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Report to the Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate

March 1996

VETERANS' HEALTH CARE

VA's Approaches to Meeting Veterans' Home Health Care Needs

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Health, Education, and
Human Services Division

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March 15, 1996

The Honorable John D. Rockefeller, IV
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

Dear Senator Rockefeller:

In fiscal year 1994, the Department of Veterans Affairs (VA) provided or facilitated the delivery of home health care services to more than 40,000 veterans at a cost of $64 million to VA and millions more to Medicare. By providing veterans with home health care services, VA allows these veterans to continue living at home and in their community, rather than caring for them in an institutional setting. Veterans may need home health care for a variety of reasons: Older veterans may have chronic medical conditions, such as heart disease, and need periodic attention to remain living at home. Others may be discharged from VA medical centers following treatment for illness or injury and continue to need such care as the changing of dressings or administration of medications. The number of veterans needing home health care is expected to grow as the veteran population ages and as VA more quickly discharges patients from its hospitals to reduce the costs of hospitalization.

Because of your interest in this important service for veterans, you asked us to develop information on how VA meets veterans' home health care needs. We are providing information on (1) the characteristics and services of the home health care programs VA uses, (2) the available data describing program costs, and (3) how VA ensures that veterans receive quality home health care services.

We did our work at 3 of VA's 173 hospitals, in Boston and West Roxbury, Massachusetts, and in Tampa, Florida. As part of our work, we visited 30 veterans in their homes to understand better how home health care services are provided. Additionally, we sent a questionnaire to 158 VA medical centers[1] and 7 other VA health care facilities asking for information on how they provide and evaluate home health care services for veterans. (See app. I for more detail on our methodology.) We performed this review from May 1994 to December 1995 in accordance with generally accepted government auditing standards.

[1]Several medical centers have more than one hospital.

Results in Brief

VA's efforts to meet veterans' home health care needs focus on providing long-term services to address veterans' chronic medical conditions as well as shorter-term services to address their acute medical conditions. VA's Hospital-Based Home Care (HBHC) program most often provides primary care to those with chronic conditions. Under HBHC, VA staff provide in-home physician, nursing, social work, and dietician services to veterans who often need such services for a year or longer. Veterans requiring short-term, skilled care, often following a stay in a VA hospital for an acute medical condition, generally receive services from community-based providers. VA either arranges for Medicare to pay for eligible veterans to receive home care from community-based providers or, under its fee-based program, pays community-based providers itself to provide care to those who are not eligible for Medicare.

VA data portray the costs of VA's HBHC and fee-based programs differently. For example, VA's fee-based program cost figures represent payments made to community-based providers but exclude administrative and other costs associated with patients; HBHCs' cost figures, on the other hand, include administrative costs. Lacking useful cost data, VA hospital administrators are making decisions about whether or not to have an HBHC program on the basis of their perceptions of the relative costs of VA's HBHC and community-based programs.

Regardless of which home health care program is used, VA monitors the quality of care provided, but it monitors care provided by its HBHC programs more directly than it does the community-based care. Nevertheless, licensing and certification assessments of community-based providers give VA some assurance that veterans receive care from qualified home health care providers. In addition, Medicare has primary responsibility for ensuring that community-based providers provide quality care to Medicare-eligible veterans for whom VA arranges such care.

Background

VA arranges for the delivery of home health care services to veterans through two methods. Under its HBHC programs, teams of VA hospital staff deliver primary care services directly to veterans in their homes. Under VA's second method, community-based providers deliver home health care services to veterans. VA pays for these community-based provider services through its fee-based home health services program unless the veteran is covered by Medicare's home health care benefit. Generally, for these veterans, VA hospital staff facilitate the delivery of these services and Medicare pays for them.

Begun in July 1972, VA's HBHC program consists of individual HBHC programs affiliated with hospitals and medical centers around the country. HBHC is an extended care program designed to meet the long-term care needs of veterans who have chronic multiple medical and psychosocial problems, a terminal illness, or a need for post-hospital rehabilitation or monitoring. The objectives of the program are to provide primary care services to homebound patients in their homes; create a therapeutic and safe home environment; support the caregiver—the veteran's spouse, other family member, or friend—in caring for the patient; reduce the need for, and provide an alternative to, hospitalization or other institutionalization; promote timely discharge of patients from hospitals or nursing homes; and provide an academic and clinical setting for students of the health professions. Veterans may or may not be charged a fee for HBHC services, depending upon their eligibility for outpatient services. In fiscal year 1994, VA served 9,953 veterans under this program.

