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SOCIAL WORK IN HOME HEALTH CARE (HHC): CHALLENGES IN THE NEW PROSPECTIVE PAYMENT SYSTEM (PPS)

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**SOCIAL WORK IN HOME HEALTH CARE (HHC):
CHALLENGES IN THE NEW PROSPECTIVE PAYMENT SYSTEM (PPS)**

Policy Action Paper

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CHALLENGES IN THE NEW PROSPECTIVE PAYMENT SYSTEM (PPS)

Policy Action Paper

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I. Executive Summary

A policy advocacy roundtable discussion on the “Impact of Prospective Payment System (PPS) on Social Work Services in Home Health Care (HHC)” took place on April 17, 2001, at Fordham University Graduate School of Social Service in New York City. A distinguished panel and by-invitation only audience of health care leaders shared much information and ideas on this issue. This document integrates the comments of panelists and participants with other information and data from the literature, and is intended to serve as a starting point for discussion, research, and advocacy. It covers background on Medicare, Prospective Payments, Home Care, and Social Work roles. It ends with a series of proposed action steps, the highlights of which are:

1. An integrated health care system with seamless transition between acute care and long term care (LTC) should be created.
2. Caregiver/natural helping network education and support should be integrated into the HHC PPS case mix methodology.
3. Independent case finding should be established for social work services, in place of the current system of dependence on nurses and physicians.
4. A HCFA (Medicare, Medicaid and SCHIP Agency) waiver program should be established allowing for demonstrations of alternative case mix models. Social care models and models incorporating caregivers should be demonstrated and researched.
5. In order to deal with the opportunities endemic to PPS and capitation for “stinting” or rationing of care, it is proposed that a systematic mechanism be created to safeguard against such practices, including comprehensive quality assurance programs. Tripwires should be established for additional case reimbursement when the cost of care of complex cases exceeds the PPS case mix. Mechanisms must also be established to counter the potential for abuse of such tripwires.

6. Social work roles should be clearly defined in HHC and understood by other health care professionals.
7. Development of true interdisciplinary HHC teams (which include social work) will be the key to successful patient care under PPS.
8. Evidence-based research on the effectiveness of social work services must be conducted for the survival of social work in HHC.
9. Screening instruments for social work services should be developed for use in HHC to ensure that all patients will receive timely social work services.

II. Policy/Regulatory Background

Following World War II, America embarked on an aggressive program of hospital construction—primarily voluntary, not-for-profit, and teaching hospitals. At the same time, from the 1950s into the 1980s, private, indemnity insurance grew considerably, providing many Americans, as a fringe-benefit, with health insurance coverage. In 1965, Titles 18 and 19 were passed, creating Medicare and Medicaid, and establishing a large government presence in health care financing and delivery. Among the many consequences of these factors were: the centrality of the acute care hospital in the health care system; the disease-focus of care, as opposed to a prevention focus (indemnity insurance provides reimbursement for illness, not preventive care); and by the 1970s, severe health care cost inflation. (Starr, 1982; Rock, in press)

“Medicare is a national health insurance program for which people over the age of sixty-five and those deemed totally disabled are eligible, regardless of income and assets, provided they have paid into the Social Security system. Medicaid is health insurance utilizing combined federal and state funds. It is defined, regulated, and managed by each state. There is a trend across the country for both of these government insurance programs to be administered by managed care providers, which may restrict the number, frequency, and duration of visits of home health disciplines” (Abel-Vacula, Nathans, Phillips, & Robbins, 2000, p.10). See Figure 1 for some historical highlights of the Medicare program.

Figure 1. Historical Highlights of Medicare

July 30, 1965	The Medicare program, authorized under Title XVIII of the Social Security Act, was enacted to provide health insurance coverage for the elderly.
July 1, 1966	Medicare benefits began for more than 19 million individuals enrolled in the program.

Based on De Lew, N. (2000). Medicare: 35 years of service. Health Care Financing Review, 22 (1): 75-103.

