



Published in final edited form as:

Psychiatr Serv. 2014 July ; 65(7): 905–910. doi:10.1176/appi.ps.201300158.

Misalignment between Medicare Policies and Depression Care in Home Health Care: Home health provider perspectives

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Abstract

Objective—Depression affects one in four older adults receiving home health care. Medicare policies are influential in shaping home health practice. This study aims to identify Medicare policy areas that are aligned or misaligned with depression care quality improvement in home health care.

Methods—Qualitative study based on semi-structured interviews with nurses and administrators from five home health agencies in five states (n=20). Digitally recorded interviews were transcribed and analyzed using the grounded theory method. A multi-disciplinary team iteratively developed a codebook from interview data to identify themes.

Results—Several important Medicare policies are largely misaligned with depression care quality improvement in home health care: Medicare eligibility requirements for patients to remain homebound and to demonstrate a need for skilled care restrict nurses' abilities to follow up with depressed patients for sufficient length of time; the lack of explicit recognition of nursing time and quality of care in the home health Prospective Payment System (PPS) provides misaligned incentives for depression care; incorporation of a two-item depression screening tool in Medicare-mandated comprehensive patient assessment raised clinician awareness of depression; however, inclusion of the tool at Start-of-Care only but not any other follow-up points limits its potential in assisting nurses with depression care management; under-development of clinical decision support for depression care in vendor-developed electronic health records constitutes an important barrier to depression quality improvement in home health care.

Conclusions—Several influential Medicare policies and regulations for home health practice may be misaligned with evidence-based depression care for home health patients.

Older patients are typically admitted to home health care after hospitalization or other medical events that result in substantial decline in health and functioning. In addition to high burden of medical illness and disability(1), prevalence of co-morbid mental health conditions are disproportionately high in this population. In particular, major and minor depression meeting clinical diagnostic criteria affected almost 1 in 4 older home health patients(2), but was seriously under-recognized and poorly managed in this setting(2-4). In addition to enormous amount of suffering, depression was associated with an increased risk of falls(5, 6), hospitalization(7), and excess service use(4, 8) in this population.

Important features of the home health setting and profession offer opportunities for improving the quality of depression care in this setting. Home health nurses made, on average, 17.2 visits to every user of Medicare-covered home health care in 2011(9). They therefore are well positioned to assess depression, to help initiate treatment if needed and to follow up with treatment response and adjustment. Home health nurses have the privilege of visiting patients at their homes and witness the psychosocial (e.g., family, financial, and environmental) issues that may contribute to depression and/or complicate patient self-care and recovery. Finally, home health nurses commonly manage multiple chronic conditions(10) and are trained and expected to take “a holistic approach” to patient care. They also strongly identify with the notion that mind and body are inseparable and that home health providers are to care for the “whole person”.

Based on these premises, recent research developed a nurse-delivered depression care management intervention called CAREPATH (Care of Patients at Home) for the home health setting(11, 12). This intervention builds on but also adapts the primary care-based Collaborative Care Model(13, 14) to fit the organization and practice of home health care. The clinical components of the Depression CAREPATH model, including ongoing symptom assessment, care coordination with the patient’s primary care physician and other specialists, medication management, assistance with self-care and goal setting, and education, are comparable to those of the primary care model, but also consistent with typical home health practice and designed to fit naturally within a routine home visit by the patient’s nurse.

The role of home health care in caring for depression among older patients may be substantially influenced by Medicare policies. Medicare is the dominant payer for home health care received by patients 65 years or older, covering care received by 75% of this population(15). Because many Medicare policies and regulations serve as preconditions for Medicare reimbursement, these policies may provide important incentives and play a critical role in shaping the practice of depression care in home health care.

In this paper, we ask the research question: how well aligned are current Medicare policies with depression care quality improvement in home health care? We sought to answer the question by capturing home health administrators’ and nurses’ perspectives on this topic through an interview study.

Overview of Medicare Policies for Home Health Care

In this section, we provide an overview of several Medicare policies and regulations that our interview study identified as relevant to depression care in home health care.

