

# Community Needs Dictate Move To Home Care

FPO

Kathleen Lourde

**More and more providers are considering branching out into home care, but what are the pros and cons?**

**H**elen Cherry, RN, was a director of nursing for a Medicalodges skilled nursing facility before she became its home care division's community services coordinator. Medicalodges, Coffeyville, Kan., a mid-sized skilled nursing facility (SNF) and assisted living facility (ALF) provider, has been offering home care for 10 years, serving an average of 350 clients during a year. Some are their own assisted living clients.

"One of the hardest things, one of the most difficult things, was making the mind shift" to community care, says Cherry.

It's a sentiment echoed by many providers who



have branched out into home care, no matter which of its many incarnations the home care organization falls into.

## **Independence For Caregivers, Clients**

Managing employees in a home care program is very different from doing so in a SNF or ALF, providers agree. And staffing issues of all kinds are the biggest challenge faced by home care providers.

"No one punches a clock; they're unsupervised; they may work for two hours and have an hour when they don't have a client. They may work from 7:00 a.m. until noon, then not work until



five,” says Cherry. “You have to have employees extremely flexible in scheduling and do a great deal of inservice training.”

“It’s very different because a SNF or ALF is able to supervise all their caregivers under one roof,” says Cindy Susienka, president and chief executive officer of Golden Innovations. The Ft. Smith, Ark.-based company is the service business group of Golden Living—one of the largest SNF providers in the country—that includes home care. The company has been providing home care for four years—mostly to the community, although it also provides some in-house services—and has served close to 20,000 patients.

“So if you have a SNF with 100 patients—100 patients in home care is very different,” says Susienka. “You’re in 100 different people’s homes and not supervising those people as they’re delivering care.”

Another aspect of the “mind shift” is in giving over control of what happens

and when to the client, whose preferences are paramount in home care.

“You’re in their home, and they’re the ones that are making the choices as to what the priorities are,” Cherry says. “Many times in a facility the priorities are dictated by survey regulations,” she says. “A home care-based schedule is dictated by the clients and their needs.”

Different or not, long term care providers are taking on the challenges and reaping the benefits of branching out into home care, although increasing competition, often-slim profit margins, and regulatory pressures can complicate the effort. That’s because, like it or not, home-based care appears to be the wave of the future.

### **Demand, Supply Growing Dramatically**

Home care has been around in the United States since the 1880s but has grown significantly in recent years. According to the National Association

of Home Care and Hospice (NAHC), drawing on U.S. Census Bureau data, 7.6 million individuals receive home care from 17,700 professional providers.

“More and more, the move is to home-based” care, says Denise Spiewak, Life Care Services’ vice president and chief operating officer. The Des Moines, Iowa-based company has been providing home care for 23 years, primarily on its own continuing care retirement community campuses. The company has 20 programs in 13 states. About half of its programs are Medicare-certified, and the remainder are private-duty only.

“People want to be in their homes surrounded by their loved ones,” Spiewak says. “And they want to be on their own schedule.”

R.E. Howe, president of Elimcare Communities, has provided long term care for 18 years to the greater Fresno, Calif., area. Elimcare has been offering home care for about six months. Currently, it has about 35 home care clients. Elimcare’s home care is private-duty, and the company provides custodial care. Its clients are either private-pay or have long term care insurance.

“During that [18 years] I’ve seen more and more people wanting to stay in their homes as long as possible with independence,” Howe says. “I think you’re just going to see the curve grow. People want to stay in their own castle as long as possible.”

“Providing that choice is critical,” says Jennifer Pfeffer, regional director for Ecumen, Shoreview, Minn., a non-profit provider of SNFs, ALFs, and adult day care. The company has been offering home care since the mid-1980s. It serves 110 clients—some in their own facilities, most in homes in the community.

“Our customers down the road are going to want choices, and we want to be prepared to offer them,” says Pfeffer.

