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PPS rollout: Agencies say predictions were on target

Cash flow, supply issues already are affecting home health

Credit home health industry experts with calling it right. October's rollout of the new Medicare prospective payment system (PPS) has led many agencies into a severe short-term cash crunch, just as predicted.

The decision of the Baltimore-based Health Care Financing Administration (HCFA) to bundle supply costs into the payment and require agencies to pick up the tab for supplies unrelated to the plan of care has caused problems for agencies, just as anticipated.

As agencies strive to be more efficient, they're starting to see changes in visit patterns that many in the industry had forecast early on.

But some say it's still too early to predict whether PPS will ultimately work — allowing home care providers to get needed care to their clients and be compensated fairly.

Joe Hafkenschiel, president of the California Association of Health Services at Home in Sacramento, says his member agencies are saying they don't yet know how well they're doing under the new system, in part because computer glitches and other start-up problems still are being worked out.

"This is a massive change," he says. "The point of comparison is, was it better than IPS [the interim payment system]? Well, anything would have been better than IPS. But is this a good system for paying providers to deliver home care? The jury's still out on that one."

Mary St. Pierre, director of regulatory affairs for the Washington, DC-based National Association for Home Care (NAHC), says reports to her organization have been mixed. Many have encountered problems submitting requests for anticipated payment (RAPs) because of software problems. The resulting slowdown in payments has forced agencies to rely on lines of credit they established before Oct. 1.

But others are able to transmit RAPs and final claims with relative ease. So far, no agency, she says, has indicated that it will have to shut

its doors because it can't meet expenses.

St. Pierre says agencies are beginning to adjust to the different expectations of the new system. "Providers I've talked to who really feel like they did their homework and prepared for PPS feel that they are doing very well with it," she says.

Glitches in the system

The experience of Home Health Group-Decatur (AL), shows how dependent agencies are on a smooth flow of data between them and their fiscal intermediaries.

Director **Jimmie Galbreath**, RN, MSN, says his hospital-based agency couldn't even send RAPs until Dec. 28, and was attempting unsuccessfully to transmit its first final bills in mid-January.

"The biggest problem was our computer software vendor was not prepared for the most part," he says. "HCFA was late sending out the final [rule], and then the software vendors not only had to write the program, but test the software at the same time."

As the vendor found problems with the software, it would issue fixes and upgrades — Galbreath estimates he's seen 18 upgrades since October. "We were getting two or three upgrades a week, and at some point we were saying, 'We can't wait for the next upgrade; we've got to go ahead and do something.' And the vendor was saying no, don't do anything yet because we've got a fix coming for this and a fix coming for that."

Galbreath says his agency had warned the hospital financial team ahead of time that billing was going to be a problem. But the software glitches ended up affecting more than just Medicare payments.

"With our software vendor, if you can't close your month, you can't bill anything," he says. "So we not only couldn't bill Medicare, but we couldn't bill any pay source of any kind.

"We had no billing going out after Oct. 1 for anybody, so there was no revenue coming in."

Complicating the issue was his agency's merger with another home health agency, effective Jan. 1. Both were hospital-based and were using the same software vendor.

Now, with payments finally coming in from last year's RAPs, that money is supposed to go back to the two hospitals. Revenue from 2001 bills will be applied to the newly merged home health entity.

Galbreath says he's been dissatisfied with the response of the software vendor, but doubts at this point that the agency could afford to make a change.

"These things are expensive — it would probably cost us $500,000-$600,000 for a new vendor. And when your reimbursement has been cut and slashed, it's not a good time to start going to your financial gurus asking for a $500,000 capital outlay. You usually don't get it."

But even smoothly running software hasn't guaranteed agencies a steady flow of income in the early months of PPS.

Cash flow a problem

H. Kenneth McNulty, vice president of finance for the Visiting Nurse Association of Boston, says cash flow has been a "significant problem," but not because of transmission difficulties. "We've probably sent in close to 4,000 RAPs, but the real issue is they're not really paying for the RAPs on the time frame they had led us to believe," he says. "It's running seven to 10 days to get a RAP."

