

Identification of factors contributing to the utilization of home health agencies in North Dakota
by LaVerne Elizabeth Lee

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF NURSING
Montana State University
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Abstract:
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Data were collected by use of an open-ended questionnaire devised by the researcher and sent to 228 physicians, 52 public health nurses, and 60 hospital nurses, employed in the geographic areas of the nine home health agencies in North Dakota.

A total of 151 questionnaires were returned. This included 39 percent of physicians, 62 percent of public health nurses, and 45 percent of hospital nurses.

The respondents identified those factors limiting the effectiveness of the home health programs to be: 1. limited physician referrals 2. cost to the home health agency as well as to the patient 3. restrictive government regulations 4. lack of knowledge of the program by physicians, hospital nurses and the public In spite of obvious problems, the prevailing feeling is that there is a future for the home health programs in North Dakota.

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Date February 7, 1975

IDENTIFICATION OF FACTORS CONTRIBUTING TO THE UTILIZATION OF HOME HEALTH AGENCIES IN NORTH DAKOTA

by

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF NURSING

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ABSTRACT

The purpose of this study was to identify those factors contributing to the limited utilization of the home health agencies in North Dakota.

Data were collected by use of an open-ended questionnaire devised by the researcher and sent to 228 physicians, 52 public health nurses, and 60 hospital nurses, employed in the geographic areas of the nine home health agencies in North Dakota.

A total of 151 questionnaires were returned. This included 39 percent of physicians, 62 percent of public health nurses, and 45 percent of hospital nurses.

The respondents identified those factors limiting the effectiveness of the home health programs to be:

1. limited physician referrals
2. cost to the home health agency as well as to the patient
3. restrictive government regulations
4. lack of knowledge of the program by physicians, hospital nurses and the public

In spite of obvious problems, the prevailing feeling is that there is a future for the home health programs in North Dakota.

Chapter I

INTRODUCTION

Advances in medical science have made it possible for human beings to attain senescence in ways never before thought possible. This longevity has resulted however in myriad health problems. Such health problems are compounded by the fact that the majority of the aged population is economically deprived and, to a large extent, medically indigent. Because of this the elderly often forego needed medical treatment.

It was with these people in mind that the government envisioned health insurance for the aged. Although such insurance was considered as early as 1935, it was not until thirty years later, in 1965, that amendments to the Social Security Act (enacted in Public Law 89-97) established a comprehensive program of health insurance, commonly known as "Medicare," for individuals 65 years and over. This law provided a mechanism for financing an array of health services, including in-hospital care, extended care benefits, and home health services. As a result of this legislation home health agencies were established throughout the country, nine of which are located in North Dakota.

Unfortunately the home health agencies, specifically in North Dakota, are experiencing limited utilization. Of the many problems contributing to this limited utilization the greatest of these appears to be limited understanding (and thus, limited support) of the home

health program by those physicians and nurses who are in a position to implement the program at the local level. Without referrals from physicians and follow-up from the nurses, home health agencies cannot survive.

This study will attempt to identify the reasons why home health agencies in North Dakota are under utilized. It is hoped the results of this study will provide both physicians and nurses with insight relevant to the delivery of health care services to the elderly in their homes.

Major Purpose of the Study

The major purpose of this study is to identify those factors which are contributing to the limited utilization of the home health agencies in North Dakota.

Specific Objectives

1. To determine the acceptance of and willingness to participate in the home health program by:
   a. physicians
   b. hospital nurses
   c. public health nurses
2. To determine the individuals' understanding of their role in the utilization of the home health program by:
   a. physicians
   b. hospital nurses
   c. public health nurses

Need for the Study

Home health programs are designed to serve the patient in his home, by offering an array of services to achieve and sustain an optimum state of health, activity, and independence for the individuals. Some advantages of the home health programs are to:

1. reduce the length of hospitalization by making early discharge possible.
2. diminish the need for readmission to the hospital.
3. prevent many admissions to nursing homes.
4. provide a more economical alternative to institutional care.
5. release hospital and institution beds for the acutely ill patients.
6. provide patient care in the normalcy of the home environment.
7. teach homebound patients to live independently.[1]

Although home health programs would appear to provide the solution to many health needs of the elderly, these programs are under utilized, under-financed, and diminishing as the need increases.

There are currently eight home health agencies in North Dakota, seven of which are still operating. (See Appendix B for a map identifying the locations of the home health agencies in North Dakota.)

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[1]Brajan Trager, Home Health Services in the United States, A Report to the Special Committee on Aging, Government Printing Office, Washington, D.C., 1972, p. 60.

The home health agencies in North Dakota are confronted with limited physician referrals, insufficient public health nursing staff, great distances to travel from the home health agency to the patient's home, and inadequate funding. All these problems appear to be contributing to the limited utilization of the home health agencies. Government funding for the development of viable home health services has been minimal. The regulatory conditions are so narrow that they make the product negligible in terms of meeting real need.[2]

Of the above mentioned problem areas, limited physician referrals has had the greatest impact. Without patient referrals the home health agencies cannot survive. The federal law states that home health services may be furnished to any individual who is under the care of a physician; it requires therefore, that the attending physician establish a written plan of care along with a statement certifying that there is a necessity for the home health services. (See Appendix D for the portions of the Social Security Act relating to home health services.)

There appears to be an appreciable lack of understanding of the home health program by the physicians. It is a widely accepted fact that some physicians need prompting to initiate a referral. Without physician prompting, a referral is not forthcoming and the patient is

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[2]Ibid., p. 5.

denied home health care. There are other physicians who seemingly refer every patient for home health care, appropriately or not, and will not accept the limitations of the services.[3]

A lack of understanding and interest in the home health program by the nursing profession is another area contributing to the limited utilization of the home health programs. Some hospital nurses appear unaware that there is such a program available for their patients upon discharge while other hospital nurses apparently lack the knowledge and understanding of the home health program and the types of patients who are eligible for services. Ideally, plans for home health care should begin when the patient is admitted to the hospital. This is not occuring in a majority of hospitals in North Dakota.

Still other factors contributing to the limited utilization of the home health programs include limited public health nursing staff, the great distances to be traveled from the home health agencies to the patients' homes, and insufficient funding.

Assumptions of the Study

It was assumed by the researcher at the beginning of the study that:

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[3]Marie Brennan, "Home Health Agencies in Rural Communities," (unpublished paper, North Dakota State Department of Health, 1973), p. 3.

1. the home health agencies in North Dakota are experiencing limited utilization, resulting in diminished benefits being offered to the elderly.

2. the success of the home health program is dependent upon the physicians and nurses in a position to implement the program in their area.

3. generally, the elderly are economically deprived and medically indigent.

4. elderly people wish to maintain their independence, preferring to remain in their own homes.

Limitations of the Study

The limitations of this study are those inherent in survey research utilizing a mailed, open-ended questionnaire.

It is agreed by researchers that the subjective type of questionnaire, as used in this study, lends itself to possible misinterpretation.

Definition of Terms

The following definitions were formulated for the purposes of this study to provide clarification of the terminology used.

1. Public Health Nurse - a registered nurse, employed by a community or hospital to offer home health care.

2. Provider of Services - a hospital, extended care facility, or a home health agency.

3. Home Health Agency - a public or private organization, or a subdivision of such an agency or organization, which:

   a. is primarily engaged in providing skilled nursing and other therapeutic services,

b. has policies established by a professional group associated with the agency or organization,

c. maintains clinical records on all patients.[4]

4. Home Health Services - include those items and services furnished to an individual, who is under the care of a physician, and a home health agency, which gives care on a visiting basis in the client's place of residence:

a. part time or intermittent skilled nursing care;

b. physical, occupational, or speech therapy;

c. medical social services;

d. intermittent services of a home health aide;

e. medical supplies.[5]

5. Covered Service - those home health services for which reimbursement will be received from Medicare.

6. Benefit Period - a period of consecutive days during which services furnished to a patient, up to a certain specified maximum amount, can be paid for by the hospital insurance plan.[6]

7. Fiscial Intermediary - Blue Cross of North Dakota handles the Medicare claims for the home health agencies in North Dakota.

