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HOME HEALTH CARE IN NORTH DAKOTA:

A STUDY OF PROGRAM EFFECTIVENESS

by
Dana L. Tinnes

An Independent Study

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Master of Public Administration

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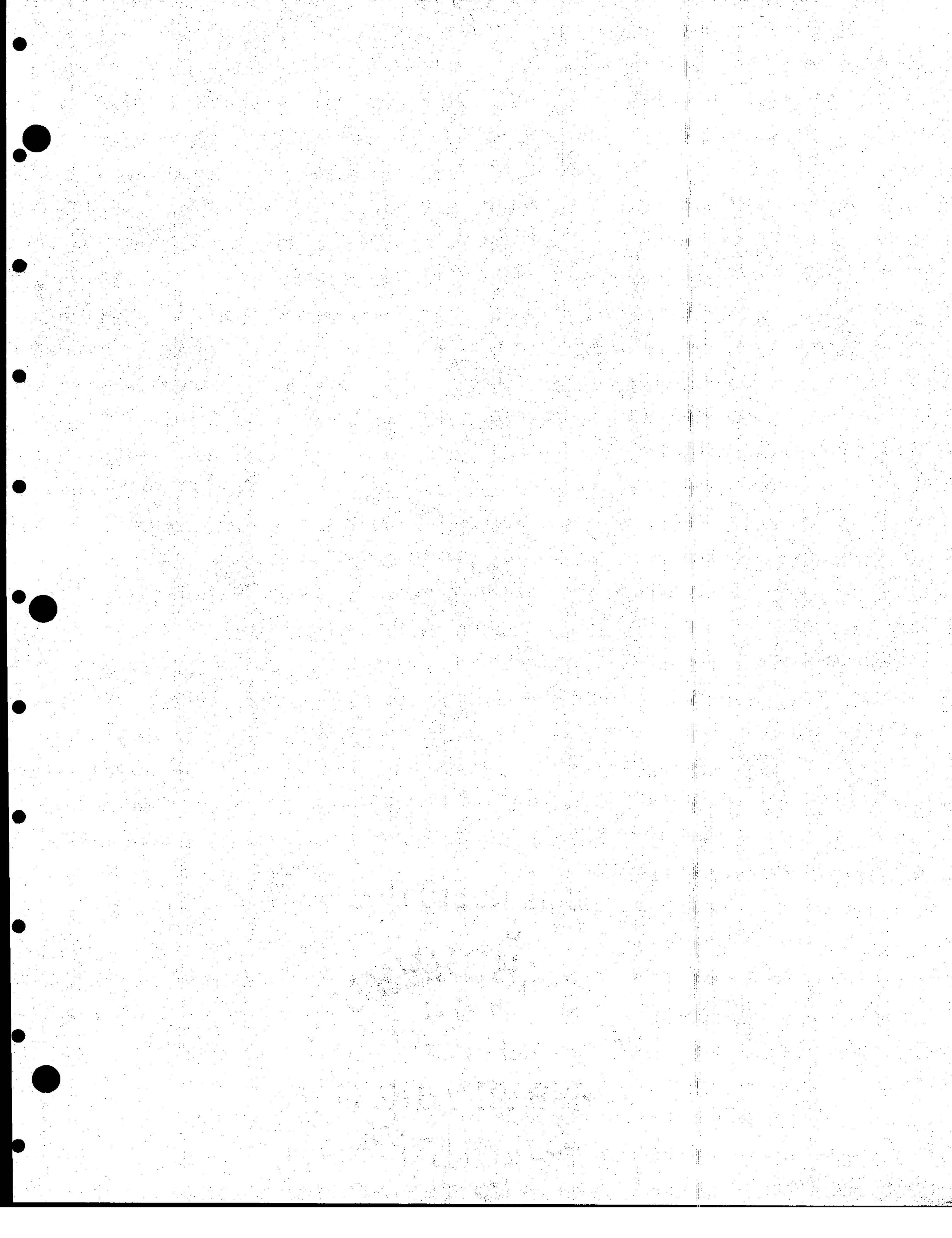
1982



This independent study submitted by Dana L. Tinnes in partial fulfillment of the requirements for the Degree of Master of Public Administration from the University of North Dakota is hereby approved by the faculty advisor under whom the work has been done.

____
(Advisor)

Permission

Title HOME HEALTH CARE IN NORTH DAKOTA: A STUDY OF PROGRAM EFFECTIVENESS

Department Political Science

Degree Master of Public Administration

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Signature Dana C. Turner

Date July 24, 1982

TABLE OF CONTENTS

LIST OF TABLES v

ACKNOWLEDGMENTS vi

CHAPTER I. INTRODUCTION 1

Background 1
Purpose of the Study 5

CHAPTER II. DISCUSSION AND REVIEW OF LITERATURE AND REPORTS . . 7

Home Health Utilization and Demand 7
The Economics of Home Health Care 14
Role of the Physician 19

CHAPTER III. METHODOLOGY 23

Design of the Study 23
Data Source, Collection and Analytic Methods . . . 24

CHAPTER IV. ANALYSIS OF DATA AND RESULTS 28

Physician Survey Findings 28
Summary of Physician Responses to Open-Ended Questions 33
Home Health Agency Survey Findings 34
Summary of Home Health Agencies Responses to Open-Ended Questions 37

CHAPTER V. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS 39

A Summary of the Findings 39
Conclusions 41
Recommendations for Further Study 43

CHAPTER VI. ADDITIONAL VIEWS 45

APPENDIX A. Counties Certified to Participate in Medicare . . . 54

APPENDIX B. Physician's Questionnaire 56

APPENDIX C. Home Health Agency Questionnaire 59

BIBLIOGRAPHY 62

LIST OF TABLES

Table | Page

1. Medicare: Participating Home Health Agencies, Selected Years 1966-82. 9

2. North Dakota Participating Home Health Agencies by Type of Agency - January 1982 10

3A. Medicare: Participating Home Health Agencies Offering Selected Services, January 1981. 11

3B. Medicare: Participating Home Health Agencies Offering Selected Services - North Dakota, January 1982 12

4. Reasons for Referral to Home Health Care - Physicians. 30

5. Ranking of Home Health Agency Goal Statements. 34

6. Patient Caseload 36

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CHAPTER I

INTRODUCTION

Background

Home health care may generally be defined, for purposes of this study, as "an array of services which may be brought into the home singly or in combination in order to achieve and sustain the optimum state of health, activity, and independence for individuals of all ages who require such services because of acute illness, exacerbations of chronic illness, long-term or permanent limitations due to chronic illness and disability."

The concept of home health care has a long history. The home was the locale of choice for medical care before the emergence of the hospital as the center for the care and treatment of major illness. Healers and midwives, our first health professionals, delivered their care in the home. They were often called in to consult on diseases and offer opinions on possible cures while also providing emotional support to the family. The first home care program in the United States, the Boston Dispensary, was founded in 1796 to assure that, "The sick, without being pained by separation from their families, may be attended and relieved in their own homes."[1]

Even with the emergence of hospitals, the role and importance of the family continued to be recognized. The wealthy and more

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[1] Cynthia R. Driver, How To Get The Best Health For Your Money (Emmans, PA: Rodale Press, 1979), p. 81

prosperous population usually preferred treatment at home under the care of a physician as many possessed a great fear of hospitals. Some of that fear undoubtedly still exists today but tremendous advances throughout the fields of health care and medicine in the past several decades have given many a much more positive outlook. Technological innovations such as intensive care units and artificial kidney machines have made the treatment of illnesses increasingly effective.

Homes began to be displaced by hospitals and clinics as the primary site for medical care within the last century as the physician found the hospitalization of patients to be much more convenient and efficient, particularly with the availability of hospital laboratory facilities and skilled manpower resources. In addition, prepaid insurance programs covering services performed in the hospital made hospitalization an economically feasible alternative to home care.

The rising cost of institutional health care in recent years, however, has prompted the re-establishment of a home health care structure--a structure that relies on a combination of the family, professional medical personnel, social service agencies, and informal social support networks. Another factor prompting consideration of home health care as an effective and less expensive means of providing health services, and as an alternative to more costly institutional care, is the lengthening life span of the population. Longer life spans have resulted in an increase in the number of elderly, the more prevalent victims of costly, chronic illnesses.

Public funding of home health services became available during the 1960s with the passage of Medicare-Medicaid. Medicare made available a broad health insurance program for most Americans age 65 and over

and certain individuals under 65 who are disabled or have chronic kidney disease. Medicare provides two insurance protection programs for the aged and disabled--hospital insurance (part A) and supplemental medical insurance (part B). Hospital insurance is generally financed by Social Security payments from employers, employees, and the self-employed. Medical insurance is a voluntary program financed by general tax funds and monthly premiums collected from participating beneficiaries. Both insurance programs cover health services provided to eligible beneficiaries in their homes (home health care).

