Home Health Care: Who's Where?

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Abstract: Referrals to two home health agencies, one public and one private, were examined over a one-year period (n=290). Clients in the public agency required greater frequency of visits, more nursing services, and care for a longer period of time than did those in the private agency. The public agency served a larger proportion of indigent and Medicaid clients. Increased service delivery with a decreased financial base may forebode an unhealthy future for traditional public home health agencies. (*Am J Public Health* 1987; 77:733–734.)

Introduction

Changes in home health care reimbursement and efforts toward hospital cost-containment have predictably stimulated the growth of home health care agencies, especially in the private sector.[1–4] Government figures show increases in Medicare certified home health agencies, and a concurrent increase in home care admissions for Medicare beneficiaries.[5,6] Public expenditures for home care during the last decade grew from $164 million to over $1 billion, with total expenditures in 1985 estimated at $8 billion. The number of Medicare-certified home health agencies rose from 1,275 in 1966 to 4,703 in 1984, during which the proportion of nongovernment sponsored home health agencies increased from 54.6 per cent to 73.7 per cent.[7,8]

The growth and privatization of home care is a relatively recent phenomenon, but is expected to continue at a rate between 12 and 20 per cent at least through 1990.[9] This situation has prompted questions regarding competition for clients, comparability of care, and stability of financial bases between the public and private agencies. These questions led to the design of an exploratory study of differences in care and sources of payment between public and private home health agency clients.

Methods

We studied referrals to one public and one private agency, both of which served the same geographic area and received almost all the home health referrals of the local acute care general hospital. The private agency is not-for-profit and is owned and operated by the referring hospital; the public agency, situated on the grounds of the hospital, is the county health department home health service.

All post-hospital home health client records (total 290) were reviewed retrospectively covering a 12-month period. HHS Form 2043A, required for all home health referrals in the state, was the primary data source.

Frequency of care was tallied from the HHS Form 2043A. The number of nursing services was scored by assigning a value of "1" to each of the 23 categories of skilled nursing services on Form 2043A, and summing across categories. Length of care was the number of days recorded from the first to the last home visit. Source of payment was as recorded in the record at the time of referral.

Results

Referrals were fairly equally distributed between the two agencies. Table 1 displays the findings. Hospital length of stay was not significantly different between groups.

Clients of public and private agencies differed with respect to nursing care delivered. Public clients had greater frequency of visits, tending to receive visits two times per week on the average, while the private clients were visited one time per week. The most frequent type of visit was daily (49 cases) for public clients, and twice per week for private clients (34 cases). Public service clients required more nursing services than private clients, and received care over a longer period of time than did the private clients.

Medicare was the source of payment for the majority of clients in both agencies. However, the distribution of all home health care clients according to source of payment differed. The public agency served a much larger proportion of indigent clients than the private agency (12.4 per cent public, 1.7 per cent private); and a much larger proportion of Medicaid clients than the private agency (11.2 per cent public, 4.1 per cent private).

Discussion

Public and private agencies appear to serve different populations with respect to manpower resources required. Public agency clients receive more frequent visits for longer periods of time. Public agencies, however, are constrained by "frozen" positions and vacancies, making them unable to increase the number of nurses. Instead, many home health nursing agencies are establishing quota systems to guarantee that a given complement of nurses can serve an increased number of clients. Nurses in such agencies have expressed concern about quality of care, because of the need to "cut corners" to make the minimum number of visits.

The visits made by public and private agencies may not be equivalent. The number of services delivered during visits is higher in public agencies. More services delivered within the same visit will often consume more resources. Nevertheless, within the current payment structure, home visits are paid for by the visit, not by the care delivered in the visit.

As home health moves to a prospective payment system, the pressures for cost containment in that arena are inevitable. The Health Care Financing Administration is presently funding demonstration projects for prospective payment in home health care.[10] Private home health agencies have much greater flexibility in accepting the types of clients they wish to serve and the types of services they wish to provide. The

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TABLE 1—Comparison of Public and Private Home Health Clients by Hospital Length of Stay, Service Requests (Frequency of Visit, Number of Services, and Length of Care), and Source of Payment

Variables	Public (n = 169) %	Private (n = 121) %	Absolute Difference* (95% C.L.) %
Length of Hospital Stay (days)			
≤10	29.8	32.2	2.4(−8.4,13.2)
11–21	40.4	33.9	6.5(−4.7,17.7)*
22–40	20.3	24.0	3.7(−6.0,13.4)
≥41	9.5	9.9	0.4(−6.5,7.3)*
Frequency of Visits**			
daily	28.9	17.4	11.5(1.9,20.7)*
3 times week	10.7	26.4	15.7(6.6,24.8)
2 times week	27.8	28.1	0.3(−10.2,10.8)
1 times week	24.3	11.6	12.7(4.3,21.3)*
q 2 week	1.8	1.7	0.1(−2.9,3.1)*
q 3–4 week	3.6	0	3.6(.8,6.4)*
<q4 week	3.0	14.9	11.9(5.1,18.7)
Number of Services			
≤2	20.2	26.4	6.2(−3.7,16.1)
3–4	43.5	40.5	3.0(−8.5,14.5)*
5–6	30.9	25.7	5.2(−5.2,15.6)*
≥7	5.4	7.4	2.0(−3.8,7.8)
Length of Care (days)			
≤14	19.9	35.8	15.9(5.4,26.4)
15–42	35.1	36.7	1.6(−9.6,12.8)
43–56	15.2	10.0	5.2(−2.4,12.8)*
≥57	29.0	17.5	11.5(1.9,2.1)*
Source of Payment***			
Medicare	62.1	86.8	24.7(15.2,34.2)
Medicaid	11.2	4.1	7.1(1.2,13.0)*
Indigent	12.4	1.7	10.7(5.2,16.2)*
Blue Cross/Blue Shield	2.4	4.1	1.7(−2.5,5.9)
Other	11.9	3.3	8.6(2.8,14.4)*
Mean Length of Hospital Stay (days)	19.2	20.8	1.6(−2.0,5.2)
Mean Number of Services	3.9	3.5	0.4(.01,.79)*
Mean Length of Care (days)	58.1	38.8	19.3(6.9,31.7)*

* = Public home greater
**$X^2 = 37.1$ $p < .001$
***$X^2 = 27.4$ $p < .001$

strategies which can be considered in responding to the pressures inherent in a prospective payment system are much more limited in public agencies.

Public agencies appear to serve a much larger proportion of Medicaid and medically indigent clients. The shift of paying clients to the private sector that is suggested in this study could have major implications for the viability of our public system of home health care.

These differences merit further attention. The difference in client services delivered could be indicative of a difference between the family and home assessment orientation of the public agency and the more short-term, acute care focus of the private agency. One also wonders whether the case mix of public clients actually requires different services than that of private clients.

The differences suggested in this study may be peculiar to the region in which the study was conducted, to the time period covered, or to the agencies studied. These differences may be exacerbated or reversed as changes in the environment are reflected in the home health care system. Anticipatory surveillance and further studies in this area are needed to maintain and improve all systems of home care.

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