Hospital Operations Toolkit for COVID-19

Patient Care Policies/Processes:

Case Management

November 30, 2020

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Proper case management practice during the COVID-19 pandemic is integral to ensuring appropriate care is provided to patients while safeguarding the health of staff. Hospitals must recognize the challenges of navigating care for large numbers of COVID-19 patients, including many who have complex clinical care and social support needs.

Pre-planning is essential to anticipate needs of patients from arrival to post-discharge. Case management planning should account for healthcare access challenges, unique treatment needs, and potential follow-up care such as rehabilitation. Case managers should plan to:

- Collaborate with the care team to prioritize patient needs. Understand there may be several specialist providers to coordinate with depending on illness severity and pre-existing patient conditions. Plan for multiple scenarios and have care options and backup plans ready.
- Establish contact with support services (e.g., behavioral health, social worker, post-acute care, home health) early. Consider potential long-term, palliative, rehabilitation, dialysis, or hospice care needs
- Work with payers early to understand coverage for medical and support services. Be aware of changes to private insurer policies and flexibilities and waivers available under federal and state emergency declarations and their associated effects on healthcare coverage and reimbursement. Be prepared to educate patients and their loved ones on available services and treatment options.

> Additional information is available in the Financial Sustainability section.

- Integrate patients' loved ones into care discussions. Seek to understand the concerns, needs, and desires of the patient and loved ones and employ shared decision-making to negotiate a plan of care that is safe and appropriate.
- Be prepared to have difficult conversations (e.g., worst case scenarios, do not resuscitate). Plan for decedent management and be aware of each patient and their loved ones' expectations and practices around the dying process.
- Make use of an ombudsmen to advocate for patient needs related to treatment plans and suitable support services.

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Many hospitals have shifted to the use of remote case management to improve physical distancing by allowing staff to work from home or to engage with the loved ones of patients while in-person visitation is restricted. Hospitals should be aware of the consequences of remote case management on both the staff working from home and patients and their loved ones.

- Consider what technology or workflows will be required for case management staff and patient interaction. This may include using e-signatures, requesting email read receipts to track when vital information is received, knowing how to check out physical files when electronic records are not available, or establishing consistent meeting times to discuss patient progress.

> Additional information may be found in the Telehealth/Virtual Medicine section.

- Understand the best means to communicate with each patient's loved ones during hospitalization in the absence of in-person discussion and with the patient for any post-discharge case management. Patients and their loved ones may have preferences or access issues relative to use of telephone, email, or internet communications.
- Engage information technology staff to ensure technology is able to support remote case management and staffing is available to troubleshoot issues. This includes support of assistive technologies to enable use by those with sensory impairments or who need interpretation or translation services.
- Ensure case management staff are aware of and able to comply with new telework policies and procedures that may have been implemented during the pandemic, including the ability to adhere to cybersecurity requirements.

Resources Related to General Case Management
- Institute for Healthcare Improvement: COVID-19 and Patient Flow: How Case Management Can Help
- Professional Case Management: The Impact of COVID-19 and Critical Need for Case Management
- Tahan, H.:
  - Essential Case Management Practices Amidst the Novel Coronavirus Disease 2019 (COVID-19) Crisis: Part 1
  - Essential Case Management Practices Amidst the Novel Coronavirus Disease 2019 (COVID-19) Crisis: Part 2

Discharge Support

COVID-19 patients should remain hospitalized for as long as medically necessary. Discharge criteria vary based on factors including an individual's current medical condition and disease stage, hospital capacity and capabilities, and current disease transmission dynamics in the community. In areas where disease transmission and hospitalization rates are high, those with mild symptoms may be released from the emergency department to isolate and monitor their symptoms from home while inpatients may be discharged once their condition has improved even if they remain symptomatic.

Hospital clinical and case management staff should establish a discharge plan for each patient that accounts for the patient's discharge location. This discharge plan should also account for the feasibility of patient compliance with discharge instructions.

