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Pre-existing Inequality II: Social Workers Assess Impact of COVID-19 on Medicare Home Health Beneficiaries

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Abstract

There is significant data on the adverse impact of COVID-19 on persons who were poor, minorities, had compromised physical or mental health, or other vulnerabilities prior to the COVID-19 pandemic. A significant portion of the Medicare population has such vulnerabilities. The Medicare home health beneficiary population is even more vulnerable based on gender, race, income level, living alone status, and number of chronic conditions. A literature review indicated there were no studies on the impact of COVID-19 on Medicare home health beneficiaries. In a previous issue of this journal, the author addressed the literature gap by presenting a study on home care nurses' perceptions of the impact of COVID-19 on Medicare home health beneficiaries. The current study is a companion qualitative study to the nurses' study. It is based on interviews of a convenience sample of 52 home care social workers from 11 different home health agencies in New York City between April 1 and September 30, 2020. Seven major themes emerged, 6 of which were identical to the themes identified by the nurses. The only new theme was limits on the ability to provide psychosocial interventions had more severe consequences. The 7 themes were: need for social service supports increased; loneliness and depression increased among patients; physical and mental health conditions became exacerbated; substance use and abuse increased; evidence of domestic violence against patients increased; there was limited staff and equipment to care for patients; and limits on the ability to provide psychosocial interventions had more severe consequences.

Keywords

COVID-19, medicare, home health, home health nurses

Introduction

The purpose of the study presented in this article is to further address a gap in the existing literature on the impact of COVID-19 on Medicare home heath beneficiaries. In a previous issue of this journal, the author addressed the literature gap by presenting a study on home care nurses' perceptions of the impact of COVID-19 on Medicare home health beneficiaries.[1] However, the previous study did not present perceptions of social workers who are the primary professionals responsible for home health beneficiaries psychosocial and social needs. This study reflects social worker perceptions based on interviews conducted July 1, 2020 through September 30, 2020. The interviews were conducted after the nurse interviews and before the nurse interviews were analyzed to avoid any bias in conducting and analyzing the social work interviews.

There is significant evidence that the COVID-19 pandemic has had adverse impacts on many individuals who experienced adverse impacts of inequality related to race, gender, age, income, or being a Medicare beneficiary prior to COVID-19. Long et al.[2] found such adverse impacts on gender and racial minorities regarding job losses with Hispanics having the steepest initial job losses; African Americans have recovered just over a third of their jobs lost in the pandemic compared to White Americans recovering more than half of their jobs; women lost more jobs than men; and African American women faced the largest setback in job losses. Adhikari et al.[3] found infection rate and death rate disparities by poverty level and race in a study of ten combined statistical areas, all of which were urban areas. In comparing high poverty level counties which were substantially White to substantially non-White, they found the non-White counties had an infection rate nearly 8 times higher and a death rate more than 9 times greater. Overall, they found that

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the higher the poverty level of a county, regardless of race distribution, the higher the infection and death rate.

Leopold[4] found in a New York City study that COVID-19 death rates in poor neighborhoods were more than 2.5 times higher than in wealthier neighborhoods. Leopold[4] also found that African-Americans and persons born in Latin America had 9.0 and 18.4 more deaths per 100,000 than Whites, respectively; low-income persons had 27.6 more deaths per 100,000 than higher income persons; and the elderly had 23.2 more deaths per 100,000 than persons of other ages. The Centers for Disease Control and Prevention[5] has reported that the elderly had the highest rate ratios of any age category for both COVID-19 hospitalization and death compared to the 18- to 29-year old category. For hospitalizations, the 65- to 74-year old hospitalization rate was 5 times higher, for the 75- to 84-year old category the rate was 8 times higher, and for 85plus year old category the rate was13 times higher. For deaths, the 65- to 74-year old hospitalization rate was 90 times higher, for the 75- to 84-year old category the rate was 220 times higher, and for 85plus year old category the rate was 630 times higher.

The PAN Foundation, using federal data, found COVID-19 has had a disproportional impact on older adults.[6] They found, as of April 30, 2020, 30.7% of all Covid-19 deaths in the United States were for persons 85 and older and that another 27.3% for persons 75 to 84 years old. They also found, based on a 27-state analysis, the Covid-19 death rate for African Americans was 2.7 times higher than Whites and that while African Americans represented 13% of the population in the 27 states, they represented 28% of the deaths in those states.