During the past 35 years, Medicare has provided health care coverage to more than 93 million elderly and persons with disabilities; more than 39 million are alive today. As a consequence, Medicare has made important contributions to improvements in health status for elderly and disabled beneficiaries. (De Lew, 2000)

III. Definitions and Descriptions of Home Health Care and Social Work

1. Medicare Home Health Care (HHC)

The home health benefit has been part of the Medicare program since its inception. The main goal of Medicare home health care is to provide for beneficiaries who need acute medical care that requires the services of skilled health care personnel. About 3.6 million of Medicare's 33 million beneficiaries in the traditional fee-for-service Medicare program and nearly 6 million Medicare + Choice beneficiaries received HHC in 1997. (US House of Representatives, 2000)

To qualify for Medicare home health services, a beneficiary must be:

- Physician-certified as homebound;
- In need of intermittent skilled nursing care or physical or speech therapy; or
- Under the care of a physician who certifies that care in the home is necessary.

It is important to note that a patient who only needs personal care (e.g. help with bathing and dressing), and has no need for skilled medical care, does not qualify.

Medicare HHC is provided to homebound individuals who need skilled nursing care, physical therapy, or speech-language pathology services. Specifically, Medicare home health services include:

- Part-time or intermittent skilled nursing and home health aide services;
- Physical, speech, and occupational therapy;
- Medical social services; and
- Medical supplies, and durable medical equipment.

Part time or intermittent skilled mostly refers to skilled nursing and home health aide services provided any number of days per week as long as they are provided (combined) less than 8 hours each day and 28 or fewer hours each week. The one caveat in the covered services is that Medicare beneficiaries must need skilled nursing care, physical therapy or speech therapy to also receive occupational therapy, services from a medical social worker, and home health aide services. In addition, only occupational therapy can

be provided after the need for skilled nursing care, physical therapy and speech therapy ends (Green Book, 2000)

Profile of Medicare Home Health Users

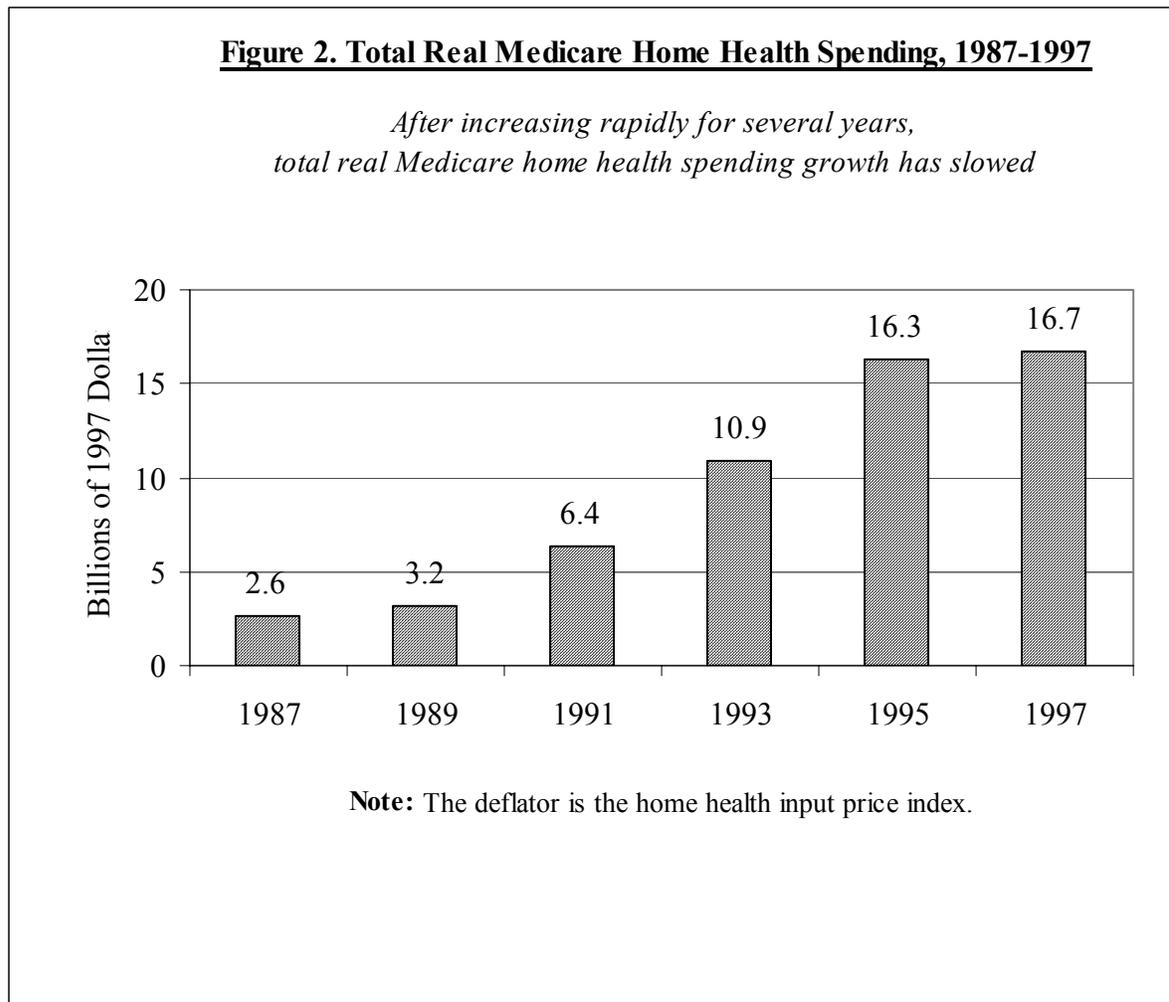
In general, home health patients tend to be older than the overall Medicare population. Medicare beneficiaries who are age 85 and older are proportionately the largest users of Medicare home health (HCFA, 1999). Between 1987 and 1997, home health use has increased, especially among the oldest and youngest (disabled) beneficiaries. As of 1997, 26% of home health users were age 85 and over while they represent only 11% of the all Medicare beneficiaries (HCFA, 1999). Home health users are also likely to be female. Of all home health users, 67% are female compared to 55% among non-users. With an older age group utilizing HHC, they were more likely to have three or more impairments to activities of daily living, than beneficiaries who do not use HHC (HCFA, 1999). Home health users are also poorer than non-users and are more likely to be dually eligible for Medicare and Medicaid. Home health users are more likely to live alone compared to non-users. About 40% of home health users live alone compared to 30% among non-users (HCFA, 1999)

