AMERICAN HEALTH CONSULTANTS®

HOMECARE
Quality Management™

INSIDE

APRIL 2001

VOL. 7, NO. 4
(pages 37-48)

Experts say home care staffing may be a long-term problem

Joint Commission committee is taking close look at issue

The health care industry's difficulty in recruiting all of the necessary professional staff has taken on a new sense of urgency this year as the National Association for Home Care (NAHC) and the American Hospital Association (AHA), both of Washington, DC, have brought the problem to the attention of Congress.

Both organizations contend that today's employee shortage is different from the cyclical shortages of previous years because it's the beginning of a long-term shortage. This problem is compounded by the demographic trend of aging baby boomers, who will use health care services in unprecedented numbers as they turn 60 and older in the coming decade. **(See story on AHA and NAHC reports to Congress, p. 39.)**

Home health agencies are suffering from the combination of nursing and aide shortages, says **Mary St. Pierre**, RN, BSN, NAHC vice president for regulatory affairs.

"Home health, I think, has always had a problem with recruiting because you have the added burdens of staff needing a car and adequate transportation," St. Pierre says. "Also, there are problems competing with salaries that hospitals are paying and the fact that home health was hit with the interim payment system [IPS]."

Stepping up to the staffing challenge

Staffing home health agencies is an ongoing quality issue that is likely to grow only more complicated in coming years. This article is part of an occasional series about how the industry is coping with the problem. Look for articles on overseas recruiting, new ways to market health care jobs, and other related topics in coming issues.

IPS has forced many agencies out of business and made it nearly impossible for agencies to offer competitive raises.

Nonetheless, the current nursing shortage is unlike anything else the industry has experienced, St. Pierre notes. "We're looking at an aging work force with fewer people going into nursing and fewer young people in nursing."

Trends affect everyone

The shortage also is widespread across the health care continuum, which amplifies the problem. In the past, there might have been times when hospitals were cutting back on nurses, and home health agencies could more easily find job candidates. Also, some hospital-employed nurses are drawn to home health's more flexible environment.

"Home health staffing has been more manageable for our institutions over time, because with home health, you can staff more to adapt to your workers' lifestyle," says **Rick Wade**, AHA senior vice president. "So in terms of home health, we've been able to manage that a little better, but that doesn't mean we can continue to manage it in the future."

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, has recognized the unfavorable trends and now is reviewing potential changes to its policies on assessing the effectiveness of staffing in health care organizations, says **Maryanne Popovich**, RN, MPH, executive director of the home care accreditation program.

"What we're looking at is the enrollments in nursing schools, because that trend is what affects the future nursing employment," Popovich says. "Those enrollment trends are down."

JCAHO reviewing home care

Staffing problems may make it difficult for agencies to balance their various clinical pressures, such as maintaining quality, holding down costs, and providing as many necessary services for the community as possible.

Recognizing this juggling act, the Joint Commission has begun to review its policies and standards regarding the competencies of staffing, including home care agencies. "We have always had standards that evaluate the number and competencies of staff," Popovich says. "That's not a change. Quite honestly in home care, the issues in the past have revolved around the therapists; and in certain parts of the country, we've had issues with pharmacists being available."

Popovich says it's not just a nursing shortage issue. "If you can't service a patient, you can't admit the patient, and maybe another organization in your county will be able to do that."

The Joint Commission is looking for indicators

CE questions

1. What are some of the contributing factors to the current home care staffing crisis?
   A. Agencies have to keep a tight rein on costs because of the prospective payment system, since it's difficult to offer competitive salary and benefits to staff.
   B. Health care jobs are no longer seen as stable and desirable as in previous decades.
   C. Fewer people are enrolling in nursing schools at the same time the population is aging and will be in greater need of health care services.
   D. all of the above

2. What are some of the advantages of providing a home-based primary care service, according to a recent Veterans Affairs study?
   A. Home care services that include physician visits are cheaper in the short and long term than traditional home care services.
   B. Patients report a higher health-related quality of life and greater satisfaction with care among the primary care group.
   C. Doctors like to make home visits and are therefore easy to recruit.
   D. all of the above

3. What factors can cause infection definitions designed for hospitals to be inadequate for use in home care?
   A. the difference in the home care environment
   B. a lack of necessary lab tests
   C. less frequent nursing care
   D. all of the above

4. When an agency first begins using a new infection definition, it may see a spike in the number of reported infections because of an increased awareness of infection.
   A. true
   B. false

Sources

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organizations could use to identify problems with staffing before they reach a critical stage, Popovich says.

