Home Health Care

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THERE ARE many definitions of "home health care." In general, this means the provision of health care services in the patient's home rather than an institutional setting or a provider's office. Opinions differ as to which patients should receive home health care, what services should be included, who should provide the care, and how long it should last. Certain home health services are covered to some extent by government programs such as the Older Americans Act Program (Title III), Medicare (Title XVIII), Medicaid (Title XIX), the social services programs under Title XX (including Aid to Families with Dependent Children), and by the Veterans Administration. Private insurance carriers, health maintenance organizations, and other third-party payers also provide coverage in varying degrees for some home health services.

Interest in home health care is growing as the federal government as well as state governments and private insurers seek to reduce health care costs by encouraging the discharge of patients from hospitals as soon as possible. Medicare's prospective payment system, by which hospitals receive a flat amount per admission based on diagnosis-related groups regardless of the actual cost of care provided, has created powerful incentives to send Medicare patients home quickly. As the elderly population continues to expand and as patients are discharged from hospitals "quicker and sicker," the demand for home health services is intensifying. In addition, home health care is often seen, at least on a temporary basis, as an alternative that can help satisfy the growing demand for nursing-home care.

In 1980, an estimated 3.4 million American adults required help in daily activities (such as eating, walking, bathing, dressing, use of the toilet, getting in and out of bed) (1). Needed assistance for these functions can generally be provided at home at much less cost and with greater patient satisfaction than in institutional settings. Such assistance was needed by about 7% of persons 65 to 74 years of age, 16% of those 75 to 84, and 39% of those 85 and older. Projections based on these data indicated that 4.2 million adults would need such assistance by 1990, and 5.2 million would by the year 2000 (2). However, recent statistics show that there are already 1.4 million elderly in nursing homes and 5.2 million adults remaining at home who need such care (3).

Because home health care today is not limited just to homemaker services or assistance with daily tasks, such care today is vastly different from what it was 5 or 10 years ago. In addition to doctors, dentists, nurses, and homemakers, home health care teams now often include physical therapists, occupational therapists, social workers, psychologists, speech pathologists, respiratory therapists, and clinical dietitians. Advances in medical technology have made possible the provision of an expanding array of services previously available only in hospitals or nursing homes.

Health care equipment now available in the home includes renal dialysis machines and supplies, equipment for intravenous infusion therapies (including nutrition, antibiotic, and continuous chemotherapy), respirators and other equipment for respiratory and physical therapy, and many other sophisticated medical devices. In addition, there is a growing list of disposable home medical products. Heart and lung monitors with telecommunications links to hospitals, physicians, and nurses are also available. Home health care is seen by market analysts as a burgeoning industry with annual sales in excess of $6 billion in 1983. Expectations of growth range from $13.8 to $18.3 billion by 1990 and to almost $25 billion by 1995 (2, 4).

Yet, there are many unresolved public policy questions concerning home health care. Are services being provided appropriately? Are there adequate assurances that home health services are of good quality? Is home health care really cost effective? Has the Veterans Administration been successful in integrating home health care into their health care system? Will greater availability of home care services increase aggregate national health care costs? Physicians and patients are not aware of what home health services are available or how to obtain them. Too frequently, physicians are not involved in home care. Coverage under governmental programs and by other third-party payers is often unclear, subject to misinterpretation, and generally inadequate. Funding for home health care services, particularly under the Medicare program, is increasingly imperiled, and out-of-pocket costs to the elderly are rising.

These are some of the questions and problems this position paper seeks to address. Although the American College of Physicians recognizes that home health care is also appropriate for patients other than the elderly, par-

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ticularly the disabled and infants, this paper focuses on home health care for the elderly and further examines issues raised by the College's 1984 position paper (5) on long-term care of the elderly. That paper urged development of a comprehensive, coordinated, and continuous system of long-term care in which a full array of services (including home health care) is available to enable the family to meet the changing, but continuing, needs of the elderly in the least restrictive setting possible.

Position 1

Home health care is an option that should be available to serve patient care needs. Home health care may not be appropriate for all patients, and the availability of services on a home care basis does not justify denial of needed institutional services.

RATIONALE

Home health care can enable elderly people with physical or mental limitations to remain in their normal environment, with their families, and to continue their lives with a minimum of disruption or restriction. It can help some persons avoid institutionalization and can help others recover after a hospital or nursing home stay. Many persons believe that with proper care, patients recover sooner at home than in other settings. Although there is little scientific evidence to substantiate this belief, numerous articles as well as testimony before Congress (4, 6-13) report great satisfaction with home health care by patients and their families. Home health care is an option that should be an integral component of a comprehensive health care delivery system that offers an array of services in settings that can best serve differing community health care needs. It is an option that can serve to meet the nonacute health care needs of patients requiring long-term care. Under certain circumstances it can also meet the acute care needs of some patients.

