the home care program is more cost-effective than institutional care. Eligibility is often based on issues of dependency in activities of daily living (ADL) or cognitive impairment. Not all states participate in Medicaid waiver programs, and localities within a state may differ in the services (e.g., qualifications and training of staff, type, frequency, and duration of services) that are covered.^{4,5}

Commercial insurance and managed care programs

Medicare managed care organizations must provide the same home care benefits that would be allowed to a patient enrolled in fee-for-service Medicare. If a physician believes that home-based services are necessary and the type and frequency of services are within Medicare benefit limits, the managed care organizations must authorize and pay for the services or must provide the patient with a denial letter along with information about the appeal process. Most plans and programs cover some home care services; their eligibility requirements, benefits, and limitations (e.g., deductible, coinsurance, type or amount of service) vary widely. Many plans follow some or all of the Medicare guidelines but frequently limit the number of visits allowed. Some capitated programs are developing disease management and other special home care programs based on the most cost-effective setting to provide care. These innovative programs ignore traditional Medicare guidelines of homebound status and intermittent

or part-time care and place their emphasis on clinical outcomes and cost.

Private long-term-care insurance

Long-term-care insurance can cover a variety of home-based services. Often, the patient can be reimbursed by the insurer up to a maximum per day for services not covered by other health insurance. Eligibility for the benefits varies by policy and usually relies on functional impairment and cognitive impairment measures. The most commonly used functional impairment measure is the need for assistance or supervision in two or more ADLs (number and description vary). Clinical evidence or standardized testing such as the use of the Mini-Mental State Examination is used as a measure of cognitive impairment. Coverage may be restricted by cost, type, frequency, and duration of services, and policy definitions are often vague. A recent study found that one-third to one-half of patients currently living in the community who are relying on paid assistance (out-of-pocket) for one or more of their ADLs would not qualify for benefits, based on the current long-term-care insurance definitions and measurements.⁶

Prolonged home care services

For many patients, there are continuing long-term-care needs when the patient and family cannot regain their independence and must rely, at least in part, on outside help. Medicare Part A rules for 60-day home health coverage periods may limit the patient's access to care. Medicare pays only for the acute home health benefit and does not cover custodial or prolonged care unless medically justified. Since there is no cap on the number or length of physician services, the use of home visits by the physician to provide medical evaluations in the absence of home health benefits may be appropriate under Medicare Part B rules, as long as such visits are medically reasonable and necessary.

Some home care patients with continuing skilled monitoring needs may be eligible for Medicare coverage. If the patient meets the criteria described in the “Management and Evaluation of the Patient Care Plan” section of the Centers for Medicare & Medicaid Services *Home Health Agency Manual* (Table 5), he or she can continue to receive Medicare-covered home health services including the skilled nursing and aide services. Patients receiving this benefit must be frequently re-evaluated and their ongoing eligibility documented.

Table 5	Medicare criteria for prolonged care
	“Underlying conditions or complications such that only a skilled nurse can ensure that essential non-skilled care is achieving its purpose, or...
	The complexity of the unskilled services that are a necessary part of the treatment must require the involvement of a registered nurse to promote the patient’s recovery and safety in view of the patient’s overall condition.”

Most often, the services required for such patients to live at home, especially if the patient is supported by physician house calls, are not skilled, but rather of a domestic or custodial nature. Under the Medicare provisions for maintenance therapy, similar continued skilled monitoring and intervention by therapists can be provided for some patients.

For those patients who cannot regain their independence, some services may not be covered. Custodial or unskilled services that are necessary to maintain the patient at the optimum level of well-being and function are not covered by the Medicare home health benefit. Private insurance, long-term-care insurance, Medicaid, and state and local community programs may provide some coverage for these patients; the majority of unskilled services are paid for by the patient and family.

The physician’s role in these cases is to refer to social services to help identify whatever resources are available (see Chapter 7, Case management: Making use of community resources) to counsel the patient and family, and to initiate discharge planning from Medicare home health services when no further skilled services are needed.

Physician reimbursement for home-care-related activities

Home-care-related activities are generally reimbursable. An understanding of how to bill for such activities will permit physicians to be compensated for the additional time and effort associated with ordering and overseeing HHA services or performing home visits.³ The basics of coding and billing are reviewed in Table 6. *Making Home Care Work in A Medical Practice: A Brief Guide to Reimbursement and Regulations*, a booklet published by the American Academy of Home Care Physicians, is a good general reference for coding and billing issues.

Table 6	How home care activities are coded and billed
	Certification and recertification of skilled home care services
	Medicare has created a Healthcare Common Procedure Coding System (HCPCS) code to compensate physicians for the activities related to the review and return of Form 485 (described in Chapter 5).
	Care plan oversight
	Almost all insurers reimburse for time spent completing paperwork and communicating regarding home health patients. Typically, such reimbursement requires more than 30 minutes in a calendar month to be dedicated to these activities. Coding and documentation requirements vary by payer. Medicare currently uses HCPCS codes, while other payers use Current Procedural Terminology (CPT®) codes.
	Discharge planning
	Hospital and nursing home Evaluation and Management (E/M) CPT codes have specific codes for the discharge day. Work related to referral to an HHA is included in the values of those codes.
	Office visits
	Review of home health records and communication with family or HHA staff that is part of a patient’s office visit should be documented and considered in determining the complexity of decision-making, which helps determine the most appropriate CPT code for the visit.
	Home visits
	There is a family of CPT codes specifically for physician home visits. Office-based codes should not be used for home visits. Reimbursement for home visits is generally higher than for comparable office visits, in part because of the additional types of assessments that are performed in the home. The definition of “home” versus “domiciliary care” or “nursing home” has been defined by Medicare.
	<i>Current codes, code descriptions, and values can be found on the AAHCP Web site at www.aahcp.org</i>

References

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Chapter 5

Implementation and oversight of the home care plan

The physician initiating home care plays the central role in managing the patient's in-home care. When referring a patient to a home health agency (HHA), the physician must develop and/or approve the care plan. Ongoing oversight of home care services is then required by that physician or by another physician, nurse practitioner, or physician assistant identified by the referring physician. This oversight involves collaboration and communication between the referring physician and a variety of others participating in the care of the patient.

The initial referral may occur in the course of hospital discharge planning or may be initiated from the home or clinic. The referral is usually made by directly contacting an HHA representative or through referral to a facility-based discharge planner, case manager, or community-based nurse or social worker.

When referring a Medicare patient to an HHA, that agency must be Medicare-certified and the patient must meet the Centers for Medicare & Medicaid Services' definition of homebound if Medicare is to provide payment. For third-party insurers, the referring physician must attest to medical necessity for home care for the services to be reimbursed. For some services (e.g., 24-hour personal attendant), it is necessary for the patient to provide payment. It is important for the referring physician and family to clearly understand the terms and cost of such care.

Patients discharged to home from the hospital or after a short-term nursing home stay often have ongoing needs for nursing, rehabilitation, or custodial care. Care planning should anticipate these needs before discharge to ensure timely start of the appropriate services and delivery of

Table 1 The physician's role in the initiation and management of home care

Consider the feasibility of the home as an alternative setting of care upon admission to the hospital or nursing home and reassess this frequently.
Collaborate with nursing and social work staff to plan for post-discharge home-based care beginning early in the stay.
Clarify which physician(s) will be responsible for oversight of post-discharge care on all discharge forms, including home health referral forms. Inform patient and caregivers how/when/whom to contact for specific problems and when follow-up appointments are or should be scheduled.
Participate in the choice of an HHA to ensure that the patient's right to choose is maintained and that the agency selected can provide the services the patient requires in a timely and appropriate manner.
Consider the appropriateness of the housing for the patient's types of disabilities and needs (i.e., handicapped accessibility issues).
Consider the informal caregivers' (family, neighbors) capacities to help the patient and their needs for respite or training.
When home health care is required, prepare a clear prescription for initial home care needs, including disciplines to be involved (e.g., nursing, therapies, social work), special assessments desired (e.g., orthostatic blood pressures, laboratory tests), and treatments required (e.g., wound dressings).
Complete prescriptions for all new medications, for refills for medications that may have run out, and any equipment that is needed to permit discharge (e.g., hospital bed, wheelchair).
Prepare documentation summarizing the inpatient/nursing home stay for the HHA. Ideally, a discharge summary can be sent home with the patient or faxed to the HHA at the time of discharge.
Participate in patient/caregiver education related to medications, self-management strategies for the patient's illness, and expected course of illness.

needed equipment. The hospital discharge planner or nursing home social worker will usually work with the patient and family in selecting an HHA in these settings. An interested physician can be involved in this process, but the physician's usual responsibility is determining the scope of home care.

Children may require special considerations in this process (Table 2).

Table 2	Additional physician responsibilities when caring for children with chronic illness/disability
	Assess school-based and community options for health care and promotion of optimal development (e.g., early intervention programs).
	Understand and help coordinate the multiple care plans created by home health care providers, medical equipment vendors, early intervention programs, schools, and government and insurance company case managers.
	When school-aged children are technology-dependent, ensure that school staff and environment are adequate to meet the child's needs.

As outpatient care becomes increasingly complex, many patients require home health services without a preceding hospitalization. Physicians must be able to refer to an HHA or other community resources without the assistance of an institution's discharge planner. Some HHAs will provide referral forms similar to those used in hospitals to simplify the documentation process.

Throughout the course of the home care episode, the referring physician is responsible for reviewing the care and completing the paperwork. These activities are reimbursed in many cases.

The care plan

When an HHA initiates care, a written care plan is developed. The care plan is developed in a collaborative process between the HHA staff and the attending physician.¹ It must be reviewed, usually on a federally mandated form called Form 485 (Table 3). Recertification is generally required every 60 days on the same form. The care plan is based upon a comprehensive assessment of the patient, the home, and the availability of other caregivers. The patient's third-party insurance coverage for home care services and his or her ability to pay for needed services not covered by insurance should also be considered.

Specific services rendered by physical, speech, and occupational therapists may involve different modalities. Modalities usually mentioned are for heat, ultrasound, cold, and electronic stimulation. Instructions defining the amount or duration of each modality are necessary when a discipline is providing a specific modality for therapy (e.g., PT – To apply hot packs to the C5-C6 x 10 minutes 3x/wk x 2 wks).

Example of a physician's orders	
OT – Eval., ADL training, fine motor coordination	3x/wk x 6 wks
ST – Eval., speech articulation disorder treatment	3x/wk x 4 wks
SN – Skilled observation and assessment of C/P and neuro status, instruct meds and diet/hydration	3x/wk x 2 wks
AIDE – Assist with personal care, catheter care	3x/wk x 9 wks

PRN visits may be ordered on a plan of care only where they are qualified in a manner that is specific to the patient's potential needs. Both the nature of the services and the number of PRN visits to be permitted for each type of service must be specified on the order form. Open-ended, unqualified PRN visits are not acceptable.

Table 3 Key elements of Form 485

Patient demographics
When home care was initiated
The 60-day period for which the plan is being used
The home care provider's name and provider number
Medications: dose/frequency/route
Diagnoses and surgical procedures
Durable medical equipment and supplies that are separately billable
Safety measures ordered by the physician
Physician's order for the diet, including specific therapeutic diets and/or any specific dietary requirements; record fluid needs or restrictions and total parenteral nutrition (TPN)
Allergies to medications, food, or supplies (e.g., adhesive tape, latex)
Functional limitations
Activities permitted
Mental status
Prognosis (e.g., poor, guarded, fair, good, or excellent)
Orders for the amount, frequency, and duration of visits for each discipline that will be involved in home care, including duties and treatments; disciplines include skilled nursing (SN), physical therapy (PT), speech therapy (ST), occupational therapy (OT), social work (SW), or home health aide (AIDE)

Example of an appropriate PRN order

Skilled nursing visits 1 x m x 2m for Foley change and PRN x 2 for emergency Foley irrigations and/or changes

Skilled nursing visits 1 x m x 2m to draw blood sugar and PRN x 2 to draw emergency blood sugar if blood sugar level is above 400

Example of realistic goals

Independence in transfers and ambulation with walker

Healing of leg ulcer(s)

Maintain patency of Foley catheter; decrease risk of urinary infection

Achieve optimal level of cardiovascular status

Medication and diet compliance

Ability to demonstrate correct insulin preparation and administration

A home care plan should also include specific treatment goals and a realistic evaluation of rehabilitation potential. This can serve as the basis for the development of an effective discharge plan.

The physician must sign Form 485 certifying the need for the home care prescribed and attesting to the patient's status as being homebound. When Medicare is paying for the home care, there are federal penalties for falsely completing this certification.

