# Practice Paper of the American Dietetic Association: Home Care—Opportunities for Food and Nutrition Professionals

**ABSTRACT**
Home care continues to expand. With this growth are opportunities for registered dietitians (RDs) to demonstrate the vital role that they play not only in providing optimal nutrition care, but also in contributing to each patient's quality of life. Home care nutrition services range from individual patient counseling to managing and monitoring parenteral nutrition. RDs' knowledge of nutrition, reimbursement, and new technologies position them to improve care and control costs. Current roles and responsibilities along with emerging areas of professional growth give RDs a multitude of options to provide and expand their services and value in home care.
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Home care is a dynamic area of health care. Since its inception in the 1880s, home care has grown to provide care to more than 7.6 million people with annual expenditures exceeding $57.6 billion in 2007 (1). Ninety-three percent of home care patients are treated by a Medicare- or Medicaid-certified agency (2). There were 9,824 Medicare-certified home-health agencies in 2008 (3), with a total of 253,162 full-time employees (1). The total number of home-health employees was estimated at 867,100 people in 2006 (1). No data are available on the number of RDs or dietetic technicians, registered, included under the "other" category representing 14% of full-time and 21% of the total number of home care employees.

Nutrition care in the home runs the gamut from providing durable medical equipment, conducting nutrition counseling and assessment, and managing parenteral nutrition therapy, to transitioning patients to end-of-life care. Seventy-five percent of home care patients received skilled nursing care, 8% received durable medical equipment, 4% received therapeutic nutrition, 4% received intravenous therapies, and fewer than 1% received other high-tech therapies such as dialysis and enteral nutrition (2). Opportunities for RDs are nutritional, technical, and supportive in nature. RDs provide the necessary nutrition components across the continuum of care that not only facilitate health care needs but could also improve patients' quality of life. Dietetic technicians, registered, working in home care perform duties under the supervision of RDs and as such will benefit along with RDs from the opportunities described in this paper.

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## DEFINITION OF TERMS

Home care encompasses many types of care, from highly skilled to basic housekeeping needs. The programs detailed in this paper are those that provide support for ill or recovering patients. Definitions of various types of home health care programs are shown in Figure 1 (4,5). Ideally, each of these programs is staffed by an interdisciplinary team of health care professionals so that all the medical, emotional, and nutrition needs of the patient are met. The specifics of each therapy as provided by a particular home care agency varies. In addition, although the site of care is most often the home of the recipient, alternate sites may also apply, such as group homes, day-care centers, welfare hotels, and shelters.

Home care organizations may be structured in several ways (4):

- Not-for-profit organizations are voluntary agencies with a philanthropic mission. These organizations are exempt from federal income tax.
- Proprietary organizations are for-profit agencies and are either privately held by owners or are publicly traded and have stockholders.
- Public organizations are operated by state and local governments.
- Subdivision home care organizations are part of an integrated health care system such as a hospital or a managed care organization.

Regulatory bodies, such as the Centers for Medicare and Medicaid Services (CMS) and state health departments, provide oversight for the health care system. The CMS rules for home health agencies are available in the State Operation Manuals (www.cms.hhs.gov/Manuals/PBM/list/.asp). Accreditation is voluntary. The Joint Commission, a CMS-approved accrediting body, established an accreditation process for home care services in 1988 and accredits more than 3,400 organizations providing health care services by health care professionals (6). The Accreditation Commission for Health Care is another CMS-approved accrediting body for home health care providers originally developed to meet the needs of small providers of home care (7). The Accreditation Commission for Health Care was initiated in 1985 in North Carolina and expanded nationally in 1996. The Community Health Accreditation Program is a CMS-approved home-health and hospice accreditation organization (8). The Community Health Accreditation Program has been an independent and nonprofit accrediting body since 1965. Some of the services and programs accredited by these three organizations are medical equipment and supplies, respiratory care, complex rehabilitation and assistive technology, home

**Home health care**—Any service provided by a health professional in the home setting. According to the Joint Commission, services can include assessments, care provision, counseling, and monitoring of patients with a wide range of clinical conditions by nurses; registered dietitians; dietetic technicians, registered; physical therapists; occupational therapists; speech therapists; social workers; dentists; physicians; and other licensed health care professionals.

**Home medical equipment/durable medical equipment**—Physical equipment required by the patient or used to provide the therapy in the home, such as wheelchairs, hospital beds, infusion pumps, oxygen, prosthetics, orthotics, and supplies to provide nutrition therapies such as tubing, enteral formulas, enteral feeding bags, and syringes.