Other factors can drag out the process longer. First, McNulty says, it can take time to get verbal orders and other documentation necessary to even submit a RAP. "Obviously, you can't do all the things they want to have you do in one day from the date of admission," he says. "So you have the start of care date and then you have to do all of the OASIS [Outcome and Assessment Information Set]."

If a patient requires the participation of multiple disciplines — a physical therapist, for example — that requires another visit to complete the OASIS, he says. "You've got all those complexities, and then you submit the RAP and it takes seven to 10 days to get your credit. So it's taking a long time."

He's finding the same kinds of issues in submitting final claims. Billing has to wait while documentation for all the visits trickles in, for example, from per diem aides who don't report to the office every day.

McNulty estimates that final claims can't be filed until another seven to 10 days after the end of the episode. While he concedes that his agency's fiscal intermediary is getting the payments back in 14 days, the process is still interrupting the immediate cash flow.

"We had a line of credit, and we're tapped out on it," he says. "I'm overdrawn at the bank as we speak. So far, the bank has covered us because we've given them all the documentation about

Taking steps to control supply costs

Agencies share strategies for coping with PPS

Some agencies aren't waiting to see what happens with supply costs under PPS. They've already taken steps to acquire new vendors and ensure greater oversight of supply use.

The goal: Keep overall costs down as much as possible, while still providing the best care. Sometimes, that doesn't necessarily mean cheaper supplies.

In fact, says **Jimmie Galbreath**, RN, MSN, director of Home Health Group-Decatur (AL), his agency has often turned to more expensive wound care supplies that can save the agency in the long run by requiring fewer visits to change dressings.

"It's cheaper for the agency to use a more expensive supply and go less frequently than it is to go daily and use a less-expensive supply," Galbreath says. "Before, it was normal saline, [gauze], and tape, and you'd do it daily. Well, that's OK; but if you use Duoderm and it's changed twice a week, is it as effective — or even more effective? It just depends on the wound."

Home Health Group also shopped around for a cheaper vendor before PPS was implemented.

At the Visiting Nurse Association of Boston, a system was instituted to give more oversight to supply orders. **H. Kenneth McNulty**, vice president of finance, says a supply committee of clinicians created a new formulary for the agency, showing supplies that should be used for different types of cases. The list was distributed to district offices.

On each clinical team, one person was given responsibility for ordering all supplies. A nurse now submits an order to the district office, where it's reviewed to make sure it's appropriate for the diagnosis and the quantities needed are correct.

Total supply costs for each patient also are reviewed, and a unit supervisor must sign off on any order that exceeds a certain amount. McNulty says that while some patients will inevitably exceed that amount, the overall average should stay within a certain range.

"It's perfectly acceptable for the cost to be more than [the limit]; if in fact, the clinical diagnosis required those supplies," he says. "But you've got to justify that."

Doesn't this create more paperwork for the staff? "It is a pain," McNulty says. "And it's tough on the folks in the unit. But once they get used it to it, it just becomes one more thing in their day and they just do it.

"It's also true that the nurses knew they could have been doing a better job reducing costs without a whole lot of effort."

Galbreath says that Home Health Group is now considering a new arrangement for delivering supplies — contracting with a supplier that can deliver them directly to patients. This saves clinicians time spent delivering supplies themselves, an important step when the goal is to improve efficiency.

Combined with a proposal to issue nurses laptop computers, it could mean much less time spent in the office and more time spent with patients.

"We want staff under PPS to be delivering care and providing care," Galbreath says. "We don't want staff to be coming in and out of the office to get what they need in order to provide the service to the community. We're paid by the services we deliver, not what it costs us to operate."

He says direct delivery of supplies wouldn't be appropriate for all patients, including some who live in high-crime areas or those whose home environments can't support hygienic storage. ■

what's going on. But we're not paying bills. We're making the payroll, but that's all. And they're letting me go overdrawn to do that."

In January, he was pleading with his fiscal intermediary to expedite payments under the temporary extension of the periodic interim payment (PIP) approved late last year.

St. Pierre says the PIP extension may have helped some agencies hold things together a while longer, depending on when their cost reporting period ended.

When the final rule was published last year, home health providers objected to its handling of supply issues — specifically the bundling of

supplies into the episodic payment and the requirement that agencies provide all nonroutine supplies used by the client, even those unrelated to the plan of care.

