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A Survey of Non-Certified and Non-Licensed Home Health Agencies in Ohio*

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Background

In the past decade, growth in the number of home health agencies nationwide has been dramatic. An increasing older population, reduced length of stay in hospitals resulting from Medicare prospective payment changes, more consumer interest in receiving care at home, and the expansion of federal, state and private insurance coverage for home health services have given home care services an important position in the health service delivery system. Home care services include both “high technology” skilled care and “high touch” personal care services. With total public expenditures of close to $30 billion and private costs estimated to be equally as high, home care has clearly come of age (Congressional Budget Office, 1999).

The public expansion of home care expenditures has occurred through the Medicare and Medicaid programs. Medicare home health, with its primary focus on acute care, has risen considerably, going from $2.5 billion in 1987, to $10 billion in 1995, with 1998 estimates at $15 billion. Medicaid growth has occurred in both skilled home health services and in the personal care services area. Medicaid home health has grown from $440 million in 1987 to over $2.2 billion in 1998. Ohio spent about $34 million on Medicaid home health in 1997. The home and community-based waiver designed for people with chronic disability, has increased nationally from $3.2 million in 1982 to over $9 billion in 1998. Ohio’s aged and disabled waiver program called PASSPORT has increased from $5 million in 1987 to over $125 million in 1998 (Burwell, 1999; Health Care Financing Administration (HCFA), 1998).

Delivered through some 20,000 providers to over 8 million Americans, (NAHC, 1999) home care is available via a range of local and national organizations. The number of Medicare certified

agencies grew dramatically in the early 1980's as Medicare rules made funding more easily available for proprietary agencies. Fewer than 3,000 agencies were certified in 1980 but that number doubled to about 6,000 by 1986. By 1997, there were about 8,500 Medicare-certified home health providers (HCFA, 1998). Privately funded agencies, not participating in the Medicare and Medicaid program, also grew rapidly, with estimates now suggesting that the non-certified agencies actually outnumber those that receive federal certification (National Association of Home Care (NAHC), 1998).

Home health agencies that participate in the Medicare and Medicaid programs have certification and quality review requirements established and enforced by federal and state regulatory units. There are also current efforts underway to identify and track the outcomes of certified home health care via the use of a standardized reporting mechanism on client conditions (OASIS). Although the methods and resources allocated to monitoring the quality of care are routinely criticized, these efforts do exist and are being expanded and improved. Agencies are also under state licensure in 39 states. Eleven states, including Ohio, do not license or regulate home health agencies in any manner.

Certification requirements typically center around the structure of the agency (policies, practices, and staff) and the processes for providing care. Agencies certified for Medicare reimbursement must adhere to established standards for patient rights, qualifications and licensure of agency personnel, service provision, and training of personnel. Each agency is required to evaluate their policies and administrative practices annually, as well as reviewing a sample of ongoing and closed client cases for adherence to clinical practice standards (42 CFR 484). Home health agencies with Medicare or Joint Commission on the Accreditation of Health Care

Organizations (JCAHO) certification are deemed eligible to provide services under Ohio's PASSPORT program. If not certified in these ways, PASSPORT rules stipulate that home health agency representatives must attend training sessions, agencies must have policies in place for providing back-up staff when regularly scheduled staff cannot provide services, have written plans of care, respect patient confidentiality, and give clients 30 days notice regarding termination of service. They must also adhere to the patient rights standards established by Medicare. In addition, personnel who have direct client contact must undergo criminal background checks (OAC 5101:3-12-05). While these activities do not necessarily assure high quality of care, they do ensure that standards for professional practice are observed. They provide a minimal level of security for consumers regarding the qualifications, training, and professional standards of the workers and agencies providing their services. In states such as Ohio, that do not require licensing or certification for operations, home health agencies are not required to adhere to any of the above standards; it is unclear whether they actually do so.

Because of the growth of the home health industry and the tremendous increase in out-of-pocket expenditures allocated to such care, considerable interest has been raised about those home health providers not subject to any regulatory control. How many providers actually exist in this category? What do such providers look like? Should they be regulated by federal, state or private entities? Are there advantages to the consumer in having limited regulations? To respond to these key questions this study examines the non-certified home health providers in Ohio. Because Ohio has no licensing mechanism, these agencies presumably operate without oversight from any governmental authority.