Home health care is “the fastest

## **Pay For Performance On The Way**

**P**4P—tying a portion of reimbursement to delivery of care that has been proven to be effective—is a new CMS priority and is expected to be part of its planning for the future.

Beginning this month, CMS will roll out its two-year home health P4P demonstration project in seven states: Alabama, California, Connecticut, Georgia, Illinois, Massachusetts, and Tennessee.

Under the demonstration, home health agencies will be eligible to receive incentive payments if their quality improvement efforts result in the highest performance levels or significant improvements in patient outcomes.

The availability of incentive payments will depend on whether the demonstration results in quality-of-care improvements and on the actual savings to the Medicare program overall—not just for home health services provided under the demonstration.

“System-wide savings can be achieved when a home health agency prevents a re-hospitalization of the Medicare beneficiary or a further complication stemming from their illness,” said CMS in a news release.

The quality measures from the existing outcome-based quality improvement set that will be used to evaluate home health agencies’ performance are incidence of acute-care hospitalization and of any emergent care and improvement in bathing, ambulation/locomotion, transferring, status of surgical wounds, and management of oral medications.

growing segment of health care provider types, with a 55 percent growth rate from 2000 to 2005,” according to an OCS white paper. OCS, Seattle, which maintains the nation’s largest proprietary home care benchmark databases of patient-level data across clinical, financial, operational, visit utilization, and patient satisfaction components, provides organizations with performance improvement solutions.

According to the U.S. Department of Labor, “The development of in-home medical technologies and patients’ preference for care in the home have helped change this once-small segment of the industry into one of the fastest-growing parts of the economy.”

Further, some studies indicate that, for many patients, outcomes don’t suffer when post-acute care is provided in the home rather than in residential settings.

### Comparing Outcomes

A study by the Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare-related issues, found that post-acute care patients who go into home care to convalesce have outcomes equal to those of their peers in nursing or assisted living facilities and that home care is significantly less expensive for the government.

Because of all this, many states are moving Medicaid toward home care.

“There will always be a need for long term care centers,” Alan Ormsby told the *Deseret Morning News*. Ormsby is the director of the Utah Division of Aging and Adult Services who proposed a new pilot program to determine whether outcomes are as good in home care.

“But when you can provide safe and often more effective services at home and at a fraction of the cost for many seniors, we have to at least begin moving in that direction.”

“Anything that can be done to effec-

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### Medicare Home Health Utilization By Principal Diagnosis, 2004

Diseases of the circulatory system	20.5% (582,000)
Heart disease	10.9% (309,000)
Endocrine, nutritional, and metabolic diseases and immunity disorders	9.2% (260,000)

*Source: “Basic Statistics About Home Care,” NAHC, updated 2007. CMS, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information. “Health Care Financing Review: Medicare and Medicaid Statistical Supplement,” 2006.*

tively treat and keep the elderly at home is not only what we need to be promoting, it’s what the new wave of baby boomer senior citizens is demanding,” Josefina Carbonell, assistant secretary for the aging at the U.S. Department of Health and Human Services (HHS), told reporters. At least 200,000 U.S. elderly could be diverted from nursing facility care over the next decade, she said.

“It’s critical that we have these programs in place and running, because 10 years is exactly when the largest wave of the baby boomers becomes seniors.”

### Many Things To Many People

Home care can mean quite a number of things. There are home care agencies, home health agencies, home care aide organizations, hospices, and visiting nurse associations. Some home care organizations are based out of

hospitals, some out of SNFs, some out of rehabilitation facilities, and many are freestanding. Some are proprietary and for profit, some governmental, some voluntary, some private and non-profit. Some are Medicare-certified and offer primarily medical services; some are “private duty” and provide almost anything the client is willing to pay for, from nursing to walking the dog, although non-nursing tasks are mostly chore-related and assistance with activities of daily living (ADLs).

The number of Medicare beneficiaries using home health care in 2005, the most recent year for which MedPAC had data, was 2.9 million, a 6.1 percent increase over the previous year. “This growth rate is higher than the 1.6 percent growth in the number of Medicare beneficiaries,” MedPAC wrote in its 2007 report to Congress on home health care.

