Home Health Care & Licensing Standards

Executive Summary

Home health is a type of medical care that delivers care in patients' homes rather than in a centralized location (such as a nursing or convalescent home). This type of care is making up a growing portion of the marketplace for medical needs of older adults. Many of these services are approved and funded by the federal Medicare or Medicaid programs, and require relatively minimal training requirements. While some states have restrictive policies regarding the scope of practice of health aides or duties aides can perform under a supervising nurse, some pilot studies have looked into the viability of delegating more duties to home health aides. Introduced in the Missouri 2022 legislative session, HB 2371 expands the list of medical professionals that are eligible to plan and provide support for home health services to include podiatrists, nurse practitioners, clinical nurse specialists, and physician assistants

Highlights

- One study has found that **when nurses were authorized to delegate home health treatment plans** (such as medications and other tasks) to home health aides, **there were no adverse outcomes to health and higher levels of patient satisfaction**.
- Home health was estimated to cost $18 billion in annual Medicare spending in 2017, covering roughly 3.4 million home-bound Americans.
- There is a growing need for workers in the home health care field; Missouri has seen a steady increase of workers from 2009-2020.
- Rural, Black and Latino minorities, and low-income older adults are less likely to utilize and have access to high-quality home health services.
- Barriers to increased workforce recruitment and retention of home health aides include:
    - Low wage or hours, uncertainties in immigration policies, low-quality supervision, lack of career mobility, occupational safety hazards, stigma of work, lack of training, and perceived lack of value.

Limitations

- Overall, there is little research on the impact of home health and home care aide scope of practice or delegation of duties to aides on access to care.

Research Background

Home Health Care Use and Access

Increasingly, many adults may seek to remain in their homes and "age in place" as opposed to shared community facilities. However, obstacles such as cost, access to home services, and the

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ability for family members to help may serve as a barrier to this desire.[1] *Home health* is a collection of medical services (such as glucose monitoring, administering of enemas, eye drops, feeding tubes, medications, suppositories, catheters, oxygen, insulin, nebulizers, or injections) that delivers care in patients' homes rather than in a centralized location such as a doctor's office, hospital, nursing home, or hospice.[2,3] Timely initiation of home health care, particularly in acutely ill patients, can prevent re-hospitalizations; a study in diabetes patients has found that delayed home health care initiation can result in four-times greater odds of re-hospitalization after a diabetes-related admission.[4] Maintained home health care and screening procedures can also prevent patients from having to be admitted to the hospital (such as by preventing low-grade infection from progressing to sepsis).[5] As a growing segment of the Medicare program, home health was estimated to cost $18 billion in annual spending from the program as recently as 2017, covering roughly 3.4 million home-bound Americans.[2]

Nationally, Black and Hispanic Americans have a roughly 2-3% lower use of high-quality home health services compared to their White counterparts. Low-income Americans are also a percentage point lower in their use of high-quality home health services.[2] Missouri placed in the bottom 40% of states in the use of home health services through the Medicare (Part B) program in 2018. Patients approved through Medicare in Missouri utilized the service roughly 2-3 times per month compared to states like Tennessee, where Medicare patients use the service roughly 3-4 times a month on average (**Figure 1**).[6] Rural seniors often lack the ability to access home health services given a lack of qualified professionals that are licensed to provide home health care in these areas.[7]

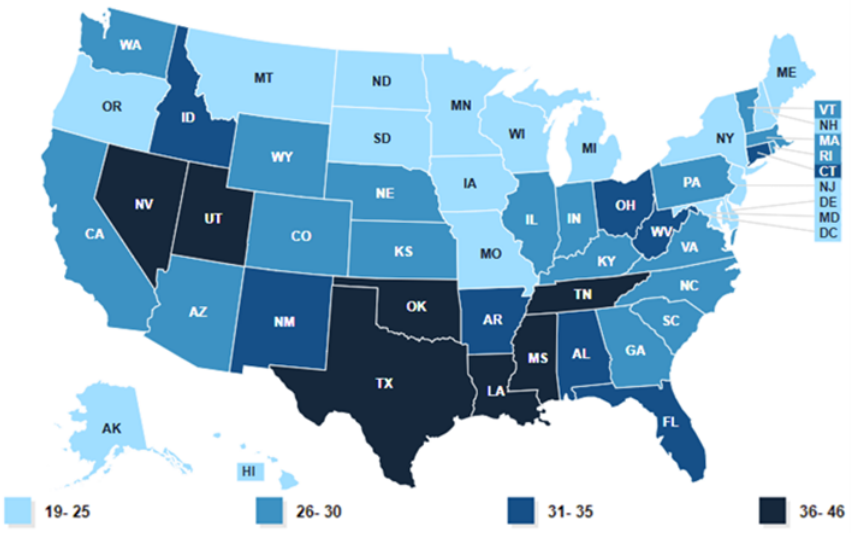

Figure 1: Map of use of Home Health Services by Medicare Patients. This map shows the number of home health visits for the average Medicare patient in each state when utilizing home health care services. Map reproduced from the Kaiser Family Foundation.[6]