In addition to the Form 485, HHAs typically have more detailed care plans for use in communicating between professionals within the agency. The roles and tasks of each professional at each visit are described. In addition, these care plans should describe the roles of the patient, family members, or other people in the home who participate in the care plan. In some agencies, pathways for care for common diagnoses are developed.

Alternatives to home care

The initiation or continuation of home care is not always appropriate (Table 4). The emotional and physical well-being of the caregiver, the safety of others in the home, and the willingness of the patient to participate as a partner in the home care plan are critical at all stages of home care.

Table 4	Home care may not be appropriate when:
	Goals of treatment have been reached and the patient and/or caregiver are independent
	Changes in the course of illness or the required treatment make the home an inappropriate site for care
	Patient or caregiver refuses to continue home care
	Patient is nonresponsive to home care interventions
	Caregiver burnout and inability to obtain alternate caregiver is evident
	There is evidence of patient abuse or neglect that has not responded to home care interventions
	Gross noncompliance is identified
	Safety of patient or provider is threatened
	Irresolvable problems persist between patient/caregiver and home care team

Table 5	Other care settings/strategies may include the following:
	Acute or chronic care hospital
	Outpatient services/clinic programs
	Nursing homes
	Continuing care facility (board and care, life care community, licensed adult home)
	Adult day care/PACE (Program of All Inclusive Care for the Elderly)
	Medical day care for children with special needs
	Other family care options
	Group home with shared services, assisted living facility
	Foster homes
	Respite care
	Hospice care

The decision not to initiate or to terminate home care requires the physician to offer another care strategy (Table 5) while continuing to provide medical management throughout the patient's course of illness (unless discharged by the patient). The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, unless provisions are made for the patient to obtain alternative physician services, or the patient refuses all further treatment.

The interdisciplinary team

A unique aspect of home health care is the nature of the collaborative team effort. Team members must be chosen with careful attention to the role that each member can be expected to fill, and the services they can provide. Unlike most other health care teams, however, home health professionals, including the attending physician, have roles that typically overlap in a set of shared tasks. This model has developed because, unlike in hospitals, each type of professional cannot visit the patient daily, and professional home care services are typically intermittent and part-time rather than being provided around the clock. Knowing the expectations and limitations of each service can help ensure that the appropriate members are on the team.

At each home visit and during every physician encounter, the following four tasks should be performed regardless of the professional discipline involved (Table 6).

Table 6	Review of interdisciplinary team and coordination of care
	At each home visit and during every physician encounter, the following four tasks should be performed regardless of professional discipline involved:
	<ul style="list-style-type: none"> • Assessment of the overall effectiveness of the comprehensive home care program • Assessment of interactions between the patient and informal caregivers and their satisfaction with the home care program • Identification, documentation, and communication to appropriate team members of any new problems and needed follow-up • Encouragement of the patient and informal caregivers related to instructions provided by all disciplines involved

The physician can improve the quality of the team and strengthen teamwork by volunteering to serve on the agency's clinical review committee, quality assurance committee, or other committees affecting clinical care, and by volunteering to give lectures at agency in-service educational programs for nurses and other professional staff.

Finally, always remember that the most important members of the home care team are the patient and his or her family and friends who are caregivers. The professional team members should make every effort to support these caregivers.

Privacy and confidentiality issues

The Health Insurance Portability and Accountability Act (HIPAA) does not require formal or written patient consent for physicians to communicate with home health providers for the purpose of coordination and ongoing care. All communications with HHAs are confidential, however. Patient-related documents received from the HHA should be filed in the medical record. Use of the Internet to communicate with HHAs and caregivers must be on HIPAA-compliant systems or must be with the consent of the patient.

Reference

1. Centers for Medicare & Medicaid Services. *Home Health Agency Manual*, section 204.2.

Chapter 6

Choosing a home care organization or agency

When selecting a home health agency (HHA) or organization, physicians should exercise the same care they use to select the hospitals with which they are affiliated.¹

Physicians often need to use several agencies to ensure geographic coverage and appropriate services for all their patients. In most regions, there are several agencies providing similar services; the challenge for the referring physician is how to select the best providers. The referring physician is responsible for selecting an organization that provides high-quality care that meets all the patient's home care needs. A prudent due diligence process will help a referring physician to choose among the many HHAs available.

On-site visits to an HHA may be helpful in assessing its capability. Visits allow referring physicians to address key questions (Table 1) with the director of nursing and the medical director; review the process of referrals, admissions, and communication procedures; review sample charts; and initiate personal contact with field staff. It is important to know the disciplines available within the agency. Home health agencies may provide the services of a wide range of providers (Table 2). The relative breakdown of HHA staff by discipline is shown in Figure 1.²

Table 1 Key questions to ask a home health agency

What are the agency's accreditations? A voluntary process, accreditation signifies that an agency meets national standards. Organizations offering such certification include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National League for Nursing's Community Health Accreditation Program (NLN/CHAP).

What is the range of services? Does the agency have a wide range of providers on staff, or does it use subcontractors? How does the agency communicate with and manage subcontractors?

How long has the agency been in business, and what is its general reputation in the community? A review of annual reports is helpful.

Are there appropriate policies, procedures, and care management protocols?

What are the agency's policies for coverage of underinsured or uninsured patients?

What is the agency's general response time?

How is the agency managed? Who are its directors, director of nursing, medical director, and other key personnel?

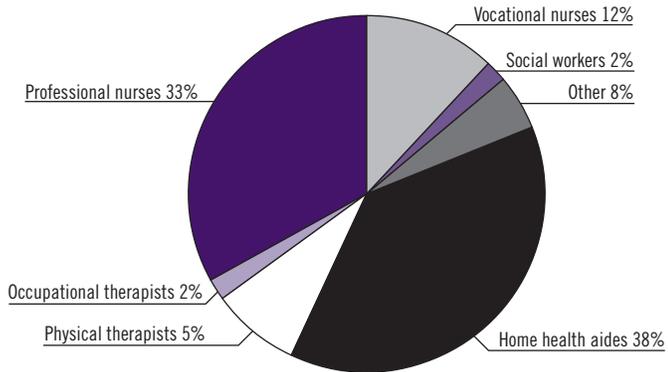
How are weekend and "after business hours" communications between nurses and physicians handled? During evening and weekend management of complex cases, it is preferable to choose an HHA that allows telephone access to the patient's primary nurse rather than only to an "on-call" nurse.

When patients are sick on the weekend, what type of staff is available to go to the home? This question has bearing on the ability of the agency to decrease the need for homebound patients to make weekend visits to the emergency room. Regarding opening new cases, the HHA should be able to visit a new patient on any weekend of the year.

How does the agency coordinate care among its field staff (nurses, physical therapists, occupational therapists, etc.) and the referring physician? The old model of HHAs provides little in the way of involving physicians in home care. Superior models now include various interfaces with the referring physician, especially if the physician is performing house calls.

What is the agency's capacity and experience in dealing with special populations (e.g., pediatrics, HIV/AIDS)?

Figure 1 Home health care agencies personnel mix, 2003



Source: Centers for Medicare & Medicaid Services

Table 2 Services that may be provided by a home health agency

Registered nurse (RN), medical or surgical
Certified WOCN nurse (wound/ostomy/continence nurse; previously known as ET nurse)
Certified infusion nurse
Certified psychiatric nurse
Certified diabetic educator (either nurse or dietitian)
Physical therapist
Occupational therapist
Medical social worker
Registered dietitian
Speech therapist
Home health aide
Licensed practical nurse (under supervision of a registered nurse)
Physical therapy assistant (under supervision of physical therapist)

As a practical consideration, some agencies may have serious limitations in the availability of their physical, occupational, and speech therapists. Before referral, ascertain whether a therapist is available, the level of training and expertise, how long a delay is anticipated before services can start, and at what frequency per week the agency can provide therapy staff. If the proposed service cannot meet the patient’s needs, the physician must try to find another HHA that can provide the appropriate skill level, frequency, and duration of services.

A comprehensive HHA will go beyond the requirements and provide the services outlined in Table 2.

The physician often plays a more passive role in selecting an HHA for follow-up after a hospitalization. While physician input is critical in determining the scope of home care, hospitalized patients usually have a discharge planner assisting them in choosing an HHA. Medicare-participating hospitals, as part of their discharge planning evaluations, are required to provide Medicare beneficiaries a list of Medicare-certified HHAs or organizations that serve a patient’s geographic area.

Other home services

The same care and attention to quality should be part of the process in selecting organizations to provide services such as:

- Laboratory/x-ray and other ancillary services
- Pharmacy
- Private-duty nursing services
- Homemaker services
- Specialized high-technology services

Many of these providers are not Medicare-certified, but some have state licenses or are accredited by entities such as the JCAHO, Clinical Laboratory Improvement Amendments (CLIA) accreditation, or National League for Nursing’s Community Health Accreditation Program (NLN/CHAP). These organizations should keep records on each patient they serve that are more extensive than the forms they send to the physician for signature. A physician who wishes to learn more about the quality of these organizations can ask to see the record resulting from his/her referral.

Private-duty nursing and homemaker services are particularly unregulated, and referring physicians need to be especially prudent in evaluating these services prior to recommending them to a patient (Table 3).

Table 3	Questions for the private-duty agency
	What are the rates for services? Charges for care should be quoted on an hourly, daily, or live-in basis.
	What hours can be arranged? Determine daily minimum and maximum hours available and flexibility in arranging split shifts. For example, some patients may require two shifts of three hours, for a total of six hours a day. Other patients may require continuous staffing 24 hours a day, seven days a week.
	Is staff bonded and insured? Patients or families should be encouraged to ask the agency to provide documentation.
	If the patient or family is dissatisfied with the staff, are there substitutes available?

Durable medical equipment

When utilizing organizations providing durable medical equipment (DME), an efficient way to perform due diligence is to question the nursing administrators of several local HHAs. Larger agencies might have a greater ability to provide the physician with recommendations of several reliable DME providers.

Table 4	Questions to ask a home health agency regarding durable medical equipment providers
	Which DME organizations have you found to provide the highest quality service? Be sure the DME provider has a reputation of adequately teaching the patient and family how to utilize equipment that is delivered to the home. Also look for DME providers that are able to quickly deliver urgently needed products such as oxygen and wound care supplies.
	What is the range of services provided by the DME organization?
	How does the DME provider deal with equipment maintenance? Are repair costs included? Does it loan equipment during repairs?

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Chapter 7

Case management: Making use of community resources

The goal of all health care is patient independence in self-care (i.e., the patient acts as his or her own case manager). A remarkable array of goods and services are available for the home care patient. When the patient's health problems worsen and the patient becomes dependent on others, assistance with management and decision-making may be necessary. Case management includes those activities necessary to determine the patient's needs, arrange for and coordinate the appropriate services, monitor the effectiveness of services, and reassess them as needed.¹ The case manager usually comes from a nursing, social work, or fiduciary background. This approach may be generalized or disease-oriented (i.e., disease management). Disease management generally involves specially trained nurse case managers to implement detailed clinical protocols in managing chronic medical conditions.²

Effective case management focuses on integrating care across subspecialty and medical-social boundaries. Home-care-based case management programs can have a significant impact on hospitalization and cost.³ Likewise, specialized disease-management programs have been shown to be cost-effective for selected populations (e.g., heart failure patients).⁴ These findings are not universal, however. One study failed to demonstrate reduced use or cost of health care for high-risk older people, but noted that other potentially favorable effects of this type of case management need to be evaluated.⁵ It is important, therefore, to assess the individual patient's needs carefully and understand the limits and abilities of specific case or disease management programs.

Table 1	The levels of case management are as follows
	The patient is his or her own case manager.
	The patient needs assistance from family members or significant others in planning/coordinates care.
	Problems are too complex for the family to deal with alone, but can be managed with regular input from the treating physician.
	For the most complex levels of care, a multidisciplinary professional team is needed to assist the patient and family. Such a team should have a designated case manager/team leader.
	Flexibility is needed to move between levels of case management with the ultimate goal of patient independence and continuity of care.

Physicians are a crucial link to community resources, and the physician with a well-trained office staff may serve many of the roles of a case manager. Patients traditionally rely on their physician to inform, order, supervise, and coordinate the many services that are instrumental to successful home care programs. Most patients and families turn to their physician for advice when they perceive the need for additional resources.⁶ Surveys indicate that 80% of patients requiring care in their home receive all their needed assistance from family and friends.⁷ The physician may be the only health professional who provides care and advice in these cases. The physician can function effectively in this role for most patients with a resultant decrease in cost and increase in quality.⁸

In more complicated cases, the physician may encourage the use of a designated case manager. Patients with problem behaviors, greater functional disability, informal support problems, and problems with service provider agencies have been shown to require a higher level of case management.⁹ A variety of agencies—governmental, not-for-profit, and for profit—offer case management services; it is important for physicians to become familiar with these resources in the community.