At the time, there was concern that the arrangement would put a burden on agencies with a high volume of certain types of cases, such as patients with wounds. And agencies were unsure how they'd keep track of supplies that arrive from other sources.

In its initial months, providers agree, the effect of the supply requirements has been pretty much as expected. And some agencies have established plans to help keep a handle on rising supply costs **(see story, p. 27)**.

Lucy Lee, RN, MHA, CHCE, owner of Lee Health Care Inc. in Hamilton, TX, says because her agency is small, she thinks the problem is manageable — as long as she doesn't have a lot of wound care patients.

"But especially with small agencies like we are, it doesn't take many to skew the numbers to the point that it would be a big problem," she says. "We're maintaining control at this point; it's all we can do."

St. Pierre says that when NAHC queried members to prepare the association's regulatory blueprint for action for 2001, medical supplies were ranked as the top issue among 35 issues surveyed. "It's their biggest concern that they want us to take some action on."

While she doesn't think HCFA will change its interpretation of the rules, the agency may support the industry's position in Congress.

In fact, while Hafkenschiel overall advises holding back on many changes to PPS for the next few years while things shake out, he says supplies are the big exception.

"The medical supply issue is still very confusing and very problematic," he says. "Certainly, we don't feel the agencies should be responsible for medical supplies that are not part of the plan of treatment for a specific patient, so we'll be pushing for that."

Already signs of change

Although analyzing the effects of PPS has temporarily taken a back seat to working out its mechanics — it's hard to note trends when one hasn't yet been able to transmit claims — agencies already have seen some changes in their visit patterns.

Some are the results of concerted pre-PPS efforts to emphasize efficient delivery of care. But others are not as easy to explain.

Lee says she noticed soon into the PPS rollout that her agency didn't have as many episodes as she had expected. "Primarily, we have found that in most of our areas, the intakes are remaining pretty steady in number, but we're not recertifying people as much as we thought we would. It's hard to know whether it's a market change or a market shift. And I'm wondering if our nurses' thinking has shifted, perhaps."

She's not alone. Galbreath, too, saw fewer recertifications for the second episode than he had expected, and thinks the staff's mindset may have something to do with it.

"I think they're getting out there teaching and being more aggressive," he says. "There was not a strong reason for having to be superaggressive before; because as long as that patient was homebound, you were showing improvement and you could justify your visit, then you were going to be okay and you were going to be paid.

"Now you're paid per diagnosis, so the sooner you get in there, the sooner you get taught and the sooner you get out, the better your reimbursement."

Galbreath says he's also seen a decrease in the number of visits per patient — from an average of 30-35 last summer to 14 in November. Those decreases have been consistent across disciplines.

Sources

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McNulty believes that one factor in changing visit patterns is the 60-day episode and the process required to recertify a patient for the next episode.

"Where in the past they might have held off on discharging a patient, now the discharges are getting done on a more timely basis," he says. "It looks to us like the total unduplicated census will go down, but on a 12-month rolling average basis, it will not. We'll still have the same number of patients a year; they just won't all be out for more than one month, so their length of stay will be shorter. But the number of visits won't."

From an operational end, McNulty is noticing another change — an emphasis on tightening up procedures to make sure things get done quickly. That has become more important as many agencies change their billing practices from monthly to weekly and even daily.

"You've got to have procedures in place to be sure that everything that needs to be done gets done, and it gets done within the time frame that is appropriate and is required," he says. "Once we get over the hump of the working capital problem, I think it should work. But it's important that everybody's got to understand the sense of urgency of getting everything done, done on time and done right the first time." ■

Agency brings back house call doctor visits

Research shows better outcomes with MD team

Here's an ad that you won't see in many newspapers, at least not yet: "Home Care Opportunities for Physicians . . ." But that's exactly what was said in an ad recently placed by The Visiting Nurse Association (VNA) of Greater Philadelphia.

The large home care agency, which has about 250,000 visits in southeastern Philadelphia, has added a physician and nurse practitioner service to its home care operations.

"When you look at the breadth of our services, we're typical VNA with everything from prenatal to hospice and all kinds of specialties," says **Lynn T. Rinke**, RN, MS, executive vice president CEO. "What we missed was the ability to prescribe and diagnose, and you can only do that with doctors and nurse practitioners."