Medicaid legislation, the companion program to Medicare, provides medical assistance for certain low-income persons. As with other aspects of the Medicaid program, the states are given wide discretion as to the content and administration of their programs, and services vary considerably from state to state.

The 1966 Medicare legislation seemed favorable to home care and the movement grew. But after a period of time it became obvious that some of the Medicare requirements were short-sighted and restricted effective use of home care services. The original intent of Medicare was to cover acute episodes and specified convalescence, and its focus could not be shifted to chronic care. As this narrow approach continued, with the focus on acute care, it hindered the capacity of home care programs to care for the chronically ill patient.

A major shift in emphasis relative to home care utilization developed with passage by Congress of the Omnibus Reconciliation Act of 1980. This legislation relaxed or removed many of the restrictions governing Medicare and Medicaid reimbursement of home care costs. In particular, the lifting of the 100-visit limit on home health services

and the addition of occupational therapy as a qualifying home benefit has improved the potential of home care programs to benefit the chronically ill.* Although there are still certain incentives within the Medicare and Medicaid programs which tend to favor care for the elderly and chronically ill in institutional settings rather than the community, it is expected that these recent changes in legislation will act as a catalyst in terms of encouraging further home care development throughout the United States.

Another important program that prompted the expansion of home health care during recent years was the Health Revenue Sharing and Health Services Act of 1975. This legislation included the federal Home Health Grant Program and was designed to increase the provision of home health services by means of grants for the expansion of existing home health agencies and the development of new ones. A recent evaluation of the grant program indicates that it did lead to service expansion and development, and the "return" to the grant program was reasonable.[2]

Home health care is recognized as a less expensive and more effective means of providing health services to those who do not need, or who no longer need, twenty-four hour a day professional supervision. Thus, while receiving quality health care, the individual may remain at home with family and friends, enjoying a way of life as closely related to normal as possible.

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*The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) eliminated occupational therapy as a qualifying service, effective December 31, 1981.

[2]Robert E. Schlenker, Ph.D., Expanding Home Health Services and Evaluation of the Federal Grant Program, (Home Health Care Services Quarterly, Vol. 1, No. 3, Fall 1980), p. 63.

Purpose of the Study

Home health care has been the subject of a long and continuing debate; there is little agreement relative to the goals and purposes of that care, the kinds of population groups it should serve, or the costs and benefits to be expected.

There seems to be general agreement that the two major goals of home care are to keep people in their normal environments, and to aid people in recovering after an institutional stay. The first is supported by the philosophy that people should remain in their homes as long as possible, and the provision of certain services can enable them to do so. Care at home would continue until the end of the episode, or until placement in an institutional setting became necessary.

The second concept contains a presumption of institutionalization; a person is first admitted to and remains in a hospital or nursing facility until it is determined that the person can be cared for at home. Under this concept, the primary purpose of home health services is to allow for earlier discharge from institutions.

This study focuses on the present effectiveness of home health care throughout North Dakota by examining the level of functional compatibility among the providers of home health care services, principally the home health agencies and physicians. Compatibility is measured in terms of agreement relative to (1) the stated mission and/or purpose of the home health care concept and (2) respective roles and responsibilities within the program. The study is designed also to identify various factors which adversely affect proper utilization of the home health benefit.

The study can be construed as a form of evaluation research in a limited sense. Of particular significance are the survey procedures that were employed which generated feedback on program results that may be used to increase the effectiveness of the overall program statewide. Therein lies the importance of this study.

CHAPTER II

DISCUSSION AND REVIEW OF LITERATURE AND REPORTS

Home Health Utilization and Demand

While home health care providers have grown both in absolute numbers and in numbers of services provided, home health care is still not uniformly available to all Medicare and Medicaid beneficiaries. There is also evidence that certain types of providers are expanding more rapidly than others.

Home health providers can generally be categorized into three broad categories, based on ownership/governing authority:

1) Public agencies, including all agencies operated by State or local government units;

2) Nonprofit agencies, including nongovernment tax-exempt organizations such as Visiting Nurse Associations (VNAs) or agencies located in hospitals, Skilled Nursing Facilities (SNFs), or rehabilitative facilities as well as private, nonprofit agencies organized and operated by an individual; and

3) Proprietary agencies, including all privately owned, profit-making agencies.

The definition of a home health agency under Medicare regulations is a public or private organization primarily engaged in providing skilled nursing and other therapeutic services. Regulations specify that the agency must provide part-time or intermittent skilled nursing services and at least one other therapeutic service, on a visiting basis,

in the patient's place of residence. A public or nonprofit private agency must provide one service directly through its own employees, but may contract for the provision of additional services. Proprietary agencies must provide all services directly.

A 1979 Department of Health, Education, and Welfare (DHEW) report to Congress on home health care noted that, in 1963--two years prior to the enactment of Medicare and Medicaid--fewer than 250 agencies met the definition of a home health agency later set forth by Medicare and also adopted by Medicaid. At that time, 1,163 agencies offered a program of nursing care at home, but only 141 of these met the Medicare program requirement that at least one other therapeutic service be provided. Ninety percent of the agencies offering in-home services were operated by state and local governments and by Visiting Nursing Associations (VNAs).[3] The situation changed rapidly with the implementation of Medicare and Medicaid in 1966, and by October of that year, 1,275 home health agencies were certified for participation. Since that time the total number of certified agencies has escalated to approximately 3,200 as of January, 1982. Table 1 shows the number of participating home health agencies under Medicare for selected years 1966-1982.

The growth of home health care throughout North Dakota has been slow and intermittent until recent years. There were approximately seven home health agencies certified for Medicare in North Dakota following the enactment of Medicare and Medicaid legislation. The North Dakota State Department of Health reported a total of nine participating home health agencies in 1975 and a significant increase to 18 as of January,

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[3]United States Senate, Report of the Committee on Labor and Human Resources, Community Home Health Services Act of 1981, Report No. 97-325, March 23, 1982, p. 18.

TABLE 1

MEDICARE: PARTICIPATING HOME HEALTH AGENCIES, SELECTED YEARS 1966-82

Year[1]	All Agencies	Official Health Agency[2]	Visiting Nurse Association	Combined Govt. & Voluntary Agency	Hospital Based Program	Other[3]
1966	1,275	579	506	83	81	36
1970	2,311	1,334	552	102	202	121
1975	2,254	1,259	530	47	270	148
1982	3,178	1,225	515	54	444	904

[1]As of October 1966, as of January 1970, 1975 and 1982

[2]An agency administered by a state, county, or other local unit of government.

[3]Included skilled nursing facility-based programs, rehabilitation facility-based programs, proprietary or other home care programs. For 1982, the 904 agencies included 332 proprietary, and 551 private nonprofits.

SOURCE: U.S. Department of Health, Education and Welfare, Health Resources Administration. "Health Resources Statistics: Health, Manpower and Health Facilities 1976-77," p. 394, and unpublished data of the Health Care Financing Administration for 1982.

1982[4]. The majority of recently established home health agencies have been hospital-based programs. Table 2 provides a breakdown of North Dakota home health agencies by type of agency certified to participate in Medicare as of January, 1982.

The 1979 DHEW report to Congress on home health included data that indicated home health agencies are more readily available to residents of metropolitan areas than non-metropolitan areas. In the Northeast, where the greatest percentage of Medicare beneficiaries reside in metropolitan areas, the availability of home health care is nearly universal. In other

[4]Division of Nursing, North Dakota State Department of Health, Home Health Needs in North Dakota, July 1977, p. 4; Division of Health Facilities, North Dakota State Department of Health, Home Health Agencies, January 1982.

TABLE 2

NORTH DAKOTA PARTICIPATING HOME HEALTH AGENCIES BY TYPE OF AGENCY

Type of Agency	Total
Official Health Agency[1]	7
Hospital-based Program	10
Proprietary	1
TOTAL ALL TYPES	18

[1]An agency administered by a state, county, or other local unit of government.

SOURCE: North Dakota State Department of Health, Division of Health Facilities and the Division of Nursing.

regions, however, agency and service availability is considerably less, particularly in non-metropolitan, rural areas. Presently it is estimated that over 600 of the 3,105 counties in the United States are without a home health agency certified to participate in Medicare.[5] Most of these counties are considered rural with widely-dispersed populations.

As of January, 1982, ten of the 53 counties within North Dakota were not served by a home health agency certified to participate in Medicare (Appendix A).[6] The extent of home health service coverage in North Dakota is statistically similar to the national situation in terms of percent of coverage and the lack of services in rural, sparsely populated counties.

The uneven geographic development of home health agencies nationally is also reflected in service utilization by Medicare beneficiaries.

[5]Report of the Committee on Labor and Human Resources, p. 20.

[6]North Dakota State Department of Health, Division of Health Facilities, Home Health Agencies, January 1982.