Although Medicare beneficiaries utilize home health services for a variety of diagnoses, the ten most common diagnoses of home health users in 1997 in order of prevalence are: diabetes, hypertension, heart failure, osteoarthritis and allied disorders, cerebrovascular disease, chronic airway obstruction, other forms of chronic ischemic heart disease, cardiac dysrhythmias, and general symptoms (HCFA, 1999)

Medicare Home Health Utilization and Spending

Medicare home health use grew rapidly in the 1990s. The proportion of Medicare beneficiaries using home health increased from 5.8% in 1990 to 10.8% in 1997. Between 1987 and 1991, the annual average number of home health visits per patient doubled from 23 visits to 45 visits per user. By 1997, the number of visits rose to 73. It is important to note that during this time, there has been a significant increase of patients who received more than 200 visits. In 1987, less than 1% of all home health users

received more than 200 visits. By 1997, home health users who received more than 200 visits represented about 10% of all home health users (HCFA, 1999). These patients represent more than 46% of the total Medicare expenditures (HCFA, 1999).



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

The types of visits to home health users have also changed since 1987. Within the total Medicare home health visits, about 51% were skilled nursing care and 33% were accounted for by home health aide services. The types of visits shifted in 1997, where skilled nursing services fell to 41% and home health aide services rose to 48%. This may point to the use of home health care as more of a long term care service rather than a

short term outpatient care services for patients who need skilled nursing care (HCFA, 1999).

Medicare spending has also grown rapidly, reflecting the growth in utilization. Medicare home health expenditures increased at an annual rate of 21% between 1987 and 1997. Home health represented 2% in 1987 and 9% in 1997 of the total Medicare spending (HCFA, 1999).

2. Social Work in Home Health Care

Provisions of medical social service have been a part of Medicare home health since the start of the program. Medicare requires that every home health agency make social work services available to the patients (HCFA, 1992). However there is no requirement that social workers see patients or participate in the planning of their care (Dhooper, 1997). Under Medicare, social work services are not considered a primary service such as skilled nursing, physical therapy and speech therapy. Therefore, social work services cannot be the only services provided to a patient in home health care. For that reason, the traditional pathway for a patient to receive social work services under Medicare is to receive a referral from a nurse or a physical or speech therapist.

