Home Health Care: Healing Where the Heart Is

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For select patients, care at home can be as good or better than care in a hospital/clinic; this improves quality of life for patients and lowers costs for the payers.

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Tension exists for patients between the desire of being comfortable in the familiar setting of home, the need for treatment of ongoing illness, and advances in medical technology and health care delivery systems. This tension is a relatively recent occurrence and is associated with the industrialization of medical care into larger institutional settings.[1] Home health care serves an important role in lessening this tension by providing much of the benefit of modern medical care in the home setting.

Home care often best meets patients' emotional needs during their experience of illness. Home care can lessen the need and challenge of gaining access and travel to physician offices and/or medical care facilities. An increasing number of basic and sophisticated services are being provided by home health care agencies coupled with improvements in technology available in the home. With value-based purchasing and other changes in health care finance, home care is potentially an attractive means of lowering institutional costs and keeping health care costs low. There is evidence that for select patients, care at home can be as good or better than care in a hospital/clinic; this improves quality of life for patients and lowers costs for the payers.[2]

The experience of home is deeply rooted and intrinsic to a person's understanding of self. Activities of adults tend to revolve around home. As a person's abilities become restricted due to illness and disability, activities become even more home based. Gillsjo, in a qualitative study, summarizes the desire of older adults to stay at home as follows: "The home is the place the older adult cannot imagine living without. The home, is built with others, it is the place closest to the heart, where the older adult is at home, one's stronghold and place of freedom that has a special atmosphere."[3] When medical problems or needs develop, there is a clear desire that health services not disrupt the home experience. This desire manifests in various ways: patients want medical care to minimally interfere with home time and, when possible, medical care to be delivered at home or at least in home like settings.

During the 20th century, with improvements of public health, patterns of disease shifted to chronic illness from the previous prevailing infectious illness.[4] Chronic disease care often extends over many years of life and may reduce quality of life and threaten independent living.[5] Organized home care developed early in the United States, with the Charleston Ladies Benevolent Society taking

For select patients home health care can be higher quality and lower cost than hospital or nursing home care.

up the cause in 1829. Over the ensuing years, other efforts ensued, most notably Metropolitan Life Insurance funding of Visiting Nurse Association home visits between 1909 and 1950. Changes in physician and institutional reimbursement, increasing use of technology, and medical specialization has resulted in increasing use of hospitals and associated facilities, a trend that accelerated in the USA in the 1950s.[6] With increasing reliance on technology unavailable in the home, physicians have largely abandoned the venerable tradition of physician home visits ("house calls") in favor of the patient traveling to physician offices, hospitals, and outpatient testing facilities.[7] Most home visits are now made by nurses or allied health professionals. Provisions were written for funding home care in the 1965 passage of Medicare and Medicaid in part due to the ongoing popularity of home visits among the constituents of legislators as well as evidence of lower costs of care.[8]

A common time of entry into home health care services for patients is at hospital discharge. In the U.S. in 2007, 11% of all discharged patients received home health care services upon discharge with 1,459,900 patients receiving home care services daily for an average of 315 days after admission to home care. [9] Commonly provided home care services include home safety evaluations, nurse aides, skilled nursing, social work, wound care, physical therapy, occupational therapy, speech therapy, hospice care, and monitoring of use of medications and other treatments. In 2007, 1,045,100 patients were discharged from hospice care, with an average length of service of 65 days with the predominant reason for discharge being that the patient died.[9]

The benefit of home care is dependent on the treated condition and not uniform.[10] Older patients with acute stroke and moderate resulting disability who were discharged early to home care were more likely to regain independence and less likely to become institutionalized than were a similar group of patients treated in the a rehabilitation hospital setting.[11] Cardiac rehabilitation appears equally effective in the home setting when compared to a hospital-based setting.[12] Patients with COPD have higher health care related quality of life, but no clear reduction in hospitalizations or costs of care.[13] Where home health is used to shorten hospital stays, there is considerable complexity in a successful transition from acute settings to home as well as determining services that will improve outcomes. Medicare criteria often do not provide coverage to those that would benefit; also the selection of services and patients who will benefit remains imprecise.[14-18] A lack of standardization and agreement on measurement metrics, such as a standardized scale for cognitive assessment, likely plays a role in the variable outcomes reported.[19]