Study Methods

Because non-certified home health agencies in Ohio do not register with federal, state, or local governmental units, identifying the population of home health agencies in Ohio was our initial study challenge. We collected information about home health agencies from a wide array of data sources including: the Dunn and Bradstreet business listing of home health agencies, yellow page listings for each community in the state, classified advertisements for home health providers appearing in newspapers around the state, a listing of all home health agencies that had contracts with the state aged and disabled Medicaid waiver program (PASSPORT); and a listing of those home health agencies certified by the state of Ohio. (See Appendix A for a detailed description of methods.)

After eliminating agencies that were not in the home health business, such as medical equipment companies, and agencies that had gone out of business or changed names, the population included 1,032 home health agencies (See Table 1). Of this group, 475 agencies were certified for Medicare and were excluded from the study population. A somewhat unexpected finding occurred in surveying the remaining providers. Because these agencies were not listed by the Ohio Department of Health as certified agencies we assumed that this group represented our population of non-certified providers. However, during the survey follow-up process we discovered that a number of these agencies are certified to participate in the Medicare and Medicaid programs as satellite providers under the umbrella of one of the 475 certified agencies. For example, one certified home health agency provided the certification for 22 other agencies operating under the same

Medicare certification number. These agencies operate with different names in different localities of the state, but are actually viewed by Medicare as one provider.

Table 1
Home Health Agencies in Ohio

Type of Agency	Number
Medicare/Medicaid Certified	475
Satellite Agencies*	367
Non-certified or Unlicensed by State or Public Entity	190
Total Home Health Agencies in Ohio	1,032

*Listed as a separate free standing agency but operating under the license of a certified agency.

Because there was no state or federal listing of these satellite agencies we used a telephone survey process to redefine our study population. We contacted each of the agencies that had not been contacted or identified as certified during our survey follow-up process, and identified 190 actual non-certified agencies, and 367 "satellite" certified agencies. Some of the non-certified agencies had been included in our original sample; we drew a second random sample to bring our total random sample to 100. Data were collected by two interviewers using a structured telephone interview. Fifty-nine of these non-certified providers either completed the original mailed survey or the follow-up telephone interview. Of the remaining respondents, 4 refused to participate, 1 did not know if they were certified, and the others were not available for an interview after 3 telephone attempts.

Agency Profiles

Concerns about non-certified agencies were dominated by the issue of whether home health providers should be allowed to operate without any regulating oversight, leaving the consumer totally responsible for assuring quality of care. We found that a large proportion of the non-certified agencies had some form of external oversight. In order to draw comparisons among these providers, we classified them by type of oversight, as follows: (1) those affiliated with a regulated entity such as a certified home health agency and other related businesses, (2) those receiving public dollars through the state PASSPORT program, Social Services Block Grant, Older Americans Act funds, or through county levy programs, and (3) agencies serving only private pay clients, and thus receiving no external regulatory oversight (see Table 2). Just under one-third of the non-certified agencies were placed in the affiliation category. All of these are affiliated with a Medicare certified agency, and one quarter are also affiliated with a hospital. A little over 10% of these agencies were also affiliated with a nursing home, and another 10% were also affiliated with a temporary employment agency. About one-half received public funds that included some level of regulatory requirements. About one in five of the agencies served exclusively private pay clients. Some of the agencies actually can be categorized in two ways. For example, 16 agencies are affiliated with a certified provider and also get PASSPORT funding. Because PASSPORT rules assure minimal standards in a way that mere affiliation may not, we classified agencies according to the category where they were presumed to have the greatest degree of oversight. Applying the percentages from our sample to the population of home health agencies, we estimate that 38 of the 1, 032 home health agencies in operation statewide, actually have no governmental oversight.

Table 2
Non-Certified Home Health
Agencies in Ohio: Survey Results and State Estimates

Number of Non-Certified Home Health Agencies	Affiliated with Hospital, Nursing Home, County Health, or Certified Agency	Received Public Funds and Some Regulatory Over Sight	All Private Pay	Total
Survey Responses	18 (31%)	29 (49%)	12 (20%)	59
State Estimate*	59	93	38	190

*Assumes non-responders to survey were random and may underestimate the smaller providers.