Regional utilization data for 1979 indicate that the Northeast region had the highest visit rate among the regions--980 per 1,000 enrollees. The South had the second highest--669 per 1,000 enrollees. The West experienced 554 visits per 1,000 enrollees while the North Central region had the lowest rate of 533 per 1,000 enrollees.[7] These differences in utilization may reflect differences in the demand for services by the Medicare population in various geographic areas, as well as the available supply of home health providers eligible to participate in the program.

It is also important to note that the availability of a provider does not necessarily mean that a particular needed home health service is available. Table 3-A shows that, of the number of Medicare certified home health agencies as of January, 1981, only about 40 percent offered occupational therapy or medical social services.

TABLE 3-A

MEDICARE: PARTICIPATING HOME HEALTH AGENCIES OFFERING SELECTED SERVICES JANUARY 1981

Service	Number	Percent of Total
Total	3,042	100.0
Nursing Care	3,042	100.0
Physical Therapy	2,405	79.1
Occupational Therapy	1,194	39.3
Speech Therapy	1,683	55.3
Medical Social Service	1,262	41.5
Home Health Aide Service	2,770	91.1

SOURCE: Unpublished data of the Health Care Financing Administration, January 1981.

[7] Report of the Committee on Labor and Human Resources, p. 20.

The availability of various home health services throughout North Dakota is also diverse, as shown in Table 3-B.

TABLE 3-B

MEDICARE: PARTICIPATING HOME HEALTH AGENCIES OFFERING SELECTED SERVICES - NORTH DAKOTA

JANUARY 1982

Service	Number	Percent Of Total
Total	18	100.0
Nursing Care	18	100.0
Physical Therapy	11	61.1
Occupational Therapy	4	22.2
Speech Therapy	7	38.9
Medical Social Service	3	16.7
Home Health Aide Service	17	94.4

SOURCE: North Dakota State Department of Health, Division of Health Facilities, January 1982.

Even though its share of total expenditures remains small by comparison, home health care has in recent years become one of the fastest growing components of the Medicare and Medicaid budget and

accounts for about 2.2 percent of total Medicare expenditures. This more than doubles the percentage expenditure of fiscal year 1975. In 1980, Medicare home care expenditures rose to $750 million, from the $203 million in 1975. Over the same period, Medicaid expenditures have escalated from $70 million to $348 million. Some 1.5 million beneficiaries in the two programs received home services in 1979.[8]

Despite the growth in the home health expenditures under public programs, there still appears to be an unmet need for home care services. Measuring the actual extent of such need, however, has proven to be difficult. There have been numerous studies examining the issue. For example, in a 1977 report, the Congressional Budget Office (CBO) compared the potential need and the available supply of home health care and found that 1.7 to 2.7 million people were in potential need of expanded home services, but only 300,000 to 500,000 were receiving them.[9]

Attempts have also been made to examine the need for home care by studying the existing institutionalized population to determine if nursing home patients, for example, could be appropriately cared for in the community. In its 1977 report, CBO estimates indicated that between 20 and 40 percent of all Intermediate Care Facility (ICF) nursing home patients were inappropriately placed and could be cared for in less intensive settings, if adequate community care were available.[10]

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[8] James D. Snyder, Chris Bale, Home Health Care: Cost Cutter or Another Expense?, Physician's Management, Sept. 1981, p. 74.

[9] Congressional Budget Office, Long Term Care for the Elderly and Disabled, U.S. Government Printing Office, February, 1977 (Reprinted August, 1977), p. x.

[10] Congressional Budget Office, p. 10.

Added to current estimates of underutilization of home health are future problems associated with an expanding elderly population. Dr. Philip Brickner, of the Chelsea Village program operated out of St. Vincent's Hospital in New York, predicts that in 20 years, unless a pronounced shift to home health care occurs, almost double the number of existing nursing home beds that will have to be built.[11]

The Economics of Home Health Care

The cost effectiveness of home health care at the current time has not been determined. Even though it is frequently stated that cost effectiveness is a prime justification for expanding the scope and availability of home health services, in some instances home health care may not be cheaper. However, it is often better for the individual in promoting independence, recovery, and normal surroundings. To determine proper cost effectiveness, judgements should be made not simply on the basis of direct costs, but on the overall value of the results achieved. Cost effectiveness of a program indicates that it can accomplish a given objective more cheaply, in terms of total social costs, than can any alternative program. The question that has not yet been answered is whether money spent on home health care will be offset by a concomitant reduction elsewhere, in hospital or nursing home outlays, without adversely affecting standards of care.

The problem of cost effectiveness is difficult to determine in comparing home and institutional care because the cost data for the two do not parallel. For example, institutional costs are generally

[11] Home Health Care: Cost Cutter or Another Expense?, p. 77.

expressed in per diem terms, and include room, board, and personal care, while home care costs are expressed in per visit or per service terms, and reflect only health and health-related technical services by the provider.

Two major considerations have nearly always been left out of any discussion of cost effectiveness of home care. One is the impact on cost calculations of key health, demographic, social, and economic characteristics of the populations served. It may be demonstrated that a home care program can effectively care for a group of aged patients, most of whom are financially independent, and many of whom live with relatives, but what about the program whose clients are impaired, poor, and isolated? Similarly, a program that is cost effective in an urban setting may not be so in a rural one. Likewise, a program that selects out healthier, less dependent clients may be expected to cost less than one that has a broader mix of patients and health characteristics.

Another consideration that is important in terms of cost effectiveness is settings or levels of care. Three major levels of care have been identified as (1) intensive, (2) intermediate, and (3) basic, or maintenance.[12] Intensive level services usually involve the provision in the home of a "complex" of services, or one type of service rendered frequently. These may include frequent nursing visits, frequent physical therapy treatment, social services, nutrition services, drugs and medical supplies, the provision of equipment, homemaker-home health aide services, and other diagnostic and treatment services that can be

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[12] Judith LaVor and Marie Callender, Home Health Cost Effectiveness: What Are We Measuring?, Medical Care, October 1976, Vol. XIV, No. 10, p. 867.

safely delivered in the home. The basic or maintenance service level is aimed at preventing or arresting disease and impairment, preventing further deterioration, and maintaining health and functional status in order to delay or prevent the need for institutional care. The basic level can be interpreted very broadly and flexibly, and may include, in addition to intensive level services: homemakers, home maintenance, non-skilled services by nurses, therapists, aides, meals on wheels, friendly visiting, transportation, assistance with activities of daily living, and so on. The intermediate level of care falls somewhere between the intensive and basic levels of care. Intermediate services may vary in intensity and duration, except that in general this level of care, although of longer duration than intensive, is not usually required over extended periods, as basic services usually are. To compare two forms or levels of care, it is necessary first to be sure that the level--that is, intensive, intermediate, or basic--be matched, regardless of the place in which it is provided.

Debate continues about where home health care fits in a range or system of health services. Is it an alternative to hospital or nursing home care, or is it an independent, free-standing service to be used as appropriate to the client's needs? There is a consensus among those working in the field of home health care that community-based services including home health care can be less costly from an individual and aggregate program point of view than hospital and other in-patient care, and that they can help to improve the quality of life by helping patients maintain a fairly independent living style. It is believed that once home health care is widely available in the community, it can be assumed

that there will be total cost reductions. For example, (1) intensive home health care can reduce hospital admissions and length of stay, (2) intermediate home care can reduce inappropriate hospital and skilled nursing facility admissions, and (3) maintenance service can reduce nursing home use but is likely to be an add-on cost because it would be a new service.[13] Blue Cross sees the basic level of services increasing overall costs because they represent an add-on to already existing services, rather than just more services for those already eligible for home care.[14] Medicare takes the same position adding that these do not appear to be health services.

Much of the current literature espouses home health care as being a cost effective program. Hospital Peer Review (January, 1979) describes a hospital-based home health care program that is helping Northside Hospital in Atlanta, Georgia, reduce lengths of stay, contain costs and still provide quality care to the community it serves. Northside was in a unique situation where it continually faced a critical shortage of beds. The home health care program alleviated that problem to a great extent.

An article in Newsweek (March 10, 1980) touts home care as a program that pays off. The article cites specific examples and studies that have indicated that home health care is a feasible alternative to institutionalization. The St. Vincent's Hospital Home Health Care Program of New York was described in terms of treating patients at home for about 60 percent of the cost of living in an institution.

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[13] Charles Welew, M.D., F.A.C.P., Home Health Care, New York State Journal of Medicine, Vol. 78, No. 12, October 1978, p. 1959.

[14] Home Health Care Cost Effectiveness: What Are We Measuring, p. 868.

An American Nurse (May, 1981) guest editorial describes home care as a cost effective alternative. A typical cost saving example is discussed in the article stressing that home care costs are a fraction of hospital costs and that such measures would bring relief to insurers and to taxpayers.