The idea of a home care agency employing a full-time physician in a role other than medical director was so novel that the agency's managers spent several years overcoming all of the legal and regulatory obstacles.

One hurdle — which was recently eliminated — making it far easier for other home care agencies to hire physicians, was a change in the Stark II regulations that permits home care agencies to employ physicians and pay them an uncapped salary.

"When the Philadelphia VNA set up its physician home care program, it had to abide by the federal regulations that said a home health care agency that employs a physician could not have that physician sign-off on plans of treatment if the physician was paid more than $25,000 a year," Rinke says.

Regulation change necessitates

This regulation forced the VNA to form a parent corporation called Philadelphia Home Care that has two operating entities, the VNA of Philadelphia and HouseCalls. The doctors and nurse practitioners are hired by HouseCalls.

"That way the referrals can go between the VNA and HouseCalls," Rinke says.

Other home care agencies will have a much easier time establishing a physician home visit program because they can simply hire the doctor, Rinke notes. "The main hurdle is that home care people don't see themselves as being at the top of the food chain; but if you have the doctor, you are at the top of the food chain."

As complicated as it was to establish, why did

Special report: Home-based primary care

Homecare Quality Management brings you this two-part series on how home care agencies can provide in-the-home physician and physician-extender services to current and new home care patients. In the April issue, look for more information on the topic, including a story about a Veterans Affairs study evaluating the effectiveness of team-managed, home-based primary care. ■

the VNA want to provide physician home care services?

"Our colleagues don't understand why this makes so much sense," Rinke says. "From a purely financial perspective, it makes us the primary care provider, and now we have the patients."

For example, when the interim payment system went into effect, many home care agencies, hospitals, and other providers began to merge, form affiliations, and otherwise join forces. In Philadelphia, that meant one large university hospital that used to refer some 400 patients a year to the VNA began instead to refer those patients to the home care agency with which it became affiliated. By owning a physician home care business that can also see patients who may need other home care services, the VNA replaced that 400 patient referral source, Rinke explains.

"In the course of any 12-month period, 95% of those patients will need home care," she says.

This is because the physicians are seeing homebound patients who typically have chronic conditions.

Home care docs save ER costs

"Most of these patients haven't been seen by a physician for a number of years, and most have accessed emergency rooms when they had some exacerbation of their condition," Rinke says. "Then they go home and there is no follow-up, so it's an expensive way to treat people."

As an alternative, the HouseCalls physicians and nurse practitioners will visit the patient's home, sometimes as often as once every four to six weeks. Those visits help to prevent emergency room visits and returns to the hospital, an outcome that the VNA plans to measure as the program evolves. **(See story on how HouseCalls program works, p. 31.)**

A recent study, conducted by Veterans Affairs (VA) researchers and funded by the VA Health Services Research & Development Program and the VA Cooperative Studies Programs, already shows positive outcomes associated with physician home care services.

The VA has a home-based primary care program that is physician-led, but also consists of nursing, therapy, social work, and dietary services, says **Frances Weaver**, PhD, deputy director of the health services research and development center at Hines (IL) VA Hospital. She's also a research associate professor at the Institute for Health Services and Policy Research at Northwestern University in Evanston, IL.

The VA study found that patient satisfaction was higher with the team-managed home care program than with customary care, and patients experienced an improved health-related quality of life. Costs were higher, however, averaging 12% more than the customary care group.

"So what it boiled down to is a cost-quality trade-off," Weaver says. "How much additional dollars are you willing to pay to provide care that results in higher satisfaction of care and improved health-related quality of life and reduced caregiver burden?"

Exploring quality outcomes, saving money

The Visiting Nurse Association of Philadelphia benefits in multiple ways, both financially and from a quality perspective, from being linked to a physician home care service. And while the overall health care cost impact has not yet been assessed, Rinke predicts it will save dollars in the long run because those patients will not enter nursing homes as early as they might have without the service.

Another Medicare change of recent years that has made physician home care visits more lucrative has been the change that has Medicare Part B recognizing nurse practitioners as primary care providers in all regions. Previously, they were recognized only in rural areas.