In examining organization characteristics for our sample of non-licensed providers we find that on average agencies have been in operation for about 12 years, with the range of 1 to 43 (see Table 3). The private pay only agencies reported significantly longer tenure than the affiliated group of agencies, and also serve fewer clients than the other two types of agencies.

Table 3
Profile of Non-Certified Home Health Agencies

	Type of Agency		
Characteristic	**Affiliated**	**Govt. Payment**	**All Private Pay**
Length of Time in Business	6.8	12.5	14.2*
Mean Year's of Director Experience	13.7	9.5	10.7
Mean Number of Clients Served	101	233	68
Clients by Age (Percent)			
Under 44	2.0	1.0	5.4
45 - 64	9.8	8.9	12.3
65 and over	88.2	90.1	82.3
Size of personal Care Staff (Includes Homemaker, Home Health Aides, Personal Care Aides)	54.6	43.9	37.6

p # .05

As shown in Table 4, agencies report delivering an array of services ranging from transportation and personal care, to nursing and infusion therapy. Personal care, home health aide or homemaker services are the key services provided across these agencies. Variation occurs with some agencies specializing in supportive services and others providing services at the high tech end of the service spectrum. About 45% offer skilled nursing services, about 12% hospice, and just under 10% provided infusion therapies. Approximately 4 of 10 provide transportation and two-thirds offer a companion service. Service offerings did vary by agency type. The affiliated agencies are more likely to deliver nursing and infusion therapy compared to the other organizational types. Sixty percent of affiliated agencies offer nursing service, compared to 45% in the public payment group, and about one-third of the private pay category. Hospice service was not significantly different

across agency types. The affiliated agencies were significantly more likely to provide infusion therapy, but even in this group of agencies less than 12% reported providing the service.

Table 4
Services Directly Provided by Type of Non-Certified Agency and Unit Cost

	Affiliated Agency		Govt. Payments		All Private Pay		Total	
	Percent Providing	Avg. Unit Cost	Percent Providing	Avg. Unit Cost	Percent Providing	Avg. Unit Cost	Percent Providing	Avg. Unit Cost
Transportation	41.2		27.6		50.0		36.2	
Personal Care	100.0	$12.35	89.7	$13.56	75.0	$13.48	89.8	$12.97
Home Health	88.2	$13.20	82.8	$13.10	75.0	$12.60	82.8	$13.04
Homemakers	100.0	$11.88	93.1	$11.99	91.7	$13.74	94.9	$12.17
Companions	76.5		55.1		75.0		63.8	
Respite	100.0		65.5		66.7*		75.9	
Nursing	58.8	$35.71	44.8	$35.84	33.3***	$20.83	46.6	$33.91
Hospice	12.6		10.3		16.7		10.5	
Infusion	11.8		6.9		8.3**		8.6	
N=	18		29		12		59	

* p#.05
** p#.01
***p#.001

In reviewing service unit cost we find that skilled nursing costs are significantly lower for the private pay agencies compared to the other two agency types ($21 vs. $36). Rates were generally comparable for the personal care, home health aide, homemaker services. The cost differential on the skilled nursing services may reflect different organizational structures and policies employed by the private pay agencies. That there are no substantive or significant differences in the rates for personal care is an interesting finding. Agencies under contract to public program entities such as PASSPORT have reported that regulatory requirements have increased costs. The private pay

agencies are not subject to such regulations, but report comparable costs on the personal care services.

Quality of Care

In an effort to explore the quality of care issues faced by these agencies we asked a series of questions about employee screening and training, and agency monitoring activities. As shown in Table 5, virtually all of the agencies require references and in-person interviews, although variation exists on some of the other employee screening and hiring strategies. The private pay agencies consistently report a lower proportion of pre-employment activities, such as criminal background checks, finger printing, physical exams, drug screens, and skills testing. The private pay agencies are also less likely to have in-service training for staff.

In looking at the quality monitoring efforts we see that the majority of agencies report such activities. Table 6 shows that four of five report the use of client satisfaction surveys and about two-thirds make either random calls or home visits to check on the quality of services. The private pay agencies are consistently less likely to have monitoring activities compared to the affiliated or government agencies. For example, about three-quarters of the affiliated and government agencies reported making random home visits, compared to one-quarter of the private pay agencies. The private pay group was also less likely to have liability insurance protection for staff members. (For further information on these findings a copy of the questionnaire with total responses for each question can be found in Appendix B.)