In a study of Medicare beneficiaries, Davis and Willink[7] found that low-income Medicare beneficiaries had greater risks pre-COVID that were increased by financial hardships resulting from job and other financial losses related to COVID-19. They found that 28% of all Medicare beneficiaries are low-income, meaning their income is less than 150% of the Federal Poverty Level (FPL). Further emphasizing their limited financial resources, the study found 57% of the low-income beneficiaries also were dual eligible, meaning they had both Medicare and Medicaid, compared to only 19% of all Medicare beneficiaries. These low-income Medicare beneficiaries are at higher risk for short-term and longer-term COVID-19 consequences because of their characteristics. They found that 51% of low-income beneficiaries had 3 or more chronic conditions compared to 47% for all Medicare beneficiaries; 35% had percutaneous coronary intervention (PCI), otherwise known as angioplasty with stent, compared to 24% for all Medicare beneficiaries; and 7% had nursing home or other institutional care compared to 4% for all Medicare beneficiaries.

The Kaiser Family Foundation[8] also found that a significant portion of Medicare beneficiaries had limited financial resources prior to COVID-19 and these resources have become more limited since COVID-19. More specifically, they found: half of all Medicare beneficiaries lived on incomes below $29,650 per person in 2019 and 1 in 4 had incomes below $17,000 per person; half of all Medicare beneficiaries had savings below $73,800 per person in 2019, one fourth had less than $8,500 per person in savings, and 12% had no savings or were in debt; and half of all Medicare beneficiaries had home equity below $73,350 per person in 2019, and one fourth (27%) had no home equity at all. In a survey, Kaiser also found "Nearly half of older Americans (48%) say they are worried that their investments will be negatively affected by coronavirus disease and the spillover effects of ongoing market volatility on their economic security."

The Centers for Medicare and Medicaid Services,[9] in a July 28, 2020 update, reinforced the disproportional impact of COVID-19 on racial and ethnic minorities, stating "The updated data confirm that the COVID-19 public health emergency is disproportionately affecting vulnerable populations, particularly racial and ethnic minorities. This is due, in part, to the higher rates of chronic health conditions in these populations and issues related to the social determinants of health."[9]

Literature Review

A literature review was conducted to determine the nature and extent of existing studies on the impact of COVID-19 on Medicare home health beneficiaries. The literature review used Cinahl, PubMed, Medline, Cochrane Library, Campbell Collaboration, PsycINFO, Sociological Abstracts, and Social Science Abstracts databases with a search period of January 1, 2020 through March 31, 2020 followed by an updated search after the study was conducted covering April 1, 2020 through November 30, 2020. Multiple keywords were used in the search: COVID 19; COVID; COVID 19 and home care; COVID and home care; COVID and home health; COVID 19 and home health; COVID and Medicare; COVID-19 and Medicare. The search yielded multiple studies and data on Medicare and COVID-19, but only 1 issue brief and 2 studies specifically on Medicare home heath beneficiaries, thus validating the existence of a gap in the literature which the current study was designed to address.

Of the 2 studies, there was only 1 that used interviews of home health staff, patients, or caregivers. The 1 study interviewed 33 home care home health and personal care aides and home attendants in 24 different home health agencies in the 5 boroughs of New York City.[10] The study found these workers: were on the front lines of the COVID 19 pandemic but felt invisible; reported a higher risk for virus transmission; received varying amounts of supplies, information, and training; relied on non-agency sources for support; and were forced to make difficult tradeoffs in work and their personal lives.

The second study[11] analyzed 1409 Medicare home health patients admitted for services at the Visiting Nurse Service

of New York (VNSNY) between April 1 and June 15, 2020. Based on VNSNY data found 94% of patients upon discharges had statistically significant improvements in symptoms and function. The issue brief[12] used an unspecified number of interviews with unspecified persons at home health agencies for part of the brief but primarily discussed the structure of the Medicare home health benefit and COVID-related federal policy changes. The study found that COVID-19 infection rates among Medicare home health beneficiaries and the home health workforce "have not been systematically reported during the pandemic." The study[11] also found that federal policy changes "have provided financial support to home health agencies, expanded provider licensures to certify use of home health, facilitated wider use of telehealth, and increased flexibility in Medicare Advantage plans."

