

# There's No Place like Home:

## Rural Home Health and Hospice Care in Washington State

### *A Discussion of Challenges and Solutions*

Washington State Office of Rural Health

January 2019



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## FOUNDATIONAL SOURCES

Special thanks to Scott Ekblad and Meredith Guardino at the Oregon State Office of Rural Health for their pioneering report:

Guardino, M. Walsh-Bailey, C., Horst, J. *Aging in Rural and Frontier Oregon: Challenges Facing Rural and Frontier Home Health Agencies*, Oregon State Office of Rural Health, September 2016

“In a recent survey of Oregonians over the age of 45, eighty-five percent responded that as they age and begin to experience difficulties in basic tasks of life, they wish to remain in their own homes with caregiver assistance rather than relocate to institutional-based care.”

*Excerpt from Aging in Rural and Frontier Oregon:  
Challenges Facing Rural and Frontier Home Health Agencies*

Also gratitude for two important rural research papers:

Skillman SM, Patterson DG, Coulthard C, Mroz TM. *Access to Rural Home Health Services: Views from the Field*. Final Report #152. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, February 2016.

Knudson, A, Anderson, D, Schueler, K, Arsen, E. *Home is Where the Heart Is: Insights on the Delivery and Coordination of Rural Home Health Services in America: A Policy Brief*. Grand Forks, ND: Rural Health Reform Policy Research Center, A Consortium of the University of North Dakota Center for Rural Health & NORC Walsh Center for Rural Health Analysis, August 2017

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## METHODS

This report does not attempt to comprehensively inventory every issue and all rural agencies and sites in the state, but does seek to discuss common challenges, with an emphasis on the smallest communities serving the most remote regions.

Initial research identified the agencies currently holding Certificate of Need in the state and the counties of responsibility. This list was used to define site visit priorities and invitations were facilitated by the Executive Director of the Home care Association of Washington and characterized as joint visits. A standard set of questions (see below) was designed and used for seven key informant interviews. The interviews were conducted with key personnel at rural home health agencies and hospices during site visits. All rural agencies were invited to participate in additional interviews using virtual communication methods (Zoom); however, participation did not occur.

The papers referenced in the Foundational Sources section on page 3 served as a helpful building blocks and were augmented by a wide array of other data sources. Less structured and more informal discussions with many rural health and home health and hospice experts added to the knowledge base.

The views of the rural teams, other papers and conversations were synthesized to formulate the themes and suggested solutions for consideration. These suggested solutions may not reflect consensus at the Department of Health and are meant to serve as catalysts for further conversation and data driven decision-making about improvements.

### Key Informant interview questions for site visits

**Demographics/introductory:** Counties covered, service mix, # of offices or sites Please tell us about the people and area you serve, Anything wonderful you want others to know about? **Financial:** Estimated Payer mix: charity? Financial health Poor, fair, good, excellent. Avg visits per month? Drivers? Avg visits per month, how many visits per day for breakeven? Medicare denials? To what extent? # per month? Reasons for denials? Paid travel time? **Referral sources:** Hospitals, Clinics, Tertiary centers, coordination experiences **HIT:** Electronic Health record? Tablets in the field? Laptops? Connectivity to hospital or clinics? Any streamlining of Medicare forms into EHR?

**Workforce:** # of current openings by discipline, turnover rate if known, Recruitment and retention challenges and strategies, training challenges and successes, What specific supports would improve training? Most needed training topics? Considered mobile simulation training?

**Policy change wish list:** Is certificate of need useful for rural home health? Why or why not? What Medicare regulations or Conditions of Participation would you change if you could? What Medicaid regs? Any commercial insurance ideas? How would you envision collaboration with mobile integrated health? (Community paramedicine) **Palliative Care:** Agency offers hospice? If yes, how is it going? Staffing separate or mixed? If the CAH and RHC became more skilled at primary palliative care, resulting in potentially more referrals to hospice, how would you envision collaboration? **Other:** Any gaps in local health or human services that particularly concern you?

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## EXECUTIVE SUMMARY

Rural hospitals and clinics are often the focus of assistance efforts while rural home health and hospice agencies, facing their own significant barriers to sustainability, receive less attention from policy makers. Home health associations may or may not recognize the unique challenges of their rural constituents. Washington state is fortunate to have Home Care Association of Washington, and the Washington State Hospice and Palliative Care Organization, both taking an active role to understand and respond to rural challenges.

Rural health systems offer critical local services while experiencing challenges that threaten their sustainability. Smaller numbers of patients result in lower reimbursement levels and inherent challenges with reliable quality measurement. Rural communities face nearly relentless workforce shortages and exert great effort on recruitment and retention while responding to communities with higher rates of unemployment, uninsured, poverty, and proportionately higher percentages of aging populations. Many of Washington's rural health systems in the smallest communities are financially fragile.

Yet small rural organizations have the ability to change without drawn-out approval processes and many have strong networks of relationships that make care truly patient- and family-centered. By necessity, these organizations demonstrate considerable flexibility as they pull together to respond to unplanned disruptions.

Rural health care organizations operate in particularly interdependent relationships. When a rural home health agency lacks capacity to serve patients, the local rural hospitals report effects on length of stay, emergency department (ED) visits, long term care admissions, and readmissions. Without home health services, clinicians have fewer alternatives to help patients receive care locally in the least restrictive and often most preferred environment: home.

Home health agencies in rural communities provide high-quality care that creates desired outcomes while remaining responsive to patient preferences. Their contribution is critically important if aging residents are to retain independence for as long as possible.

This report examines Washington's rural home health agencies and hospice programs' challenges, and proposes 44 potential solutions. Each solution has short, medium or long term potential effects and can be sorted by who has influence, federal, state, regional or local entities. Many possible solutions require a combined effort from multiple levels and it is a question of who can best convene the work. Short term solutions, the often named "low-hanging fruit" can be attractive. Yet deeper systemic change requires attention to solutions with longer range effects and those interventions may pose both greater complexity and higher value.

In the report each challenge is described in detail and potential solutions are presented based on recommendations from rural health professionals, state and national organizations, and experiences in other states. A table showing the solutions sorted by influence, the time frame of the effort, and projected potential effects are included as an appendix.

Written for a broad audience of healthcare, public health and rural health leaders, the hope is to start conversation on some issues while making a call to action on others. Although this report focuses on Washington State, the discussion of proposed changes, for example, to Medicare, have potential implications for rural communities across the nation.

## HIGH-LEVEL SUMMARY OF PROPOSED SOLUTIONS

### Decreasing Underuse of Home Health and Hospice Care Services and Strengthening Fiscal Operations

- Better understand drivers of low home health and hospice use in rural areas
- Design easy entry processes
- Test standing order sets; default home health or hospice orders
- Recognize the redefinition of the need to improve
- Increase Medicaid payment and simplify preauthorization
- Integrate home health agencies (HHA) into Critical Access Hospital (CAH ) cost reports and payment
- Reduce use of homebound status and medical necessity
- Reduce over-regulation
- Increase incentives and decrease barriers for home health and hospice agencies to integrate telemedicine and home tele-monitoring services
- Create payment and design services for upstream palliative care
- Integrate more behavioral health approaches into HHAs

### Moving to Value-Based Payment and Care Systems Across the Rural Health System

- Evaluate the *Outcome and Assessment Information Set* (OASIS) measures through a rural lens
- Employ small data set strategies developed by the National Quality Forum (NQF)
- Increase interoperability with electronic health records in home health and hospice agencies
- Include rural home health and hospice care in bundled payments
- Integrate HHAs in accountable care organizations (ACOs) and accountable communities of health (ACHs)
- Engage HHAs in prevention strategies and early screening and intervention
- Build value based coding skills and business practices

### Reducing Administrative Burden

- Use the “value-added” lens to evaluate documentation, to decrease documentation requirements
- Defer to state scope of practice to allow advanced registered nurse practitioners (ARNPs) to certify care and revoke the face-to-face requirement
- Create rural waivers for durable medical equipment (DME) requirements

## **Addressing Rural HHA Certificate of Need**

- Evaluate alternatives to county for geographic responsibility for CoN
- Evaluate influence of CoN on patient access to rural home health and hospice services
- Decrease the complexity of CoN application and offer additional resources to augment proactive front end technical assistance (TA)

## **Attaining the Necessary Workforce to Meet Home Health and Hospice Needs**

- Build experience, courage, compensation, education
- Build virtual community-based training ladders
- Prioritize local region students for admissions to community colleges
- Foster new roles and greater rural flexibility
- Fund comprehensive workforce assessment for health care with an emphasis on rural
- Improve integration of rural home health in existing workforce strategies
- Anticipate the high need for home care aides
- Facilitate rural community use of Department of Social and Health Services (DSHS) contract nurses and other aging supports

## **Responding to Rural Geography/Population Density and Volume Constraints**

- Continue and increase federal rural subsidy for HHAs
- Develop more blended systems of care with less categorical regulation and payment
- Decrease barriers to co-employed staffing with regulatory relief of silo requirements
- Explore models for inclusion of HHAs in rural regionalization and networks
- Evaluate the best compensation models for time spent driving to patient homes
- Fund like a fire department for fixed cost of capacity
- Evaluate the use of HHA shortage area declarations

## **Building Community-based alternatives**

- Create supported housing alternatives with less red tape
- Incentivize day health-partial hospitalization
- Adopt and spread the CAPABLE model
- Develop congregate hospice homes

# THE WASHINGTON STATE OFFICE OF RURAL HEALTH: ROLE IN SOLUTIONS

## About the Washington State Office of Rural Health

The State Office of Rural Health (SORH) has a mission to support Washington’s rural and underserved communities to improve health and healthcare across the life span, with an overarching goal to reduce rural and urban underserved health disparities and health inequities to achieve *health justice*. Health justice says differences in health are unnecessary, avoidable, unfair and unjust and is an intent to overcome the social, legal and systemic barriers that prevent equal access to healthcare and health, to provide care to all according to need

In addition to the broader strategic plan of the Department of Health, seven strategic goals drive the SORH’s work:

Provide accurate information from data

Sustain high quality rural health systems.

Communicate reliable information, relevant to the audience.

Facilitate a robust workforce for rural and underserved communities.

Facilitate access to supports and services that enable people to have healthy lives and deaths near the people and places they love.

Instigate improved public policies for rural health and access for underserved

Continually create a healthy work place to improve SORH team member experience and performance.

## The role of the SORH related to the solutions in this report

The SORH offers training, technical assistance and funding in response to need but also seeks to lead conversations that instigate improvements in rural community health, and to proactively lead efforts that engage public- private partnerships to solve problems, magnify strengths and develop opportunities. In many instances the SORH may act as a neutral convener, with a broad mission to help others facilitate solutions. Often the best locally driven solutions evolve when the right people are brought together with a clear charter for a collaborative conversation.

To help the WA SORH identify and prioritize potential actions based on the solutions presented in this document, the following criteria are central: action has the greatest potential to solve immediate access problems; action is within state influence, and can be accomplished without regulatory changes. In addition, the SORH will instigate conversations on selected longer term solutions with deeper systemic ramifications. These priorities do not preclude conversation and movement on the other potential solutions but do outline a feasible near term scope. The hope is that others will also be motivated to select and prioritize items for action.

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## TOP PRIORITY ACTION ITEMS FOR THE STATE OFFICE OF RURAL HEALTH

Below, the proposed solution language has been edited to articulate the specific role that the WA SORH may play in supporting that particular solution. In most cases the WA SORH will act as a convener and bring together subject matter experts and stakeholders in teams to achieve the outcomes outlined. However, the WA SORH may directly implement a few of the strategies.

- Co-convene a workgroup to evaluate a pilot which tests HHA shortage area declarations.
- Instigate a discussion of alternatives to county for geographic responsibility for rural CoN.
- Offer education to build value based coding skills and business practices to rural health organizations and include rural home health and hospice in the invitations.
- Consider contracting with a highly experienced HHA manager to offer mock survey and technical assistance to rural agencies as is currently done with Rural Health Clinics.
- Improve integration of rural home health in existing rural workforce strategies at DOH and encourage integration among workforce partners.
- Anticipate the high need for home care aides and consider tasks for contracts with the Area Health Education Centers, and encourage other workforce partners to contribute to efforts.
- Inform rural communities about the use of Department of Social and Health Services (DSHS) contract nurses and related Aging, Adult and Disability Services. This includes more inclusion of Area Agency on Aging in work teams on particular rural topics.

- Explore models for inclusion of HHAs in rural regionalization and networks, through discussions with network leaders.
- Discuss the research opportunities with the Rural Research Centers, to encourage a studies related to the best compensation models for windshield time, the reasons for underuse of home health in WA, the factors that influence increases in volume for “easy entry” admission agencies, the influence of CoN on rural access to services, and comprehensive workforce assessment for HHAs and hospice.
- Seek funding for a WA state pilot to adopt and spread the CAPABLE model.

The next steps are to propose a sequence for the action items, negotiate prioritization with agency leadership, and develop a concrete work plan.

It also hoped that others will consider this report a call for action and select ideas for dialogue and active strategy development.

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## RURAL WASHINGTON STATE

Of Washington's 39 counties, 30 are considered rural, representing about 16 percent of the population. In 1999 Washington legislation defined a rural county as "... a county with a population density less than 100 persons per square mile." Subsequent legislation expanded the definition to include "... a county smaller than two hundred twenty-five square miles."<sup>1</sup> The county-level definitions are broad and omit rural places in urban counties. For example, Darrington is a fairly remote mountainous town with a population of 1,385 (2015) but is located in Snohomish County, defined as urban.

There are a number of different ways to define rural as well as frontier. Frontier is an additional description used for the most remote areas, with a federal definition of six or fewer persons per square mile. Western states hold the vast majority of frontier regions. Comparison of rural and frontier data requires careful attention to the classification and analytical methods used.

Simple definitions for rural or frontier can overlook complex issues that affect access to services, subsequent inequities in care, and isolation. For example distance and travel time are not matched variables because travel time is affected by terrain and road conditions. In addition to population density, considerations of rural health issues include:

- Distance from a population center or specific service
- Travel time to reach a population center or service
- Functional association with other places
- Availability of paved roads and road conditions
- Seasonal changes in access to services<sup>2</sup>
- Weather
- Topography and elevations

These factors are particularly germane in a state such as Washington with mountainous regions, islands, wilderness, and sparsely populated areas.

The National Center for Frontier Communities gathered frontier definitions from State Offices of Rural Health and under that definition Washington's frontier counties are: Adams, Columbia, Ferry, Garfield, Lincoln, Klickitat, Jefferson, Okanogan, Pacific, Skamania, and Wahkiakum<sup>3</sup>

Another federal definition adds three additional counties: Pend Oreille, San Juan, and Stevens. Like rural, frontier definitions can be more precisely broken out by census tract or ZIP Code than at the county level. The United States Department of Agriculture (USDA) uses four levels to classify Frontier and Remote by zip codes.

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<sup>1</sup> <https://www.ofm.wa.gov/washington-data-research/population-demographics/population-estimates/population-density/population-density-and-land-area-criteria-used-rural-area-assistance-and-other-programs>, accessed 2/16/2018

<sup>2</sup> <https://www.ruralhealthinfo.org/topics/frontier#definition>, accessed 2/16/2018

<sup>3</sup> [http://frontierus.org/wp-content/uploads/2014/12/2010\\_Frontier\\_Counties\\_Map\\_fin062612.pdf](http://frontierus.org/wp-content/uploads/2014/12/2010_Frontier_Counties_Map_fin062612.pdf) accessed 2/16/2018

Figures 1 and 2 below display USDA Frontier and Remote (FAR) Level 1 and 4.

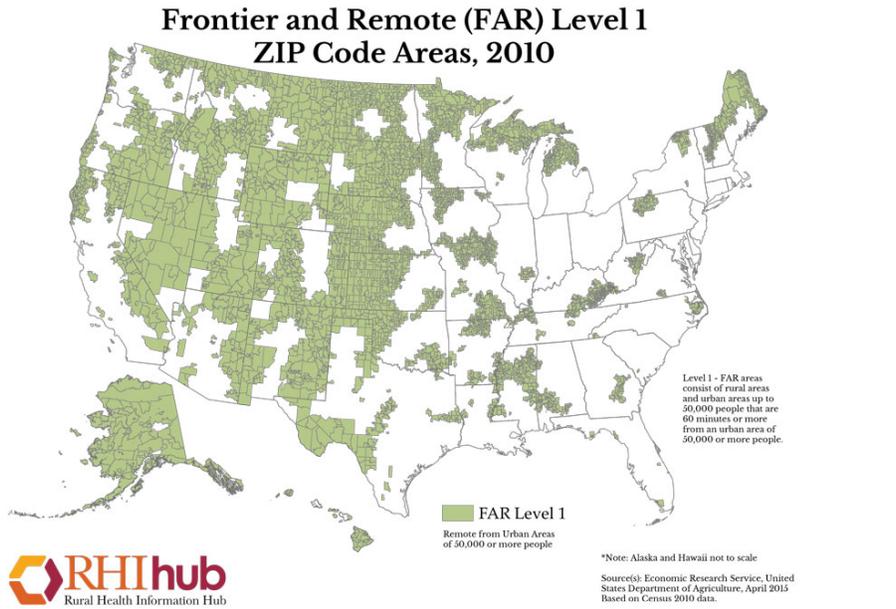


Figure 1. FAR Level 1

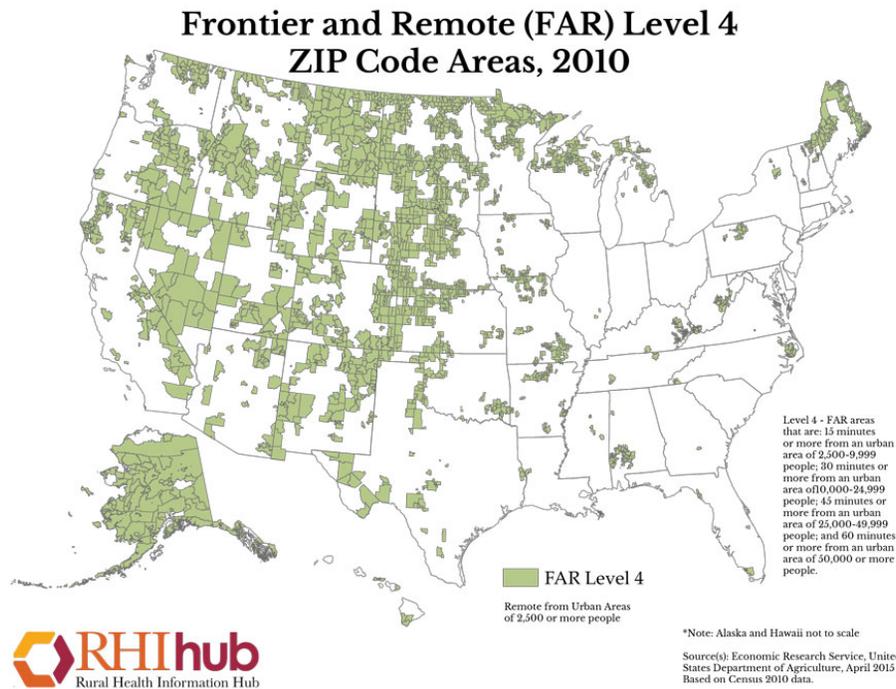
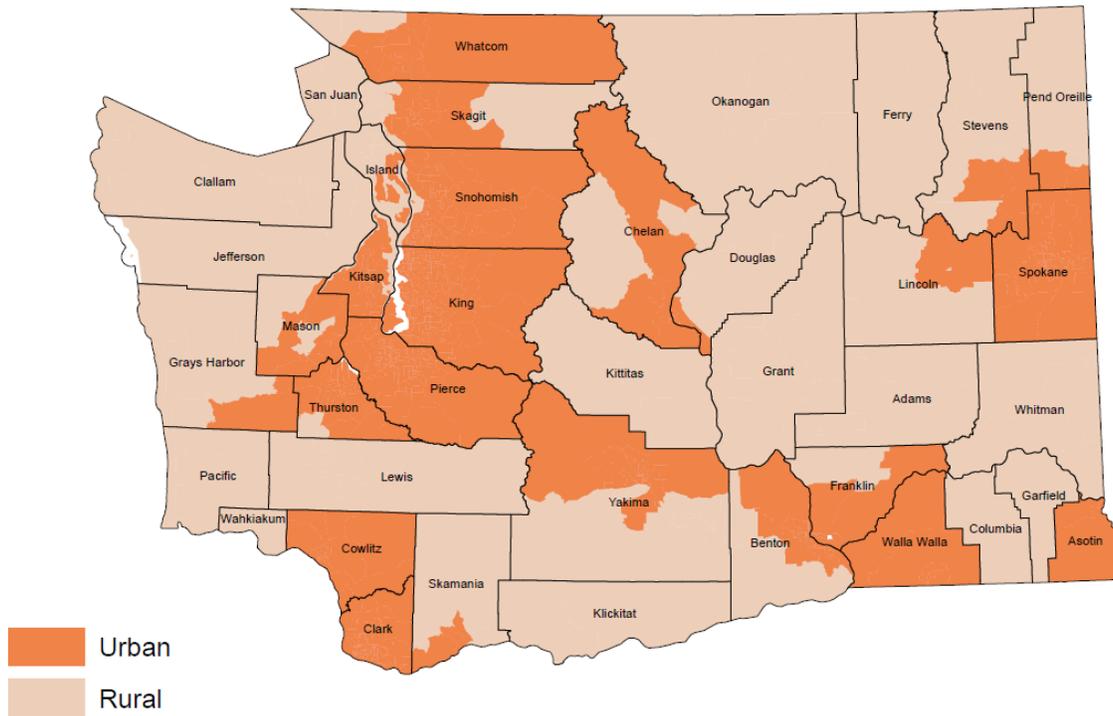


Figure 2. FAR Level 4

<https://www.ruralhealthinfo.org/rural-maps/mapfiles/frontier-level-one.jpg>, accessed 6/11/2018

Of the total land in Washington, 96.4 percent is rural and 3.6 percent urban when using the USDA Rural/Urban two category definitions, a common federal classification at the sub-county level.