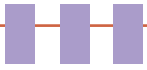
About 70 percent of home health users are age 75 or older, according to AARP. More than half are women, and more than half have family incomes of \$15,000 per year or less. About 43 percent have limitations in one or more ADLs, compared with 9 percent of beneficiaries in general.

Roughly 60 percent of home health patients were admitted after a recent discharge from an inpatient hospital, according to the OCS white paper.

Among Medicare beneficiaries, 38 percent come directly from the community, while 48 percent had prior hospitalizations and 14 percent had prior nursing facility stays within 15 days of receiving home health care, according to a 2001 study by the HHS Office of Inspector General.

According to OCS analysis of the “Medicare Current Beneficiary Survey,” nearly 90 percent reported one or more chronic conditions, especially hypertension and arthritis.

Medicare beneficiaries accounted for about 4.9 million episodes of care in 2005, according to MedPAC’s 2007 report. That number is 9 percent higher than the previous year.



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The intensity of care provided over the 60-day episode fell slightly, although the average length of stay increased slightly. The average duration of stays that were one episode was about 31.4 days, and 76 percent of all stays had only one episode. For stays with two or more episodes, the average length of stay was about 181 days.

### Who's Paying For Home Care?

How much is spent on home care annually is difficult to estimate. The Centers for Medicare & Medicaid Services (CMS) estimated that in 2005 the figure was around \$47.5 billion, but that doesn't include payments made by clients directly to independent providers or other spending unavailable in national health accounts data, according to NAHC.

Public funding sources for home care include Medicare, which paid 37 percent of all home care expenditures, Medicaid, the Older Americans Act, Title X Social Services block grants, the Veterans Administration, and Civilian Health and Medical Program of the Uniformed Services, according to NAHC.

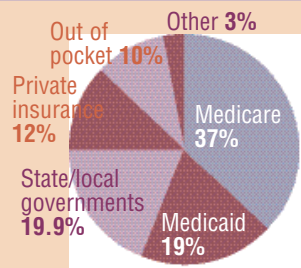
"While Medicare pays the largest share for home health care, combined federal-state Medicaid outlays for in-home services (including personal care services that Medicare does not pay for) are actually greater," wrote NAHC in a 2007 report, citing aggressive pursuit of home- and community-based long term care alternatives by the White House and the nation's governors.

Medicaid spending for home health care is growing quickly. According to a 2007 CMS report on national health expenditure projections, Medicaid's spending on home health care was projected to have grown 19.8 percent in 2006 alone. It's expected to average a 9.8 percent annual growth rate from 2007 to 2016.

Managed care is playing a growing role in home health reimbursement.

The Medicare Modernization Act of

### Sources Of Payment For Home Health, 2006



Source: "Basic Statistics About Home Care," NAHC, updated 2007, from the CMS Office of the Actuary report "National Health Care Expenditures Historical and Projections: 1995-2016," March 2007

2003 provided financial incentives that have resulted in a slow increase in Medicare beneficiaries enrolling in Medicare Advantage (MA) plans. So far only 19.7 percent of Medicare beneficiaries have enrolled.

But the percent of Medicare beneficiaries enrolled in MA is expected to substantially increase—estimates range from 16 percent to 30 percent—by 2013, according to projections from HHS and the Congressional Budget Office.

Among Medicaid beneficiaries, on the other hand, a growing number are being enrolled in managed care. By 2007, 65 percent were enrolled in managed care, according to a 2007 CMS report.

### Profit Challenges In Home Care

Tight profit margins, reimbursement issues, providing good quality assurance, staffing complexities, increasing competition, and actions of state and federal governments all pose home

care challenges. What kind of profit margin is there in home care?

"Slim," says Cherry. "It's only in recent years that we've become profitable," but even now the profits are smaller than those of their facilities.