VA's fee-based home health services program pays community-based providers to provide home health care services to veterans who received inpatient care for an acute condition at a medical center and have been discharged. It also pays for skilled medical treatment for other veterans entitled to VA medical care. Whether veterans are charged fees for services under this program depends upon their eligibility for outpatient services. In fiscal year 1994, VA served 12,800 patients under this program.

In addition to the veterans receiving hospital-based and fee-based care, VA facilities referred at least 19,000 Medicare-eligible veterans to Medicare-certified health care agencies in fiscal year 1994.

For hospitals with an HBHC program, the decision about whether a patient receives HBHC or community-based care is made by hospital staff on the basis of such factors as the patient's medical condition and the types of services needed. If HBHC would best meet the patient's needs, staff would try to use that program to provide home health care. If the hospital does not have an HBHC or if staff determine that community-based care would meet the veteran's needs, the next step is determined by the veteran's Medicare eligibility. Generally, if a veteran's care would not be covered by Medicare, VA will pay for a veteran's home health care services under the fee-based program. VA staff facilitate the delivery of home health care to veterans with Medicare coverage by referring them to community-based providers with the understanding that Medicare will pay for their services. However, VA continues to provide all medical care follow-up, drugs, and supplies that are not paid for by Medicare.

Characteristics and Services of VA's HBHC Programs

VA hospitals are not required to have HBHC programs, and most do not. In fiscal year 1995, VA operated 74 HBHC programs: 73 of its 173 hospitals had an HBHC program, and one additional program was operated by an outpatient clinic. A VA hospital can operate an HBHC program if it meets certain criteria and receives VA approval. For example, guidance from VA's Central Office requires hospitals to demonstrate that they discharge a required number of veterans with specified medical conditions and that they have staff to provide services to the veterans once they are discharged. Hospitals may also terminate their HBHC programs in response to other demands on their staff and budget. Between fiscal years 1990 and 1995, the number of programs increased from 72 to 74, with five VA hospitals initiating HBHC programs and three terminating their programs during this time.

HBHC patients tend to be chronically ill and in need of long-term care, although some may be terminally ill or need short-term care following hospitalization. In fiscal year 1994, half of the HBHC programs reported to VA that their patients had an average age of 71 years or less. There is no limit on how long veterans may stay in the program. During fiscal year 1994, half the questionnaire respondents that had an HBHC program indicated that their patients stayed in the program an average of 7 months or less. As of March 31, 1995, about 44 percent of the patients had been in the program 1 year or longer.

In order to qualify for HBHC services, veterans

- must be homebound;
- should have a caregiver—such as a spouse, family member, significant other, or friend—to assist with their care;
- must live within a defined geographic area—usually a 30-mile radius of the hospital;
- must generally only need services Monday through Friday during normal working hours; and
- must be entitled to VA medical care.

Under the HBHC program, an interdisciplinary team of VA hospital staff delivers primary care services to veterans in their homes. A typical program consists of several nurses, a social worker, a coordinator, a clerk, and the part-time services of a physician and dietician. Some programs also have a physical therapist, occupational therapist, or home health technician.

Skilled nursing is the predominant service of HBHC programs: 99 percent of the HBHC programs report providing this service.[2] Skilled nursing includes such activities as changing dressings, teaching patients how to manage their medical problems, administering medications, and drawing blood samples for laboratory analysis. Nursing services are provided in accordance with the patient's plan of care.

HBHC social workers provide psychosocial services, such as counseling and resolution of social and emotional problems that affect treatment or impede medical recovery. Ninety-six percent of the HBHC programs provide these services to veterans in their homes, according to questionnaire respondents from hospitals with HBHC programs.

HBHC physicians usually work in the programs on a part-time basis and have primary medical responsibility for all HBHC patients. Their responsibilities include identifying the patients' medical problems, defining the medical management of the problems, and determining whether to admit HBHC patients to the medical center. Approximately 80 percent of the respondents said their HBHC program provides physician services in veterans' homes.

Dietician services are another important component of HBHC programs, with almost 9 out of every 10 programs reporting that their dieticians make home visits. HBHC dieticians assess patients' nutritional needs over time in relation to changes in their condition. They also teach patients and their caregivers how to adapt and modify their food preparation practices.