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[4]United States Department of Health, Education and Welfare, Social Security Administration, Title 18 Health Insurance for the Aged, Public Law 89-97 of the Social Security Act, Government Printing Office, Washington, D.C., July 3, 1965, p. 38.

[5]Ibid., p. 37.

[6]United States Department of Health, Education and Welfare, Social Security Administration, Social Security Handbook, 4th edition, Government Printing Office, Washington, D.C., 1969, p. 352.

8. Hospital Based Home Health Agency - those agencies financed by a hospital and having their offices in the sponsoring hospital.

9. Community Based Home Health Agency - those home health agencies which are a part of a generalized public health nursing program in a city or county. These agencies are supported by local taxes.

10. Generalized Public Health Nursing Program - this involves all aspects of public health nursing, including school health, health counseling and teaching, various clinics (i.e., immunization), as well as home health services.

11. Homebound - a client who is confined to his home, unable to leave without assistance and then only for out-patient care.

12. Skilled Nursing - those services which must be furnished by or under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired results.

Chapter II

REVIEW OF LITERATURE

The 1965 amendments to the Social Security Act enacted in Public Law 89-97 established a comprehensive program of health insurance, commonly known as "Medicare," for individuals sixty-five years of age and over. This law provides a mechanism for financing an array of health services, including in-hospital care, extended care benefits, and home health services. The concept envisioned by Medicare is to allow for continuity of care as the patient moves from one level of care to another.

MEDICARE

Its Inception

At the onset of Medicare, there were few regulations specifying the kinds of care which would be covered. As a result, any person sixty-five years of age and over having medicare insurance, could receive up to one hundred free visits from a public health nurse, upon the order of a physician. Much of the care given consisted of personal care, such as assistance with bathing, shampoo, and ambulation. Skilled nursing was not always a part of this care. At this point, many of the needs of the elderly were being met, and the program was widely used. In August of 1969, Intermediary Letter No. 395 was sent to all the participating home health agencies. This letter ushered in

a drastic change in the covered services available under Medicare. This letter stated:

> ....payments may not be made for home health services unless the services were required because the individual needed "skilled nursing care" on an intermittent basis, or physical or speech therapy.[7]

Because of this letter the term "skilled nursing" has played an important role in patient care. Everyone, including the physicians, public health nurses, hospital nurses and the public, involved with Medicare, has had a different interpretation of the term. Recently the range of nursing and other services covered by Medicare has been narrowed still more by "technical definitions." These definitions have been applied without cognizance of nursing care or the patients' needs, excluding all care given to maintain or promote health or prevent regression of mental or physical well being.

Thus a conflict arose between the care ordered and the types of care which are covered under Medicare. The coverage available under Medicare is divided into two parts, Part A and Part B.

Part A

Part A, known as hospital insurance, covers in-patient care in

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[7]United States Department of Health, Education, and Welfare, Social Security Administration, Bureau of Health Insurance, "Intermediary Letter No. 395," Government Printing Office, Washington, D.C., August, 1969.

hospitals, extended care facilities, and intermittent care in the home. The hospital insurance described in Part A pays for all covered services, for as many as one hundred home visits after the start of one benefit period and before the start of another. These benefits can be paid for up to one year after the most recent discharge from a hospital or participating skilled nursing facility, but only if the following conditions are met:

1. the patient was in a participating hospital for at least three consecutive days.
2. the continuing care needed includes part time skilled nursing care, physical, or speech therapy.
3. the patient is homebound.
4. the physician establishes a written plan of care within fourteen days after the patient's discharge from the hospital or participating skilled nursing facility.
5. the home care is further treatment of a condition for which the patient was hospitalized.

Cost. The patient must pay the first $60.00. After the $60.00 deductible has been met, the patient is not required to make any additional payments for home health visits, if the care needed is a covered service.[8]

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[8]United States Department of Health, Education and Welfare, Social Security Administration, Your Medicare Handbook, Publication # (SSA) 73010050, U. S. Government Printing Office, Washington, D.C., 1973, p. 11.

Part B

Part B, known as Supplementary Medical Insurance, assists with payments of physicians' fees, out-patient services, and some home health benefits. Part B entitles the patient up to one hundred home health visits for each calendar year, without requiring prior hospitalization, but only if the following conditions are met:

1. the patient needs part time skilled nursing care, physical or speech therapy.
2. the patient is homebound.
3. the physician determines that the patient needs home care.
4. the physician initiates and periodically reviews the plan of care.

Cost. Under Part B, the patient must pay the first $60.00 and 20 percent of the total cost of the covered services.[9]

Utilization

With the passage of time and the more restrictive regulations, appropriate patient referrals have begun to decrease, until a number of the home health agencies in North Dakota are struggling for survival.

The limited utilization of home health agencies is a concern of many states, including North Dakota. Home health services are the least costly of all the medical services, yet it is the one service

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[9]Ibid., p. 20.

that is seldom used. Ambrose[10] emphasizes that, after discharge, a patient usually goes to his home or that of a relative for weeks or months of recuperation. It has become apparent that hospitals are not preparing patients for continuity of care upon discharge. To receive continuity of care, the health care system as a whole must use all the existing public and private services, facilities, and agencies that will in a very real way make health care available and accessible. The decision for home care lies with a variety of interests, mainly the physicians and nurses, but also with the patient. The patient can be influential in the decision to receive home care but only if he is informed of the value of such services and is able to articulate his need to the nurses and doctors.

Lewis[11] stresses that cooperation is an essential aspect of any home health program. The medical staff must cooperate in referring and educating the patients regarding the benefits of the home health program.

Physicians' Role. In recent months home care has received consideration by the American Medical Association. An article in the American

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[10]Anne Ambrose, Sr., "Discharge Plans--The Weakest Link," Hospital Progress, March, 1973, p. 58.

[11]David Lewis and Marie Mackey, "Home Care Programs Cuts Dollars and Days," Canadian Hospitals, May 1973, p. 37.

Medical News[12] indicates that home care programs cannot be successful unless the quality of care is high and it is effectively utilized. Physicians, individually and collectively have important responsibilities in assuring that this standard is met. The author stated that:

> The medical societies' role should be given to stimulating physicians' interest in and acceptance of home care. The society must also take the lead in improving the coordination of existing home care services and stimulating the development of new ones where they are needed.[13]

It must be kept in mind that effective programs can offer high quality care and be an extension of the physicians at little cost and effort to the physician and at considerable savings to the patient. But home care programs cannot flourish without the support and guidance of the medical community. Ambrose[14] states that "medicare coverage is predicated upon the physicians professional judgment and his plan of treatment; some physicians are still skeptical or, at best, passive."

Nurses' Role. Professional nursing is responsible for meeting the needs of all people regardless of age. The rapidly increasing numbers of individuals in the older age group must be a concern of all professional nurses, if this segment of the population is to receive

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[12]Editorial, American Medical News, January 8, 1973, p. 5.

[13]Ibid.

[14]Ambrose, op. cit., p. 59.

adequate nursing care.[15]

Dawson[16] believes that continuity of care is dependent on the nursing profession's awareness of patients' needs and the professions planning for ways of meeting these needs. The hospital nurse is in a position to identify post-hospital nursing needs of patients that may be met by public health nursing intervention. The hospital nurse is also influential in aiding the physician in initiating appropriate referrals to the home health agencies.

Upon receipt of a physician's referral, the public health nurse is able to provide home health care to the patient in his home. An article in NLN News[17] facetiously stated that, "public health nurses do far more than wash and iron the patient and carry out those tasks which are deemed skilled." The article stressed that, in addition to medical orders and providing direct nursing care treatments, the public health nurse makes total assessment of patients' needs, evaluates family resources and home situations, makes observations of disease process and symptoms, develops nursing care plans, demonstrates

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[15]"Challenges to Nursing in Medicare," American Journal of Nursing, November, 1965, Volume 13, p. 68.