For home health agencies to get reimbursed for social work visits, Medicare requires that social work visits be justified by “a clear and specific link between the social and emotional needs of the beneficiary and the beneficiary’s medical condition or rate of recovery” (HCFA, HIM 11). Medicare mostly does not limit the number of social work visits provided to a patient as long as the visits are justified (Abel-Vacula, et al., 2000). Direct patient contact is an important aspect of reimbursement for social work services. Therefore, Medicare does not reimburse social work services limited to assistance with Medicaid applications, arranging transportation for dialysis patients, and assisting with advance directives and living wills (Abel-Vacula, et al., 2000).

Roles of Social Work in HHC

Social workers fill various roles and functions in HHC. Social workers are trained to view their patients from a systems perspective. They see their patients as “person-in-environment,” where the patient and family are within a system that influences how they function. Social workers provide a wide range of services such as psychosocial assessment to grant writing. Specific to patient activities, a study by Lee (in press) points out that social workers provide three types of services. First, social workers provide direct patient activities, such as counseling patients and family members, and crisis intervention. Counseling included not only short-term therapy but also placement (e.g. hospice, nursing home) of patients after discharge from home health, and work with caregivers to lessen their burden. They also provide patient education on available services and legal rights as an additional direct patient activity. The second type of activity is indirect patient services. Among all the activities identified by Lee (in press), indirect patient activities represent the largest and most time consuming part of providing social work services. Coordination of services (e.g. referrals to other community services, placement of patients after discharge), completing application for government benefits, and collaboration with other professionals are the common indirect patient activities. Social workers often mediate between the patient and other health care professionals, when patients are unable to cope with managing the various care professionals. Social workers also advocate for patients and deal with managed care organizations. Social workers are increasingly more involved with managed care patients and are often requested by the managed care companies to perform what they call “long term financial planning.” This role was primarily performed for patients who were “financial drains” to managed care companies and to help the patients obtain other community or government funded services. Lastly, Lee (in press) also points out that social workers perform professional and organizational activities such as education of other professionals in home health about the roles of social work.

Newer primary roles for social workers have also emerged from Lee’s (in press) study. One such role is helping the family caregiver cope with providing care. Although providing support for caregivers is not a new function, it has become an increasingly

important and frequently requested service. With elderly living longer with chronic illnesses, such as diabetes, congestive heart failure, and dementia, many families are faced with long-term caregiving, which is often taxing on the caregiver (Clipp & George, 1990; Lieberman & Fisher, 1995). Another new role identified is working with managed care organizations. As Medicare and Medicaid turned to managed care organizations to provide health care for elders, disabled, and the poor, managed care patients are often referred to social workers at the request of the managed care organizations themselves. According to Lee (in press), social workers are often called on to deal with costly clients by helping patients and their families manage their illness and referring them to other community services. Lastly, a new social work role is working with the patient on advance directives.

Social work roles can also be defined using their various functions within a home health agency. According to Abel-Vacula, et al. (2000), social workers in HHC can be generalist practitioners and case managers. They can also work as a part of a specialized interdisciplinary team with at-risk populations and work in psychiatric home care, HIV and AIDS services, maternal-child health and hospice as well. Inevitably, with the variety of roles that social workers can perform, their roles often overlap with the home care nurses. This is often a source of tension between the two professions. However, social workers and nurses can optimize their expertise by clearly defining their roles within the agency as well as through continued interdisciplinary education about each other's roles.