Table 5
Employee Screening and Training Activities by Type of Non-Certified Agency

	Affiliated Agency (%)	Govt. Payments (%)	All Private Pay (%)	Total
Reference Check	100.0	100.0	100.0	100.0
Fingerprinting	72.2	89.7	41.7**	74.6
Criminal Background Check	83.3	82.8	50.0	76.3
Physical Exam	44.4	31.0	25.0	33.9
Telephone Interview	38.9	27.6	41.7	33.9
In-Person Interview	100.0	100.0	100.0	100.0
Aptitude/Skills Test	55.6	41.4	25.0	42.4
Drug Screen	33.3	20.7	0.0	20.3
Pre-Service Training				
Required	88.9	63.0	77.8	74.1
Home Health Aides	73.3	66.7	50.0	67.7
Homemakers				
Employ Certified Aides	100.0	96.4	81.8	94.7
In-Service Training				
Home Health Aides	94.4	96.4	87.5	94.4
Homemakers	86.7	92.3	50.0	84.4
Supervise in the Home				
Home Health Aides	100.0	96.4	100.0	98.2
Homemakers	100.0	91.7	75.0	93.5
N=	18	29	12	59

**p#.01

Table 6
Quality Monitoring Activities by Type of Agency

	Affiliated Agency (%)	Govt. Payments (%)	All Private Pay (%)	Total
Customer Satisfaction Surveys	88.2	79.3	72.7	80.7
Random Calls to Clients	76.5	69.0	54.5	68.4
Random Home Visits	82.4	71.4	27.3**	66.1
Complaint Line	76.5	75.0	45.5	69.6
Performance Tests for Homemakers	50.0	50.0	44.4	48.9
Performance Tests for Home Health Aides	64.7	64.3	54.5	62.5
% Doing 5-6 of Activities Above	44.4	34.4	16.6	33.8
Provide Liability Insurance for Staff	93.8	100.0	50.0*	93.8
Provide Bonded Staff	62.5	84.6	50.0	71.0
N=	18	29	12	59

* p#.05
** p#.01

Agencies were also asked a series of open ended questions about quality and regulatory efforts needed for home care agencies. Although some variation was present across respondents, the majority view was that some regulatory efforts are needed. The following quote was typical of the answers in this category: "It worries me that anyone can be a home health agency without any sort of license. Our agency is good and we adhere to strict standards of quality. Some may provide lousy care and take advantage of our elders, but by law they are allowed to do it under the current system of licensing."

Despite the general agreement on the need for some regulatory activities, there was less consensus on how to actually implement an effective regulatory strategy. "I do not want to promote

stricter regs because it will increase bureaucracy and costs," was a typical response. One provider summed up the dilemma by indicating that they are operating nicely under the current approach, but that the industry in general needs stricter regulatory controls. Thus, while providers recognized the need and importance for some regulations, they are worried about a bureaucratic, costly and ineffective approach that will add cost to services and not improve the quality of the industry.

Policy Recommendations

Results from this study indicate that about 200 or about 20% of Ohio's home care agencies operate without certification or license. Of this group we estimate that 38 (19%) operate without any regulatory controls or organizational oversight. The remaining agencies are either affiliated with organizations that are externally regulated, or have governmental contracts that include a monitoring and regulatory function. The 38 agencies with no external regulatory controls represent less than 4% of the home care agencies in the state.

The agencies with no regulatory controls do exhibit some different practices that may be related to quality of care. They are less likely to use employee screening and monitoring activities when compared to the affiliated or governmental contract agencies. They are less likely to make random visits or calls to the home, they have less employee pre-screening and lower rates of employee training. These agencies are also less likely to provide nursing care, although rates for personal care do not vary by agency type. Whether differences on these screening and monitoring activities actually have an ultimate effect on the quality of the care provided is unknown.

Based on these findings we make two key recommendations:

(1) In light of the differences between agencies we recommend that some mechanism be instituted to ensure that each agency receives some type of regulatory oversight. We do not recommend a

single system, but rather a range of options that could include: professional accreditation by JCAHO, CHAPS, or even the state home care association; governmental contract monitoring (i.e. qualifying as a PASSPORT provider or other governmental service provider); add-on to affiliated agency review, or state certification where none of the above options were met. With a requirement for a limited amount of standardized information from all providers, the state could provide flexibility, but have all agencies operating in the state under a minimum set of requirements. A random audit of agencies could be used to monitor such an approach. At minimum, each agency should be required to register their operations in order to identify the number and location of organizations providing home health services in the state.