The Wall Street Journal (March 26, 1981) included an article headlined "Home-Care Services for the Elderly and Disabled Are Advocated as Cheaper Than Nursing Homes." The article characterizes a typical cost saving example on the part of an individual and also narrates several studies suggesting the need for home health care and the financial attractiveness of the program. The article reported that studies have indicated that as many as 25 percent or more than 1.4 million persons living in nursing homes could live at home if they had adequate support. It explained that the private nursing home industry would probably not oppose proposed federal legislation to expand home health care programs throughout the United States because many in the business see far greater demand for nursing-home beds in the decade ahead than they can handle. There is a fear, however, amongst certain health and budget officials that further government assistance for home care would be in such demand that any savings would be wiped out. Reagan administration officials privately support more home care for the elderly but, like their Carter administration predecessors, cost-conscious Reaganites fear that millions of elderly currently getting by on their own or with family help might line up for federal home-care aid.

The June 9, 1981, Cost Containment Newsletter stated in a special report that there is little doubt that home health care can be cost

effective. Reports by Blue Cross plans across the country attest to the savings being realized. Typical of the experience of acute-care institutions that have launched home health care programs was that described of Lutheran General Hospital in Park Ridge, Illinois. Officials at the 780-bed facility stated that by combining what they call Home Services with an intensive program of pre-discharge planning and counseling, they have been able to implement a policy of "early discharge" that is saving an estimated $490,000 a year.

Lastly, an article titled, "The Homebound Aged: A Medically Unreached Group," in the January, 1975 Volume of Annals of Internal Medicine states that home maintenance of an aged person is one-third or less as expensive as nursing home care. It was also suggested that home maintenance programs can save money by enlarging the role of nurses. Nurses can assume many of the physician's functions, under proper medical guidance. Nurses' salaries are lower than those of a doctor, and they are available in greater numbers

Role of the Physician

In 1960, the American Medical Association House of Delegates adopted a policy on home health care which recommended that "physicians be urged to participate in organized home health care programs for any patient who can benefit from the program, and to promote such programs in their communities." Since that time, AMA has continued to encourage physician usage of home health care services, and the establishment of home care programs in those areas that need such services.

To assist physicians and their patients in understanding home health care, AMA adopted the following definition of such care: "The

provision of nursing care, social work, therapies (such as diets, occupational, physical, psychological and speech), vocational and social services, and homemaker-home health aid services may be included as basic components of home health care. The provision of these needed services to the patient at home constitutes a logical extension of the physician's therapeutic responsibility. At the physician's request and under his medical direction, personnel who provide these home care services operate as a team in assessing and developing the home care plan.[15]

The AMA believes that high-quality medical care can be provided in the home, and that the individual and communal benefits of such care can be achieved most efficiently with physician involvement in both the planning and provision of services.

Physicians should not fear an increased exposure to medical liability as a result of involvement with home care services. An AMA booklet entitled "Physician Guide to Home Health Care" notes that no cases of alleged injury to patients who received services that were ordered by their attending physicians and were provided by the employees or agents of home health care agencies or organizations have been reported to date.[16] A physician who orders services from a home health care program is not a guarantor of those services. Because most home health agencies are separately incorporated, generally speaking, the physician who orders services from them is not held legally responsible for the negligence of the agency's or organization's employees.

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[15] Gary B. Schwartz, Physician's Support for Home Health Care, Hospitals, February, 1980, Vol. 54, No. 4, p. 52.

[16] Ibid., p. 56.

As in cases that involve injuries to patients allegedly caused by the negligence or omissions of hospital employees, the attending physician who orders the hospital services is as a general rule only held liable when it can be shown that he assumed control and/or supervision of the employees.

Because home health care agencies are required to have physician's orders in writing prior to the provision of such services, the role of the physician in the delivery of home care is very important. Along with members of the home health care staff, the physician is responsible for developing an individual treatment plan for each patient who receives home health care. The physicians should discuss the plan with their patients and should be informed of their patients' condition through follow-up and reports from home health personnel. Agencies should take the initiative in keeping physicians informed of their patients' condition, and physicians should consult with the nurse or other staff members about the patient and should participate in team conferences.

Despite the AMA's positive position towards the home health care, there appears to be a certain degree of reluctance on the part of physicians to fully participate. A 1974 home care study indicated that in a sample of 2,652 patients referred to a health department facility, only 17.5 percent were physician referred.[17]

Home Health agencies oftentimes have faulty images as evidenced by the fact that many physicians think that home care consists of the Visiting Nurse Association or the county board of health and involves

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[17] David T. Nash, J. Thomas Avno, Physician Referral Failure, New York State Journal of Medicine, January 1976, Vol. 76, pp. 46-47.

only patients who need minimal care. Many also think that home care is inferior care and that patients are better off in the hospital.[18]

Such views only serve to limit physician participation. The fact that reimbursement plans pay only for a physician's visit and do not cover the consultation and planning time spent by the physician also discourages physician participation. Team coordination is important in home care programs, and physicians who do get involved do a lot of extra non-reimburseable work. It is easier for physicians to be fully reimbursed for inpatient care.

A recent General Accounting Office report stated that physicians who authorize program services do not appear to be taking a very active role in the home health program. The report related that the intent of the authorizing legislation was that the physicians would play an active role in the home health program. In practice, however, this does not appear to be the case. For example, the GAO review disclosed that generally home health agencies and not physicians determine the nature and extent of services provided.[19]

Increased physician awareness and knowledge of the home care concept must be accomplished if the full potential of home health care is ever going to be realized. The success of the program is heavily dependent upon greater cooperation and participation on the part of physicians. Their role is most important and that conclusion must somehow be conveyed to them.

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[18] Alice Allgaier, Home Care Needs Physicians Who Care, The Hospital Medical Staff, May 1980, p. 2.

[19] General Accounting Office, Report to the Honorable Pete V. Domenici, United States Senate, Medicare Home Health Services: A Difficult Program to Control, HRD-81-155, September 25, 1981, p. 26.

CHAPTER III

METHODOLOGY

Design of the Study

The goal of evaluation research is to find out if a program is effective, that is, reaching stated ends. This study was not designed to determine the accomplishment of stated ends but to determine the level of agreement relative to program mission and/or purpose among the two principle providers of home health care: (1) the home health care agency and (2) the physician. In other words, this study is actually a step in the process of program evaluation that complements actual evaluation research. It examines first whether or not the program participants (home health care providers) are working towards the same ends or possibly at cross-purposes in certain instances. If program participants (the home health care agencies and physicians in this study) are not in agreement relative to program purpose, this author is of the opinion that such a situation only serves to limit the overall productive capacity of the program. Within any program greater goal consensus reduces the number and intensity of conflicts among members, thus improving the program's overall coordination.

There is considerable emphasis on the role of the physician throughout this study because the physician is a key figure in determining utilization of health services. The level of utilization of home health services by physicians, and the basis for not making use of the service, is examined. The degree of physician involvement is

also explored and, in addition, certain factors such as physician reimbursement, physician awareness, age, and medical speciality are analyzed to determine the nature and extent of any relationship among such variables.

Further insight into the role of the physician relative to the delivery of home health care services is provided by a depiction of their role from the home health agencies' perspective. This aspect of the study provides another means of examining the level of functional compatibility between physicians and the home health care agencies.

Lastly, this study is designed to identify current issues and problems throughout the North Dakota home health care delivery system, particularly from physician and agency perspectives. Additional views from other perspectives are also provided, including Blue Cross and Blue Shield as an insurer and an intermediary.

Data Source, Collection and Analytic Methods

Data for this study resulted from two independent surveys conducted during March, 1982. One survey was of physicians identified by selected specialty categories and practicing in North Dakota counties or cities where certified home health agencies were established. The other survey was of all North Dakota home health care agencies certified as of January, 1982.

The physician survey included those physician specialties which, by the nature of the practice area, are more apt to utilize home health services than others. The physician specialty areas selected for purposes of this study were as follows:

1. Family Practice

2. General Practice
3. Internal Medicine
4. Neurosurgery
5. Pediatrics
6. Oncology
7. General Surgery
8. Urology
9. Ophthalmology
10. Physical Medicine
11. Endocrinology
12. Cardiology
13. Obstetrics & Gynecology

A total of 417 physicians were identified throughout 13 North Dakota counties and one city applying the selected physician specialty and county/city criteria discussed above. The counties and city included in the physician study are as follows:

1. Burleigh
2. Cass
3. Dickey
4. Eddy
5. Grand Forks
6. McIntosh
7. Pembina
8. Pierce
9. Ramsey
10. Richland
11. Rolette
12. Stark
13. Ward
14. City of Jamestown

The response to the physician survey questionnaire was 44.6 percent resulting in a total number of 186 physicians participating in the study. The physicians' questionnaire (see Appendix B) was mailed with a cover letter and a self-addressed return envelope included. The North Dakota Medical Association provided a current list of licensed physicians in the state of North Dakota from which physician identification and location was accomplished.