Home health care is one of many strategies being tested as hospitals and physicians respond to added pressures under value based purchasing.[20] Rising annual costs of medical care can be traced to robust use of technology and led to the establishment of diagnosis related group (DRG) based reimbursement, shortened lengths of hospital stay, and increasing need for skilled home services.[8] These pressures remain but with the added stressors to reduce readmissions under value based purchasing programs.[21] Home health care costs have not been rigorously or broadly studied, although Hammond in 1979 indicated the costs of providing

> **"There is nothing like staying at home for real comfort."**
> *Jane Austen*

care at home are less than extended hospitalization and roughly equal to the cost of care in a long term care facility.[22] Problems in physician oversight during these care transitions from hospital to home persist though; primary care physicians feel that control of care is not optimal.[23,24] Technology may aid in better communication about the patient's status with the physician ordering home care. For most physicians, the time and effort of this activity remains without reimbursement.[25] It is common for a physician to not examine the patient during the entirety the patient receives home health services.[21] Technological advances have, however, facilitated the expansion of home care. This includes the use of internet-based information portals to allow for coordination and communication among the various care providers. Some physicians feel the advent of telemedicine has provided the opportunity to develop a hybrid home care delivery system that incorporates the aspects of the old and new home health care models.[26]

An aggressive strategy, referred to as "Hospital at Home" seeks to use home care services to treat patients with acute illness that might otherwise be initially admitted to the hospital.[27] Patients with community-acquired pneumonia, exacerbations of chronic heart failure or chronic obstructive pulmonary disease, or cellulitis have been successfully treated at home with appropriate home care.[28,29] Improvements in home monitoring technology contribute the increasing acceptance of hospital at home.[30] Leff et al report in a non-randomized study that patients experience improvements in activities of daily living and improved speed of regaining independent activities when compared to a hospitalized cohort.[31] Hospital at home will likely prove to provide substantial cost savings over services at an acute care hospital. Direct physician services are a key component of the hospital at home strategy though, and it remains to be seen how the concept will be embraced by the physician community and what, if any, malpractice legal risks accrue.

Hospice care is an important part of home care services for those with terminal illness. The opportunity to be at home at time of death is important to many people in the United States. While cancer remains the most common diagnosis among patients receiving hospice care at time of death, all other illnesses accounted for 52.7% of the population receiving these services at time of death.[9]

Given the many potential benefits of home care, as well as funding sources for such care, services provided in the home multiplied after the 1965 enactment of Medicare. Changes to the Medicare interim payment system slowed this growth once implemented in 1997.[32] The growth in services from 2000 to 2007 is estimated at only 104,000 patients.[9] Regional variations exist as well, with rural areas often experiencing underutilization of services due to access issues and urban areas often experiencing overutilization.[16,33] D'Souza studied the impact of these reimbursement changes and found increased hospitalization, increased emergency department use, and higher rates of permanent nursing facility placement were associated with reduced funding.[34] Concerns about fraudulent billing have slowed any congressional enthusiasm for consideration of improved funding however.[35,36] Indeed, further cuts in home care reimbursement are part of the Accountable Care Act.[37, 38] Cuts in funding appear to disproportionally affect less skilled services, with health aides that provide assistance with activities of daily living being the first services to be cut under funding restrictions.[39]

Conclusion

Home "is the place the older adult cannot imagine living without." Medical care especially provided directly by physicians, has for decades evolved away from rendering care in the home in favor of more technologically advanced and controlled environments, mainly hospitals and skilled nursing facilities. Providing care in the home is a more patient-centered approach to care. Safety, efficacy, and cost studies have been completed in only a handful of settings with a limited number of illnesses: the evidence base for much home care is yet to be developed. With improvements in the technology of home monitoring of patients, approaches such as hospital at home seem promising. Restraints in funding appear to be slowing growth in home care

and perhaps progress understanding the value of these services.

Editor's Note

Home health care is one of the areas where there is the largest amount of Medicare fraud. See "Health Care Fraud & the FBI", March/April 2012, *Missouri Medicine*, Volume 109:2 or visit http://www.omagdigital.com/publication/?i=108895.

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