Homebound and “skilled need” requirements for Medicare coverage

The homebound condition requires that patients “have a condition due to an illness or injury that restricts their ability to leave their place of residence” except with some kind of aid or assistance(16). Medicare also requires that patients establish a need for skilled care (by nursing or therapy professionals) on an intermittent basis and that is “reasonable and necessary.” When elaborating on the “reasonable and necessary” principles, the Medicare

Benefit Policy Manual emphasizes the need to prevent future complications or acute episodes (Sec. 40.1.2.1) and to ensure medical safety (Sec. 40.1.2.2).

Home Health Prospective Payment System (PPS)

Medicare's PPS, first implemented in year 2000, specifies a 60-day episode rate with applicable adjustments. Case-mix adjustment is conducted along three dimensions reflecting clinical severity (based on home health diagnoses), functional severity (based on functional assessment) and home health service utilization(17). Only home visits received for physical, speech-language, and occupational therapies are factored into the service utilization adjustment.. The PPS provides strong incentives to home health agencies (HHAs) to contain the cost of care within the per-episode payment, and, in particular, to limit the number and duration of nursing visits within a given episode.

A related condition of participation in the Medicare program requires that HHAs conduct the initial home health assessment in a timely manner (within 48 hours of referral or within 48 hours of the patient's return to home, or on the physician-ordered Start-of-Care (SOC) date) (18). This requirement, coupled with the fact that only new admissions (but not ongoing care) generate additional revenue to HHAs under the PPS, leads HHAs to assign higher priorities to SOC visits than to follow-up visits.

OASIS, other documentation requirements, and implications for health IT

The Center for Medicare and Medicaid Services (CMS) requires every HHA to conduct standardized assessments of patients using the Outcomes and Assessment Information Set (OASIS). The OASIS is more comprehensive at the time when a patient starts an episode of care, and less so at discharge (to home), transfer (to an inpatient setting) or resumption of care (after a hospital admission). The current OASIS (OASIS-C) at SOC contains a total of 79 items(19), making the first home health visit a long and involved session. The SOC OASIS is required to be completed within 5 days of SOC(18), and, after agency review for errors and updates, submitted to the state within 30 days(20). HHAs are regularly monitored for the timeliness of OASIS submission.

The OASIS-C encourages the systematic assessment of depressive symptoms by incorporating in the SOC OASIS a two-item depression screening tool known as the Patient Health Questionnaire-2(21-23). In addition, the discharge OASIS queries whether an intervention was conducted for patients who screened positive for depression at SOC and whose physicians ordered interventions for depression in the home health plan of care.

In addition to OASIS, HHAs are subject to many other reporting and documentation regulations by CMS, partly as a result of mounting concerns regarding inefficient or inappropriate use of Medicare resources and rapidly growing expenditures(9). Software vendors responded by supplying HHAs with electronic clinical and billing systems. Because HHAs are typically small, independent, and resource-poor, home-grown systems are rare and reliance on vendor products is heavy. Clinicians routinely use laptops or tablets in the field that are synchronized or linked to a central clinical system(24). Home health managers rely on the clinical system to supervise front-line clinicians and manage ongoing cases.

Methods

Research Team

Our multi-disciplinary research team comprised complementary expertise in mental health policy (YB), evidence-based depression care intervention in home health care (MLB), qualitative research methods (JER), and health care organizational behavior (AAE).

Participant Recruiting

We sought administrators and nurses from five HHAs located in 5 states in the Northeast, South, and Midwest regions of the U.S. These agencies recently participated in a nursing team-randomized trial led by one of the co-authors to test the Depression CAREPATH intervention for older home health patients. Based on our experience with the trial, we determined three roles of key informants who would provide complementary perspectives on study topics: home health nurses who worked on a CAREPATH intervention team and home health nurses who worked on a usual care team, nurse supervisors of CAREPATH intervention teams, and medical or clinical directors who were involved in the initial decision of their agency's participation in CAREPATH and/or who played a leadership role in facilitating their agency's participation. We worked with an organizational liaison at each agency to identify potential informants who were likely to speak authoritatively on the research topics. The study team then contacted potential informants by email or phone to recruit and schedule them for interviews. After describing the interview study to informants, written informed consent was obtained. The study received approval from the Institutional Review Board at Weill Cornell Medical College.