The home health agency survey questionnaire (see Appendix C) was mailed to 18 certified home health agencies throughout the state of North

Dakota. The agency questionnaires were also mailed with a cover letter and a self-addressed return envelope included. A total of 16 questionnaires were returned which constituted a significant response of 88.9 percent. The home health care agencies included in this study were taken from a report provided by the North Dakota State Department of Health's Division of Health Facilities and are listed as follows:

1. Ashley Hospital Home Health Agency
   Ashley, North Dakota

2. City Nursing Service
   Bismarck, North Dakota

3. Burleigh County Home Health Agency
   Bismarck, North Dakota

4. Home Care Services, Inc.
   Bismarck, North Dakota

5. Pembina County Memorial Hospital
   Cavalier, North Dakota

6. Mercy Home Health Agency
   Devils Lake, North Dakota

7. St. Joseph's Hospital's Home Health Agency
   Dickinson, North Dakota

8. Southwest District Home Health Agency
   Dickinson, North Dakota

9. Fargo Community Health Center
   Fargo, North Dakota

10. The United Hospital Home Health Care Services
    Grand Forks, North Dakota

11. Jamestown Hospital Home Health Agency
    Jamestown, North Dakota

12. First District Home Health Agency
    Minot, North Dakota

13. Eddy/Foster County Home Health Agency
    New Rockford, North Dakota

14. Oakes Community Hospital Home Health Agency
    Oakes, North Dakota

15. Prairieland Home Health Agency
    Rolla, North Dakota

16. Good Samaritan Outreach Home Health Services
    Rugby, North Dakota

17. Richland County Home Health Agency
    Wahpeton, North Dakota

18. City - County Home Health Agency
    Valley City, North Dakota

Additional commentary concerning the effectiveness of home health care programs was also requested and received from the following organizations:

1. Division of Community Health Nursing
   North Dakota State Department of Health

2. Public Health Service
   Department of Health & Human Services

3. Blue Cross and Blue Shield of North Dakota

Data are statistically analyzed using frequency distributions and cross-tabulations. The SPSS computer package was used for data compilation and analysis.

CHAPTER IV

ANALYSIS OF DATA AND RESULTS

Physician Survey Findings

Characteristics of Respondents

The distribution of respondents in terms of length of time practicing medicine (indicated by the year of beginning to practice medicine) was broad. About one doctor in ten (9.9 percent) began practicing before 1950, while 10.5 percent had been in practice only since 1980. For the decades of 1950, 1960, and 1970 the percentages were 19.9, 21.5, and 38.1 respectively. The majority of respondents (58.2 percent) were in primary care practice areas (general practice, family practice, internal medicine or pediatrics). The balance of respondents were non-primary care specialty practices (e.g., surgery, obstetrics and gynecology, urology, etc.). The largest specialty group among the primary care physicians was internists (25.8 percent of all respondents) while the largest group of non-primary care specialists was surgeons (18.6 percent of all respondents). Most of the respondents were in some form of practice with other physicians (85.7 percent) while the others were in solo practice. More than nine of ten respondents reported patient care as their principal activity. Only a few reported teaching or other activities as their major time commitment.

Utilization and Referral

Physician referral to home health agencies was exceptionally high (85.5 percent) considering the fact that over 40 percent of the respondents were non-primary care specialty physicians. The number of referrals made by physicians ranged from 1-100 annually. The average number of annual referrals per physician was 13.1 and the median was 8.25. Due to the existence of several extreme values, the median may be a more accurate indicator of annual physician referrals.

The most often stated reasons for not referring patients to home health agencies were "was not aware of the availability of home health services," and "prefer follow-up office visits and/or physician home visits." Several comments indicated concern relative to the cost of home care and the quality of home care.

The general level of satisfaction among those physicians who had previous experience with home health care was very high. Over one-half of the respondents (58 percent) reported being "very satisfied" with home health services, 33 percent indicated that they were "somewhat satisfied" and most of the rest (8 percent) were "somewhat dissatisfied." Only one percent expressed considerable dissatisfaction.

The reasons for referring patients to home health agencies were indicated by physicians and a ranking of 178 valid responses is shown in Table 4.

It is most evident from the data that the primary consideration of the physician respondents is to aid family members in caring for patients. Their second consideration, most clearly, is to provide an alternative to institutionalization and presumably at less cost, as indicated by the fourth ranked consideration. It is rather interesting

TABLE 4

REASONS FOR REFERRAL TO HOME HEALTH CARE - PHYSICIANS

Reason	Number of Responses	Percent
To give family members assistance in providing care	127	71
As an alternative to a nursing home	105	59
To provide continuity of care	85	48
To provide less costly care	83	47
To instruct patient and/or caretaker about nursing needs	76	43
To provide a level of care more appropriate to need	73	41
To shorten hospital stay	68	38

that the reason "To shorten hospital stay" was the least important consideration of the respondents, particularly when this consideration is an often cited cost effective characteristic of the home health care concept.

A much broader perspective on home health care was gained from survey questions concerning the appropriate level of involvement desired by physicians and physician reimbursement for services provided under program guidelines. The majority of respondents (60 percent) reported that their present level of involvement was "about right" while another 26 percent indicated that more involvement is necessary. Only three percent stated that less involvement would be preferred and 11 percent expressed uncertainty.

Almost one-half (47 percent) indicated that reimbursement for their role in the delivery of home health services would be desirable while 30 percent were opposed. The remaining responses (23 percent) were uncertain on the question.

A significant number of respondents (50.3 percent) felt that they were not adequately informed relative to their role in home health care, 34.1 percent indicated that they were sufficiently informed and 15.6 percent were uncertain.

The hypothesis that there would be a direct relationship between physician reimbursement and level of involvement, with physician reimbursement being the independent variable, was tested through cross-tabulation analysis. It was expected that those respondents who desired reimbursement would also express a tendency towards greater involvement in terms of role and responsibilities. The cross-tabulation results, though significant ($P = 0.013$), did not sustain the hypothesis as there was no discernible relationship between the two variables (Goodman and Kruskal's Tau = 0.01).

The percentage of respondents who ever referred a patient for home health services was only slightly higher for primary care physicians than for non-primary care physicians, 90.2 percent vs. 87.6 percent, respectively. In fact, the percentage of surgeons (the largest in the non-primary care category who referred patients) was greater (94.3 percent) than the percentage for primary care physicians. This result was somewhat unexpected as one would logically reason that the broad based practice of primary care physicians would tend to demonstrate much higher levels of utilization than the more specialized practice of non-primary care physicians.

The majority of primary care physicians (53.1 percent) possessed a high home health rate of referral* while slightly more than 40 percent of non-primary care physicians maintained a high rate. These results are consistent with the explanation offered above.

The percentage of respondents who ever referred a patient for home health services was also slightly higher for physicians that had established practice prior to the year 1970 than for physicians that began practicing since 1970, 90.3 percent vs. 81.1 percent respectively. However, when utilization was examined in terms of rate of referral, slightly more than one-half (53.8 percent) of those physicians that had been practicing since 1970 demonstrated a high rate of referral while only 42.3 percent of those physicians that had established practice prior to 1970 maintained a high referral rate. These statistics examined together are somewhat confusing and contradictory. Although there is no clear explanation for these results, part of the explanation may be that some physicians view home health care as competition and thus are unwilling to avail themselves of such a service, at least not on a regular basis. There are many other factors that bear on these results, however, and thus further study of this particular outcome is necessary before any definite conclusions can be accepted.

The percentage of respondents maintaining a high referral rate was greater among those physicians who perceived themselves as being adequately informed (52.1 percent) than for physicians who considered themselves not well informed (46.6 percent) or those who were uncertain as to their level of knowledge (38.5 percent). These results are

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*Rate of referral was categorized as either high or low with a rate of 1-9 referrals on an annual basis considered low and 10 or above considered high.

consistent with the researcher's hypothesis that there is a direct relationship between level of awareness and utilization.

Summary of Physician Responses to Open-Ended Questions

Several areas of the survey questionnaire allowed the respondent to present further information or explanation of his/her remarks.

There were a significant number of comments offered which indicated a willingness to make more house calls. Although such an attitude is commendable and will certainly reinforce the overall concept of home health care, direct physician services are beyond the scope of home health care services in terms of this study and traditional reimbursement. Home Health care as defined by Medicare is primarily the provision of skilled nursing services and other therapeutic services, such as physical, speech, or occupational therapy, medical social services, and home health aide services.