For example, if a home health agency has a 30% turnover rate of nurses within one month, then that would indicate there is a problem, and the agency will need to conduct an investigation and perhaps make some human relations changes, she says.

Another potential clinical indicator in home care would be the time from referral to first visit by the clinician. "This may be a very good indication of the staff's ability," she says.

Other indicators could be the numbers of visits projected as appropriate vs. the number of visits provided and the number of patients who used the on-call service or after hours system. The latter could indicate whether patients are receiving adequate regular care.

Final decision pending

Joint Commission committees have reviewed the proposals, which will be reviewed by a home health professional and technical advisory committee, and determine if the standards are acceptable, Popovich says.

If they determine the standards are acceptable, they will forward them to a standards and survey process committee that will make the final decision on whether they will become new standards. This final step possibly could take place by the end of the year.

At this point, any changes are undetermined because the committee could decide that there is no need to change what home health standards already state. "Or they could say that developing indicators is not the way to go, or maybe it should be advice and consultation," Popovich notes. ■

Congress gets an earful about national shortage

NAHC, AHA draw attention to nursing crisis

Congress recently held a hearing about the current nursing shortage crisis, and members of the Senate's Aging Subcommittee of the Health, Education, Labor, and Pensions on Health Care Workforce listened to what health industry representatives had to say.

Here are some of the highlights from testimony by the Washington, DC-based American Hospital Association (AHA) and some excerpts from a letter the National Association of Home Care (NAHC), also of Washington, DC, had written on the topic:

1. The health care work force situation is grave.

"The dramatic reductions in reimbursement for home health agencies combined with a flood of new regulatory requirements have made agencies unable to attract nursing staff with competitive wages and benefits," wrote NAHC's **Val Halamandaris**.

Halamandaris noted the number of patients served by the Medicare home health benefit has dropped nearly 1 million between 1997 and 1999, and claims were reduced by 40%. The nursing shortage resulted in home care agencies having to turn away the more costly and intensive care patients, he says.

"The shortage of the available pool of nurses further exacerbates this problem for home health agencies, which are unable to provide adequate pay and benefits to attract nurses to home care," Halamandaris wrote.

This shortage comes in the backdrop of major cuts in home care staffing since 1996. Between 1996 and 1999, more than 51,000 nursing positions and more than 54,000 home health aide positions were lost, Halamandaris notes.

Numbers don't add up

The industry now is facing a future crisis because the employment reductions in Medicare are in sharp contrast to continued growth in demand for home care personnel, Halamandaris stated. "The Bureau of Labor Statistics forecasts an 82% increase in the demand for key home health personnel for the period 1998 to 2008," he adds. "Due to the severity of payment

reductions under the Balanced Budget Act, agencies increasingly are unable to offer competitive wages and benefits to attract qualified staff, and labor shortages are developing across the country."

The AHA told Congress the government and public's demand for the highest-quality patient care at the lowest public cost has come face to face with the tightest labor market in the last 30 years.

"For example, government predictions state that the nation will need 1.7 million nurses by 2020, but just more than 600,000 will be available," says **Brandon Melton**, vice president for human resources at Denver-based Catholic Health Initiatives, who spoke on behalf of the AHA Feb. 13 before the Aging Subcommittee.

The AHA also suggests the perception that health care providers are no longer favored employers needs to be changed.

Will quality suffer?