### Rural/Urban Areas, Washington State

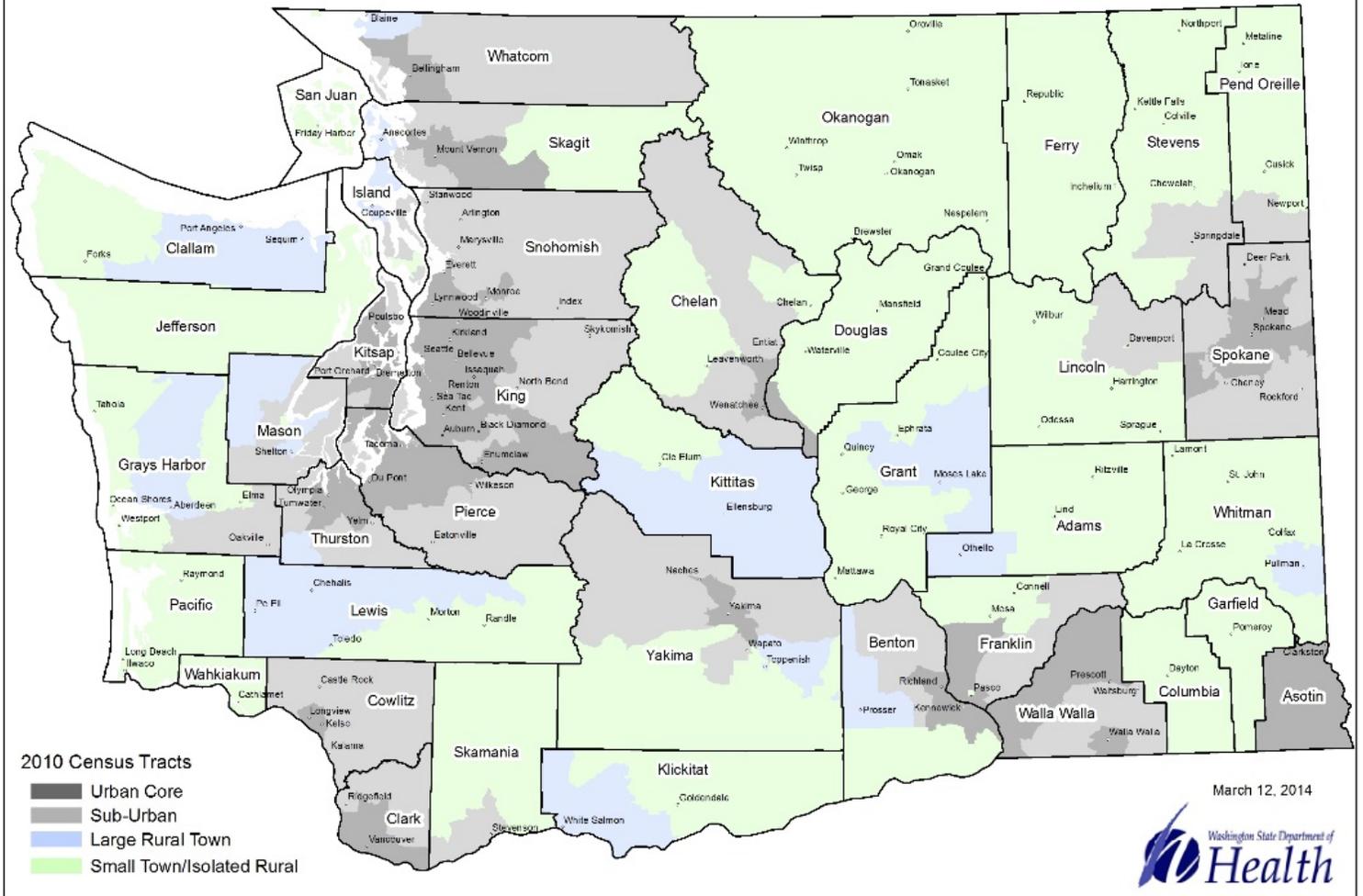


Data Source: <http://www.ers.usda.gov/data-products>

**Figure 3. USDA Two Category Classification Rural and Urban Areas.**

The Washington State Office of Rural Health (WA SORH) at the Department of Health commonly (though not exclusively), uses a geographic classification system called RUCA, or Rural Urban Commuting Area Codes. This schema is common in public health geographic analysis. Eleven primary codes and 21 sub-codes categorize geography, using ZIP Codes or census tracts. The WA SORH frequently employs a four-category RUCA as depicted in Figure 4.

## Rural and Urban Commuting Area



**Figure 4. Four Category RUCA**

The four RUCA categories include: urban core (larger populations of 50,000 or more and primary flow within the urbanized area); suburban (moderate population of 10,000-49,999; primary flow within large urban cluster; population density more than 100 per square mile); large town (population of 2,500-9,999; primary flow within small urban clusters; population density more than 100 per square mile); and small town-rural (population under 2,500; primary flow outside an urbanized area-urban cluster; population density less than 100 per square mile). The DOH rural-urban classification guideline document is available at <http://www.doh.wa.gov/Portals/1/Documents/1500/RUCAGuide.pdf>

## The Aging Rural Population in Washington

As of April 1, 2017, there were 7,310,300 Washington residents, according to annual estimates prepared by the Office of Financial Management.<sup>4</sup> More than 15.34 percent of Washington residents in this estimate are over the age of 65. Urban areas in the state average 14.6 percent of the population age 65 years and older while in rural areas the 65 years and over population composes 20.3 percent of the population. The percentage of the population age 65 and older is steadily trending upward and disproportionately rising higher in rural areas. It is estimated that by 2040, 25 percent or more of the population will be age 65 and older in 22 of the 30 counties designated rural in Washington state.

Age groups (years)	Urban	Rural
Children (0-14 )	18.8	18.8
Young adults (15-24)	12.8	14.0
Working age adults (25-64)	53.8	46.8
Retired and elderly (65+)	14.6	20.3

**Figure 5. Age groups urban/ rural comparison**

Data Source: 2017 Population Estimates: Washington State Office of Financial Management  
 Geography: Urban rural areas are identified based on a DOH modified RUCA 3.1 codes  
 Asnake Hailu | Epiround | February 2018 | WA State DOH

<sup>4</sup> [https://www.ofm.wa.gov/sites/default/files/public/legacy/pop/april1/ofm\\_april1\\_press\\_release.pdf](https://www.ofm.wa.gov/sites/default/files/public/legacy/pop/april1/ofm_april1_press_release.pdf) accessed 2/16/2018

In the Washington state counties listed below, 2017 estimates show those counties with 25 percent or more of the population age 65 and over. The second column describes the RUCA categories in each county. The final two columns show projections for age 65 and over by 2025 and 2040, with increases in all but one county: Jefferson, which is already the “oldest” county in the state in 2017.<sup>5</sup> In Jefferson County the percentage of residents aged 65 and older grows in 2025 and then shows a decline in 2040. Even with that decline, Jefferson County remains in the top two counties with the highest percentage of 65 years and older population by 2040.

County name	RUCA Categories	Percentage of residents over the age of 65	Projected percentage over age 65 by 2025	Projected percentage over age 65 by 2040 <sup>6</sup>
Clallam	Small and large rural	29.58	32.37	31.85
Columbia	Small rural	28.02	33.14	32.81
Ferry	Small rural	26.28	31.26	28.99
Garfield	Small rural	26.32	30.32	28.84
Jefferson	Small rural	36.07	39.05	34.49
Pacific	Small rural	29.73	34.53	31.37
San Juan	Small rural	32.47	38.05	34.47
Wahkiakum	Small rural	31.74	40.78	37.78

**Figure 6. Counties with highest percentages of population over age 65 by years with RUCA categories**

An additional 10 counties had greater than 20 percent of residents age 65 or older in 2017: Asotin (22.37), Grays Harbor (21.46), Island (24.28), Klickitat (23.46), Lewis (21.32), Mason (21.04), Pend Oreille (24.87), Skagit (20.62) and Stevens (22.90). Of the 18 “oldest” counties, seven or nearly 39 percent are frontier.

Older adults are naturally more challenged by health problems. About 80 percent of older adults have at least one chronic disease, and 77 percent have at least two.<sup>7</sup>

## Disability

The 2017 Disability Statistics Annual Report states that 12.8 percent of the U.S. population lives with disability, and rates range from 9.9 percent in Utah to 20.1 percent in West Virginia. Washington state falls in the second lowest rate quartile with a percentage of 11.7 to 13.1.

This definition uses six screening questions on the American Community Survey. It includes children, working adults and people 65 and older. Impairments leading to disability in rural counties in the

<sup>5</sup> [https://www.ofm.wa.gov/sites/default/files/public/dataresearch/pop/april1/ofm\\_april1\\_poptrends.pdf](https://www.ofm.wa.gov/sites/default/files/public/dataresearch/pop/april1/ofm_april1_poptrends.pdf) accessed 2/16/2018

[https://www.ofm.wa.gov/sites/default/files/public/legacy/pop/gma/projections12/GMA\\_2012\\_county\\_pop\\_projections.pdf](https://www.ofm.wa.gov/sites/default/files/public/legacy/pop/gma/projections12/GMA_2012_county_pop_projections.pdf) accessed 2/16/2018

<sup>6</sup>

<sup>7</sup> ibid

nation are 16.5 percent compared to 13.4 in urban counties. Rural counties represent about 15 percent of the U.S. population but nearly 20 percent of all people who report significant impairments.

In Washington the 2016 American Community Survey, sorted by metropolitan and non-metropolitan classifications, shows 12.68 percent of Washingtonians living in metropolitan areas report disabilities contrasted with 17.54 percent of Washingtonians in non-metropolitan areas.

## Social determinants of health and health risks

The Centers for Disease Control and Prevention (CDC) offers this description of the social determinants of health<sup>8</sup>:

*“Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health (SDOH).”<sup>1</sup>*

Healthy People 2020 explains:

*“Understanding the relationship between how population groups experience “place” and the impact of “place” on health is fundamental to the social determinants of health—including both social and physical determinants.”<sup>9</sup>*

**and**

“Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.”<sup>10</sup>

Rural residents, when compared to urban residents, on average:

- Have lower incomes and higher rates of poverty
- Have less access to health plans
- Use fewer preventive services such as breast cancer and colon cancer screening
- Have higher rates of tobacco use and obesity.
- Fewer have health insurance or a personal health care provider.
- Have less access and use of dental care.
- Have higher rates of unmet medical needs because of cost
- Have higher rates of unemployment and lower rates of education.<sup>11</sup>

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<sup>8</sup> <https://www.cdc.gov/socialdeterminants/> accessed 7/16/2018

<sup>9</sup> <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health> accessed 7/16/2018

<sup>10</sup> <https://www.cdc.gov/socialdeterminants/faqs/index.htm#faq1> accessed 7/16/2018

<sup>11</sup> Hailu, A., *Epiround*, February 2018, Washington State of Department of Health, Rural Health Section

## Rural inequities and disparities

Rural residents face barriers to education, employment, health insurance and access to services that many suburban and urban residents are less likely to encounter. The cumulative effect of inequities leads to disparities in health status.

Data from CDC demonstrates that Americans living in rural areas are more likely to die from five leading causes than their urban counterparts. Rural residents also have higher rates of suicide.<sup>12</sup> One well-known study revealed the rural-urban gap for life expectancy widening from 0.4 years in 1969 to 1971 to 2.0 years in 2005 to 2009.<sup>13</sup> The gap in life expectancy between counties in the nation is as much as 20 years.<sup>14</sup> While race, ethnicity and income are well known influences on health disparities, geographic disparities are also critically important and may be associated with a combination of social determinants that form a systemic effect.

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<sup>12</sup> <https://www.cdc.gov/ruralhealth/cause-of-death.html> accessed 7/20/2018

<sup>13</sup> Center for Advancing Health, Stephens, and S. *Gap in Life Expectancy Between Rural and Urban Residents Is Growing*. <http://www.cfah.org/hbns/2014/gap-in-life-expectancy-between-rural-and-urban-residents-is-growing>. Accessed 7/20/18

<sup>14</sup> Dwyer-Lindgren L, Bertozzi-Villa A, Stubbs RW, Morozoff C, Mackenbach JP, van Lenthe FJ, Mokdad AH, Murray CJL. *Inequalities in life expectancy among US counties, 1980 to 2014*. *JAMA Internal Medicine*. 8 May 2017. doi:10.1001/jamainternmed.2017.0918.

# WASHINGTON HOME HEALTH AND HOSPICE SERVICES

There are several kinds of home-based services, differing by intensity of services, the credential and training required to perform the service, and payment type.

- Medicare-certified home health agencies (HHAs) perform skilled care based on medical necessity to people who meet homebound criteria,
- Medicare-certified hospice is provided by home health agencies or freestanding agencies,
- Private duty nursing, which may include RN, LPN or CNA levels of care, is usually paid directly by the client or more rarely by commercial insurances.
- Paraprofessional home care by aides supports activities of daily living (ADLs), often included in the Medicaid long-term care benefits but paid privately by others.

In this brief we focus primarily on Medicare-certified home health and those hospice services run by HHAs. While freestanding hospice agencies, private duty nursing, and supportive home care are critically important, it was necessary to focus the initial scope of inquiry.

The Moran Company<sup>15</sup> released a data report in April of 2017 with the following facts based on national 2014 Medicare claims data analytic files (most recent year of available data):

- Fewer beneficiaries receive home health services in rural counties compared to urban counties.
- 27 percent of Medicare home health patients have dual status as Medicaid patients.
- 87 percent of Medicare home health patients are ages 65 and older and Medicare home health beneficiaries are older than all other Medicare beneficiaries.
- Of home health Medicare beneficiaries, 24 percent are more than 85 years old.
- The Medicare cost per beneficiary is lower for home health than for any other post-acute service.
- The number of episodes per fee-for-service (FFS) beneficiary is lower in rural counties than urban counties.
- Home health Medicare beneficiaries have a greater number of chronic conditions per person than all other Medicare beneficiaries.
- A greater proportion of home health Medicare beneficiaries have disabilities compared to all other Medicare beneficiaries.
- Rural home health beneficiaries are more likely to be below 200 percent of the federal poverty level compared to urban beneficiaries.
- Not surprisingly, rural home health beneficiaries travel farther to hospitals and physician offices compared to all home health beneficiaries and urban home health beneficiaries (based on ambulance data).

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<sup>15</sup> The Moran Company, Analysis of Medicare Home health Beneficiaries, slides prepared for LHC Group. April, 2017.

## Washington Rural HHAs

It can be challenging to count home health and hospice service providers because one agency may have offices in multiple locations and serve multiple counties.

Using the legislative determination of rural at the county level, 33 agencies serve Washington’s rural counties. This number includes only those hospices affiliated with a home health agency and omits hospice-only agencies.

Of those 33, 15 or 45 percent also serve urban counties. This may influence the level of attention the agency pays to rural areas more remote from the home office as travel time and expense act as natural disincentives.

Ownership ranges from a single rural hospital to a health system owned by a larger multi-site, multi-state company, to a multi-site home health and hospice organization to independent ownership. These organizations vary greatly in size. For example, two of the agencies described belong to an integrated health system with 50 hospitals, more than 111,000 employees, and 829 clinics. An agency focusing on frontier geography belongs to an organization with a single site in Washington, but 13 HHA and hospice sites across five rural states in the West.

Ownership by larger companies is trending up, as economies of scale help to withstand the challenging payment climate. Economies of scale can drive access to physicians, workforce recruitment, overall agility, the ability to weather downturns in revenue, and bandwidth to move capably into value-based payment systems.

Classification system used by this WA report	Number of agencies per category	Classification system used by Oregon	Number of agencies per category
Hospital Based	13	Hospital-Based	13
Owned by multi-site HHA	7	Freestanding	21
Owned by integrated health system	5		
Independent	9		
<b>TOTAL HHAs serving rural</b>	<b>33</b>		<b>33</b>

**Figure 7. Number of HHA agencies in WA and OR by type of ownership**

Of the 33 agencies serving rural Washington state, two cross state borders from Oregon with certificate of need to serve in Washington border counties. There are no Idaho agencies with certificate of need to serve in Washington.

It is noteworthy that the same number of agencies serve Washington and Oregon with state populations of 7.406 million and 4.143 million respectively. (U.S. Census Bureau). However, Oregon's rural population is 30.5 percent of the overall state population compared to 16 percent in Washington using county level definition. Washington's rural population is closer to 12 percent when using sub-county categories. In Oregon 99 percent of the land in the state is rural, and in Washington, 96.4 percent. Using the county-level 16 percent rural population definition in Washington, this equates to 1,184,960 rural Washingtonians and 1,263,615 rural Oregonians. Washington may have more overall residents, yet Oregon has a larger number of rural residents.