- Set up appropriate patient follow-up appointments.
- Consider rehabilitation, home health, long-term, dialysis, palliative, or hospice care needs.
- Ensure patients and their loved ones understand their post-hospital care instructions. Provide written discharge instructions – translated as needed – that specify isolation requirements and explain when patients should return for additional care.
- Discuss post-discharge care with primary care, visiting nurse, and other providers to enable continuity of care and to coordinate insurance coverage and other benefits.
- Identify and resolve possible challenges. Insurance coverage or ability to pay, transportation, the ability to access telehealth, access to specialty providers or services, the ability to understand and follow care plans, housing conditions, and language and cultural barriers should be considered.

Long-Term Care Discharge

Some patients who were in long-term care facilities – including nursing homes and assisted living facilities – prior to their illness will be transferred back to those facilities upon discharge. Other patients may be transferred to a long-term care facility for the first time due to the post-acute care needs associated with their illness.

Large outbreaks of COVID-19 in long-term care facilities and resulting hospitalizations and deaths among residents and staff have led to increased anxiety among long-term care facilities about accepting discharged COVID-19 patients. Differing state and local requirements related to transfers to long-term care facilities further add to confusion. Approaches to mitigating obstacles when patients are ready to be transferred to long-term care include:

- Working with long-term care facilities directly or through the healthcare coalition or other community response partners to ensure long-term care facilities have effective infection prevention and control programs in place, establish acceptance criteria for discharged patients, identify designated long-term care facilities for discharged COVID-19 patients, or otherwise set clear pathways to streamline hospital to long-term care transfers.
- Educating patients and their loved ones on patient rights when the patient originated from a long-term care facility or is being discharged to one.
- Involving state regulatory or ombudsman assistance to determine whether a rights violation has occurred during the return/referral process and negotiating a solution.
- Establishing criteria indicating when a recovering COVID-19 resident should be transferred back to a hospital.

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Home Discharge

Patients released to their homes should have a discharge plan that explains required post-hospital care activities (e.g., medication management, symptom monitoring, follow-up appointments, physical therapy), actions to reduce disease transmission in the household (e.g., isolation, respiratory and hand hygiene, use of a separate bathroom), and information on available community support services (e.g., transportation, meal delivery, isolation housing). This discharge plan should also include criteria for when patients should return to the hospital or otherwise seek immediate medical care. If contact tracing has not already begun, patients should be informed they will be contacted for follow-up.

As part of their discharge planning, hospitals must recognize that not all patients have an appropriate "home" to which they can be discharged. These vulnerable patient populations include:

- Individuals who do not have a safe place to isolate while contagious due to crowded housing conditions, fear of exposing household members, or other household challenges.
- Persons experiencing homelessness who lack stable housing in which to recover.
- Patients who no longer need acute care, but who cannot be discharged to post-acute or skilled nursing care due to bed availability issues or acceptance criteria.
- Individuals who need assistance or supervision to adhere to post-hospital care instructions.

Communities have implemented various approaches to identifying locations for COVID-19 patients who no longer require acute care, but who need to be monitored as they continue their recovery or do not have a safe place to isolate or convalesce. These approaches are based on the extent of disease transmission in the community, availability of resources, and types and numbers of patients in need of post-discharge housing. Examples of these approaches include:

- Hospitals partnered with skilled nursing facilities to establish acceptance criteria for discharged patients.
- Some health systems designated a single facility within their system for isolation or post-acute care.
- Local jurisdictions established sites such as hotels for alternate care, isolation, respite, or recovery.
- Healthcare or housing providers used telehealth to support individuals in isolation.
- Communities worked with long-term care to identify designated facilities/buildings for convalescent COVID-19 care.

Each of these approaches has different logistical considerations and staffing needs. Hospitals should work with their healthcare coalition or other community emergency planning partners to determine approaches appropriate for the patient population and available resources.

