Home Health’s Role in Post-Acute Care

Throughout D.C., home health agencies serve as an integral part of the Medicare post-acute care landscape, providing health care at home after discharge from acute care hospitals.

The Medicare home health benefit covers skilled nursing and therapy services provided to patients in their own residence. Under the benefit, the patient receives care subject to a physician-established plan of care, must meet the definition of “homebound,” and be in need of skilled services on an intermittent basis. Patients often receive home health care following an acute care hospital stay and may require rehabilitation therapy services. Services include care from highly skilled nurses, physical therapists, occupational therapists, speech-language pathologists, and medical social workers. Home health aides provide personal care services for patients if needed to support skilled services.

As the Medicare program begins to focus on alternative payment models such as bundled payments in the comprehensive care for joint replacement (CJR) model and accountable care organizations (ACOs), home health offers a strong value proposition as we seek to provide care in the community and at home where it is clinically appropriate. Home health agencies are well positioned to support cost effective care in the community and readmissions reduction.