“Changes in health care payment policies, many associated with implementation of the Affordable Care Act, include incentives to prevent avoidable hospitalizations and emergency department use. At the same time, hospital stays are shorter than in the past and more patients are being discharged with ongoing care needs. These changes should encourage hospitals, including those in rural communities, and hospital-associated health care systems to add or strengthen their ties with home health care services in order to improve patient outcomes after discharge.”

Skillman SM, Patterson DG, Coulthard C, Mroz TM. Access to Rural Home Health Services: Views from the Field. Final Report #152. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, 2/2016.

The following table shows the number of HHAs per rural county. Frontier counties (Adams, Columbia, Garfield, Ferry, Lincoln, Klickitat, Jefferson, Okanogan, Pacific, Pend Oreille, San Juan, Skamania, Stevens and Wahkiakum) are highlighted. Of the frontier counties, 54 percent are served by a single agency.

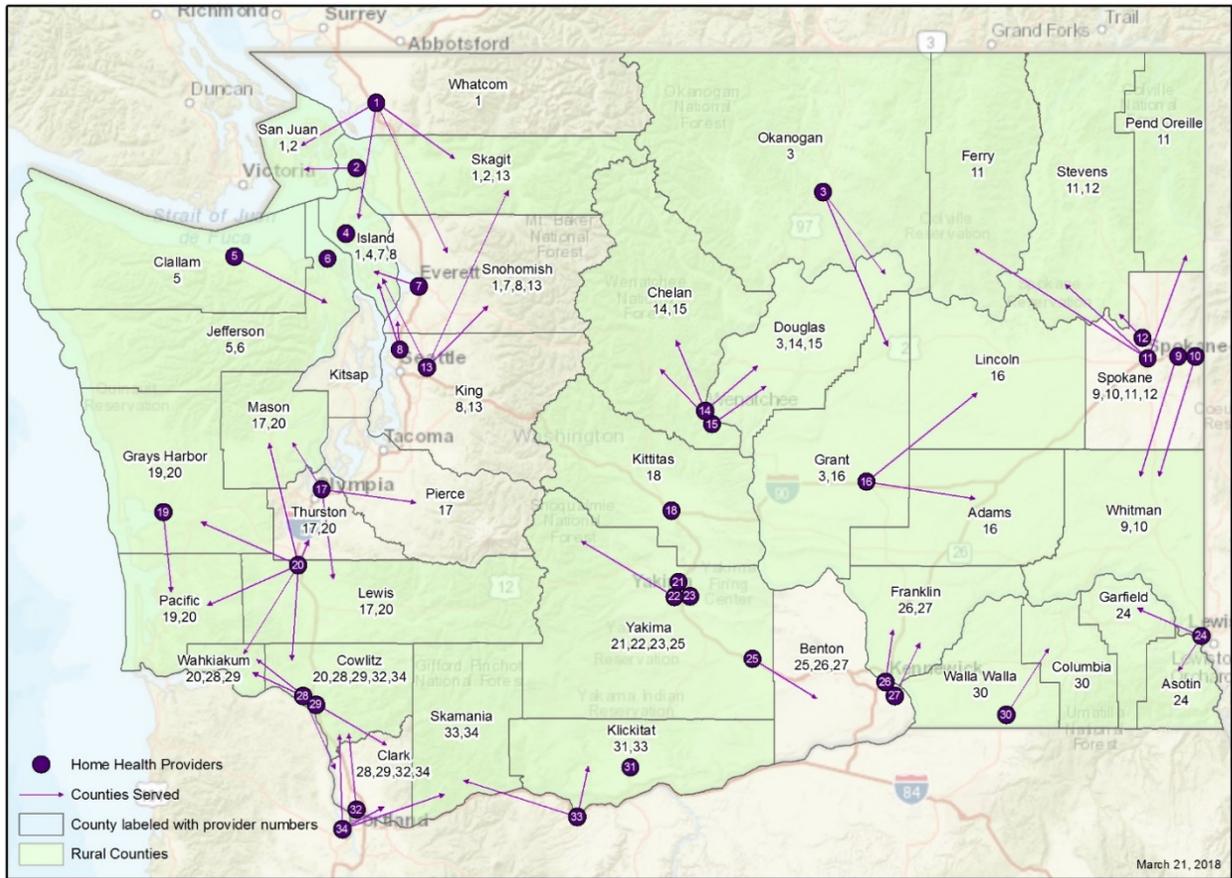
County	# of agencies with Certificate of Need	County	# of agencies with Certificate of Need
Adams	1	Klickitat	2
Asotin	1	Lewis	2
Chelan	2	Lincoln	1
Clallam	1	Mason	2
Columbia	1	Okanogan	1
Cowlitz	5	Pacific	2
Douglas	2	Pend Oreille	1
Ferry	1	San Juan	2
Franklin	2	Skagit	3
Garfield	1	Skamania	2
Grant	1	Stevens	1.5**
Grays Harbor	2	Wahkiakum	3
Island	4	Walla Walla	1
Jefferson	2	Whitman	1
Kittitas	1	Yakima	4

\*\* One agency serves only the southern portion of the county

Figure 8. Washington’s rural and frontier counties and the number of agencies with certificate of need for home health services per county.

“...staff time to serve rural beneficiaries included significant time traveling in the car. The rates of reimbursement are not enough to cover this additional time.”

Knudson, A, Anderson, D, Schueler, K, Arsen, E. Home is Where the Heart Is: Insights on the Delivery and Coordination of Rural Home Health Services in America: A Policy Brief. Grand Forks, ND: Rural Health Reform Policy Research Center, A Consortium of the University of North Dakota Center for Rural Health & NORC Walsh Center for Rural Health Analysis, August 2017



Map drawn by Craig Erickson, Department of Health

**Figure 9. Rural HHA certificate of need**

The above map depicts HHA coverage and shows the large number of square miles that many agencies serve.

## Why Home Health?

### Aging Challenges

“The number of Americans aged 65 and older is projected to more than double from 46 million today to over 98 million by 2060... from 15 percent overall to nearly 24 percent of the population.”

“The aging of the baby boom generation could fuel a 75 percent increase in the number of Americans aged 65 and older requiring nursing home care...”

“Demand for elder care will also be fueled by as steep rise in the number of Americans living with Alzheimer’s disease, which could nearly triple by 2050 ...”

Mather, M. Fact Sheet: Aging in the United States, Population Reference Bureau,  
[www.prb.org/Publications/Media-Guides/2016/aging-unitedstates-fact-sheet.aspx](http://www.prb.org/Publications/Media-Guides/2016/aging-unitedstates-fact-sheet.aspx), accessed 3/2/2018

In 2014 the American Association of Retired Persons conducted a survey of Americans age 45 and older. Respondents indicated a strong preference to receive supportive services at home or in their own community as they age. Eight in 10 strongly or somewhat agreed with the statement, “What I would really like to do is remain in my local community as long as possible.” A full 78 percent of the respondents stated that they "strongly" agree with the statement: "What I'd really like to do is stay in my current residence as long as possible."<sup>16</sup> In 1990 the historic Americans with Disabilities Act (ADA) established the fundamental rights of people with disabilities to receive care in the least restrictive setting.

## Clinical outcomes and cost

Despite people’s preference to remain home, in many rural communities, nursing home care may be the only long-term care support option. Rural home health is not evenly distributed and available in all communities despite the certificate of need process. Even urban counties face imbalance between supply and demand when workforce capacity cannot keep pace with population needs. For example, during March 2018 both Medicare-certified home health agencies in Thurston County were closed to new admissions from any source but hospital discharges.

Evidence indicates that not only is home preferred by most patients, outcomes are comparable at a lower cost. Studies of both hip fracture and stroke have found that home health agencies may provide

less expensive care with outcomes comparable to or better than inpatient rehabilitation facilities or skilled nursing facilities.<sup>17</sup>

A *Perspective* article published in the New England Journal of Medicine states,

“For patients hospitalized with congestive heart failure in 2008, Medicare paid about \$2,500 in the 30 days after discharge for each patient who received home health care, as compared with \$10,700 for those admitted to a SNF and \$15,000 for those cared for in a rehabilitation hospital.”<sup>18</sup>

“..Medicare spending in post-acute care is the largest driver of overall variation.”

“Most acute care hospitals and physicians pay little attention to post-acute care. Patients are typically discharged to a post-acute care facility or home health care with little coordination or follow-up, reappearing on the acute care provider's radar screen only if they return to the hospital in an ambulance.”

Finally;

“Hospitals and physicians have considerable influence over patients' choices of post-acute care settings, and they will increasingly exert that influence under bundled-payment programs.”<sup>19</sup>

Rural HHAs have an important opportunity to intentionally move closer in relationships with hospitals and providers to provide evidence of their outcomes and value. These ideas are discussed further under the theme *Moving to Value Based Payment and Care Systems*.

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<sup>17</sup> Beeuwkes Buntin, M., Hoverman Colla, C., Partha, D., Neeraj, S, Escarce, J. *Medicare Spending and Outcomes after Post-Acute Care for Stroke and Hip Fracture*, [Med Care. 2010 Sep; 48\(9\): 776–784.](#)

<sup>18</sup> Beeuwkes Buntin, M., Hoverman Colla, C., Partha, D., Neeraj, S, Escarce, J. *Medicare Spending and Outcomes after Post-Acute Care for Stroke and Hip Fracture*, [Med Care. 2010 Sep; 48\(9\): 776–784.](#)

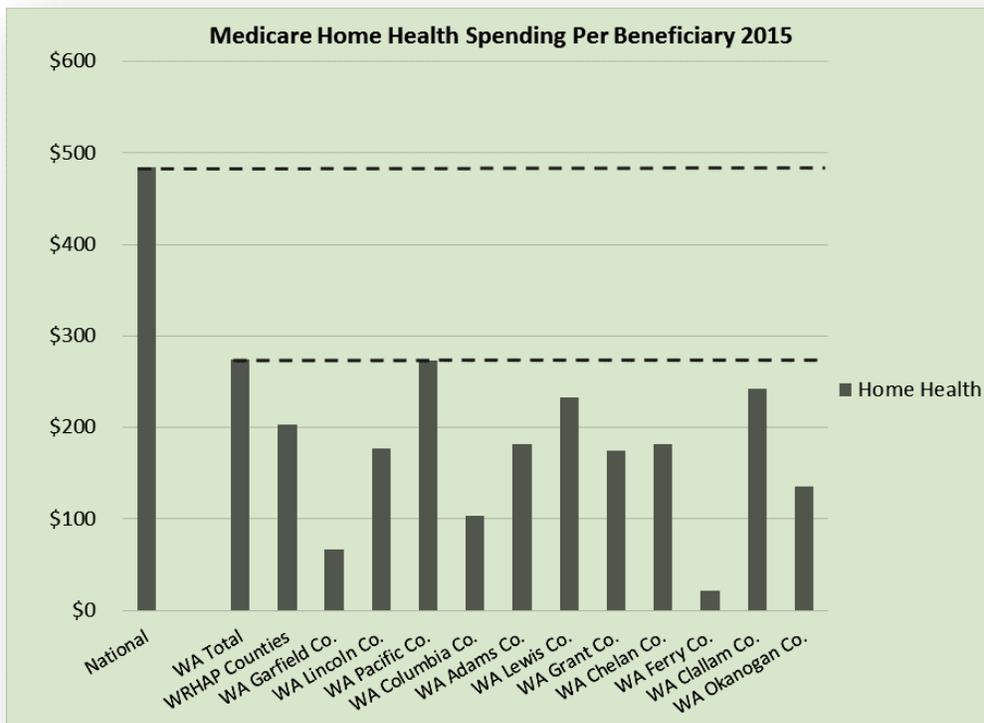
<sup>19</sup> *ibid*

# CHALLENGES AND POSSIBLE SOLUTIONS

## Challenges: Underuse and fiscal sustainability

### Low Use Rates

Most Counties in Washington spend only 10-50% of U.S. Rate on Home Health



Prepared and used by permission Harold Miller, Center for Healthcare Quality and Payment

**Figure 10. Percentage of spend per beneficiary on Medicare home health services by county**

At the Washington State Hospice and Palliative Care Organization annual conference in October of 2017, Marc Berg of BDS Healthcare data presented a workshop titled “Mining Big Data for Improvement Opportunities.” Berg made the following observations gleaned from Medicare claims data:

- All of Washington’s 39 counties admit fewer patients to home health per 1,000 Medicare beneficiaries than the national average of 111.
- Statewide, 19.8 percent of all Medicare fee-for-service (FFS) hospital discharges are hospice-eligible and only 2.8 percent are admitted to hospice.
- Only Puerto Rico and Alaska spend fewer hospice hours with patients than Washington

Washington’s underuse of home health and hospice services goes beyond rural and is not well understood. Nationally, hospice referrals often come late, with 30 percent of those served by hospice dying in seven days or fewer. Washington is also the state with the highest percentage of Medicare beneficiary hospice patients who do not receive a visit on the last two days of life<sup>20</sup>

Low use patterns in Washington for rural home health and hospice merit further investigation. Potential solutions will be discussed throughout the remainder of this brief. Workforce capacity is one self-reinforcing cause of underuse as providers who do not receive adequate response to a referral soon stop referring patients. According to key informants, nursing shortages in home health are in part attributed to a lower pay scale than hospital and clinic settings, coupled with the high degree of independence required, and in some instances the risk involved in entering patient homes alone. Others say the flexible hours are an attractor for nurses with school-aged children who can work a schedule that avoids the need to purchase after-school care. Some nurses find the independence an excellent fit. One nurse observed it was wonderful to purchase farm fresh eggs during her work day, though she had been involved in putting in some escaped goats.

“States with the highest percentage of beneficiaries with **no visits** on the last two days of life included: Washington (21.5%), Oregon (20.1%), New Jersey (19.8%), Minnesota (19.5%), and Massachusetts (19.5%).”

Christian, TJ, Analysis of Medicare Pre-Hospice Spending and Hospice Utilization, Presentation to MedPac, Abt Associates, 2017

Regulations may also play a part in limiting the population served. Physician requirements and homebound status limit those who can be admitted. The ARNP and PA clinicians that RHCs are incentivized to use through productivity calculations could be a strong source of referrals, yet may be dissuaded by the need to obtain certification by a physician. One hospital CEO observes that her hospital based ARNPs and PAs want to discharge to home health and would be much more likely to if they could certify home health care.

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<sup>20</sup> Joan M. Teno, MD, MS, Janet E. Shu, BS, David Casarett, MD, Carol Spence, RN, MSN, Ramona Rhodes, MD, MPH, and Stephen Connor, PhD. *Timing of Referral to Hospice and Quality of Care: Length of Stay and Bereaved Family Members’ Perceptions of the Timing of Hospice Referral*, Journal of Pain and Symptom Management, Vol. 34 No. 2 August 2007

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**To be eligible for Medicare home health services, a patient must have Medicare Part A and/or Part B and, per §1814(a) (2) (C) and §1835(a) (2) (A) of the Act:**

1. Be confined to the home;
2. Need skilled services;
3. Be under the care of a physician;
4. Receive services under a plan of care established and reviewed by a physician; and
5. Have had a face-to-face encounter with a physician or allowed non-physician practitioner (NPP).

Care must be furnished by or under arrangements made by a Medicare-participating home health agency (HHA). <sup>21</sup>

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## **The Ease of Entry to Home Health**

Doris Visaya, executive director of the Home Care Association of Washington until July, 2018, observed multiple issues that can complicate or delay an admission, and believes many of them are out of the control of the home health agency. The orders for home health services may be incomplete, for example, lacking wound orders for a patient with a wound. Providers may not return calls. Managed care organizations can impose substantial prior authorization requirements. The face-to-face requirement must be completed for Medicare patients by a physician. Physician assistants and nurse practitioners must obtain a physician signature on the order. If a patient does not have what is called “decisional capacity” someone else must consent for treatment and that person must be located. Agencies may limit the number of Medicaid patients they accept because the rates have not been increased for some time and too high a ratio of Medicaid patients can cause the agency fiscal distress.

There is also variability in how agencies manage the admission process. Some agencies will not become involved until a physician order for services is obtained while others will take the information and then coordinate an order for services. The former practice can turn away some referrals as patients and families experience barriers or do not understand how to go about obtaining an order for services.

Anti-fraud protections have instigated a high regulatory threshold for services and agencies, out of financial necessity, have implemented admissions processes that ensure service payments will not be denied. When home health admissions staff try to decipher if eligibility requirements are met, it can frustrate the referral source or seem too complicated. Some agencies have helpful liaisons to

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<sup>21</sup> <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-12-16-HHBenefit-HL.pdf> accessed 2/16/2018

hospitals. The liaisons must comply with HIPAA limits on access to patient information; sometimes decreasing the coordination and effectiveness of care transitions.

How an agency manages and discusses these multiple issues is important. Visaya observes that agencies who work to offer easy entry, with a service excellence attitude and facilitative practices, often have a resulting higher volume of admissions. This is self-reinforcing, when referral sources know their patients have a responsive admission, they are more likely to make future referrals.

### **Coordination and communication with hospitals**

While some HHAs have close, well-coordinated and communicative relationships with their local rural hospital, is not always the case and particularly when the hospital or HHA is a considerable distance or located in a larger community. Informally hospital staff discuss the trend toward “sicker and quicker” discharges from urban and suburban hospitals. Medically fragile patients have short stays and families must bear the burden of complex home care, and without the assistance of a home health team, the chances of readmissions increase. While “premature discharges” are identified as one of the “four factors most strongly associated with potentially preventable readmissions”<sup>22</sup> this could potentially be mitigated by robust home health care. For example, complications such as infections, medication adverse events and uncertainty about who to call are within the scope of home health nurses to assess and coordinate with providers and pharmacies.

Medical staff members at the hospital can also differ in the level of cooperation with the HHA and responsiveness to admission requests. Patients who go to a distant hospital may return to the community in fragile health without knowledge of the local health care systems, who see the patient only when they make an emergency department visit that can result in a 30-day readmission, subject to CMS penalties and also indicative of opportunity to improve care transitions and coordination between organizations. Or the patient may be driving back and forth for outpatient rehabilitation services that could have been provided in the patient’s home if the local agency knew about the discharge. One rural HHA reported physicians who often advised the patient should go to the emergency department rather than be admitted to home health services, even when this seemed clinically unnecessary. When an HHA experiences a workforce crisis, the hospital may not know why referrals are not receiving a timely response. Even though typically all intentions are honorable, patients and families experience the result of drop-offs in communication and face the cost and disruption of institution-based care.

### **The Need to Improve: The Acute Care Paradigm**

The Medicare benefit design comes from a time when infectious disease and acute ailments and injury were leading causes of illness and death. Care systems were designed with a premise of an event followed by improvement. As deaths from infectious disease wane in developed nations, and more

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<sup>22</sup> Center for Medicare Advocacy, “Reducing Hospital Readmissions by Addressing the Causes.” <http://www.medicareadvocacy.org/reducing-hospital-readmissions-by-addressing-the-causes/>. Accessed 8/31/18

injuries are prevented, serious and chronic illnesses are at odds with system design. The Medicare benefits are also a poor fit for all levels of prevention. One interviewee of the WWAMI Rural Research center declared, “The Medicare model, based on acute care, is out of date.”<sup>23</sup> Rural home health agencies work largely within the Medicare framework while caring for a population that is increasingly a poor fit for the regulation design.