IV. Prospective Payment System (PPS)

Through the 1980s and 1990s, corporations had more and more difficulty with the high cost of health plans. The Federal government was also very concerned with the large increases in the Medicare program. Cost containment became the first issue in health care at that time and remains so today. The first “managed” health care that was tried on a large scale was the Prospective Payment System (PPS) through the methodology of Diagnosis Related Groups (DRG). Beginning in 1982 in most states, hospitals were reimbursed for Medicare patients on a flat-rate basis, determined by the DRG in which the patient’s diagnosis was included. Whatever the payment was for a particular condition, the hospitals were expected to treat patients within the limits of that flat payment. If they spent less, they financially gained. If they spent more, they lost. The theory was that, in the end, gains and losses would balance out. The question of case-mix became crucial regarding the types of patients who were admitted; and social work-conducting discharge planning became central to the survival of hospitals. This was a modified version of what is called in managed care *full-risk capitation*. The role of social work in hospitals was certainly enhanced by the PPS/DRG program. Nevertheless, overall health care costs were still increasing in the early 1990s (although the PPS/DRG program did succeed in curbing the growth of inpatient acute care of the elderly under Medicare). Managed care--an old idea that has been around since the beginning of the 20th century, became the main mechanism for cost containment in the last decade of the century (Rock, in press).

Figure 3. Historical Highlights as Related to the Establishment of PPS and Managed Medicare

1982	A prospective risk-contracting option for health maintenance organizations (HMOs) was added to facilitate plan participation.
1983	An inpatient hospital PPS, in which a pre-determined rate is paid based on patients' diagnoses, was adopted to replace cost-based payments. (The PPS was subsequently adopted by other payers and other countries.)
1997	The Balanced Budget Act (BBA) included the most extensive legislative changes since the program was enacted. It established Medicare+Choice, a new array of managed care and other health plan choices for beneficiaries and created new home health, skilled nursing facility, inpatient rehabilitation and outpatient hospital PPSs for Medicare services to improve payment accuracy and to help further restrain the growth of health care spending.

Based on, De Lew, N. (2000). Medicare: 35 years of service. Health Care Financing Review, 22(1):75-103.

Managed care, capitation, and flat rate prospective payments work best for covered groups containing large numbers of relatively healthy (low-risk) people, only a small number of whom may get sick at any given time. There is not a good fit between these reimbursement methods and high-risk groups such as the poor, the elderly and frail elderly, the disabled, and the chronically ill. Nearly 30 percent of the elderly reported that they were in fair or poor health, compared with 17 percent of those aged 45 to 64. The incidence of chronic conditions among the elderly, defined as prolonged illnesses that are rarely cured completely, varies significantly by age and racial group. More than one-third

of the Medicare population reported limitations with one or more activities of daily living (ADLs). About 13 percent of the Medicare population report limitations in instrumental activities of daily living (IADLs) only (De Lew, 2000).

V. Social Work and PPS

There are three major challenges social work will face as PPS is being implemented in HHC. **First, social work needs to show and document efficiency and effectiveness in HHC.** Under the previous reimbursement system in HHC, social workers were reimbursed on a per visit basis. This meant, more social work visits translated into more agency revenue. Rather than measuring patient outcomes based on the effectiveness of social work services, social work visits itself were viewed as an outcome. Now, under the new PPS system, in which agencies will be reimbursed on a set rate per patient, social work visits alone cannot be used as an outcomes measure. Agencies will now have to look at ways to efficiently and effectively deliver services under a set rate by carefully weighing the cost and benefit of each professional, including social work. Under PPS, it is critical that social workers demonstrate that their efficiency and effectiveness in improving patient outcomes contributes to the revenue of an agency.

Second, it is critical to improve communication with other health care professionals in HHC (Lee, in press). Since social work relies on referrals from other health care professionals within HHC, social work needs to view not only the patient as their consumers but also the nurses, physical therapists and speech therapists as their consumers as well. To do so, social work needs to communicate with other health care professionals more effectively. For example, social work departments within HHC can develop a marketing tool (e.g. formal document or pamphlet) that highlights how social work can help not only patients but also help the other health care professionals do their jobs more efficiently and effectively. The pamphlets may be an easy way to remind and educate other health care professionals about the importance of psychosocial factors on the recovery process and open a dialogue between social work and other health care professionals to implement timely social work interventions for patients who need social work services. Another way is to develop a social work screening instrument which can be used by other health care professionals to identify high-risk patients for social work services. With a concrete tool to help the other health care professionals identify patients in need of social work services, this also can improve communications. Furthermore,

timely and appropriate social work interventions have been proven to reduce lengths of stays (Berkman & Henley, 1981).