Resources Related to Discharge Support

- Agency for Healthcare Research and Quality: Re-Engineered Discharge (RED) Toolkit
- Alameda County (CA): Operation Comfort: Alameda County Emergency Hotel Shelter Handbook

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- American Society of Nephrology: [Dialysis After Discharge: Transitions of Care for COVID-19 Positive Patients](#)
- ASPR: [Discharge Planning and Care Coordination during the COVID-19 Pandemic](#)
- ASPR TRACIE: [COVID-19 Alternate Care Site Resources](#)
- Beth Israel Lahey Health:
  - [Home Care Isolation Instructions for Patients and Their Caregivers when COVID-19 is Suspected or Confirmed](#)
  - [Post-ICU Care for Survivors of COVID-19](#)
- Centers for Disease Control and Prevention:
  - [Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings](#)
  - [Key Considerations for Transferring Patients to Relief Healthcare Facilities when Responding to Community Transmission of COVID-19 in the United States](#)
- City of Chicago: [COVID-19 Isolation Facilities](#)
- City of New Haven (CT): [COVID19 Respite Facility for People Experiencing Homelessness](#)
- Corporation for Supportive Housing: [Triage and Tele-Health Support Plan for Isolation Units](#)
- Florida Health Care Association, Florida Hospital Association, and Leading Edge Florida: [Hospital to Post-Acute Care Facility Transfer – COVID-19 Assessment](#)
- Hackensack Meridian Health: [Patient Resources](#)
- Los Angeles County Department of Public Health: [Coronavirus Disease 2019 Facility Transfers & Home Discharge Guidelines](#)
- National Health Care for the Homeless Council: [Medical Respite Care and Alternate Care Sites](#)
- Project ECHO: [Transitions of Care: From Acute Care to Long Term Care](#)
- The Geriatric Emergency Department Collaborative: [Emergency Department Discharge of Older Adults with Viral Syndrome During the COVID-19 Pandemic](#)
- UC Health: [COVID-19: Follow-Up Pathway for Recently Discharged Patients](#)

At-Risk Patient Case Management

While all patients need case management services, some patients require additional case management considerations during their hospital stay and upon discharge due to characteristics that place them at greater risk for unsuccessful outcomes. Hospitals should be aware of healthcare access issues in the community and determine if technology, physical infrastructure, transportation, additional testing or services, education, or targeted outreach is needed to support at-risk individuals. These challenges extend post-discharge; access to rehabilitation, supplemental support services (such as mental health, telehealth), specialized physicians, housing, acute dialysis in the outpatient setting, and prescription drugs may be severely limited.

Hospital case management staff should understand interrelated factors that may contribute to increased risk of severe illness or complications. Older adults, those with chronic health conditions, and communities of color are among the populations known to be more likely to be hospitalized or die due

to COVID-19. Become familiar with community demographics – including age, disability status, race and ethnicity, housing, education, and financial circumstances – to prepare for patient needs.

- Some rural and urban populations may experience severe lack of access to care. This can include limited providers, the need to travel long distances, limited access to transit, or an inability to access adequate technology/internet or telehealth services. In remote areas, transportation and consistent medical access will be major factors both in the timing of seeking medical care and the ability to meet post-discharge requirements.
- Low income and uninsured/underinsured persons may seek care later due to worry over cost of services or be unaware of their eligibility for services. Financial concerns may affect adherence to post-discharge care instructions. Those living in crowded housing conditions have increased exposure risks and may not be able to isolate from other household members upon discharge. Lack of reliable infrastructure such as running water or electricity also impedes post-hospital recovery.
- Immigrants and refugees may delay care seeking due to their own legal status or that of their loved ones. They may be less knowledgeable about their eligibility for services and may live in intergenerational households or other crowded housing conditions. Recently settled immigrant or refugee populations may have underlying health conditions or previous disease history not typically cared for in U.S. healthcare settings.
- Essential workers are at increased risk of exposure. Many lack paid leave, which may lead to delayed diagnosis and treatment and increase pressure to return to work before recovery is complete.
- Persons with previously limited access to routine medical care may be unaware of their medical history, including allergies to medications or vaccination/immunization records.
- Patients with chronic health conditions may experience complications due to their comorbid conditions. Post-discharge, they may require at-home assistance or long-term care support. They may also delay or interrupt ongoing care to reduce their COVID-19 exposure risk, thereby exacerbating their existing non-COVID conditions.
- Those subject to systemic inequities may be distrustful of healthcare institutions and risk communications, resulting in a reluctance to seek care or follow provider instructions.
- Children, people with dementia or cognitive impairments, people with mobility impairments, and people with substance abuse disorders may be reliant on others for care seeking and adherence to recovery instructions.
- Those residing in institutional settings such as jails, prisons, shelters, group homes, or long-term care facilities are at greater risk of exposure should the virus be introduced in their setting. Significant coordination is required with community partners for their case management.
- Misinformation is circulating in many communities about testing, treatments, and vaccines. Some individuals may have concerns about becoming infected while seeking care or may be reluctant to follow the advice of medical experts.

