NHPCO Practice Report

Performance Improvement Program for Reducing Home Health Care Costs in Hospice

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Background

The healthcare system in the United States has been plagued by service limitations imposed by financial constraints. Hospice is no exception, and hospice providers must continually seek out ways to provide cost-effective care. In response to this environment, many hospices are making a concerted effort to find efficient, low expenditure approaches to providing care without compromising the quality of that care.1

At Delaware Hospice, Inc., 65% of our patients require home health aide (HHA) care. We use a combination of employed and contracted HHAs to meet this demand. However, an initial review of expenditures showed that our contracted home health aide expenses were consistently over per patient day (PPD) budget by more than 25%, with costs escalating every month. By year-end, our expenditures were more than 30% over PPD budget, without an increase in the percent of patients receiving HHA services.

In response, we analyzed the cost and productivity of our contracted HHAs and the HHAs employed by our hospice. However, when costs were averaged for each category of HHA, we found the cost per hour was about the same for contracted and employed HHAs. Additional analysis, focused on productivity, found that patients who required HHA service were receiving an average of 4 HHA visits per week. Due to contract stipulations, contracted HHAs required a minimum of 2 hours per visit, which translated to a maximum of 20 visits per week per full time equivalent (FTE). HHAs employed by our hospice were averaging 16 visits per week per FTE, significantly less than our set standard of 19 visits per week. This below-standard visit frequency of our employed HHAs added to our use of contracted HHAs. Furthermore, several employed HHA positions were vacant, forcing us to rely even more heavily on contracted HHAs. We concluded that the under-utilization of employed HHAs adversely affected our budget in two ways: by increasing the hourly cost for visits by employed HHAs, and by increasing our dependency on contracted HHA services.

We also reviewed our HHA assessment tool, which assesses patient care needs and is used to determine how many HHA visits patients require based on the patients’ ability to care for themselves, availability of caregivers, and level of symptom management. We discovered that the tool was cumbersome and difficult to use. Moreover, nurses were either not using the tool, or were completing the form incorrectly and assigning an inappropriate number of visits to patients. We were both imprecise in our assessment of need and uncertain about whether patients were receiving the appropriate amount of HHA care.

Intervention

We filled our vacant HHA positions, and, to increase the productivity of our employed HHAs, we increased our standard from 19 to 22 visits per week per HHA. HHAs were instructed to focus solely on providing personal care, instruction to caregivers, and light housekeeping. Volunteers were assigned to supplement HHA
visits as needed to support caregivers. We revised and computerized the assessment tool to improve its ease of use and trained our staff to properly use the tool. Revisions included adding the option of recommending visits twice a week by an HHA, instead of minimally three times a week, as well as redesigning the computer formatting for better clarity. To measure the effect of these changes, we tracked our HHA costs and productivity of our employed and contracted HHAs.

To ensure that patient satisfaction was not compromised, we evaluated the scores of our phone survey assessing patient satisfaction; phone surveys are conducted 14 to 20 days following each patient’s admission to the hospice. Patients or caregivers were asked how often the patient’s personal care needs were taken care of as well as they should have been (always, usually, sometimes, or never). For the 6 months preceding this cost-savings initiative, more than 95% of our patients had responded “usually” or “always.”

We also used a second measure of patient satisfaction by having our families complete the National Hospice and Palliative Care Organization (NHPCO) Family Evaluation of Hospice Care (FEHC) survey, mailed out 6 weeks following patient death. This survey also contained a question regarding how often the patient’s personal care needs (e.g., bathing, dressing, changing bedding) were taken care of as well as they should have been by the Delaware Hospice team (always, usually, sometimes, or never). For the preceding 6-month period, 93% of our families had selected “always” or “usually.” The NHPCO national mean for the same period was 90% of families. It was important to us that we at least maintain our above average score on this question after the intervention to improve HHA productivity.

**Results**

The outcome of our interventions has been very favorable, both in terms of cost reduction and patient satisfaction. We have continued to provide the same percentage of our patients with HHA care (approximately 65%). As the productivity of our employed HHAs has increased, the cost per visit hour has decreased by 19%. The revised HHA assessment tool has been effective in providing specific criteria and guidelines for HHA placement, resulting in increased efficiency in HHA utilization. The number of visits per patient week, based on the more accurate assessments, has dropped slightly, from an average of 4 visits to 3.75 visits. We have reduced the percentage of contracted visits with a consequent 21% decrease in cost. The overall cost per patient day of HHA services decreased by 24%. At the same time, satisfaction has remained high. The results of our phone satisfaction survey have remained at the same level as that preceding the cost reduction program, with more than 95% of patients or caregivers indicating that they are “always” or “usually” satisfied with the personal care administered to the patient. Results of the NHPCO FEHC have also remained at the level they were prior to our HHA cost savings and productivity intervention.

**Comment**

Medicare reimbursement for hospice is based on a per diem all-inclusive rate from which hospices must pay for a comprehensive array of services. Consequently, hospices constantly face the challenge of meeting the end-of-life care needs of patients and families through cost-effective practices, while at the same time ensuring the provision of quality care.1,2 HHA care is one of the services hospices must provide under the Medicare conditions of participation in order to be eligible for Medicare reimbursement. Home health aides play a crucial role in the implementation of hospice care. Of all the members of the interdisciplinary hospice team, HHAs typically spend the greatest amount of time in the home and develop a trusting relationship with patients and families.3 HHAs contribute to patient well-being by observing and reporting symptoms and effects of therapy, as well as providing personal care and support for family caregivers.3

**Implications for Practice**

The intervention improved overall efficiency in provision of HHA care, which resulted in decreased expenditures and cost of patient care, while maintaining an above average level of patient satisfaction with HHA care. A multifaceted approach that focuses on accurate assessment of patient care needs, as well as expenditure reduction and productivity, can be an effective means for improving the cost-effectiveness of providing HHA care.
References