Community resources

State and local information and referral services provide the physician and patient or caregiver with access to national and local disease-specific charitable organizations and advocacy groups that can provide additional resources. A useful first step in sorting through the variety of goods and services available for a home care patient is the U.S. Department of Health and Human Services Administration on Aging Web site (www.aoa.gov). Under the direction of the Administration on Aging, there are State Units for each state and territory, as well as Area Agencies on Aging.

The Eldercare Locator ([800] 677-1116 or www.eldercare.gov) is an information and referral service that enables callers to access the names and locations of area offices on aging and others who may be able to provide resource information.

For patients under age 60 years, contact the state departments of human resources, health, social services, or vocational rehabilitation. Although the federal or state funding sources are different for different age groups, the local providers of services are often the same.

For children with special needs, there are additional resources, such as:

- Early intervention programs
- Habilitation with multiple therapies
- School-based educational/developmental programs¹⁰

Information about these programs can be obtained through the local and state agencies established through the Association of Maternal and Child Health Programs (www.amchp.org). To locate an agency in a particular area, call (202) 775-0436.

Tremendous local variation exists in the availability of services, but most programs will have information and referral services and some or all of the following:

Access services

- Information and referral
- Transportation
- Outreach services
- Case management
- Escort services
- Electronic databases for pharmacy, etc.

Community-based services

- Day care
- Elder abuse protective services
- Senior centers
- Respite services
- Congregate nutrition programs
- Legal assistance
- Congregate housing

Services to residents of nursing homes and other care providing facilities

- Long-term-care ombudsman program
- Support for elderly victims of Alzheimer's disease and their families
- Housing services
- Employment services
- Health/fitness programs
- Rehabilitation services, including vocational rehabilitation and special education
- Energy assistance
- Counseling
- Senior companions
- Foster grandparents, foster homes
- Volunteer programs
- Self-help/support groups
- Housing services
- Crime prevention/victim assistance

In-home services

- Home health services
- Skilled nursing
- Physical and occupational therapy
- Speech therapy
- Medical social services
- Nutritional guidance
- Home health aide
- Telephone reassurance
- Hospice services
- Homemaker/personal care services
- Chores/housekeeping
- Home repair
- Home delivered meals/Meals-on-Wheels
- Medical equipment and supplies
- Friendly visitor
- Portable electronic devices for communication and monitoring

Diagnostic services

- Portable x-ray
- Mobile ultrasound
- Portable laboratory instruments and mobile laboratories
- Home blood-drawing services
- Telemonitoring services networked through congregate housing structures

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Chapter 8

Special home care populations

The range of patients receiving home care services goes far beyond the stereotype of an elderly Medicare recipient.¹ Home care recipients include individuals of all ages who may be technology-dependent, medically fragile, home-bound, high-risk obstetrical, post-hospitalization and/or surgical patients who require the team management of acute and chronic diseases, as well as individuals needing palliative and end-of-life care. For all of these patient populations, the objective of home care is to provide effective and cost-efficient care in an environment that is

safe, supportive, and appropriate for the needs of the patient.

The range of conditions and care needs of these patient populations may overlap in terms of medical specialties, disease categories, and care management strategies, but the coordination of care for each of these populations may require a unique mix of medical specialists, home care nursing, and ancillary therapists as well as specialized medical equipment and community resources. It is also

Table 1 Medical categories and specialized home care services

Medical specialty	Disease states and management considerations
Cardiology	Congestive heart failure, deep vein thrombosis, dobutamine infusion, telemetry, electrocardiogram, anticoagulation
Endocrinology	Diabetes treatment, education, and monitoring
Emergency Medicine	Acute disposition when hospitalization not required or desired
GI	Nutritional therapies—parenteral nutrition, enteral feeds, pH probe testing
Hematology/Oncology	Chemotherapy, pain management, monitoring and treatment of coagulopathies, anemias, hemoglobinopathies, neutropenia
Infectious Diseases	Treatment of bacterial, viral, and fungal infections, HIV/AIDS, and other immunodeficiency states
Nephrology	End-stage renal disease, home dialysis, peritoneal dialysis, nutritional assessments and accommodations
Neurology	Stroke, dementia, Alzheimer's, demyelinating diseases such as multiple sclerosis, amyotrophic lateral sclerosis, Guillian-Barré; physical therapy, occupational therapy, speech and oral motor therapy
Obstetrics	High-risk pregnancy, fetal monitoring, post-partum care, lactation assistance, counseling and education
Ophthalmology	Pre- and post-operative care; low vision training
Otolaryngology	Pre- and post-operative care
Pediatrics	Neonatal and neonatal intensive care unit services such as apnea monitoring, home mechanical ventilation, oxygen, phototherapy for jaundice, total parenteral nutrition and enteral feeds, developmental assessment and treatment, social services, technology management
Pediatric-specific Subspecialty	Care for infectious diseases, pulmonary, neurology, gastroenterology, hematology, oncology, genetics, surgery
Podiatry	Nail and foot care
Psychiatry	Alcohol and substance abuse, depression, mood disorders, psychosis, eating disorders
Pulmonary	Sleep apnea, sleep studies, continuous positive airway pressure (CPAP), asthma, chronic obstructive pulmonary disease, ventilator management, oxygen
Rehabilitation Medicine	Rehabilitation evaluation and management
Surgery	Post-operative management, wound care, enterostomal care, pain management

important for the attending physician to understand the various special funding programs or benefit limitations pertaining to each population to assure payment for home care and other services.

Table 1 lists some of the specialized medical conditions for which home care may be appropriate and some of the specialized services provided by home care agencies.

Populations

Table 2 outlines the unique management considerations associated with specialized in-home services.

Table 2 Specialized home care services	
Service	Management considerations
Infusion	Parenteral administration of medications and therapies such as total parenteral nutrition, antibiotics, chemotherapy, transfusions, catheter placement and maintenance
Wound care	Post-operative, stoma, decubitus ulcers
Respiratory	Tracheostomy care, asthma, assisted airway technology
Pediatric	Neonatal intensive care– and pediatric intensive care–trained nursing, developmental services
Rehabilitation	Physical therapy, occupational therapy, orthotics, prosthetics
Palliative care and hospice	Bereavement services, pain management, 24-hour support

General references

The American Academy of Pediatrics' Guidelines for Pediatric Home Care and the Web site of the Academy's Home Care Section (www.aap.org/sections/homecare) are valuable resources for the management of children in the home.

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Chapter 9

Home hospice care

Dying peacefully at home is a goal for many patients, and appropriate care for the dying patient is central to quality contemporary medical care. Continuing growth in the hospice movement and recognition of the need to improve care for patients at the end of life have caused many physicians to re-examine the concept of palliative care and the rights of patients at the end of life.

Hospice care is formally defined as “a program of palliative and supportive care services that provides physical, psychological, social, and spiritual care for the dying persons, their families, and other loved ones.”¹ Diagnoses appropriate for hospice referral go beyond cancer and include illnesses such as dementia, chronic obstructive pulmonary disease, end-stage heart failure, or any other condition that is in a terminal phase. Hospice services are available in both the home and inpatient settings.

Table 1	The characteristics of hospice care
	Goals are for comfort care (i.e., palliative rather than curative)
	Coordination is by an interdisciplinary team, including spiritual advisers such as a priest, rabbi, or minister
	Support is provided for the family
	Pain management and symptom control expertise
	Family counseling and bereavement services are available for one year after patient’s death
	Patient signs a statement choosing hospice care instead of standard Medicare benefits for the terminal illness
	Patient life expectancy is six months or less

Hospice care is broadly defined. The goal of hospice care is not to cure the patient of his or her illness. It is intended, rather, to allow the patient to live without pain, with family support, and at home until death if that is the patient’s wish.² The terminal condition of hospice patients necessitates that the hospice program not be limited to physical care (e.g., symptom relief), but include spiritual

and emotional health needs of the patient and family caregivers. Furthermore, the hospice benefit is not limited to traditional palliative treatments. Any treatment to relieve symptoms, including radiation therapy, palliative surgery, and hospitalization for other conditions (e.g., exacerbation of heart failure in a patient with cancer), is appropriate and covered.

Table 2	What patients and families value in hospice care
	Explicit support for the family so the patient feels like less of a burden
	Case management services
	Experience with the issues and programs near the end of life
	Provision of all medications, supplies, and services related to terminal illness
	Support to leave positive legacies of good memories
	Having affairs in order, so as not to be a burden after death

Hospice patients and their families establish goals for care with a hospice nurse during the initial evaluation. The hospice program supports patient and family autonomy in setting the number and types of treatments (including feeding and hydration) they wish to receive. Even if a time comes when the patient can no longer indicate his or her wishes, the patient can ensure the treatment plan will follow his or her original intent through the use of advance directives and the appointment of surrogate decision-makers with durable power of attorney for health care.²

Table 3	Why physicians refer patients for hospice care
	Better care of the patient and family, including more resources to carry out the care
	Fewer urgent telephone calls and emergency department visits
	More satisfied patients and families

The formal Medicare hospice benefit and some other current funding mechanisms limit hospice care to patients with an illness or injury likely to lead to death in the next six months if the disease proceeds at its usual rate of decline.³ Medicare allows for recertification if a patient does not expire within the initial six months as long as there is a documented decline in the patient's status.

The physician's role as a palliative care provider can be demanding of time and effort. Patients and families may seek a palliative rather than a curative approach to care before meeting the hospice coverage criterion of an expected duration of six months or less of life. In these cases, the physician can implement a treatment plan stressing pain and symptom control, guidance, and reassurance to the patient and family, while continuing to evaluate the patient for eligibility in the hospice program.

Table 4	The main misperceptions regarding hospice care
	Prognostic certainty that the patient will die within six months is required
	Referral means giving up "hope"
	No life-prolonging efforts can be entertained while the patient is enrolled in hospice care
	It is uncomfortable to talk about hospice issues with the patient and family

Concern about the patient's life expectancy should not lead to a delay in hospice referral; the physician is inadvertently denying patients the full benefit of their interdisciplinary team support. Recertification of hospice care for patients whose condition is declining beyond six months is not fraud or abuse. Physicians who have questions on the appropriateness of a referral to hospice care may consult with a hospice medical director about the probable trajectory of the patient's disease process, the prognosis of less than six months of life, and the appropriateness of referral. The number one complaint hospice programs receive is that the physician did not make the patient and family aware of the services earlier.

Table 5	Physician's responsibilities when certifying the need for hospice care
	Signing the initial certification of terminal illness
	Reviewing the hospice plan of care for the patient
	Making ongoing visits with the patient
	Prescribing medication for comfort care
	Reviewing with hospice staff the patient's condition and prognosis
	Making telephone contact and house calls to the patient as necessary
	Signing the death certificate

Billing and hospice

Physician reimbursement for services provided to patients enrolled in the Medicare hospice benefit varies depending on the role of the physician in relation to the patient and the hospice program. Only a primary attending physician (unless also serving as the hospice medical director) can continue to bill Medicare Part B directly. Hospice medical directors (even if voluntary) and all specialty physicians must bill the hospice program for services rendered related to the hospice diagnosis. The hospice program, in turn, passes these costs to Medicare Part A (in addition to the hospice program's per diem reimbursement). Billing to Medicare by the primary attending physician or by other physicians for non-hospice related diagnoses requires modifiers.

A comprehensive explanation of the hospice benefit can be found on the Centers for Medicare & Medicaid Services Web site, www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf. Other general Web resources include The Hospice Foundation of America Web site, www.hospicefoundation.org, and the Hospice Association of America Web site, www.hospice-america.org. Both are good resources for patients and caregivers.

Table 6	How to bill services for hospice patients: Primary attending physician
	Bill Medicare Part B or applicable intermediary using your usual electronic system and the applicable Evaluation and Management (E/M) Current Procedural Terminology (CPT®) code for the service. Include the GV modifier, which indicates the services are related to the terminal diagnosis.
	If you are authorized to give medication or perform a procedure, bill the medication and the technical component to the hospice and the professional component to your Part B carrier. For specific instructions, call the hospice claims specialist.
	You will be paid 80% of the Medicare allowable and bill the patient or a secondary insurance for the remaining 20%.

Table 7	How to bill services for hospice patients: Consulting (or second) physician
	Sign a Services Agreement with the hospice for each patient under your care.
	Bill the hospice with the applicable CPT codes for both professional and technical components using the CMS 1500 form.
	You will be paid 100% of the Medicare allowable and will not bill the patient or a secondary insurance for any component of the bill.

