Note: This resource was published in 2021 and has not been updated. Contact ASPR TRACIE if you need technical assistance.

Home Care and Hospice during COVID: A Rural Perspective

HIGHLIGHT

In rural areas, home care and hospice often go hand in hand. ***Sue Heitkamp****, RN, BSN, President, and* ***Joelle Goldade****, RN, BSN, CHPN, COS-C, HCS-D, Director of Clinical Operations (both of CHI Health at Home), shared how they carried out these important services during the COVID-19 pandemic.*

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Please tell us more about your organization; what areas do you serve, and what is your average census?

Sue Heitkamp (SH)

We provide home care and hospice in North Dakota (Bismarck, Dickinson, Fargo, Valley City, and Williston) and in Breckenridge and Little Falls, Minnesota. We oversee seven agencies which have censuses between 50 and 150.

Because we primarily serve rural areas (with a few urban locations), all our staff are cross trained in home health and hospice. This has been a huge benefit for staff and patients, who may start off in home health and end up in hospice; oftentimes they have the same nurse throughout the process.

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Did your staff have to change how they communicated with patients when COVID hit?

SH

We reminded staff that their office could be a park, their home, their car—as long as they had the equipment they needed to take care of clients. We primarily communicated with patients via Zoom, Skype, and iPads; clients often relied on their adult child's smart devices.

Upon referral to our home health or hospice agency, we had telephone conversations with patients to determine what kind of access and tools they already had. We would use that type of communication device (e.g., iPhone, hardline, iPad). We will continue doing this in the future; it was very beneficial to providers and clients.

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Did you find any challenges associated with relying on technology so heavily at first?

SH

We have always been a point-of-care documentation organization; we bring our tablets to patients' homes and document the visit in real-time. We do not (and are not allowed to, during COVID) go back to the office to do that anymore. Some older clinicians were a bit challenged by some of the technology, but this is how we are operating now. This brought out the best in us, truly—now we are more mindful careful in our written conversation, and we are as prepared as possible before a virtual face-to-face meeting.

COVID really made us realize what home health and hospice could do; when it started in 2020, I told staff this was a chance for us to shine. We have always been flexible, worn PPE, and used nontraditional locations as our "offices."

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Did staff face any challenges accessing patients who were in medical facilities—especially since you work in two states?

SH

One state might have had different regulations regarding nursing homes or other facilities, but much of this was short lived and easy to work around. In some cases, we had our registered nurses go into facilities and report back to other staff who could work more directly with the family. That said, skilled nursing facilities were heavily regulated and visits very restricted; the pandemic really put a strain on our ability to provide hospice the way it needs to be provided.

Joelle Goldade (JG)

We worked diligently to assure both skilled nursing and assisted living facilities that we were well prepared. Our leadership team was meeting twice daily at the outset of the pandemic and updating documents relative to personal protective equipment (PPE), best practices, policies, and care of clients. This education was provided by each agency director/ clinical coordinator to their clinical staff. Once the facilities knew we were staying abreast of all changes, providing care based on best practice, they allowed clinicians to provide care. We also provided testing twice weekly to our staff and gave those results to their nursing administrative team to assure our clinicians were safe. Currently, 80% of our teams are fully vaccinated; we let these facilities know that our staff is both tested and vaccinated.

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Were your providers fit tested for N95 masks?

JG

Yes, once fit testing was available to us (via local hospitals and public health agencies), we provided it to our clinicians.

SH

Supply was a challenge, and our staff was not fit tested at first; we had to change the way we worked very quickly. First, we focused on educating our staff. Some of them were scared to care for COVID-positive patients, so we tried to share resources and answer as many questions as we could before we fit-tested anyone.

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How else did you support staff?

JG

As a leadership team, we met daily to review changes and update processes and policies. We then met daily with the agency directors and clinical coordinators to review clinical issues, mission, operations, financial, and human resources. After we had the afternoon meetings with the agency directors and clinical coordinators, they brought that information back to their teams which included nursing, social workers, chaplains, aides, therapists and administrative assistants.

SH

We also met with all staff via Zoom to review new information and guidance received as quickly as it was coming out. Sometimes you felt you were in a "MASH" unit, and sometimes you were in total awe at how your staff could handle everything. Everyone was glued to the TV, and we felt like we were in it together.

Some staff did have to be quarantined, or stay home to care for an ill relative, but we did not lose any staff. We did have to essentially "triage" our services at times when our staff numbers dropped. We focused our teams' wellbeing, too; we knew they were taking care of children and elderly parents while serving as clinicians.

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How was your patient census affected by COVID-19?

SH

When numbers started to increase in ND and MN, home health numbers remained stable. Where there was a surge of cases in ND, home health numbers surged with them. Hospice numbers actually declined, because some patients did not make it out of the hospital, some facilities were not allowing outside staff in at the beginning, but also because of the nature of the field. Hospice is not just made up of clinical care—it includes spiritual, emotional, and psychological care—and it seems like hospice was not perceived as a "good fit" with COVID, despite it taking so many lives. I think it is viewed as a philosophy and not so much from a clinical lens, even though we do provide clinical care. In turn, with so much death and grieving over the past year, I think we missed out on what hospice could have provided.

I also think there were non-COVID deaths that were not referred into hospice. We just got a bit lost in the shuffle. We could have provided grief support and I think we owe it, looking forward, to ensure something as valuable as the services we provide are not pushed aside.

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Have you been involved in vaccination?

SH

We said we would take a role in that, and we are in patients' homes—it is the perfect opportunity to vaccinate people! This has not been rolled out yet, but when it is, we would be happy to participate.

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Did you benefit from Centers for Medicare & Medicaid Services (CMS) waivers?

SH

CMS waivers decreased some unnecessary paperwork, making it much easier for us to get care to clients quickly. One of the waivers that has been especially helpful was allowing non-physician providers (e.g., nurse practitioners and physician's assistance) to order / refer patients to home health. They could order hospice before, but now they can order home health, too. This is extremely important in rural areas like ours, as it saves money and improves the services, we deliver.

JG

Another important waiver is the ability to do remote visits for both home health and hospice services. Although Medicare is not providing reimbursement for these services, conversations are continuing regarding the importance of telehealth and remote visits. At the height of the pandemic, the homebound status was updated to include any individual determined by their physician to be at high risk of contracting COVID-19 virus due to a compromised health condition, because it is "medically contraindicated" to leave the home. This allowed us to care for clients who required care but did not leave to go to medical appointments and did not fit the traditional "homebound" criteria.