[16]Norma Dawson and Martha Stern, "Perceptions of Priorities for Home Nursing Care," Nursing Research, March - April, 1973, Volume 22, p. 145.

[17]Editorial, NLN News, Volume 21, No. 8, National League for Nursing, September, 1973, p. 3.

care and instructs the patient's family, supervises care provided by auxillary personnel, and coordinates services. Along with these services the public health nurse is responsible for the education of physicians, hospital nurses, and the public regarding the Medicare benefits available through the home health program. The American Hospital Association supports the idea that "the public should be informed of the potential for expert care in the home through various types of home care programs."[18]

HOME CARE TODAY

Nationwide

In a recent report Ryder[19] stated:

> ....home care offers a personal choice in medical care. Studies of older people show that up to 50 percent of those in institutions would really rather be in their own homes. Home care most importantly provides us with a way of allowing the individual to remain in comfort and dignity in his own home while at the same time it prevents dependency and loss of human resources.
>
> Despite these virtues, home care in the United States at this moment is at a standstill, if not in regression. There are about 2,300 home health agencies certified for Medicare reimbursement, and yet there are large geographic areas of the nation still with no such service. Fifty percent of our counties have no home health services and, although these counties represent a small proportion

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[18] American Hospital Association, The Hospital and the Home Care Program, 1972, p. 14.

[19] Claire F. Ryder, "In-Home Care Towards a National Policy and Strategy," Paper presented at 1972 Regional Meetings of Home Health Agencies and Community Health Services.

> of our population, they pose particular problems of distance and isolation in rural areas. Over half the agencies that are certified have only one or two nurses on staff. Since over 60 percent of the certified agencies are administered by health departments, these nurses often have many other responsibilities beyond the delivery of care to the patient in his home...

In North Dakota

Home care in North Dakota is experiencing difficulties. In 1969, there were nine agencies certified for Medicare reimbursement. As Medicare regulations became more restrictive and patient referrals began to decline, the home health agencies found it increasingly difficult to maintain their programs. As a result, in 1974, one home health agency terminated its services, leaving eight agencies in North Dakota. Of the remaining eight agencies, only seven are continuing to offer home care. The eighth agency is in serious financial trouble, with the possibility of closure within the year.

Although North Dakota has eight home health agencies, there are large areas of this rural state which do not have access to home care. North Dakota has fifty-one counties, twenty of which have access to home health programs. With the possible closure of another agency, North Dakota would be left with only twelve counties offering home health care.

An article in the NLN News[20] quoted Senator Muskie as saying

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[20] NLN News, op. cit., Volume 21, No. 8, p. 3.

"restrictive reimbursement policies have limited payments for home health services to less than one percent of Medicare expenditures. What should be an important segment of our national health system has been badly crippled by a combination of negative attitudes."

A statement from Trager's[21] report sums up the situation well.

> A review of home health services available in the United States must lead to the conclusion that they do not constitute a valid resource for the population which could make appropriate use of them.
>
> They are in short supply, they do not offer the comprehensive range of services required, they are limited in their capacity to provide for any significant volume of the population in need, and they have no geographic coverage. Where they do exist, the services are fragmented and are decreasing rather than expanding.

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[21] Brajan Trager, Home Health Services in the United States, A Report to the Special Committee on Aging, Government Printing Office, Washington, D.C., 1972, p. 61.

Chapter III

METHODOLOGY

The data presented in this study were collected through the use of a survey instrument. The written questionnaire was considered to be the best method for collection of data in this nonexperimental descriptive research effort. The design is also conducive to data collection over a large geographic area with relative speed and ease.[22]

An open-ended questionnaire was devised by the researcher to be sent to the target population located in the geographic areas of the nine home health agencies in North Dakota.

PILOT STUDY

In order to validate and refine the proposed tool, the initial questionnaire was mailed to four public health nurses, four physicians and four hospital nurses associated with home health agencies in Montana. Several problem areas relating to clarity and ease of response were identified in the initial questionnaire. Revisions were then made to produce the final version of the questionnaire.

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[22] Hillway Tyrus, Introduction to Research (Boston: Houghton Mifflin Company, 1956), p. 201.

SELECTION OF THE POPULATION

A purposive sample was selected from physicians, public health nurses, and hospital nurses employed in the geographic areas of the nine home health agencies in North Dakota.

Physicians

There are approximately 500 physicians in North Dakota. From this group 228 were selected. A current listing of physicians was acquired from the North Dakota State Department of Health. This listing was reviewed by the researcher and those physicians were eliminated who were deemed least likely to utilize the services of a home health agency. The physicians eliminated are as follows:

1. pediatricians
2. obstetricians
3. gynecologists
4. ear, nose and throat specialists
5. osteopaths
6. dermatologists
7. allergy specialists
8. dentists
9. psychologists
10. adolescent medicine
11. neurosurgeons
12. radiologists
13. psychiatrists
14. physicians employed by Veterans Hospitals and Air Base Hospitals.

Hospital Nurses

A total of sixty hospital nurses were selected for the researcher by the executive secretary of the North Dakota State Nurses Association. The executive secretary was provided with the criteria for the selection of these nurses. The criteria were as follows:

1. four nurses were to be selected from each of the specified hospitals. The twenty-two hospitals selected for the study were located in the geographic areas of the nine home health agencies.
2. each nurse must be employed.

The sample population selected to participate in this study was smaller than anticipated. In some cases, fewer than four nurses were selected, because some of the small, rural hospitals did not employ four registered nurses.

Public Health Nurses

There were seventy-five public health nurses employed in North Dakota. Of these seventy-five public health nurses, fifty-two work in local agencies offering home health services under medicare. These fifty-two public health nurses were selected to participate in this study.

METHOD OF COLLECTING THE DATA

The questionnaire, a cover letter explaining the purpose of the study and requesting the participation of the respondent, along

with a self addressed envelope, were sent to the sample population selected for this study. Every effort was made to maintain total anonymity throughout the study.

One month following the initial mailing, a follow-up letter was sent to all study participants. (An example of the questionnaire and cover letters are located in Appendix A.)

The sample population for this study totaled 340 physicians, public health nurses, and hospital nurses. Table 1 indicates the percentage of questionnaires returned by the respondents.

Table 1

RESPONSE TO QUESTIONNAIRE BY GROUPS OF RESPONDENTS

Respondents	Number Sent	Number Returned	Percentage
Physicians	228	91	39
Public Health Nurses	52	32	62
Hospital Nurses	60	28	45

Chapter IV

PRESENTATION OF DATA

The data presented in this study were collected by the survey questionnaire method. Each response was reviewed and categorized by the researcher. (A categorization of responses is presented in Appendix C.) The data gathered were then analyzed for possible significant findings. These findings are presented in tabular form in this chapter. It should be noted that the percentages in each table have been rounded to the nearest whole number.

The reader will note that each table contains a large percentage of "no response," occuring most frequently in the responses made by the physicians and hospital nurses. It is the opinion of the researcher, that these two groups were unable to answer those questions, due to limited knowledge of, or association with, a home health agency.

Table 2

EFFECTIVENESS OF HOME HEALTH PROGRAMS IN NORTH DAKOTA AS PERCEIVED BY PHYSICIANS, PUBLIC HEALTH NURSES AND HOSPITAL NURSES

Degree of Effectiveness	Physicians N-91		PHN N-32		Hospital Nurses N-28		Total N-151	
	No.	%	No.	%	No.	%	No.	%
Very Effective	8	9	6	25	2	7	16	16
Effective	25	27	12	22	5	18	42	28
Ineffective	32	35	10	41	14	50	56	32
No Response	26	29	4	12	7	25	37	24
Total	91	100	32	100	28	100	151	100

A fairly even distribution of responses was observed in the data presented in Table 2. Of those responding, the largest percent felt the home health programs were less than adequate in North Dakota. A further analysis of the responses show that 35 percent of the physicians, 41 percent of the public health nurses, and 50 percent of the hospital nurses felt the home health programs were ineffective.