Interview Guides

We designed a semi-structured interview guide to assess informants' perceptions of depression and perceived roles and responsibilities of home health providers for depression care, current practice of caring for depression either by themselves (nurse informants) or at their agency (administrator informants), and perspectives regarding facilitators and barriers to depression quality improvement at the system (including policy), organization (HHA), provider (both home health and non-home health), and patient levels. Open ended questions allowed informants to elaborate or focus on issues that they found most salient. Three versions of interview guides were developed to cover the same domains of inquiry but worded differently to account for informants' different roles. The interview guides were pilot-tested on one home health clinical director, one nursing team supervisor, and one nurse outside the CAREPATH agencies and iteratively revised throughout the interviews (see Appendix I for final interview guides).

Interviews

The first author conducted telephone interviews with informants. Notes taken during and immediately after every interview were incorporated into data analysis(25).

Data management and analysis

Audio recorded interviews were transcribed into Microsoft Word documents by a third-party service and analyzed using grounded theory methodology(26). The grounded theory methodology is an established qualitative analytic approach by which researchers generate overall themes from transcripts by iteratively reading and reviewing interview text, attributing labels (“codes”) to salient text, and documenting recurring topics that “emerge” from those transcripts.

Following accepted qualitative analytic methods,(27-30) two investigators (YB and AAE) independently coded each transcript and met to discuss the definitions of codes and negotiate consensus around codes. To demonstrate further analytical rigor, a third investigator (JER) independently coded selected transcripts and participated in coding meetings to provide outside voice and help negotiate consensus. The process was documented throughout and led to the development of a codebook and themes (the final codebook is available from the authors upon request).

Data were organized and managed using the qualitative analysis software, Nvivo version 9 (QSR-International 2010). The software facilitated text and code consolidation into larger themes intended to reflect how current Medicare policies are aligned (or misaligned) with depression care quality improvement in home health care.

Results

We conducted interviews with 20 individuals recruited in the study (6 directors, 5 supervisors, and 9 nurses) from the five CAREPATH agencies. All but one informant were females. Average years of experience in home health care were 16 for administrators, 9 for supervisors and 10 for nurses. The average interview lasted 45 minutes in duration (ranging from 33 to 56 minutes). Below, we detail each of the four primary themes that emerged from our analysis.

Home health eligibility requirements are at odds with depression care

Informants in our study expressed concerns that the Medicare eligibility requirements for patients to remain homebound and to demonstrate a “skilled need” were at odds with evidence-based depression care. Informants expressed frustration that they were not able to follow up with patients to track progress once patients were no longer homebound or their “skilled needs” were considered met and therefore ought to be discharged. This was a prominent theme voluntarily endorsed by more than half of informants of all three roles. One supervisor stated, “You [home health nurse] know that you’ve called the doctor, you’ve expressed to the doctor how you felt, but at this point—it’s not a skilled need to keep the patient open... I’ve felt a lot of times that I’ve abandoned the patient, in a way. There’s no skilled need.”

Informants believed that the eligibility requirements were especially restrictive for antidepressant management since it takes 4-8 weeks before any psychotropic medication can be determined effective or not. This concern intensified and became more difficult to reconcile among supervisors and nurses assigned to the CAREPATH intervention, since

they received training on antidepressant medication management as part of the CAREPATH protocol and practiced it in their routine care.

Meanwhile, several administrators and nurses recognized the fiscal reality of Medicare and believed that Medicare could not afford to have patients stay longer in home health care because “the problem [need for depression and other chronic condition management] is so pervasive” These informants reflected on the short-term, transitional nature of home health care and believed that the role of home health providers was to get patients “on track” and to leave them to community-based providers for long-term management: “...it would just feel better if there was good mental health support to turn [patients] over to... after we leave.”