Eligibility for continued services has typically been justified by measurable clinical improvement. The 2015 class action case *Jimmo v Sebelius* asserted that to maintain a patient’s function or to prevent or slow decline is a legitimate standard for care provision. Under the *Jimmo* Settlement Agreement, the Centers for Medicare and Medicaid Services (CMS) is mandated to comply with this rationale for services but this has not been widely enforced. The Center for Medicare Advocacy states if “the *Jimmo* Settlement is implemented correctly – it opens doors to Medicare coverage and necessary care for beneficiaries who require maintenance care, including people with long-term, progressive, or debilitating conditions. As required by the Court, CMS also provided additional training for Medicare decision-makers.” Yet value measures, now linked to Medicare payment in Washington state, focus on measurable improvements rather than stability or avoidance of decompensation.

“Hospital-based rural home health services frequently struggle to be profitable, however, and often are maintained because of community commitment rather than as a sound business line.”

WWAMI Rural Health Research Center

## Medicaid payment

Medicaid payments to home health vary by state. Rates are in tension with the need to serve the greatest number with available funds, and the state Medicaid plan and legislature usually set rate ceilings. Leslie Emerick, speaking on behalf of the Home Care Association of Washington (HCAW) attests Washington home health Medicaid rates have held steady for an extended period without increase and are lower than many other states. She proposes that Medicaid raise home health rates to sustain services.

Low payment rates compound challenges in rural areas where workforce recruitment can require competitive pay as an incentive and long drive times affect productivity. These factors create a combined fiscal burden that can limit the ability of the agency to serve referrals. Agencies reluctantly set limits on the number of Medicaid patients they accept so they can stay solvent. Ambulatory care

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<sup>23</sup> Skillman SM, Patterson DG, Coulthard C, Mroz TM. *Access to Rural Home Health Services: Views from the Field*. Final Report #152. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, February 2016.

clinics also report they have adopted this practice of rationing the Medicaid proportion of the payer mix, despite a strong ethical wish to do otherwise.

Managed care organization (MCO) pre-authorizations can also slow down home health admissions, limit visits in ways the clinical team finds challenging, and can cause a burden of increased documentation. Slow responses to preauthorization requests can cause lags that impact the timeliness of services.

### **Critical Access Hospital (CAH) Payments**

Home health agency ownership hurts CAH fiscal performance because the CAH has to deduct the cost of home health operations, and accordingly reduce revenue for the health system in the CAH overall cost report where HHA overhead and allocated expenses are not allowable costs that lead to payment. CAHs who own HHAs wish they could count those units of service and allocated costs in their cost-based payment system for both Medicare and Medicaid.

Jefferson Healthcare in Port Townsend is one Critical Access Hospital and health system that owns a home health and hospice agency. In a September 2018 report entitled “Expanding Cost Based Reimbursement under the Critical Access Hospital Entity: The Critical Access Hospital Modernization and Stabilization Act,” they write,

“If a service is provided at a CAH that was not included in the 1997 list of cost-based reimbursed services, such as specialty behavioral health ( or home health<sup>24</sup>) the service is paid at fee-for service rates which are than lower than what it costs a rural medical system to provide. Additionally these services are assigned overhead, which is not paid. That overhead allocation means less overhead is paid for cost based reimbursed services.”

Without that payment mechanism, it is very difficult to sustain viable services as other parts of the health system have to subsidize losses. In the current payment system, HHA ownership hurts the CAH bottom line substantially. This is also an unfortunate penalty for CAHs that own emergency medical services (EMS) or behavioral health organizations.

### **Over-regulation**

Leaders in Washington’s home health agencies have a general concern about the effects of overregulation and believe they could be more responsive to referrals, and provide more needed care, if some of the regulatory burden was lifted. The overreach of regulation can prevent innovation, add to fiscal burden, and may do little to authentically protect patients. Nursing Academic Vice President Dr. Jan Jones-Schenk suggests a three-key test for nursing care regulations:

1. Is there credible evidence to support regulating the issue of care?

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<sup>24</sup> Insertion by author of this paper

2. Is this issue related to primary mission of public protection or does it potentially exceed the bounds of regulatory mission?
3. If it passes Nos. 1 and 2, do the stakeholders have a consensus that there is no other way short of regulation to address the issue?

In July of 2018 CMS launched a strategic initiative called *Patients over Paperwork*. CMS Administrator Seema Verma stated, "The entire CMS team is committed to doing our part to make sure caring professionals can do their job without the burden of unnecessary requirements."<sup>25</sup> Though home health is not specifically listed under current strategies, some broader work may have helpful implications.

CMS is also actively gathering suggestions. Health care teams are encouraged to email CMS at [ReducingProviderBurden@cms.hhs.gov](mailto:ReducingProviderBurden@cms.hhs.gov) and describe which requirements are difficult to follow or understand.

## **Behavioral Health**

Many home health patients have mental health and substance abuse problems in conjunction with physical illness. While social work is covered under Medicare, currently the Medicaid program covers MSWs under collaborative care and rehabilitative/mental health but not under the home health benefit. The HHAs offer the visits without any compensation because they are essential to the patient's care plan. Without Medicaid payment for social workers, adequate care for these patients puts HHAs at financial risk. The state Medicaid program may be willing to revisit this policy.

Numerous studies<sup>26</sup> have shown that because chronic diseases are often interwoven with conditions such as depression and anxiety, health in any direction will not improve without whole-person interventions. Blood sugar levels, hypertension and depth of depression have been shown to move in lockstep.<sup>27</sup> Medicare funded social work may not be enough resource to truly respond to the level of behavioral health need, particularly in rural areas where other behavioral health resources may be scant and older clients are reluctant to seek out care in traditional behavioral health settings. As Washington works to integrate behavioral health, oral health and primary care, it is important that the population served by HHAs is not left behind.

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<sup>25</sup> <https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html> accessed 8/31/2018

<sup>26</sup> Katon WJ, Lin EH, Von Korff M, et al. Collaborative care for patients with depression and chronic illnesses. *N Engl J Med* 2010; 363(27):2611–20.

<sup>27</sup> *ibid*

## **Potential solutions: Decreasing Underuse of Home Health and Hospice Care Services and Strengthening Fiscal Operations**

### **Better understand drivers of low home health and hospice use in rural areas**

The complex web of variables influencing Washington's low HH and hospice use rates should be studied so that solutions are responsive to root causes. Information could be gathered from hospital discharge planners, physicians and other referring providers as well as the HHA. Patient and family input would also be valuable. Differences between Washington state and other largely rural western states with higher rates of utilization could be studied.

### **Design easy entry processes**

Study those agencies with higher volume rates of admissions and document their admission processes. Study those agencies known to seek out physician orders on behalf of the patient and family, and ease other admission barriers. Create a peer learning network for transfer of successful practices. Consider contracting with a highly experienced HHA manager to offer mock survey and technical assistance to rural agencies as is currently done with Rural Health Clinics. Hospital teams may benefit from increased exposure to home health, perhaps by shadowing on joint visits or training offered by the HHA to better orient the acute care team to the post-acute service strengths and challenges.

Payment for an in-home visit by home health to determine needs and assess eligibility would benefit the patient, family, the agency and likely the hospital as readmissions and their fiscal penalties may be avoided.

### **Improve coordination and communication with hospitals and primary care medical homes**

A key finding of the Rural Health Reform Policy Research Center's policy brief on rural home health reads: "Strong relationships between rural home health agencies and local hospitals facilitates the provision of home health services to rural beneficiaries."<sup>28</sup>

Strong relationships are unlikely to happen without an intentional, regular structure for two-way communication. Even with a hospital liaison staff member from the HHA, there may be benefit to leadership and quality team discussions two to four times per year. It may take an interorganizational quality improvement team project to design improved transitions and coordination.

The same opportunity lies with primary care medical homes. A regular contact to create a relationship of trust with consistent communication to discuss processes and system issues rather than just clinical

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<sup>28</sup> Knudson, A, *Home is Where the Heart Is: Insights on the Delivery and Coordination of Rural Home Health Services in America*, A Consortium of the University of North Dakota Center for Rural Health & NORC Walsh Center for Rural Health Analysis, August 2017

cases is likely to result in referrals. Home health can be an extender of primary care and participate in prevention and co-management of chronic care management. Accountable care organization participants may see ways to design care using contractual service arrangements that extend outside typical HHA Medicare-certified care. Medicaid Accountable Communities of Health could benefit from a close study of the potential role for home health services in their region.

### **Test standing order sets; default home health orders**

Because home health orders depend on physician behavior to write the order, one Idaho rural hospital tried a novel approach and made home health orders a default order for any patient over a particular age or with a particular clinical profile. Providers were required to write the order *not* to have home health. Although those patients did have to be screened for homebound status and medical necessity, the home health admissions went up significantly and hospital readmissions went down dramatically.

### **Recognize the redefinition of the “need to improve”**

The Jimmo settlement determined Medicare services can and should be available to prevent decline of a chronic illness. This settlement and the instructions to all Medicare claims processing organizations should be more visible and more strongly reinforced. Denials of payment for lack of improvement should decline and in time subside.

Value-based payment systems should recognize maintenance of health with chronic or serious illness as a desirable outcome worthy of incentive payments and align policy, quality metrics and payment. Home health services are far less expensive than hospital or skilled nursing facility care, and align with the preferences of most patients. Home health can be a natural extension of primary care and care management services.

### **Raise Medicaid rates and simplify preauthorization**

The authorizing environment needs to place value on services that retain independence by paying rates that allow for sustainable services. States with higher rates of home health use and lower rates of facility-based care should be studied for exemplary fiscal models. The legislature could consider an increase to home health rates paired to a need to demonstrate a decrease in avoidable readmissions, emergency department visits and inpatient days.

Payment for social work visits could improve responsiveness to behavioral health needs of home health patients. A time standard could be set for response to preauthorization requests and pre-authorization processes simplified and standardized across MCOs.

### **Integrate HHA services into Critical Access Hospital (CAH) cost reports and payments**

Enable CAH owned HHAs to integrate the HHA costs in their existing cost-based reimbursement methods and receive payment through the cost report method for Medicare and Medicaid when the CAH includes the allocated costs of home health services.

## **Reduce over-regulation**

CMS could strengthen their *Patients before Paperwork* strategy by convening a task force of rural home health agency direct line managers, nurses and other clinical team members, to develop a challenge to the most burdensome regulations with the least evidence. State Medicaid program engagement would be helpful. Rural HHAs can offer a set of recommendations from their qualitatively different experience. The withdrawal of regulations can be tested using a pilots and data driven evaluation.

The new *Patients over Paperwork* effort is encouraging. Ideally this will have influence on HHA regulation and documentation requirements. It will take an active voice from HHA teams to inform CMS about the most important things to improve.

## **Reduce use of homebound status and medical necessity**

The agencies believe that homebound status is not a good index for who needs home health services. Just because patients could conceivably make it to a clinic appointment, this does not mean they will make the clinic visit or that the clinic is a preferable setting to meet their needs. It is not clear why homebound status is required for home health services. If the requirement were softened or eliminated, a greater number of rural residents could receive home health care. This would potentially help rural agencies stay viable, help residents use emergency department and inpatient care less frequently, and maintain independence. Removal of homebound limitations could support avoidance of nursing home based long term care, or significantly delay the need.

Chronic care management can be managed effectively by skilled home health nurses and the other home health disciplines of physical therapy, occupational therapy, speech, and social work, but medical necessity and skilled care criteria make this challenging. The *Jimmo v Sebelius* lawsuit settlement (discussed on the previous page) holds to the skilled care standard.

If CMS could recognize that patient support needs extend beyond skilled care, this skilled team could work with other paraprofessional disciplines such as community health workers and home care aides to create optimal, home-based chronic care management services for patients with diabetes, congestive heart failure, chronic obstructive pulmonary disease and other conditions that require nursing management as well as support for activities of daily living (ADLs).

The Chronic Care Act of 2018, included in the Bipartisan Budget Act of 2018, gives Medicare Advantage (MA) Plans the “use of flexible new tools and strategies to better manage care for individuals with complex needs. The new law gives MA plans greater flexibility to cover non-medical benefits to identified high need/high risk members, such as bathroom grab bars and wheelchair ramps. MA plans and ACOs may now offer a broader array of telehealth benefits.”

Tumlinson, A. Burke, M., Alkema, G. “The Chronic Care Act of 2018: Advancing Care for Adults with Complex Needs”, *The Scan Foundation*, March 2018,

[http://www.thescanfoundation.org/sites/default/files/chronic\\_care\\_act\\_brief\\_030718\\_final.pdf](http://www.thescanfoundation.org/sites/default/files/chronic_care_act_brief_030718_final.pdf)

Accessed 6/19/2018

Per §1814(a) and §1835(a) of the Act, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

Criteria One	Criteria Two
<b>One Must Be Met:</b>	<b>Both Must Be Met:</b>
Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.	There must exist a normal inability to leave home.
Have a condition such that leaving his or her home is medically contraindicated.	Leaving home must require a considerable and taxing effort.

**Figure 12. Homebound criteria**

“...telehealth services or any services provided via a telecommunications system are not covered as part of the Medicare home health benefits and home health prospective payment, although they are covered for other medical services under Part B.”

Skillman SM, Patterson DG, Coulthard C, Mroz TM. Access to Rural Home Health Services: Views from the Field. Final Report #152. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, February 2016.

**Increase incentives and decrease barriers for home health and hospice agencies to integrate telemedicine and home tele-monitoring services**

Hospitals and clinics in rural areas in many locations have integrated telehealth. In 2016 a Washington state Senate bill passed making home a site for telehealth services. A subsequent bill added a site of the patient’s choosing. Yet many payers are still not offering payment parity and originating site fees are not included in some instances.

Home health agencies can facilitate telemedicine provider visits for patients or for other professions, particularly for remote locations or regions prone to inclement winter weather. An originating site fee could compensate for the clinical expertise needed by the nurse to assist the tele-provider with the exam. Tele-monitoring equipment could also prove valuable and is in some limited use. Payment systems are described as beginning to develop but still currently largely untested for both telehealth and tele-monitoring by HHAs. Patients and families could be given or rented tablets for home monitoring data as well as telemedicine interactions.

One problem expressed by a HHA was that tele-monitoring payments by one payer could not occur for the ongoing monitoring of data values. Payment is triggered only when an abnormal value requires a response. Yet ongoing monitoring is a value-added activity that requires clinical skill and judgment, and should be compensated at some level. Under a value-based payment system, this might be solved by the inherent flexibility to manage care. It might be possible to create regional economies of scale for tele-monitoring with sufficient volume to warrant payment for the newly emerging role of tele-monitoring data coordinator, employed by a rural network of organizations in several rural communities.

One home health agency offers the idea that it is difficult to “just add on” telehealth care and in her perception the agencies who do well invest in a specific role to manage the telehealth services. Regional pooling of resources may make this more feasible for the smallest communities.

### **Create payment and design services for upstream palliative care**

Hospice referrals come late, with 30-35 percent of patients dying within one week of admission.<sup>29</sup> There are many reasons cited, including difficulty with an unclear prognosis, stigma that labels hospice as a “death sentence” and the clinical team’s ability to detect and report signs of decline. Some propose it is difficult for providers because the referral symbolizes failure. Data suggests that family perceptions that a referral is made “too late” are associated with greater unmet needs, more concerns and lower satisfaction. Washington is one of five states with the highest percentage of “too late” referrals using family member perceptions as the index.<sup>30</sup> One study showed a “dramatic variation” in referral timing among physicians despite similarities in patient populations. The study authors considered referrals within seven days of death “a marker of poor quality of care and family and patient dissatisfaction.”<sup>31</sup> The majority of caregivers and families of patients who have received hospice services say they would have welcomed more information about palliative care and hospice from their primary care physician at the time of the diagnosis of a serious and likely terminal illness. This includes patients with dementia when they have become dependent in most or all activities of daily living with a diminished ability to communicate.<sup>32</sup>

One study found that 51 percent of a sample of 4,168 patients over age 65 were seen in an emergency department in the last three months of life. A total of 77 percent of those emergency department

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<sup>29</sup> Wang, X., Knight, L., Wang, J., Smith, T. “Variations Among Physicians in Hospice Referrals of Patients with Advanced Cancer.” *Journal of Oncology Practice* 13, no. 5 (May 1 2017) e496-e504.

<sup>30</sup> Teno, J., Shu, J.E., Casarett, D., Spence, C., Rhodes, R. Connor, S. “Timing of Referral to Hospice and Quality of Care: Length of Stay and Bereaved Family Members’ Perceptions of the Timing of Hospice Referral.” *Journal of Pain and Symptom Management* Vol 34 No.2 August 2007

<sup>31</sup> Wang, X., Knight, L., Wang, J., Smith, T. “Variations Among Physicians in Hospice Referrals of Patients with Advanced Cancer.” *Journal of Oncology Practice* 13, no. 5 (May 1 2017) e496-e504.

<sup>32</sup> Wekmann, M. “The Role of the Family Physician in the Referral and Management of Hospice Patients.” *Am Fam Physician*. 2008; 77(6):807-812, 817-818.

visiting patients were admitted to the hospital in the last month of life and 68 percent of that group died in the hospital. Repeat visits were common. It is a gross understatement to say, “Emergency departments are not designed for end-of-life care and are in many ways poorly suited to do so.”<sup>33</sup>

“Although the movement towards value-based payment helps to align incentives towards crisis prevention, much of America’s current health care system remains poorly-equipped to appropriately care for the seriously ill. A recent study of physicians found that a full two-thirds of medical practices lack systems to assess patients’ wishes or adequately assess symptom burden. These gaps leave patients and families with few viable options for the relief of symptoms and stresses, except for calling 911 or visiting the ED. Once there, the severity of their underlying illness and their distress often result in admission, where too many of these patients decompensate.”

CAPC, “Serious Illness Strategies for Health Plans and Accountable Care Organizations; Driving Better Value and Quality of Life for High Risk Populations.”

[https://media.capc.org/filer\\_public/2c/69/2c69a0f0-c90f-43ac-893e-e90cd0438482/serious\\_illness\\_strategies\\_web.pdf](https://media.capc.org/filer_public/2c/69/2c69a0f0-c90f-43ac-893e-e90cd0438482/serious_illness_strategies_web.pdf) accessed 2/12//2018

Most patients would prefer to die at home. All hospice is palliative care but not all palliative care is hospice or needs to be restricted to end-of-life care. People with serious illness that cannot be “fixed” can benefit from a different paradigm of care that goes beyond chronic disease management to truly position quality of life and the goals and wishes of patient and loved ones at the center of care. The Washington Rural Palliative Care Initiative has adapted this definition of palliative care:

Palliative care is specialized care for people living with serious illness. Care is focused on relief from the symptoms and stress of the illness and treatment—whatever the diagnosis. The goal is to improve and sustain quality of life for the patient, loved ones and other care companions. It is appropriate at any age and at any stage in a serious illness and can be provided along with active treatment. Palliative care facilitates patient autonomy, access to information, and choice. The palliative care team helps patients and families understand the nature of their illness, and make timely, informed decisions about care.<sup>34</sup>

Upstream palliative care is shown to be helpful to control symptoms, and builds rapport with the team to facilitate much earlier and more common hospice referrals when illness progresses. Upstream palliative care also reduces symptom burden, improves experience and quality of life, and decreases overall cost of care. The payment for palliative care is currently a “patchwork.” It is hoped that CMS will draw positive conclusions from its second cohort in the palliative care demonstration at hospice agencies, and will move to reform payment structures and policies to allow expansion of palliative care

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<sup>33</sup> Smith, A., McCarthy, E., Weber, E. Cenzer, IS, Boscardin, J. Fisher, J, Covinsky, K. *Half Of Older Americans Seen In Emergency Department In Last Month Of Life; Most Admitted To Hospital, And Many Die There.* Health Aff (Millwood). 2012 June; 31(6): 1277–1285. doi:10.1377/hlthaff.2011.0922.