Medicalodges' first home care organization wasn't profitable for five years. "Reimbursement is \$14 to \$15 an hour in Kansas. By the time you put an employee in there and pay full-time benefits, the profit margin can be very slim. Referrals [to a company SNF or ALF] are the only things that offset" a new agency's lack of profitability, Cherry says.

Anecdotally, most providers seem to find it a struggle to make a profit.

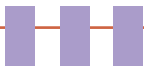
"Private duty tends to be a low-margin business," says Spiewak. "It's definitely volume-driven."

"I think there is a profit margin. I don't think it's big," says Howe. "You have to stay in the black if you're going to be able to succeed and help people, but [profit] isn't our motivation for being in the business."

According to Susienka, the public companies may do a little better, perhaps because their case mix differs in some way. "Looking at the public companies, the margin on home care, depending on your mix of business, is probably a little higher than a SNF," says Susienka. "If you have a lot of managed care or Medicaid, your profits are much lower."

MedPAC's model of home health organizations' profit margins reported to Congress in 2007 is based on data from about 4,500 freestanding home health organizations not affiliated with hospitals. The margin for hospital-based home care organizations was -1.5 percent in 2005, but MedPAC doesn't attribute this to the payment rates but to higher costs such as the allocation of overhead from the hospital.

The organization has recommended that "Congress should eliminate the update to payment rates for home care services for the year 2008." The report



claims that profit margins on Medicare-reimbursed services were more than adequate at 16.8 percent for freestanding agencies. About 20 percent of organizations reported negative margins, the median margin was 15 percent, and the margin at the 75th percentile was 27.3 percent.

“Home health agency margins for 2007 are projected to be 16.8 percent,” MedPAC reported. Further, it said that the growth in the average cost per episode in 2005 was small, at 0.7 percent.

MedPAC has been recommending that Congress freeze home health payments every year since 2003, based on its findings regarding the profit margins of freestanding facilities.

According to NAHC, “more comprehensive” studies of home care organizations’ margins “have found significantly lower Medicare profit margins that virtually disappear when all payers are taken into account. Further, when agency profit margins are considered on an individual basis, they reflect dramatic ranges,” the association wrote in its “2007 Legislative Priorities” report.

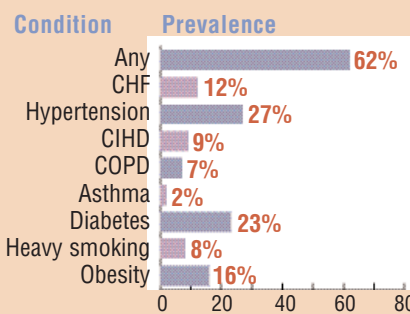
### Is Home Care Rewarding?

Slim or not, at least some SNF and ALF providers find the business line rewarding enough to continue to work to make the business both high-quality and cost-effective.

“Are there opportunities for financial return in Medicare home care? Certainly there are,” says Bill Kubat, vice president of resident, community, and quality services for The Evangelical Lutheran Good Samaritan Society, Sioux Falls, S.D. Good Samaritan is a nonprofit with 240 campuses in 24 states. It’s been providing home care for a number of years, but it’s become a focused strategic initiative within the past five to seven years. The society visits about 1,500 clients per day. Depending upon the area, it delivers home health care to both the residents on its campuses and in the community.

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### Prevalence Of Conditions Appropriate For Disease Management In Home Health Patients\*



Source: “Predictive Modeling: An Important Opportunity in Home Health,” OCS, 2006  
\*Based on OCS database—patients admitted in the first quarter of 2006 (more than 250,000)

“You have to manage [a Medicare-certified operation] well, stay on top of it, but the opportunities are there,” Kubat says. “On the private side, that’s every bit as challenging but for different reasons: issues of service creep and charges accurately reflecting costs.”

Operating a home health organization, as with much of health care, is a delicate balance between the cost of providing care and the quality of the care provided. Pay-for-performance (P4P), when it enters the picture, will narrow the margin of error as organizations attempt to achieve top-level quality “within the parameters of appropriate resource expenditure,” according to the OCS white paper.