Responses to our questionnaire showed that most HBHC programs in fiscal year 1995 did not provide skilled physical, occupational, or speech therapy; home health aide services; or pharmacy services to veterans in their homes.

In fiscal year 1994, VA reported expenditures of $36.6 million on this program.

[2]We did not determine how frequently veterans used services provided under the home health care approaches used by VA.

Characteristics and Services of the Community-Based Programs

Most veterans receive home health care services from community-based providers through either VA's fee-based program or Medicare's home health care benefit. These veterans tend to need short-term home health care associated with an acute medical condition, although some have longer-term needs. Many of the services commonly provided by the fee-based program and Medicare are the same, but more types of services are generally available to veterans covered by Medicare.

VA's Fee-Based Program

Nearly all VA hospitals used the fee-based program in fiscal year 1995 to purchase skilled home health care services from community-based providers. Most veterans in this program receive short-term home health care services to address acute medical conditions, such as hip fractures or surgical wounds. Some veterans, however, receive long-term home health care services to address chronic conditions, as in the case of a patient with Parkinson's disease, for example, who has an ongoing need for skilled services, such as intramuscular injections.

Half of our questionnaire respondents reported that their fee-based patients in fiscal year 1994 had an average age of 61 years or less. VA will authorize payment to community providers for a maximum of 12 months following a veteran's hospital discharge, and reauthorization can be extended upon the approval of a VA physician. During fiscal year 1994, half of our questionnaire respondents indicated that their fee-based patients had an average length of stay in the program of 90 days or less.

To qualify for this program, veterans must be entitled to VA medical care. Veterans are not required, however, as in the HBHC program, to have a caregiver at home, live within a certain distance of the hospital, or generally need services only during certain hours of the work week.

Skilled nursing is the predominant service covered by the fee-based program. Nearly all respondents to our questionnaire said that they usually purchase skilled nursing services for veterans.

Physical, occupational, and speech therapy services are each purchased for patients in the fee-based program in over half of the medical centers, according to questionnaire respondents. Physical therapists work with patients to improve their capacity to perform simple daily activities, and occupational therapists assess patients' rehabilitation needs, develop plans of care, and provide training. Speech therapists help patients such as stroke victims improve their ability to communicate.

The fee-based program also covers the services of physicians and psychologists. However, only about one-fifth or fewer of the respondents said that they usually purchase these services under the fee-based program.

Although VA cannot use fee-based program funds for home health aide services, 22 percent of the respondents said they provide this service to veterans in that program.[3] Medical centers can pay for these services through VA's Homemaker/Home Health Aide program.[4]

In fiscal year 1994, VA reported payments of $27.3 million on fee-based home health care services.

Medicare's Home Health Care Benefit

Most respondents to our questionnaire indicated that they refer veterans covered by Medicare's home health care benefit to community-based providers. Most people who receive Medicare home health care benefits do so for services associated with an acute medical condition, often following hospitalization. Since 1989, however, Medicare has been providing more long-term home health care services to chronically disabled elderly beneficiaries. VA officials told us that Medicare-eligible veterans follow the same basic pattern, with most receiving short-term home health care services around an acute medical condition requiring hospitalization. We were unable to determine how long veterans referred by VA hospitals received Medicare-funded home health care. However, in 1992, about three-quarters of the general Medicare population that used the home health care benefit received services for fewer than 120 days; the average duration of services for these beneficiaries was 42 days.

To qualify for Medicare home health care coverage, beneficiaries must be eligible for Medicare (almost all elderly and some disabled people), homebound, in need of skilled nursing or therapy services on a part-time or intermittent basis, and under the care of a physician who prepares and periodically reviews their care plan. The VA physician usually fulfills Medicare's physician requirement for veterans discharged from a VA hospital. Unlike the HBHC program, Medicare does not require beneficiaries

[3]Under its Spinal Cord Injury program, VA may pay for home health aides who provide bowel and bladder care for quadriplegic veterans.

[4]Through the Homemaker/Home Health Aide program, VA hospitals can spend up to 15 percent of their Community Nursing Home program funds on homemakers and home health aides for veterans residing at home. This includes veterans in the fee-based and HBHC programs. During fiscal year 1995, 122 medical centers participated in this program. Expenditures totaled approximately $15 million, or about 4 percent of the Community Nursing Home budget.

to have a caregiver at home or live within a certain radius of the hospital that discharged them.