<sup>34</sup> Adapted from the Center for the Advancement of Palliative Care (CAPC) and the National Consensus Project for Quality Palliative Care

services delivered from any setting – home health, hospice, clinic, hospital, community settings, and long-term care.

The Medicaid agency in Washington, Washington Health Care Authority, has pediatric palliative care benefits that allow concurrent curative treatment and is in the process of adding adult palliative care. This is not a new expenditure but an organized programmatic approach to a group of relevant modalities, packaged with administrative rules and provider guidance. Concurrent active treatment for adults will be allowable under the new rules.

The American Academy of Hospice and Palliative Care Medicine (AAPHM) proposed a tiered value-based payment system for palliative care to CMS in 2017, through the Physician-Focused Payment Technical Advisory Committee (PTAC). Health and Human Services responded with agreement that “a payment model addressing the unique needs of seriously ill beneficiaries should be tested by CMS.” The challenges and potential disagreements on method relate to how the population is selected and tiered for payment levels.

### **Integrate more behavioral health approaches into HHA**

Behavioral health integration in home health services is essential and should follow the pattern of integration occurring with primary care. The Washington State Health Care Authority, Department of Social and Health Services and Department of Health all contribute to a state strategy to develop the infrastructure, services and payment for behavioral health integration. The executive sponsor is Governor Jay Inslee. Because home health is paid by both Medicaid and Medicare, federal support for integration will also be important.

CMS allows for skilled home health visits by psychiatric nurses to homebound patients but the program is difficult to maintain because travel times increase even in urban areas for “psych only” visits, which would be exacerbated in rural areas. The required level of experience can also make recruitment a challenge, especially in rural communities. Yet some model of home health behavioral health integration, also addressing substance misuse and abuse, is needed. With recognition that home health can play a key role in addressing behavioral health, from prevention through assessment, intervention and treatment, training, compensation and referral patterns could follow.

# Challenges: Moving to value-based payment and care

## Quality Measures

The movement from a volume-based payment and care system for volume to one that incentivizes and pays for quality is a large shift in the health care system. Hospitals and clinics are engaged in transformation work, and home health is also being brought under value-based arrangements.

The Centers for Medicare and Medicaid (CMS) instituted home health outcome measures in 1999 to assess the results of home health care experienced by patients. The data for the Home Health Outcome Measures are derived from two sources: (1) data collected in the Outcome and Assessment Information Set (OASIS) submitted by home health agencies; and (2) data submitted in Medicare claims.<sup>35</sup> OASIS-based quality performance has been reported by CMS for the public since 2003. In 2016 CMS updated the data set to OASIS C-2, which was released on January 1, 2017.

OASIS has three types of outcome measures for home health: improvement measures that describe the patient's function, activities of daily living and general health; measures of potentially avoidable events that are markers for quality of care problems; and use of care during and after home health care is completed. All OASIS measures are risk-adjusted "using a predictive model developed specifically for the measures which takes into account differences in patient health status, as measured by the patient's previous Medicare claims."<sup>36</sup> These measures, again, are not in alignment with the Jimmo vs Sebelius ruling that said that lack of deterioration is a reasonable and valid justification for home health care for some patient populations.

Key informant interviews revealed a concern common to other rural healthcare settings. Small data sets either do not meet the minimum set standard and are omitted from reports or are volatile and swing widely in response to particular patients. Small data sets are prone to "noise" that distort the data and can obfuscate meaning that informs quality improvement. Risk is also difficult to manage with small populations. Prospective payment systems need enough volume of low-acuity patients to balance the high-acuity patients. This is difficult with smaller, older, sicker populations served by rural home health.<sup>37</sup> Patient satisfaction surveys with small numbers of respondents may not be representative and unhappy patients seem more likely to submit surveys. Family members less familiar with care also complete the surveys.

The HHA measures have been reported publicly with a star rating on Medicare site [Home Health Compare](#) since 2015. One home health manager stated, "Our star rating is not an accurate reflection of the quality of our care because it is thrown off by small things or some of our measures do not even

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<sup>35</sup> <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.htmlInstruments/HomeHealthQualityInits/HHQIQualityMeasures.html>, accessed 3/10/2018

<sup>36</sup> *ibid*

<sup>37</sup> Skillman SM, Patterson DG, Coulthard C, Mroz TM. *Access to Rural Home Health Services: Views from the Field*. Final Report #152. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, February 2016.

count because we had too few patients.” The star ratings are made for the public without any details about the specific organization’s performance that contributed to the overall rating nor any caveats about rural volumes and how they affect the reliability of the data. Agencies have felt so unfairly judged and penalized by the flawed data contributing to star ratings that they elect not to admit some patients from health plans who use the star rating most punitively.

Small patient volumes pose fiscal problems under fee-for-service contracts when visit numbers or patient census fail to cover the fixed costs to maintain capacity. Under any payment system, without economies of scale it is difficult to contract favorably with payers, purchase less costly malpractice insurance, obtain access to specialty services, or make discounted purchase arrangements with vendors for supplies and equipment.

### **Network relationships**

While clinics and hospitals have developed network relationships and formed accountable care organizations (ACOs), home health has been largely left off the menu of services in those arrangements. Bundles are a particular threat to rural health care organizations of all kinds who may face further erosions of market share when bundles and narrow networks drive patients out of rural health systems, particularly for post-acute rehabilitation – for example, after a stroke or joint replacement surgery. Specialty providers may also be incentivized to do procedures that are outside the bundle to receive additional revenue with less risk for the outcomes.

For example, one home health physical therapy assistant alleges that she is observing fewer home health patients with total hip replacements for hip fractures for those providers in bundles. If the orthopedic surgeon instead performs an Open Reduction and Fixation (ORIF) it is outside the bundle and can generate income without the same level of risk for quality. She reports that ORIF surgeries can lead to longer recovery, longer restrictions on weight bearing, and a higher risk of complication compared to total joint replacement. Studies posted by the American Academy of Orthopaedic Surgeons support her report on comparable outcomes.<sup>38</sup> New payment models can open the door to new unintended consequences and a system of checks and balances between quality, value and patient experience is critical to prevent care rationing. Rural HHAs and other rural health organizations are fiscally fragile enough to make unexpected consequences of grave concern.

Home health providers and CAH swing bed teams both report more patients being referred to rehab services owned by or affiliated with the distant hospital that performed the joint replacement or other joint surgery. The downside of the new payment models are the fiscal incentives to control where patients receive care to keep the control among those who have the potential for shared savings or other quality incentives. Many rural home health agencies are at a significant disadvantage related to network inclusion, ACOs, bundled payments and value-based contracting based on quality measures.

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<sup>38</sup> Stanton, T. “Investigators Compare Outcomes of ORIF Versus THA for Femoral Neck Fractures”, American Academy of Orthopaedic Surgeons, AAOS Now, May 2017  
<https://www.aaos.org/AAOSNow/2017/May/Clinical/clinical04/?ssopc=1> accessed 9/7/2018

“Effective January 1, 2016, the Center for Medicare and Medicaid Innovation (CMS Innovation Center) implemented the Home Health Value-Based Purchasing (HHVBP) Model among all home health agencies (HHAs) in nine states representing each geographic area in the nation. All Medicare-certified HHAs that provide services in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee will compete on value in the HHVBP model, where payment is tied to quality performance. HHAs in these nine states will have their payments adjusted in the following manner:

- a maximum payment adjustment of 3 percent (upward or downward) in 2018,
- a maximum payment adjustment of 5 percent (upward or downward) in 2019,
- a maximum payment adjustment of 6 percent (upward or downward) in 2020,
- a maximum payment adjustment of 7 percent (upward or downward) in 2021, and
- a maximum payment adjustment of 8 percent (upward or downward) in 2022.”<sup>39</sup>

**Figure 13. CMS Value-Based Purchasing Model for HHAs in nine states**

Thus far the HHAs in Washington have reported measures and only begun to experience the change in payment. There are concerns about how the rural small data sets will be managed in the new payment system.

### **Electronic Health Records and Interoperability**

Quality reporting is driven by population level data collected and reported out of electronic health record registries or other registries that pull data from health records. In networks or ACO arrangements the ability to move clinical data throughout the network is desirable to prevent waste and better coordinate care without fragmentation. The right care for the right patient at the right time in the right setting rests on real-time accurate information flow.

Large urban systems invest in robust electronic health record and registry tools, and the teams to perform analytics. Rural health systems overall face large challenges with their electronic health records, as less expensive products often pose significant hurdles to reporting, including charges to build queries, poor data migration for updates, poor support, and interfaces that do not allow line staff members to influence how data fields map to reports or to customize reports.

In one rural health system, different electronic health records serve inpatient, primary care, long-term care, and home health; the systems have no electronic connection. This makes continuity of care across settings more challenging. In another system, home health is “isolated” on an electronic medical record that is rudimentary and the rest of the health system shares a much more sophisticated common platform. Because some of the dominant electronic health records originated in hospital settings, the home health platform may be less functional than a specifically designed home health product. Yet if the HHA stays with the better designed HHA product, their data is effectively locked in a silo.

<sup>39</sup> *Home Health Value-Based Purchasing*, <https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model>, accessed 5/16/2018

## **Prevention**

The health care system is working in new partnerships with public health to understand and address social determinants of health. Value-based payments incentivize population health goals and push strategies upstream to primary and secondary prevention. Rural home health has the challenge and opportunity to define its relationship to the transformation.

Overall the tight staffing and fiscal challenge make it harder for all rural health organizations to do the stepping back and restructuring necessary to revamp systems of care and payment. This is accentuated in rural home health agencies where clinical care is in the field, and bringing teams together is more expensive and logistically challenging.

## **Coding**

Coding for value-based care requires a shift in thinking from a single episode to a longer view of health. There is a need to make it clear how complex the patient's clinical picture is, with accuracy. CAHS and RHCs under cost reporting may experience this as a more dramatic shift in coding objectives, but as rural HHAs engage in value-based payment, they too may need to reexamine their coding and seek training to develop a new value based approach to documentation and coding.

## Potential solutions: Moving to value-based payment and care systems across the rural health system

### Evaluate OASIS measures through a rural lens

HHAs have a number of concerns about OASIS. The sheer volume of measures drives an enormous set of documentation tasks that are highly time-consuming. Not all the measures have equal importance to quality of care and it is possible that system designers sit too far from the point of service to understand what a burden is placed by their wish for the high volume of data. Second, rural agencies need rural relevant small-volume measure strategies applied to give them more confidence that publicly reported performance truly represents their quality. When pay begins to be driven by these measures in the nine demonstration states, this will become a critical issue that could make or break sustained access to rural home health services. CMS released a rural health strategy in May of 2018 that articulates an objective to “Apply a rural lens to CMS programs and policies.” A rural lens could be applied to the value-based payments proposed for rural HHAs as well as the requirements of the OASIS system.

### Employ small data set strategies developed by the National Quality Forum (NQF)

The National Quality Forum (NQF) published a report in September 2015 called *Performance Measurement for Rural Low -Volume Providers*. The report includes principles and practices to make measures rural-relevant and meaningful within small data sets. Example strategies are incentives without penalties, voluntary provider grouping, aggregating measures over longer times, and “continuous variable measures” such as ensuring on-time medication delivery rather than just whether it is given. This gives multiple data points per patient and allows for larger data sets.

Another suggestion are “ratio measures” where the numerator is not necessarily a part of the denominator and allows a single patient to contribute many “units” to the measurement, such as a measure of bloodstream infections where the numerator is the number of bloodstream infections but the denominator is the number of days the patient has a central line.

In August of 2018 NQF published a final report entitled [\*A Core Set of Rural-Relevant Measures and Measuring and Improving Access to Care: 2018 Recommendations from the MAP Rural Health Workgroup\*](#). This report suggests specific measures relevant for rural healthcare organizations and could be studied for relevance to rural HHA.

### Integrate HHAs in Accountable Care Organizations (ACOs) and Accountable Communities of Health (ACHs)

Agencies stretched to meet basic operations can find it difficult to participate in planning activities. Accountable care organizations around the country often omit home health agencies. This could be corrected, particularly for rural Medicare ACOs.

The Home Health Care News suggests HHAs emphasize a better care experience and compare the cost of a home health admission to an emergency department visit. “Agencies must go out and share their data with potential partners and make relationships.”

Relationships with others in the rural community may exist but other ACOs may hold urban members that might see benefit in rural partners committed to the triple aim. The Home Health Care News articles concludes, “Agencies should be experimenting in various arrangements.”

Cate Bradford, the chief operating officer of Pyramid Home Health Services outside the state, says, “Traditionally home health has been considered a post-rehabilitative service, after-care relating to an illness, procedure or hospitalization that aids in a patient’s recovery and return to function. However, in the post-ACA world, and specifically when working in partnership to an ACO, a home health company’s infrastructure is a powerful tool to aide physicians wishing to extend their positive influence further into their patient’s decision-making processes – which is occurring, not in their office, but in their home and community.”<sup>40</sup>

ACHs are regional Medicaid entities combining multiple counties. Many ACHs are largely rural. Public health and health care strategies integrate in areas of regional focus, based on local data and state Medicaid priorities. Although the ACHs move beyond primary care and hospitals to consider behavioral health, oral health and social services that affect determinants of health, home health and hospice services are not well integrated into most planning discussions. Rural home health agencies might consider what data they can assemble to tell a compelling story about not only the current picture of HHAs services but their potential in a redefined health system.

### **Include rural home health in bundled payments**

If a rural resident needs post-acute rehabilitation services and a narrow network for a bundle has been formed that excludes rural providers, that resident is forced to continue to travel to health systems that are not local. Bundled payment agreements should include a hub-and-spokes design that draws rural home health into the bundle as a prime setting for post-acute rehabilitation for rural residents. If travel distance is added to network adequacy definitions to ensure plan members have the most proximal options that meet quality standards, rural home health can be considered essential to network adequacy.

Rural HHAs must also step up and market themselves with outcomes data to show they are the rehab site of choice for the community. There may be advantages for Critical Access Hospitals with skilled rehab swing beds and HHAs to join and market shared capacity for skilled rehab with desirable outcomes. Elective hip, knee and shoulder replacements have long been an economic engine for tertiary hospitals and can possibly be a sustaining source of referrals and payment for rural home health with the right positioning. In some locations workforce shortages in the rehab therapies may make this less feasible.

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Bradford, C. *A Working Relationship between Home Health and ACO*, the Pyramid Point, September 3, 2014.<sup>40</sup><http://pyramidhhs.com/blog/a-working-relationship-between-home-health-and-the-aco/>, accessed 5/17/2018

## **Increase interoperability with electronic health records in home health and hospice agencies**

The more rural home health agencies that connect electronically to other parts of the health system, the better for patients. Options include state or regional health information exchange, shared clinical data repositories, cloud-based common templates, and common electronic health records. Rural home health agencies may need subsidies to afford the infrastructure necessary to achieve full interoperability but there may be interim solutions created by shared networks, data file exchange protocols and cloud-based data solutions.

## **Engage HHAs in prevention strategies and early screening and intervention**

In Pakistan, “lady health workers” go door-to-door with vaccinations. Home health could make a new contribution to community wellness efforts and prevention activities. This could include early developmental screening, TB testing, blood pressure monitoring, health coaching, flu vaccines, and other public health efforts that could be integrated with care delivery. While some agencies do this work as community service, it could become a formally recognized service coupled with payment.

Historically, this home-based prevention work might have been the role of local public health, yet rural local health jurisdictions (LHJs) lack resources. Passage of the Affordable Care Act created a national policy that reduced direct service delivery by LHJs and incentivized their role to move toward policy, structure and environmental change work. Rural LHJs often have very sparse staffing that would make home visiting difficult. If the LHJs could collaborate in a service design for prevention that was then integrated into home health care and payment, residents could have reduced barriers to preventive services.

## **Build value-based coding skills and business practices**

When payment incentives change, care processes also necessarily transform. All of the “back desk” business functions that support the business of clinical delivery also need to integrate the changes. Some skills, knowledge and processes may need to be updated. Coding in particular may emphasize different things when seen through the lens of value. Training on value-based coding practices is beginning to emerge.

## **Challenges: Administrative burden of Medicare**

### **Documentation requirements**

The CMS documentation requirements for home health agencies have grown steadily and the complexity has increased as the OASIS measure set was integrated throughout the documentation system. According to an HHA admission nurse, the initial admission intake documentation takes clicking through 68 screens to complete, and often exhausts the patient and family, lasting two hours or longer.

Denials of claims are often in response to “incorrect” physician documentation. HHA teams believe the documentation requirements for physicians are a deterrent to making referrals. Oregon reports that more than half of the denied claims in rural agencies were because of physician documentation, a practice the HHAs have little influence over. Denial appeals can take up to a year to process, and are complex, robbing precious time and decreasing available income in a small agency that cannot afford to write off claims. Agencies have tried educating physicians on documentation requirements and often use dedicated FTEs for intakes because of the way those longer visits and documentation disrupt other visits. When errors are common, it often points to process design as the root cause and no amount of training will lead to sustained improvements.

### **Certs and Face to Face Requirements by ARNPs and PAs**

Rural Health Clinics are required to use at least 50 percent advanced registered nurse practitioners (ARNPs) and physician assistants (PAs). In Washington state PAs must practice under the supervision of a physician but ARNPs have an independent scope of practice. An ARNP might be the only provider in a remote town but is unable to authorize home health or hospice services without an arrangement with a physician to sign off to meet the requirement of “working in collaboration with a certifying physician.” Because CMS is the very agency that certifies RHCs based on use of ARNPs and PAs, this regulatory framework is inherently contradictory for rural communities.

Medicare regulations require that a patient be under the care of a physician to receive home health services and the “face to face encounter” requirement can be met only by a physician. “Collaborating with” a physician as outlined below usually requires a contractual relationship that exerts a burden. The face to face requirement has come and gone and returned again and nurses in rural HHAs perceive it as a wasteful barrier to services.

“Per 42 CFR 424.22(a) (1) (v) (A), the face-to-face encounter can be performed by: The certifying physician;

The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health);

A nurse practitioner or a clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician; or

A certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.<sup>41</sup>

and

The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care.<sup>42</sup>

### **Durable Medical Equipment (DME)**

In order to be paid for DME a physician or qualifying provider must have had a face-to-face visit within the past six months and obtain competitive bids. Deliveries of DME are also challenging in rural areas.<sup>43</sup> DME is also associated with a large documentation burden. Rehab facilities are not able to order equipment for a patient prior to discharge as it will then be charged to the facility rather than the patient. This gap can cause hardship during the already stressful transition home.

