National Alliance for Care at Home

Statement of Opposition: Oregon SB1168

The National Alliance for Care at Home (Alliance) opposes Oregon SB1168 which, among other things, would prohibit home health and hospice providers from establishing requirements regarding total number of patients or the number of visits made to patients by a home health care staff person or a home hospice care staff person. We are specifically concerned that this legislation would:

- Negatively impact Oregonians' access to home health and hospice services;
- Reduce, rather than increase, quality of care provided;
- Run counter to Medicare policies;
- Lead to agency closures, exacerbating care deserts; and
- Exacerbate caregiver shortages.

The most pressing concern about this legislation is the negative impacts it would have on access to care for individuals who need home health and hospice services. Under the Medicare Conditions of Participation (COPs) for home health providers in 42 CFR 484.105(i), agencies must have specific policies that ensure the capacity to provide patient care prior to accepting a patient. Without the ability to ensure that care providers are available to deliver services via standards for caseload and/or hours of care, agencies have no way to meet this regulatory requirement. Participants would therefore be denied access to necessary services.

The legislation also risks unintended consequences of harming the quality of services provided. The Institute of Medicine (IOM) has developed the following six aims for the healthcare system.[1]

- **Safe**: Avoiding harm to patients from the care that is intended to help them.
- **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as geographic location and socioeconomic status.

[1] Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.

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Adhering to this framework, to maintain high-quality care and patient safety, staffing levels must remain consistent and aligned with patient needs. Significant variations in staffing ratios can compromise care quality, efficiency, and overall patient outcomes. Establishing a standardized approach allows for better resource planning, improved patient experience, and adherence to regulatory and ethical care standards.

The inability to establish a staff-specific framework for visits and clients would also prevent agencies from aligning their staffing and caseloads with Medicare payment models, thus undermining sustainability. Agency closures would occur, which would further exacerbate challenges with access to care that exist across the state. Additionally, an inability to ensure that staff are working at full capacity will further limit the ability to serve all individuals who require home health care.

Home health and hospice providers must make informed decisions regarding patient care that prioritize safety and minimize harm. Ensuring that staffing levels align with patient needs is the foundation of providing safe and effective care. Without a defined minimum standard, visits outlined in plans of care may not be completed. According to the requirements at 42 CFR §484.60 Condition of participation: Care planning, coordination of services, and quality of care and 42 CFR §484.105(i) HHA acceptance-to-service standard, care delivery must be patient-centered, efficient, and structured to meet both clinical requirements and operational feasibility. Establishing clear staffing guidelines is essential to maintaining quality outcomes, optimizing resource allocation, and upholding regulatory and ethical standards.

While we understand and agree that staff providing direct care should have the ability to modify the amount of time spent with participants based on individual client needs, a wholesale prohibition on metrics evaluating the number of patients or visits undermines the ability to provide appropriate, quality, care. Instead, we recommend ensuring that there are procedures to establish exceptions to the productivity measures based upon the individual needs and care goals of specific clients served by a direct care provider. Such procedures should ensure that exceptions are determined by a supervisor with clinical expertise in the type(s) of services under consideration.

About the National Alliance for Care at Home

The National Alliance for Care at Home is the unified voice for providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of different sizes and types—from small rural agencies to large national companies—including government-based providers, nonprofit organizations, systems-based entities, and public corporations. Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. The Alliance is dedicated to advancing policies that support care in the home for millions of Americans at all stages of life, individuals with disabilities, persons with both chronic and serious illnesses as well as dying Americans who depend on those supports.