Incentives of home health PPS are misaligned with depression care

The lack of explicit recognition of nursing time and quality of care in the home health PPS provides misaligned incentives for chronic condition management in general and depression care in particular. Several agency directors described myriad challenges providing quality, evidence-based mental health services in ways that were financially sustainable: “...the payment system is the same whether you focus on completing tasks ... or if you spend this additional time [on depression care management]... Nursing salary is very high, so yeah, we’re doing great care...but it’s destroying our budget.”

Two sub-themes emerged regarding how the PPS incentives “trickled down” to affect the way home health nurses manage their caseloads, and, in turn, compromise their abilities of caring for depressed patients. First, productivity expectation for nurses (in the range of 6-7 home visits per day) is pervasive and pressures nurses to contain the time they spend in patients’ homes. Informants acknowledged that there was a lot more care coordination and patient and caregiver education they would like to do but simply did not have the time as they felt “*rushed about 90% of my day.*” Although one agency’s practice allowed nurses to schedule extended visits for complex patients, interviews with nurses revealed that extending visits to needy patients was not always feasible in the face of heavy caseloads: “Being an RN case manager, ..., you don’t always have the luxury of doing those extended visits.”

Second, incentives embedded in PPS coupled with regulation regarding timely assessment at SOC led HHAs to assign higher priority to new admissions compared to ongoing cases. When there was a scheduling conflict between a SOC and a follow-up visit, a common solution was to have other nurses “pick up” the follow-up visit. However, several informants expressed concern that doing so might potentially disrupt clinician-patient relationship and continuity of care as a result of “*having too many hands in the pot.*” One nurse noted that patients with depression or other mental health needs in particular may be adversely affected by the inconsistency in care providers: “I try to make sure that I’m the person that sees [patients with mood issues]...because they don’t like a lot of change.”

Current design of OASIS provides limited support for depression care

Several administrators in our study applauded the inclusion of the two-item depression-screening tool in the current OASIS. They believed that the inclusion raised awareness of

depression among home health clinicians that would otherwise be easily “missed.” However, informants noted that the way the screening tool is currently incorporated into OASIS limits its potential to assist nurses with depression care management for two primary reasons. First, the SOC visit may not be the best time to screen for depression and therefore should not be the sole screening attempt or result relied on to determine a patient’s depression care need. According to our informants, the OASIS assessment at SOC typically took 2 hours to complete and was too involved to allow nurses to adequately assess for depression other than just asking the two questions and taking down the patient’s answers. In addition, patients were not always willing to discuss mental health issues at the first visit since they had yet to establish a trusting relationship with the nurse. Several informants mentioned that, as a remedy, they would re-administer the screening within a week or two to either confirm or update the initial assessment, which is consistent with the evidence-based practice of depression assessment and the Depression CAREPATH protocol. However, because the OASIS assessment became “locked” to the nurse after 5 days (in compliance with the requirement of timely completion of SOC OASIS), nurses who re-administered the screening normally did not go back and revise the SOC assessment. This was in spite of the fact that nurse supervisors or other agency administrators were able to “unlock” it to correct errors or to make updates. As a result, the adequacy and accuracy of the depression screening results recorded in SOC OASIS is of concern.

Second, the lack of follow-up assessment for depression in OASIS represents missed opportunities to facilitate continued evaluation and to guide ongoing management. Currently, depression assessment is not included in the OASIS at resumption of care (after hospitalization), recertification (for another 60-day episode), transfer (to an inpatient setting), or discharge. An agency director put it this way: “I think it [OASIS] needs to go a whole lot further because, as you know, it just asks, ‘Was an assessment done?’ But it doesn’t ask, you know, ‘What was the result? What was the follow-up?’” Challenges with vendor-developed home health electronic health records

Under-development of clinical decision support for depression care management in vendor-supplied electronic health records (EHRs) for home health care and the high cost of customization constitute an important barrier to depression care quality improvement in this setting. Several informants affirmed that having structured prompts or protocols built into the clinical system would help significantly with nurses’ adoption of evidence-based depression care. They pointed out that, before the CAREPATH study customized their EHRs to support the intervention, functionalities for documenting depression care were weak compared to other major medical conditions such as congestive heart failure and diabetes. In particular, informants noticed that once a nurse documented depression, the system they worked with offered little guidance (e.g., through prompts or drop-down menus) on what to do next.

