

COVID-19 Issue Brief: Surge

Overview

Vermont's home health and hospice agencies can be of assistance to hospitals during the COVID-19 crisis. They can care for COVID-positive or suspected COVID-positive patients at home with a community referral, a referral from the ED or post-discharge. **Recent Federal waivers have lifted several critical regulatory and reimbursement barriers that would normally limit those services.** Where appropriate, hospice staff and hospice medical directors can support the home health team with pain control or assistance with goals of care conversations. Other examples already underway in Vermont include helping to staff external surge sites and taking on blood draws, injections and infusions that would normally be done in the hospital.

Relevant Federal Policy Changes:

- (1) [Expanded definition of “homebound”](#) allows home health agencies to receive **Medicare reimbursement** to provide skilled care for COVID-19 patients—and patients *at risk* of COVID-19. “A beneficiary is considered homebound when their physician advises them not to leave the home because of a **confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19.**”
- (2) [New flexibility on respiratory related devices, oxygen and oxygen equipment, home infusion pumps and home anticoagulation therapy](#) allows more care to take place at home. For example, Medicare will cover non-invasive ventilators, respiratory assist devices and continuous positive airway pressure devices based on the clinician’s assessment of the patient. The rules are different on the hospice benefit; agencies can assist with the details.
- (3) [NPs can order home health](#) and develop a care plan. This was formerly limited to physicians.
- (4) Community physician practices can meet the “face-to-face” order requirement [through a remote visit.](#)

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Primary Barriers:

Planning and coordination at the community level between hospitals and home health and hospice agencies is essential. Barriers vary by community, and they will also vary over time depending on supplies and the extent to which our workforce remains healthy. In addition, like all providers, home health and hospice agencies have documentation requirements to meet federal and state regulatory requirements that will require coordination.

- (1) **PPE:** Home health agencies have worked hard to obtain equipment through all available mechanisms, public and private, but were considered “low-priority” when the stockpile still had supplies available. Agencies have carefully been conserving PPE to prepare for serving COVID-positive patients, but this is an important area to discuss in the planning process.
- (2) **Workforce:** Like all providers, home health agencies entered this crisis with a nursing shortage. We are working hard to protect our staff from exposure in the field. We are also asking CMS for changes that will allow us to maximize our workforce and welcome the advocacy support of hospitals in this effort.
- (3) **Family Support:** Patients who live alone and need 24-hour care are not appropriate for intermittent home health services. Discharge plans need to consider if family members are also ill and unable to provide support to patients.