"Prior to the change in the Balanced Budget Act of 1997, we were looking at how we could afford to have doctors on staff because doctors are expensive," Rinke says. "But with the right mix of doctors and nurse practitioners, you should be able to make it work."

The program's goals are threefold: to improve patient care outcomes, become financially viable, and achieve replication of the physician home care services model among other home care agencies.

Quality outcomes that will be analyzed and explored include:

- functional status;
- symptom management;
- medication management;
- emergency room visits;
- hospital admissions;
- nursing home admissions;
- inpatient length of stay;
- patient and family satisfaction.

In fact, the service has already resulted in one 15-year nursing home resident being discharged to her daughter's home, Rinke says. A young woman

lost her father to a sudden death when she was a teen-ager; soon after his death, her mother had a stroke and had to be admitted to a nursing home. "This woman vowed to her mother that when she could she'd bring her home," Rinke recalls. "So many years later, this daughter is bringing her mother home; without our services, she could not do this."

The HouseCalls service is building toward financial success, and it already has become successful clinically and with regard to patient satisfaction, Rinke says.

"People love their visiting nurse; multiply that by 10, and that's how they feel about their nurse practitioner," Rinke explains. "Patients are just so thrilled that we are willing to come to their home and provide them with necessary care."

Although the results of patient satisfaction surveys have not yet been tabulated, the return rate of the actual surveys is about 80%, double what it has been for the traditional home care agency. "And 80% of the surveys we get back have notes from patients who've taken time to handwrite a note specifically about their care, naming every practitioner who they have had encounters with and naming office staff who were helpful to them on the phone," Rinke says. ■

Agency provides needed services to patients

VNA service well-received by all involved

The Visiting Nurse Association (VNA) HouseCalls, which was founded by the VNA of Greater Philadelphia, provides a needed medical service to homebound patients by sending physicians and advanced practice nurses (APNs) to patients' homes.

Although the service is fairly new, it has quickly become popular among patients and has had no difficulty recruiting staff, says **Lynn T. Rinke**, RN, MS, executive vice president and chief operating officer.

Here's how the physician home care service works:

1. Recruit physicians and physician-extenders.

The home care agency has had little difficulty finding physicians who are willing to be employees and visit patients in their homes.

"Doctors don't want to be involved with all the billing garbage, and they don't want the hassle of running a small business," Rinke says. "They just want to see patients."

One of HouseCalls' physicians said that she wanted to be 100% clinical with no administrative work, Rinke says. "She had a medical assistant she brought with her from her previous practice, and he was the office manager."

Depending on a state's prescribing and referral regulations, a home care physician practice could save some expenses by having physician-extenders, such as nurse practitioners and physician assistants, also make home care visits. The VNA now has two full-time physicians and four full-time nurse practitioners.

2. Establish services.

The physician home care services include having physicians and nurse practitioners visit homebound patients, typically patients with chronic conditions who are covered by Medicare B insurance. It's a patient-driven, comprehensive, and collaborative primary care model.

A nurse practitioner will visit each new patient for two to three hours. The visit includes a thorough history and physical and evaluation of the patient's home environment, and psychosocial and medical history.

Other services include:

- assessing the patient's ability to perform activities of daily living;
- minor skin surgery;
- writing prescriptions;
- diagnostic tests and medication management;
- Pap smears;
- symptom evaluation and treatment;
- osteopathic manual medicine;
- routine lab services;
- home safety advice;
- caregiver support and advice;
- referral to other medical or community services;
- home care coordination.

The physicians or nurse practitioners typically visit patients once every four to six weeks. They assess patients' medications and make changes when appropriate. They also assess the patient for comorbidities that were previously not diagnosed, including depression which is common among such patients.

Depressed patients can be seen by HouseCalls' psychiatric nurse, who may also provide behavioral therapy intervention. The staff also are available to patients on a 24-hour basis through an on-call service.

HouseCalls' patients may include the physicians' own patients or patients who are referred by community physicians who do not desire to make home care visits.

"The community doctor usually asks the nurse practitioner," Rinke says. "Usually, the visit targets some specific issue the doctor wants addressed, and then if the patient gets better and goes back to the community doctor's office, that's fine."

