

# Understand the Models of Care: Make Appropriate Referrals

**There are many choices for in-home care that vary in types of care, payment options and services. Making an appropriate referral is dependent upon understanding the differences and how each fits the situation where care is needed: financial ability, acuity or needs, formal and informal support, to name a few.**

**Private Duty Home Care** (care for which services are paid directly) can be non-medical or medical.

“Private duty services are basically any supportive type of services. They run the gamut of errands and transportation, to companionship, to personal care, to nursing. Basically, whatever services someone needs to stay at home, or to supplement care in a facility for which they have the resources to pay, can fall under private duty or privately paid services. There is not usually a doctor’s order needed, nor is there necessarily even a medical component to the services. The definition of private duty is therefore hard, as it really can be any type of service that is provided to someone who is frail or elderly to allow that person to have more independence in his or her lifestyle or choice of living situation.”  
Excerpted from Caring Magazine, August 2008, Merrily Orsini, MSSW, author.

Private duty/private pay services are usually paid directly by the patient or his or her family members. Long-term care insurance, workers’ compensation and some armed services funding may cover private duty/private pay services if the agency qualifies for reimbursement under the policies, and if the recipient has the policies.

Private duty home care varies according to state licensure and can range from non-medical custodial care services to skilled nursing services provided to clients in their place of residence.

For **Private Duty/Private Pay Services**, there are two models: a full service agency and a nurse registry. The full service model actually employs the caregivers. There is far more safety in this model and far less potential liability for the care recipient. The care provided is by employees of the agency who are screened, trained, monitored and usually bonded and insured.

**Nursing Registries/Healthcare Registries** are the other model of private duty/private pay services. Registries can provide a wide range of services from basic homemaker services to skilled nursing care. This model of agency acts as a “matchmaker” service, assigning workers to clients and patients who need home care. However, they place the responsibilities of managing and supervising the worker on the patient, a family member, or a family advisor or care manager. When a registry or privately placed care provider is in a private home, supervision, monitoring, government-mandated taxes and workers’ compensation coverage usually fall on the consumer. Since the registry does not employ the caregivers, the registry personnel cannot supervise the in-home workers and oftentimes the workers are not trained.



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365 Lake Street • Bristol, NH 03222

**(603) 217-0149**

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**Medicare Home Health** is generally called “Home Health Care” and is a term used to refer to Medicare-certified agencies that provide services which are paid for by Medicare. Medicare is not, and was never intended to provide long-term in-home care. Services are “reimbursement driven”, meaning that the patient has to fit into a specific category for which care is reimbursed by Medicare.

A **Certified Home Health Agency** is an agency that has been surveyed and certified by a state agency to assure all Medicare Conditions of Participation have been met. These include clinical services, operational, financial, billing and other organizational issues.

Certified agencies can also be accredited by the Joint Commission for Healthcare Organizations (Joint Commission) or the Community Health Accreditation Program (CHAP) or the Accreditation Commission for Health Care (ACHC)—any of the three have “deeming authority”. If an agency meets the criteria for accreditation, it also covers the Medicare certification.

**Home Health Care** is skilled nursing care and certain other health care services one receives in a home setting for the treatment of an illness or injury. Medicare covers some home health care if **all** the criteria below are met:

- A doctor decides medical care at home is needed, and makes a plan for that care at home, **and**
- At least one of the following: intermittent (and not full time) skilled nursing care, or physical therapy or speech language pathology services, or a continued need for occupational therapy is needed, **and**
- The patient is homebound—meaning being normally unable to leave home and leaving home is a major effort. If one does leave home, it must be infrequent, for a short time. The patient may, however, attend religious services or leave the house to get medical treatment, including therapeutic or psychosocial care. Receiving care in an adult day-care program that is licensed or certified by a state or accredited to furnish adult day care services is also permitted while receiving home health benefits paid for by Medicare, **and**
- The care must be medically reasonable and necessary. It must be related to problems encountered by the illness or injury and the care plan must address realistic outcomes. The plan and care needed has to show potential for an improvement in health/activities of daily living, **and**
- The home health agency providing the care must be approved by the Medicare program.



**Hospice Care** is a special concept of care designed to provide comfort and support to patients and their families when a life-limiting illness no longer responds to cure-oriented treatments. Hospice care neither prolongs life nor hastens death. Hospice staff and volunteers offer a specialized knowledge of medical care, including pain management. It is generally depicted as end-of-life care and can be in a home or a hospital setting, but one requirement is that someone be with the dying patient at all times.

Most hospices accept patients who have a life expectancy of six months or less and who are referred by their personal physician. The goal of hospice care is to improve the quality of a patient's last days by offering comfort and dignity. Hospice deals with the emotional, social and spiritual impact of the disease on the patient and the patient's family and friends.

Hospice coverage is widely available—offered by most private insurance providers and through Medicare nationwide, and as an optional Medicaid service covered by 47 states (excluding Connecticut, New Hampshire, and Oklahoma).

**Medicaid Home and Community Based Care** is a Federal/State partnership funded by both entities that is intended to provide services for those who cannot afford to pay for care.

Coverage criteria and covered services are determined by each state and recipients do not need to be homebound or ill to receive the services, unlike Medicare-reimbursed home care. Medicaid payments for home care are divided into three main categories: 1) the mandatory traditional home health benefit and two optional programs, 2) the personal care option and 3) home and community-based waivers.

To access Medicaid services, the client must first be assessed by a state agency that gate-keeps the program and be approved for a specific number of home care hours or given a voucher for a certain amount of care. Depending on the state, these vouchers can be used to pay individuals, agencies or registries.