Discussion

Our study suggested several Medicare policy areas that are largely misaligned with the need to improve the quality of depression care in home health care. Specifically, Medicare’s homebound and “skilled need” eligibility requirements, OASIS’ inclusion of depression

assessment at SOC only but not any other time points, and lack of minimum standards for vendor-developed home health electronic clinical systems to support depression care are at odds with the chronic nature of depression and evidence-based depression care. Under home health PPS, the strong incentives for HHAs to contain nursing time within a given payment episode and to increase volume of care (in terms of new admissions) are misaligned with the need for more nursing time and continuity of care when caring for depressed patients. We discuss below potential policy solutions and how current health care reform initiatives could be leveraged to address some of these policy issues.

Our findings provide clear directions for incremental policy changes in the following areas. Future revision of the OASIS should consider incorporating PHQ-2 at resumption of care (after hospitalization) and recertification since these two time points provide prime opportunities to re-assess depression and incorporate depression care into Plan of Care if needed. In addition, depression assessment in the discharge OASIS would promote inclusion of information on depression as part of care transition. To further support ongoing management, OASIS designers may consider incorporating PHQ-9(31, 32), a 9-item assessment tool, for patients whose PHQ-2 scores indicate significant depressive symptoms. Ongoing assessment using PHQ-9 is part of the CAREPATH intervention; currently adopted by a small number of HHAs on a voluntary basis, PHQ-9 is widely used in primary care for depression care management. Inclusion of PHQ-9 in Medicare-mandated OASIS for patients at heightened risk would improve the quality of clinical information available for treatment decision-making and for ongoing treatment management. A complementary policy would be to require vendor-developed home health EHRs to incorporate a PHQ-9 assessment tool and clinical decision support for evidence-based depression care as a certification criterion for these systems. Feasibility of such a mandate is supported by the experience of the CAREPATH study, which worked with EHR vendors to integrate the intervention protocol into the clinical system of each HHA. Requirements of clinical decision support for depression are highly consistent with the Stage 2 federal “meaningful use” objectives(33) and recent recommendations on health IT to support integrated behavioral health and medical care (34).

Policy barriers associated with home health eligibility criteria and PPS reflect fundamental mismatch between depression care specifically and chronic care generally and the post-acute nature of home health care. It may not be fiscally feasible to lift the homebound and skilled need requirements, which are essential in defining patient eligibility and for Medicare to rein in the rapidly increasing spending on home health care. Changing the key structures of the home health PPS (e.g., by incorporating nursing visits in case-mix adjustment) may be politically difficult and may have unintended consequences such as providing incentives for overusing nursing service. Rather than home health setting-specific remedies, these policy issues call for system-wide approaches.

Emerging health care delivery and payment reform models under the Affordable Care Act (e.g., the Accountable Care Organizations or ACOs) may be leveraged to address the need to align incentives system-wide.(35) To the extent that ACOs recognize the importance of depression care for overall quality and costs of care for their patient population, the shared

savings provision in an ACO contract should provide incentives for depression care coordination between home health clinicians and community providers.

Despite a focus of our study on depression care, several of our findings (e.g., as related to home health eligibility and PPS) have implications for chronic condition management in home health at large. While system-level reform efforts discussed above will help address the general issue of misaligned incentives, it is imperative that specific policy tools – in particular, accreditation, payment and performance evaluation policies – be deployed to ensure attention to depression and other behavioral health conditions.(35) For example, as a structure measure, ACOs may be required to implement PHQ-9 as a standard assessment tool across all settings of care; significant improvement in depression (based on PHQ-9 scores) within 6 months of treatment initiation (regardless of settings of care) may be considered as a patient outcome target.