The key to making the service successful financially, as well as clinically, is for the physicians and nurse practitioners to learn how to provide every needed health care service during their home visits.

Often what happens is the HouseCalls service will see the patient for six months or longer, and at some point the community physician will suggest transferring the patient into HouseCalls' practice, Rinke adds.

HouseCalls potentially could provide a variety of health care services, including foot care, ear lavage, cognitive exams, hospice care, dietary consultation, and others.

Podiatry visits can increase revenue

"One of the services we want to add is podiatry where we hire a podiatrist to make 10-15 home visits per day," Rinke says, adding that this could increase revenues substantially.

The key to making the service successful financially, as well as clinically, is for the physicians and nurse practitioners to learn how to provide every needed health care service during their home visits.

For example, the psychiatric nurse could conduct a mini-mental exam on every patient who has suspected psychological or cognitive difficulties. This exam is reimbursed by Medicare at a rate of $80 to $100. **(See following story on how to maximize reimbursement for physician home care services, right.)**

3. Organize office to manage reimbursement issues.

One of the main reasons physicians are interested in becoming employees is to eliminate the office management and reimbursement hassles.

HouseCalls has a medical practice director whose job is to run the office like a business while looking closely at the bottom line.

Before hiring the new director, HouseCalls staff have not been collecting all of the reimbursement they were entitled to collect. For instance, no one had time to bother collecting the copay and deductible dollars, which are similar to what patients would pay if they were to visit a doctor at the doctor's office. "But we hadn't invested anything into the infrastructure to collect these," Rinke says.

HouseCalls improved its billing process by purchasing an inexpensive software package to generate bills. Physicians generate the bill after a visit by identifying the level of home visit, and any procedures performed in the home. Then the physician ranks the patient's diagnoses. The electronic bill is then handled by the finance staff, who submit it to Medicare. ■

Make the most of Medicare reimbursement

HouseCalls relates own learning experiences

Adding a primary care practice to your home care services may be complicated and expensive at the beginning. But there are some strategies that can make the whole learning curve a lot shorter than it otherwise might be.

For instance, it's important to know exactly what sort of services and procedures will be covered under the Medicare Part B Physician Fee Schedule, which would be the primary reimbursement for such services, says **Lynn T. Rinke**, RN, MS, executive vice president and chief operating officer of The Visiting Nurse Association (VNA) of Greater Philadelphia. The VNA formed a separate business, VNA HouseCalls, in order to begin offering primary care services to homebound patients.

The Baltimore-based Health Care Financing Administration (HCFA) published in January 1998 the Medicare Part B Physician Fee Schedule, which included changes that improved reimbursement for home care physician visits. The number of current procedural terminology (CPT) codes went from six to nine, and reimbursement rates rose from the previous range of $45-$98 to a range of $46 to $173 per visit. In January 2000, the new

Medicare Part B physician schedule of fees increased again to a range of $61 to $200 per home visit.

HCFA changes no help

"None of HouseCalls' patient visits results in the lowest payment because all of the patients have complex cases," Rinke says.

"You go see a doctor because you have a sore throat, and the doctor looks at your throat, writes a prescription, and you leave," she explains. "That type of simple intervention never occurs with our patients because they are all old with multiple morbidities, so our visits tend to average $150."

HouseCalls physicians and nurse practitioners have learned to bill for every single reimbursable intervention and service they provide. For example, the psychiatric nurse will bill for a behavioral therapy intervention that she provides to a moderately complex patient who has a clinical psychiatric disorder.

"There are four or five behavioral interventions and probably 40 other procedures we can do in the home and bill for," Rinke notes.

It's important to keep in mind that the allowable reimbursement for nurse practitioner services is less than it is for physicians, but this doesn't have to be a financial problem so long as all options are explored, she adds. For example, a nurse practitioner is paid 85% of what's allowable for physicians for general medical services. However, for psychiatric visits, the nurse practitioner receives only 66% of what the physician would have received.

Discovering untapped revenue

"At the beginning — because we didn't know what we were doing — a lot of psychiatric nurse visits were billed just for behavioral interventions, which is the 66% reimbursement," Rinke says. "Then we asked the nurses what else they do when they make one of these visits, and we learned that they do an evaluation and management visit, as well as the intervention."