The Current Study

In a previous issue of this journal, the author addressed the literature gap by presenting a study on home care nurses' perceptions of the impact of COVID-19 on Medicare home health beneficiaries.[1] The current study is a companion qualitative study to the nurses' study.

The condition of Medicare home health beneficiaries during the COVID-19 crisis was the focus of both studies because these beneficiaries are more vulnerable than Medicare beneficiaries in general and because of the lack of studies on their situation. Avalere Health[13] found, based on 2017 Medicare data, that compared to all Medicare beneficiaries, Medicare home health beneficiaries are poorer (50.4% with income less than $25,000/year compared with 37.3% for all Medicare beneficiaries); and have more chronic conditions (47.3% with 5 or more chronic conditions compared with 22.4% of all Medicare beneficiaries with 5 or more chronic conditions). In addition, Avalere Health[13] found that 27.8% of Medicare home health beneficiaries had 2 or more Activities of Daily Living limitations (ADLs) compared to 10% of all Medicare beneficiaries.

Food insecurity is another pre-existing condition for Medicare beneficiaries and even more for home health beneficiaries. A 2020 study using 2016 Medicare data found that 10% of Medicare beneficiaries were food insecure, with lower-income beneficiaries more likely to report food insecurity.[14] While the study did not focus on home health beneficiaries the higher percentage of low-income beneficiaries in Medicare home health indicates they may have higher levels of food insecurity than Medicare beneficiaries in general.

Mental health issues have increased during COVID-19[15] and mental health is a significant vulnerability for Medicare home health beneficiaries. CMS reported in 2017 that 38.3% of all Medicare home health beneficiaries had a severe mental illness (SMI), which is defined "as having depression or other mental disorder including bipolar disorder, schizophrenia, and other psychoses (p. 28)."[13] This rate compared with only 28.3% among all Medicare beneficiaries (p. 28).[13] Of those Medicare home health users with SMI, 96.2% had depression and 23.6% had an additional mental disorder. In addition, 57% of Medicare home health beneficiaries had an income less than 200% of the Federal Poverty Level (FPL) compared to 44% of all Medicare beneficiaries and 27% had an income less than 100% of the FPL compared to 18% of all Medicare beneficiaries (p. 12).[13]

Social workers were selected for the study because they are the only professionals covered under the Medicare home health benefit who are trained to conduct psychosocial interventions for mental health andsubstance abuse disorders, both of which increased due to COVID-19.[7,16-20]

A 2019 study by the National Academies of Science, Engineering, and Medicine (NASEM 2019)[21] further emphasized the need to integrate more social care, delivered by social workers, at all levels in the health delivery system to better address substance use and mental health conditions. There also is significant literature on the effectiveness of social workers addressing social work in multiple health care settings for substance use and mental health conditions.[22-26]

Methods

The study used a grounded theory approach.[27] Grounded theory is the research methodology of choice because it was developed for interpreting qualitative data in the absence of a pre-existing theory. Thecurrent study was conducted because the existing literature did not provide insight into how home care social workers perceive the impact of COVID 19 on their homebound beneficiary population. Data were collected through interviews of 52 home care social workers from 11 different Medicare-certified home care agencies in the 5 boroughs of New York City from July 1, 2020 through September 30, 2020. The interviews were conducted after the nurse interviews and before the nurse interviews were analyzed to avoid any bias in conducting and analyzing the social work interviews.

All interviews were conducted virtually by computer, using Zoom software, and an interview guide was used to help standardize the data collection. Participants were selected using a snowball convenience sampling technique, whereby home care industry professionals known to the author identified potential interviewees. An interview guide was used to help standardize the data collection. The study was self-funded by the researcher and therefore not subject to any Institutional Review Board approval. However, all study participants received and signed informed consents written in compliance with federal regulations and all participants were assured of anonymity and confidentiality. Qualitative analysis began shortly after the initial data were collected and resulted in additional questions and probes that were applied to subsequent interviews, in an ongoing

iterative process. Analysis followed the grounded theory three-stage coding of interview data: open, axial, and selective coding.