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Chapter 10

Technology and home care services

Technological advances, including miniaturization, automation of portable devices, and telephonic or wireless digital transmission methods, have expanded the possibilities for in-home diagnosis and treatment. Technology may be used for both evaluation (Table 1) and management (Table 2) in the home setting.

Table 1	Examples of high-technology diagnostic devices available in the home
	Portable laboratory instruments (for measuring blood chemistries, hemoglobin, and gases)
	Oximetry devices (including those connected remotely through telemonitoring)
	Portable x-ray with film development or digitization on-site
	Cardiac impedance (noninvasive measurement of cardiac output, etc.)
	Mobile ultrasound
	12-lead EKG devices integrated with computing devices
	Sleep studies

Technology-based home therapies have been shown to reduce long-term hospitalizations for chronic conditions in the context of disease management programs (e.g., heart failure)¹ and permit patients with acute illness to receive intensive treatment in the privacy of their own homes. For example, community-based pediatricians have found that children with special needs (e.g., children on ventilators) can be cared for at home rather than at specialized hospital units.^{2,3} Interdisciplinary team planning is usually crucial in high-technology in-home care for both chronic and acute illness, and community teams providing this care typically work closely with a hospital-based team in chronic disease management.^{1,4}

The use of high-technology devices in the home is rarely simple or straightforward. Although technology enables dramatic extensions of emergency and critical care into

Table 2	Examples of high-technology therapeutic methods in home care
	IV antibiotics and hydration
	Chemotherapy
	Mechanical ventilation
	Dialysis
	Transfusion therapy
	Minor laceration closure
	Fracture assessment and stabilization

the home environment, it is important that physicians have the staff and expertise to supervise an adequate infrastructure. Patients quickly adapt to the convenience of new levels of care in the home and come to expect it. The physician should be aware of the potential risks inherent with such high-level expectations by patients.

As with other aspects of home care, physicians are expected to document the need for home-based technology at the time it is ordered and reassess its ongoing need over time.⁵ If more than one agency or organization is involved (durable medical equipment company, home health agency [HHA], personal care service), the physician must ensure that services are coordinated.

The physician who uses specialists as consultants in the hospital to handle these high-technology modalities should also use those consultants in developing and supervising the home care plan of treatment.

Finally, the use of technology does not relieve the physician of basic human requirements of patient care. There is no substitute for a home visit in monitoring chronic care and dealing with problems as they arise. Arrangements need to be made for regular physician hands-on care of the patient receiving high-technology

Table 3	Questions when considering the use of high-technology treatment in the home
	Is the high-technology therapy necessary to treat the patient's condition?
	Does the technology exist to deliver care in the home?
	Is the physician familiar with the technology?
	Has it been evaluated for safety and effectiveness?
	Is the technology acceptable to the patient and caregiver?
	Is the service safe for the patient, given circumstances such as caregiver ability, home environment, patient alertness, and hemodynamic stability?
	Does the HHA staff have expertise in this area?
	Does the agency have the capacity to provide reliable and continuing services, or will there be gaps in coverage?
	Can the agency provide its protocol for this treatment?
	Can the physician be accessible both by phone and in person to the patient and the HHA in a timely fashion?
	Is there a scientific basis for the use of the technology?
	Once treatment has begun, is it effective?

home care to remain fully aware of the patient's health status and maintain a strong therapeutic alliance with the patient and any caregivers.⁶

Tele-home care

Three types of tele-home care (beyond traditional audio phone services) are increasingly available. First, HHAs and hospices can use videophone technology to perform visits within the skilled home health or hospice benefit. These visits may substitute for some, but not all, visits by the nurse or therapist. Second, some patients and families contract for long-term monitoring by nurses via videophone technology. Third, physicians can use videophone and other technology to perform evaluation and management services, monitor physiological parameters, and verify function of medical equipment (e.g., pacemakers). Televisits can include telestethoscopes and high-definition cameras for diagnosis of skin lesions. With increasing speeds of connection available (e.g., through broadband Internet connections), it is possible to evaluate movement disorders and ambulation remotely.

Results of the few preliminary studies suggest that these systems reduce home care costs and hospitalizations, while maintaining quality of care, staff acceptance, and patient satisfaction.^{7,8} While studies are beginning to appear supporting the use of telemedicine approaches to specific diseases such as heart failure,⁹ research in general is scant in this field and the value of telemedicine compared to in-person physician visits has yet to be widely demonstrated.¹⁰

With the expanded use of Internet and telephonic digital devices, the application of Health Insurance Portability and Accountability Act (HIPAA) privacy rules becomes extremely complex and increasingly important to the patient and medical communities. The physician who plans to use or receive information from these intensive and demanding devices must be knowledgeable not only about the diagnostic and treatment modalities, but also about the privacy risks inherent in Internet communications and be sure that all of his or her programs are HIPAA-compliant.

Table 4	Examples of high-technology communication devices
	Laptop computers with electronic medical records and/or automated OASIS databases
	Hand-held scheduling and prescription computers
	Memory cards with patient, clinical, or pharmaceutical databases
	WiFi wireless connection capability
	Fixed wireless connectivity
	Bluetooth wireless piconets to connect laboratory devices to the clinical records
	Broadband cellular phones with e-mail capability
	Remote cardiac rhythm monitoring through phone lines or the Internet

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Chapter 11

Medical ethics in home care

1. Principles

Home care involves a wide spectrum of participants and occurs in a venue that is beyond the physician's direct control. It is important, therefore, to understand ethical issues and pitfalls when applying a home-based approach to patient care. The following are each of the American Medical Association (AMA) Principles of Medical Ethics subsections that are applicable to physicians involved in home care.

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients but also to society, to other health professionals, and to self. The following principles, adopted by the AMA, are not laws, but standards of conduct, which define the essentials of honorable behavior for the physician.

Section 1

A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

1. The home care physician will respect the dignity and privacy of the patient and the patient's home.
2. The home care physician will be vigilant regarding the physical and emotional boundaries of the doctor/patient relationship.
3. The home care physician will not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.

Section 2

A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

1. The home care physician will practice and provide services within his/her usual area of competence, exclusive of emergent needs.
2. The home care physician will explicitly establish the terms of the financial arrangements with the patient.
3. Payment to physicians by home health agencies must be compensation for appropriate activities and must not be provided as an inducement for referrals.
4. Physician referrals for home health agency services, home diagnostics, home medical equipment, and other non-physician home care services will be determined by legitimate clinical needs and will not be motivated by personal gain or self-interest.
5. Physicians practicing in the home care setting will be honest and forthright with patients, informing them of any factors that may affect their care, including, but not limited to, expectations and/or changes regarding visit frequency, identity of who will be rendering the care, and the relationship of that individual to a medical group or organization, if not in solo practice.

Section 3

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

1. The home care physician will request payment only for those services rendered.

2. The home care physician will render only those services indicated by the circumstances of the clinical setting.
 3. Specifically, those physicians ordering patient services or supplies from a home health agency will be responsible for timely approval of the care plan and subsequent orders, including service lines involved (occupational therapy, physical therapy, etc.), frequency of home visits, and medications.
 4. A physician who requests payment for Care Plan Oversight is expected to have provided the services detailed within the guidelines and regulations provided by the payer source.
1. In view of rapid development of technological advances affecting medical care provided in the home, the home care physician will be responsible for his/her own continuing education and be mindful that theirs must be a lifetime of learning.
 2. The home care physician will often be involved with providers of services from a variety of fields. The home care physician needs to recognize both his/her role in the leadership and direction of the patient's care and his/her role in facilitating the activities of the other providers.
 3. When possible, the home care physician will provide education and/or consultative services to home health agency personnel, so as to encourage continual learning and improvement in clinical skills.

Section 4

A physician shall respect the rights of the patient, of colleagues, and of other healing professionals, and shall safeguard patient confidences within the constraints of the law.

1. The home care physician will protect the patient's confidentiality as expected in a patient/physician relationship with special attention to protecting records or other pertinent information from public exposure, for example, within view in the physician's automobile.
2. The home care physician may release confidential information only with the authorization of the patient or under proper legal compulsion.
3. The home care physician will respect the advance directives already established or seek clarity from the patient or appropriate family member when no clear directive has been prepared.

Section 5

A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

Section 6

A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to service, with whom to associate, and the environment in which to provide medical services.

1. The home care physician will determine whether or not the home is the appropriate environment in which to diagnose and treat the patient.
2. The home care physician may refuse to provide treatment to a person who, in the physician's opinion, cannot be adequately evaluated in the home setting.
3. The home care physician has a right to determine if entering a neighborhood or specific domicile is safe. If determined or suspected to be unsafe, the physician has the right to decline the home visit. A physician who declines to make a visit under these circumstances has an obligation to communicate with the patient/caregiver and arrange for an alternative approach to care for the patient.

Section 7

A physician shall recognize a responsibility to participate in activities contributing to an improved community.

1. Home care physicians are encouraged to communicate and cooperate with health care and government organizations in order to promote an improved environment for the practice of medicine in the home.
2. Physicians with home care experience are encouraged to teach their colleagues about treating patients in the home setting, convey their experience, and establish techniques that provide for a safe and secure environment for the practice of medicine.
3. Physicians will respect the professional integrity and needs of non-physicians on the home care team and will interact with these others in an appropriate manner commensurate with that professional respect.

2. Recognizing fraudulent practices

Unscrupulous suppliers and providers may steer physicians into signing or authorizing improper certifications of medical necessity.¹ The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services has identified home health care and hospice as vulnerable to fraud and abuse.² Medicare requires physicians to play a key role in determining the medical need and utilization of home health care. The Medicare program relies on the professional judgment of the patient's treating physician to authorize services from home health agencies (HHAs) and products from medical equipment suppliers.

Table 1 To avoid fostering or participating in home health fraud

Learn the basic coverage guidelines for home health care and durable medical equipment (DME).
Never sign the HHA "Home Health Certification and Plan of Care" (Form 485) for patients who are clearly not homebound. (Note: the Medicare definition of homebound allows the HHA to service a wide range of patients.)
Never sign a blank certificate of medical necessity for the durable medical equipment supplier.
Never accept compensation in exchange for your signature. Such compensation can take the form of cash payments, free goods, services or products offered below fair market value, and rental of space offered above fair market value.
If you cannot provide house calls to your homebound patients, consider making a referral to a consulting physician who specializes in home care (a home care consultant).

Avoid participating in fraudulent practices

The OIG's Operation Restore Trust audit in 1997 identified four main classes of abusive home health practices:³

- Unnecessary visits and services were provided
- Patients were not homebound
- There were no valid physician orders
- There was insufficient documentation

Of the physicians who signed plans of care for unallowable claims, 64% relied on the HHA to prepare the plan of care, 60% were not aware of the homebound requirement for home services, and 8% had no knowledge of the patient's condition.⁴

Table 2 Red flags for abusive durable medical equipment (DME) authorization requests

Frequent requests from a particular vendor or provider to sign for devices or services that you did not order
Added features on DME orders (e.g., deluxe or electric features on a wheelchair)
High-frequency tests or test results not reported (e.g., home glucose or INR monitoring)

How to manage certifications for home health agency services

Examining the plan of care (Form 485) is the key to the physician’s ability to minimize risk for fraud. The physician should not sign the care plan without first reviewing its contents.

Durable medical equipment (DME)

Medicare covers DME (e.g., hospital beds, wheelchairs, home oxygen), prosthetics, orthotics, and supplies for home use. As a condition for payment, Medicare requires the treating physician to provide a signed prescription. For certain equipment and supplies, the prescription takes the form of a certificate of medical necessity (CMN), which may be filled out by the physician’s employee.

The physician should not let a DME company specify what to order for the patient. Medical equipment or supplies should only be prescribed by physicians. Before signing prescriptions and CMNs, always review the contents and be alert for additions to the original order. Also, be sure that what was ordered is delivered. For example, if a humidifier was ordered while prescribing home oxygen, check with the patient or caregivers that it was provided.

Table 3	Examples of kickbacks that the OIG has prosecuted include:
	Payment of a fee to a physician for each plan of care certified by the physician on behalf of the home health agency.
	Disguising referral fees as salaries by paying referring physicians for services not rendered or in excess of fair market value for the service
	Offering free services to patients, including transportation and meals, if they agree to switch home health providers
	Providing hospitals with discharge planners, home care coordinators, or home care liaisons in order to induce referrals
	Providing free services, such as 24-hour nursing coverage, to retirement homes or adult congregate living facilities in return for home health referrals
	Marketing uncovered or unneeded home care services to patients

Paying or receiving kickbacks in exchange for Medicare or Medicaid referrals

Physicians need to carefully examine financial relationships with providers of home care services. Under the anti-kickback statute, “it is illegal to knowingly and willfully solicit, receive, offer or pay anything of value to induce, or in return for, referring, recommending or arranging for the furnishing of any item or service payable by Medicare or Medicaid.”