Home Health Workforce & Licenses

As of 2020, roughly 800,000 home health aides served patients through the various Medicare, Medicaid, and private-insurance programs. A study found increased need in home health care workforce, with Missouri seeing a growth of approximately 60 more home health employees per 1,000 people with disabilities in the state (as well as a consequent drop in nursing home

workforce) between the years 2009–2020.[8] Finally, one study found that home health care agency chains made up higher proportions of the market, and yet for-profit, non-chain agencies were the most likely to serve dual-eligible Medicare-Medicaid beneficiaries, African Americans, and those living in urban areas.[9]

Workers are mostly female (88%), minority (50%), have no college education (50%), and are low paid (average wage in 2017 was $11.12 per hour).[10] While formal education and training requirements vary by state, employees serving the Medicare and Medicaid patient pool must have 75 hours of training and pass a competency exam. Home health agencies are also required to have business-specific licenses by the Bureau of Home Care and Rehabilitative Standards within the Department of Health and Senior Services. Barriers to increased workforce recruitment and retention of home health aides include stigma of work, lack of training, perceived lack of value, low wage or hours, uncertainties in immigration policies, low-quality supervision, lack of career mobility, and occupational safety hazards.[11] Unlicensed aides include independent workers, family, or friends who may provide aid unaffiliated with a regulated home health agency, and therefore have a limited scope of permitted care, often limited to home maintenance.[3]

Research on Home Health Coverage, Care, and Practices

Some individuals enroll in the Medicare Advantage (Part C) plan, in which health insurance companies negotiate contracts with the federal government to cover traditional services covered in Medicare, plus any tailored services the patient may anticipate needing not normally covered in Medicare (often at an added cost). A review showed home health care use through this plan was significantly lower than through traditional Medicare, and that beneficiaries in these Part C plans were more likely to get low-quality home health services. Qualities of a good home health care service may include the timeliness of initiation of care, drug education and management of patient medications, distribution of flu shots, whether the patient improves their ability to walk, get out of bed, bath, have less pain, breathe easily, and whether the patient must go back to the hospital).[12,13]

The Medicare Payment Advisory Commission has recommended home health services to adopt a fee-for-service incentive model (currently in use in IA, NE, and TN) for home health care that focuses on quality of service over number of patients covered.[14] Another study found that reducing Medicare reimbursements, if not previously hospitalized, may put vulnerable patients' needs at risk. It also found that Medicare patients who were receiving home health care through a community referral were more likely to have concurrent Medicaid needs and coverage, have dementia, and have more episodes of home health needs than individuals who had previously been hospitalized.[15]

In regards to scope of practice (SOP) policies, some evidence indicates that expanding home health aide SOP (particularly when administering medications and other treatments) would allow for more well-rounded care and reduce nurse workload. Conversely, there is no evidence that restrictive SOP improves patient outcomes and safety.[3]

Further, a New Jersey study of 19 home health agencies found that **when nurses were authorized to delegate home health treatment plans** (such as medications and other tasks) to home health aides, **there were no adverse outcomes to health and higher levels of patient satisfaction**. Another study found that worse patient outcomes were most likely to occur when nurses were planning and delegating medical work for less than 5 years to unlicensed home health aides.[3] A survey of home health aides in 4 states (MA, MT, OR, and TX) found that workers were willing to take on more tasks if granted more training from supervising nurses (with the exception of injections and wound care) and that teleconsulting technologies could help with properly administering tasks and treatments.[16] However, overall, there is little research on the impact of home health and home care aide scope of practice or delegation of duties to aides on access to care.

Effects of the COVID-19 Pandemic

In 2020, the home health care industry saw a roughly 92% drop in revenue as a result of the start of the COVID-19 pandemic. Over the course of the COVID-19 pandemic, need for social service supports increased, loneliness and depression increased among patients, physical and mental health conditions became exacerbated, substance use and abuse increased, and evidence of domestic violence against patients increased. However, there was a limited amount of staff and equipment to care for home health care patients.[17] Generally, physicians are the only authorized professionals to certify patients through Medicare for home health services. The 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act, however, further authorized nurse practitioners, clinical nurse specialists, and physician assistants to certify Medicare patient eligibility for home health.[10]

Federal Policies and State Legislation

Some states (such as IA and IL) have elected to provide expanded home health care through the Medicaid program (in particular for seniors between the age of 50-64 before Medicare eligibility) in addition to available Medicare home health support.[18] These states are required to apply for a "Home and Community-Based Service Waiver" through the 1915(c) Medicaid waiver program.[7] Importantly, at present Missouri does not have an active 1915(c) Medicaid waiver for home health care for older adults.[19] As recently as 2020 (before the expansion of MO HealthNet), data shows home health support was provided to 3,500 Missourians through the state Home Care Program, with explicit eligibility criteria including the patient needs are short-term or for an acute condition, the patient is homebound, and the services are ordered by a physician.[20,21] A remaining 35,100 Missourians who fall under developmental/autistic disabilities, AIDS disabilities, general medical fragility, long-term daycare services, living with family members, or require limited community support services, are supported through Medicaid Home and Community-Based Support.[21,22]

Introduced in the Missouri 2022 legislative session, HB 2371 expands the list of medical professionals that are eligible to plan and provide support for home health services to include

podiatrists, nurse practitioners, clinical nurse specialists, and physician assistants, in addition to the already approved physician.

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