2. The shortage is threatening quality of care.

Halamandaris gives these examples of how the crisis has impacted patients:

• New Jersey's home health aide and nursing shortage is so severe that some home health agencies were forced to refuse all new admissions for several days to a week or more due to lack of sufficient nursing staff.

• The Connecticut Colleagues in Caring Project has reported nursing vacancy rates in state hospitals have doubled in the past four years, and the number of newly licensed nurses last year declined by 25% from four years ago.

• Demand for nurses currently exceeds the supply, and this trend will worsen as the population age 85 and older doubles by the year 2025 to an anticipated 7 million. By the year 2010, the number of people who have two or more activities of daily living limitations is expected to increase from 4 million in 1990 to nearly 6 million.

3. The crisis demands immediate action.

Halamandaris offers these suggestions for solving the problem:

• Providers, nursing education institutions, and secondary schools should form partnerships to increase nursing school enrollment. This could be done through programs that forgive loans, reimburse tuition, offer staff development, and provide career ladders for unlicensed personnel.

• Media campaigns should be aimed at junior high and high school students, making them aware of health care as a potential career choice.

• The service delivery model should be transformed to a team approach to service model in which RNs are involved in all aspects of quality.

• Agencies need to use technology to streamline paperwork and to create staff models that relieve RNs of nonclinical duties and paperwork.

• Technology also should offer some solutions through use of telemedicine, improved scheduling, and education offered through Internet or telephone sessions.

Melton told Congress about innovative programs being used across the country to recruit and retain health care workers, including the following:

• A medical center in Great Bend, KS has formed an alliance with community colleges to increase enrollment in nursing schools, and the center has joined with the state board of regents to make scholarships available to nursing students who agree to service payback agreements.

• A Des Moines, IA-based medical center has offered staff flexible scheduling, premium pay and compensation, and four different weekend work packages of which the richest package offers full benefits and pay at 170% of the base pay, plus a 12% night differential.

• A hospital in Little Falls, MN, promotes health care careers in area elementary and middle schools and offers employees a bonus for referrals that result in part-time or full-time employment.

Collaboration is key

4. Long-term solutions still are needed.

Melton told Congress the solution lies in a multitiered, collaborative approach among hospitals, health care facilities, academia, and the work force.

The AHA also suggests the perception that health care providers are no longer favored employers needs to be changed. In recommendations developed by the AHA Strategic Policy Planning Committee, dated Jan. 23, AHA stated health field careers have become less popular in the past two decades due, in part, to the perception that health care is low-tech employment and health care jobs are unstable and chaotic.

Additionally, health care no longer is one of the few options available to women, and health care workers no longer have time to develop supportive relationships with patients because hospital stays are relatively short compared to previous decades. ■

Homegrown tracking project goes nationwide

The goal? Standard infection definitions

Eight years ago, a few home care nurses began meeting in a spare conference room at the Missouri Alliance for Home Care (MAHC) in Jefferson City. Their goal: to begin a program of tracking infection rates at state agencies.

Today, that effort has spread to 91 agencies across the country that report quarterly on rates of bladder catheter and central venous catheter infections within their organizations. Participating agencies use the nationwide data as a benchmark for their own rates.

The MAHC infection surveillance project also has joined a larger nationwide effort to create infection definitions that apply specifically to home care operations. That effort has led to collaborations with the Washington, DC-based Association for Professionals in Infection Control and Epidemiology (APIC) and the Centers for Disease Control and Prevention (CDC) in Atlanta.

The Missouri project members soon hope to field-test a range of different draft infection definitions created by APIC.

"Everybody has the same goal, which is really to standardize the home care definitions and get them out there for the masses," says **Anne Dillon**, projects manager for MAHC's infection surveillance project.

Home care infection experts say standardization is sorely needed. **Libby Chinnes**, RN, BSN, CIC, a infection control consultant with Mount Pleasant, SC-based IC Solutions, heads up APIC's home care section.

Chinnes says that in the past, home health nurses have had to use infection definitions written for acute-care settings, which often are unsuited to a home care environment. "The hospital definitions many times call for a lot of specific lab tests, and you may not have that in home health — maybe the wound was not cultured, or maybe a urine culture was not obtained."