**Personal care/support care**—Assistance with activities of daily living and household tasks performed by paraprofessionals in the home of a patient with a health-related condition.

**Home infusion therapy**—Provision of intravenous therapies, including home enteral and parenteral nutrition. This can also include intravenous pain management, anti-infectives, blood products, chemotherapy, and intravenous fluids. These therapies may be given in the home or in an ambulatory infusion center.

**Palliative care**—Comprehensive care focusing on symptom management for patients with life-threatening or life-limiting diseases or illnesses.

**Hospice**—A multidisciplinary organized program to provide symptom management and psychosocial and spiritual support to patients diagnosed with a terminal illness during the final months of life. Nutrition services can include oral diet, tube feeding, or in some cases parenteral nutrition, depending on patient need and the capacity of the hospice to provide more technical care.

**Figure 1.** Definitions of various home care programs. Data from references 4 and 5.

health, home infusion, infusion nursing, hospice, private duty nursing and aides, specialty pharmacies, and ambulatory infusion centers. Other accrediting bodies are available for specific areas such as private duty home care, durable medical equipment, and nonmedical senior home care.

## FINANCIAL COVERAGE FOR NUTRITION SERVICES

Health insurance in the United States is provided by both private payers and public payers such as the federal and state governments. Private insurance is purchased independently or as part of a group through an employer. Specific benefits and covered home care services depend on the agreement between the parties involved. Insurance companies often use clinical case managers to oversee care provided for chronically ill patients to help control costs and monitor outcomes.

There are two main government programs under CMS that provide coverage for home health care services: Medicare and Medicaid. Medicare is a national health insurance program for people age 65 years or older, disabled, or on dialysis (1). Medicaid provides health insurance to poor individuals who meet the eligibility requirements established by the states in which they live.

Medicare reimbursement for home care covered under Medicare Part A includes intermittent medically necessary skilled care, rehabilitation treatment, medical equipment, and hospice (9). Home enteral and parenteral nutrition are primarily covered under prosthetic devices in Medicare Part B, which is purchased separately from Part A. Part B can also be billed for home nursing visits if the patient does not have Part A coverage. Medicare Part D is the prescription drug benefit and covers intradialytic parenteral nutrition and intraperitoneal nutrition for dialysis patients. Part D does not entirely cover home parenteral nutrition (HPN), but may cover some of the components provided in HPN. Medicare services require that the patient be homebound; under the care of a physician; in need of skilled care from at least one qualifying service, such as nursing, physical therapy, and occupational therapy; and in need of services on a part-time, intermittent basis. Home care nursing services must be provided by a Medicare-certified home-health agency.

Medicare, covering approximately 37% of home health services, is the single largest payer of health care services in the home (1). In 2006, more than 3 million patients received almost 104 million visits with a total reimbursement exceeding $14 billion (8,10). The projection of expenditures for home care is $15.4 billion for 2007 (1). There are no specific data on the number of patients or expenditures related to home enteral nutrition (HEN) and HPN covered by Medicare, although a portion of the estimated 7,000 long-term HPN patients and more than 40,000 HEN patients are receiving Medicare Part B coverage. Hospice became a Medicare benefit in 1982 (11). In January 2008 the total number of Medicare-certified hospice agencies was 3,257 (11).

The principal diagnoses of Medicare recipients receiving home care are diseases of the circulatory system (21.4%); endocrine, nutritional, and metabolic diseases and immune disorders (10.8%); heart disease (10.7%); and diabetes mellitus (9.7%) (1). It is clear when looking at these diagnoses that nutrition is an integral part of the therapy. The effect of chronic disease has the potential to contribute to diminished appetite and intake and reduced ability to shop, cook, and prepare foods (12).

Under Medicare Part A, nutrition services such as nutrition assessment, consultations, and medical nutrition therapy (MNT) are not separately billable. RDs can provide these services for a Medicare-certified agency or a home infusion company; however, RD services will be bundled with other Part A services provided by the agency and billed to Medicare. Reimbursement for MNT under Medicare Part B is limited to outpatients with certain diagnoses, including nondialysis kidney disease, post kidney transplant, diabetes, and gestational diabetes. RDs must be enrolled with Medicare to receive direct Medicare reimbursement for MNT services. RD services associated with HPN and HEN for qualified patients are not directly billable to Medicare Part B.

Medicaid covers approximately 19% of home-health services and is administered at the state level with differences in eligibility criteria, coverage, and level of reimbursement for services. In 2004, 16.3% of Medicaid ex-