

## Hospital-based Home Care (& Hospice)

...So Much Has Changed ...Yet, So Much Remains the Same!

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Once the most dominant sponsorship of the Homecare Industry, hospital-based homecare providers continue to dwindle in both numbers and profitability. Most of the larger, more progressive hospital-based agencies continue to operate successfully, however many of the small and medium sized agencies have been sold or closed because of their apparent lack of apparent financial success. Yet, those hospital-based agencies that have been purchased are now owned by other organizations, mostly proprietary, that identified the potential and added them to their ranks. The new owners somehow were able to “magically” change the destiny, and improve profitability, productivity, case capacity and clinical outcomes of those agencies. These results cannot be attributed to some secret formula or divine management approach that could not be identified or practiced by the original hospital executive management.

So what happened? To understand this miraculous transition, the problems experienced by these sold and closed agencies under their previous ownership must be outlined and understood. It should be noted at the outset that not all of these agencies experienced all of the problems discussed below, but all of them experienced some of them to the extent that caused performance issues that led directly to their disposition.

### Staffing and Compensation

A common finding is that the process required to add needed home health (and hospice) staff is both problematic and cumbersome. The justifications needed are almost always retrospective instead of proactive. Approved increases in staff (FTEs) must usually be posted internally before recruitment through advertising can begin. The entire process is generally handled by the hospital's HR Department staff who generally have little knowledge of home care or hospice clinical practices and needs. The ads are generally institutional and combined with all of the other open positions that the hospital is looking to fill. When staffing needs are from multiple hospital departments, generally the inpatient and out-patient requests are given preference. The continued shortage experienced by the agency limits the agency's capacity to accept patients and ability to provide the needed care, so patients are refused and referred to agencies outside the health system. Those patients and families are likely forever lost and the discharge planning staff has been left with the definite impression that their own agency is not capable of staffing patient needs. This is one of the most common controllable reasons for loss of internal market share. When hospital administration looks to cut costs,

generally the biggest target is almost always staffing and FTE restrictions are put in place within the agency's budget or, even worse, staff reductions indiscriminately applied to all departments without the recognition by hospital administration, especially finance, that the agency is truly a revenue center, not a cost center.

Clinical compensation almost always follows the hospital's structure for its inpatient and outpatient staff – mostly hourly, non-exempt with compensatory time off for covering weekends leaving the weekdays short staffed for the home care (and hospice) agency. The agency's need to accept and care for patients often create issues of increasing case capacity and productivity for the agency and the need to drive the clinical staff without providing incentives and appropriate recognition of effort except for overtime. This causes staff dissatisfaction and unhappiness, leading to potential efforts to organize, if they are not already involved in that effort. Those agencies subject to the hospitals' Collective Bargaining Agreements (CBA) often find themselves subject to the same provisions, because the hospital negotiators failed to consider the home health (and hospice) agency's structure, patient care requirements and the nature of the care into consideration during negotiating process. This is most commonly due to a lack of knowledge or interest because of the agencies' relative size..."the agency is immaterial". Managing the clinical staff becomes an even greater challenge under the specter of a CBA. As an example, the addition of tele-monitoring equipment to the clinical practice standards has been considered a change of work rules, requiring union negotiation and membership approval.

Recruitment and retention has become an even greater issue than before because of the increase in the number of agencies nationally, except for those states with CON provisions. But, even in those states, the acquisition of hospital-based agencies by proprietary entities has changed the playing field dramatically. Compensation and benefits are the biggest attracters. Incentive based compensation, based upon productivity, case capacity and clinical outcomes together with more than competitive fringe benefits provided by proprietary agencies accomplish the staffing goals. If the supervisory staff incentives are also aligned and the clinical model fits the agency's tactical objectives, the clinical and financial outcomes are also achieved.

#### Loss of Internal Market Share

It is surprising, but many hospital-base home health (and hospice) agencies do not have home care liaisons on staff to work with their hospital's discharge planning staff. But the competition does and they do call on the discharge planners and social service departments and develop the relationships, attracting referrals that give them the opportunity to further develop relationships with the patients'

physicians who then refer their non-hospitalized patients. This is another one of the most common controllable reasons for loss of internal market share.