In an era of cost containment with incentives to discharge patients from hospitals as soon as is medically sound, home health care offers a means of providing continuing care after discharge to the sick and the frail. Home health care should not be a substitute for needed acute hospital care but should be available as one alternative among various community and home-based services that are coordinated to serve patient needs for continuing care effectively and efficiently.

Of primary importance are the medical needs of the patient and the ability of the patient and his or her family to manage an individually designed treatment plan at home with assistance from a team of home health care professionals. Home health care can be physically and emotionally draining for the family. The cost of preparing the home and purchasing or renting equipment and supplies needed to care for the patient at home can be substantial. Lack of health insurance or limits on coverage can create financial obstacles for many families.

Home health care is not for everyone. Patients with major medical problems requiring care that cannot be provided at home or those with unstable conditions requiring frequent monitoring and changing of therapy may need hospital or skilled nursing home care. Appropriate home health equipment and personnel must be available. Home health care requires involvement of the patient and the family in the provision of care. Patients and their families must be able to follow prescribed treatments and therapy on their own. An adult other than the patient often must be available on a 24-hour basis.

Medicare reimbursement policy to reduce the length of hospital stays and shortages of nursing home beds may be forcing some patients to resort to home health care as an alternative to hospital and nursing home care rather than as an option voluntarily chosen by the patient, family, and physician. The General Accounting Office (GAO) reports that Medicare patients under the prospective payment system "are being discharged from hospitals after shorter lengths of stay and in a poorer state of health" (14). The average hospital stay for Medicare patients dropped from 13.4 days in 1968 to 10.2 days in 1982, an annual rate of decrease of 1.9% (15). Since implementation of the prospective payment system in October 1983, the rate of decrease has accelerated, yielding an average length of stay of 7.7 days by June 1985 (16). Meanwhile, the GAO found that home health agencies are reporting "more visits per case, more cases requiring multiple visits per week, and more need for specialized services" (14).

A survey of 90 area agencies on aging also showed a dramatic increase in demand for home and community-based services since the adoption of the prospective payment system. The survey showed a 365% increase in requests for case management services and a 196% increase in demand for in-home skilled nursing services. The survey further reported that patients were being readmitted to hospitals because of inadequate family support, lack of support services (such as, meals on wheels), inadequate discharge planning, and unavailable home health services (17).

The American College of Physicians believes that home health care should be available and be used when appropriate for the treatment of the sick or infirm elderly. The reimbursement system should not force premature discharge of patients from hospitals or cause denial of admission to hospitals or nursing homes. Patients should not be discharged from hospitals without adequate discharge planning involving the patient, family, physician, discharge planner, and other members of the hospital team involved in the treatment of patient conditions that will require ongoing medical care.

Before discharge, a functional assessment should be done and the functional needs of the patient should be clearly identified. Arrangements with a home health agency or a community-based agency that will assist the family, if necessary, should also be made before the patient leaves the hospital. Under no circumstances should patients be discharged without the physician's conviction that discharge is medically justified or without the physician's approval of any plan for continuation of treatment. A system should be in place to maintain ongoing communication between the physician and home health personnel concerning changes in the patient's condition.

Position 2

Home health-care personnel should be appropriately trained and certified as to what services they provide. The delivery of home health services should involve members of a team of health care professionals that will vary depending upon the individual needs of each patient. Certification requirements for home health agencies and reimbursement regulations that impede the provision of medical and nursing services in the home should be reduced to a minimal level sufficient to maintain high quality care and discourage fraud and abuse.

RATIONALE

Home health care is provided by private agencies (both for-profit and not-for-profit), hospitals (both public and private), public health departments, and by the Veterans Administration. Various organizations review home health agencies to maintain standards of quality. The National Home Caring Council accredits homemaker and home health aide services. The National League for Nursing and the American Public Health Association accredit skilled-care agencies. The Joint Commission on Accreditation of Hospitals accredits hospital-sponsored home health services.