It should be noted that 6 or 25 percent of the public health nurses felt the program was very effective, while only 8 or 9 percent of the physicians responding felt the program was very effective.

Table 3

INDICATORS OF THE EFFECTIVENESS OF THE HOME HEALTH PROGRAMS IN NORTH DAKOTA AS PERCEIVED BY THE PHYSICIANS, PUBLIC HEALTH NURSES, AND HOSPITAL NURSES

Indicators	Physicians N-91		PHN N-32		Hospital Nurses N-28		Total N-151	
	No.	%	No.	%	No.	%	No.	%
Physician Referrals	1	1	10	31	1	4	12	8
Number of people served	7	8	11	34	8	29	26	17
Feedback from patients and families	31	34	--	--	--	--	31	21
Those who were able to remain out of the institutions	2	2	2	6	2	7	6	4
Met physicians' needs	5	5	--	--	--	--	5	3
Accessability of program in regards to geography and staff	5	5	2	6	1	4	8	5
Follow up reports from PHN	4	4	--	--	--	--	4	3
No response	36	40	7	21	16	56	59	39
Total	91	100	32	100	28	100	151	100

The data in Table 3 indicate that the largest percent of the respondents measure their home health program's effectiveness by the number of patients which it serves. Further analysis of the data show that 34 percent of the public health nurses and 29 percent of the hospital nurses felt that the number of patients served was a good indicator of their program's effectiveness. Thirty-four percent of the physicians identified feedback from the patients and their families as the means by which they measure the program's effectiveness.

It is interesting to note that only 8 percent of all respondents found physician referrals an important means of measuring the effectiveness of the home health program. The public health nurses were the only group who identified this as an area of importance.

Table 4

FACTORS LIMITING THE EFFECTIVENESS OF THE HOME HEALTH PROGRAMS IN NORTH DAKOTA AS PERCEIVED BY THE PHYSICIANS, PUBLIC HEALTH NURSES AND HOSPITAL NURSES

Limiting Factors	Physicians N-91		PHN N-32		Hospital Nurses N-28		Total N-151	
	No.	%	No.	%	No.	%	No.	%
Cost	16	18	5	16	--	--	21	14
Limited physician referrals	2	2	6	19	3	11	11	7
Restrictive government regulations	11	12	9	28	2	7	22	15
PHN staff limitations	15	16	3	9	8	29	26	17
Lack of knowledge,RN	2	2	1	3	2	7	5	3
Lack of knowledge,MD	6	7	5	16	2	7	13	9
Lack of knowledge,Pt.	7	8	1	3	1	4	9	6
Limited community publicity	2	2	1	3	1	4	4	3
No response	30	33	1	3	9	32	40	26
Total	91	100	32	100	28	100	151	100

The data presented in Table 4 identify two areas, considered by the respondents, to be the greatest limiting factors of the home health programs. Seventeen percent of the respondents felt that the limitations of the public health nursing staff was the greatest limiting factor. Restrictive government regulations were identified by 15 percent of the respondents to be the second greatest limiting factor.

It should be noted that 9 or 19 percent of the public health nurses felt that limited physician referrals was a limiting factor for the home health programs in North Dakota, while only 2 or 2 percent of the physicians indicated this to be a problem.

Table 5

FACTORS CONTRIBUTING TO THE SUCCESS OF THE HOME HEALTH PROGRAMS IN NORTH DAKOTA, AS PERCEIVED BY THE PHYSICIANS, PUBLIC HEALTH NURSES AND HOSPITAL NURSES

Factors	Physicians N-91		PHN N-32		Hospital Nurses N-28		Total N-151	
	No.	%	No.	%	No.	%	No.	%
Communication with other professionals	6	7	3	9	3	11	12	8
Qualified PHNs	33	36	6	19	2	7	41	27
Public awareness	1	1	4	13	2	7	7	5
Increased referrals	4	4	2	6	3	11	9	6
Patient feedback	2	2	5	16	1	4	8	5
No response	45	50	12	38	17	61	74	49
Total	91	100	32	100	28	100	151	100

The array of data in Table 5 indicate that the largest percent of the respondents felt that the success of the home health programs was the result of qualified public health nursing staff. A dichotomy has occurred, with Table 4 presenting conflicting data. It identified the greatest limiting factor of the home health program to be the

limitations of the public health nursing staff.

Public awareness of the home health programs was identified by 7 or 5 percent of the respondents to be a factor in the success of the home health programs. Data in Table 4 also indicated that lack of knowledge by patients (public) was a limiting factor. Again, there appears to be disparity among the responses.

It should be noted that 7 percent of the physicians, 9 percent of the public health nurses, and 11 percent of the hospital nurses felt that communication with other professionals was contributing to the success of the home health programs.

Table 6

PHYSICIANS' REACTIONS TO THE HOME HEALTH PROGRAMS IN NORTH DAKOTA, AS PERCEIVED BY PHYSICIANS, PUBLIC HEALTH NURSES, AND HOSPITAL NURSES

Physician Reactions	Physicians N-91		PHN N-32		Hospital Nurses N-28		Total N-151	
	No.	5	No.	%	No.	%	No.	%
Favorable	28	31	5	16	6	21	39	25
Mixed	13	14	7	22	6	21	26	17
Indifferent	17	19	8	25	11	39	36	24
Neutral	1	1	--	--	--	--	1	1
No response	32	35	12	12	5	19	49	32
Total	91	100	32	100	28	100	151	100

Examination of the data presented in Table 6 show an interesting picture of the physicians' reactions to the home health programs, as perceived by all respondents. Of those responding, 25 percent felt the physicians' reactions were favorable, 17 percent felt the reactions were mixed, and 24 percent felt the physicians' reactions were indifferent.

It should be noted that 31 percent of the physicians saw their reactions as favorable, 14 percent as mixed and 19 percent as indifferent. Of the nurses responding, 36 percent of the public health

nurses and 38 percent of the hospital nurses felt the physicians' reactions to the home health program were indifferent.

Table 7

PHYSICIANS' RESPONSIBILITIES IN THE HOME HEALTH PROGRAMS IN NORTH DAKOTA, AS PERCEIVED BY PHYSICIANS, PUBLIC HEALTH NURSES, AND HOSPITAL NURSES

Physician Responsibilities	Physicians N-91		PHN N-32		Hospital Nurses N-28		Total N-151	
	No.	%	No.	%	No.	%	No.	%
Referrals	46	51	25	78	19	68	90	60
Support and assistance	6	7	--	--	1	4	6	4
Communicate with PHN	2	2	1	3	--	--	3	2
Be aware of services available	11	12	2	6	3	11	16	11
No response	26	29	4	12	5	16	36	23
Total	91	100	32	100	28	100	151	100

Table 7 indicates that 60 percent of the respondents felt that the physicians' major responsibility was the writing of complete referrals.

A further review of the data reveals that only 2 percent of all respondents felt that communication with the public health nurse was a

responsibility of the physician, yet Table 5 indicates that communication among professionals was a factor in the success of the home health programs. The data collected in this study continue to point out a discrepancy in responses.