“You have to be very conscientious in day-to-day business expenditures,” says Cherry. Potential clients must be evaluated before they’re taken on.

Medicalodges serves many people in rural areas, and “windshield time”—drive time for the employee to get to the client’s home—isn’t reimbursed.

“Take a client that’s 30 miles away, and that’s not unusual,” says Cherry. “If you don’t have an employee who lives in that vicinity and you may be paying them an hour for drive time, that’s not reimbursable, and maybe seeing that client two hours a week” just may cost the agency more to provide the care than it gets in reimbursement. Keeping in mind where staff members live and being very careful about how they’re scheduled “is one of the single most important things you do,” she says, “along with the customer being satisfied.”

The answer to how to best balance costs with quality of care, according to OCS, is called Business Intelligence—integrated quality outcomes, financial performance, visit utilization, operational practice, and patient satisfaction data within and across business lines presented to management in reports that make it easier to see the effect of one factor on another.

“Effective management requires that executives have a handle on their organization’s key performance indicators—both within and across business lines,” OCS writes. “We are talking about patient-level linkage of all OASIS [outcome and assessment information set] data elements—visit utilization by discipline, patient satisfaction outcomes, and indicators of participation in specialty programs—in the context of financial metrics by episode type and operational practice benchmarks, representing over 800 potential measures of analysis.”

### Reimbursement’s Role

The governmental reimbursement environment is different from and may be more complicated than that for a SNF, say providers.

“The reimbursement on home care is much more complex than the SNF side,” says Susienka. “There are new

regulations coming up again. Any sector, there's always challenges. But it's complicated. And the billing is complicated."

Private pay and long term care insurance have their own difficulties. "Private pay requires intensive monitoring of accounts receivable," says Spiewak. "We also bill long term care insurance, and that can be a challenge. It extends the period of time-accounts' age simply because it's a 60-, 90-, to 120-day period of time until you get paid, depending on the insurance company."

The Medicare home health program went to a fully prospective payment system (PPS) in late 2000. The PPS system is similar to that for SNFs except that it's based on a 60-day episode rather than a patient day. The home care organization receives half of the estimated base payment as soon as the fiscal intermediary receives the claim. The rest of the payment comes at the close of the 60-day episode.

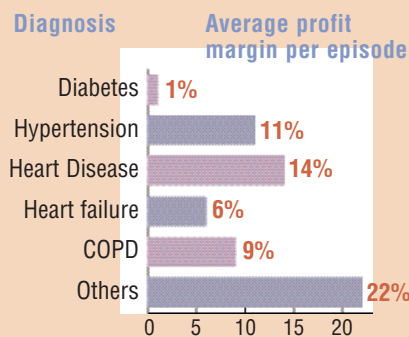
Beginning this month, the home health PPS will be based on a 153-category case-mix adjuster, up from 80 categories. This sets payment rates based on patients' characteristics, such as functional status, clinical severity, and need for rehabilitative therapy services.

The home health PPS partially reimburses for "outliers": patients whose costs are unexpectedly high. Payments are also adjusted for geographical differences in wages.

Reimbursement is also based on whether a provider participates in OASIS. Home care organizations that submit performance indicator data using OASIS are paid based on the full home health market basket update of 2.9 percent for 2008. If the home care organization doesn't submit the data, the market basket is reduced by two percentage points, to 0.9 percent, for the year.

But Medicare reimbursement levels "have failed to adequately cover the rising costs of providing care, includ-

### Average Profit Margin Per Episode, By Primary Diagnosis At Start Of Care\*



Source: "Predictive Modeling: An Important Opportunity in Home Health," OCS, 2006  
 \*Based on OCS database—non-LUPA Medicare episodes ended in 2005 (about 168,000 episodes). Excludes supply costs.

ing increased labor costs for home health agencies," according to NAHC.