A definition written specifically for home care might include not just lab tests as an indicator, but other signs and symptoms that could be used if tests weren't available.

Carolyn Crumley, RN, MSN, CS, CWOCN, a clinical nurse specialist at John Knox Village Home Health Agency in Lee's Summit, MO, says hospital definitions don't take into account the tremendous difference in the home environment. Patients are seen by nurses less frequently, the cleanliness standards are different — there sometimes are even different types of bacteria to contend with.

According to Dillon, home care definitions also can help differentiate between infections acquired in home care and infections the patient acquired in the hospital — an important distinction when an agency is trying to determine if its infection control procedures are optimal.

Over the years, many agencies have cobbled together their own working definitions of home care infections for use by their own staff. But Chinnes says those definitions vary from agency to agency. The goal of the APIC effort is to offer a standardized set of written definitions across the home care discipline.

Years of work pay off

The standardization process hasn't been easy. Chinnes says the APIC home care section worked on its set of definitions for more than three years.

The MAHC group spent two to three years refining only two definitions — one for central venous catheter infections and one for bladder catheter infections.

"I think they were interested in learning about other types of infections," Dillon says. "But as the project progressed, and they got into nitty-gritty of developing definitions, they thought that the bladder catheter and central venous catheter definitions were more manageable."

For the first few years, the group of volunteer nurses would meet, hammer out a definition, then return to their agencies to field-test it. They'd come back, share their opinions about what worked and what didn't, refine the definition, and go home to try it out again.

Crumley, who joined the MAHC project in 1995, says the refinements came not only from the agencies' experiences, but also from what little literature was starting to appear on home care infection surveillance.

"It was right about that same time we started seeing more articles that pointed us toward specific definitions and criteria that some of the agencies were starting to collect data."

Dillon says it wasn't until 1996, when she first was hired, that the nurses had fine-tuned the two catheter definitions to the point that they could use them for an entire year before tweaking them

again. Crumley says the definitions have changed very little since then.

As word spread about the project, more Missouri agencies asked to be included. The effort also spread across state lines, as nurses heard about the infection surveillance project at conferences.

Dillon says MAHC has always been open to extending the reach of the project, believing that every agency that participates brings valuable data that the others can use. The project now includes 91 agencies in 22 states, including Michigan, whose state home care association has a formal relationship with MAHC that allows 23 Michigan agencies to participate at a reduced price.

The project is free to MAHC members. Members in other states (excluding Michigan) pay $300 for the first year of participation in the project, and $200 each subsequent year.

Dillon says MAHC only charges what is necessary to run the project.

"The first year, it was $100 per company and that was not helping at all with expenses," she says. "We changed it so that it would be $300 for the first year, which is the most labor-intensive year as far as the staff here. After that, it's only $200."

Collecting the data

When an agency signs up, it is assigned a trainer who reviews the agency's plan for collecting and reporting the necessary infection data. The goal is to make sure the plan is comparable to what other agencies in the project are doing, Dillon says.

"They can collect the data however they would like — based on their own internal system — as long as they're counting days correctly, counting patients correctly, and meeting the criteria of the definition."

MAHC provides quarterly reports to participants, breaking out the data so that an agency can measure itself against other similar agencies.

"We have every participating company fill out a demographics sheet," Dillon says. "And we use those elements to put them into categories. The reports show breakouts based on whether they're urban or rural, hospital-based or freestanding, and the size of their agency."

Agencies that receive an information packet on the project and decide not to join still are allowed to use the definitions and data collection recommendations for their own personal surveillance, but won't have access to the benchmarking information, Dillon says.

Jeanne Schrader, RNC, BS, clinical care coordinator at Memorial Hospital Home Care in Belleville, IL, says when she first looked into the infection surveillance project, her agency couldn't afford the fee. So they used the definitions and created their own smaller benchmarking group with other Illinois agencies.