To receive cost reimbursement from Medicare and Medicaid, home health agencies must be certified for participation in these programs. Passage of Medicare in 1965 required home health agencies to provide nursing service plus one additional service such as physical therapy, occupational therapy, speech therapy, medical social service, or home health aide service. Medicaid coverage for home health care was optional for the states until 1971, when it was made mandatory. It was estimated that of the 1100 agencies offering home nursing care in 1963, only 250 could have qualified for Medicare certification (18). Approximately $16 million was spent to bring home care agencies up to Medicare standards, and by October 1966, 1275 agencies were certified for Medicare participation (18). As of 3 September 1985, there were 5755 Medicare- and Medicaid-certified home health agencies (19).

Some mechanism must exist to safeguard the quality of home care services. Certification of home health agencies is essential to assure that minimum standards of quality are met. Certification showing that persons providing home health services have received adequate training is also needed. However, existing Medicare and Medicaid certification requirements may deter some physicians and other health care professionals from providing services in the home. The requirement that home health agencies must offer specific services in addition to nursing services may discourage innovative arrangements by physicians, nurses, and others to provide care in the home.

Home health care typically requires a team of health care professionals to serve the patient's medical, nursing, social, nutritional, and other needs for continuing care. These teams should include the patient, the family, and the physician, and may also include, depending on the individual needs of the patient, a nursing director or coordinator, registered nurses, licensed visiting or practical nurses, home health aides, a homemaker, companions, physical therapists, respiratory therapists, occupational therapists, speech pathologists, clinical psychologists, social services personnel, and dietitians. The patient's needs for services from these various professionals may change during the course of any treatment program and should therefore be periodically reevaluated. Reimbursement policies should be flexible enough to permit patients to obtain the services they need at home from a coordinated network of qualified health care providers.

Accreditation by a recognized national accreditation organization or certification by Medicare or Medicaid is one method of quality assurance. A better approach might be for state professional practice laws to encompass all professionals providing home health care. Licensure laws could require certification of training to deliver specific types of health care services. Homemakers and others who provide home care services, but do not provide health care, would not need to be certified or licensed. Currently, 28 states have licensure laws applying to home health agencies, but only one state (Minnesota) requires certification of all persons providing home health services. No state requires certification for people providing homemaker or other personal care services (20).

The American College of Physicians believes that all professional health care services, including home health care, should be provided only by highly qualified health care professionals in accord with state licensing laws. State licensing laws should be flexible enough to recognize evolving and overlapping spheres of professional practice, but strict enough to assure minimum standards of competency. Rigid requirements for certification of home health agencies may deter some highly qualified health care professionals from providing their services in the home setting.

Position 3

Medical equipment and technologies should be reviewed for safety and effectiveness in the home care setting.

RATIONALE

The American College of Physicians believes that all medical technologies and procedures, including those used in the home care setting, should be evaluated for their safety, clinical efficacy, and effectiveness before widespread usage. Evaluations should determine risks to patients, potential benefit when used appropriately under ideal conditions (efficacy), and effectiveness when applied under the usual conditions likely to be encountered by medical practitioners.

The College's commitment to this principle is shown by its participation in the Blue Cross-Blue Shield Medical Necessity Project, begun in 1976. This project evaluated the medical necessity of numerous medical tests, procedures, and therapies. In 1981, the project was renamed the Clinical Efficacy Assessment Project (CEAP) and

expanded with the help of a 3-year $650 000 grant from the John A. Hartford Foundation. The CEAP evaluations determine the safety, efficacy, and effectiveness of medical technologies in internal medicine. Since 1984, the College has continued to operate this program without outside funding.

There are no counterparts in other medical and surgical specialties to the CEAP project. The Medicare program has no systematic way of evaluating medical technologies. There are no reviews of new technologies for their safety and effectiveness in the home care setting, although new products intended for the home care market are becoming increasingly available. Nor are there any systematic evaluations of the appropriateness of applying therapies and procedures used in the hospital setting to the home environment. Likewise, there is little or no review for the safety or efficacy of unsupervised home administration of drugs and laboratory tests (such as for blood or urine glucose screening). Consequently, there is the danger that patients will receive care that is inappropriate and possibly dangerous.

Guidelines are needed as to what medical technologies and procedures can be safely and effectively administered in the home by appropriately certified health care professionals and which—with adequate education, training, and supportive services—can be done by the patient and the family. Approval of new technologies by the Food and Drug Administration and evaluations by the Office of Technology Assessment should consider the appropriateness of applications in the home.

Position 4

Adequate funding for home health services should be provided by Medicare, Medicaid, and other health care programs to assure that appropriate services are accessible.