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<sup>41</sup> <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-12-16-HHBenefit-HL.pdf> accessed 2/16/2018

<sup>42</sup> <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/face-to-face-requirement-powerpoint.pdf> accessed 8/31/2018

<sup>43</sup> Skillman SM, Patterson DG, Coulthard C, Mroz TM. *Access to Rural Home Health Services: Views from the Field*. Final Report #152. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, February 2016.

## **Potential solutions: Reducing administrative burden of Medicare**

### **Use the “value-added “lens to evaluate documentation and decrease documentation requirements**

Apply Lean quality improvement principles to decrease documentation requirements for home health services. Engage clinicians and leaders from the point of service to propose the improvements rather than have CMS impose changes. Facilitate an appraisal of the requirements, and change statutes as needed to bring the requirements to the leanest necessary to ensure patient safety and prevent fraud. Recognize that administrative burden threatens sustainable rural services as well as quality of care.

### **Defer to state scope of practice to allow ARNP certification and revoke face-to-face requirement**

It is suggested that CMS defer to the scope of practice laws for providers as regulated by state laws, and revoke the face-to-face requirement unless it can be unequivocally proven to improve clinical quality.

### **Create rural waivers of Durable Medical Equipment (DME) requirements**

Define the DME competition rule to come into effect only at a certain size of population – for example, 50,000 or greater – and allow rural areas an exception or accept their documentation that only one vendor serves their geography, using a simple format. Reduce the documentation burden for DME and allow rehab programs to place an order on behalf of a patient so that the DME plan is smoothly integrated into the transition without unduly stressing the patient and family with arrangements.

## Challenges: Rural home health and hospice Certificate of Need

Washington's Certificate of Need (CoN) (RCW [70.38.015](#) and WAC [246-310](#)) program requires potential new home health and hospice providers, as well as a set of other health organizations defined in law, to submit an application with fees to demonstrate the needs of the population and their organization's ability to respond effectively to those needs. The Department of Health is responsible to administer the CoN laws, maintain administrative rules and apply objective standards to the applications. The CoN team evaluates submitted applications and grants CoNs based on legally mandated criteria.

CoN requires a data driven approach to matching demand and capacity, which is intended to reduce the excessive cost of service duplication, and to some degree protect the public from fiscally unstable health organizations ill prepared to offer services from a stable financial platform. CoN is also a method to assure that all people have access to the services in a given geography, and discourage agencies from being arbitrarily selective about who they serve. This has the intent to protect rural regions and assure they are not ignored despite sparse populations.

In October of 2017 the Department of Health delivered a report<sup>44</sup> to the Legislature on the Certificate of Need program and outlined suggested program improvements that reflect views from that team's expertise as well as the views of stakeholders. Because competing applications often cause appeals and necessarily create a denial, a great deal of the CoN's team attention can be paid to denials. The report describes the most common cause of denials as cost containment ([WAC 246-310-240](#)) and financial feasibility ([WAC-246-310-220](#)). Rural and urban applicants are not compared as it was not an objective of this report.

Although Certificate of need is intended to promote access to care, the way it's currently designed creates some challenges in rural communities from the perspective of the agencies. The complexity of the application may discourage some applicants. Unlike the urban areas, competition to provide services in rural communities is not common. The larger issue is assurance of geographic coverage.

"...health planning should be concerned with public health and health care financing, access, and quality, recognizing their close interrelationship and emphasizing cost control of health services, including cost-effectiveness and cost-benefit analysis."

RCW [70.38.015](#) Declaration of public policy for Certificate of Need  
<http://app.leg.wa.gov/RCW/default.aspx?cite=70.38.015>

### County as geographic unit

While it is unclear what effect the overall presence of CoN has on Washington rural HHAs' capacity, it is clear that the current system of county-level CoN sometimes fails to follow the natural referral patterns for patients, and can result in longer drive times and disjointed systems of care. CoN and

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<sup>44</sup> Wiesman, J. *Report and Recommendations: The Certificate of Need Program*, Washington State Department of Health, Publication # 346-093, October 2017

actual service patterns for healthcare do not always align. Agencies are required to serve an entire county when they receive a certificate of need, yet there are instances where this does not occur largely because of workforce and economic capacity at the agency. If a complaint is made, the Department of Health will send a letter notifying the agency of its obligation to serve a client.

In one example, an HHA travels nearly two hours to reach the far western communities in their county, yet those communities are only 20 minutes from a large town where the patients receive the majority of their care. This “edge of county” problem was described by multiple rural agencies. Some researchers have found that rural CoN regulation is associated with longer travel distance to care.<sup>45</sup> The effect of Certificate of Need regulation in rural Washington has not been specifically studied.

### **Application process**

The CoN application process is formidable in the perceptions of some smaller organizations. There are no data to explain to what degree CoN application fees facilitate or discourage additional home health and hospice service providers in rural communities in Washington. The CoN program staff provide free technical assistance whenever requested.

Key informants offered varied views, some voicing a concern that the fees are out of scope for the smallest rural organizations and the complex process discourages applicants. Many rural healthcare organizations believe they lack the internal talent to complete the applications and rely on paid consultants, adding to their expense.

### **Different opinions on how to retain optimal access in rural areas**

Rural HH and hospice agencies have differing views related to Washington state’s certificate of need (CoN) requirements for rural home health agencies. While some believe the program keeps out “for profit” national chains, others believe that CoN creates higher than necessary travel times and dissuades improved capacity. Others think it is helpful to ensure that agencies feel responsible to serve the entire population under their CoN.

One agency disclosed they admit “only 40 percent of referrals” and would welcome another agency in the area but an additional agency would “be dealing with the same limited labor pool.” That agency would increase capacity for patients if it could successfully recruit more clinical staff members, and believes any other agency would also face this significant challenge. CoN in this instance was perceived as neutral and not connected to the workforce shortages.

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<sup>45</sup> Mitchell, Matthew *Mercatus on Policy; Certificate of Need Laws: Are they achieving their purpose?*, George Mason University, 2017

## **Potential solutions: Addressing Rural HHA Certificate of Need**

### **Evaluate alternatives to county for geographic responsibility for CoN**

Patients do not use county lines to determine where to go for health care services. Dartmouth Atlas has Hospital Referral Areas, Hospital Service Areas or Primary Care Service Areas based on Medicare patterns of utilization. Other patient utilization patterns based on claims data could potentially delineate census tract or zip code clustered CoN regions and decrease drive times for rural HH & H agencies. This would support more cohesive referral patterns based on proximity and lower travel time expenses for rural agencies and allow for more natural clustering of visits. For example a nurse could see patients within two communities that fell on opposite sides of a county line, but which both used services within a common geographic area for most of their care. These changes could still co-exist with a mandate to serve all communities within a given area of responsibility. The same principals would apply to a differently configured geographic footprint.

### **Evaluate influence of CoN on patient access to rural HH and H services**

The influence of CoN on rural communities-as currently legislated-needs study to determine if the approach assists or detracts from improved access to HHA services for rural residents. The CoN effects may be qualitatively different if urban and rural service systems are compared and contrasted. CoN is intended to protect sparsely populated areas that may be less attractive to agencies with profit motives by mandating legal responsibility for coverage. It may be that CoN laws can be revised to accommodate the attributes of rural communities and health systems, with a goal to balance the tension between the need to improve access to services while holding agencies accountable. Rural health organizations may have relevant suggestions about effective ways to ensure capacity for patients to receive needed care. The program would require additional resources to study and implement changes.

### **Decrease the complexity of CoN application and offer additional resources to augment proactive front end technical assistance (TA)**

By decreasing the complexity of the application process, and increasing front end proactive TA, returned applications with-questions and rework for the applicant and DOH team may decrease. People may not know what they do not know, and are unable to pose the questions needed to avoid later rework. The voluntary nature of TA may have historically allowed uninformed applicants to proceed. A mandatory minimum orientation now addresses this to some degree.

The mandatory one and a half day training currently helps potential applicants understand the CoN application process, agency licensing, the operational expectations linked to compliance with regulations, and surveys. This course helps to better prepare applicants and at times screens out potential applicants who did not fully appreciate or have knowledge of requirements.

The 2017 legislative report previously referenced discusses this theme at length. Examples of solutions outlined include a “how to guideline”, step by step templates, and the ability to increase applicant

awareness of available technical assistance paired with regular trainings. The report also outlines strategies to increase transparency for applicants and the public.

With additional resources, the CoN team could explore and test ways to increase assistance services. Previous applicants might be interviewed or gathered in a focus group to gather suggestions about where to pinpoint assistance to the greatest needs.

Self-paced learning modules, video or other forms of automated but individualized assistance could be potentially helpful. “Chat bots” have been used successfully to help in other situations where those being served need help through a complex multi-step process, such as student financial aid forms for higher education. These tools rely on artificial intelligence and machine learning which provides systems the ability to automatically improve without being explicitly programmed for every particular instance. This technology requires an upfront investment but then offers less resource-intensive forms of technical support for applicants.

## Challenges: Workforce

Rural workforce is a large, perennial challenge. Proximity to communities with larger populations, recreation opportunities, housing stock, public school quality, organizational culture, leadership skills, and a variety of other factors influence how difficult it is to recruit and retain medical staff and employees. Some communities have health systems with longstanding openings for key positions. Service obligation incentives may bring temporarily bring providers or other key personnel, but are not a panacea for retention.

“Let’s face it, no one is going to move here. We have to help the best people we have train up the ladder.”

Rural Chief Nursing Officer

The somewhat intangible dynamic of workplace culture has a large influence on the experience of the clinical team. Recruitment and retention are complex multi-variable issues without clear remedies in some cases. Immigration policies have the potential to influence health worker visas, one avenue HHAs have used for recruiting from the Philippines and other countries.

A recent work group at the Department of Health focused on the challenges for long term care work force across the state, in both urban and rural areas. A significant number of the challenges and proposed solutions for rural HHA workforce are aligned with long term care workforce challenges and proposed recommendations.

### **Experience, courage, compensation, education**

Rural home health faces recruitment challenges magnified by several factors. Home health is not the best place for new graduates. The care is complex; it requires more clinical judgment and independent work, skills that come from experience. The work is also not for the timid; providers must have the courage to find their own way through weather and sometimes challenging topography, to enter homes that may have undesirable risks to safety –such as sanitation issues, hostile pets, disruptive family members, or unknown weapons on the premises. This vulnerability is magnified when outside the limit of broadband or cell coverage.

Because of the largely public-funded payment through Medicare and Medicaid, agencies pay lower wages than either hospitals or clinics, though this does vary by discipline. Nursing appears to have the greatest variability from setting to setting. Some rural health systems are long distances from any colleges or universities that might serve as a pipeline for recruitment. Rural health care leaders also allege that local students often cannot gain admission to local community colleges because they compete against students from more urban and suburban areas with higher grade point averages.

### **Attracting workforce to rural communities**

Many rural communities have trouble attracting new residents. Some lack housing stock. The intact workforce is likely to have historical ties or family in the area. Urban students are less likely to work in rural settings when they graduate. These communities seek ways to “grow their own.” Students may also not have the income to commute to courses too far from their home community.

## **Shortage data**

Shortages exist for nursing and also for physical, occupational and speech therapies. The state does not yet have a systematic way to capture data on workforce shortages across disciplines and settings. A voluntary sentinel network for health workforce has only partial participation, and uncertain continued funding. The sentinel network has had some participation from rural home health agencies.

## **New Physical Therapy Requirement**

As of 2015, physical therapists are required to obtain a doctorate before licensure. This may compound a shortage for this profession key to rehabilitation, though many agencies make wider use of Physical Therapy Assistants working under the direction of PT's plan of care. Some agencies report more challenges with speech and occupational therapist recruitment and retention than physical therapy.

## **The aging boom effect on workforce**

Lacking an adequate workforce, older adults may face greater difficulty staying at home, especially in rural areas experiencing a much higher percentage of adults over the age of 65 with greater increases in this age bracket in the near future. Current shortages are likely to be exacerbated. Although this paper focuses on skilled home health and hospice, home care is an essential service to retain independence for older adults facing illness and disability that interferes with tasks of daily living. The Bureau of Health Statistics projects the demand for personal care and home health aides will increase by 64 percent by 2024, much faster than the rate for all other occupations.<sup>46</sup>

## **Paraprofessional training sites**

"Because of limitations placed by federal regulations, nursing homes but not home care agencies can be accredited as a training site for the on-the-job training of their own nursing aides/assistants."<sup>47</sup>

## **Border towns**

Locations near the Oregon and Idaho borders attract applicants to open positions but then report long waits for licensure. When patient care is jeopardized by short staffing and qualified applicants are waiting to work, it is particularly frustrating.

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<sup>46</sup> Reinhardt, S. Accius, J., Ujvari, K., Alexis, J, Fox George, W. *Picking up the Pace of Change: A State Scorecard on Long-term Supports and Services for Older Adults, People with Disabilities, and Family Caregivers*. AARP Policy Institute, The Commonwealth Fund, The Scan Foundation, 2017 Edition

<sup>47</sup> Skillman SM, Patterson DG, Coulthard C, Mroz TM. *Access to Rural Home Health Services: Views from the Field*. Final Report #152. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, February 2016.

## **Potential solutions: Attaining the necessary workforce to meet home health and hospice needs**

### **Build experience, courage, compensation, education**

Training programs might create rural residency or internship tracks in home health for multiple disciplines including nursing, physical therapy, occupational therapy, speech therapy, and social work. Physical therapists could be more actively included in loan forgiveness incentive programs as a recruitment tool for rural HHAs

Improved compensation is dependent on multiple other factors, previously discussed, such as building patient volumes and improving income from payers. To attract a workforce, HHAs need to be competitive with clinic and hospital wages.

Courage to work in rural home health can be improved locally through support offered in mentoring relationships that agencies could design and sustain with adequate revenue. Improved fiscal performance can drive capacity for longer orientation periods and more formal peer mentoring or formal nursing or therapist residency programs.

More concretely, cell and broadband coverage will add a safety net when traveling to remote locations. A national program called FirstNet is translated into Washington state's effort called OneNet, which intends to close many of the remote coverage holes over time by building out the infrastructure. This is a dedicated network for first responders to bring communications into the 21<sup>st</sup> century and to eliminate the current communication system fragmentation. Leaders of the national and state efforts anticipate they will have capacity to sell network access as part of their sustainable business model. Rural home health and hospice agencies could be a high-priority audience for a discounted access to this network.

### **Build virtual community-based training ladders or “lattices.”**

Training programs that blend virtual distance education with local clinical experience are desired by healthcare leaders in hospitals and clinics, and may also serve home health. Talented paraprofessionals can be offered a route to a professional credential in exchange for a local service commitment. The term “lattice” is now often substituted for ladder to indicate cross-functional development of skills and knowledge that lead to a wider selection of opportunities. Movement may be vertical, lateral or diagonal.

In the past, a program for nursing called Rural Outreach Nursing Education (RONE) folded because of challenges to sustainability related to cost and preceptor availability. A recent workgroup coordinated by the Area Health Education Center of Western Washington at Whatcom Community College found the RONE model is not fiscally or operationally feasible. The group developed a report with a set of suggested actions. These include a nursing pathway from Certified Nursing Assistant to Associate

Registered Nurse with a “contextualized distance learning ‘step in step out’ program.”<sup>48</sup> Non-traditional national programs can face deterrents related to Washington state regulations constructed for more traditional approaches to education. The regulations might be assessed to identify and decrease barriers to innovative rural approaches to training, while maintaining rigor and accountability for clinically competent graduates.

Modern health care clinical training programs use simulation labs to train using clinical scenarios. Mobile sim labs are used for rural training in other states. Simulation has the ability to mitigate the risks associated with “high risk low frequency” clinical interventions where critical skills are used rarely and are difficult to keep current. The challenge of high risk low frequency clinical scenarios is magnified in rural settings. Current established sim labs might be incentivized to develop mobile capacity to bolster skills of current workforce as well as train students.

### **Prioritize local region students for admissions to community colleges**

The term “community” in the name community colleges could be taken to heart to prioritize students in the immediate vicinity. If admission policies gave priority weight to regional residency, formally organized supportive education wraparound services could be established to assist students who enter with lower grade point averages, to foster their academic skills and achievement.

Community colleges could target underserved populations to decrease social determinants of health. Local students are more likely to bring skills back to the local region in a self-reinforcing loop that has a positive effect on population health and local economies. With our aging population demographic swell, magnified in rural areas, health professions and paraprofessional certificate programs for roles such as home care assistant should be given high priority and be designed to primarily serve the local health system.

### **Foster new roles and greater rural flexibility**

Among emerging healthcare roles, community health workers are perhaps best known, but the list also includes navigators, health coaches, telehealth home monitoring coordinators, and telehealth presenters. The behavioral health field is exploring how to use more paraprofessional roles or behavioral health techs. Education institutions can anticipate what skills these new roles require for curriculum design. The Department of Health faces a challenge to balance patient safety and protection with new models for licensing that respond to new and perhaps more fluid health care roles.

The DOH draft Long Term Care (LTC) Workforce report has a recommendation that reads, “Analyze the needs of LTC populations and identify what needs to be included for the basic scope for nursing

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<sup>48</sup> Area Health Education Center for Western Washington, The Home Grown Nurse: Assessing needs and possibilities for a distance-learning program to train talent and address nursing shortages and distinctive healthcare needs in rural and tribal communities, September 2018

assistants that applies uniformly across all LTC settings and is supported by a base or foundational curriculum.”

In rural settings in particular, there is a need to reduce categorical restrictions and increase the ability to flex services and personnel to respond to the needs of the population. Greater flexibility need not threaten patient safety if redesign teams intelligently imagine new ways to regulate. This could perhaps begin with a bridge between two or three similar roles with a dual or combination certification or license – for example, medical assistants, nursing assistants and the paraprofessional staff in assisted living facilities might be able to share requirements and staff flexibly across settings. Core competencies cross cut and can be augmented by setting specific required knowledge and skills.

### **Fund comprehensive workforce assessment for health care with an emphasis on rural**

Workforce shortage data is a longstanding need. If a data resource is developed, it will be important to give rural health care priority and to be inclusive of HHAs rather than the historical emphasis on hospitals and clinics. The DOH LTC Workforce draft recommendations also align here, reading, “Determine the current and projected vacancy rates in the long-term care sectors compared to the workload projections for these sectors.”

### **Improve integration of rural home health in existing workforce strategies**

The State Office of Rural Health (SORH) and Primary Care Office (PCO) within the Rural Health Section at Washington State Department of health offers a number of workforce strategies, including direct assistance with recruitment and retention. Rural home health can be better integrated into those services and HHAs can be offered more information about the availability of recruitment and retention assistance. The SORH and PCO also contract general state funds to two area health education centers (AHECs), one on each side of the state. These centers also receive federal funds via a contract with the University of Washington WWAMI<sup>49</sup> AHEC Center. These AHECs focus on healthcare workforce to serve rural and urban underserved populations, and could also increase their engagement with rural home health and hospice agencies.

### **Anticipate the high demand for home health aides**

Rural communities will have an amplified need for home care aides. Training programs should be designed using apprenticeships, in-high school vocational training and other innovations to attract local rural youth to serve the needs of the older adults in their community. The DOH LTC Workforce draft recommendations read, “Strengthen the career ladder between high school/skills center programs and the LTC industry.” The Department of Social and Health Services is poised to launch a pilot high school home care aid training program that may be feasible in small rural communities.