That group, which began three years ago with 12 members, has since dwindled to seven. But Schrader says they, too, have benefited from the opportunity to compare their rates against each other and against rates they've found while reviewing medical literature.

"I think MAHC did a really good job with setting up the program, and I couldn't see any reason to reinvent the wheel," she says.

More definitions to become available

With its infection surveillance program in place, MAHC established a relationship with APIC several years ago to join in the association's efforts to standardize infection definitions in home health.

Chinnes credits MAHC and particularly its executive editor, Mary Schantz, with providing valuable feedback on APIC's draft definitions.

MAHC and APIC also collaborated on the first national infection control conference addressing home care issues in October 1999, and on a second conference last year. Dillon says a third conference is tentatively scheduled for Oct. 11-12 in St. Louis.

Also involved in the effort is the CDC, which has conducted period prevalence studies among Missouri agencies. The goal of the studies is to determine the number and types of home care infections during different one-month periods. Information from the surveys was made available at the 1999 home care infection surveillance conference.

"They've been absolutely wonderful," Chinnes says of the CDC. "They have a lot of interest in home care, and they're trying to help us as struggling practitioners in the field to get in there and make this work."

The next step is to field-test APIC's definitions, which include such areas as wound infections, respiratory infections, and gastrointestinal infections. The definitions, which were approved by the APIC board, were published in the December issue of the *American Journal of Infection Control.*

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They also are available on the association's Web site at www.apic.org.

Dillon says MAHC is anxious to begin working the APIC definitions, but will need more money to administer the project. The alliance has applied for a grant to cover the increased costs.

Crumley says that while gathering data on the new set of definitions will require more work, it definitely will be worth the effort. She says one result of all of the nationwide efforts at standardizing home care infection surveillance has been an increased awareness of the issue throughout the home health industry.

"I think in the whole home health setting, we're more aware of infections than we ever were before," Crumley says. "We're more aware of our role in infection surveillance, and more agencies are actually doing infection surveillance." ■

Surveillance program gives agencies valuable data

Agencies use MAHC to improve infection care

Agencies that have signed on to the Missouri Alliance for Home Care's (MAHC) Infection Surveillance Project say it has helped them learn more about infections within their agencies — which ones are causing the most problems and what might be the source of some of them.

Even those agencies that already had successful infection surveillance in place say the benchmarking provided by the nationwide data collection gives them a much better idea of how their agencies are doing.

"I think most of us — those who have been in the project for a while and even the new participants — think it's benefited their agencies," says **Carolyn Crumley**, RN, MSN, CS, CWOCN, a clinical nurse specialist at John Knox Village Home Health Agency in Lee's Summit, MO. "While they've been providing data for this overall project, within their individual agency it's been a benefit to them."

Crumley, who has been associated with the infection surveillance project since 1995, now serves as a trainer for new, out-of-state agencies that join. She leads project managers in new agencies through the minutiae of collecting and reporting data, and reviews their work to make sure it's consistent with the data being collected by other agencies.

Project manager does most work

Crumley says a participating agency must assign a project manager, who usually does the bulk of the data collection.

"We started out in our agency relying on nurses to do more of the data collection, she says. "Through the years, that has changed somewhat to where I try to only ask of the nurses what I have to ask of them, and I try to do the rest."

"I think with PPS [prospective payment system], staffing changes, and other things put on the field nurses, I think it's pretty similar at most agencies. The project coordinator tries to do as much of the paperwork and chart reviews and all that, just relying on the nurses for the information [he or she] needs to get from them."

At John Knox, the nurses need only tell Crumley which of their patients have bladder or central venous catheters. She does the rest, using chart reviews, physicians' orders, and lab reports to determine whether a patient meets the definition MAHC has established for a home care catheter infection.

She says it's "definitely more" work than the agency employed to track infections before she became associated with the MAHC project.

"At that time we didn't have anybody doing any type of infection surveillance within the agency, as I think was pretty common in most agencies at that point."