A recent study by MedPAC and CMS indicates that the PPS case-mix adjuster does not, in most cases, accurately predict the costs of providing care.

If reimbursement is inadequate, agencies may find that they can't accept patients, such as outliers or

those who live in deeply rural areas, whose care costs would place it at financial risk.

"Insufficient payments could create perverse incentives to place limits on care, affecting the overall health care outcomes of patients," writes NAHC in its "2007 Legislative Priorities." "Congress should direct CMS to develop a more adequate system of outlier payments under PPS so that high-cost patients will have continued access to services."

CMS has issued proposed regulatory and legislative cuts to Medicare payment rates that would reduce payments by nearly 12 percent over the next four years. "If Congress allows Medicare to put these cuts in place, over 50 percent of all home health agencies will be paid less than it costs to deliver care," said NAHC President Val Halamandaris in a news release. "No health care provider can sustain that impact."

### Measuring Quality

Key new CMS priorities, other than P4P (see box, page 20), relating to quality are standardizing assessment and quality measurement across post-acute health care settings, integration of measures of process and systems, and

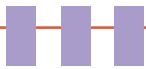
### Competition Growing

One result of the tremendous growth of the home health sector is competition.

"Large metropolitan areas have this horrendous, uncontrolled growth" in home care organizations, says Mary St. Pierre, vice president for regulatory affairs for NAHC. Examples are Chicago, Los Angeles, and Houston.

"The county for Houston has 421 home care organizations," she says. "So in metropolitan areas where they don't have certificates of need we're seeing agencies spring up" at uncontrolled rates.

Competition is a significant challenge, says Denise Spiewak, Life Care Services' vice president and chief operating officer. "Everybody sees the demographics," she says. "The leading edge of the boomers are turning 60, and as a result there's been a huge increase in providers. The franchise organizations have gotten very large very quickly. Home Instead, for example, has 700 locations. There are also a lot of people opening up to serve their own communities."



electronic health records. CMS has directed quality improvement organizations to work with home care organizations to reduce hospitalization rates and to encourage the adoption, use, and monitoring of best practices and quality measures.

Since 1999, home care organizations have been collecting and reporting performance indicator data via CMS' OASIS data collection tool.

In 2003, CMS started making some of that data public on its Home Health Compare Web site. The performance measures include improvement in ambulation/location, bathing, transferring, management of oral medication, pain interfering with activity, dyspnea (shortness of breath), and urinary incontinence; acute care hospitalization; emergent care; and discharge to community.

OASIS data form the basis for patient case-mix profile reports and patient outcome reports used by home care organizations for quality improvement purposes and by state survey staff in the certification process. They're also used for case-mix adjustment of per-episode payment.

### Avoiding Hospitalizations

Quality measures are showing improvement, according to MedPAC. But the national norm for acute care hospitalizations—something Medicare wants to avoid—was 30 percent in 2006, ranging from 19.6 percent to 36.1 percent among the 10 Medicare regions, according to OCS.

In the proposed P4P methodology for determining performance bonuses, acute-care hospitalization and emergency care rates are given the most weight, according to CMS.

Because of the focus on avoiding expensive hospitalizations and emergency room visits, innovations have proliferated to help home care organizations in this effort, according to a 2006 OCS white paper. "Examples of such innovations include telemedicine, disease management, point-of-care

software, care pathways, care plans, advanced wound care technologies, specialized therapies, advanced medication dispensers, and educational offerings," OCS writes.

All of these innovations cost money to implement, and balancing that cost with the benefit is a struggle. OCS recommends using something called predictive modeling to make a cost-benefit determination.

### Share Of Medicare Home Care Patients Achieving Positive Outcomes Continues To Increase

Measure*	2003	2006
Improvement in:		
Walking	34%	40%
Getting out of bed	49	52
Bathing	57	63
Managing oral meds	35	41
Patients have less pain	57	62
Any hospital admission	28	28
Any unplanned ER use	21	21

Source: Report to Congress 2007, MedPAC, March 2007

\*These quality measures are the items from OASIS that Medicare reports to the public. These quality indicators are risk-adjusted to account for patients' diagnoses, comorbidities, and functional limitations.