Third, social work must advocate for becoming an equal member of the interdisciplinary HHC team. In both hospital and primary care settings, social workers have been incorporated into interdisciplinary teams and have been shown to improve patient outcomes (Sommers, Marton, Babaccia & Randolph, 2000; Cowles & Lefcowitz, 1992). However in HHC, despite the contribution of social workers to patient care, social work still struggles to be accepted by other health care professionals (Baer, Blackmore, Foster, Rose, & Trafon, 1984). Under the new PPS system, agencies must develop an optimal mix of services that has the best chance of improving patient outcomes under the set rate. This means more agencies will look towards an interdisciplinary model to deliver services. The integration of various health care professionals will be no easy task, but without the understanding of each other's expertise and effectiveness, "turf" issues will be further highlighted under PPS.

VI. Roundtable

A policy advocacy roundtable discussion on the “Impact of Prospective Payment System (PPS) on Social Work Services in Home Health Care (HHC)” took place on April 17, 2001 at Fordham University Graduate School of Social Service in New York City. The event was co-chaired by faculty members Drs. Ji Seon Lee (Hartford Geriatric Social Work Faculty Scholar) and Barry Rock, who presented a distinguished panel consisting of:

- Henry Goldberg, Project Director for “Case-mix adjustment for a National Home Health Prospective Payment System”, Abt Associates
- Carol Raphael, CEO, Visiting Nurse Service of New York
- Bob Wardwell, Director, Division of Community Post-Acute Care, Health Care Finance Administration
- Rita Webb, Senior Staff Associate, Division of Professional Development and Advocacy, NASW
- Gail Gill, Executive Director, American Network of Home Health Care Social Workers

Many of the remarks and comments of this panel, and of a distinguished, by invitation audience of leaders in health care, social work and home care who attended the roundtable, are integrated throughout this document.

VII. Action Steps

- 1. An integrated health care system with seamless transition between acute care and long term care (LTC) should be created.**

Rationale

The system as it is currently constructed emphasizes acute care. A clause in the original Medicare legislation limits reimbursement to services which can demonstrate patient improvement. This has characteristically been interpreted as acute care, rehabilitation, and skilled care. The non-acute, non-rehabilitation, unskilled care primarily identified with custodial long term care, is publicly supported by Medicaid, not Medicare. There is thus a disconnect between acute and long term care, codified in a dichotomous pair of policies--Medicare/Medicaid--and resulting in considerable transitional problems between them at the delivery level. Patient need is not dichotomous, and a biopsychosocial approach understands a continuum of need and the inter-relatedness of biomedical conditions and social/functional decline.

Actions Required

- a. The most ambitious action is the establishment of a universal, comprehensive health care policy in the US for all.
- b. A more incremental action is the creation of a local and a national task force to examine ways in which Medicare and Medicaid, and acute and long term care transitions can be improved for the elderly, especially under PPS HHC.

Responsible Agents

- a. Local and national NASW.
- b. American Network of Home Health Social Workers.
- c. NYC Division of Medical Assistance, of HRA

Expected Outcomes

- a. A more seamless integration of acute care, skilled long term care (nursing facility and HHC), and “unskilled” home health services.
- b. Improved coordination of Medicare and Medicaid home care benefits.

2. Caregiver/natural helping network education and support should be integrated into the HHC PPS case mix methodology.

Rationale

The current PPS case mix methodology does not integrate the agency effort/professional resources required for educating and supporting the caregiver and natural helping network roles that are essential for quality care. This is related to the overall de-emphasis on psychosocial factors in constructing the PPS HHC patient case mix formulas.

Actions Required

- a. Revision of the case mix methodology to better incorporate caregiver functions.
- b. Revision of the case mix methodology to better incorporate psychosocial factors.

Responsible Agents

- a. NASW.
- b. American Network of Home Health Social Workers.
- c. Abt Associates.
- d. Health Care Financing Administration.
- e. Researchers at Fordham Graduate School of Social Service.

Expected Outcomes

- a. A case mix methodology which appropriately reflects a biopsychosocial understanding of HHC.
- b. The above can be determined by empirical research and financial analysis.

3. Independent case finding should be established for social work services, in place of the current system of dependence on nurses and physicians.