Table 8

FACTORS THAT MIGHT CONTRIBUTE TO GREATER UTILIZATION OF THE HOME HEALTH PROGRAMS IN NORTH DAKOTA, BY PHYSICIANS, AS PERCEIVED BY PHYSICIANS, PUBLIC HEALTH NURSES AND HOSPITAL NURSES

Factors	Physicians N-91		PHN N-32		Hospital Nurses N-28		Total N-151	
	No.	%	No.	%	No.	%	No.	%
Increased publicity	9	10	2	6	3	11	14	9
Awareness and understanding of H.H.program	28	31	11	34	12	43	51	34
Improved communication with PHN	9	10	8	25	2	7	19	13
Confidence in PHN	3	3	--	--	2	7	5	3
PHN demonstrate that this is a needed service	3	3	--	--	1	4	4	3
No response	39	43	11	34	8	29	58	38
Total	91	100	32	100	28	100	151	100

An examination of the data presented in Table 8 reveal that the largest percent of respondents felt that the factor which would contribute most to the physicians' utilization of the home health program was their awareness and understanding of the services offered by the program. Thirty-one percent of the physicians, 34 percent of the public health nurses, and 43 percent of the hospital nurses identified this as the major area of importance.

Improved communications with the public health nurse was again noted as being a contributing factor. Ten percent of the physicians, 36 percent of the public health nurses, and 7 percent of the hospital nurses felt the physicians would utilize the home health program more, if communications were improved.

Table 9

HOSPITAL NURSES' RESPONSIBILITIES IN THE HOME HEALTH PROGRAMS IN NORTH DAKOTA, AS PERCEIVED BY PHYSICIANS, PUBLIC HEALTH NURSES AND HOSPITAL NURSES

Hospital Nurses' Responsibilities	Physicians N-91		PHN N-32		Hospital Nurses N-28		Total N-151	
	No.	%	No.	%	No.	%	No.	%
Identify patients needing home care	44	48	22	69	18	64	84	56
Know scope of program	3	3	5	16	2	7	10	7
Inform patients re: H.H. benefits	6	7	4	13	3	11	13	9
No responsibility	7	8	--	--	--	--	7	5
No response	31	34	1	3	5	18	37	25
Total	91	100	32	100	28	100	151	100

The data presented in Table 9 indicate that 56 percent of all respondents felt the major responsibility of hospital nurses was the identification of patients needing home care.

Of those responding, 7 percent felt the hospital nurses must be knowledgeable regarding the scope of the home health program. Nine percent felt the hospital nurses should inform the patients of the

benefits of the program.

It is of interest to note that 8 percent of the physicians responding felt that the hospital nurses had no responsibility in the home health program.

Table 10

MOST EFFECTIVE METHOD OF PROMOTING THE HOME HEALTH PROGRAMS, WITH THE HOSPITAL NURSES, IN NORTH DAKOTA, AS PERCEIVED BY PHYSICIANS, PUBLIC HEALTH NURSES, AND HOSPITAL NURSES

Methods	Physicians N-91		PHN N-32		Hospital Nurses N-28		Total N-151	
	No.	%	No.	%	No.	%	No.	%
Increased personal contact with RNs	38	41	27	84	12	43	77	50
Publicity	5	5	--	--	5	18	10	7
Hospital visits to patients by PHN	5	5	1	3	1	4	7	5
Demonstrated usefulness by PHN	2	2	--	--	5	18	7	5
No response	41	45	5	16	5	18	51	33
Total	91	100	32	100	28	100	151	100

The array of data in Table 10 show that 50 percent of those responding felt the most effective method of promoting the home health program was frequent personal contact by the public health nurse with the hospital nurse.

It was interesting to note that 5 or 5 percent of the physicians and 5 or 18 percent of the hospital nurses felt that publicity played an important role in promoting the home health program. None of the public health nurses saw this as being important. Eighteen percent of the hospital nurses indicated a desire to have the public health nurse demonstrate that the home health program is a needed and useful service.

Table 11

FUTURE OF THE HOME HEALTH PROGRAMS IN NORTH DAKOTA, AS PERCEIVED BY THE PHYSICIANS, PUBLIC HEALTH NURSES, AND HOSPITAL NURSES

There is a Future:	"YES RESPONSES							
	Physicians N-91		PHN N-32		Hospital Nurses N-28		Total N-151	
	No.	%	No.	%	No.	%	No.	%
If it maintains patients' independence	4	4	1	3	1	4	6	4
If it shortens hospital stay	4	4	5	16	3	11	12	8
If there were increased referrals	--	--	5	16	--	--	5	3
Because it is a needed service	22	25	9	28	11	38	42	28
Because of its success to date	10	11	4	13	1	4	15	10
Yes with no comment	13	14	2	6	6	21	21	14
Total of YES Responses	53	68	26	82	32	78	101	76
There is no Future:	"NO" RESPONSES							
Without cooperation of MDs and RNs	--	--	1	3	--	--	1	1
Because costs are too high	2	2	1	3	--	--	3	1
Because regulations are too restrictive	2	2	2	2	--	--	4	3
Because of poor management	1	1	--	--	1	4	2	1
No with no comment	6	7	--	--	--	--	6	4
Total of NO Responses	11	12	5	8	1	4	16	11
No response	27	30	2	6	5	18	34	23
Final Totals	91	100	32	100	28	100	151	100

The array of data presented in Table 11 is divided into two general categories of responses: "YES," the home health programs have a future, and "NO," the home health programs have no future. A total of 101 or 76 percent of the respondents feel that there is a future for the home health program in their area.

Further examination of the data reveals that 28 percent feel the program has a future, because it is a needed service, while 10 percent indicated that the program would have a future based on the program's success to date.

Of those responding "YES," only 2 percent indicated that the future of the home health program depends on increased referrals, yet Table 4 identifies limited physician referrals as one of the factors contributing to the limited success of the program.

Only 16 or 11 percent of the respondents felt there is no future for the home health program in their area. The largest percent of respondents identified restrictive government regulations as a factor hindering the success of the home health programs.

Table 12

POSSIBLE CHANGES WHICH COULD BE MADE IN THE HOME HEALTH PROGRAMS IN NORTH DAKOTA, AS PERCEIVED BY PHYSICIANS, PUBLIC HEALTH NURSES, AND HOSPITAL NURSES

Possible Changes	Physicians N-91		PHN N-32		Hospital Nurses N-28		Total N-151	
	No.	%	No.	%	No.	%	No.	%
Update PHN skills	3	3	1	3	3	11	7	5
Increase govt. reimbursement	3	3	10	31	2	7	15	10
Continuing education for MDs and RNs re:HHP	1	1	5	16	1	4	7	5
Expand the services of HHP	10	11	4	13	5	18	19	13
More publicity	3	3	3	9	2	7	8	5
Better communications between MDs, PHNs and RNs	--	--	1	3	1	4	2	1
More complete referrals	1	1	4	13	1	4	6	4
No changes necessary	4	4	--	--	--	--	4	3
No response	66	73	4	13	13	44	83	54
Total	91	100	32	100	28	100	151	100

The data presented in Table 12 indicate that 13 percent of the respondents felt that the most needed change in the home health program would be the expansion of services offered. This expansion would include a twenty-four hour call system and more diversified services to meet the ever changing health needs of elderly.

Communication appears again in this table, with only 1 percent of all respondents identifying the need for better communications among physicians, public health nurses, and hospital nurses as a change needed to promote and encourage the growth of home health programs.

Further analysis of the data show that 3 percent of the physicians, 36 percent of the public health nurses, and 15 percent of the hospital nurses felt that increased government reimbursement is necessary.

It should be noted that 16 percent of the public health nurses felt that continuing education for the physicians and hospital nurses was needed. Another 13 percent of the public health nurses indicated a need for more complete referrals.

Additional Comments

The questionnaire utilized in this study allowed for additional comments to be made by the respondents. Only seventeen or 11 percent of the respondents used this section. A verbatim listing of those comments relevant to this study is included in Appendix E.

Chapter V

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to identify those factors contributing to the limited utilization of the home health agencies in North Dakota.

Data were collected by use of an open-ended questionnaire devised by the researcher and sent to 228 physicians, 52 public health nurses, and 60 hospital nurses, employed in the geographic areas of the nine home health agencies in North Dakota.

A total of 151 questionnaires were returned. This included 39 percent of physicians, 62 percent of public health nurses, and 45 percent of hospital nurses.