RATIONALE

Home health care can be an effective means of supplying assistance to the elderly and infirm who are dependent due to chronic physical or mental impairments. It can enable the frail and dependent to obtain an optimal level of physical, social, and psychological functioning, while permitting them to stay in familiar surroundings. It may be the most cost-effective means of assistance when only minimal services are required to avoid costly institutionalization. Home health care includes preventive health care, as well as treatment of illness, and maintenance services. The availability of home health care services must be an integral part of a comprehensive, coordinated, and continuous system of long-term care. Adequate funding is essential if this important component of our health care system is to be accessible.

In 1980, it cost Medicare an average of $3291 for each elderly Medicare enrollee who received inpatient hospital services. During that same year, it cost Medicare $1336 for each elderly enrollee who received skilled nursing home care and $613 for each who received home health agency services (21). Ideally, the services provided in each of these different settings met differing levels of patient need, and the average cost differences reflect justifiable differences in the cost of providing services. It cannot be implied from these data that any enrollees received care in one setting that would have been more appropriately provided at another. However, to the extent that home health services might have been appropriately substituted for some hospital and skilled nursing home care, the cost savings to Medicare could be significant.

Institutional care invariably involves overhead and the cost of having other services and personnel available that Medicare and other third-party payers would not need to pay when care is furnished in the home. Home dialysis costs $14 500 per year at home compared with $23 000 per year in a clinic; chemotherapy costs $42 500 per year at home compared with $126 000 per year as a hospital inpatient; and total parenteral nutrition can be provided at home (with the use of an intravenous infusion pump, an implantable catheter, and home delivery of infusion products) for $73 000 per year compared with $200 000 per year in the hospital (6).

Despite its apparent cost effectiveness, funding for home health services has been limited. Public policymakers concerned about rapidly rising aggregate costs at a time of increasing pressures for health care cost containment and intensifying federal budgetary restraints have been reluctant to expand coverage under Medicare or Medicaid. Instead, they have sought to curtail home health care costs under these programs.

The GAO issued a report in December 1982 stating that "when expanded home health services were available to the chronically ill elderly, longevity and client-reported satisfaction improved" (9). The GAO further found that availability of these services did not reduce overall nursing home or hospital use or total service costs. The GAO (9) concluded, "The growing public support for wide diversity in long-term care services indicates that the critical policy issue is not whether expanded home health care services are less costly than institutional care but, rather, how these services should be organized for maximum efficiency and effectiveness."

A major concern of public policymakers has been that because home care is so popular, if it were made more available under government-financed programs like Medicare and Medicaid, the demand would be so great as to make total costs prohibitive. The National Association for Home Care responds that such arguments merely acknowledge the tremendous unmet need and pent-up demand (20). This association further argues that rather than substituting services presently provided by friends and family, home health services increase interfamily support. Nevertheless, funding for home health care has increasingly been a target for federal budget-cutters. Copayments and deductibles for home health care, as well as limitations on the duration of Medicare coverage, have been considered.

On 5 July 1985, the Health Care Financing Administration (HCFA) announced final regulations establishing new national limits on amounts Medicare will pay for specific home health services (22). Previous Medicare limits were based on a single maximum charge, calculat-

ed as that amount at the 75th percentile of all charges of all home health agencies. The new regulations provide separate limits for skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide services. Declining rate limits for each of the six major types of service will be imposed over a 3-year period. In the period 1 July 1985 to 30 June 1986, the limits for each type of service will be set at 120% of the mean industry cost of providing the service. Limits for the following years will be set at 115% and 112%, respectively. Total savings were estimated to be $443 million over the 3-year period (22).

Former Secretary of Health and Human Services Margaret Heckler announced that these new cost limits would not impose any new burdens on Medicare beneficiaries (23). However, witnesses at a Congressional hearing noted that the new regulations would result in a 5% cut in reimbursements to home health agencies at a time when costs are rising and more patients are being discharged earlier from hospitals. These patients were said to be sicker and requiring more complex care for longer periods of time (24).

Subsequently, a home health industry trade publication (25) reported that Beverly Enterprises had reduced its number of home health agencies serving Medicare patients from 128 to the low 20s. Kelly Services was reported to be reducing their Medicare operations from 46 certified agencies in March 1984 to 16, as of the end of August 1985. Both companies indicated, however, that they were not abandoning Medicare or moving out of the home health care market (25).

