

The Hidden Costs of Moving Care Home

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The past century was dominated by facility-based care, but a transition to health care at home is underway. For the first time since the early 1900s, Americans are now more likely to die in their homes than in facilities.¹ Medicare spending on traditional home health more than doubled between 2001 and 2017²; looking ahead, the agency projects an annual growth rate of 7% for home health, more than any other category, and it estimates that spending will reach \$186 billion by 2027.³ These trends reflect not just growth but also substitution. For example, postsurgical patients who otherwise might have spent 30 days at a skilled nursing facility (SNF) are instead being discharged with home health.⁴ Demand for home-based services will only accelerate amid coronavirus disease 2019 imperatives to minimize patient contact and patients' fear of entering health facilities.

The shift toward home care is often depicted as a panacea for achieving the Triple Aim of better care, improved quality, and lower costs. However, this trend may also create new challenges. As care in the United States is increasingly delivered at home, a detailed exploration of potential unintended consequences is needed. We focus on 3 that are already apparent in traditional home health services and home hospice.

First, current models of home-based care have meaningful—and sometimes unexpected—gaps in patient support. In home hospice, for instance, payment for all medications, equipment, and visits in routine home care—the most commonly used hospice service—is \$200 or less daily, 10-fold lower than the \$2000 cost of a hospital night. As a result, routine home hospice care offers relatively little direct support day-to-day, often with only a few in-person visits weekly. For many patients, their needs fall into the large gulf between the low-touch levels of support available at home and the high-touch care available in hospitals, SNFs, or inpatient hospice. In these cases, relying on home-based services may pose risks to patient safety. These gaps may in part explain why a 2019 Office of the Inspector General report found that 1 in 5 hospices had a situation in which the “health and safety of beneficiaries were in jeopardy.”⁵ Gaps in home-based care may also extend to postacute care home health. Despite saving Medicare money, discharging patients home with

TAKEAWAY POINTS

Home-based care is on the rise. With this transition, a detailed exploration of the potential unintended consequences is necessary. This article discusses this trend and focuses on 3 effects that may be already underway:

- ▶ gaps in support and quality;
- ▶ increased informal caregiving and costs to society; and
- ▶ failure to meaningfully engage clinicians.

just a few hours of in-person paid care instead of to a SNF with around-the-clock services has been linked to a greater risk of readmission.⁶ Although many patients benefit, home-based services may provide insufficient access to support for some.

Second, although home hospice or home health can relieve caregiver duties for short periods, the substitution of institutional care with these services largely transfers responsibility from the health system to informal caregivers, like friends and family. The need to provide routine care at home can create new stressors for caregivers, detracting from their own work or medical needs. Respite care to provide relief for caregivers, although sorely needed, is frequently limited in duration and accessibility; one of the main programs funding support for caregivers, the Older Americans Act, appropriates less than 1% of the unpaid care informal caregivers provide. Moreover, estimates of spending reductions from home-based care compared with institutional care often do not account for informal caregiving, vastly underestimating the societal costs. With 1 in 10 adults providing long-term services assistance to a family member, the unpaid economic value of informal caregiving is enormous; informal care in 2017 amounted to \$470 billion, more than the economic value of all paid long-term support services including postacute care.⁷ Although home hospice and home health may reduce direct health care spending, they may simultaneously reduce economic productivity by demanding unpaid labor from employable caregivers, limiting the overall benefit to society and risking harm to patients.

Third, just as families may be unfamiliar with the gaps in home health and hospice services, so too may the clinician who orders them. A recent study found that the vast majority of physicians certify plans of care for home health care services, yet nearly half spent less than 1 minute reviewing the care plan.⁸ This finding is consistent with earlier evidence that most primary care clinicians rarely read plans for home health carefully, suggesting that they may arrange a home-based service without understanding its scope or devoting sufficient attention to their role in it. Ideally, growth in home-based care would be accompanied by increased efforts to train clinicians about home services, each program's features, and how to select the appropriate service for each patient—but signs that this trend is underway are lacking.