The general ethical guidelines for physicians involved in home care are presented in Table 4.

Table 4 Protecting yourself and your patients

Never sign a home health plan of care or a certificate of medical necessity (CMN) for home equipment for a patient for whose care you are not responsible. While you are taking calls or covering for another physician, you have the responsibility for those patients' care needs, including their home care.

Before you sign a Medicare home health plan of care, be certain that the patient meets eligibility requirements (through your own observations and knowledge of the patient and through discussions with the patient and home health agency [HHA] staff).

Read the home health plan of care, double-checking not only the diagnosis and medications but also the services provided and their frequencies. If you have any doubts, call the agency and ask for clarification about why the services are necessary.

Correct any errors you find on the home health plan of care or CMN and initial any corrections before you sign it.

Discuss with the patient and family the limited nature of the Medicare home health benefit and the fact that they may need to find and pay for additional home care services. Provide them with information about community resources.

While the patient is receiving home health services, periodically discuss with the patient and family whether these services are occurring, whether they are satisfied with the care, whether they can see they are making progress, and how long they feel the services will be needed. If they identify continuing long-term care needs beyond Medicare or other insurance coverage, talk to the HHA social worker about arranging for community resources.

If home medical equipment has been ordered, periodically check for continuing use and need.

While the patient is receiving home health services, request periodic written reports from the agency verifying the patient's continued homebound status and eligibility for Medicare or other home health benefits.

Reporting home care fraud and abuse

To report suspected home health care or Medicare fraud, call the Office of the Inspector General at (800) 447-8477 or send an e-mail to HHSTips@oig.hhs.gov.

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Chapter 12

A patient's rights and responsibilities

Patients receiving in-home services and their caregivers possess certain basic rights and bear particular responsibilities. The patient is in control of many aspects of health

care rendered in his/her home. With that control, concomitant responsibilities arise that must be met if the patient is to achieve the desired health care benefits.

Table 1 A patient's rights

The patient has the right to:

Be treated with dignity and consideration, respect, and timely attention to his or her needs.

Have his or her property be treated with respect.

Have confidentiality of all information related to care within required regulations.

Be fully informed of the care and treatment that will be provided by the physician and others, how much it will cost, how payments will be handled, and whether the patient is responsible for any of those payments.

Discuss benefits, risks, and costs of appropriate treatment alternatives.

Receive guidance from his/her physicians as to their recommended course of treatment.

Be advised of potential conflicts of interest that physicians may have, and of the right to receive independent professional opinions.

Have freedom of choice in care providers, to receive care from professionally competent personnel, and to know the names and responsibilities of people giving the care.

Accept or refuse treatment or forms of health care recommended by the physician, and to be informed of the consequences of this action.

Participate actively in the design of a care plan, and help update it as needs change.

Receive training in all aspects of self-care.

Experience continuity in the home care provided.

Be informed by a home health agency (HHA) of anticipated termination of agency service and to be referred elsewhere.

Have the freedom to make a complaint or recommend changes in services, or in agency policy, and to know how to do so.

Exercise his or her rights as a patient of the HHA.

Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding lack of respect for property by anyone who is furnishing services.

Be informed in advance about the care to be furnished, and of any changes in the care to be furnished.

Have confidentiality of the clinical records maintained by the HHA.

Be informed in advance about payment—what will be reimbursed by Medicare or other sources, and what may be required from the patient.

Be advised of the availability of the toll-free HHA hotline(s).

Table 2 A patient's responsibilities

Remain under a physician's care while receiving home care services.

Inform the home care team of any changes in physicians involved in the patient's care.

Provide the physician and the agency with a complete and accurate health history.

Provide the physician and the agency with all requested insurance and financial information.

Sign the required consents and releases for insurance billing.

Provide a safe home environment in which care can be given; allow necessary changes in the home environment.

Cooperate with the physician, the agency staff, and other caregivers by complying with the agreed upon therapy.

Accept responsibility for refusal of treatment.

Treat the physician and other health professionals with respect and consideration.

Advise the physician or agency administrator of any dissatisfaction or concerns about the care provided.

Inform the physician/agency of medical appointments, hospitalizations, changes in residence, or other reasons patients will not be home for scheduled visits.

General reference

42 CFR 484.10 (Code of Federal Regulations).

Chapter 13

Detection and treatment of abuse in home care

Abuse is a particular risk in the home care arena. Elderly patients, young patients, and people with disabilities of all ages are at risk. In 1991, a report from Congress suggested that between 1.5 and 2 million adults older than 60 years of age are abused annually in the United States. In 2001, approximately 903,000 children were found to be victims of child maltreatment.¹

Elder abuse and the abuse of people with disabilities

Elder abuse and the abuse of people with disabilities is a manifestation of a dysfunctional patient/caregiver relationship. The recognition of mistreatment depends on understanding the risk factors for abuse, and diagnosis is greatly aided by evaluation in the home. Inflexible caregiver support, loneliness, family conflict, alcohol abuse, psychiatric illness, lack of ease interacting with others, and short-term memory problems have been associated with a potentially abusive environment.²

Mistreatment is often unintentional due to ignorance, inexperience, or lack of ability or desire of the caregiver to provide adequate care.³ Less frequent are intentional neglect, physical abuse, and financial exploitation. Verbal or emotional abuse and abrogation of civil rights are generally not included in reports on elder abuse, but clearly play a role in the mistreatment of older individuals.

Early recognition of warning signs should prompt interventions on behalf of the caregiver to prevent a situation that may result in abuse.⁴ Where the patient is able to give a consistent history, a private discussion of his or her care and well-being may help to elucidate the problems. When financial abuse is suspected, patients should be assessed for the need for a financial and personal guardian. Physical abuse should be documented with drawings and, when available, photographs, x-rays, and other laboratory studies.

Table 1 Evidence of elder abuse is most easily obtained during a home visit

Neglect is sometimes manifested as poor hygiene, inadequate nutrition, or noncompliance with medications. However, it is important not to over-interpret these findings, as some patients may refuse to eat, take their medications, or resist treatments or personal attention.
Verbal and emotional abuse may be suspected if a patient demonstrates fear or hostility in the presence of the caregiver.
Intentional neglect or misappropriation of finances may be signaled by the absence of prescribed medications or supplies.
Physical abuse may result in bruises or welts on the trunk, rope burns around the wrists or ankles, and hemorrhages in the scalp; however, unlike in child abuse, fractures of the long bones or ribs in the elderly are more often pathologic rather than signs of abuse. Recurrent cancellations of previously scheduled house call appointments should alert the physician to the potential for abuse.

The diagnosis of abuse should lead to intervention designed to result in a resolution acceptable to all involved. The most successful approach includes counseling both the victim and the caregiver. It is important to note that many competent individuals are unwilling to accept intervention, and their wishes need to be respected if the situation is not felt to be immediately dangerous. In these circumstances, it is crucial that the patient is educated about the likely repetitiveness and increased frequency of future abuse and that he or she is given written information for emergencies and for other referral resources. The patient should develop a safety plan that includes a mechanism for notifying the physician in the future that an intervention is desired. The degree of further risk dictates whether the patient should be hospitalized immediately or if care can continue at home with added supports. Sometimes the best course of action is a planned nursing home admission for respite care, if all parties are in agreement.

Adult protective services

Adult protective services (APS) are available in all 50 states and the District of Columbia. These governmental programs are intended for the elderly and people with disabilities who are at risk of being abused or neglected and are unable to protect themselves. Mandatory reporting laws have been enacted in most states and provide protection for the physician, patient, and caregiver. Notification of APS may facilitate access to respite services or alternative placements and obviate the need to pursue criminal prosecution of the caregiver should the patient require an emergency room evaluation or hospitalization. When criminal prosecution is appropriate, APS will greatly facilitate the collection of evidence and pursuit of legal action.

Table 2	Adult protection interventions include, but are not limited to:
	Receiving reports of elder/vulnerable adult abuse, neglect, and/or exploitation
	Investigating these reports
	Assessing victim's risk
	Assessing victim's capacity to understand his/her risk and ability to give informed consent
	Developing a case plan
	Arranging for services
	Service monitoring
	Evaluation

Adult protective services investigate allegations of abuse, neglect, abandonment, and financial exploitation. The APS investigation is conducted at no charge and without regard to the income of the alleged victim. The APS investigators report suspected criminal activity to law enforcement and may work with law enforcement during the investigation. Based on the outcome of an investigation, APS may offer legal or social protective services. A competent patient has the right to refuse protective services. The vulnerable adult (Table 3) or the legal representative must give written consent for protective services and may end the services at any time. Some protective services may be provided without cost.

Table 3	Who is a vulnerable adult?
	A person 60 years of age or older who lacks the functional, physical, or mental ability to care for him or herself
	An adult with a developmental disability
	An adult with a legal guardian
	An adult living in a long-term care facility (an adult family home, boarding home, or nursing home)
	An adult living in his or her own or family's home

The APS system covers the following situations:

- **Physical abuse.** Physical abuse is intentional infliction of injury or physical mistreatment, including: slapping, pinching, choking, kicking, shoving, inappropriate use of drugs or physical restraints.
- **Sexual abuse.** Sexual abuse is any nonconsensual sexual contact. (Note: Any sexual contact between a facility staff person [such as in a nursing home, adult family home, boarding home, or supportive living] and a vulnerable adult is considered nonconsensual). Sexual abuse includes: unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing.
- **Mental or emotional abuse.** Mental or emotional abuse is the intentional action or inaction of verbal abuse. Mental abuse includes: intimidation; coercion; ridicule; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; using silence to control behavior; yelling or swearing resulting in mental distress.
- **Neglect or self-neglect.** Neglect or self-neglect means that, through action or inaction, by themselves or someone else, a vulnerable adult is deprived of the care needed to maintain physical or mental health. This does not include a competent person who decides to live in a way that may threaten his or her safety or well-being. Neglect or self-neglect includes: untreated or improperly attended medical conditions; poor personal hygiene; unsafe living conditions (for instance, no heat); unsanitary living quarters (for instance, no

toilet); lack of appropriate clothing; lack of necessary medical aids; failure to take medications as prescribed.

- **Exploitation or financial exploitation.** Exploitation is exerting undue influence or forcing a vulnerable adult to perform services for the benefit of others. Financial exploitation is the illegal or improper use of the property, resources, or income of a vulnerable adult for another person's profit or gain. Examples of exploitation include: an adult relative living in the home of a vulnerable adult without contributing to the household, or an unexplained sudden transfer of assets to a family member or someone outside the family.
- **Abandonment.** Abandonment is leaving a vulnerable adult without the ability to get necessary food, clothing, shelter, or health care. An example of abandonment is when a caregiver deserts the individual in a public place or in his or her own home.

The National Center on Elder Abuse (NCEA) is a useful national resource for elder rights, law enforcement and legal professionals, public policy leaders, researchers, and the public. The Center's mission is to promote understanding; knowledge sharing; and action on elder abuse, neglect, and exploitation. The NCEA is administered under the auspices of the National Association of State Units on Aging. Its Web site (www.elderabusecenter.org) has links to state APS Web sites and other useful information on elder abuse.

Child abuse

Data collected by the National Child Abuse and Neglect Data System (NCANDS) was developed by the Children's Bureau of the U.S. Department of Health and Human Services in partnership with state child protective services (CPS) agencies. It was found that more than half of child victims of abuse (57%) suffered neglect; 2% suffered medical neglect; 19% were physically abused; 10% were sexually abused; and 7% were psychologically maltreated. As is the case with elder abuse, the perpetrators of child

abuse tend to be basic caregivers, with a parent or parents responsible for 84% of the cases.

Child protective services

In 2001, services to prevent the abuse or neglect of children were provided by various state and local agencies to an estimated 2 million children. More than half of the child victims (58%, or an estimated 528,000) received post-investigation services, including about one-fifth of all victims who were removed from their homes and placed in foster care as a result of the investigation or assessment conducted by the CPS agency. In addition, more than one-quarter of children (29%, or an estimated 629,000 children) who were not found to be victims of maltreatment also received services.¹

The Federal Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Keeping Children and Families Safe Act of 2003, defines child abuse and neglect as, at minimum:

- Any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse or exploitation; or
- An act or failure to act that presents an imminent risk of serious harm.