The American College of Physicians is concerned that low Medicare and Medicaid reimbursement rates for home health care will make such services less available to the elderly and the poor. Because home health care is an appropriate option for the treatment of both acute and chronic long-term care conditions encountered by the elderly, it should be adequately funded by federal and other health care programs. At a time when there is growing demand for home health services, the elderly and especially the poor elderly, will have great difficulty in competing for services if Medicare and Medicaid reimbursement levels are much below market prices. Short-term budgetary savings may ultimately have major adverse long-term consequences not only in terms of health care costs but also in terms of the quality and length of life of many elderly persons and their families.

Position 5

Efforts need to be made to reduce confusion concerning home health care coverage under Medicare and other national health care programs.

RATIONALE

As with most health insurance, coverage for home health care when available is often not well understood. A survey (26) of members of the American Association of Retired Persons by the Gallup Organization in 1984 showed that many elderly thought that Medicare or their private insurance would cover all health care costs, including nursing home costs. Although private insurers are increasingly offering coverage for home health and other long-term care, there is much confusion as to what is covered.

There are currently 47 designated fiscal intermediaries for Medicare home health agencies. Each of these intermediaries provides its own interpretations of Medicare regulations and determines what services are eligible for Medicare payment. Interpretations differ among intermediaries and are not always consistent even from the same intermediary. Recognizing this problem, Congress directed in the Omnibus Deficit Reduction Act of 1984 (P.L. 98-369) that a new system of ten or fewer intermediaries should be implemented by 1 July 1987.

Since 30 October 1972, Medicare had allowed reimbursement for services rendered when neither the beneficiary nor the provider knew or could reasonably have been expected to have known that services would not be covered because they were not "reasonable and necessary." This "waiver of liability" provision (§1879 of the Social Security Act) allowed beneficiaries to receive services and home health agencies to provide services that might be denied upon retrospective review by a fiscal intermediary. On 12 February 1985, HCFA published a proposed rule to eliminate such "waivers of liability," indicating that henceforward home health agencies would be presumed to have the ability to know reasonably whether or not services would be covered. Home health agencies argued that Medicare does not provide sufficient guidance so that such determinations can easily be made in advance, and that claims reviews are so inconsistent that it is difficult to establish patterns of approval. Nevertheless, final rules were published by HCFA on 21 February 1986, eliminating the concept of a favorable waiver presumption for hospitals, skilled nursing homes, and home health agencies. Payment decisions are now made on a case-by-case basis, without any presumption as to a provider's knowledge of what might be covered, when coverage is denied for services found to be custodial or not reasonable and necessary.

Before 1981, payment for home health care would be authorized under Part A of Medicare only if the patient had first completed at least a 3-day hospitalization. Payments were possible under the Supplemental Insurance of Part B, but patients had to first meet a $60 deductible and then could be reimbursed for only 80% of covered charges. Since implementation of provisions of the Omnibus Reconciliation Act of 1980, the 3-day previous hospitalization requirement and the deductible under Part B have been eliminated.

Medicare authorizes payment for home health care services for homebound patients only if the services would be considered as covered services if provided on an inpatient hospital basis. Home health services must be provided on a visiting basis in the patient's home under a treatment plan certified by a physician. Coverage is provided for part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy; medical social services provided under the direction of a physi-

cian; part-time or intermittent services of a home health aide; medical supplies; and medical services provided by an intern or resident in an approved teaching program. Medicare home health benefits had included full coverage for prescribed medical appliances, but since the passage of the Deficit Reduction Act of 1984, payment for such durable medical equipment (whether rented or purchased) is provided with a 20% co-insurance requirement.

Medicare beneficiaries, as well as physicians, generally are unaware of or are confused about Medicare coverage for home health care. The impression is often received that coverage is unlimited. The Medicare Handbook (27) provides some clarification and is available from HCFA without charge. For a Medicare patient to qualify for home health coverage, the law requires that he or she must be under the care of a physician; confined to home; receiving services under a plan of care established and approved by a physician; and in need of skilled nursing care on an intermittent basis or physical or speech therapy.

Medicare does not cover full-time nursing care, custodial or maintenance care, drugs and medicines, personal comfort items, general housekeeping services, "meals-on-wheels," ambulance or other special transportation services, or blood transfusions (27). Medicare insists that the patient be "homebound" to receive home health care. Patients who are able to leave home other than on an occasional basis are not covered for home care but are expected to obtain care on an outpatient basis (28). Medicare will not continue to pay for the nonskilled services of a home health aide after a patient recovers from an acute illness and no longer requires skilled nursing care on an intermittent basis. Likewise, Medicare will not pay for skilled observation and evaluation or patient education at home unless it can be shown that there is another need for intermittent skilled nursing care or physical or speech therapy.