Open coding was used to fracture the data to "identify some categories, their properties, and dimensional locations."[27] The coding and classification generated a list of 238 codes. Code and category labels were created, systematically sorted, compared, and contrasted until they were complete, with no new codes or categories produced and all data accounted for. Through axial coding, multiple phenomena were identified from the connected categories and subcategories. These phenomena included the nature of the beneficiary population in terms of vulnerability factors such as income, living alone status, gender, race and number of chronic conditions; availability of information, supplies, and training to deal with COVID; social isolation, depression, and loneliness among beneficiaries; physical and mental health conditions among beneficiaries; and evidence of physical and emotional abuse among beneficiaries. Finally, using selective coding, a "story line" was identified and a "story" written that integrated the axial coding phenomena.[27] The story that emerged was the adverse impact of COVID 19 on a Medicare home health population composed largely of persons with significant vulnerabilities due to the impacts of inequality pre-COVID 19.

In keeping with the grounded theory approach, the data analysis and interpretation were facilitated by analytical and self-reflective memo writing, which helped move empirical data to a conceptual level; expanded and refined the data and codes; developed core categories and interrelationships; and integrated the experiences, interactions, and processes embodied in the data.[27] All initial abstraction, analysis, and interpretation were done by the author of this article. After the initial process, all abstraction, analysis, and interpretations were reviewed by 2 additional experienced qualitative researchers, each of whom had a doctoral degree in social work and more than 15 years' experience doing government-funded qualitative research on substance abuse. Any differences were discussed by the 2 external reviewers and the author to reach final decisions used for the study results. All analyses were done using ATLAS.ti software.

Limited demographic data was collected from study participants using a short survey. The results appear in Table 1. Overall, the social workers were 45 to 55 years old (75%); female (92%); Caucasian non-Hispanic (71%); had 6 to 10 years of home care experience (75%); and had an average caseload of less than 20 patients (77%). Statistical analysis of the demographic variables' impact on study outcomes was not done due to the qualitative nature of the study.

Table 1. Social Worker Participant Demographic Characteristics.

Characteristic	Number	Percent (%)
Gender		
Male	4	8
Female	48	92
Race/ethnicity		
Caucasian, non-Hispanic	37	71
Hispanic	6	12
African American	6	12
Asian American	2	4
Other	1	1
Age range		
>55	2	4
45-55	39	75
36-44	7	13
25-35	4	8
Years as a home care nurse		
>10	7	13
6-10	39	75
1-5	5	11
<1	1	1
Average patient caseload		
26-30	2	4
20-25	10	19
<20	40	77

Results

Seven major themes emerged, 6 of which were identical to the themes identified by the nurses. The only new theme was limits on the ability to provide psychosocial interventions had more severe consequences. The 7 themes were: need for social service supports increased; loneliness and depression increased among patients; physical and mental health conditions became exacerbated; substance use and abuse increased; evidence of domestic violence against patients increased; there was limited staff and equipment to care for patients; and limits on the ability to provide psychosocial interventions had more severe consequences.

The themes were consistent across all social workers, regardless of their demographic characteristics (Table 1) or agency. The 7 themes from interviews are detailed below with supporting quotes.

> ***Need for Social Service Supports Increased. "The need was always there. Now it has become near desperation level for some patients."*** Social Worker TG

That quote was from Social Worker TG, who continued saying:

> I have been doing home care social work for 9 years. Before that I worked in an outpatient mental health clinic mainly for the elderly. I was shocked when I came to home care because I could not help with services. I could not effectively case manage and these patients were homebound and so isolated and in need of social services. Now with COVID it is unbearable to see the unmet need. Social Worker TG

Other social workers agreed with Social Worker TG that patient unmet needs for social supports pre-existed COVID.