Within the minimum standards set by CAPTA, each state is responsible for providing its own definitions of child abuse and neglect. Most states recognize four major types of maltreatment: neglect, physical abuse, sexual abuse, and emotional abuse. Although any of the forms of child maltreatment may be found separately, they often occur in combination.

The examples provided below are for general informational purposes only. Not all states' definitions will include all of the examples listed below and individual states' definitions may cover additional situations not mentioned here.

Neglect is failure to provide for a child's basic needs. Neglect may be:

- Physical (e.g., failure to provide necessary food or shelter, or lack of appropriate supervision)
- Medical (e.g., failure to provide necessary medical or mental health treatment)²
- Educational (e.g., failure to educate a child or attend to special education needs)
- Emotional (e.g., inattention to a child's emotional needs, failure to provide psychological care, or permitting the child to use alcohol or other drugs)

These situations do not always mean a child is neglected. Sometimes cultural values, the standards of care in the community, and poverty may be contributing factors, indicating the family is in need of information or assistance. When a family fails to use information and resources, and the child's health or safety is at risk, then child welfare intervention may be required.

Physical abuse is physical injury (ranging from minor bruises to severe fractures or death) as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise harming a child. Such injury is considered abuse regardless of whether the caretaker intended to hurt the child.

Sexual abuse includes activities by a parent or caretaker such as fondling a child's genitals, penetration, incest, rape, sodomy, indecent exposure, and exploitation through prostitution or the production of pornographic materials.

Emotional abuse is a pattern of behavior that impairs a child's emotional development or sense of self-worth. This may include constant criticism, threats, or rejection, as well as withholding love, support, or guidance. Emotional abuse is often difficult to prove and, therefore, CPS may not be able to intervene without evidence of harm to the child. Emotional abuse is almost always present when other forms are identified.

Reporting child abuse

All 50 states, the District of Columbia, and the U.S. Territories have enacted statutes specifying procedures that a mandatory reporter must follow when making a report of child abuse or neglect. Mandatory reporters are individuals who are required by law to report cases of suspected child abuse or neglect.⁵ In most states, the statutes require mandated reporters to make a report immediately upon gaining their knowledge or suspicion of abusive or neglectful situations. In all jurisdictions, the initial report may be made orally to either the CPS agency or to a law enforcement agency.

Childhelp USA[®] is a national organization that provides crisis assistance and other counseling and referral services. The Childhelp USA National Child Abuse Hotline is staffed 24 hours a day, 7 days a week, with professional crisis counselors who have access to a database of 55,000 emergency, social service, and support resources. All calls are anonymous. Contact them at (800) 4-A-CHILD, or (800) 422-4453.

References

1. National Clearinghouse on Child Abuse and Neglect Information. www.childwelfare.gov/index.cfm.
2. Shugarman LR, Fries BE, Wolf RS, Morris JN. Identifying older people at risk of abuse during routine screening practices. *J Am Geriatr Soc.* 2003;51:24-31.
3. *Diagnostic and treatment guidelines on elder abuse and neglect.* American Medical Association. October 1992.
4. Taler G, Ansello EF. Elder abuse. *Am Fam Physician.* 1985;32:107-114.
5. For a listing of mandated reporters, see Department of Health and Human Services, Statutes-at-a-Glance: Mandatory Reporters of Child Abuse and Neglect (2003). http://childwelfare.gov/systemwide/laws_policies/statutes/repproc.cfm.

Chapter 14

Alphabet soup: Rules and regulations in home care

Home care is subject to a number of non-financial rules and regulations that affect the home health agency (HHA) and others involved in managing patient care at home. Understanding these rules facilitates the development and direction of the care plan.

The HIPAA privacy rule¹

“HIPAA” refers to the federal “Health Insurance Portability and Accountability Act of 1996,” P.L. 104-191. Title II of HIPAA concerns “Administrative Simplification.” Title II is intended to improve the efficiency of the health care system by standardizing the electronic exchange of health care data and protecting the security and privacy of individuals’ health care information.

The HIPAA privacy rule is a lengthy and detailed regulation providing extensive and comprehensive federal protection for the privacy of health information that affects all health care providers, including HHAs and hospices. Compliance with HIPAA involves all aspects of an HHA’s or hospice’s operation and will be a continuing cost to those providers.

Who is covered?

HIPAA covers health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a HIPAA-covered transaction. HIPAA-covered transactions are:

- Health claims or equivalent encounter information
- Health claims attachments
- Enrollment and disenrollment in a health plan
- Eligibility for a health plan
- Health care payment and remittance advice
- Health plan payments
- First report of injury

- Health claims status
- Referral certification and authorization

Who is a “health care provider”?

According to HIPAA, a “health care provider” is a provider of services for purposes of Medicare, a provider of medical or health services for purposes of Medicare, and “any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.”

“Health care” includes, but is not limited to, “preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, services, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.”

Penalties for noncompliance

Since April 14, 2003, virtually all home health providers and hospices must comply with the privacy rule’s requirements. If not, HIPAA provides for civil penalties of \$100 per incident, up to \$25,000 per person, per year, per standard. It also permits criminal penalties ranging up to \$250,000 and up to 10 years in prison.

Concerns about HIPAA should not compromise the quality of home care. Compliance with the HIPAA regulations does not preclude communications between health care providers involved in the patient’s care as long as the provider knows with whom he or she is communicating, the provider has reasonable confidence that the communication is secure so that the patient’s medical information is kept private, and the provider keeps a record of communications. A general blanket waiver should be included in the initial enrollment papers signed by patients and families that authorizes providers to share

medical information as needed with other medical providers involved in the patient's care.

A copy and information concerning the privacy rule and guidance may be found at www.hhs.gov/ocr/hipaa.

OASIS

All HHAs that participate with Medicare are required to use a specific clinical assessment tool called the Outcome and Assessment Information Set (OASIS), and for all Medicare patients, the agencies must submit the OASIS data to a central database for use in quality improvement. The 89-item OASIS assessment is oriented to functionality and symptom improvement, is designed to evaluate the key endpoints that are important in home care, and has been extensively tested for validity. A full OASIS must be completed at entry to home care and at discharge. The requirements for interval assessments are being reworked.

Although OASIS is lengthy, when the OASIS items are incorporated as part of the patient assessment instrument (replacing other items, rather than “added on”) and performed by a trained and experienced provider, OASIS does not add time to the assessment process. OASIS is now used for dual purposes: quality improvement (the original purpose when OASIS was designed) and payment (a later use of OASIS, added when the Prospective Payment System [PPS] was developed). About one-quarter of the OASIS items are used for payment to determine assignment of the patient into one of the 80 PPS categories.

OBQI

Prior to the PPS, 10 years of research was conducted on quality improvement in Medicare home health, focusing on 41 outcomes and leading to the development of the Centers for Medicare & Medicaid Services (CMS) Outcomes Based Quality Improvement (OBQI) initiative. In two concurrent major demonstrations, altogether involving nearly 250,000 patients in 19 states and 73 agencies, demonstration (intervention) agencies were given feedback on their outcomes, adjusted for differences in

case-mix.² The agencies were carefully trained in how to read the OBQI reports and how to use them for quality improvement. They received no other intervention. Comparison patients received care from other agencies similar in size and geography. Targeted outcomes improved significantly in the intervention agencies, while outcomes that were not targeted for improvement showed no change. Importantly, hospitalization was one of the targeted outcomes, and a 25% annual reduction in hospitalization was documented for patients cared for by those agencies that were in the intervention group. Subsequently, state-level replications of these studies have demonstrated similar results.

The OBQI program is now an ongoing national initiative that is required for all agencies. As part of this effort, the content (items) and the application of OASIS (frequency of assessment, number of items) is being revised and updated on a continuing basis. Additionally, 11 OASIS items are now being used for posting public reports on the quality of care provided by HHAs. These reports appear on the CMS Web site.

The OASIS and OBQI efforts are a watershed event in home health care. This is the first time there have been reliable national-level data about these patients and about the impact of services rendered through home care. Home care has suffered from being a “black box” and lack of measures that could be used for accountability. This is also particularly important now that the PPS creates an incentive for agencies to provide fewer services.

From a physician perspective, OASIS and OBQI are likely “invisible” since OASIS data are not sent to physicians, and physicians normally do not need to see the OASIS. Review of OASIS is also not required for any physician activity, including billing for care certification or care plan oversight. The impact of OBQI on the improvement of quality is enormously important to physicians and their patients.

References

1. Adapted from: *The Remington Report HIPAA Privacy Compliance Resource Manual* and published with permission of the author and copyright owner, John C. Gilliland II, Attorney at Law, Gilliland & Caudill LLP, 6650 Telecom Drive, Suite 100, Indianapolis, Indiana 46278, jcg@gilliland.com. Information on the *HIPAA Privacy Compliance Resource Manual* can be obtained by contacting Mr. Gilliland directly or from his firm's Web site (www.gilliland.com).
2. Shaughnessy PW, Hittle DF, Crisler KS, Powell MC, Richard AA, Kramer AM, et al. Improving patient outcomes of home health care: findings from two demonstrations of outcome-based quality improvement. *J Am Geriatr Soc.* 2002;50:1354-1364.

Chapter 15

Resources

State Departments on Aging

For the most up-to-date contact information as well as information on regional offices, refer to the Web site maintained by the U.S. Department of Health and Human Services Administration on Aging at www.aoa.gov/eldfam/How_To_Find/Agencies. Also, check with the Eldercare Locator ([800] 677-1116 or www.eldercare.gov) to find the agency on aging closest to you.

Alabama

Department of Senior Services
RSA Plaza, Ste 470
770 Washington Ave
Montgomery, AL 36130-1851
(334) 242-5743
Fax: (334) 242-5594
www.adss.state.al.us

Alaska

Alaska Commission on Aging
Division of Senior Services
Department of Administration
PO Box 110209
Juneau, AK 99811-0209
(907) 465-4879
Fax: (907) 465-4716
www.alaskaaging.org

American Samoa

Territorial Administration on Aging
American Samoa Government
Pago Pago, American Samoa 96799
011 (684) 633-1251 or 633-1252
Fax: 011 (684) 633-2533

Arizona

Aging and Adult Administration
Department of Economic Security
1789 W Jefferson St, #950A
Phoenix, AZ 85007
(602) 542-4446
Fax: (602) 542-6575
www.de.state.az.us/aaa

Arkansas

Division of Aging and Adult Services
Arkansas Dept of Human Services
PO Box 1437, Slot S-530
1417 Donaghey Plaza S
Little Rock, AR 72203-1437
(501) 682-2441
Fax: (501) 682-8155
www.state.ar.us/dhs/aging

California

Department on Aging
1600 K St
Sacramento, CA 95814
(916) 322-5290
Fax: (916) 324-1903
www.aging.state.ca.us

Colorado

Division of Aging and Adult Services
Department of Human Services
1575 Sherman St, Ground Fl
Denver, CO 80203-1714
(303) 866-2636
Fax: (303) 866-2696
www.cdhs.state.co.us/oss/aas/index1.html

Connecticut

Elderly Services Division
Department of Social Services
25 Sigourney St
Hartford, CT 06106
(860) 424-5277
Fax: (860) 424-5301
www.ctelderlyservices.state.ct.us

Delaware

Division of Services for Aging & Adults with
Physical Disabilities
Dept of Health & Social Services
1901 North DuPont Hwy
New Castle, DE 19720
(302) 577-4791
Fax: (302) 577-4793
www.dsaapd.com/index.htm

District of Columbia

Office on Aging
One Judiciary Sq, 9th Fl
441 Fourth St NW
Washington, DC 20001
(202) 724-5622
Fax: (202) 724-4979
www.dcoa.dc.gov

Florida

Department of Elder Affairs
Bldg B, Ste 152
4040 Esplanade Way
Tallahassee, FL 32399-7000
(850) 414-2000
Fax: (850) 414-2004
E-mail: information@elderaffairs.org
<http://elderaffairs.state.fl.us>

Georgia

Division of Aging Services
Department of Human Resources
2 Peachtree St NE, 9th Fl
Atlanta, GA 30303-3142
(404) 657-5258
Fax: (404) 657-5285
E-mail: dbrconstituentservices@dbr.state.ga.us
<http://aging.dbr.georgia.gov>

Guam

Division of Senior Citizens
Department of Public Health & Social Services
PO Box 2816
Agana, Guam 96910
011 (671) 475-0263
Fax: 011 (671) 477-293

Hawaii

Executive Office on Aging
No 1 Capitol District
250 South Hotel St, Ste 109
Honolulu, HI 96813-2831
(808) 586-0100
Fax: (808) 586-0185
www2.state.hi.us/ea