The respondents identified those factors limiting the effectiveness of the home health programs to be:

1. limited physician referrals
2. cost to the home health agencies as well as to the patients
3. restrictive government regulations
4. lack of knowledge of the program by physicians, hospital nurses and the public

In spite of obvious problems, the prevailing feeling is that there is a future for the home health programs in North Dakota.

In light of the foregoing data, the following conclusions

have been formulated by the researcher.

General Conclusions

1. Restrictive government regulations, controlling patient care and funding, is contributing to the limited success of the program.

2. Sixty percent of all those responding indicated that the physicians' major responsibility to the home health program is the writing of complete referrals, including a plan of care.

3. In spite of obvious problems, the prevalent feeling is that there is a future for the home health programs in North Dakota.

4. Home health services would be more effective if they were offered on a twenty-four hour, seven day a week basis; and larger, more diversified staff to meet the health needs of the elderly.

5. Fifty-six percent of all respondents indicated that the hospital nurses' major responsibility to the home health program is identifying those patients needing home health services and bringing them to the attention of the physician.

6. A majority of the respondents felt that promotion of the home health programs could best be accomplished by the public health nurse through personal contact with physicians and hospital nurses.

7. Most respondents identified the need for improved communication among nurses and medical staff.

8. More publicity is needed to inform the public of services offered through a home health program.

Specific Conclusions

Physicians

1. The physicians diverged in their perception of the home health programs with 27 percent indicating it was effective, and 35 percent indicating it was ineffective. Only 9 percent viewed the program as very effective.

2. Although both groups of nurses perceived the physicians' reluctance to make referrals as a limiting factor, the physicians themselves did not see it as a limiting factor in the effectiveness of the home health programs.

3. Greater awareness and understanding of the services available through the home health programs would lead to better utilization of the programs by the physicians.

4. A dichotomy exists between the physicians' perception of those factors which limit the program's success and those factors contributing to its success. On the one hand, they identified the greatest limiting factor as their lack of confidence in the public health nurses' ability to care for patients in the home. (See Table 4) On the other hand, they indicated that the one factor contributing most to the success of the home health program was the qualified public health nursing staff. (See Table 5)

Hospital Nurses

1. Regular inservice education, provided by the public health nurse, would enlarge their understanding and acceptance of the program, enabling them to identify patients needing home health services.

2. A majority of the hospital nurses viewed the home health program as ineffective.

3. Twenty-nine percent of the hospital nurses perceived the public health nurses as not possessing the necessary skills needed to provide the required health care in the home.

4. The hospital nurses felt that greater understanding of the services provided through the home health programs would

assist her in explaining the program to patients and their families.

Public Health Nurses

1. There is a discrepancy in the public health nurses' perception of the home health program. Forty-one percent viewed the program as ineffective, 22 percent as effective, and 25 percent viewed it as very effective.

2. The public health nurses identified the limited knowledge and understanding of the home health program by the physicians, as well as lack of physician referrals, to be important factors contributing to the limited success of the home health program.

Implications

The following implications have been drawn from the findings of this study and the researcher's past experience with the home health programs in North Dakota.

1. Because the home health programs in North Dakota were felt to be greatly needed, but at the same time ineffective, it would appear that there is a disparity in recognizing the need and actually providing the care.

2. If government regulations controlling patient care and funding continue to be restrictive, the home health programs will find it difficult, if not impossible, to maintain or improve their services.

3. Because the home health programs in North Dakota are viewed as ineffective by many of the respondents, it would appear that a majority of the health needs of the elderly are not being met.

4. The home health programs will continue to experience difficulties as long as physicians, nurses, and the public remain uninformed regarding the services available through the home health programs.

5. Home health programs will continue to flounder without improved communication among the nurses and physicians.

Recommendations for Program Development and Further Study

The following recommendations are based on the researcher's findings, her knowledge of the related literature and research, her knowledge gained in conducting this study, as well as her past experience with the home health programs in North Dakota.

Program Development

1. Educational programs relating to Medicare should be provided for the following:
   a. physicians
   b. public health nurses
   c. hospital nurses
   d. public
2. Regular publicity in local news media should be utilized to acquaint the public with the services available through the home health programs.
3. Periodic meetings between public health nurses and the North Dakota intermediary should be held to review the regulations governing the home health programs.
4. Home health services should be expanded to include a twenty-four hour call system.
5. The State Department of Health should provide regular consultative services to the home health staff.
6. There should be more public health nursing involvement in on-going, personal contact with hospital nurses and

physicians.

7. Workshops and follow-up for public health nurses should be provided to aide them in effective documentation of patients' needs, to justify payment by the intermediary.

Further Study

The following recommendations are based on the researcher's findings, as well as her past experience with the home health programs in North Dakota. There should be:

1. a survey of intermediaries regarding their interpretation of government regulations.

2. a survey contrasting and comparing hospital-based programs and community-based programs.

3. a survey of potential clients, evaluating their knowledge of home health programs, as well as their expectations of the program.

4. a pilot or demonstration program, illuminating the role and importance of the home health programs, to the following:

   a. physicians

   b. public health nurses

   c. hospital nurses

   d. public

APPENDIX A

COVER LETTERS AND SURVEY QUESTIONNAIRE

816 17th Avenue North
Bozeman, Montana 59715

June 12, 1974

Dear

As a graduate student at Montana State University, I am writing my thesis on the "Utilization of Home Health Agencies in North Dakota."

In an effort to acquire significant information, I am requesting your assistance. I would appreciate your completing the enclosed questionnaire and returning it to me in the self-addressed stamped envelope at your earliest convenience. Please feel free to express your opinion openly, as the questionnaire need not be signed.

May I express in advance my sincere appreciation for the time and energy you have invested in making this a meaningful study.

Sincerely,

(Miss) LaVerne Lee, R.N.

LL:lm

QUESTIONNAIRE

UTILIZATION OF HOME HEALTH AGENCIES IN NORTH DAKOTA

1. a) In your personal opinion, how effective is the Home Health Program in your area?

   b) How do you measure its effectiveness?

2. What do you feel are the greatest limiting factors and/or problems in the Home Health Program in your area?

3. What aspects of the Program in your area are contributing to its success?

4. What, in your opinion, has been the reaction of the physicians to the Home Health Program in your area?

5. What do you feel are the physicians' responsibilities in the Home Health Program?

6. What, in your opinion, would contribute toward greater utilization by the physicians of the Home Health Program in your area?

7. What do you feel are the responsibilities of the hospital nurses in the Home Health Program?

8. What do you feel are the most effective methods of promoting the Home Health Program with hospital nurses?

9. Do you feel that the Home Health Program, in your area, has a future?

YES_____ NO_____

Please give reasons for your answer.

10. What changes do you feel should be made in the Home Health Program?

ADDITIONAL COMMENTS

816 North 17th Avenue
Bozeman, Montana 59715

August 27, 1974

Dear Nurse:

Some time ago you were sent a questionnaire concerning a study on "The Utilization of Home Health Agencies in North Dakota."

Many of the completed questionnaires have been returned. Since only a selected number of nurses were included in the study, it is important that I receive your reply. Would you take a few moments to complete the questionnaire?

In the event that you have already returned the questionnaire please disregard this letter.

Thank you for your assistance in making this a meaningful study.

Sincerely,

(Miss) LaVerne Lee, R.N.

816 North 17th Avenue
Bozeman, Montana 59715

August 27, 1974

Dear Doctor,

Some time ago you were sent a questionnaire concerning a study on "The Utilization of Home Health Agencies in North Dakota."

Many of the completed questionnaires have been returned. Since only a selected number of doctors were included in the study, it is important that I receive your reply. Would you take a few moments to complete the questionnaire?

In the event that you have already returned the questionnaire please disregard this letter.

Thank you for your assistance in making this a meaningful study.

Sincerely,

(Miss) LaVerne Lee, R.N.