> Our patients always needed social services. That is not new. Medicare tied our hands. We can't provide these services directly and we can't even help them complete forms to get support through Medicaid, meals-on-wheels, local elderly and disabled transit programs. With COVID it has become a nightmare. Talk about making a bad situation worse! Social Worker LR

Social Worker SH emphasized the lack of social services pre-COVID:

> It always has been the norm. Sometimes it would make me cry. Here are these homebound, frail elderly with limited mobility, multiple chronic conditions and often living alone and I can't even help them get to the grocery store, the doctor, or to a senior center. It's always been so sad. COVID just makes it worse. Maybe the government will wake up. That's the only good thing that could come from this COVID situation. Social Worker SH

The lack of such social needs services to deal with the social determinants of health and lack of social work coverage has been documented in peer-reviewed journals in addition to the social workers' perceptions.[28,29] MedPac reported that Medicare home health social work visits historically represent the smallest percentage of all 6 Medicare home health services nationally and have been on a steady decline from 0.3 of all Medicare home health visits per episode in 1998 to 0.1 in 2018, for a 36% decline.[30]

> ***Social Isolation, Loneliness, and Depression Increased: "Well what do you exoect? Our patients are homebound so with COVID they become even more homebound which means more isolation, more depression."*** Social Worker TJ

Social workers also emphasized that social isolation, loneliness, and depression increased during COVID, but were always the norm, reinforcing the pre-existing conditions theme.

> If you are in [Medicare] home care long enough, I've been in it for over a decade, you know these patients are isolated, depressed and lonely. It is in your face the minute you walk in the door [to their homes]. And Medicare does not allow us to do anything except a one-time assessment for depression, but no treatment. Does that make sense? No. So, what do you expect with COVID. It's all gotten worse. Social Worker FK

> I had this patient, let's call her Thelma. She was 85, very frail, had multiple chronic conditions, and last year [2019] her husband died. She became really depressed. We could not get her out to an adult day care or a senior center because she was either too frail or, even on her best days, we could not get her someone to accompany here and get her transportation. That was pre-COVID. Now it is worse. Some of those places aren't even open or they are high-risk for COVID. Social Worker DT

> ***Physical and Mental Health Conditions Became Exacerbated: "Of course their conditions became worse. They were more homebound and we could not visit as consistently."***Social Worker LT

Social Worker LT continued, noting the mental health concerns went well beyond depression, loneliness, and social isolation.

> As usual, during pre-COVID, even when we visited, we social workers could not do much therapy, we couldn't take them for a walk, we couldn't help them with applications for government or community-based assistance. Now we visit less because of staffing issues and so their mental and physical health deteriorates even more. We are not even there as often as someone to talk to, which is really important to these patients. Social Worker LT

> I saw several patients whose health really deteriorated during COVID. Some became almost delusional. I think it was the usual fact of being alone compounded by all the craziness and uncertainty surrounding COVID. It's been horrible. Social Worker KW

> I have patients who are falling more. I'm not sure it is related to COVID but I think it is. When I ask what happened they tell me they felt they had to get up and move around because they could not get out because of the COVID. Of course, the more they try to get up, the more likely they fall and get injured. That makes their health worse. Social Worker GT

> ***Substance Use and Abuse Increased: "It's definitely become more of a regular coping mechanism for many clients. The alcohol especially is there and seems like a readily accessible friend to comfort them in the midst of the pandemic."***Social Worker EF

Social Worker EF continued:

> I have a lot of patients who regularly use drugs, mostly alcohol. Some also have spouses or friends or relatives who use and abuse [drugs]. I think it helps some to some degree if they moderate. It helps them socialize. If they are alone it helps them feel comforted, like having a companion. Now, with COVID, I feel the stress and anxiety of the disease makes people so on edge that they need that [drug-based] companionship even more. Social Worker EF

Other social workers emphasized the normal pre-COVID inter-relationship between mental health, physical health, and substance abuse and the worsening situation during COVID.

> This always has been a problem, well before COVID. They [patients] are frail, homebound, lonely with multiple physical and mental health issues. They drink, or some use other substances, because it is acceptable for their generation. But at their age the temporary pleasure of the drink or drug wears off quickly and their mental health becomes worse—more sadness, depression, crying—and the diabetes, which many have gets worse, and so many fall more and create new injuries, new bruises, more pain and then more depression. It is so sad. With COVID it seems to be happening more. I think the uncertainty of it all with COVID is so scary that it takes many of them to a dark place more quickly than usual. Social Worker SD

Studies have found Medicare home health lacking in its assessment and treatment of substance use and abuse pre-COVID.[31]

Evidence of Domestic Violence Increased: "No doubt domestic violence has increased. The travel restrictions locally with places closed has made it worse to be home with another, usually sick elderly person. That increases the risk of violence." Social Worker GH

Social Worker GH continued with her discussion regarding increased domestic violence and her belief it related to COVID.