Since the elimination of the 100-visit limitation in 1981, Medicare fiscal intermediaries are not supposed to impose maximum limitations on the number of hours of allowable skilled home health care. Each intermediary is responsible for reviewing each unique case according to the statutory criteria and making appropriate payments for covered care.

Medicaid coverage of home health care differs from state to state. All states cover certain home health services (such as nursing, home health aide, and prescribed medical equipment and supplies). Medicaid coverage is optional with the states for services such as physical, occupational, and speech therapy, and audiology services. As indicated previously, home health care was optional for the states until it was mandated in 1971.

Under provisions of the Omnibus Budget Reconciliation Act of 1981 (§2176 of P.L. 97-35), states may request that the HCFA grant a waiver from certain sections of the Medicaid statute to enable the state to provide home and community-based services to persons who would otherwise receive Medicaid services in a skilled or intermediate care facility. As of 31 May 1984, 76 such waivers had been obtained by 44 states covering 50 000 elderly, disabled, and developmentally disabled and mentally retarded persons (20).

The Veterans Administration provides hospital-based home care to eligible veterans who require medical care after hospitalization that can be provided at home. As of October 1984, this home care was only available to qualifying veterans living within a 30-mile radius of one of the 49 Veterans Administration medical centers with a home care unit. Covered services include physician services, skilled nursing care, rehabilitation therapy, social services, nutritional services, medical equipment and supplies, and prescription drugs. Home health aides and physical, speech, respiratory, and occupational therapy are provided when available at some hospital-based home care units.

The Veterans Administration will pay for some community-based home care, but only for former prisoners of war, veterans of World War I, veterans with a service-connected disability rated at 50% or more, and those enrolled in a Veterans Administration vocational rehabilitation program. The Administration does not pay for home care for other qualifying veterans not living within the service area of a Veterans Administration hospital-based home care unit. Candidates for home care must have a caregiver (usually a family member) with the ability and willingness to participate in the program. Home care is provided without charge and without time limitations. Primary health care is provided for homebound patients who require long-term therapy to maintain status and retard decline, for terminally ill patients, and for patients who with their family need some relatively short-term home health care training to remain at home.

Private insurance differs depending on the company and the plan. The availability of coverage for home health care is, however, increasing as insurance companies respond to consumer demand for home care and the potential for cost savings compared to more expensive hospital care.

The American College of Physicians believes that both patients and providers should be fully informed as to what home health care is covered by Medicare and other insurance. Confusion, especially regarding the Medicare program, should be reduced to a minimum. Variations in interpretation by fiscal intermediaries should also be kept to a minimum, and patients and providers should not be placed at financial risks for denials of coverage that could not be reasonably anticipated. Accordingly, this paper seeks to increase physician understanding of home health care and third-party coverage for home health care services.

Position 6

Physicians need to be more involved in home health care. Physicians should be actively involved in continuing assessments of the functional needs as well as the medical needs of homebound patients and should be able to advise patients on the availability and use of home health services.

RATIONALE

All too often the physician's involvement in patient care management seems to end when the patient is discharged from the hospital. Although Medicare requires the physician to certify a home health treatment plan, typically the physician describes the patient's medical condition to a home health agency and a registered nurse actually develops and implements the home care plan.

Physicians should play an important role in home health care, not only as providers of medical care, but also as case managers and coordinators of care. Physicians should assure that their patients continue to receive high-quality medical care after discharge from a hospital and while receiving treatment in the home.

Unfortunately, the current reimbursement system does not provide any incentives for physicians to become more involved in home health care. Time spent communicating with home health care personnel, devising home treatment plans, completing certification forms, consulting with the patient and family by telephone, or traveling to a patient's home is not reimbursible. Indeed, HCFA maintains that these costs are subsumed in physicians' payments for office visits and home visits.

Many physicians know little about home health care (29). Undergraduate medical education gives home health care little or no attention, graduate residency training provides little or no exposure, and it has received little notice in continuing medical education. Home health care is also generally given scant attention in medical research, except in health services research as a means of cost containment.

The American College of Physicians believes that physicians should become more familiar with what home health care services are available and more actively involved in the treatment and management of patients at home. Changing needs of homebound patients and the necessity for treatments to adjust to changing levels of patient self-sufficiency necessitate that physicians provide ongoing supervision of their homebound patients. The American College of Physicians encourages internists, in particular, as primary care physicians specializing in the health care needs of adults, to take a leadership role in the provision of home health care.

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