Ultimately, a greater role for home-based care is needed in the United States. Growing evidence, including a Cochrane review and subsequent randomized trial in the United States,^{9,10} shows that even hospital acuity-level care can be provided at home with at least minimal to no difference in effect on patient health outcomes. However, several measures should be taken simultaneously with this transition to address a slowly emerging crisis.

First, payers can start to align home-based services reimbursement to reward high-quality care; for example, the Medicare Home Health Value-Based Purchasing Model has shown early signs of not only reducing spending but also modestly improving quality metrics and utilization of unplanned inpatient care.¹¹ Along with patient outcomes, caregiver outcomes should also be assessed for such home-based services. Second, to avoid a one-size-fits-all approach, payers and providers can establish more gradations of intensity for each home service, enabling clinicians to select the appropriate level for a patient and thereby grant the benefits of receiving care at home to even those patients who need more support. Third, much like telehealth training is becoming a necessity for clinicians, more intensive clinician exposure to and education about home services can enable better coordination of a patient's otherwise piecemeal home care.

Decades ago, clinicians providing care in homes was deemed "a vanishing practice."¹² Enabled by financial incentives and digital tools, the pendulum is now swinging from facility- to home-based care. This transition could greatly benefit patients, but only if we

use these services to improve health rather than pass the buck to another setting without deeper scrutiny. ■

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REFERENCES

- Cross SH, Warraich HJ. Changes in the place of death in the United States. *N Engl J Med*. 2019;381(24):2369-2370. doi:10.1056/NEJMc1911892
- Medicare Payment Advisory Commission. Home health care services. In: Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Commission; 2019:227-248. Accessed June 24, 2020. http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch9_sec.pdf?sfvrsn=0
- Sisko AM, Keehan SP, Poisal JA, et al. National health expenditure projections, 2018-27: economic and demographic trends drive spending and enrollment growth. *Health Aff (Millwood)*. 2019;38(3):491-501. doi:10.1377/hlthaff.2018.05499
- Barnett ML, Wilcock A, McWilliams JM, et al. Two-year evaluation of mandatory bundled payments for joint replacement. *N Engl J Med*. 2019;380(3):252-262. doi:10.1056/NEJMsa1809010
- Hospice deficiencies pose risks to Medicare beneficiaries. Office of Inspector General. July 2019. Accessed June 24, 2020. <https://oig.hhs.gov/oei/reports/oei-02-17-00020.pdf>
- Werner RM, Coe NB, Qi M, Konetzka RT. Patient outcomes after hospital discharge to home with home health care vs to a skilled nursing facility. *JAMA Intern Med*. 2019;179(5):617-623. doi:10.1001/jamainternmed.2018.7998
- Reinhard SC, Feinberg LF, Houser A, Choula R, Evans M. Valuing the invaluable: 2019 update—charting a path forward. AARP. November 2019. Accessed June 24, 2020. <https://www.aarp.org/content/dam/aarp/ppi/2019/11/valuing-the-invaluable-2019-update-charting-a-path-forward.pdf>
- Boyd CM, Leff B, Bellantoni J, et al. Interactions between physicians and skilled home health care agencies in the certification of Medicare beneficiaries' plans of care: results of a nationally representative survey. *Ann Intern Med*. 2018;168(10):695-701. doi:10.7326/M17-2219
- Shepherd S, Iliffe S, Doll HA, et al. Admission avoidance hospital at home. *Cochrane Database Syst Rev*. 2016;9(9):CD007491. doi:10.1002/14651858.cd007491.pub2
- Levine DM, Ouchi K, Blanchfield B, et al. Hospital-level care at home for acutely ill adults: a randomized controlled trial. *Ann Intern Med*. 2020;172(2):77-85. doi:10.7326/M19-0600
- Home Health Value-Based Purchasing Model. CMS. Updated October 8, 2020. Accessed June 24, 2020. <https://innovation.cms.gov/innovation-models/home-health-value-based-purchasing-model>
- Meyer GS, Gibbons RV. House calls to the elderly—a vanishing practice among physicians. *N Engl J Med*. 1997;337(25):1815-1820. doi:10.1056/nejm199712183372507

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