Skilled nursing and home health aide services—along with physical therapy, occupational therapy, speech therapy, and medical social services—are the home health care services that VA usually facilitates for veterans covered by Medicare. Approximately 70 percent or more of the respondents to our questionnaire indicated that they facilitate the delivery of these services.

Physician, dietician, and pharmacy services are not covered under Medicare's home health care benefit. However, physician services are covered by other parts of the Medicare program; pharmacy and dietician services may be covered by Medicare under some circumstances.

Medicare, and not VA, pays for community-based providers to deliver home health care services to veterans covered by Medicare's home health care benefit. VA incurs some administrative costs in referring patients to Medicare, as well as the costs of VA physicians' developing and reviewing plans of care, but VA does not separately identify these costs.

Cost Data for VA's Home Health Care Programs Portrayed Differently

Data on the costs of VA's home health care programs are reported differently, both among HBHCs and between HBHCs and fee-based programs. As a result, to the extent that VA administrators make decisions about whether to have an HBHC program on the basis of the relative costs of HBHCs and fee-based programs, they do so on the basis of their perceptions of cost rather than comparable data.

HBHC program costs are based on data developed by the hospitals that support the programs. VA Central Office officials told us that hospitals have wide latitude in deciding which costs to charge to their HBHC programs. This results in different cost charges among the 74 HBHC programs. For example, some HBHC programs include costs of librarians or chaplains, while others include costs of anesthesiologists or optometrists. In addition, hospitals commonly charge costs to their HBHC programs for certain administrative support functions, such as costs for a portion of one full-time-equivalent staff person in the Office of the Chief of Staff. One hospital, for example, charged $8,600 for support from the Chief of Staff's Office in fiscal year 1994. However, we found another case in which a hospital charged $80,500 for approximately 2 full-time-equivalent staff from the Chief of Staff's Office. A VA Central Office official agreed that a

charge this high was an error. Central Office officials further stated that they discuss questionable charges that appear in VA's cost reports with hospital staff but that it is up to the hospitals to appropriately allocate costs.

VA's reported costs of its fee-based program, on the other hand, represent payments made to community-based providers but exclude costs such as program administration and other indirect costs associated with caring for veterans in this program. For example, costs for staff who administer the program are included in the operating costs of the hospitals where the staff work and are not identified as a cost of the fee-based program. In addition, approximately 70 percent of our questionnaire respondents stated that they case-manage fee-based patients, yet costs associated with case management are not included in the fee-based program.

Since VA reports the costs of its programs differently, VA hospital officials are left to make decisions on whether or not to have an HBHC program based on their perceptions of the relative cost of HBHC and fee-based programs. These perceptions vary widely. For example, about 3 years ago, the Tampa HBHC program began treating patients who previously would have received fee-based care. One reason for doing so was to reduce the costly fee-based payments for nursing services. The Kansas City Missouri hospital, on the other hand, terminated its HBHC program in 1994 and referred some of its HBHC patients to community-based providers. A former HBHC official told us that hospital administrators believed that it was less costly to pay for community-based services than for an HBHC program.

Respondents to our questionnaire also expressed very different views regarding costs and why they either have or do not have an HBHC program. Over three-fourths of the questionnaire respondents with an HBHC program stated that one reason their medical center has an HBHC program is that it is less costly than purchasing fee-based services. Conversely, approximately half of the respondents without an HBHC program said that one reason they do not have an HBHC program is that it would be more costly than community-based care purchased under the fee-based program.

Respondents to our questionnaire also expressed very different views on whether HBHC was more cost effective as compared with community-based care. In this instance, cost-effectiveness refers not only to the actual costs incurred in treating a veteran but also to the effectiveness of the care. For example, who has fewer hospital admissions and shorter hospital stays:

HBHC patients receiving primary care services or patients receiving skilled services from community-based providers? About 40 percent of our respondents said they had no basis to judge whether HBHC was more or less cost effective than community-based care. The remaining respondents were evenly divided on which method of providing home health care to veterans was the more cost effective.