(2) Given the limited information available concerning which regulatory approaches are indeed successful, we recommend additional research examining the effectiveness of regulatory and quality strategies. For example, do the annual surveys that other states use for licensing relate to differences in outcomes for clients? Studies in this arena will help the state add meaningful regulations in a cost-effective manner.

Comments from our telephone interviews indicate that the majority of providers would welcome a simple set of standards with which all providers should comply. Some providers are not certified only because they do not provide skilled nursing or other services that would qualify them for certification. The ability to legitimize their operations through a registration procedure appears to be welcomed by a number of respondents. Because the proportion of non-certified agencies operating without any outside oversight is so low, it is also necessary to minimize the burden on the majority. The multiple option approach would allow those organizations who already have some oversight mechanisms in place to continue current operations, while ensuring that those without oversight could be monitored.

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Appendix A

Identifying the population of non-certified home health agencies had two main challenges: 1)Identifying all home health agencies, and 2) excluding agencies that were certified from the population in the study. The database of home health agencies was developed during the summer of 1998. The following sources were used:

1) Dunn and Bradstreet data on 758 home health organizations provided by the Ohio Department of Health.

2) OSCAR Facility Listing of Certified Home Health Agencies from the Ohio Department of Health. These agencies were checked against the Dunn and Bradstreet data and identified as certified. If they did not appear in the Dunn and Bradstreet data they were added to the database.

Organizations identified through the following sources were checked against the existing database. If they did not appear as a match (i.e. same name, address, and telephone number) they were added.

3) Internet Yellowpages Telephone Directories. These included GTE Superpages, Ameritech Yellowpages, and AOL Yellowpages. (All of these searches conducted May 13, 1998.) New organizations not appearing in the first two data sources were added.

4) Area Agencies on Aging. All were contacted and asked to provide lists of home health agencies in their area. In most cases, there were two lists—one for distribution to the public as a referral list, and another list of PASSPORT providers. The Ohio Department on Aging also provided their list of PASSPORT Procurement Providers—those organizations that contract with the PASSPORT program.

5) Classified advertisements for home health aides. The web site http://www.ohio.com allows for a search of classified ads from 90 newspapers, and from other job web sites. Each address and phone number were searched against the database built from the above sources and added if they were not in the list already. In addition, two Sunday issues from the Cincinnati Enquirer were also searched. It appeared that no different ads appeared in the paper than on the web site.

6) Other newspapers in Butler County. As a final check on the completeness of the database small weekly or bi-weekly newspapers from Westchester, Fairfield, Oxford, and suburban Cincinnati were collected. No new agencies were identified from these sources so we felt confident that a search of smaller newspapers would not be effective. Several specialized senior publications were also checked against the database with a similar result.

7) The Home Care on the Internet web site http://www.homecare.org/) was searched for Ohio agencies. These agencies were checked against the existing database and added.

A final step sorted the database by agency name, street address, and telephone number to identify duplications. In some cases agencies with different names had the same street address or the same telephone numbers. Other agencies with the same name showed different street addresses or different telephone numbers. These agencies were contacted by telephone in order to determine which name or address was correct. Those with disconnected telephone numbers were eliminated, and discrepancies in name or address were corrected after talking with agency personnel. We also excluded a number of agencies that were included in the Dunn and Bradstreet data but listed their primary business as other than home health. We eliminated all organizations having Standard

Industrial Codes (SIC) other than 80820000, 80829901, and 80829902 listed as their primary or secondary line of business. (Dunn and Bradstreet listings provide up to three SIC codes for each organization.) These final steps reduced the number of home health agencies in our study population from 1708 to 1507, with an assumed non-certified population of 1,032 agencies. Telephone contact with the presumed non-certified agencies identified 367 satellite offices of certified agencies and 190 non-certified agencies.