One respondent expressed an opinion that home health care should play an expanded role in health care, particularly in North Dakota because of the state's rural character. Several physicians expressed concern over the qualifications of home health personnel and indicated that the agencies must strive towards gaining physicians' confidence in terms of competency if the program is to be successful. The most numerous remarks offered were directed towards the high cost of home health care services and that such high costs precluded the optimal utilization of home health care. There were a noted number of comments indicating a disdain for governmental involvement relative to the delivery of health care.

Home Health Agency Survey Findings

Characteristics of the Respondent Agencies

The oldest agency was one established in 1962 while the most recent was established during 1982. Annual agency patient caseloads ranged from 28 to 1,311 patients. The mean or average annual patient caseload was 298.7 with a standard deviation of 388.8. Annual agency visit caseloads ranged from 788 to 30,000 visits. The mean or average annual visit caseload was 5,014 with a standard deviation of 8,149.

Data concerning charges for services were collected relative to skilled nursing and home health aide services. Charges for the first hour of skilled nursing services ranged from $18 to $53 among all respondents. The mean was $34.69. Home health aide first hour charges ranged from $8 to $43 with a mean of $22.07.

Agency Mission or Purpose

The mission or purpose of the respondent home health agencies is reflected through a ranking of statements describing broad agency goals. A ranking of the 16 respondents' statements is shown in Table 5.

TABLE 5

RANKING OF HOME HEALTH AGENCY GOAL STATEMENTS

Statement	Number of Responses	Percent
To give family members assistance in providing care	15	93.8
To provide less costly care	15	93.8
To provide continuity of care	14	87.5
To provide a level of care more appropriate to need	14	87.5
To shorten hospital stay	13	81.3
To instruct patient and/or caretaker about nursing needs	12	75.0
As an alternative to a nursing home	11	68.8

Other statements describing an agency's purpose included: To promote independence and return the patient's family to independent level of functioning, To allow the patient to die at home with family support and to maintain quality and level of comfort until death, and To support the family and survivors through the bereavement process. There was one comment received from an agency which stated that home health is considered part of the continuum of care--not as an alternative to nursing homes. This view is somewhat opposed to the cost saving alternative to institutionalization argument that is embraced by many advocates of the home health care concept.

Home Health Agencies' Appraisal of Physician Participation

A greater level of physician involvement in home health care was desired by 75 percent of the agency respondents. The balance of respondents, or 25 percent, indicated that the present level of involvement was about right.

The response to the question of physician reimbursement was slightly in favor of physician reimbursement as eight agencies indicated that reimbursement should be allowed (50 percent) and seven agencies were opposed; one was undecided.

The respondent's appraisal of physician's knowledgeableness relative to home health care services was somewhat critical as 62.5 percent of the respondents indicated that physicians were not adequately informed, 31.3 percent indicated that physicians were adequately informed, and one agency (6.3 percent) was undecided.

The response to the question of responsibility for development of the patient's plan of treatment was as follows: ten of the sixteen respondents (62.5 percent) indictated that it was primarily the agency's

responsibility, four (25 percent) stated that it was the physician's responsibility, and two (12.5 percent) stated that a team approach was employed.

The relationship between patient caseloads and visit-loads and skilled nursing charges was comparatively analyzed as shown in Table 6.

TABLE 6

PATIENT CASELOAD

Range of Patient Caseloads vs. Skilled Nursing Charge

Annual Patient Caseload	28	30	35	40	70	71	100	350	360	470	720	1311
First Hour Skilled Nursing Charge ($)	40	45	20	40	25	43	24	42	40	25	40	30

Range of Visitloads vs. Skilled Nursing Charge

Annual Visitload	788	850	1000	1464	1800	1964	3623	4377	6000	7000	30000
First Hour Skilled Nursing Charge ($)	40	24	30*	43	40	45	35	30	53	42	40

*This amount is the mean (or average) first hour skilled nursing charge of two agencies possessing the same visitload estimates.

It is evident that there is no consistent pattern or trend towards lower charges as the caseload (volume) of the agency increases (i.e., economies of scale). Similar findings resulted upon analyzing patient caseloads and visitloads of home health aide charges. It was not expected, however, that there would be any evidence of economies of scale because the types of agencies (governmental, hospital-based, and proprietary) included in this study are mixed and thus the economics of the various

types of agencies differs. The service philosophy of agencies may vary also as certain agencies extend the welfare concept and subsidize the cost of services further than others.

Summary of Home Health Agencies Responses to Open-Ended Questions

The majority of remarks offered by the home health agencies concerned physician involvement and reimbursement. Several agencies indicated a lack of familiarity relative to the concept of home health care on the part of many physicians and one agency suggested that the problem may be the result of physicians not being exposed to such alternative modes of care through their previous training. Many remarks cited the need for greater cooperation on the part of physicians in terms of referrals and one suggested that the lack of referrals may be the result of "a feeling of being threatened and a feeling that home health agencies are competing for patients and revenue."

The issue of reimbursement provoked several mixed remarks. Several agencies stated that physicians should be reimbursed for their advice, orders, plan of treatment, certifications, etc., while others indicated that the existing methods of reimbursement are appropriate. One agency remarked in a summarizing manner that the present system of health care does not provide physicians with reimbursement for services incident to inpatient care, nor is there reimbursement when they take calls from patients throughout the community and thus implying that reimbursement should therefore not be available for services incident to the delivery of home health care. In addition, the agency stated that "physicians should view home health as a facilitator in providing care to patients in a different setting than institutional."

Remarks relating to the problem areas of home health care concerned a lack of <u>public</u> awareness and understanding of home health care and a problem of transportation (distance to travel) throughout rural North Dakota. There was also a comment hinting that proprietary agencies are abusing the program in terms of over-utilization of services for monetary gain only.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The primary purpose of this study was to research the effectiveness of home health care service delivery in North Dakota by means of examining the level of agreement (compatibility) among home health agencies and physicians in terms of overall mission or purpose and also individual roles and responsibilities. The following summary of findings presents the results of this research effort. Where appropriate, limitations to the findings have been offered.

A Summary of the Findings

The majority of respondents were primary care physicians. This result was expected because the concept of primary care is by nature total patient care.

The percentage of physician respondents that had experienced home health care (by means of initiating referrals) was very high (85.5 percent). However, this statistic must be cautiously interpreted because it is uncertain what the actual use of home health services is since only 44.6 percent of the target population responded. The level of satisfaction among respondent physicians was also high but this result must also be qualified by recognizing the fact that less than one-half of all potential respondents participated in the study.

A comparative analysis of the ranking of home health agency and physician program goal (mission) statements suggests that there is

considerable agreement in terms of providing the family assistance with the care of the patient. There is a certain amount of divergence or disagreement, however, relative to recognizing home health care as an alternative to nursing home institutionalization. The physician respondents indicated that home health was very important in this respect while five of the 16 respondent agencies did not include this particular goal as part of overall agency philosophy

Neither the physician nor the agency respondents, and particularly the physicians, attributed much importance to the potential of home health care in terms of reducing the length of hospital stays. This result is not consistent with the generally accepted concept of home health care being a cost effective program in terms of reducing the length of hospital stays. It was expected that this particular goal statement would have been accorded a much higher ranking by both physicians and agency representatives. Another limitation of the study data that must be recognized at this point, however, is that the number of home health agencies established in the State of North Dakota at the time of this study was small; thus measurement becomes much more sensitive. In other words, a slight change in data would produce a significant change in results.

On the issue of involvement, 75 percent of the home health agencies indicated that greater physician involvement is desired while 60 percent of the physician respondents stated that their level of involvement was about right. Only 26 percent of the physicians indicated that greater involvement was desired.

Approximately one-half (47 percent) of the physician respondents indicated that reimbursement would be desirable and exactly 50 percent

of the agency respondents agreed. However, the degree of opposition to reimbursement was greater on the part of the agency respondents (44 percent) than the physician respondents (30 percent).

Slightly over one-half (50.3 percent) of the physician respondents perceived themselves as not being adequately informed relative to the concept of home health care and this statistic was substantiated by the home health agencies' appraisal of physician knowledgeableness. Almost two-thirds of the respondent agencies (62.5 percent) indicated that physicians were not adequately informed. Only 34.1 percent of the physician respondents perceived themselves as being adequately informed.

Although the percentage of physicians that had experienced home health care was somewhat greater among older than younger physicians, the level or degree of utilization was greater among the younger physician group.

Conclusions

The following conclusions have been drawn from the findings. It is important to note that any conclusions based on the findings discussed above must be qualified because the number of physicians participating in the study is considerably less than the number of potential participants.

A further limitation is the small number of home health agencies available for purposes of study in the State of North Dakota. It is difficult to develop conclusions with a significant level of confidence from a small population.

1. There is a limited amount of disagreement relative to goal statements or program philosophy among physicians and home health

agencies, particularly in terms of recognizing home health care as an alternative to nursing home institutionalization.

2. Neither physicians nor home health agencies fully recognize the potential of home health care as an alternative to certain hospitalization.