Quality Assurance Approaches for VA Programs and Medicare

VA monitors the quality of care provided by its home health care programs, but it is more directly involved in monitoring the care its own employees provide, through HBHC, than the care delivered by community-based providers. Licensing and certification assessments of community-based providers conducted by independent organizations provide VA some assurance that veterans in the fee-based program and those covered by Medicare's home health care benefit receive care from qualified home health care providers.[5] HBHC programs are assessed by outside organizations as well, but in addition, they use case management and quality indicators to evaluate the care they deliver.[6] Medical centers are less likely to use these additional means to monitor the quality of care delivered by community-based providers.

Medicare has the primary responsibility for ensuring that quality care is furnished under its home health care benefit. Medicare requires community-based providers to have internal quality assurance programs. Moreover, Medicare requires VA physicians referring patients to prepare and review plans of care.

Assessment of HBHC and Community-Based Providers

All HBHC programs are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and are subject to a performance review every 3 years. JCAHO staff apply standards contained in their Accreditation Manual for Home Care to evaluate how well the home health care provider assessed the patient's service needs, planned for the patient's care, and monitored the patient's response to the care provided. Before 1995, JCAHO's reviews did not measure actual outcomes of care but instead focused on processes and the capacity of a provider to deliver quality care. JCAHO's 1995 standards, however, place more emphasis on outcomes of care.

[5]We did not review individual state licensing requirements, which vary by state, or compare them with Medicare's certification requirements.

[6]We did not determine the extent to which community-based providers case manage their patients or use quality indicators to evaluate the care they deliver.

Community-based home health care providers that are certified to treat Medicare beneficiaries are assessed at least once every 15 months by a state survey agency (usually a component of the state health department), by JCAHO, or by the National League for Nursing's Community Health Accreditation Program (CHAP). These surveys are intended to ensure that Medicare beneficiaries receive care from qualified home health care providers. State survey agencies, under contract with the Health Care Financing Administration (HCFA), which administers Medicare, survey community-based providers[7] to determine if they meet Medicare's conditions of participation. These conditions cover such topics as acceptance of patients, medical supervision, and skilled nursing services. Survey staff visit home health care providers and examine organizational, functional, personnel, and patient records and visit with patients in their homes to evaluate the quality and scope of services provided. Home health care providers that meet JCAHO's or CHAP's standards are also deemed to have met Medicare's conditions of participation. Thus, veterans in HBHC programs and those receiving home health care services covered by Medicare are assured of receiving care from Medicare-certified providers.

Most, but not all, fee-based patients also receive care from Medicare-certified providers. About 83 percent of the respondents to our questionnaire said they purchase care from Medicare-certified providers most, almost all, or all of the time for their fee-based patients. For example, the three hospitals we visited use only Medicare-certified home health care providers. These hospitals select the providers on the basis of factors such as which providers serve the area where the veteran needing home health care lives, whether the provider is Medicare-certified, and whether the hospital's past experience with the provider has been positive. However, fee-based patients who are paralyzed do not always receive care from Medicare-certified providers because the fee-based program allows family members who have been trained and certified by VA to deliver bowel and bladder care to quadriplegic veterans. Also, a VA Central Office official told us that there are not enough Medicare-certified providers in some areas of the country.

Case Management

VA's programs also employ case management to ensure quality care. Case management, in general, involves coordinating the services needed by and provided to a patient. Case management may address only a veteran's health needs or the total needs of a veteran and his or her family. Similarly, case management may be limited to the process of arranging

[7]At the end of 1994, the number of Medicare-certified home health care providers totaled 7,864.

initial services or may be an ongoing process for the duration of an illness. Not everyone discharged to home health care from a hospital needs case management; some veterans and their families may act as their own case managers. When case management is appropriate, it is seen as important to the adequacy of the home health care veterans receive: 68 percent of the questionnaire respondents said that case management greatly improves the adequacy of care patients receive.

The way in which a veteran's care is managed by VA may differ somewhat depending upon the program that is providing for the veteran's services. Nearly all (96 percent) of the respondents with HBHC programs said that they typically case manage patients and that nurses are usually the primary case managers. For veterans receiving fee-based services, most respondents (73 percent) said the VA physician who orders the home health care reviews the provider's periodic reports on the patient's health status most, almost all, or all of the time, and 62 percent said someone (most often a nurse) serves as a case manager for patients. For veterans receiving care paid for by Medicare, about the same number of respondents (72 percent) said the VA physician who orders the home health care reviews the provider's periodic reports most, almost all, or all of the time, but fewer (49 percent) said that someone (usually a nurse) case manages the patient's care.