Appendix B

The 1998-1999 Survey of Non-Certified Home Care Agencies in Ohio

Description of Findings

(n= 59)

*** Percentages may not add up to 100% due to rounding or missing responses.*

Agency Characteristics

1. In what year did your non-certified home care business begin? **1987 (1956 – 1998)**

2. Is your business operated as part of a chain?

    81% No
    19% Yes

3. Is your non-certified business owned or operated in conjunction with a Medicare/Medicaid certified home health organization?

    64% No
    31% Yes

4. Is your business associated with another type of health care organization such as a hospital, nursing facility, medical equipment supplier, or a temp agency?

    61% No
    24% Yes

    If **Yes,** please specify in the space below the **type** of organization you are associated with? *(i.e., hospital, nursing home, medical equipment supplier, temp agency)* ***(n=21)***

    33% Hospital
    14% Nursing Home
    5% Durable Medical Equipment Supplier (DME)
    29% Temporary Staffing Agency
    5% Adult Day Care
    5% MRDD Group Homes
    5% County Health District

Services

5. Which of the following services are provided by your non-certified business? For each category, please check only **one** box:

DIRECTLY- *provided by your business, either by your own employees or*

through subcontractors

RELATED BUSINESS- *Provided by a separate company within your business's corporate structure (i.e., affiliate or subsidiary organization)*

NOT AVAILABLE- *Not available through your business*

Services	Directly	Related Business	Not Available
Transportation Services	36%	7%	56%
Personal Care Services	90%	2%	9%
Home Health Aides	81%	3%	14%
Homemakers	95%	0%	5%
Companion Services	63%	2%	32%
Respite Care	75%	0%	24%
Nursing Services	46%	12%	41%
Hospice Services	10%	12%	73%
Infusion Therapy Services	9%	17%	73%

Other services offered by a few agencies include: **Physical, Occupational, or Speech Therapy, Case Management, Housekeeping, Meal Delivery Service, Emergency Response System, Telephone Reassurance.**

6. What are the charges for services that are directly provided by your non-certified business?

Directly Provided Services	Cost	Per	Unit
Nursing Services (RN, LPN)	$ 29.95	Per	Hour
Range: $10-$75 per hr			
Home Health Aide	$ 13.04	Per	Hour
Range: $10-$18 per hr			
Homemaker	$ 12.17	Per	Hour
Range: $7-$18 per hr			
Personal Care Assistant	$ 12.97	Per	Hour
Range: $7-$16 per hr			

7. Typically, what **percentage** of your non-certified business' income comes from each of the following sources below? *(Percentages for all categories should equal 100%)*

43%	**Out of Pocket (insurance, private pay)**
0%	**Workers Compensation**
1%	**Veterans Administration**
3%	**County Levy**
2%	**Title III (Older Americans Act programs)**
2%	**Title XX (Social Security Block Grant)**
43%	**PASSPORT Waiver (Home Services Facilitation Waiver)**
1%	**Staffing services at facilities (hospitals, nursing homes, etc.)**

Other sources of income include: **Care Coordination, Managed Care Payors, Hospitals, Alzheimer's Association, Nursing Home-Sitters, United Way, and MRDD.**

Client Characteristics

8. Please provide a count of your **active clients** as of September 1, 1998 by gender and age groupings. (*Use the age of the client on the date of admission.)*

Age in Years	Male *Avg. Count (Range)*	Female *Avg. Count (Range)*
0-2	0 (0-15)	0 (0-15)
3-18	0 (0-11)	0 (0-5)
18-44	1 (0-10)	1 (0-15)
45-64	4 (0-108)	10 (0-262)
65 and Over	45 (1-915)	96 (0-1921)
Total	53 (1-1023)	105 (0-2183)

Total: 159 (1-3206)

Staffing

9. For each position listed below, indicate how many full-time, part-time, or contract employees currently fill each position.

	Full-Time Employee *Avg. Count (Range)*	Part-Time Employee *Avg. Count (Range)*	Contract Employee *Avg. Count (Range)*
R.N.	1 (0-7)	2 (0-25)	0 (0-5)
L.P.N.	1 (0-10)	2 (0-40)	0 (0-5)
Personal Care Aide	10 (0-60)	13 (0-200)	6 (0-150)
Homemaker	2 (0-50)	4 (0-50)	0 (0-0)
Home Health Aide	3 (0-50)	8 (0-85)	0 (0-25)

10. What percentage of your direct care staff perform both personal care and homemaking duties? **91%**

11. How many home health aides and homemakers (both full and part time) left your agency in the last 12 months?

Average Turnover Rate: **59%**
Range of Turnover Rates: **0% - 230%**

Turnover Rates were estimated by the total number of paraprofessional staff that had left the agency in the past 12 months divided by the total number of paraprofessional staff of the agency.