3. There is considerable disagreement relative to the degree of involvement that is necessary on the part of physicians to increase the effectiveness of the home health program. The majority of home health agencies have indicated a need for much greater physician involvement while the majority of physicians feel that their present level of involvement is adequate.

4. The issue of physician reimbursement deserves further consideration as a greater number of physicians and home health agency representatives favored reimbursement over those that opposed it.

5. The majority of physicians do not perceive themselves as being fully knowledgeable or understanding of the concept of home health care. A marked number of home health agencies agree with this conclusion.

6. Length of time practicing medicine does not appear to be an appreciable factor in terms of program acceptance or utilization.

Although the cost of home health care services was not a primary consideration of this study, the issue did surface when the respondents (physicians) had an opportunity to comment via open-ended questions. There was sufficient comment generated through this study to warrant a secondary conclusion that the present costs of home health care services are preceptively high enough to discourage utilization to some degree.

Recommendations for Further Study

1. The North Dakota Association of Home Health Agencies, in cooperation with the North Dakota Medical Association, the North Dakota State Department of Health (Division of Community Nursing), and the various Health System Agencies, should develop a statewide education program designed to encourage greater physician participation through greater awareness and understanding. Greater agreement relative to program mission and purpose may also be achieved through such an effort.

2. That further research be conducted on the matter of physician reimbursement for their attendant role in the delivery of home health care services. A physician's role appears to involve considerable responsibility, time, and paperwork if it is carried out in accordance with program regulations. At the present time physicians are not compensated for their participation in home health care because such services are considered incident to the program. There is certain justification, however, to study the issue further.

3. That further research be conducted relative to the method of determining the costs of services among the various types of home health agencies. Present Medicare costing methods result in certain inequities among the various types of home health agencies, and appear to be particularly burdensome to hospital-based programs. Because North Dakota has a larger number of hospital-based programs than other types, this recommendation is important. Because hospitals possess considerable potential in terms of supporting home health care programs, particularly in rural settings (refer to Additional Views Section, p. 47), it is most important that inequitable cost factors be removed and thereby

encourage, rather than discourage, the further development of hospital-based programs.

CHAPTER VI

ADDITIONAL VIEWS

The following correspondence is information complementary to this study and includes letters from (1) the Department of Health & Human Services, (2) the North Dakota State Department of Health, and (3) Blue Cross & Blue Shield of North Dakota.

The letters were in response to inquiries made by this researcher for purposes of gaining further information on the subject matter. These views represent organizations that are indirectly involved with the system of home health care services but yet impact considerably in terms of program development quality, effectiveness, and financing.

There has been no attempt to incorporate these responses into this study in terms of developing conclusions or recommendations. The information, however, provides further insight into the problems and issues facing the development of home health care in North Dakota.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Region VIII

Federal Office Building
1961 Stout Street
Denver CO 80294

March 26, 1982

Dan L. Tinnes, Research Analyst
Bureau of Governmental Affairs
University of North Dakota
PO Box 7167
Grand Forks, ND 58502

Dear Mr. Tinnes:

I have received your letter dated March 4, 1982, regarding your study of the effectiveness and utilization of home health care services throughout North Dakota. The following are my responses to the questions that you asked:

1. The Federal Government established the grants for home health services program in an effort to develop and expand home health services to areas in which these services did not exist, or were insufffficent to meet the demand.

   A recent General Accounting Office study indicated that the care and management of some patients at home is less costly than caring for them in an institutional setting. However, it may be more costly to care for patients at home who are seriously disabled and need a considerable amount of constant attention and care. This is a question that is constantly asked about home health services. If we put as much energy into developing home health services as we do talking about this question, we would have the most effective and efficient home health care systems in the world.

2. I realize that many of your hospitals are small and are located in very rural settings. I also realize that some of these hospitals have occupancy problems. However, I do not think the development of a home health service in an area where there is a small rural hospital is counter-productive to the occupancy problem of the hospital. Patients who need home health services are patients who should be in a home setting and not in a hospital. A hospital will not solve its occupancy problems by keeping these patients longer than they should stay.

3. There are many serious problems that face the delivery of home health care in our country today, such as the cost of this service. However, the cost is not the only problem which effects the delivery of home health care in our rural areas. For example, there are people who think their county is an independent entity rather than an integral part of their

state. I have found this to be a problem in developing home health agencies which need a base of support that is larger than the population of one county. You would think that this would be a very simple problem to solve, but I have seen it prevent the development of home health services in rural areas.

The travel distance needed to provide services to some patients in their homes in a rural area is definitely an issue that must be addressed, and can be a deterrent in providing a full-range of services in rural communities.

4. The struggle for the limited number of health care dollars by the various types of providers is an issue that must be recognized and dealt with if home health agencies are going to survive. The ability of some industry associations to lobby for a significant amount of the Medicaid dollars in some states has effected the amount of funds available for home health services. Only three of the states in our Region have Home Health Agency Associations and only one of these has a significant membership. They are no match for the other industry associations who are also looking for a share of these funds.

One of your past State Health Officers stated that he would like to develop as many hospital-based home health agencies as possible, throughout the state of North Dakota. In a rural area, a hospital-based home health agency may be very appropriate since the hospital is the major health care organization in the area and everyone looks to it for health care. It has a billing and collection department and many of the other administrative mechanisms necessary to support a home health service that would be certified for Medicare and Medicaid. I support the development of home health services in official, private non-private and private for profit agencies, but in those rural communities where there are no other agencies with the capacities to develop additional health care services, the hospital may be the most appropriate institution.

Expanding the service areas of existing agencies to cover adjacent counties which have small populations makes more sense than developing new agencies with small populations that cannot support these services. This could help expand the delivery of home health in North Dakota.

Where possible, we have encouraged both public and private agencies to utilize personnel on an as-needed basis in outlying areas in an

effort to reduce travel costs. This may be an effective way to reduce the costs of services in rural areas.

The development of home health services in a rural state like yours is definitely a problem. However, I have had the pleasure of working with a number of competent people in your state in this endeavor. Your HSAs, especially the Agassiz HSA, have been very active in helping communities develop home health services. Your Director of Community Nursing, Laverne Lee, was most helpful when we were trying to develop home health grants in North Dakota. I have always enjoyed a good working relationship with the Health Facilities Section of your State Health Department. They were always ready to help agencies develop the appropriate materials needed to become a certified home health agency. These agencies have demonstrated a sincere desire to develop home health services in North Dakota and it would be inappropriate not to mention this in your study.

Please feel free to call me if you have any questions about the information in this letter. My telephone number is (303) 837-4781.

Sincerely,

Michael Oliva
Chief, North and South Dakota
Program Operations Branch

NORTH DAKOTA
STATE DEPARTMENT OF HEALTH
State Capitol
Bismarck, North Dakota 58505

M. A. K. Lommen, M.D., R.P.E.
State Health Officer

February 23, 1982

Community Health Section

Dan L. Tinnes
Research Analyst
Bureau of Governmental Affairs
University of North Dakota
Box 7167
Grand Forks, ND 58202

Dear Mr. Tinnes:

I am writing in response to your letter of February 19, 1982. I will answer each of your questions in numerical order.

1. The major advantage to home health care is the fact that it is a less costly level care. Equally as important is the opportunity for individuals to recuperate or, in some instances, die in the familiar surroundings of their own home. This fosters a certain level of independence and a great deal of happiness.

2. For starters - physicians should be aware that home health care exists and be willing to utilize the services. Because the level of care required by home health clients does not require more than a skilled nursing visit, physicians are not actually involved in the delivery of home health care. If a visit by a physician to the clients home would enable that individual to postpone or eliminate entering a hospital or nursing home, the physician should definitely be involved. I wonder how many physicians would want this type of involvement. The physician's visit should not replace the skilled nursing visit.

3. If physicians are making visits to a client's place of residence, the Home Health Agency should be entitled to bill for his services at a predetermined rate, established by a cost analysis and agreed upon by both the agency and physician.

4. Serious Problems:

   a. Financial: Home health services are not "money making." All agencies must be willing to absorb those clients whose condition does not fall within Medicare guidelines or who have no reimbursement mechanism.

b. In some areas of the state limited utilization by physicians is a problem.

c. As of the last legislative session Home Health Agencies no longer fall within the Certificate of Need process.

d. National home health groups proposing to flood the State home health market.

Sincerely,

LaVerne Lee, Director
Division of Community Health Nursing

Blue Cross
and
Blue Shield
of North Dakota

4510-13th Avenue S.W.
FARGO, NORTH DAKOTA 58121
701 / 282-1100

February 23, 1982

Dan L. Tinnes
Research Analyst
Bureau of Governmental Affairs
University of North Dakota
Grand Forks, North Dakota 58202

Dear Mr. Tinnes:

In response to your letter of February 19, I would first like to review how Blue Cross of North Dakota approaches home health care with regard to benefit payments.