Respondents also described different primary functions of case managers in the different programs, as shown in table 1. Nearly all respondents with an HBHC program said that their case managers performed the primary functions listed in the table, while respondents without an HBHC program indicated that their case managers were much less likely to perform these functions. The greatest difference among respondents was that evaluating the patient's home environment was much less likely to be a primary function of the community-based program case manager than it was to be a function of the HBHC case manager.

Table 1: Primary Functions of VA Case Managers in the HBHC and Fee-Based Programs and Under the Medicare Home Health Care Benefit

Case management function	Percent of respondents who said this was a "primary function" of their case managers		
	HBHC program	Fee-based program	Medicare benefit
Participate with provider staff in initially assessing needs of patients	90	46	44
Coordinate development, evaluation, and review of patient care plans	94	53	43
Evaluate patient's home environment	85	21	14
Evaluate ability of caregiver to meet the care needs of the patient	90	39	34
Monitor and manage the overall delivery of care to patient	92	43	32
Review and assess periodically the medical condition of the patient with provider staff	92	54	41

The HBHC and community-based programs we visited replicated the difference in primary case management functions described in the questionnaires. Case management at the Boston and Tampa HBHC programs involves each of the six functions cited in table 1. For example, each program holds team meetings at least weekly to discuss veterans' status and needs. The Boston, Tampa, and West Roxbury hospitals also case manage patients in their community-based programs, but the management is not as extensive as that conducted by HBHC programs. For example, case management at West Roxbury is limited to defining a plan of care and arranging for the veteran to receive it. At the Tampa hospital, case managers participate with community provider staff in assessing the care needs of patients, coordinate development of patient care plans, and periodically review patients' medical conditions with community provider staff. However, case managers at Tampa do not have the primary functions of directly monitoring and managing the overall delivery of home health care services provided patients under the fee-based or Medicare programs or, for those patients covered by Medicare, directly evaluating the patient's home environment and ability of the caregiver to meet the care needs of patients.

Our discussions with medical center staff in the three locations we visited suggest some additional reasons why the primary functions of case management in the community-based programs may differ from those in HBHC. First, case managers for veterans receiving community-based care may also be responsible for a variety of other functions, leaving less time

to devote to case management. For example, a Tampa medical center nurse who manages veterans' cases in the fee-based and Medicare programs told us that she coordinates services for two other sets of veterans as well: those that need hospice services and those that are in contract nursing homes. None of the HBHC case managers we spoke to told us that they had similar responsibilities for veterans outside of the HBHC program. Second, medical center case managers may be responsible for arranging home health care services for a large number of veterans as compared with the number of veterans managed by HBHC case managers, which would also leave them less time to devote to case management functions. The two nurse case managers at the Boston medical center, for example, referred 1,074 veterans to community providers in fiscal year 1994. In contrast, Boston's three HBHC case managers were responsible for case managing and providing care to 112 veterans that same year.

Quality Indicators

Another way VA assesses veterans' care is by monitoring performance indicators that VA believes are related to the quality of care provided. For example, if a provider frequently used by a VA hospital has high rates of patient deaths or patients' being readmitted to the hospital, visiting an emergency room, falling, having impaired skin integrity, or getting an infection, this may reflect a problem with the care being provided. Patient satisfaction is also useful as a way of assessing the quality of care. For example, one HBHC program we visited set a standard that at least 90 percent of its veterans would be satisfied with their care, as measured by a patient satisfaction survey. In the fourth quarter of fiscal year 1994, 99.5 percent of the veterans surveyed said that they were satisfied with their care. Indicators such as these are useful to assess performance, identify problems, develop corrective actions, and monitor the effectiveness of the changes made.

As table 2 shows, more medical centers track selected quality indicators for their HBHC programs than for their community-based programs.[8] We did not ask how often the community-based providers themselves track these indicators for their patients.

[8]The table lists only those indicators we included in our questionnaire; it does not provide a comprehensive list of all indicators that might be used by a medical center.