Our study has a few potential limitations. By design, the qualitative data we collected reflected the perspectives of home health nurses and administrators in our study and not perspectives of other stakeholders such as home health patients, non-home health providers, and policymakers. Compared to the average HHAs, our study HHAs may have perceived a greater need to improve the quality of depression care than the average HHAs, as signified by their voluntary participation in a depression intervention study. Their experience in implementing evidence-based depression care generated first-hand insights regarding the alignment between policies and evidence-based practice. Finally, this research, like qualitative research in general, is not intended to be generalizable. However, readers may consider the findings “transferrable” to other circumstantial or organizational contexts.(36)

Conclusions

In this study, we found that several Medicare policy areas influential for home health practice may be misaligned with evidence-based depression care for home health patients. Concerning the design of OASIS and of home health EHRs, incremental policy changes may provide immediate remedies and are not likely to encounter substantial political hurdles. Although major changes to patient eligibility requirements and home health PPS are at odds with the post-acute nature of home health care and therefore unlikely policy solutions, current initiatives spurred by the health care reform that either strengthen care coordination across settings or provide targeted incentives for quality improvement may, to some extent, address the misalignment.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgements

This research is funded by the National Institute of Mental Health (K01MH090087 – Designing Payment and Performance Evaluations in Depression Care Management; R01 MH082425 – Effectiveness of a Depression Care Management Initiative in Home Healthcare). The authors would like to thank Catherine Riley, MPH for assistance with recruitment of study informants.

References

1. Caffrey C, Sengupta M, Moss A, et al. Home health care and discharged hospice care patients: United States, 2000 and 2007. *National health statistics reports*. 2011;1–27. [PubMed: 21568135]
2. Bruce ML, McAvay GJ, Raue PJ, et al. Major depression in elderly home health care patients. *The American journal of psychiatry*. 2002; 159:1367–74. [PubMed: 12153830]
3. Brown EL, Bruce ML, McAvay GJ, et al. Recognition of late-life depression in home care: accuracy of the outcome and assessment information set. *Journal of the American Geriatrics Society*. 2004; 52:995–9. [PubMed: 15161468]
4. Shao H, Peng TR, Bruce ML, et al. Diagnosed depression among Medicare home health patients: national prevalence estimates and key characteristics. *Psychiatr Serv*. 2011; 62:538–40. [PubMed: 21532081]
5. Byers AL, Sheeran T, Mlodzianowski AE, et al. Depression and risk for adverse falls in older home health care patients. *Research in gerontological nursing*. 2008; 1:245–51. [PubMed: 20077999]
6. Sheeran T, Brown EL, Nassisi P, et al. Does depression predict falls among home health patients? Using a clinical-research partnership to improve the quality of geriatric care. *Home healthcare nurse*. 2004; 22:384–9. quiz 90. [PubMed: 15184780]
7. Sheeran T, Byers AL, Bruce ML. Depression and increased short-term hospitalization risk among geriatric patients receiving home health care services. *Psychiatric services*. 2010; 61:78–80. [PubMed: 20044423]
8. Friedman B, Delavan RL, Sheeran TH, et al. The effect of major and minor depression on Medicare home healthcare services use. *Journal of the American Geriatrics Society*. 2009; 57:669–75. [PubMed: 19392959]
9. Medicare Payment Advisory Commission. [Accessed September 20, 2013] Chapter 9. Report to the Congress: Medicare Payment Policy. 2013. Available at: http://www.medpac.gov/documents/Mar13_EntireReport.pdf
10. Murtaugh C, Peng T, Totten A, et al. Complexity in geriatric home healthcare. *Journal for healthcare quality : official publication of the National Association for Healthcare Quality*. 2009; 31:34–43. [PubMed: 19350878]
11. Bruce M, Sheeran T, Raue P, et al. Depression care for patients at home (Depression CAREPATH): intervention development and implementation, part 1. *Home healthcare nurse*. 2011; 29:416–26. [PubMed: 21716043]
12. Bruce M, Raue P, Sheeran T, et al. Depression Care for Patients at Home (Depression CAREPATH): home care depression care management protocol, part 2. *Home healthcare nurse*. 2011; 29:480–9. [PubMed: 21881429]
13. Gilbody S, Bower P, Fletcher J, et al. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Archives of internal medicine*. 2006; 166:2314–21. [PubMed: 17130383]
14. Williams JW Jr, Gerrity M, Holsinger T, et al. Systematic review of multifaceted interventions to improve depression care. *General hospital psychiatry*. 2007; 29:91–116. [PubMed: 17336659]
15. Bao Y, Shao H, Bishop TF, et al. Inappropriate medication in a national sample of US elderly patients receiving home health care. *J Gen Intern Med*. 2012; 27:304–10. [PubMed: 21975822]
16. Centers for Medicare and Medicaid Services. [Accessed September 20, 2013] Medicare Benefit Policy Manual Chapter 7 - Home Health Services. 2011. Available at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>
17. Medicare program; home health prospective payment system rate update for calendar year 2012: final rule. *Federal Register*. 2011; 76:68526–607. [PubMed: 22059280]
18. Medicare program, home health prospective payment system rate update for calendar year 2012: final rule. *Federal Register*. 2011; 76:68593.
19. Centers for Medicare and Medicaid Services. [Accessed September 20, 2013] OASIS User Manual. 2012. Available at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html>
20. Medicare program; home health prospective payment system rate update for calendar year 2012: final rule. *Federal Register*. 2011; 76:68584.

21. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care*. 2003; 41:1284–92. [PubMed: 14583691]
22. Li C, Friedman B, Conwell Y, et al. Validity of the Patient Health Questionnaire 2 (PHQ-2) in identifying major depression in older people. *Journal of the American Geriatrics Society*. 2007; 55:596–602. [PubMed: 17397440]
23. Lowe B, Kroenke K, Grafe K. Detecting and monitoring depression with a two-item questionnaire (PHQ-2). *Journal of psychosomatic research*. 2005; 58:163–71. [PubMed: 15820844]
24. Resnick HE, Alwan M. Use of health information technology in home health and hospice agencies: United States, 2007. *Journal of the American Medical Informatics Association : JAMIA*. 2010; 17:389–95. [PubMed: 20595305]
25. Miles, MB.; Huberman, AM. *Qualitative Data Analysis: An Expanded Sourcebook*. 2nd. 1994.
26. Glaser, BG.; Strauss, AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Aldine De Gruyter; Chicago, IL: 1967.
27. Armstrong D, Gosling A, Weinman J, et al. The place of inter-rater reliability in qualitative research: An empirical study. *Sociology*. 1997; 31:597–606.
28. Bradley EH, Curry LA, Webster TR, et al. Achieving rapid door-to-balloon times: how top hospitals improve complex clinical systems. *Circulation*. 2006; 113:1079–85. [PubMed: 16490818]
29. Morse, JM. Designing funded qualitative research. In: Denzin, N.; Lincoln, Y., editors. *Handbook of Qualitative Research*. Sage Publications; Thousand Oaks, CA: 1994.
30. Hill CE, Knox S, Thompson BJ, et al. Consensual qualitative research: An update. *J Couns Psychol*. 2005; 52:196–205.
31. Ell K, Unutzer J, Aranda M, et al. Routine PHQ-9 depression screening in home health care: depression, prevalence, clinical and treatment characteristics and screening implementation. *Home health care services quarterly*. 2005; 24:1–19. [PubMed: 16446263]
32. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med*. 2001; 16:606–13. [PubMed: 11556941]
33. Centers for Medicare and Medicaid Services. [Accessed September 20, 2013] Stage 2 Eligible Professional Meaningful Use Core Measures. 2012. Available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPCore_6_ClinicalDecisionSupport.pdf
34. Center for the Advancement of Health Information Technology and RTI International. [Accessed September 20, 2013] Using Information Technology to Integrate Behavioral Health and Primary Care: Summary Report of Roundtable Findings. 2012. Available at: <http://www.healthit.gov/policy-researchers-implementers/behavioral-health-initiative-overview>
35. Bao Y, Casalino LP, Pincus HA. Behavioral health and health care reform models: patient-centered medical home, health home, and accountable care organization. *J Behav Health Serv Res*. 2013; 40:121–32. [PubMed: 23188486]
36. Patton, MQ. *Qualitative Research & Evaluation Methods*. 3rd edition. SAGE Publications, Inc; 2001.