Home health agencies should be allowed to be accredited training sites in collaboration with other accredited programs as necessary, for nursing aides and assistants, as well as other paraprofessional

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<sup>49</sup> WWAMI stands for Washington, Wyoming, Alaska, Idaho and Montana, and is a regional medical education program sponsored by the University of Washington so serve the WWAMI states. The program is a primary care, family medicine and rural medicine training school.

roles such as certified occupational therapy assistants and physical therapy aides and assistants, as long as they can demonstrate qualified instruction and supervision of students or work with the appropriate level of contact intensity with accredited programs. Rural experiences during training, even if just a portion of an overall course of study, could increase the odds that an interest in rural home health could be fostered. Exposure to rural settings in training programs is known to help rural recruitment.

### **Facilitate rural community use of Department of Social and Health Services (DSHS) contract nurses and other aging supports**

To serve a Medicaid client, a registered nurse may contract directly with DSHS via the Area Agency on Aging to serve a client with home visits. In some instances this [Nurse Delegation Program](#) may help fill a need that is otherwise unmet. While some rural health systems may be aware of this option, others may not know about this program or other services the Area Agency on Aging has to offer. Many home supports are designed for Medicaid plan members and are less available to others.

Under a new Medicaid Demonstration, the [Tailored Support for Older Adults \(TSOA\)](#) program is targeted for those at risk for being Medicaid eligible but not yet enrolled and focuses on support of unpaid family caregivers. The care receiver must need help with some activities of daily living such as bathing, walking, medications or moving from one place to another (transfers). The [Community Living Connections website](#) is a portal to link people to needed services for older adults, persons living with disabilities, caregivers and those living with dementia.

### **Expedite licenses from bordering states for health care organizations in Health Professional Shortage Areas and consider interstate licensures for more health professions**

A rural health system CEO says, “I wish Washington and Oregon would get on the same page with licensing.” Consider creation of interstate compacts or agreements for border states for multiple health professions and paraprofessional roles. Establish working agreements between state licensing agencies that allow for expedited credential verification if the job is within a health professional shortage area.

## **Challenges: Too far and too few: Geography/population density and volume**

The smallest and most remote communities are likely to face the greatest challenges accessing home health and hospice services. Rural hospitals in general report better access and faster response to referrals to hospice compared to requests for skilled home health services. This may be in part because the two workforces are usually – though not always – different, and serve different sizes of patient population. Further study is needed to define why hospice services are in general more responsive to referrals than home health in the most remote communities.

Low volumes may make it difficult to earn sufficient revenue to pay for the fixed costs to maintain capacity. Workforce challenges can make it difficult to increase patient volumes. If an agency is not responsive to referrals, referrals diminish. This becomes a self-reinforcing negative spiral.

“The patient lived so remote that they had to send down a family member in a four-wheel truck to meet us at the end of their driveway and then we had a 40-minute ride up into the mountains to reach the residence.”

Nurse describing a visit in a frontier Washington County

### **Capacity for every category of care**

Services have parallel categorical regulations and restrictions for licensure of the program, facility and professions. While this separation of functions may be reasonable in urban and suburban settings, it sits artificially on top of the daily reality of rural health systems where personnel and other resources must flow between settings in response to changing conditions. For example, on a site visit to an RHC, a door was pointed out. The nurse providing the tour said, “...and that leads to the emergency department, and if they get busy it’s all hands on deck.”

Rural health systems that operate inpatient, skilled rehab in swing beds, assisted living, long-term care, emergency medical services, and home health and hospice services may have practical suggestions about how to make the boundaries between those services less rigid to allow them to move resources and personnel to the right service at the right time for the right patient. Home health and hospice services may benefit if appropriately trained and qualified personnel can flex into the service in response to spikes in census or specialized patient needs, including geography.

### **Windshield time**

Rural home visits cost more than urban because of longer travel distances and subsequent time. Some agencies pay their clinical teams for travel time using an hourly wage. Others pay per visit, and nurses and others are then motivated to keep visit volumes up by clustering the visits closer to the home office. This close in clustering is still incentivized for those paid hourly when productivity requirements

are set that discourage travel time. While it is at first blush inefficient to travel 90 minutes to reach one patient, the cost of doing so is significantly less than that patient requiring emergency transport, an emergency department visit, hospitalization or a skilled nursing care home bed.

The Oregon State Office of Rural Health offered this summary of the rural add-on payment: "Several versions of a rural 'add-on' payment have been implemented to supplement reimbursements for patients in rural areas where covering a large geographic area can result in much higher mileage and staffing costs. Add-on ranged from 10 percent (in 2001) and decreased steadily to 3 percent (2016). The add-on expired at the end of 2017."<sup>50</sup> The federal budget bill passed in the first quarter of 2018 reinstated the 3 percent rural add on but also called for phasing out over time.

Both CoN and workforce issues can prevent or contribute to travel times. Nurses who live in outlying communities may work for the local Critical Access Hospital (CAH) or a Rural Health Clinic and could conceivably provide a limited number of home visits due to their proximity.

One CAH chief nursing officer (CNO) said nurses from the distant agency were not paid for travel time and were therefore not incentivized to make the one-way 90-minute trip to see a single patient in her community. The nurse would face a three-hour round trip of uncompensated time to see a patient discharged from this CAH. Consequently, there were lag times to respond to referrals and sometimes no service offered. This CNO and others have observed a direct relationship between a lack of home health service and emergency department visits and hospital readmissions.

Another key informant describes an arrangement where the nurse was employed by the home health agency as well as the distant CAH. This nurse found the requirements for education, orientation, and occupational testing such as TB to be a burden across two different work sites with differing but overlapping requirements.

One HHA employee believes that HH agencies have "triple" the training requirements of other settings. She believes is to limit agency liability for care that is not directly supervised. Training requirements have the intent to protect patients by assuring teams are competent to provide the necessary care in that particular context. Different settings also carry different forms of liability insurance.

Challenges and solutions related to telehealth and telemedicine were discussed within the theme of underuse and fiscal sustainability earlier in this report. Telehealth and telemedicine collapse geography and can solve some percentage of distance problems.

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<sup>50</sup> Guardino, M. Walsh-Bailey, C., Horst, J. *Aging in Rural and Frontier Oregon: Challenges Facing Rural and Frontier Home Health Agencies*, Oregon State Office of Rural Health, September 2016

## **Potential solutions: Responding to geography/population density and volume constraints**

### **Continue and Increase Rural Subsidy**

Funding spent to compensate rural home health agencies for long distances would potentially cost less than more expensive levels of care. The 3 percent rural subsidy was not adequate for many agencies. Resumption of the subsidy at a higher percentage would put more remote agencies back “in the black.” The rural subsidy should not be phased out. If the subsidy is raised, agencies could be required to compensate for travel time. The Medicare subsidy could be augmented by a Medicaid rural subsidy. Data could be collected to evaluate whether improved home health access for Medicaid clients decreases total cost of care after using the rural add-on to ease provision of rural home health services. Consider matching state funds to local levy funds as an incentive for local support for program capacity.

### **Develop more blended systems of care with less categorical regulation and payment**

Gather input from rural health systems and rural home health and hospice services in particular to determine which categorical divisions between services pose barriers to deploying the services to the right patient with the right personnel in the right place at the right time. Develop some flexibility within boundaries that ensure patient safety is still protected. Extend this flexibility of integration to payment systems by redesigning allowable encounters for the cost reports to allow other services to be integrated without penalizing the CAH or RHC. Stop reductions that result from forcing overhead and allocated expense for other services to be divided away from allowable expenses on the cost report.

“The really interesting part of being a rural provider is how intertwined all our programs become and how an interruption in one affects others. ”

Leslie Hiebert, CEO, Klickitat Valley Health System

### **Decrease barriers to co-employed staffing with regulatory relief of silo requirements**

Health care settings, programs and professions each bring a set of requirements. Some employee requirements overlap in settings; for example, TB testing. If employment requirements such as CPR or TB tests, or mandatory education, were documented in a central data base, the burden on employees to repeat or provide documentation if dually employed would be lessened and co-employment would have fewer drawbacks for the employee. This would allow home health agencies to potentially hire CAH or Rural Health Clinic (RHC) nurses in outlying communities to provide a low volume of skilled home health visits. This strategy could also be used for physical, occupational, and speech therapists.

## **Explore models for inclusion of HHAs in rural regionalization and networks**

When rural health systems hear discussions of “hub-and-spoke” models, they often associate that concept with urban hubs that benefit from rural spokes with considerably less benefit for the rural systems. Hub-and-spoke concepts can also apply to rural hubs as well as rural spokes, using rural centers of excellence. This can provide rural organizations with a different degree of leverage over design and potential benefits.

The CAHs and their affiliated clinics have two dominant networks in the state; some organizations belong to both. A third more geographically focused network is in the early stages of formation. However, these networks have little connection to rural home health. Inclusion of rural home health in current networks might be an area for exploration.

Regionalization – where some entities may let go of some services and become centers of excellence for others – may be less desirable for home health as it would extend already formidable drive times. Yet for very specialized services, like pediatric palliative care, the small volumes of patients may call for imperfect solutions across a wider rural geography, as it is still preferable to keep families closer to home and out of urban hospitals. Families with very ill children otherwise find themselves unable to return home and are held captive in the urban center, which can be expensive and split apart the family as one parent tries to maintain the home for other children. This separation is tragic at a time when togetherness is most needed. Telehealth solutions may work as a strong complement to regional hubs.

## **Evaluate the best compensation model for time spent driving to patient homes**

Compare agencies who pay per hour, per visit, or that pay only for patient actual visit but not drive time, and study what percentage of their CoN geography is covered while controlling for other variables. If a link between the payment model and coverage percentage is proven, develop a staff payment model guidance for rural that leads to the most desirable coverage. A Medicaid rural add on payment could be linked to an incentive to use the most effective staff compensation model.

## **Fund like a Fire Department for Fixed cost of capacity**

Harold Miller, president and CEO of the Center for Healthcare Finance and Policy, has developed proposed draft primary care clinic, emergency department, inpatient and long-term care conceptual models for value-based payment in rural health care systems in Washington state. These concepts may have relevance to rural home health and anticipate the unwanted downside to more simplistic capitated or global budget approaches. Miller points out, “... most people don’t realize that the ‘fixed costs’ of rural hospitals aren’t really ‘fixed,’ but it’s not because of variability in the volume of patients but variability in what it costs to acquire and maintain those fixed costs.”<sup>51</sup>This variability is largely driven by the interplay between workforce instability, recruiting incentives and thin to non-existent

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<sup>51</sup>Miller, Harold. *Creating a Payment System to Sustain Community Long-Term Care in Rural Areas, Draft for Discussion*, Center for Healthcare Quality and Payment Reform, January 2018

margins to allow for flux. These qualities are also present in rural home health agencies though perhaps at a different magnitude.

Harold Miller's concept for a payment model is modular, resting on a foundation of payment for the costs for essential staffing and related costs as capacity, borne by the payers based on a percentage of lives in the defined geographic area. The second module is fee-for-service to flex with units of service of certain types of care – for example, lab tests – with discounts or not depending whether that patient is a resident and whether the payer already contributes to the capacity cost. Third is a quality incentive. There are a number of adjustment mechanisms and calibrations. Though complex, this model avoids pitfalls that come with a fixed budget and provides for a baseline of essential service plus variable conditions.

Fire and police departments are funded to be available with a 24/7 core capacity that does not rest only on the number of calls. This model must be at the heart of rural funding for essential services. Funding based on a number of events will usually fall short of covering the fixed costs for capacity in the most lightly populated rural areas.

### **Evaluate the use of HH shortage area declarations**

The Centers for Medicare and Medicaid Services (CMS) has regulations in Chapter 2-446 of the CMS State Operations Manual that allow Rural Health Clinics (RHC) to provide skilled nursing home visits if 1) the patient meets the medical necessity and homebound status care standard required of home health agencies, and 2) a home health shortage area has been declared. The process for determining a shortage is delegated to the licensing and regulatory agency for the state. The proposed process to determine HHA shortage areas must be approved by the CMS regional office. (Region X for Washington, based in Seattle). Each shortage declaration must be approved. Washington has not to date declared a home health shortage area. Only two states could be identified who use this method. One, Oregon, calls shortages only if a HHA closes. The other, Idaho, requires the RHC to submit data to the state demonstrating the shortage but does not disclose by what standard the submission is judged. They do not specify a time standard for how long the shortage areas are determined because it is judged by "multiple factors."<sup>52</sup>

The primary goal is for all rural residents who need home health services to receive timely services, defined as an intake within 48 hours of an order for services. If a shortage area is determined, the desire is to not adversely affect the HHA or in any way diminish the agency's sustainability. It would also be premature to establish a shortage designation if any misunderstandings in communication or the referral process have not been assessed and problem solved in a constructive dialogue before a

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<sup>52</sup>Idaho Department of Health and Welfare, "Rural Health Clinic (RHC) Request to Provide Visiting Nurse Services",

<http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RHCProvideVisitingNursing.pdf>  
accessed 12/14/2017

shortage declaration. If Washington elects to explore this option, a number of questions would have to be answered by a work group that includes key stakeholders.

- How could communication or coordination difficulties between HHA and hospitals or clinics be ruled out or resolved before gathering data on shortages?
- If an RHC wishes to propose a shortage area, what data must it provide to demonstrate the shortage?
- What standard will the DOH use to determine if a shortage area has been objectively documented?
- For what time is the shortage granted, and what conditions must be met to revoke the shortage area determination?
- How will the geography of the shortage area and its boundaries be determined?
- What rights to challenge the shortage determination are granted to the HHA?

## Challenges: Community-based alternatives and the aging boom

Rural areas face a disproportionate share of the growth in the population over age 65. Rural older adults are also more likely to experience chronic disease, disability and poverty.<sup>53</sup> Half of all men and about three-fourths of all women over the age of 75 years live alone. Yet rural communities have the least number of resources to help their vulnerable older residents “age in place.”<sup>54</sup>

“Our region is an adult family home desert.”

CEO of a frontier community health system

Across the nation, rural older adults, when compared to urban, tend to rely more heavily on institutional long-term care for lower levels of illness or disability.<sup>55</sup>

National data indicate that rural long-term care users had lower home and community based alternative rates and spends than those Medicaid clients who live in urban areas.<sup>56</sup> Data contributed by the Washington Department of Social and Health Services Aging and Long Term Service Administration (DSHS-AL TSA) for a grant application “*Realizing Community Based Long Term Care Services and Workforce Availability in Rural Washington*” found rural nursing home days were 9 percent higher than the state average, while the Resource Utilization Group scores (RUG scores) were 6 percent lower. If community-based alternatives were more available, these rural residents would be less likely to receive institution-based long-term care. More simply, rural residents are more likely to be in a nursing home bed earlier with less sickness because of fewer alternatives.

“Our average home in Dayton was built in the 1930s and that means narrow steep stairways, bathtubs with big lips and other hazards that truly make it unsafe for a vulnerable older adult to move around.”

Shane McGuire, CEO, Columbia Health System, Dayton, WA

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<sup>53</sup> Coburn, A., Griffin, E., Thayer, D., Croll, Z., Ziller, E. *Are Rural Older Adults Benefitting from Increased State Spending on Medicaid Home and Community-Based Services?* Main Rural Research Center Research and Policy Brief PB-65, June 201

<sup>54</sup> Byock, I. *The Best Care Possible: A Physician’s Quest to Transform Care through the End of Life*. Page 254, Avery, 2013

<sup>55</sup> Coburn, A., Lundblad, J., *Rural Long Term Services and Supports: A Primer*. Rural Policy Research Institute, November, 2017

<sup>56</sup> Coburn, A., Griffin, E., Thayer, D., Croll, Z., Ziller, E. *Are Rural Older Adults Benefitting from Increased State Spending on Medicaid Home and Community-Based Services?* Main Rural Research Center Research and Policy Brief PB-65, June 2016

The housing in many communities does not support continued independence when health begins to fray. Older homes can pose multiple challenges to safety and continued independence. Poverty puts home maintenance and repairs out of reach for many. Heating systems may rely on firewood.

Long-term care insurance fails to be helpful as few people have purchased the insurance. Even those who want to purchase long-term care insurance may be unable to do so. “Most carriers have exited the market. Those remaining carriers are raising premiums, cutting discounts, implementing tougher underwriting requirements and eliminating products. The current environment is one in which the premiums are unaffordable and unpredictable, there are limitations in the amount of protection offered, underwriting is costly and extensive and consumers are confused and distrustful.”<sup>57</sup>

Hospice and home health providers also report that some long term care policies impose a 90 day wait period from request to service coverage, leaving older adults to die before their coverage kicks in after paying years of premiums.

An older adult may have a family willing to provide care, yet the adults in the family have employment outside the home. When the older adult reaches a certain level of frailty, a crisis is reached if the older adult cannot safely stay alone during the day.

Washington is among the top-ranked states in the nation for community-based alternatives to long-term care, “no wrong door” entry to services, and in the top quartile and higher for virtually every measure of community-based alternatives. Leadership for those programs has readily recognized that most efforts to develop alternatives have occurred in the population centers and less so in rural communities.

### **Assisted Living and other residential options**

A number of rural communities have not been able to sustain assisted living facilities because of the high proportion of Medicaid and the small number of units. Payment models for many kinds of long-term services or supportive residential options are based on higher counts of participants and/or a higher proportion of insured or financially resourced residents.

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<sup>57</sup> Reinhardt, S. Accius, J., Ujvari, K., Alexis, J, Fox George, W. *Picking up the Pace of Change: A State Scorecard on Long-term Supports and Services for Older Adults, People with Disabilities, and Family Caregivers*. AARP Policy Institute, The Commonwealth Fund, The Scan Foundation, 2017 Edition

### **PACE aka ON-LOK**

The PACE model is a wraparound set of services that combine social and health supports with a day health program and transportation. The programs receive a capitated amount from both Medicare and Medicaid for nursing home-eligible residents. The PACE model has survived only in rural areas with a higher population or “large rural” or when run by an integrated health system that can subsidize operations. A national consultant defines a threshold for eligible residents in a community that few if any rural locations in Washington can support.

### **Adult Family Homes**

One CAH attempted to develop an adult family home to be run by the hospital and help transition patients out of long term care use of swing beds and into that more home like setting. The rural hospital found the “amount of red tape” to be very challenging to navigate and gave up its effort. This occurred despite its purchase of the home from a citizen who had already gone partially through the startup process.

### **Older adults with serious illness who live alone**

Older adults who lack the family support or someone else to step in as caregivers to at home cannot be enrolled in the hospice program and few communities have inpatient units for hospice. The rural residents are forced to face the end of illness in institutional settings, sometimes far from home and sources of emotional support.

## **Potential solutions: Building community-based alternatives**

Home health and hospice are integral to aging in place but cannot exist in a vacuum. People must have a place to stay in order to be seen by home health or hospice. Consequently, this last section discusses solutions that are not directly part of home health but need to be in place for home health to have an optimally effective role in the community. A comprehensive cataloging of all the community based alternatives for long term care will not be attempted.

If a community has the full continuum of community-based services, it offers supported housing, such as lightly supervised and subsidized apartments, assisted living, home maintenance and repair services that include adaptive modifications, home care, home health, community palliative care, hospice, adult family homes, day health or adult social day programs, family caregiver supports and transportation. Local primary care accepts both Medicare and Medicaid. Residents have access to care management for those who have the most serious conditions, care coordination from a primary care medical home for all, and assistance with navigation from community health workers based on need.