"A predictive model forecasts the likelihood of future events (hospitalization, death, or experiencing an unexpected response to a treatment) based on data from the past," writes OCS.

"The model is made up of a number of predictors (gender, age, medical history). To create a predictive model, data are collected for the relevant predictors and outcomes, a formula is created using statistical techniques, predictions are calculated, and the resulting model is tested and validated using additional data."

A basic form of predictive analysis is simply completing a checklist of high-risk characteristics, drawn from clinical studies.

Such modeling enables home care organizations to know, as soon as an

assessment is completed, the probability of the patient needing hospitalization or emergent care, for example. These patients tend to be more costly to care for than others (*see graph, page 25*), and technologies or specialty programs can be implemented to counter that risk and create a better outcome for the patient.

Another measure home care can take to improve outcomes is disease management, in which patients having specific chronic conditions receive specialized, evidence-based care along with education about self-managing their condition and regular follow-up to ensure compliance. This helps to prevent hospitalizations and emergent care and improves the patient's quality of life.

Conditions commonly seen in the home care population, according to OCS, that would benefit from disease management include diabetes, congestive heart failure, chronic obstructive pulmonary disease, smoking, and obesity.

### Checking On Services

Elimcare's quality assurance efforts center around the caregivers. "We have an intensive training program for quality assurance purposes," Howe says. And every two weeks coordinators visit every home to "spot check" and "to make sure things are being done correctly and families don't have a problem, or if there is a problem that it's out on the table where we can work it through to resolution," says Howe.

"Often the family members aren't there, and that's why we encourage them to call any time they have an issue or question."

"We're very focused on quality and our clinical programs," Susienka says. "Through OASIS you have the option of participating in CMS Compare, so you're very transparent if you choose to participate in that," she says.

Medicalodges determines satisfaction with and quality of services via phone, by mail, and through unscheduled vis-

its both when the worker is there and when he or she is not, says Cherry. Visiting when the worker isn't in the home is important. "One of the things I've found through the years," says Cherry, is that "many individuals become very dependent on a personal care attendant in their home, and if they're not performing at the highest level, the elderly will tolerate it instead of complain for fear of not having anyone. So that's a constant teaching you have to do with your clients as well."

### **Finding Caregivers**

Virtually every provider interviewed for this article said staffing-related issues were the biggest challenges they face. "One of the biggest challenges we face every day is staffing," says Cherry. "And in home care it has to be staff who have reliable transportation, are self-motivated, can work unsupervised, and understand the necessity of having paperwork completed accurately on a timely basis."

Although the annual growth in home care employment is 5.4 percent, simply getting staff is one of the biggest problems, say providers. "The workforce, the supply of registered nurses, is our No. 1" challenge, says Pfeffer. "It's tough to compete."

Along with the labor shortage, learning how to manage home care staff is a major challenge. Understanding "the different ways that you work, manage, and deploy staff" and hold staff accountable is key to making a success of a home care business, says Kubat.

And having an adequate number of staff means having some in reserve, not necessarily an easy thing to achieve. "If you're in a care facility, you know how many beds you have, and therefore you know how to staff," says Howe. "In home care, there's no limit to the number of potential clients you can have. But you've got to have a caregiver ready when the telephone rings."

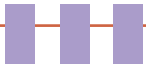
The staff shortage affects the ability of individuals needing home care to access it, especially in rural areas.

"In rural areas we're seeing home care organizations close down or shrink their visiting area because of the cost of providing services to people that live in remote areas," says Mary St. Pierre, vice president for regulatory affairs for NAHC. "Because of the nursing shortage," it's an issue of "get-

ting more service to more people than having all that time spent driving the car."