By contrast, the United Visiting Nurse Association in Trumbull, CT, which joined the project three years later, already had begun conducting infection

Find out more about infection surveillance

• For more information on the Missouri Alliance for Home Care's infection surveillance project, contact the alliance at 2420 Hyde Park, Suite A, Jefferson City, MO 65109-4731. Phone: (573) 634-7772; fax at (573) 634-4374. Web: www.homecaremissouri.org.

• The Association for Professionals in Infection Control and Epidemiology published its draft infection definitions in the December issue of the *American Journal of Infection Control*. It also has made those definitions available in the resources section of its Web site: www.apic.org/resc/. ■

surveillance and had even joined in a smaller attempt at a similar benchmarking project with a handful of New York agencies.

But **Susan Brunoli-Stiller**, director of quality management, says she never was able to get the kind of useful benchmarking information she was looking for until she joined the Missouri project.

The definitions used were similar to the ones her agency already had been using, so the infection rates reported by her agency were pretty similar to what it had been seeing previously, she says.

Initial rates sometimes high

Crumley and **Anne Dillon**, MAHC's projects manager for the Infection Surveillance Project, say that's not always the case.

Often, Crumley says, new participating agencies may not have been tracking infections as carefully before, and the immediate spike in infection reports may startle or even depress them.

Dillon says when an agency sees itself compared to others in the project, it may have the worst score of the group at first.

"I tell them, 'Don't look at this as though you had the worst infection rate ever,"' she says. "'Look at it like there were 41 zeros (meaning no infections) ahead of you, and your infection rate is 1.26. That's not bad.'

"Our longtime members will be the first ones to tell you they use these data as an active surveillance process," Dillon says. "They follow it from quarter to quarter, looking to see if their infection rate is higher than they would like; and if so, why it is higher?"

Improve one thing at a time

Most of the time, she says, one quarter's high rate may be because of variables the agency can't control — a chronic patient, for example. But in other cases, an agency may be able to link an increase to one factor that can be corrected.

Dillon gives the example of a project participant that linked a series of catheter infections to one physician who had inserted the catheters himself.

"They went back to the physician, tactfully saying, 'This is what we think; and this is the information we're using to support our theory,'" Dillon says. "The physician actually relinquished that task to one of his nurses, and their infection rate went down."

Brunoli-Stiller says when her agency found itself a bit above the benchmark for urinary tract infections, it focused on those cases to see what was wrong.

"Out of that group of who had [Foley catheters], we isolated that group that developed infections and what was different about them," she says. "We found a couple of things. One was a higher rate of bowel incontinence. We also saw a difference with the type of catheter — people with the latex catheter had higher infection rates."

To address these issues, United Visiting Nurse Association switched to silicone catheters and developed a teaching booklet to educate patients regarding infection control measures.

The number of infections that agencies in the surveillance project can track soon may grow.

Sources

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MAHC soon hopes to be able to field-test a range of new home care definitions drafted by the Washington, DC-based Association for Professionals in Infection Control and Epidemiology.

Those definitions cover everything from respiratory infections such as the common cold and pneumonia to gastrointestinal infections.

MAHC hopes to receive grant funding to help address the expected increase in the cost of tracking the wider array of infections.

For her part, Brunoli-Stiller says she hopes the project will be able to start using the new definitions.

"One of the other definitions would be for wound infection, which we're very interested in and for which we don't have a definition, and for pneumonia," she says. She also encourages other agencies to become involved in the project. ■

VA takes team approach to in-home primary care

Part 2 of a two-part series

Recent research shows that a Veterans Affairs' (VA) program providing home-based primary care has resulted in patients reporting a higher health-related quality of life and greater satisfaction with their care than the typical home care program.

The VA's home health program is multidisciplinary with a physician leader, nurses, therapists, a social worker, often a dietitian, and even some other disciplines, such as a pharmacist or clergy, depending on the particular VA program's size, budget, and needs, says **Frances Weaver**, PhD, deputy director of the health services research and development center at Hines (IL) VA Hospital, and a research associate professor at the Institute for Health Services and Policy Research at Northwestern University in Evanston, IL.