### **Create supported housing alternatives**

Many small communities do not have a local housing authority to collaborate with health care entities on housing solutions. In Port Townsend in Jefferson County, a very modest population health mini-grant from the Department of Health Rural Hospital Program helped the local CAH and healthcare system, Jefferson Healthcare, to afford to engage with other partners to develop housing alternatives for the community's "most vulnerable."

A number of options are possible on the spectrum between independent living and nursing home. Supportive housing with small degrees of support, small group homes, assisted living and adult family homes could be reasonable options for rural communities if the payment supported basic costs. This could be calculated as a reduction in nursing home, inpatient and ED costs. The developmental disabilities field has been able to create a wide array of alternatives between institutional living and total independence, and may be a useful body of work to study for supportive housing alternatives.

Rural health organizations motivated to assist their community with supported housing options should not be discouraged by the complexity of the process. Patient or resident safety can be protected and fraud prevented without undue regulatory burden. This "sweet spot" should be sought. At minimum, navigators from the license-granting organization might assist organizations overtly and proactively to reduce the burden of application on small rural organizations that lack specialized or dedicated staff to manage this sort of project. Whatever the method, the goal is to make it easier for tightly resourced rural communities and organizations to develop supported housing options for vulnerable adults, primarily though not exclusively for those over age 65.

## **Incentivize Day Health /Partial Hospitalization**

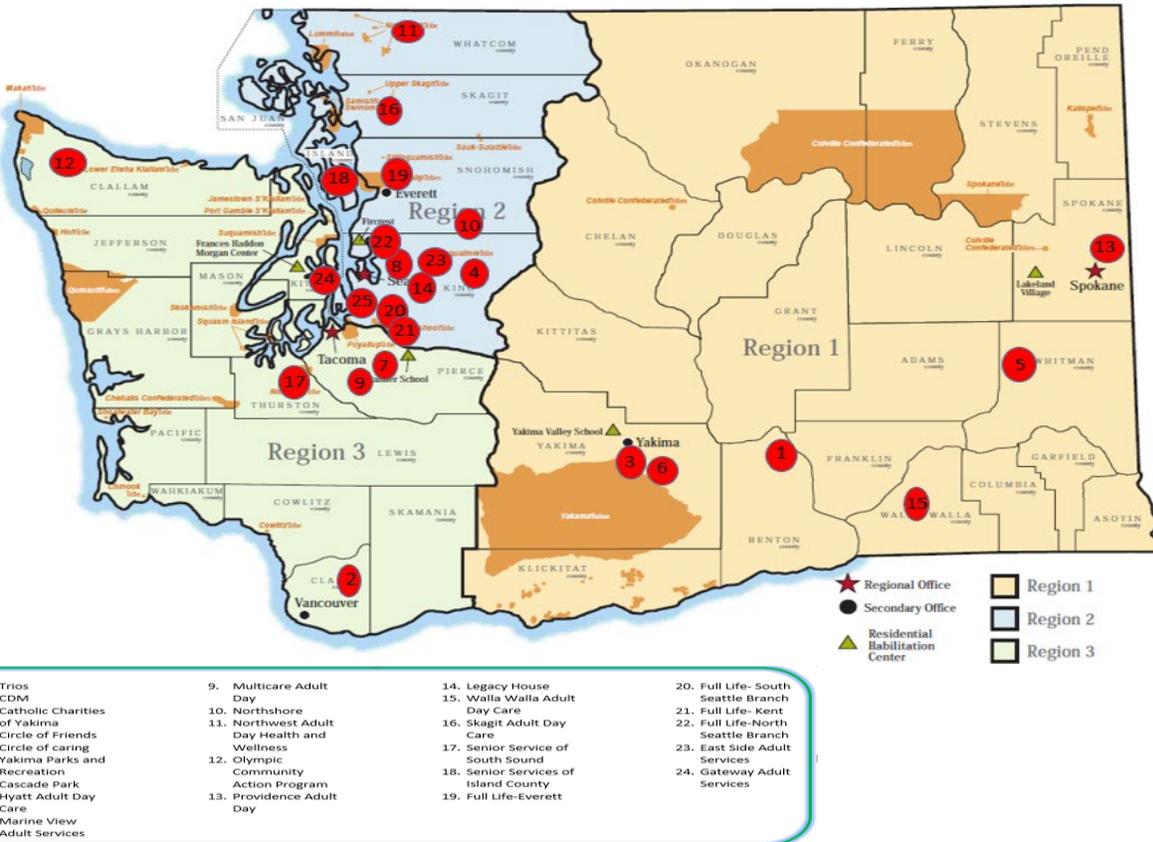
A day program can support families to continue caregiving while maintaining employment, saving older adults from early transitions to more restrictive settings, or in some cases removal from their community. However, most day health programs are only four hours long, which does not allow a full-time employee adequate respite to allow work. Day care program hours vary, but medically fragile adults may not be eligible if they have medical problems that require the skills of a registered nurse or licensed rehabilitation therapist. These programs range in cost from \$38.48 to \$45.55 for day care and \$65.52 to 73.91 for day health, with the highest rates charged in the most urban counties. If a resident is not Medicaid-enrolled, there are scant resources to assist with payment of day-health or day care services.

Family members who must maintain employment face critical choices when a family member becomes too vulnerable to be left at home during the day. Even home health, with its pattern of visits but not steady care, cannot solve this dilemma. Figure 15 on page 73 depicts the adult day sites contracted with the Department of Social and Health Services to provide services. These programs can offer health services (day health) or social support only (adult day care) and sometimes offer transportation to help attendees to the meeting location. In-home care can be provided by the Medicaid program, but the working poor and even middle class often cannot afford to pay an hourly rate to bring in private care.

Rural day health or day care programs might be blended with existing swing bed programs or long-term care activity programs. If the relevant regulations were flexed, residents could access a needed resource and rural health systems could provide more services from the capacity they have available with a fixed cost. Acute patients can also benefit from “day” or partial hospital programs where medical services are offered for eight hours and then the patient is released each day to return home overnight. These programs can offer many of the clinical treatments of an inpatient stay without the large cost overhead for staffing 24/7, and again give working adults an opportunity to obtain care for their loved one and remain working.

## DSHS CONTRACTED ADULT DAY SITES

**Figure 15. Department of Social and Health Services (DSHS) contracted adult day sites**



Using a county definition of rural, four of the 24 adult day licensed programs are located in rural counties, or a little over 16 percent. While this might be strictly proportional to population, (the county definition of rural indicates that 16 percent of Washington’s residents live in a rural county), it still leaves many rural communities without a viable alternative to more restrictive and costly environments. Leaving home is particularly tragic for those long rooted in their communities, living on land held by a family for generations. In a recent case example from Columbia County, a 97 year old gentleman had lived in the same small town his entire life. Sparsely populated regions need a model for day care or day health alternatives that can operate with low volumes.

### **Adopt and spread the CAPABLE model**

The [CAPABLE Model](#) (Community Aging in Place-Advancing Better Living for Elders) is a model first introduced at Johns Hopkins School of Nursing. It focuses on low-income client strengths and goals for self-care. The services are client-directed. An occupational therapist, RN and handyman make visits

with a total average cost of \$2,825 per client.<sup>58</sup> The OT evaluates the home in relationship to the client’s goals for living and then writes a work order for the handyman to make adaptive changes such as stair railings, grab bars and lowering storage situated too high to reach. Some solutions are simple, like weighted silverware for someone with a severe hand tremor.

“Poor function is costly, it’s what older adults care about and it is virtually ignored in medical care. It is also modifiable.”

Institute for Healthcare Improvement WIHI program, *Aging in Place with Disability and Dignity*, February 22, 2018.

The CAPABLE model has been tested in 10 sites across multiple states with a National Institutes of Health-funded randomized trial. Functional limitations and depression improved and home hazards were decreased. The program also saved Medicare more than \$10,000 per patient per year. The return on investment is more than six times.

### **Develop congregate hospice homes**

Friends of Hospice in Whitman County are opening a hospice house in 2018-19. Serenity House will offer “comfort and care at the end of life.” Community homes for the dying, sometimes called social model hospice houses, have been around for more than 25 years. They are typically run by non-profit community-based collaborative organizations working with a coalition of local resources, including trained volunteers. The licensed hospice agency provides all the Medicare hospice benefits and medical treatment just as it would for any eligible patients in their home. The Whitman County home is designed to serve those in the last month of life. Without this option, those who live alone are unable to receive hospice services unless a friend or family member assumes care for 24/7.

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<sup>58</sup> Institute for Healthcare Improvement WIHI program, *Aging in Place with Disability and Dignity*, February 22, 2018.

## RECENT FEDERAL CHANGES

### The CMS Rural policy

In May of 2018 the Centers for Medicaid and Medicare Services (CMS) released a “Rural Health Strategy.” The CMS Rural Health Council “sought input on the challenges and local solutions associated with providing high quality health care in rural communities through a series of listening sessions with rural stakeholders and consumers.” The result has led to the identification of several specific health care provider issues, better understanding of the impact of CMS policies on providers, and a rural health strategy that focuses on five objectives:

1. Apply a rural lens to CMS programs and policies
2. Improve access to care through provider engagement and support
3. Advance telehealth and telemedicine
4. Empower patients in rural communities to make decisions about their health care
5. Leverage partnerships to achieve the goals of the CMS Rural Health Strategy <sup>59</sup>

The effect on rural home health from this new CMS strategy is unknown but holds promise. Regulations and increasingly, payment models, rolled out for all agencies, may need modifications for rural HHAs to succeed. For example, a low-volume measure strategy for quality incentives is desirable for rural HHAs.

### Chronic Care Management (CCM)

“One in four adults have two or more chronic health conditions. Through the *Connected Care* campaign, the CMS Office of Minority Health and the Federal Office of Rural Health Policy at the Health Resources & Services Administration will raise awareness of the benefits of CCM for patients with multiple chronic conditions and provide health care professionals with resources to implement CCM.”

While a provider from a HHA may be able to bill for CCM, other members of the team cannot. At this point approved billers include physician assistants, clinical nurse specialists, nurse practitioners, and certified nurse midwives. Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals can also bill for CCM services. Only one practitioner per patient may be paid for CCM services for a given calendar month. While this visit frequency may not fit with exacerbation of symptoms and

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<sup>59</sup> Centers for Medicaid and Medicare Services, *Rural Health Strategy*, <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf>, accessed 6/19/2018

higher acuity, rural home health agencies could benefit from offering this service in addition to their usual payments, if allowed.<sup>60</sup>

## The Rural Add On Payment and Other Provisions of the 2018 Federal Budget

On February 9, 2018, Congress passed the *Bipartisan Budget Act of 2018* (the Act), which contained several policies and payment provisions affecting HHAs, including an extension for the 3 percent HHA rural add-on, which had expired December 31, 2017. Maria Cantwell, Washington state Senator co-sponsored the bill to reinstate the add-on. The bill does call for a gradual phase-out of the rural add-on payment, however. Rule-making proposes different rates for counties with different population density.

According to Home Health News, “The big change to grab headlines is a new payment model for home health care providers, which will shift the current 60-day unit of payment to a 30-day model.”<sup>61</sup> Home health agencies forecast increased administrative burden because they will have to increase the number of times they request continuation of services and require approval of that request.

The other changes include:

- While CMS has more discretion related to the “face to face” requirement, it is unclear how it will interpret the language and if that will result in change.
- The bill also extends Independence at Home, a demonstration program from CMS that incentivizes primary care at home. The bill extends the program by seven years.

## The Chronic Care Act

The new Chronic Care Act law gives CMS greater flexibility to respond to beneficiaries with complex chronic conditions such as:

- “The Chronic Care Act within the spending bill, expands telehealth coverage under Medicare. By 2020, Medicare Advantage plans can also provide additional telehealth benefits to enrollees.
- The rules and fee schedules for expanded telehealth services introduce new possibilities but some issues remain. A detailed discussion is beyond the scope of this paper. The themes surround new versus established patients, levels of payment and more. There appears to be favorable language for asynchronous or store and forward services. New codes for “Chronic Care Remote Physiological Monitoring” better known as telemonitoring are introduced. At the time of this writing there are still questions about the extent of physician supervision required

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<sup>60</sup> Centers for Medicaid and Medicare Services, *Connected Care: The Chronic Care Management Resource*, <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/ccm/hcpresources.html>, accessed 6/19/18

<sup>61</sup> Baxter, A. Spending Bill Holds Wins and Losses for Home Health Care, Home Health News, February 11, 2018, <https://homehealthcarenews.com/2018/02/spending-bill-holds-wins-and-losses-for-home-health-care/>

that are not yet resolved. There is a code for the set up and teaching for remote patient monitoring equipment.

- Accountable care organizations (ACOs) can also offer broader telehealth benefits.
  - The new law gives Medicare Advantage plans flexibility to cover non-medical benefits for high-need/high-risk members, such as bathroom grab bars and wheelchair ramps.
  - ACOs are able to “proactively target members and provide incentives for beneficiaries to choose high-value primary care.”
  - Promotes integration of behavioral health and long term care services.
  - Expands access to home dialysis therapy
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# APPENDIX

## Solutions sorted by influence and the time frame of the effort and potential effect

### Key to definitions

**Agency**-Home health and hospice agencies working as a coalition or through their state member association. National member association issues are listed under national.

**Local**-within a specific rural community, includes local rural hospital and clinics

**Regional**-within a county, public health district or group of counties organized into a regional structure.

**State**-WA state government administrative law, statute or agency policy or a collaboration across statewide associations

**Short**-can be influenced within 6 months   **Medium**-can be influenced in 7-18 months Long-more than 18 months

**Research needed**-the scope of the question(s) would benefit from research rather than agency or community study

**XX**-indicates suggested instigator of action

Possible Solution	Who can influence the proposed solution?					Time frame of effort and potential effect			Research needed
	Agency	Local	Regional	State	National	short	medium	long	
<b>Underuse and Fiscal Operations</b>									
Better understand drivers of low home health use in rural areas	<b>XX</b>		<b>X</b>	<b>X</b>			<b>X</b>		<b>X</b>
Design easy entry processes	<b>XX</b>					<b>X</b>			<b>X</b>
Test standing order sets; default home health orders	<b>XX</b>					<b>X</b>			

Possible Solution	Who can influence the proposed solution?					Time frame of effort and potential effect			Research needed
	Agency	Local	Regional	State	National	short	medium	long	
Recognize the court ordered redefinition of <i>the need to improve</i>					XX	X	X		
Increase Medicaid payment and simplify preauthorization				XX			X		
Integrate home health agencies (HHA) into Critical Access Hospital (CAH ) cost reports and payment				XX	XX			X	
Reduce use of homebound status and medical necessity					XX		X		
Reduce Medicare over-regulation					XX		X		
Increase incentives and decrease barriers for home health agencies to integrate telemedicine and home tele-monitoring services	X			XX			X		

Possible Solution	Who can influence the proposed solution?					Time frame of effort and potential effect			Research needed
	Agency	Local	Regional	State	National	short	medium	long	
Create payment and design services for upstream palliative care				<b>X X</b>	<b>X X</b>			<b>X</b>	
Integrate more behavioral health approaches into HHAs	<b>X</b>		<b>X</b>	<b>X X</b>	<b>X</b>		<b>X</b>		
<b>Moving to Value-Based Payment and Care Systems</b>									
Evaluate the <i>Outcome and Assessment Information Set</i> (OASIS) measures through a rural lens	<b>X</b>			<b>X</b>	<b>X X</b>			<b>X</b>	
Employ small data set strategies developed by the National Quality Forum (NQF)					<b>X X</b>			<b>X</b>	
Increase interoperability with electronic health records in home health agencies				<b>X</b>	<b>X X</b>			<b>X</b>	

Possible Solution	Who can influence the proposed solution?					Time frame of effort and potential effect			Research needed
	Agency	Local	Regional	State	National	short	medium	long	
Include rural home health in bundled payments	<b>X X</b>		<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>		
Integrate HHAs in accountable care organizations(ACOs) and accountable communities of health (ACHs)	<b>X</b>		<b>X</b>	<b>X X</b>	<b>X</b>		<b>X</b>		
Engage HHAs in prevention strategies and early screening and intervention	<b>X</b>			<b>X X</b>	<b>X X</b>			<b>X</b>	
Build value based coding skills and business practices	<b>X</b>		<b>X</b>	<b>X X</b>		<b>X</b>			
<b>Administrative Burden</b>									
Use the “value-added “lens to evaluate documentation, to decrease documentation requirements	<b>X</b>			<b>X X</b>	<b>X X</b>		<b>X</b>		

Possible Solution	Who can influence the proposed solution?					Time frame of effort and potential effect			Research needed
	Agency	Local	Regional	State	National	short	medium	long	
Defer to state scope of practice to allow advanced registered nurse practitioners (ARNPs) to certify care and revoke the face-to-face requirement					<b>X X</b>			<b>X</b>	
Create rural waivers of durable medical equipment (DME) requirements					<b>X X</b>			<b>X</b>	
<b>Certificate of Need</b>									
Evaluate alternatives to county for geographic responsibility for CoN				<b>X X</b>			<b>X</b>		
Evaluate influence of CoN on patient access to rural HH and H services				<b>X X</b>				<b>X</b>	<b>X</b>
Decrease the complexity of CoN application and offer additional resources to augment proactive front end technical assistance (TA)				<b>X X</b>				<b>X</b>	

Possible Solution	Who can influence the proposed solution?					Time frame of effort and potential effect			Research needed
	Agency	Local	Regional	State	National	short	medium	long	
<b>Workforce</b>									
Build experience, courage, compensation, education	X		X	X			X		
Build virtual community-based training ladders			X	XX	X			X	
Prioritize local region students for admissions to community colleges				XX			X		
Foster new roles and greater rural flexibility				XX					
Fund comprehensive workforce assessment for health care with an emphasis on rural.				XX				X	X
Improve integration of rural home health in existing workforce strategies				X		X			

Possible Solution	Who can influence the proposed solution?					Time frame of effort and potential effect			Research needed
	Agency	Local	Regional	State	National	short	medium	long	
Anticipate the high need for home care aides				<b>X X</b>			<b>X</b>		
Use Department of Social and Health Services (DSHS) contract nurses	<b>X X</b>		<b>X</b>	<b>X</b>		<b>X</b>			
<b>Geography/population density and volume</b>									
Continue and increase federal rural subsidy					<b>X X</b>			<b>X</b>	
Develop more blended systems of care with less categorical regulation and payment				<b>X X</b>	<b>X X</b>			<b>X</b>	
Decrease barriers to co-employed staffing with regulatory relief of silo requirements				<b>X X</b>				<b>X</b>	
Explore models for rural regionalization and networks	<b>X</b>		<b>X</b>	<b>X X</b>			<b>X</b>		

Possible Solution	Who can influence the proposed solution?					Time frame of effort and potential effect			Research needed
	Agency	Local	Regional	State	National	short	medium	long	
Evaluate the best compensation models for windshield time				X			X		X
Fund like a fire department for fixed cost of capacity				X X	X X			X	
Evaluate the use of HHA shortage area declarations	X		X	X X	X	X			
<b>Community-based alternatives</b>									
Create supported housing alternatives				X X				X	
Incentivize day health-partial hospitalization				X X	X X			X	
Adopt and spread the CAPABLE model				X			X		
Develop congregate hospice homes	X X		X X	X	X			X	