

# Medical Home Visit Programs During COVID-19 State of Emergency

*Donna Seminara, MD; Anita Szerszen, MD; John R. Maese, MD; and Zeel Shah, MD*

**A** vulnerable segment of society is composed of elderly homebound individuals who can no longer care for themselves. We have witnessed bravery by families who embrace their elders with respect and love. Homes are redesigned to incorporate safety and creative design to facilitate accessibility for those with disabilities. Unfortunately, there also are those who suffer neglect by family and social isolation. We care for those who experience financial abuse, poverty, and burdens of chronic disease.

Our medical home visit program is embedded in the Division of Geriatrics at Staten Island University Hospital in New York. We provide ongoing medical visits for 325 families with a professional staff of geriatricians, family practice physicians, a physician assistant, nurse practitioners, a social worker, and a clinical pharmacist. Our office staff facilitates every imaginable need of this population. We have seen our share of natural disasters. While our hospital was being evacuated for Hurricane Irene in 2011, we approached Incident Command with our plan of contacting each family to assess needs. In 2012, while preparing for the impact of Superstorm Sandy, we had some homebound individuals transferred by ambulance to shelters. Staff members purchased and delivered food, and processes were coordinated with oxygen companies, visiting nurse agencies, and Meals on Wheels to predeliver goods. After each disaster, we assisted patients in recovery and safe relocation. The needs emerging from our current emergency are unlike those from any of our past crises. During the coronavirus disease 2019 (COVID-19) pandemic, we have experienced a myriad of unique challenges.

There is an exceptional amount of fear on the part of patients and families to access the health system with concern of coming in contact with COVID-19. This fear impairs good judgment. For instance, a patient taking Coumadin developed black diarrhea and light-headedness yet refused to go to the hospital for decreasing serial measurements of hematocrit. He said, "Hospitals are full of coronavirus and I won't go there." There is a fear of isolation because hospitals will not allow visitors, which also leads to poor decision-making. A patient with an acute cerebrovascular accident, with new-onset oropharyngeal dysphagia and the pocketing of food, progressed to fatal aspiration pneumonia because the

## TAKEAWAY POINTS

A greater awareness of the unique challenges faced by home health programs in the coronavirus disease 2019 (COVID-19) era will allow decision makers to take a holistic approach to patient management.

- ▶ Fear of encountering COVID-19 precipitates poor decision-making.
- ▶ Inadequate supplies of timely diagnostics for COVID-19 adversely affect services for homebound patients.
- ▶ A lack of personal protective equipment also diminished services by vendors such as visiting nurses and physical therapists.
- ▶ COVID-19 triggered altered end-of-life decisions by those afraid to be without loved ones in the hospital.
- ▶ Home visit medical care benefited from a boom in the use of telehealth services.

caregiver could not bear the thought of sending their loved one to the hospital alone.

Another challenge is the decrease in diagnostic support for patient evaluation compared with a pre-COVID-19 world. Vendors have been limiting their home visits, and as a result, our program has had less diagnostic support. Our portable radiology vendor went on hiatus. Previously reliable laboratories for home phlebotomy offered fewer rounds, and patients lost the benefit of urgent testing from home. Testing for COVID-19 by both polymerase chain reaction and antibody identification has been relatively nonexistent for the first few months of this pandemic for the homebound.

The inability to access personal protective equipment (PPE) placed severe limitations on our visiting nurse partners. They were unable to visit patients because they did not have PPE to protect themselves and not all the agencies were prepared to conduct telehealth services. Without these community agencies, support services such as physical therapy, occupational therapy, and speech therapy came to a staggering halt.

Another burden with the loss of diagnostic and therapeutic agencies is the emotional toll of losing the reassurance that these providers gave to patients. Regular contact by nurses and therapists plays an integral role in providing emotional support to overstressed caregivers. Positive reinforcements from these service providers

ensure validation for families that they are providing appropriate care. Such reassurance is invaluable in supporting caregiver efforts.

COVID-19 has had a tremendous health and financial impact on home health aides. Some of these dedicated professionals have contracted the disease themselves. While ill and convalescing, they are unable to work, and this has taken a financial toll on this force. Conversely, when a long-serving aide is taken out of rotation for a patient with advanced dementia, there is an increased risk of the patient developing delirium. Continuity of care providers is one key to success in care of adults with dementia. Additionally, there is the risk that aides may bring COVID-19 to patients either by having mild illness or as asymptomatic carriers. Our program has seen this tragically affect younger patients who are compromised by congenital ailments such as Down syndrome and older patients with dementia.

Another impact of COVID-19 on the homebound community is the pressure it brings to end-of-life decision-making. Even in patients who are chronically ill with a high degree of disease burden, some patients and families refuse to address issues relating to assigning someone as a health care proxy, establishing advanced directives such as Medical Orders for Life Sustaining Treatment, and considering palliative care and hospice programming. As patients become “persons under investigation” for COVID-19, their families have been forced to consider these issues under scenarios of increased emotional strain. An increased number of patients have transferred to hospice whose families previously would not consider it. The driving force in most of these situations was that the family did not want to be separated from the patient as they were dying. Most of these cases should have been on hospice already, but pre-COVID-19, there was a significant amount of familial resistance.

Technology has assisted in our provision of services. Families have embraced telehealth and have been very supportive and understanding of the strains on our professional and support staff during this crisis. They express appreciation for telehealth visits and to staff for their assistance in day-to-day operations. Patients have benefited in ways that would not have been earlier imagined. For instance, a patient had fallen and, after being lifted into a chair, was afraid to move for fear of hip fracture. When we were called, we had the family extend her legs with underlying support so we could see whether there was leg shortening or outward rotation of the foot. Upon seeing neither, we were able to coax the patient to ambulate with direct visualization. Other assessments have included shingles, bed bugs, olecranon bursitis, cellulitis, and exacerbations of congestive heart

failure and chronic obstructive pulmonary disease—all handled with minimal exposure to the patient and with gratitude from the family. We have trained families to assist in meaningful data collection activities like tracking temperatures, measuring heart rate, and performing pulse oximeter checks so that we could identify patterns of concern. Additionally, we have embarked on a program to have medical students provide “social calls.” They check on how patients are doing, and if a need is identified, including the need for psychological services, then appropriate referrals can be made.

We have been grateful for actions the federal government has taken to help ease transitions from the community to a skilled nursing facility when needed—for example, for the urgent care of a patient with dementia who could no longer be handled at home. CMS rescinded the “3-day rule,” which required a hospitalization for 3 days before Medicare allowed for payments in a skilled nursing facility.<sup>1</sup> Further federal and state allowances to decrease regulation and support payment for telehealth visits have provided needed fiscal support of programs that virtually bring medical professionals into the home to direct care.<sup>2</sup> We anticipate continuing to be nimble in the face of challenge and to provide timely and meaningful care for those who depend on our efforts. ■

**Author Affiliations:** Division of Geriatrics, Northwell Staten Island University Hospital (DS, AS, JRM, ZS), Staten Island, NY.

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**Address Correspondence to:** Zeel Shah, MD, Division of Geriatrics, Northwell Staten Island University Hospital, 420 Lyndale Ave, Staten Island, NY 10312. Email: zeelshah8994@gmail.com.

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2. Medicare telemedicine health care provider fact sheet. CMS. March 17, 2020. Accessed April 24, 2020. <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>

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