Cultural, religious, and language factors also pose unique challenges to case management. Cultural awareness and understanding community sensitivities can shape more positive health outcomes.

- Be aware that cultural and religious beliefs can conflict with traditional treatment plans.
  - There may be a reluctance to take medications, eat traditional hospital food, or use medical supplies. Skepticism in seeking medical care, especially traditional Western medicine, or misinformation circulating in the community may lead to mistrust of medical professionals.
  - Knowing patient demographics, understanding cultural norms and differences in care expectations, and properly preparing to educate patients and their loved ones can alleviate many of these issues.
- Recognize the need for certain cultures to practice ceremonies and rituals during their stay. Spiritual care of patients has been shown to significantly improve health outcomes.
  - If participation of family or community companions is not possible, virtual support or telephone services should be considered.
  - Discuss with hospital operations and infection prevention staff if concessions can be made to accommodate a patient's request.
- Ensure appropriate interpreters are used during all encounters where language barriers can restrict adequate case management. Identify sources of translated and pictorial materials to communicate with and educate patients and their loved ones. This applies not only to non-English languages commonly used in the community, but also to communications with the blind and visually impaired as well as those who are deaf or hearing impaired.
- Identify a family or community point of contact who can serve as a "cultural interpreter." They may be integral in post-care compliance and follow-up needs.
- Engage cultural, faith-based, and other at-risk community leaders to look at materials and the process of care to assist in identifying opportunities for improvement.
- Ensure staff have adequate tools and resources to handle sensitive cultural and racial concerns.
- Recognize that communities of color and older adults have been disproportionately affected during the pandemic and that understanding the factors that contribute to their increased risk of hospitalization can ensure proper treatment and quality of life outcomes.
- Understand the basic civil rights of all patients.

Resources Related to At-Risk Patient Case Management
- American College of Emergency Physicians: ACEP COVID-19 Field Guide
- ASPR COVID-19 Response Assistance Field Team: COVID-19 and Minority/Vulnerable Populations
- ASPR TRACIE:
  - COVID-19 At-Risk Individuals Resources
  - Rural Health and COVID-19
- Care Excellence: The Impact of Culture in Case Management
- Centers for Disease Control and Prevention:
  - Social Determinants of Health: Know What Affects Health

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- o COVID-19 in Newly Resettled Refugee Populations
- o Guidance for Large or Extended Families Living in the Same Household
- Center for Urban and Racial Equity: Equitable Response Community Commons
- COVID-19 Healthcare Resilience Working Group: Rural Healthcare Surge Readiness
- COVID-19 Real-Time Learning Network: Disparities & Culturally Competent Care
- HIV Medicine Association: Access to Prevention and Healthcare Services for Immigrants with Communicable Diseases: A Resource for Public Health, Prevention & Care Providers
- National Association for the Advancement of Colored People: Coronavirus Equity Considerations
- National Association of Community Health Centers: The Impact of COVID-19 on PRAPARE Social Determinants of Health Domains
- National Voluntary Organizations Active in Disaster: A Guide for Spiritual Care in Times of Disaster
- Public Health Institute: COVID-19: Addressing Discrimination and Racism
- Relias Media: Cultural Competency Is Essential in an Increasingly Diverse Society
- The COVID Tracking Project: Racial Data Dashboard
- Toronto Central Regional Cancer Program: Tip Sheet: Indigenous Access to Ceremony during COVID-19
- U.S. Department of Health and Human Services: Initiatives to Address the Disparate Impact of COVID-19 on African Americans and Other Racial and Ethnic Minorities
- U.S Health and Human Services Office for Civil Rights: Civil Rights and COVID-19

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