Table 2: Quality Indicators Used in VA's HBHC and Fee-Based Programs and for Medicare's Home Health Care Benefit

Quality indicator	Percentage of medical centers that reported tracking each indicator		
	HBHC program	Fee-based program	Medicare benefit
Patient deaths	70	31	29
Visits to the medical center's emergency department	52	22	18
Visits to other hospitals' emergency departments	41	14	10
Hospital readmissions	66	36	31
Falls	89	15	14
Impaired skin integrity	70	22	24
Infection rates	93	17	13
Patient satisfaction	97	62	59

Although VA hospitals less often track these quality indicators for community-based providers and patients receiving their care from those providers, they do take other steps to ensure that veterans in community-based programs receive quality care. Eighty percent of questionnaire respondents stated that they have periodic telephone or personal contacts with provider staff most, almost all, or all of the time to discuss the health status of veterans in the fee-based program, and 65 percent said that they have similar contacts for veterans that are covered by Medicare's home health care benefit. About 80 percent said that they require providers to submit periodic written reports regarding the health status of veterans in the fee-based program most, almost all, or all of the time, and about 70 percent said they ask for similar reports for those veterans in the Medicare program. Further, VA officials told us that hospitals evaluate patients' medical conditions when they have an inpatient or outpatient visit at the hospital.

Observations

Because VA's home health care programs provide different arrays of services to veterans who generally have different home health care needs and because consistent program cost data are not available, it is difficult to compare the relative costs of VA's methods of meeting veterans' home health care needs. And although VA itself more directly monitors care provided under its HBHC program, the quality of care furnished by community-based providers paid for by both VA and Medicare is evaluated in other ways—including by HCFA as part of its responsibility for administering the Medicare program.

Agency Comments and Our Evaluation

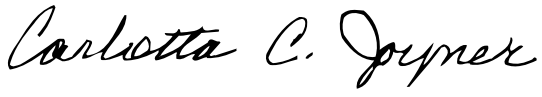
We obtained comments on a draft of this report from VA officials, including the Deputy Under Secretary for Health. The officials noted that the lack of consistent cost data, in this case for the various types of home health care provided, is a problem not unique to VA and is a challenge for all health care providers. They said that VA, in making improvements to its financial management and information systems, is attempting to better identify costs associated with all of its programs, including each component of its home health care programs.

The officials also told us that VA is developing performance measures that will allow managers at multiple levels to understand and identify desired program outcomes. Once these outcomes are in place, managers will be accountable for meeting them in the most cost-effective and efficient manner. VA officials also said that they intend to do cost-benefit analyses for home health care and other programs, once enough data are available. The VA officials additionally suggested some technical changes, primarily for clarification, which we incorporated as appropriate.

As arranged with your staff, unless you announce its contents earlier, we plan no further distribution of this report for 7 days after its issue date. At that time, we will send copies to the Secretary of Veterans Affairs, the Senate and House Committees on Appropriations, and other interested parties. We will also make copies available to others upon request.

This report was prepared under the direction of James Carlan, Assistant Director, Health Care Delivery and Quality Issues. If you or your staff have any questions concerning this report, please contact Robert Dee, the evaluator-in-charge, at (617) 565-7470. Other staff contributing to this report were Sally Coburn, Patricia Jones, Clarita Mrena, Joan Vogel, and Leonard Hamilton.

Sincerely yours,



Carlotta C. Joyner
Associate Director, Health Care Delivery
and Quality Issues

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Abbreviations

CHAP	Community Health Accreditation Program
HBHC	Hospital-Based Home Care
HCFA	Health Care Financing Administration
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
VA	Department of Veterans Affairs

Scope and Methodology

To develop our description of the ways VA provides home health care, we obtained both nationally descriptive data and additional data at three locations. Collecting these data required audit work at VA's Central Office as well as at the Boston, Massachusetts, and Tampa, Florida, medical centers and at the West Roxbury division of the Brockton Medical Center in Massachusetts. In addition, we reviewed VA's policies and procedures for operating its HBHC and fee-based programs as well as Medicare's regulations concerning its home health care benefit. We also obtained various VA reports detailing operations of its HBHC and fee-based programs.