Rationale

A regulatory/structural issue in social work practice in HHC, which has disadvantaged the social work role and thus limited appropriate psychosocial care in HHC, is the lack of independent case finding by social work.

Actions Required

- a. Advocacy for regulatory change.

Responsible Agents

- a. NASW.
- b. American Network of Home Health Social Workers.
- c. National Home Care Association.

Expected Outcomes

- a. Regulatory change.

4. A HCFA (Medicare, Medicaid and SCHIP Agency) waiver program should be established allowing for demonstrations of alternative case mix models. Social care models and models incorporating caregivers should be demonstrated and researched.

Rationale

Based on action steps 1-3 above, there is considerable concern in the professional community that PPS, like so much else in the Medicare program, is based on a

biomedical view of health care and ignores or limits social and psychosocial factors. Systematic attention to these factors has been demonstrated to be value added to both cost containment and quality. Many federal programs allow for waivers to demonstrate alternative approaches which may be more effective and in the public interest. Very large scale waivers are currently implemented to test out models of managed Medicare and Medicaid. It is recommended that a waiver program be created for PPS. If established, it is the intention of selected participants and sponsors of this Roundtable to apply for waivers to engage in demonstration research of social care models.

Actions Required

- a. Advocacy by a variety of community and professional organizations directed at HCFA and/or Congress to establish such a waiver.

Responsible Agents

- a. NASW.
- b. American Network of Home Health Social Workers.
- c. Health Care Financing Administration.
- d. US Congress.
- e. Researchers at Fordham Graduate School of Social Service.

Expected Outcomes

A waiver program will be established.

Demonstration research will be conducted to test the cost effectiveness of social care models.

5. In order to deal with the opportunities endemic to PPS and capitation for “stinting” or rationing of care, it is proposed that a systematic mechanism be created to safeguard against such practices, including comprehensive quality assurance programs. Tripwires should be established for additional case

reimbursement when the cost of care of complex cases exceeds the PPS case mix. Mechanisms must also be established to counter the potential for abuse of such tripwires.

Rationale

After 20 years experience with PPS in Medicare and recent managed care experience, it is well known that any health care system which reimburses prospectively or on a flat rate or capitated basis runs the risk of denial of appropriate care when the cost of such care greatly exceeds the flat or case-based reimbursement. PPS began in 1982 with acute hospital care. In order to shorten lengths of stay, many patients were rapidly transferred to nursing facilities and sub-acute care developed as a new, post-acute modality. The RUGS system was introduced as a cost-containment mechanism for nursing home care. Now PPS has begun for home care, which has become the fastest cost growing sector of the Medicare program, because home care was the logical sequel and “outlet” to a cost contained hospital and nursing home industry. With the addition of both public and commercial managed care arrangements throughout the health care system, there is the clear danger of rationing of necessary care for the most vulnerable (often the most expensive) population. While it is fully acknowledged that cost containment is necessary, it must take place in the context of comprehensive policy provision and a seamless continuous delivery system, with protection to assure the highest quality of care.

Actions Required

Establishment of a national quality assurance program to specifically monitor this issue.
Establishment of a national database on quality of home care.

Responsible Agents

- a. NASW.
- b. American Network of Home Health Social Workers.
- c. HCFA.
- d. JCHCO and other national quality improvement and health care accrediting bodies.

Expected Outcomes

- a. Empirical evidence that PPS has not compromised quality of HHC under PPS.

6. Social work roles should be clearly defined in HHC and understood by other health care professionals.

Rationale

Medicare requires that every home health agency make social work services available. But, there is no requirement that social workers see patients or participate in the planning of their care (Dhooper, 1997). Furthermore, the home health nurse is usually the care manager and determines the need for social work services and makes the referral. Under PPS, social work services will be weighed carefully against the agency's PPS rate for the patient and the use of these services will depend on the interdisciplinary understanding between nurses and social workers about social work's professional role and value in home health care. Therefore, it is critical that social work roles in HHC are clearly defined and communicated to other members of the home health care team.

Actions Required

- a. Develop a consensus list of social work specific roles in home health care using the Delphi technique.
- b. Create a formal document on social work roles in home health care.
- c. Institutionalize the social work role in home health care using the formal document.
- d. Provide training and education to other professionals in home health care about the role of social workers and their contributions to improving patient outcomes.