12. What prior experience/training does the Administrator/Director have? (*Answer these questions based on the highest level person at the non-certified agency.)*

A. Highest level of education/highest degree

7% **High School/ GED**
12% **Some College**
42% **College Degree**
25% **Masters Degree**
7% **Doctoral Degree (PhD, MD, PharmD)**
2% **Specialized Training/Certificate**

B. Number of years in the home health field **11 years (0-30)**

C. Number of years working for this agency **6 years (1-20)**

Staff Selection and Training

13. Before hiring any employee, which of the following occur: *(Check all that apply)*

100% **Employment Application Forms**
100% **Reference Check**
75% **Fingerprinting**
76% **Criminal Background Check**
34% **Telephone Interviews**
100% **In-Person Interviews**
42% **Aptitude/Skills Test**
20% **Drug Screen**
34% **Physical/ Medical Exam**

14. Do you require pre-service training for your home health aides? *(n =54)*

26% **No**

74% **Yes**

If **Yes,** how many hours of training do you require? **32 hours (0 - 83)**
If **Yes,** where is the training usually obtained?

67% In-house
22% Certified Training Course for Nursing Assistants
6% In the clients' homes
3% CPR Certification Course

15. Do you require pre-service training for your homemakers? *(n = 31)*

29% **No**
68% **Yes**

If **Yes,** how many hours of training do you require? **23 hours (2 - 75)**
If **Yes,** where is the training usually obtained?

75% In-house
19% Certified Training Course for Homemakers
6% In the clients' homes

16. Do you currently employee any certified home health aides? *(i.e., CNA, STNA)*

5% **No**
92% **Yes**

If **Yes**, how many certified home health aides do you currently have? **31 (1-125)**

17. Do you offer on-the-job/inservice training for your home health aides? *(n =54)*

6% **No**
94% **Yes**

If **Yes,** how many hours of training do you offer annually? **15 hours (6–48)**

Describe the on-the-job/inservice training that is required annually of home health aides: **Back Safety/Lifting (51%), OSHA/Infection Control (84%), Documentation Skills (40%), Job-Related Skills (31%), Skills Check/Test (4%), Monthly Staff Meetings (7%).**

18. Do you offer on-the-job/inservice training for your homemakers? *(n=31)*

29% **No**
68% **Yes**

If **Yes,** how many hours of training do you offer annually? **23 hours (2-75)**

Describe the on-the-job/inservice training that is required annually of homemakers: **Back Safety/Lifting (59%), OSHA/Infrection Control (77%), Documentation Skills (59%), Job Related Skills (18%), Skills Check/Test (5%), Monthly Staff Meetings (9%).**

19. Do your supervisors observe home health aides in the home? *(n=55)*

2% **No**
98% **Yes**

20. Do your supervisors observe homemakers in the home? *(n=31)*

7% **No**
93% **Yes**

21. What is the hourly pay for your home health aides?

$7.95 ($6-$11) **Highest Paid Home Health Aide**
$6.60 ($5.45- $9) **Lowest Paid Home Health Aide**
$7.27 **Average Pay**

22. What is the hourly wage for your homemakers?

$7.34 ($5.25-$9) **Highest Paid Homemaker**
$6.43 ($5.25-$7) **Lowest Paid Homemaker**
$6.88 **Average Pay**

Service Delivery and Monitoring

23. Which approaches do you use to monitor the delivery of your non-certified services? *(Check all that apply)*

81% Customer Satisfaction Surveys
68% Random Verification Calls to Clients
65% Random Home Visits
61% Performance Tests for Home Health Aides
40% Performance Tests for Homemakers
68% Complaint Line (Telephone)

24. What are the **advantages**, if any, of not being certified for Medicare and/or Medicaid reimbursement? ____
____
____
____
____
_____

25. Many other states license home care. What is your opinion regarding licensing for home care agencies in Ohio? ____

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Thank you for your time and input.