In all, more than 70, or one-third of all VA hospitals, have a home-based primary care program, and these programs have existed since the 1970s, Weaver says.

Weaver was one of the investigators involved with studying the program's outcomes, publishing the results in the Dec. 13 issue of the *Journal of the American Medical Association*. The study was funded by the VA Health Services Research and Development Program and the VA Cooperative Studies Program.

It works, but it costs more

The study found that patients and caregivers receiving the team-managed home-based primary care approach, when compared with patients receiving the typical and customary care, were more satisfied with their care, caregiver burden was lower, and health-related quality of life was better. The primary care approach also resulted in fewer hospital readmissions in the short term, although this difference dissipated over a 12-month period, and did not save money because the primary-based home care was more costly than the typical home care treatment.

"The reason we got involved in the study was because there was a physician here at Hines who was the medical director of the home care program; she thought it was a unique program, and [thought] we ought to evaluate it to take a look at its cost and whether it was worth the investment," Weaver explains. "We also wanted to see what impact the program had on patients and informal caregivers."

That particular study actually took place in the late 1980s. It found upon evaluation of a single site that there was a cost savings and increased patient and caregiver satisfaction. Based on that small study, the VA agreed to fund a multisite study, which began in the 1990s and involved 16 programs across the country, Weaver says.

The study, which was conducted from October 1994 to September 1998, involved 1,966 patients with a mean age of 70 years. The patients in the home-based primary care group and in the control group were greater than 96% male and had very similar demographics with regards to race, income, education, marital status, and living

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. The first part in the March 2001 issue included information about how one large home care agency provides a house call doctor service.

arrangements. The patients had two or more activities of daily living impairments or a terminal illness, congestive heart failure (CHF), or chronic obstructive pulmonary disease (COPD).[1]

Researchers measured patients' functional status, patient and caregiver health-related quality of life and satisfaction, caregiver burden, hospital readmissions, and costs over 12 months.[1] **(See story on study's findings, p. 47.)**

"We monitored all health care costs for both VA and non-VA care over 12 months; and at the end of the study, we found that those individuals followed by the VA home care program had costs averaging 12% more on average than the usual customary care group," Weaver says.

"The VA program has more flexibility than customary home care, and it can change care plans."

Here's how the VA program typically works:

1. Provide active physician involvement.

Physicians make home visits and participate in team meetings to discuss patients and their status, Weaver says.

The study showed that on average patients received 0.8 physician visits to their home. "A significant number did have a physician visit, and I believe that plays into their higher satisfaction rate," Weaver says.

Physicians monitor patients' use of VA inpatient hospital care and keep in close communication with hospital personnel.

2. Offer multidisciplinary care.

Besides having a physician on the primary care team, most of the VA home-based primary care programs also have a RN or MSN nurse, a social worker, and a dietitian. Some of the programs provide services from LPNs, nurse practitioners, pharmacy, physical therapy, occupational therapy or kinesiotherapist, health tech, or even a laboratory technician, although personal aide services are not provided.[2]

Patients particularly like the interdisciplinary nature of the program, Weaver says.

"The VA program has more flexibility than customary home care, and it can change care plans," she explains. "If a patient is having a nutritional problem or a psychological problem, then we can have a nutritionist or psychologist go out to the home."

Two more advantages the VA program has over traditional home health is that it is not constrained to restorative or post-acute care, and there are no limits placed on the number of visits staff might make to see a patient. The VA programs are funded out of the hospital budgets so home care visits are assessed according to the value of the visit, vs. admitting a patient to the hospital for care.[2]

3. Offer patients after-hours assistance.

The VA study found that patients of the VA home-based primary care program were more likely than customary home health patients to know whom they should call if they had an emergency, Weaver notes. "The patients in the VA program identified the VA's home care program as the place to call, while the customary care folks were less certain about who to call."