816 North 17th Avenue
Bozeman, Montana 59715

August 27, 1974

Dear Public Health Nurse:

Some time ago you were sent a questionnaire concerning a study on "The Utilization of Home Health Agencies in North Dakota."

Many of the completed questionnaires have been returned. Since only a selected number of public health nurses were included in the study, it is important that I receive your reply. Would you take a few moments to complete the questionnaire?

In the event that you have already returned the questionnaire please disregard this letter.

Thank you for your assistance in making this a meaningful study.

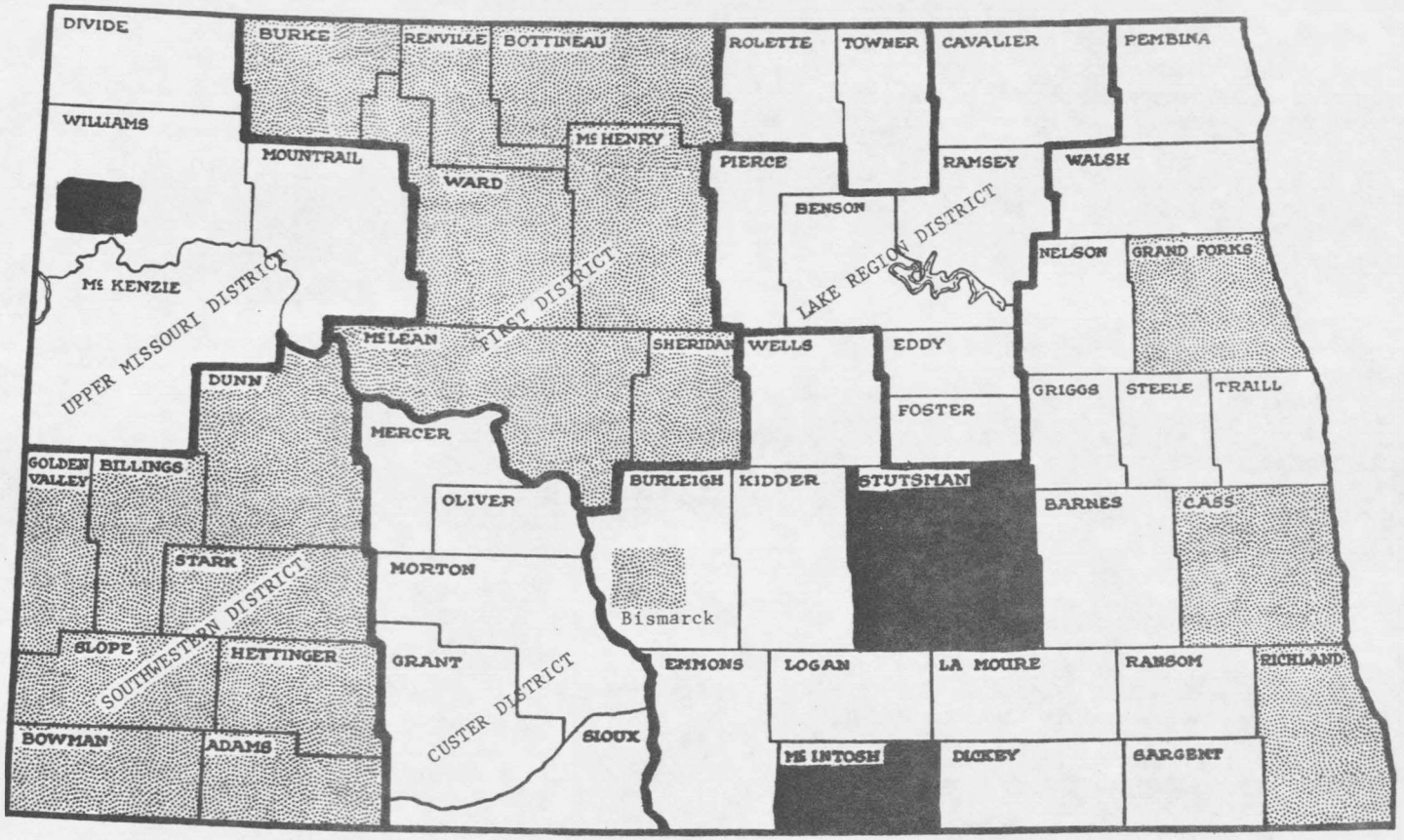
Sincerely,

(Miss) LaVerne Lee, R.N.

APPENDIX B

MAP OF NORTH DAKOTA INDICATING THE LOCATIONS OF HOME HEALTH AGENCIES

HOME HEALTH AGENCIES IN NORTH DAKOTA



----COMMUNITY BASED HOME HEALTH AGENCIES

----HOSPITAL BASED HOME HEALTH AGENCIES

The agency in Williams Co. discontinued its program as of April 1, 1974.

APPENDIX C

CATEGORIZATION OF RESPONSES

CATEGORIZATION OF RESPONSES

The following are examples of responses made to each question, according to categories.

1. a. In your personal opinion, how effective is the Home Health Program in your area?

Very Effective

1. very good
2. very much so

Effective

1. quite good
2. moderately
3. adequate

Ineffective

1. lukewarm
2. so-so
3. of minor importance
4. gaining effectiveness

1. b. How do you measure its effectiveness?

Physicians' referrals

1. lack of patient referrals

Number of people served

1. number of people seen
2. follow up reports

Feedback from patient and family

1. personal contact with patient and family
2. responses of patient

Those who were able to remain out of institutions

1. end results of care
2. need provided in the home
3. lack of return visits
4. recurring illness

Categorization of Responses, (continued)

Met physicians needs

1. satisfaction
2. services to patients as ordered

Accessibility of program in regards to geography and staff

1. availability of home health program
2. patients needing help get it
3. prompt use of service

Follow up reports from public health nurse

1. written reports from public health nurses
2. communication with public health nurse regarding patients

2. What do you feel are the greatest limiting factors and/or problems in the Home Health Program in your area?

Cost

1. distance and time
2. overhead

Limited physician referrals

1. lack of referrals

Restrictive government regulations

1. definition of skilled nursing
2. limitations on services
3. physicians' visits limited

Public health nursing staff limitations

1. staffed by non-degreed people
2. limited staff
3. lack of equipment
4. not enough adequately trained personnel

Categorization of Responses, (continued)

Lack of knowledge, RN

1. limited knowledge of program
2. need educational program regarding home health services

Lack of knowledge, M.D.

1. limited need
2. not many patients need it

Lack of knowledge, patient

1. patient unaware of services
2. publicity for the community regarding home health benefits

Limited community publicity

1. need more publicity
2. people do not know about the program

3. What aspects of the Program in your area are contributing to its success?

Communications with other professionals

1. frequent communication with public health nurse regarding patient care

Qualified public health nurses

1. interested nurses
2. good patient care

Public awareness

1. public asking for care

Increased referrals

1. home health agency located in hospital
2. hospital nurses refer patients
3. efforts of district medical society

Categorization of Responses, (continued)

Patient feedback

1. patient pleased with services

4. What, in your opinion, has been the reaction of the physicians to the Home Health Program in your area?

Favorable

1. interested
2. positive
3. receptive

Indifferent

1. slow to accept
2. lukewarm
3. refuse to use it

Mixed

1. some use--some not
2. improving
3. warmer
4. moderate to favorable
5. some apathy

5. What do you feel are the physicians' responsibilities in the Home Health Program?

Complete referrals

1. write orders
2. make referrals
3. plan of care

Support and assistance

1. give support
2. be available to nurses
3. cooperation

Communication with public health nurses

1. discuss patient care
2. frequent contact with public health nurse

Categorization of Responses, (continued)

Be aware of services available

1. know about home health program
2. aware of program

6. What, in your opinion, would contribute toward greater utilization by the physicians of the Home Health Program in your area?