### **A Hard Time To Enter Home Care?**

Getting into home care will likely be more difficult in the future, warns Susienka. Home care agencies typically



are certified by the state, according to NAHC. However, the length of time to become certified may be getting longer, says Susienka, “because the dollars are getting cut back to do the surveys” to certify new providers. “State certifications are very backlogged,” she says.

Texas and New Mexico aren’t Medicare-certifying new home care organizations at all. “It’s CMS saying [these states] can’t certify any new home health agencies because they haven’t fulfilled their requirement to survey existing home health agencies at the required frequency,” says St. Pierre.

“They’ve been surveying new agencies and not surveying existing agencies at the frequency they’re supposed to,” she says.

In July 2007 HHS announced a two-year demonstration project, the goal of which is to strengthen the ability of CMS to detect and prevent fraud. The demonstration will focus on Medicare-certified home health agencies in greater Houston and greater Los Angeles. “If the demonstration project proves successful, it will grow and spread,” says St. Pierre.

CMS’ focusing on these parts of Texas and California is tied to the tremendous growth in home health agencies in those areas.

In addition to the certification problems and greater attention by CMS on areas where the numbers of home health agencies are growing too fast, “there’s a moratorium on new home care agencies in many states,” says St. Pierre. “It’s almost like it’s not the time to get into home health,” she says.

But along with the challenges come the benefits.

### SNFs, ALFs, See Benefits

Referrals into the facility, continuing to care for rehab patients after they return home, and diversification of services are a few of the benefits SNF and ALF providers see in branching out into home care.

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### Average Compensation Of Home Health Agency Executives, October 2006

#### Salary range by percentile median

Executive director/CEO	\$90,000
COO/program director	\$72,100
Top-level financial executive	\$84,700
Director of clinical services	\$66,542
Director of social work & counseling	\$54,766
Quality improvement/ utilization review manager	\$63,123

### Average Compensation Of Home Health Agency Caregivers, October 2006

#### Per-hour rates by percentile median

Registered nurse	\$25.00
LPN/LVN	\$18.50
Occupational therapist	\$29.87
Physical therapist	\$32.54
Respiratory therapist	\$21.19
Speech/language pathologist	\$29.00
Medical social worker	\$22.14
Home care aide III	\$11.00

Source: NAHC, Hospital & Healthcare Compensation Service. “Homecare Salary and Benefits Report 2006-2007.” October 2006

Home care gives long term care companies an opportunity to reach out into the community and demonstrate their ability to provide care that really is caring, thereby building a good reputation for their entire continuum of services, providers say.

Howe says the biggest benefit to Elimcare Communities of doing home care “is word of mouth in this area that Elimcare is concerned about seniors,”

says Howe. The company has the ability to care for people “in their homes, in assisted living, at the skilled nursing level. And there’s a comfort level that a lot of people take from that. The thing [for the family] is, do the people who care for Mom and Dad really care for them?”

Cherry agrees. “It’s your first opportunity to introduce the company and what you offer and how well you provide your service,” she says. “In the future, as their needs increase and as their health needs become more prominent, you’ve had an opportunity to build a relationship with them. It’s very important to me that when we go into that home we provide excellent service,” she says. It also works the other way, especially for facilities that do a lot of rehabilitation.

Many of Golden Innovations’ home care patients come from their SNFs and ALFs, especially those who need rehabilitation, says Susienka. “In a facility that has a lot of rehabilitation and they’re sending a lot of patients home, I would say between 50 percent and 75 percent of patients go home with home care,” she says.

The benefit to a long term care company in providing home care is being able to offer “continuity of care, a continuum of care,” says Susienka. A patient can be in a Golden Living SNF for rehabilitation, “be evaluated by the rehab company while there, then we’ve trained our home care staff on specialty clinical programs in the SNF so they can continue those programs at home,” she says. “You have that synergy” between your business lines.

“I think it makes sense to think about” going into home care, says Kubat, “because you have to think about what the future of aging services is in your community, what that’s going to look like in the future, and what your part in the continuum is going to be. ■

KATHLEEN LOURDE is a freelance writer based in Dacoma, Okla.