Idaho

Commission on Aging
PO Box 83720
Boise, ID 83720-0007
(208) 334-3833
Fax: (208) 334-3033
www.idahoaging.com

Illinois

Department on Aging
421 E Capitol Ave
Springfield, IL 62701
(217) 785-2870
Fax: (217) 785-4477
www.state.il.us/aging

Indiana

Bureau of Aging and In-Home Services
 402 W Washington St
 PO Box 7083
 Indianapolis, IN 46207-7083
 (317) 232-7020
 Fax: (317) 232-7867
www.state.in.us/fssa/elderly

Iowa

Department of Elder Affairs
 Clemens Bldg, 3rd Fl
 200 Tenth St
 Des Moines, IA 50309-3609
 (515) 242-3333
 Fax: (515) 242-3300
www.state.ia.us/elderaffairs

Kansas

Department on Aging
 New England Bldg
 503 S Kansas
 Topeka, KS 66603-3404
 (785) 296-5222
 Fax: (785) 296-0256
www.agingkansas.org

Kentucky

Office of Aging Services
 Cabinet for Families and Children
 Commonwealth of Kentucky
 275 E Main St
 Frankfort, KY 40621
 (502) 564-6930
 Fax: (502) 564-4595
<http://chs.ky.gov/dhss/das>

Louisiana

Governor's Office of Elderly Affairs
 PO Box 80374
 Baton Rouge, LA 70898-0374
 (225) 342-7100
 Fax: (225) 342-7133
www.gov.state.la.us/depts/elderly.htm

Maine

Bureau of Elder and Adult Services
 Department of Human Services
 35 Anthony Ave
 State House, Station #11
 Augusta, ME 04333
 (207) 624-5335
 Fax: (207) 624-5361
 E-mail: webmaster_beas@state.me.us
www.state.me.us/dhs/beas

Mariana Islands

CNMI Office on Aging, DC & CA
 PO Box 2178
 Saipan, MP 96950
 011 (671) 734-4361
 Fax: 011 (670) 233-1327

Maryland

Department on Aging
 State Office Bldg, Rm 1007
 301 W Preston St
 Baltimore, MD 21201-2374
 (410) 767-1100
 Fax: (410) 333-7943
www.mdoa.state.md.us

Massachusetts

Executive Office of Elder Affairs
1 Ashburton Pl, 5th Fl
Boston, MA 02108
(617) 222-7451
Fax: (617) 727-6944
www.800ageinfo.com

Michigan

Office of Services to the Aging
PO Box 30676
7109 West Saginaw
Lansing, MI 48909-8176
(517) 373-8230
Fax: (517) 373-4092
www.miseniors.net

Minnesota

Board on Aging
444 Lafayette Rd
St. Paul, MN 55155-3843
(651) 296-2770 or TTY: (800) 627-3529
Fax: (651) 297-7855
www.mnaging.org

Mississippi

Division of Aging and Adult Services
750 N State St
Jackson, MS 39202
(601) 359-4925
Fax: (601) 359-9664
E-mail: webspinner@mdhs.state.ms.us
www.mdhs.state.ms.us/aas.html

Missouri

Director of Division of Senior Services
Department of Health & Senior Services
PO Box 570
615 Howerton Ct
Jefferson City, MO 65102-0570
(573) 751-3082
Fax: (573) 751-8687
www.dhss.mo.gov/SeniorServices

Montana

Senior and Long Term Care Division
Department of Public Health & Human Services
PO Box 4210
111 Sanders, Rm 211
Helena, MT 59620
(406) 444-4077
Fax: (406) 444-7743
www.dphhs.state.mt.us/sltc

Nebraska

Division of Aging Services
Dept of Health & Human Services
PO Box 95044
301 Centennial Mall S
Lincoln, NE 68509
(402) 471-2307
Fax: (402) 471-4619
www.bhs.state.ne.us/ags/agsindex.htm

Nevada

Division for Aging Services
Department of Human Resources
3416 Goni Rd, Bldg D-132
Carson City, NV 89706
(775) 687-4210
Fax: (775) 687-4264
<http://aging.state.nv.us>

New Hampshire

Division of Elderly and Adult Services
State Office Park S
129 Pleasant St, Brown Bldg #1
Concord, NH 03301
(603) 271-4680
Fax: (603) 271-4643
www.dhhs.state.nh.us/DHHS/BEAS

New Jersey

Division of Aging & Community Services
 Division of Senior Affairs
 Department of Health & Senior Services
 PO Box 807
 Trenton, NJ 08625-0807
 (609) 943-3345
 Fax: (609) 943-3343
www.state.nj.us/health/senior/sraffair.htm

New Mexico

State Agency on Aging
 La Villa Rivera Bldg
 228 E Palace Ave, Ground Fl
 Santa Fe, NM 87501
 (505) 827-7640
 Fax: (505) 827-7649
 E-mail: nmaoa@state.nm.us
www.nmaging.state.nm.us

New York

Office for the Aging
 Two Empire State Plaza
 Albany, NY 12223-1251
 (518) 474-7012
 Fax: (518) 474-1398
aging.state.ny.us

North Carolina

Department of Health and Human Services
 Division of Aging
 2101 Mail Service Center
 Raleigh, NC 27699-2101
 (919) 733-3983
 Fax: (919) 733-0443
www.dhhs.state.nc.us/aging/home.htm

North Dakota

Department of Human Services
 Aging Services Division
 600 S 2nd St, Ste 1C
 Bismarck, ND 58504
 (701) 328-8910 or (800) 451-8693
 TDD: (701) 328-8968
 Fax: (701) 328-8989
 E-mail: dhssrinf@state.nd.us
<http://lnotes.state.nd.us/dhs/dhsweb.nsf/ServicePages/AgingServices>

Ohio

Department of Aging
 50 W Broad St, 9th Fl
 Columbus, OH 43215-5928
 (614) 466-5500
 Fax: (614) 466-5741
www.state.oh.us/age

Oklahoma

Aging Services Division
 Department of Human Services
 PO Box 25352
 312 NE 28th St
 Oklahoma City, OK 73125
 (405) 521-2281 or 521-2327
 Fax: (405) 521-2086
www1.okdhs.org/en/whoweare/visd/asd

Oregon

Senior and Disabled Services Division
 500 Summer St NE, E02
 Salem, OR 97301-1073
 (503) 945-5811
 Fax: (503) 373-7823
www.dhs.state.or.us/seniors

Pennsylvania

Department of Aging
Forum Place
555 Walnut St, 5th Fl
Harrisburg, PA 17101-1919
(717) 783-1550
Fax: (717) 772-3382
www.aging.state.pa.us

Puerto Rico

Commonwealth of Puerto Rico
Governor's Office of Elderly Affairs
Call Box 50063
Old San Juan Station, PR 00902
(787) 721-5710, 721-4560, or 721-6121
Fax: (787) 721-6510
E-mail: administrator@ogave.prstar.net

Rhode Island

Department of Elderly Affairs
John O. Pastore Center
Benjamin Rush Bldg, #55, 2nd Fl
35 Howard Ave
Cranston, RI 02920
(401) 462-0500
Fax: (401) 462-0503
www.dea.state.ri.us

South Carolina

Department of Health and Human Services
PO Box 8206
1801 Main St
Columbia, SC 29202-8206
(803) 898-2513
Fax: (803) 898-4515
www.dhhs.state.sc.us

South Dakota

Office of Adult Services and Aging
Richard F. Kneip Bldg
700 Governors Dr
Pierre, SD 57501-2291
(605) 773-3656
Fax: (605) 773-6834
E-mail: asaging@dss.state.sd.us
<http://dss.sd.gov/elderlyservices>

Tennessee

Commission on Aging and Disability
Andrew Jackson Bldg, 9th Fl
500 Deaderick St
Nashville, TN 37243-0860
(615) 741-2056
Fax: (615) 741-3309
www.state.tn.us/comaging

Texas

Department of Aging and Disability Services
701 W 51st St
Austin, TX 78751
(512) 438-3011
E-mail: mail@dads.state.tx.us
www.dads.state.tx.us

Utah

Division of Aging and Adult Services
Box 45500
120 North 200 West
Salt Lake City, UT 84145-0500
(801) 538-3910
Fax: (801) 538-4395
E-mail: DAAS@hs.state.ut.us
www.hsdaas.utah.gov

Vermont

Department of Aging and Disabilities
 Waterbury Complex
 103 S Main St
 Waterbury, VT 05671-2301
 (802) 241-2400
 Fax: (802) 241-2325
www.dad.state.vt.us

Virgin Islands

Senior Citizen Affairs
 Department of Human Services
 #19 Estate Diamond Fredericksted
 St. Croix, VI 00840
 (340) 692-5950
 Fax: (340) 692-2062

Virginia

Department for the Aging
 1600 Forest Ave, Ste 102
 Richmond, VA 23229
 (804) 662-9333
 Fax: (804) 662-9354
 E-mail: aging@vdh.state.va.us
www.aging.state.va.us

Washington

Aging and Adult Services Administration
 Department of Social & Health Services
 PO Box 45050
 Olympia, WA 98504-5050
 (360) 725-2310 or in-state: (800) 422-3263
 Fax: (360) 438-8633
 E-mail: askdshs@dshs.wa.gov
www.aasa.dshs.wa.gov

West Virginia

Bureau of Senior Services
 Holly Grove, Bldg 10
 1900 Kanawha Blvd E
 Charleston, WV 25305
 (304) 558-3317
 Fax: (304) 558-5699
 E-mail: info@boss.state.wv.us
www.state.wv.us/seniorservices

Wisconsin

Bureau of Aging and Long Term Care Resources
 Department of Health and Family Services
 1 W Wilson St, Rm 450
 Madison, WI 53707-7850
 (608) 266-2536
 Fax: (608) 267-3203
www.dhfs.state.wi.us/Aging

Wyoming

Division on Aging
 Department of Health
 6101 Yellow Stone Rd, #259B
 Cheyenne, WY 82002
 (307) 777-7986 or (800) 442-2766
 Fax: (307) 777-5340
<http://wdhfs.state.wy.us/aging/index.htm>

National organizations/programs

Administration on Aging

Washington, DC 20201

(202) 619-0724

E-mail: AoAInfo@aoa.gov

www.aoa.gov

Alzheimer's Disease and Related Disorders Association, Inc

225 N Michigan Ave, Ste 1700

Chicago, IL 60601

(312) 335-8700 or (800) 272-3900

Fax: (312) 335-1110

E-mail: info@ALZ.org

www.alz.org

American Academy of Home Care Physicians

PO Box 1037

Edgewood, MD 21040-0337

(410) 676-7966

Fax: (410) 676-7980

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www.aahcp.org

American Academy of Hospice and Palliative Medicine

4700 W Lake Ave

Glenview, IL 60025-1485

(847) 375-4712

Fax: (877) 734-8671

E-mail: info@aahpm.org

www.aahpm.org

American Academy of Pediatrics

Section on Home Care

National Center of Medical Home Initiatives

141 Northwest Point Blvd

Elk Grove Village, IL 60007

(847) 434-4000

Fax: (847) 228-7035

E-mail: medical_home@aap.org

www.medicalhomeinfo.org

Association of Maternal and Child Health Programs

1220 19th St NW, Ste 801

Washington DC 20036

(202) 775-0436

Fax: (202) 775-0061

E-mail: infor@amchp.org

www.amchp.org

Centers for Medicare & Medicaid Services

7500 Security Blvd

Baltimore, MD 21244-1850

(877) 267-2323 or (410) 786-3000

General: www.cms.hhs.gov

Home health agencies: www.cms.hhs.gov/providers/hha

Physicians: www.cms.hhs.gov/physicians

Childhelp USA

1-800-4-A-CHILD ([800] 422-4453)

Joint Commission on Accreditation of Healthcare Organizations

One Renaissance Blvd

Oakbrook Terrace, IL 60181

(630) 792-5000

www.jcaho.org

Community Health Accreditation Program, Inc.

39 Broadway, Ste 710
New York, NY 10006
(800) 656-9656 or (212) 480-8828
Fax: (212) 480-8832
E-mail: info@chapinc.org
www.chapinc.org

National Association for Home Care and Hospice

228 7th St SE
Washington, DC 20003
(202) 547-7424
Fax: (202) 547-3540
www.nahc.org

The National Center on Elder Abuse

1201 15th St, NW, Ste 350
Washington, DC 20005-2800
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E-mail: NCEA@nasua.org
www.elderabusecenter.org

National Hospice & Palliative Care Organization

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www.nhpco.org

Visiting Nurse Associations of America

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Fax: (617) 737-1144
E-mail: vnaa@vnaa.org
www.vnaa.org

Chapter 16

Glossary of home care terms

Activities of daily living (ADL): Self-care abilities related to personal care including bathing, dressing, eating, toileting, continence, transferring, and ambulating.