We selected the three hospitals we visited to give us examples of hospitals that have an HBHC program (the medical centers in Boston, Massachusetts, and Tampa, Florida) and one that does not (West Roxbury, a division of the Brockton Medical Center). At these locations, we interviewed staff and obtained documents about their programs. Additionally, we visited 30 veterans in their homes to understand better how their home health care services were provided; 12 were receiving HBHC services, while 18 were receiving community-based services. Of the 12 veterans receiving HBHC services, 6 were cared for by the Boston HBHC program and 6 by Tampa's program. Of the 18 veterans receiving community-based care, we visited 6 discharged by each of the three VA hospitals. Seventeen of the 18 veterans were covered by Medicare's home health care benefit, and 1 was covered by VA's fee-based program. During our visits, a registered nurse on our staff interviewed veterans and discussed their care and activities, observed their medical conditions, and reviewed information from their medical files. We then discussed our observations with appropriate officials at the three medical centers.

To obtain nationally representative data about the three home health care programs, we sent a detailed questionnaire to 158 VA medical center directors and 7 other VA health care facilities. We asked respondents to answer questions about their HBHC program, if they had one, and about their community-based program for health care. The questions covered general descriptive information, program staffing, patient admissions and discharges, program services, case management, quality assurance measures, reasons why they did or did not have an HBHC program, and other issues. We pretested the questionnaire at three medical centers, obtained comments from VA officials, and revised it accordingly. A total of 151 medical centers and 6 other VA health care facilities responded to the questionnaire. We were unable to verify independently most of the information provided through the questionnaire. However, questionnaire responses from programs at the three hospitals we visited were consistent

with the information we obtained at those locations. In addition, questionnaire responses were consistent with selected aggregate information provided by the VA Central Office.

VA Medical Centers With HBHC Programs and Their Fiscal Year 1995 Staffing Authorizations

Medical center location	Authorized FY 1995 full-time-equivalent staffing[a]
Albany, NY	9.70
Albuquerque, NM	6.25
Allen Park, MI	9.40
Asheville, NC	5.00
Atlanta, GA	6.85
Baltimore, MD	11.00
Batavia, NY	7.15
Bay Pines, FL	7.20
Birmingham, AL	9.80
Boston, MA	8.20
Bronx, NY	7.00
Buffalo, NY	12.90
Brooklyn, NY	[b]
Butler, PA	4.90
Castle Point, NY	[c]
Charleston, SC	3.50
Chicago (Lake Side), IL	6.75
Chicago (West Side), IL	7.50
Cleveland, OH	7.20
Columbia, MO	6.50
Dallas, TX	8.00
Danville, IL	5.00
Dayton, OH	5.00
Denver, CO	7.65
Des Moines, IA	5.30
Durham, NC	8.00
East Orange, NJ	5.75
Ft. Wayne, IN	3.00
Fresno, CA	5.00
Gainesville, FL	7.80
Hines, IL	14.65
Honolulu, HI	5.00
Houston, TX	7.75
Indianapolis, IN	8.00
Iowa City, IA	6.13
Lexington, KY	7.75

(continued)

Medical center location	Authorized FY 1995 full-time-equivalent staffing[a]
Little Rock, AR	13.50
Long Beach, CA	9.70
Madison, WI	7.55
Manchester, NH	5.50
Martinez, CA	8.95
Memphis, TN	9.00
Miami, FL	11.00
Milwaukee, WI	7.75
Minneapolis, MN	12.80
New Orleans, LA	11.00
New York, NY	[b]
Newington, CT	4.88
North Chicago, IL	9.00
Northport, NY	7.90
Oklahoma City, OK	6.85
Palo Alto, CA	7.00
Philadelphia, PA	[b]
Phoenix, AZ	9.60
Pittsburgh, PA	9.60
Portland, OR	8.00
Providence, RI	5.50
Salt Lake City, UT	7.73
San Antonio, TX	8.00
San Diego, CA	8.00
San Francisco, CA	5.75
San Juan, PR	6.30
Seattle, WA	8.25
Sepulveda, CA	10.00
Shreveport, LA	8.00
St. Louis, MO	6.80
Syracuse, NY	6.25
Tampa, FL	8.27
Tucson, AZ	8.00
Washington, DC	10.70
West Haven, CT	3.75
West Los Angeles, CA	4.50

(continued)

Medical center location	Authorized FY 1995 full-time-equivalent staffing[a]
White River Junction, VT	3.90
Wilkes Barre, PA	4.50

[a]Staff size is based on the HBHC program's full-time-equivalent employee authorization.

[b]The medical center did not respond to our questionnaire.

[c]Information was not provided on the questionnaire received from the medical center.

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