OREGON NURSES ASSOCIATION
ACTION REPORT
HOME HEALTH AND HOSPICE
PAY-PER-VISIT COMPENSATION

Submitted by
Cabinet on Economic and General Welfare and
Cabinet on Health Policy

Recommended action:

1. The Oregon Nurses Association oppose pay-per-visit compensation for Registered Nurses employed in Home Health and Hospice settings; and

2. The Oregon Nurses Association work to pass legislation in 2009 to prohibit pay-per-visit compensation for Registered Nurses employed in Home Health and Hospice settings in the State of Oregon.

Background:

A number of Oregon home health care agencies have proposed and some have adopted a pay-per-visit system of reimbursement for Home Health and Hospice registered nurses rather than an hourly wage. This move toward a pay for performance or pay per visit system began in July of 2000, with the introduction by Health Care Financing Administration (HCFA) of a new Medicare payment system targeting home health care service delivery, called the prospective payment system (PPS). Medicare expenditures are critical to the financial viability of the home healthcare industry as Medicare is the single largest payer for home health care services (National Association of Home Care and Hospice, 2007). These changes were motivated by a need to make Medicare expenditures more controllable and predictable than they had been under the previous fee for service system. (3)

This change resulted in a shift from per patient visit home health care billing to a “lump sum” payment for each patient based on “episodes of care.” Episodes of care were defined as a sixty (60) day period beginning from the point at which the patient is enrolled in home health care agency service and corresponds to the initial Outcome and Assessment and Intervention Set, (OAIS) patient assessment and evaluation (Center for Health Services and Policy Research, 2003). The home health PPS relies on an 80-category case-mix adjuster (153 beginning in 2008) to set payment rates based on patient characteristics including clinical severity, functional status, and the need for rehabilitative therapy services. The case-mix adjusted payment rate is similar to the Medicare Skilled Nursing Facility (SNF) and inpatient hospital prospective payment systems.

One of the strategies used by home health care agencies is the reimbursement model of “pay-for-performance” or “pay-per-visit.” The overall objective of the pay-per-visit strategy is to serve more patients and provide more total visits, thereby increasing agency revenues, without increasing total staffing costs. (4) Pay for performance is basically a system of payment to home health care nurses and other service providers for achieving a specific production standard. This translates into pressure on home health care nurses to maintain a daily quota of patient visits and arbitrarily allocating a specific pre-determined charge per patient visit, and frequently an expected time limit on the length of the visit. Many nurses report these time limits are unrealistic and inadequate and result in curtailed services to the patient.
In part, as a result of implementation of this system, many agencies evaluate a nurse’s productivity in home care largely based on the average number of patient visits provided by the nurse per day. The current national home health care visit staff productivity rate (actual visits performed) for RNs per eight (8) hour day is 5.13. (2)

Issues:

Both the agency evaluation system and pay-per-visit compensation are problematic and serve to undermine the nurse’s professional independent judgment and practice and can result in curtailed patient care delivered by the nurse. Another criticism of the pay-per-visit or pay for performance model is the lack of allocated time needed to provide patient and family teaching, thorough patient assessments and psychosocial assessments and basic counseling. This “streamlining” of home health care services translates into fewer and shorter visits to a particular patient during an “illness episode.”

Many health care organization administrations analyze pay-per-visit models from a cost-savings perspective without assessing and appropriately evaluating the impact of this system on quality of patient care, nurse job satisfaction and patient clinical outcomes. Particularly impacted by these issues is nurse job satisfaction. Recent studies have found that the major sources of job dissatisfaction for home health care nurses include feeling “not respected and valued as an employee and lack of control/autonomy in decision-making,” and “too much paperwork, and documentation.” (5) Pay-per-visit reimbursement systems have resulted in increased nurse工作loads, job stress and pressure to meet minimum quotas and resulting job dissatisfaction. Requiring a quota for patient visits per work day in the Home Health and Hospice setting is indistinguishable from mandated staffing ratios in an acute care setting.

It should also be noted that pay-per-visit compensation is increasingly an inappropriate measure of productivity by a Home Health and Hospice nurse because the in-person patient visit patient care related tasks completed outside of the home environment. The pay-per-visit model does not adequately allocate and include time to complete patient care related tasks including coordinating of services among agency service providers, communicating with physicians and primary care providers, referrals to community resources and documentation of patient care delivered as well as lengthy patient assessment protocols.

Conflict of Interest:

The pay-per-visit reimbursement financial incentives foster ethical issues in the delivery of nursing care to home health patients. The model by nature creates a potential conflict of interest between the nurse's financial self-interest and the patient’s welfare. The quality delivery of nursing care and job satisfaction in a Home Health and Hospice setting is further undermined by pay-per-visit competition among RNs for desired low acuity patients or convenient visitation routes to increase individual wages.

Empirical View

Higher levels of nurse staffing and allocation of nursing hours in the care of patients have been shown (in acute care) to be associated with better patient outcomes.
Empirically patient assessments and treatments such as hygiene maintenance, proper wound care, decubiti treatment, medication evaluation and other environmental assessments suffer when an insufficient number of nursing hours are allocated for patient care in the home care setting.

Time allocated for nursing treatment and patient assessment in a home care setting is best determined by the registered nurse, not by a quota system or a supervisor unfamiliar with nursing practice in the field and specific patient needs.

Time allocated for completion of patient care delivery tasks including oversight and coordination of patient care among professional and non-professional staff, as well as home care-givers, is best determined by the registered nurse’s professional clinical judgment.

Oregon Impact:

The adoption of this action report will have little impact on current financial compensation levels and practices by health care facilities and organizations that have collective bargaining agreements with the Oregon Nurses Association. Currently, there is no Home Health or Hospice agency represented by ONA that is utilizing a pay-per-visit compensation model for its represented RNs. The adoption of a legislative bar on pay-per-visit Home Health and Hospice compensation among employers will assure a level competitive playing field. It will avoid the need to individually fight adoption of this type of model each time a collective bargaining agreement is negotiated with a home health care agency.

Financial Impact:

No additional expense above current budgeted program responsibilities.

References


(2) Source: National Association for Home Care & Hospice, Hospital & Healthcare Compensation Service. Homecare Salary