These extra services were potential untapped revenue because those services could be billed at 66% of what the physician would have received.

HouseCalls also bills for care plan oversight, which generates $100 per month per case, and a little less than one-third of patients receive care plan oversight, Rinke says.

Then, starting this year, the business can start billing for physician sign-off on the patient certification or recertification for traditional home care services. An estimated 95% of the HouseCalls patients will have at least one episode of home care within the year, Rinke says.

Now Medicare will pay physicians $75 for every certification and $60 for every re-certification they sign, she explains. "This is a brand new revenue source."

By HouseCalls' 11th month of operation the practice was generating enough revenue to cover its costs. The goal is to have it make a profit or break even, when taking all overhead and other expenses into account, by the third year, Rinke says.

Also, HouseCalls should do very well under the prospective payment system (PPS), she notes.

"These patients are the patients you want in PPS because most of these patients should have six 60-day episodes in a year," Rinke says. "They are sick and with PPS, we want these patients because HouseCalls' referrals to the VNA will be on average much more profitable than the average referral from a local hospital."

A future source of revenue potentially will be managed care organizations, which could benefit from having lower long-term costs in managing the care of patients with chronic and comorbid conditions.

It costs insurers about $500 just for an ambulance trip when one of these patients has an exacerbation of a chronic condition. HouseCalls could, for about the same price per visit, prevent multiple emergency room visits and hospitalizations, Rinke predicts.

In a couple of years HouseCalls should have ample data to prove that theory, she adds. "It may cost an HMO $7,000-$8,000 a year to have

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a person by our primary care patient, but that's nothing compared with one hospitalization." ■

Train staff to identify psychiatric disorders

Maryland study points to benefits of referrals

A Baltimore program that trains public housing staff to identify elderly residents with undiagnosed psychiatric symptoms could have relevance for home health agencies, one of its coordinators says.

"We believe that nurses are in the best position to be able to look at folks and make an assessment and bring the psychiatric issues to the attention of the primary medical provider," says **Beatrice Robbins**, RN, CSP, manager of geriatric outpatient mental health services in the community psychiatry program at Johns Hopkins Bayview Medical Center in Baltimore.

"Our point in educating the folks in the housing situations was not to teach them to diagnose, but to help them recognize unusual behavior as not just being 'nuts,' but a sign that a person may have some serious medical psychiatric problems."

Robbins says that uncovering undiagnosed psychiatric problems can result in an outcome near and dear to home health nurses' hearts — keeping a patient in the home longer. She says the erratic speech and behavior associated with such mental health problems as dementia, depression, and schizophrenia often lead to public housing residents' evictions.

"If we can get them assessed and get them on medications, they can lead a very pleasant, normal life and stay aging in place."

Outreach program leads to treatment

According to the U.S. Department of Health and Human Services, the prevalence of mental illnesses among the elderly is approximately 20%. That number would include patients with early-onset disorders such as schizophrenia, as well as later-onset dementias and other illnesses.

Psychiatric disorders aren't easily diagnosed

Unfortunately, Robbins says, those disorders aren't always quickly diagnosed, even if a patient is seeing a doctor regularly. It's a twofold problem, she says: Physicians aren't quick to pick up on the clues, and patients are reluctant to share their fears about mental illness.

"I think the general medical providers are just not as alert to the symptoms of mental illness as they should be," Robbins says. "The primary care providers seem to focus on medical issues and just don't see the psychiatric components. Someone who has a depression can present by being sluggish, not motivated, etc., and [doctors] look for the medical cause rather than the psychiatric cause.

"At the same time, I think the geriatric

Mental health resources

For more information on mental disorders, contact the following organizations:

- **National Alliance for the Mentally Ill**, Prince Georges County chapter — Agnes Hatfield, who works with this organization, says it has fact sheets available on different mental disorders and coping strategies. P.O. Box 959, Greenbelt, MD 20768. Phone: (301) 925-7373. Web: www.nami.org.
- **American Psychiatric Association** — this professional organization also has fact sheets for consumers and ordering information for useful reference books. Web: www.psych.org.
- **American Association for Geriatric Psychiatry** — provides consumer information on depression and other mental disorders, ordering information for publications, and information on geriatric psychiatrists available locally. Web: www.aagpgpa.org. ■

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Source

- **Beatrice Robbins**, Manager of Geriatric Outpatient Mental Health Services, Community Psychiatry Program, Johns Hopkins Bayview Medical Center, Mason Lord Building, D3-East, 4940 Eastern Ave., Baltimore, MD 21224. Phone: (410) 550-0019. Fax: (410) 550-1748. E-mail: brobbins@jhmi.edu.

population is not ready to come forward with mental health issues."