Increased publicity

1. promotion
2. more publicity
3. need PR work

Awareness and understanding of program

1. awareness
2. education
3. discharge planning

Improved communication with public health nurse

1. PHN involved in discharge planning
2. teamwork

Confidence in public health nurse

1. skilled public health nurses
2. qualified public health nurses
3. better prepared public health nurses

Public health nurses demonstrate that this is a needed service

1. demonstration program
2. show need
3. identify need

Categorization of Responses, (continued)

7. What do you feel are the responsibilities of the hospital nurses in the Home Health Program?

Identify patients needing care

1. recommend home health services
2. discharge planning
3. coordination

Know scope of the program

1. know what services are offered by the Home Health Program

Inform patients regarding Home Health benefits

1. teach patients
2. interpret Home Health Program to patients

8. What do you feel are the most effective methods of promoting the Home Health Program with hospital nurses?

Increased personal contact with RNs

1. frequent inservice given by PHN
2. PHN visit hospital weekly

Publicity

1. distribute materials regarding the Home Health Program
2. PR work

Hospital visits to patients by PHN

1. explain services to patients

Demonstrated usefulness by PHN

1. show that the Home Health Program works

Categorization of Responses, (continued)

9. Do you feel that the Home Health Program,in your area, has a future?

YES_____ NO_____

Please give reasons for your answer.

Yes there is a future:

If it maintains patient independence

1. keeps patients in their homes
2. gives care to patients at home
3. keeps patients out of hospitals and nursing homes

If shortens hospital stay

1. frees hospital beds by early discharge
2. allows continuity of care

If referrals increase

1. need more referrals
2. more referrals from physicians

Because it is a needed service

1. great need
2. fills a need
3. very badly needed

Because of its success to date

1. meeting the needs of the elderly
2. successful up to now
3. working well

Categorization of Responses, (continued)

No, there is no future:

Without cooperation of physicians and hospital nurses

1. cooperation
2. feedback
3. must know and use program
4. more referrals

Because costs are too high

1. too costly
2. expensive service

Because government regulations are too restrictive

1. regulations very restrictive
2. regulations limit care given
3. regulations restrict payment

Because of poor management

1. managed poorly
2. needs better management

10. What changes do you feel should be made in the Home Health Program?

Update public health nursing skills

1. highly trained PHN
2. better qualified PHN
3. more knowledgeable PHN

Increase government reimbursement

1. better payment by intermediary
2. improved regulations relating to reimbursement
3. increased coverage

Categorization of Responses, (continued)

Continuing education for physicians and hospital nurses regarding the Home Health Program

1. inservice education
2. ongoing inservice education
3. personal contact by PHN to explain Home Health Program

Expand the services of the Home Health Program

1. include 24 hour day, 7 days per week
2. have 24 hour call system
3. include more nursing procedures
4. offer more aide services

More publicity

1. word of mouth
2. printed materials
3. newspaper articles
4. radio and TV spots

Better communications between PHN, MDs and RNs

1. regular meetings between PHN, MDs, and RNs
2. one to one contact
3. personal contact
4. written reports of patient care from PHN to MDs and RNs

More complete referrals

1. complete orders
2. plan of care
3. referrals completed
4. all inclusive referrals

No changes necessary

1. no change needed
2. O.K. the way it is
3. nothing to change

APPENDIX D

HOME HEALTH RELATED SECTIONS OF TITLE XVIII

HEALTH INSURANCE FOR THE AGED

P.L. 89-97 OF THE SOCIAL

SECURITY ACT

HOME HEALTH RELATED SECTIONS OF

SOCIAL SECURITY ACT

Sec. 1831. Establishment of supplementary medical insurance program for the aged.

There is hereby established a voluntary insurance program to provide medical insurance benefits in accordance with the provision of this part for individuals 65 years of age or over who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

Sec. 1832. Scope of benefits.

(a) The benefits provided to an individual by the insurance program established in this part shall consist of---

1. entitlement to have payment made to him or on his behalf (subject to the provision of this part) for medical and other health services, except those described in paragraph (2) (B); and

2. entitlement to have payment made on his behalf (subject to the provisions of this part) for---

(A) home health services for up to 100 visits during a calendar year;

(B) medical and other health services (other than physicians' services unless furnished by a resident or intern of a hospital and the services for which payment may be made pursuant to section 1835(b)(2) furnished by a provider of services or by others under arrangements with them made by a provider of services; and

(C) outpatient physical therapy services.

(b) For definitions of "spell of illness", "medical and other health services", and other terms used in this part, see section 1861.

Sec. 1834. Limitation on home health services.

(a) Payment under this part may be made for home health services furnished an individual during any calendar year for 100

visits during such year. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items and services described in section 1861(m) shall be determined in accordance with regulations.

(b) For purposes of subsection (a), home health services shall be taken into account only if payment under this part is or would be, except for this section or the failure to comply with the request, and certification requirements of or under section 1835 (a), made with respect to such services.

Sec. 1836. Eligible individuals.

Every individual who---

(1) has attained the age of 65, and

(2) (A) is a resident of the United States, and is either (i) a citizen or (ii) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part, or (B) is entitled to hospital insurance benefits under part A, is eligible to enroll in the insurance program established by this part.

Sec. 1861. Definitions of services, institutions, etc.

For purposes of this title---

Spell of Illness

(a) The term "spell of illness" with respect to any individual means a period of consecutive days---

(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility.

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home---

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy:

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or extended care facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and--

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A), but not including transportation of the individual in connection with any such item or services; excluding, however

any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

Post-Hospital Home Health Services

(n) The term "post-hospital home health services" means home health services furnished an individual within 1 year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within 1 year after his most recent discharge from an extended care facility of which he was an inpatient entitled to payment under part A for post hospital extended care services, but only if the plan covering the home health services (as described in subsection (m) is established within 14 days after his discharge from such hospital or extended care facility.

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which--

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physician and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any such State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and

(5) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency

or organization;

except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

Sec. 1862. Exclusion from coverage.

(a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services--

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in such cases as the Secretary may specify;

(4) which are not provided within the United States (except for emergency inpatient hospital services furnished outside the United States under the conditions described in section 1814 (f);

(5) which are required as a result of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items;

(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during

the course of an eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations;

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet;

(9) where such expenses are for custodial care;

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute changes imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth; or

(13) where such expenses are for---

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor.

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other hygenic care)

(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan.

APPENDIX E

VERBATIM STATEMENTS MADE BY RESPONDENTS TO "ADDITIONAL COMMENTS" ON QUESTIONNAIRE

VERBATIM STATEMENTS MADE BY RESPONDENTS TO

"ADDITIONAL COMMENTS" ON QUESTIONNAIRE

Physicians

"...Education of nurses and physicians is probably the key to demonstrating what can be done by an agency of this sort, plus the home health nurse must make weekly contact with the physicians to keep it alive."

"There needs to be a carefully screening of individuals who perform this service, to make sure that they are capable of comprehending the problems of others, that they are compassionate and understanding, yet have a firmness to get across their point and to find a way that is acceptable to each physician involved, so that they can report to him at an appropriate time, either in writing or verbally, at a time where his patients are not interrupted by inappropriate or untimely communications.."

"In my mind, in this area, the program is a FLOP!"

"Too much paper work involved."

"Public health nurses should be involved in discharge planning and post discharge care conferences."

"Our program died for lack of funds and lack of utilization."

Public Health Nurses

"We are paying more for paper work than nursing services."

"Most physicians refer patients who need long term care, but those who would benefit from just a few visits are not being referred often times."

"We have discontinued our program as of April 1, 1974, due to lack of referrals."

Verbatim Statements Made by Respondents to "Additional Comments" on Questionnaire, (continued)

Hospital Nurses

"In many situations....doctors don't necessarily like suggestions from hospital nurses."

"There needs to be a good record keeping system that cuts down on the multitude of paper work that is done by most home health agencies."

"The program should be given more publicity to acquaint the medical and nursing professions as well as the public of its services."

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