Under the Blue Cross and Blue Shield system as a whole, home health care is divided into 3 categories: intensive, intermediate or custodial. At this time, most Plans reimburse for intensive home health care only. Some Plans are in the process of expanding their benefits to include the intermediate level, but this is a rare situation. For the purpose of administering benefits, intensive home health care is defined as services which include an array of professional, technical and other health related services usually provided by hospitals to inpatients. Such services are provided under active physician and nursing management. They are provided through a central administrative unit and are professionally coordinated by a registered nurse.

Intensive home health care is appropriate for patients who require active treatment or rehabilitation of an unstable disease or injury; require a concentrated degree of physician or professional nursing management including frequent observation or treatment; without the availability and use of home health care would require inpatient care.

Under the terms of the Blue Cross Hospital Service Contract, members are entitled to benefits for intensive home health care when provided by a licensed home health care provider, if home health care is in lieu of hospitalization or for the continued treatment of an acute or chronic illness for which the member was previously hospitalized and when a plan of treatment is submitted to the Blue Cross Plan which includes specific recommendations, as set forth by the attending physician, for the member's medically necessary care and treatment.

One of the issues you have raised is whether home health care is considered a cost containment alternative or if there are other considerations which would lead to the utilization of this type of care. Home health care is not viewed only as a cost containment alternative. While it is true that utilization of home health services in lieu of hospitalization can greatly decrease medical care costs, there are other factors which make home health care a desirable alternative.

Some conditions require continuous medical observation (continuous meaning once, twice or three times a day). However, hospitalization is not always necessary to provide this observation. Examples of these conditions are the problem pregnancy where the blood pressure must be monitored twice a day, a post surgical patient who needs a dressing change once or twice a day, the accidental injury patient who requires P.T. once a day, etc. In these instances, the level of care required may be safely rendered in the patient's home.

Another factor is that the patient may feel more comfortable and at ease in their home when receiving the care. A desire of the patient to be at home and the ability of the home health agency to bring care to the patient creates a very viable alternative.

It is also possible that the patient is not ambulatory and able to seek necessary care in the outpatient department, but not acutely ill enough to necessitate hospitalization. This type of situation creates an ideal environment in which an adequately staffed home health agency can thrive.

In response to the second issue raised, physicians need to be made more aware of the potential of home health care programs. Without physician support and approval, home health care programs cannot be effective. In most patient-doctor relationships, the patient relys on the physician to recommend the most appropriate source of treatment for their condition. If a physicain is not aware of the capabilities of a local home health agency or is not convinced that the agency can provide adequate care, he will be reluctant to refer patients to that agency.

A major challenge to new and existing home health agencies is to adequately promote their services to physician staffs in their communities, assuring both the physicians and the citizens of the community that a valuable service is present and should be utilized.

Your third issue is whether physicians should be reimbursed for their role in the delivery of home health services. Definitely; reimbursement should be available for the physician who renders medical care in the patient's home. However, reimbursement should be limited to only the care actually rendered by the physician.

The fourth issue raised is what is considered to be the most serious problem with home health care at the present time. In our experiences in establishing a home health care program for our members, there are three significant problems which provide obstacles for the program. The first is the lack of referrals by physicians. Agencies seem to have a problem soliciting the support of area physicians and attaining referrals. Without a close relationship with a clinic or a physician, the referral process is stifled and the home health agency's potential as a prominent health care provider within a community cannot be fulfilled.

-3-
Dan Tinnes
February 23, 1982

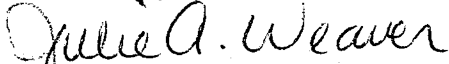
The second problem encountered by our staff in visting with home health agencies was that many of the agencies were not staffed to provide the intensive level of home health care to area patients. Many of their programs focused on the maintenance or intermediate care level and to provide an intensive level of care would have required that their personnel take a refresher or further training courses.

And finally, because North Dakota is a rural state, there are many small communities which take great pride in their local hospitals and clinics. There is a great deal of community spirit and drive that expresses a desire to see the local hospital survive, even in these financially difficult times. To "survive", the hospital must attempt to keep its beds filled. Therefore, there is no urgency or incentive for the early discharge of a patient and, as a result, not a great need for home care.

Blue Cross of North Dakota is very supportive of the further development of the home health care industry in North Dakota to provide an alternative source of necessary medical care to our subscribers. Our program has been in effect for approximately 3 years and, we are sorry to say, we have not seen a significant increase in the use of home health care services.

If you have any further questions or desire any additional information, please feel free to contact me at your convenience.

Sincerely,



Julie A. Weaver, Coordinator
Planning and Development

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APPENDIX A

Counties Certified to Participate in Medicare

APPENDIX B

Physician's Questionnaire

PHYSICIAN'S QUESTIONNAIRE

1. Have you ever referred a patient to the home health service in your community?

___Yes ___No

IF "YES", and considering your overall experience with home health care, how satisfied would you say you were? (Check one)

_____Very satisfied
_____Somehwat satisfied
_____Somewhat dissatisfied
_____Very dissatisfied
_____No experience with home health

IF "YES", what is the estimated number of patients referred during 1981? ______________

IF "NO", why haven't you referred patients to home health agencies?

_____Was not aware of the availability of home health care
_____Too Much "red tape"
_____Prefer follow-up office visits and/or physician home visits
_____The service provided is too costly
_____Concerned about quality of service delivered in the home
_____Other (Please explain)

____

____

2. In your opinion, which of the following reasons for referring patients to home health care are most significant? (Please check below)

_____a. To give family members assistance in providing care
_____b. To provide less costly care
_____c. As an alternative to a nursing home
_____d. To instruct patient and/or caretaker about nursing needs
_____e. To shorten hospital stay
_____f. To provide continuity of care
_____g. To provide a level of care more appropriate to patient's needs
_____h. Other (Please explain)

____

____

3. Do you think that physicians should become more involved or less involved with home health care, or do you think the present level of involvement is about right? (Please check below)

_____More involvement (see Question 3a below)
_____About right
_____Less involvement (see Question 3b below)
_____Don't know

3a. If you believe MORE involvement is needed, what involvement should be encouraged?

____

____

3b. If you believe LESS involvement is desirable, please explain.

____

____

4. Do you think physicians should be reimbursed for their role and responsibilities in the delivery of home health services?

_____Yes _____No _____Don't Know

5. Do you believe that physicians are adequately informed about their role in home health care delivery?

_____Yes _____No _____Don't Know

6. In which of the following activities do you spend the majority of your practice time?

_____Patient care
_____Teaching
_____Research
_____Other (Please explain)

____

____

7. When did you begin practicing medicine?

_____Prior to 1950
_____1950 - 1959
_____1960 - 1969
_____1970 - 1979
_____Since 1980

8. What is your medical specialty?______________________________

9. Please indicate your type of practice:

_____Solo
_____With others

REMARKS: Please feel free to make additional comments.

____

____

____

____

THANK YOU FOR YOUR ASSISTANCE

Please return to: Bureau of Governmental Affairs
Box 7167, University Station
Grand Forks, North Dakota 58202

APPENDIX C

Home Health Agency Questionnaire

HOME HEALTH AGENCY QUESTIONNAIRE

1. Which of the following statements concerning home health care do you consider consistent with the mission, purpose and philosophy of your home health agency? (Please check below)

_____To give family members assistance in providing care.
_____To provide less costly care.
_____As an alternative to a nursing home.
_____To instruct patient and/or caretaker about nursing needs.
_____To shorten hospital stay.
_____To provide continuity of care.
_____To provide a level of care more appropriate to patient's needs.
_____Other (please explain)

____

2. Do you think that physicians should become more involved or less involved with home health care or do you think the present level of involvement is about right? (Please check below)

_____More involvement (see Question 2a below)
_____About right
_____Less involvement (see Question 2b below)
_____Don't know

2a. If you believe MORE involvement is needed, please explain.

____

____

2b. If you believe LESS involvement is desirable, please explain.

____

____

3. Do you think physicians should be reimbursed for their role and responsibilities in the delivery of home health care services?

_____Yes _____No

Please explain your response:_________________________________

____

4. Do you believe that physicians are adequately informed about their role in home health care delivery?

_____Yes _____No

5. In what year was your home health agency established?_______________

6. What is your agency's average annual patient caseload and visit caseload? Patient____________ Visit____________

7. Please indicate your agency's <u>first hour</u> charge for the following services:
   a. Skilled nursing $________________
   b. Home health aide$________________

8. In your opinion, what are the most serious problems of home health care?

____

Based on the experience of your agency, the actual preparation of the home health patient's Plan of Treatment is usually accomplished by:

_____the home health agency

_____the physician

REMARKS:____

____

____

____

THANK YOUR FOR YOUR ASSISTANCE

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Grand Forks, North Dakota 58202

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