And when the VA patients did call the home-based primary care program, they were more satisfied than the control group with the telephone interaction and were less likely to end up going to the emergency room because the VA team could provide them with triage over the telephone, Weaver adds.

4. Train nurses to work toward the most important goals.

The patients selected for the study were extremely ill. About 20% were terminally ill, and about 75% of those who were not terminally ill were severely disabled. Small percentages of the patients who were not terminally ill had CHF or COPD.

The home-based primary care team nurses were trained to attend to the most important goals of those patients.

For example, the VA nurses work with caregivers to help prevent patients from having exacerbations that could lead to hospitalization. This

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Source

- **Frances Weaver**, PhD, Deputy Director of Health Services Research and Development Center, and Research Associate Professor, Institute for Health Services and Policy Research, Northwestern University, Evanston, IL, and Hines VA Hospital, HSR&D 151H, Hines, IL 60141. Phone: (708) 202-8387.

is particularly true in the cases of CHF and COPD patients, who are among the highest users of health care services because of their frequent symptom flare-ups and the chronic nature of their diseases.

"Seventy percent of them — within a year — had one or more readmissions," Weaver says. "Those particular populations are very difficult to manage because of acute exacerbations."

The nurses also focus on teaching patients and caregivers how patients can maintain their weight, follow dietary plans, reduce salt intake, and identify symptoms and problems before they become serious enough to require hospitalization, Weaver says.

Members of the VA's home-based primary care team typically had a smaller caseload than the customary home health providers.

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1. Hughes SL, Weaver FM, Giobbie-Hurder A, et al. Effectiveness of team-managed home-based primary care: A randomized multicenter trial. *JAMA* 2000; 284:2,877-2,885.
2. Weaver FM, Hughes SL, Kubal JD, et al. A profile of Department of Veterans Affairs hospital-based home care programs. *Home Health Care Serv Q* 1995; 15:83-96. ■

VA study shows both higher quality, costs

Study is first of its kind

Research shows that a primary-care based home care system can result in greater patient satisfaction and other benefits, although it may cost more to provide than the traditional model of care for those types of patients.

A randomized, multicenter study funded by

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. ■

Homecare Quality Management™ (ISSN 1087-0407) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Homecare Quality Management™**, P.O. Box 740059, Atlanta, GA 30374.

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the Department of Veterans Affairs (VA) Health Services Research and Development and the VA Cooperative Studies Program of Washington, DC, has found some significant benefits to patients receiving home care services by physicians, nurse practitioners, and other disciplines. The drawback might be the cost, which at the VA study found to be higher over a 12-month period.

Patient satisfaction higher

Here are some of the study's results:

• Patients assigned to the VA's home-based primary care team cost an average of $31,401 over a 12-month period; patients receiving customary care and assigned to the control group cost an average of $28,008 in the same period.[1]

• The primary care group had 9.3 rehospitalizations on average over the first six months, while the control group had 9.5 rehospitalizations in the same period.[1]

• Over a 12-month period, the primary care group had an average of 14.7 hospitalizations, compared with 13.3 for the control group.[1]

• Patients in both groups had a mean of 3.2 activities of daily living impairments, most commonly involving bathing, dressing, and transferring. Four out of five of the patients lived with a family caregiver, and most of the patients were at medium-to-high risk of rehospitalization.[1]

• Researchers assessed patient and caregiver satisfaction by using the Barthel Index. Their quality of life was assessed through the *Medical Outcomes Study, Short Form-36.*[1]

• Both terminally ill patients and nonterminally ill patients in the primary care group had a significant improvement in their health-related quality of life when compared with the control group.[1]

• Nonterminal patients in the primary care group reported a significantly higher satisfaction with care.[1]

• Caregiver ratings of satisfaction also were higher among the primary care group.[1]

• The trial spanned four years at 16 hospitals across the United States.

Reference

1. Hughes SL, Weaver FM, Giobbie-Hurder A, et al. Effectiveness of team-managed home-based primary care: A randomized multicenter trial. *JAMA* 2000; 284:2,877-2,885. ■