### Infrastructure

Technology in home care is advancing in keeping with the changes in payment structures and the information necessary to evaluate operations, efficiencies, standards of clinical practice and clinical outcomes. Acquisition of this needed software and replacement of now obsolete hardware is often a major challenge for the hospital-based agency because of Capital Budget issues. The home health (and hospice) agency is most often at the bottom of the ladder for allocations of this nature. Even if the new software and/or hardware has been acquired, the IT department's sense of priorities most often leaves the agency last on the list for installation, testing and going live. Wireless cards to facilitate e-communications and transmission of documentation from the field during the day are often not included due to the additional cost, despite the efficiencies and the potential additional productivity. Office space in so many cases is that which has been abandoned by other hospital owned operations such as physician offices, a section of a closed floor, etc including bathtubs, showers and sinks. These facilities are almost never re-designed to promote efficient office operations and the agency staff are placed where they can fit and not to facilitate their processes. Participation by home care (and hospice) directors and managers on hospital committees unrelated to the agency's operations or integration within the system continues despite the inordinate time required and the lack of interest by the other participants in home care (and hospice) operations and needs. Not to participate on these committees creates a perception that the agency executive staff is not "Team Players". The required time that is consumed often greatly impacts the administrative staff's ability to do their job and creates significant unneeded stress. Education of agency personnel at all necessary levels is most critical in today's changing revenue and regulatory environment, yet budget restrictions are always applied, reducing or eliminating the opportunity for the necessary knowledge to operate effectively and efficiently to produce the desired revenue stream and potential profitability.

### Financial Information

The financial information to the home care (and hospice) agency's Director/Administrator generally follows the same format as provided to every other hospital department. The revenue is often understated and miscalculated unless accepted by hospital finance staff as provided directly by agency business office personnel. If the revenue is understated, so is the bottom line! The reported expenses are generally consolidated into single classifications, such as salaries, payroll taxes and fringe benefits, purchased services, etc. The identification and proper classification of expenses categories for personnel and related costs are generally not considered very important, even for Medicare Cost Report

preparation. Information related to the cost per visit by discipline is almost always not available except for outdated inaccurate data from a poorly prepared Medicare Cost Report. The current and year to date costs per visit by discipline, direct and indirect, and the incremental costs are the very lifeblood of analysis and daily decision making. Requests for a homecare (and hospice) specific financial statement format has often been met with..."Why do you need something different?" Yet, the agency director/administrator is held responsible for the financial performance without the necessary revenue and cost information, even when patient acceptance decisions are directed by hospital's policy that creates losses to save much greater inpatient losses by the hospital.

### Champion Sponsorship

The hospital-based agency that is a hospital department needs a Champion from within at a high level in the hospital's executive structure that will take the time to understand its potential to the contribution margin, its image in the community being served, its service components and it needs to fulfill its goals and objectives. Too often, reporting ladders change, the champion is replaced with someone with little interest, mainly because they are too busy, and the agency becomes a "step-child", if not one already, or worst case, is no longer considered a "Core Service".

### The Big Changes....Today and Tomorrow

The latest changes to Home Health PPS (the Refinement of 2008) have created an additional level of sophistication with an opportunity to succeed, provided that the tools for success are made available and operationalized. CMS recognized patient care needs that were created by the original PPS model. Longer term chronic, severe wound care and stroke patients had difficulty accessing homecare because the payment methodology was a discouragement to the agencies' use of the available resources. Additional compensation for expensive and continued use of non-routine medical supplies did not exist except for some wound care items. Patients requiring significant therapy found themselves with limited service because of the payment structure to the agencies which in turn limited the affordability and approval for acquiring and retaining the needed therapists. So, CMS re-designed PPS to make it more responsive to diagnostically needy patients and to provide a payment structure that followed that premise, including separate, but increased, to six levels for non-routine medical supplies. The number of case-mix weights increased dramatically, over five tiers from just one, taking patient episode sequencing into consideration and specific diagnoses became more important. Diagnosis coding has become a necessary science, but with added homecare knowledge.

The next major change to affect home care will be Valued Based Purchasing, the CMS term for pay-for-performance (P4P). The CMS demonstration project is

currently underway. This concept is being promoted both by CMS and MedPAC. Its shape and form are the subject of much speculation, but it is likely to be based upon clinical outcome achievement and improvement linked to incentive payments that will come from a revenue withhold that will negatively affect the under achievers. This could begin as early as 2010 for home care.

#### Maybe a New Vision is at Hand

There are now some hospital executives, scattered around the country, that have come to the realization that their home care (and hospice) agency is a part of the core service. These executives see that home care and hospice ARE different...as profit centers, and as such, have operational needs and support unlike other departments in the hospital or health system. Their staffing needs are based upon patient requirements driven by both internal and external market share and demand. Compensation packages must be competitive. Home care liaisons, with field staff experience, should be in place. Technology must be state-of-the-art to promote the highest levels of efficiency, including timely support from the IT department. Facilities must be of a size and configuration to promote effective and efficient office operations and eliminate the existing work-arounds that are often required to live with. Participation by home care (and hospice) directors and managers on hospital committees should be limited to that which is mutually beneficial. Available education necessary to promote the accomplishment of clinical and financial outcomes is both desirable and required, whether provided within the state or nationally. Financial information must be complete, in accordance home care (and hospice) specific management needs and revenue recognition should follow the most accurate method, allowing for proper gross profit measurement by discipline and payor and allows for actual negotiation of realistic payment rates. These executives have now become the agency's champions, even going so far as to realize and then suggest a new strategic operating structure that follows their free-standing, proprietary competition who often seem to be doing a better job in the same market.