APS (adult protective services): These services protect vulnerable adults by investigating allegations of abuse, neglect, abandonment, and financial exploitation. Based on the outcome of an investigation, APS may offer legal or social protective services. An adult maintains the right to refuse protective services. The vulnerable adult or the legal representative must give written consent for protective services and may end the services at any time. APS conducts an investigation at no charge and without regard to the income of the alleged victim. Some protective services may be provided without cost.

Assessment: The process by which a physician or another health care professional evaluates a person's health status. Assessment is related to, but distinct from, diagnosis. It may involve the use of formal assessment instruments along with more informal interviews with the patient, the patient's family, and other caregivers, and with observation of the patient's behavior.

Assessment instruments: Specific procedures, tests, and scales used to measure and evaluate cognitive and self-care abilities, problems, functional limitations, and other patient characteristics.

Attending physician: The physician designated by the client patient who is to have the most significant role in the determinations and delivery of the individual's medical care.

Care plan oversight (CPO): Ongoing oversight of home care services after the physician has referred a patient to a home care agency and developed and/or approved the care plan. CPO can be done by the referring or other physician, nurse practitioner, or physician assistant

identified by the referring physician. Oversight includes collaboration and communication between the referring physician and a variety of others participating in the care of the patient.

Case management: Those activities necessary to determine the patient's needs, arrange for and coordinate the appropriate services, and monitor the effectiveness of services and reassess them as needed.

CHAP: Community Health Accreditation Program of the National League for Nursing (NLN).

Childhelp USA: A national organization that provides crisis assistance and other counseling and referral services.

CLIA (Clinical Laboratory Improvement Amendments): The CMS program that regulates all clinical laboratory testing in the United States. Some states (e.g., California) and professional societies (e.g., College of American Pathologists) have stricter guidelines.

CMN (Certificate of Medical Necessity): Required by Medicare for certain categories of durable medical equipment.

CMS (Centers for Medicare & Medicaid Services): The branch of the Department of Health and Human Resources that issues rules and regulations for the Medicare program. Formerly HCFA.

Conditions of participation: The regulations under which a home health agency may be allowed to participate in Medicare and Medicaid programs.

Continuous improvement: A philosophy or attitude of looking for methods to improve the quality of products or services as an ongoing part of the administration of a health care delivery system.

Custodial care: Treatments or services, regardless of who recommends them or where they are provided, that could be given safely and reasonably by a person not medically skilled and are mainly to help the patient with activities of daily living.

Duplication of services: The same service being provided by two disciplines.

Durable medical equipment (DME): Defined by Medicare as equipment that can withstand repeated use; is primarily designed to serve a medical purpose; is generally not useful to a person in the absence of injury or illness; and is appropriate for use in the home. Examples of DME are oxygen tents, wheelchairs, walkers, and suction machines.

Enteral nutrition therapy: Therapy that addresses the nutritional needs of patients who are unable to take food orally. A feeding tube, passed through the nose, stomach, or small intestine, supplies the patient with vital nutrients. Home enteral nutrition supplies and equipment are reimbursable under Medicare Part B for patients with Medicare-specified diagnoses.

The Federal Child Abuse Prevention and Treatment Act (CAPTA): CAPTA, as amended by the Keeping Children and Families Safe Act of 2003, defines child abuse and neglect.

Form 485: Form used in home health certification and plan of care. (See Chapters 4 and 5.)

Fraud: Intentional deception or misrepresentation that an individual knows to be false and untrue.

Functional limitations: Translate the patient's signs and symptoms into problems that describe the limitations of performance and the impact of these limitations on the patient's lifestyle.

HHS (Health and Human Services): The department under which the Medicare program is administered.

HCFA (Health Care Financing Administration): See CMS.

HIPAA (Health Insurance Portability and Accountability Act): Refers to the federal "Health Insurance Portability and Accountability Act of 1996," P.L. 104-191. Title II of HIPAA concerns "Administrative Simplification." Title II is intended to improve the efficiency of the health care system by standardizing the electronic exchange of health care data and protecting the security and privacy of individuals' health care information.

High-technology home care: The application of technology at home to patients with acute, subacute, or chronic organ system diseases, dysfunction, or failure.

Home care: The provision by one or more organizations of nursing care, social work, therapies (e.g., diet, occupational, physical, psychological, speech), vocational and social services, and homemaker services, or home health aide services to disabled, sick, or convalescent persons in the home. Services can range from high-technology care (e.g., administration of intravenous drugs) to relatively simple supportive care (e.g., the provision of home-delivered meals).

Home health agency or organization (HHA): An organization that provides patients with skilled nursing and/or other therapeutic care in their homes, usually following the Medicare model of approved services (see home health care).

Home health aide: A trained individual who works under the supervision of a nurse or therapist, providing personal care and assistance with activities of daily living. Home health aides may assist home care patients with medication, exercise, and the performance of basic activities of

daily living. Effective August 14, 1990, Medicare required that home health aide training and competency evaluation must be carried out before the aide renders care in the home.

Homebound: The patient has a condition, caused by an illness or injury, that restricts the ability of the patient to leave his or her home except with the assistance of another individual, or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or the patient has a condition such that leaving his or her home is medically contraindicated. (Also see Chapter 4.)

Home health care: As defined under the Medicare Part A benefit, covers skilled, medically necessary care provided on an intermittent, part-time basis, by registered nurses, physical therapists, or speech therapists. If the patient qualifies for one or more of these “skilled” services, he or she is then eligible to receive services, if needed, from home health aides, dietitians, occupational therapists, and social workers.

Homemaker: A person paid to help in the home with personal care, light housekeeping, meal preparation, and shopping.

Instrumental activities of daily living (IADL): Activities that facilitate independence, such as the management of finances, use of the telephone, use of public transportation, meal planning and preparation, shopping, and taking medications appropriately.

Intermediary: The organization handling claims from hospitals, nursing homes, home health agencies, and other health care providers under federal or state health coverage programs.

Intermittent: A qualifying criterion for Medicare home health services, meaning that continuous 24-hour/day nursing services will not be covered, but only those services “either provided or needed on fewer than 7 days each week or less than 8 hours each day and 28 or fewer hours each week for periods of 21 days or less with extensions in

exceptional circumstances when the need for additional care is finite and predictable.” Most Medicare home health patients do not require such intensive services.

JCAHO: Joint Commission on Accreditation of Healthcare Organizations.

Management and evaluation of the care plan: Skilled nursing where underlying conditions or complications require that only a registered nurse can ensure that essential nonskilled care is achieving its purpose. The complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient’s recovery and medical safety in view of the patient’s overall condition.

Medicaid (Title XIX): A state/federal program designed to provide medical benefits to indigent persons of all ages.

Medically necessary care (under Medicare): “To be considered reasonable and necessary, services must be consistent with the nature and severity of the patient’s illness or injury, his or her particular medical needs, and the accepted standards of medical and nursing practice, without regard as to whether the illness or injury is acute, chronic, terminal, or expected to last a long time.”

Medical necessity: Services required and medically appropriate for the treatment of an illness or injury. Such services must be consistent with recognized standards of care.

Medical social services: Social services in home care are directly related to the treatment of the patient’s medical condition and, most recently, Medicare will allow two to three visits for family intervention directly related to the patient’s health and safety.

Medicare: Public Law 89-97, which provides hospital and physician benefits for eligible persons (aged 65 years or older, permanently disabled after 24 consecutive months of disability, or those with chronic renal disease

who require hemodialysis or kidney transplant after a three-month waiting period). Medicare Part A provides hospital and home health benefits; Medicare Part B provides benefits for professional services, home health, durable medical equipment (DME), and supplies.

Medicare-certified: A home health agency or organization that is found by the Centers for Medicare & Medicaid Services (CMS) to meet Medicare's Conditions of Participation, is certified by CMS, and is thus allowed to participate in the Medicare program.

Medicare criteria for skilled services: "To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel."

Medicare's OASIS: See OASIS.

Mini-Mental State Examination (MMSE): A simple screening test to detect dementia; it assesses a range of cognitive abilities, such as memory, calculations, language, and spatial ability.

The National Center on Elder Abuse (NCEA): Useful national resource for elder rights, law enforcement and legal professionals, public policy leaders, researchers, and the public administered under the auspices of the National Association of State Units on Aging. Its Web site (www.elderabusecenter.org) has links to state adult protective services Web sites and other useful information on elder abuse.

NAHC: National Association of Home Care Organizations.

NCQA (National Committee for Quality Assurance): Founded in 1979, the NCQA performs external review of quality assurance programs in prepaid health plans.

NLN (CHAP): National League for Nursing's Community Health Accreditation Program (CHAP).

Nutritional services: The assessment, planning, and recommendations for a patient's nutritional needs by a dietitian.

OASIS (Outcome and Assessment Information Set): Assessment and data collection instrument for purposes of outcome-based quality improvement, developed for use in Medicare-certified home health agencies and organizations. All home health agencies are required to conduct this assessment on a regular basis and report the results to CMS.

Occupational therapy services: Assist the patient to attain the maximum level of physical motor skills, sensory testing, adaptive or assistive devices, activities of daily living, and specialized upper extremity/hand therapies. While occupational therapy does not, in itself, constitute a basis for entitlement to Medicare reimbursement, a beneficiary of home health services (i.e., skilled nursing care, physical, and/or speech therapy) is also covered for occupational therapy.

PACE: The Program of All Inclusive Care for the Elderly is an optional benefit under both Medicare and Medicaid in which dually-eligible persons who are frail enough to meet state standards for nursing home care are offered an alternative to institutionalization. Under PACE, they are offered comprehensive medical and social services through adult day centers, and home and/or inpatient facilities. PACE is available only in states that have chosen to offer it under Medicaid.

Parenteral nutrition therapy: Therapy to assist patients unable to digest food by the gastrointestinal tract. A catheter, usually centrally placed, attached to an infusion pump, supplies nutrients to the patient's bloodstream. Supplies and equipment are reimbursable under Medicare Part B for patients with Medicare-specified diagnoses.

Personal care: Assistance with activities of daily living, including bathing, toileting, dressing, grooming, transfer to and from bed, and feeding.

Physical therapy services: The treatment of neuro-muscular and musculoskeletal dysfunctions through the application of physical agents (heat, cold, water, etc.) and neuromuscular procedures to alleviate pain, prevent disability, and rehabilitate function after disease or trauma. Based on patient need, and should have a restorative function. This usually means that the patient has a fair or good rehabilitation potential. The physical therapy documentation must show progress toward established goals.

Primary family caregiver or care partner: Relative or significant other who assumes many of the tasks involved in caring for a home care patient that the patient is unable to perform.

Private-duty nursing: Nursing, chore service, housekeeping, and other types of patient care administered in a hospital, in a nursing home, or by a home health agency. Private-duty nursing is covered by some private-pay insurers or is self-pay.

Psychiatric nursing: With the Medicare manual revision of 1989, the role of the psychiatric nurse was clarified. The kinds of problems seen in the home are depression, bipolar disorder, and evaluation of medication therapeutic levels, as well as many geriatric disorders. The nurse must meet specific credentialing and training requirements to do home health psychiatric nursing.

Quality control: A management process where performance is measured against expectations and corrective actions are taken.

Recertification: The attending physician certifies that the beneficiary requires continued skilled services after the expiration date of the initial certification, and then periodically thereafter.

Respiratory care services: Required by patients who suffer from a variety of chronic pulmonary or heart-related problems. Home respiratory care treatment (oxygen therapy, intermittent positive-pressure breathing

[IPPB] therapy, etc.) is covered under Medicare Part B, based on criteria of medical necessity.

Respite care: Services provided on a short-term basis to individuals unable to care for themselves. Respite care provides a relief (respite) for those persons normally providing care to the individual, allowing these caregivers time off to attend to their own needs or the needs of other family members.

Skilled nursing services: Occurs when a registered nurse uses knowledge as a professional nurse to execute skills, render judgments, and evaluate process and outcomes. The skills allowed in home health are assessment and observation, teaching and training, direct procedures, and management and evaluation of the care plan.

Speech therapy services: Provided by a speech and language pathologist as part of the home rehabilitation program for patients with cerebrovascular accidents, tracheostomies, laryngectomies, and various neuro-muscular diseases.

ISBN-13: 978-1-57947-865-0
ISBN-10: 1-57947-865-4

OP221201

SEE:06-0225:2.5M:11/06

ISBN-13: 978-1-57947-865-0
ISBN-10: 1-57947-865-4