Responsible Agents

- a. NASW in collaboration with American Network of Home Health Social Workers.
- b. Social work managers and directors in home health agencies.

- c. Social work research community.

Expected Outcomes

- a. Consensus of social work roles in home health care will be adopted by NASW.
- b. Within 3 years, majority of home health agencies will integrate the formal document on social work roles into their agency policies and procedures.

7. Development of true interdisciplinary HHC teams (which include social work) will be the key to successful patient care under PPS.

Rationale

With the new PPS reimbursement system, the approach to patient care must change to a more targeted care by developing an optimal mix of services that would improve patient outcomes under a set PPS rate for the patient. This includes a mix of both medical and social services, since the largest portion of home health users has a chronic illness (Mauser and Miller, 1994) often presenting psychosocial problems along with their medical condition. Other health care settings, such as hospitals (Cowles & Lefcowitz, 1992; Kaltreider, Martens, Montesrosa, & Sachs, 1975) and primary care (Sommers, Marton, Barbaccia, & Randolph, 2000; Badger, Ackerson, Buttell, & Rand, 1997), have recognized psychosocial factors as an important factor contributing to patient outcomes and have been incorporating social work into their interdisciplinary teams. Thus, for effective care under PPS, social work must become a true member of the interdisciplinary team to address psychosocial issues for many of these chronically ill patients. Furthermore, given the current reimbursement environment in health care, knowing how to work as a team to improve patient outcomes will be critical to the survival of social work in health care settings.

Actions Required

- a. Develop interdisciplinary team curricula in schools of social work and other health care professional schools.
- b. Conduct interdisciplinary team training for professionals in HHC and provide continuing education credits for attendance.

Responsible Agents

- a. CSWE and other health care professional educational accrediting organizations.
- b. HHC providers.
- c. National Home Care Association.

Expected Outcomes

- a. A significant increase in the awareness and knowledge about social work roles and their contribution to improving patient outcomes by other professionals in home health care.
- b. Increased acceptance of social workers as part of home health team.
- c. Within 3 years, establish a course on interdisciplinary team work in schools of social work.

8. Evidence-based research on the effectiveness of social work services must be conducted for the survival of social work in HHC.

Rationale

Given the current reimbursement environment in health care, advocacy for changes to include social work services can only begin with the social work profession's ability to demonstrate their capacity to improve patient outcomes in HHC. Specifically, it is critical to demonstrate social work's effectiveness on the traditional cost-based outcomes, such as length of stay, hospitalization, and re-admission, as agencies are looking towards all professionals in home health to show their cost effectiveness and efficiency related to positive patient outcomes.

Actions Required

- a. Funded research that demonstrates the cost effectiveness of social work services in HHC.

Responsible Agents

- a. NIA.
- b. Foundations.
- c. Faculty of universities and colleges
- d. Social work researchers.

Expected Outcomes

- a. Demonstrated track record of funded research in the area of social work effectiveness in HHC.
- b. Publications in peer-reviewed journals.
- c. Increased use of social work services in home health care.

9. Screening instruments for social work services should be developed for use in HHC to ensure that all patients will receive timely social work services.**Rationale**

To address the psychosocial needs of home health patients appropriately, effective screening is the key to determining which patients need social work intervention. As nurses continue as the case managers under PPS, it is critical to provide easy to use tools to help nurses identify patients in need of social work services. Early identification and intervention will be critical to address the patients' psychosocial needs while they receive medical care, as well as to plan for their discharge. With HCFA's requirements to collect outcomes data on all home health patients using the Outcomes and Assessment Information Set (OASIS), screening instruments can be developed using these data and forms. This will not create additional burdens on the nurses as well as the patients.

Actions Required

- a. Using OASIS, develop and test screening instrument for social work services.
- b. Publications of the screening instrument in a peer-reviewed journal.
- c. Advocate for adoption of the screening instrument by professional organizations such as NASW and American Network of Home Health Social Workers, and National Home Care Organization and HCFA.

Responsible Agents

- a. Social work faculty and researchers.
- b. Professional organizations.
- c. HCFA.

Expected Outcomes

- a. Adoption of the screening instrument by professional organizations and home health agencies.

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