> It happened pre-COVID, but not as much. These people are homebound, sick, and elderly, with limited mobility. If they have a spouse or partner, that person is often old and sick. The more they are confined the more they get on each other's nerves. And that increases the likelihood of violence and abuse. And if they drink, which many do to ease their pain, then that increase the likelihood of violence. I have seen more signs of it since COVID and had more patients confide in me that their spouse or partner, or even a relative or friend, has verbally or physically abused them. Tolerance levels are down; violence is up. Social Worker GH

> Yes, I see more. I can't prove it but more of my patients tell me about arguments and throwing of things, sometimes they are hit by a flying pot or pan or ashtray. They show me bruises. If it is really bad and consistent, I call APS (Adult Protective Services), but APS is limited with staff and what they can do. And sometimes I can't tell if they just fell and got bruised or if it was caused by someone else. It's always a difficult judgment, but now I am seeing more situations where I have to make that judgment. Social Worker TR

OASIS does not gather data on alleged domestic violence in Medicare home health and the Centers for Medicare and Medicaid Services (CMS) does not otherwise collect such data. There is limited research on the nature and extent of domestic violence witnessed, recorded or reported by home care workers.[32]

There Was Limited Staff and Equipment for Caring for Patients. ***"Yes we were definitely short staffed and then if we had the staff to do the visit, we did not have the proper protective gear so yes, we visited less. The need was still there but we visited less."*** Social Worker TY

Social workers emphasized the connection between patients pre-existing needs and the inability of staff to visit as frequently due to staffing and equipment limitations. As Social Worker AL said:

> The [patient] needs did not disappear. They were the same as pre-COVID and in many cases I would say the needs increased due to COVID. Fear, stress, and anxiety definitely were up. In many cases people were home alone more because friends and relatives who used to visit had COVID or were afraid to go out because they thought they'd get COVID. So that resulted in more isolation. We were even more important as visitors but then we couldn't visit as much because we also had staff who were out with COVID or in quarantine because a member of their family had tested positive. Often if we could staff a visit, we did not have enough masks, gloves or other protective gear. It has been so frustrating. Social Worker AL

Other social workers agreed with the COVID situation "Definitely reduced our visit frequency even when the patient needs stayed the same or increased," according to Social Worker VB, who continued saying:

> They [the home health agency] do not authorize many social work visits in normal times. I think it has something to do with reimbursement. Anyway, with COVID the priority was on nursing and [home health aide] visits because we had limited supplies, equipment and staff. As a result, social work, as usual, took a back seat, and patient social and emotional needs took a back seat, despite their importance. Social Worker VB

Social Worker EH furthered the point observing:

> I can't tell you how many times I was scheduled for a visit and it was canceled due to lack of masks, gloves, equipment. We do not get out there to patient homes all that often so it was really frustrating not to be able to go. Once we eventually got to make the visit, the patients were in worse shape than if we had made the visit as scheduled on the plan of care. Social Worker EH

The preceding 6 themes were the same as those articulated by nurses in the preceding study in this journal.[1] In addition, the social workers identified a seventh theme:

Limits on the ability to provide psychosocial interventions had more severe consequences. ***"We never can do much with psychosocial interventions in normal times so the COVID period has increased the need for such interventions but limited our ability to provide them*** **much** ***more than usual."*** Social Worker HJ

Social Worker HJ continued, stating:

> These patients need psychosocial help all the time. It is as important than nursing interventions and home health aide, but Medicare does not allow us to do much. The most we get is 1 or 2 therapy visits while most psychosocial interventions require 2-4 weeks at twice a week to have any possibility of having a positive impact. So that is the norm pre-COVID. Now our patients are more psychologically fragile during COVID, need more care, and we actually are providing the same limited care or less. Social Worker HJ

Other social workers emphasized the impacts of limited social work services, even more than in the pre-COVID-19 years:

> I agree. The need for social work interventions have increased due to the added stress and anxiety, and fear created by COVID. Now, on top of all the normal stressors that our clients have, we and they are expected to do more with less- cope better with less care. It is ridiculous. Social Worker KH

> I came from an outpatient mental health clinic mostly with elderly patients before I came to home care about 6 years ago. In the clinic we could see patients for at least a month and usually 2 visits a week. It allowed us to use evidence-based psychosocial interventions and bill Medicare [Part B]. Then I came to home care and we are handcuffed. Pre-COVID we could barely do any visits, let alone a professional intervention. COVID made it even worse. Social Worker NM

The social workers comments were consistent with the limited coverage and use of social work in Medicare home health. Medicare home health visits historically have averaged 1% of all national Medicare home health visits.[30] In 2019 they were less than 1% of all Medicare home health visits.Currently the home health social work benefit is limited to only a few individual psycho-social therapy visits, no family therapy and no group therapy.[29,33]

Limitations

The study was a qualitative, exploratory study. As such it does not address causality and has several limitations including: small sample size; lack of random sampling for sample selection; and lack of a randomized controlled trial experimental design to test specific interventions against a control group. The study also is limited to 1 geographic area and based on interviews only of home care social workers and home care social workers who were accessed through the researcher's contacts with home care nurses. As a qualitative study there also was no quantitative analysis of results by key demographic characteristics such as age, gender, years of experience in home health.

Discussion and Conclusions

As previously noted, the limited research on Medicare home health and COVID-19 has focused on staffing and equipment limitations, the increased use of telehealth, federal financial assistance, increased flexibility of Medicare Advantage plans, and 1 study of home health patient functional and symptom outcomes upon home care discharge. These studies do not address how Medicare home health care during the COVID time period has been affected by the very nature of the patient population and underlying limits on treating patients due to eligibility, coverage and reimbursement issues in Medicare home health. The social workers interviewed indicated that the underlying patient situations and Medicare home health requirements pre-existing COVID affected patient care, with COVID making the situation worse. The negative impact of COVID-19 was not surprising; however, the strength and consistency of social worker views across all 7 themes, as well as the strong agreement with previous responses from nurses, was not totally predictable and underscores the need to address basic opportunities for improvement in the Medicare home health care system.

At least 1 issue brief,[12] noted the increased flexibility of Medicare Advantage plans covering non-medical benefits (i.e., meal delivery, non-medical transportation, home modifications, other social supports) in discussing COVID. However, the brief only stated the regulatory change and did not mention any study linking the increased flexibility to improved Medicare home health patient care. As noted by the social workers interviewed, the Medicare home health population has always had, pre-COVID, significant needs which might benefit from expanded non-medical or social support benefits, even more than Medicare Advantage plan beneficiaries. However, only a small portion of all Medicare Advantage beneficiaries (5.2%) are home health users[13] so the expansion of non-medical coverage in Medicare Advantage plans will benefit few home health beneficiaries. In addition, Medicare home health beneficiaries are a more vulnerable population in terms of social and environmental factors compared to all Medicare beneficiaries, as discussed earlier in this article.[13]

The COVID-19 phenomenon impacted Medicare home health as it did all of society. However, the narrow and limited research focus on COVID-19 impacts on home health agency staffing, protective equipment and financing seems to avoid the underlying failure of the Medicare home health benefit to address the care needs of its beneficiaries. As the social workers observed, these unmet needs pre-existed COVID-19 and, without policy changes, will continue during and after the COVID-19 pandemic period or, for that matter, any other medical or other crisis. Given the themes that emerged in this study and the previous nurses' study, it seems policymakers should seriously consider revising the Medicare home health benefit to better address the unmet needs. Based on the social workers and nurses' insights, legislative and regulatory changes might best focus on expansion of the home health social work benefit; approving coverage of existing evidenced-based psychosocial interventions by social workers; requiring substance abuse assessment of all Medicare home health patients at admission and treatment thereafter if merited; revising the OASIS to require assessment and follow-up treatment of more mental health conditions; revising regulations to require treatment of assessed mental health and substance abuse needs; and allowing home health agencies the same flexibility in addressing social needs as have been granted Medicare Advantage plans.

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