A team from Johns Hopkins responded with a new approach: A grant-funded psychogeriatric outreach program targeted at elderly residents of high-rise public housing buildings in Baltimore.

The Psychogeriatric Assessment and Treatment in City Housing (PATCH) program relies on specially trained public housing staff — everyone from management and social workers to cashiers and maintenance staff — to identify seniors who may need help.

The resident then would be contacted by a psychiatric nurse, who would ask to come to the resident's home to do an evaluation. During that visit, the nurse would take down a psychiatric, medical, and social history. The case would be presented to a team psychiatrist, who would accompany the nurse on a subsequent home visit and develop a treatment plan that includes further in-home visits.

More residents take advantage of system

In its 13 years, the program has expanded to all of Baltimore's 17 public housing developments for the elderly. Robbins says that within individual sites, more residents have taken advantage of the referral system, referring spouses and even themselves.

"For someone to feel comfortable enough with us to self-refer that was the most incredible outcome measure," Robbins says. "It really demonstrated that we, the nurses in the program, were doing something right, to be able to approach us."

Clearly, agencies already stressed by the outpatient prospective payment system and other budget strains may lack the resources to mount a program as expansive as Johns Hopkins'. But Robbins says home health staff, who meet with patients over time and see them more intimately than a physician would, are in an ideal position to take note of possible psychiatric symptoms and notify the primary physician.

"An educational program is the way to start

CE objectives

After reading each issue of *Homecare Quality Management*, the quality manager will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care management.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Cite practical solutions to the problems that their profession encounters in home care and integrate them into their daily practices. ■

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with home health staff, the aides and nurses — they are the front line, they are the ones who see people most often in the home health situation," Robbins says.

The PATCH program uses a series of monthly inservices for public housing staff, in which PATCH nurses cover a range of topics including depression, dementia, schizophrenia and substance abuse.

They discuss the emergency petition process for emergency interventions, as well as scheduling additional inservices for other topics suggested by the staff.

Robbins suggests agencies seek out community resources, particularly any local geriatric psychiatry resources.

Once trained, the lay "case finders," are surprisingly good at identifying patients with problems. A study done in the early years of the PATCH program showed that 89% of residents who were referred did end up having a psychiatric diagnosis.

Some of the cases were fairly extreme: an elderly couple who accused neighbors of subjecting them to X-rays, or an 83-year-old schizophrenic woman who described hallucinations.

But other problems picked up on by housing staff were subtler, Robbins says. "The staff thought one lady was pretty strange because she would go out and walk around the building at certain times of the day in certain patterns," she says. "They just thought that she was kind of odd and unusual, while in fact she was a person who was diagnosed with schizophrenia that wasn't being treated. So she's being talked about as this kooky, eccentric person when in fact she was a person who had a significant need for treatment."

Reach out to other geriatric organizations

Robbins suggests agencies seek out community resources, particularly any local geriatric psychiatry resources. Those professionals can act as consultants to develop educational programs, as well as becoming a resource when a patient requires intervention.

Robbins says she'd like to see the PATCH program extended outside of its roots in public housing, in order to reach seniors in the general population. It would be a more difficult task to identify seniors who need the help — a role she suspects would be a perfect fit for home health.

Related reading

• Rabins P, Black B, Roca R, et al. Effectiveness of a nurse-based outreach program for identifying and treating psychiatric illness in the elderly. *JAMA* 2000; 283:2,802-2,809. ■

Update

Information that appeared in the January issue of *Homecare Quality Management* regarding the Ernest A. Codman Award has been updated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The entry fee for applications is $350. Winners will present their winning initiatives in November at a JCAHO conference in Chicago.

The deadline for applications is April 2. ■