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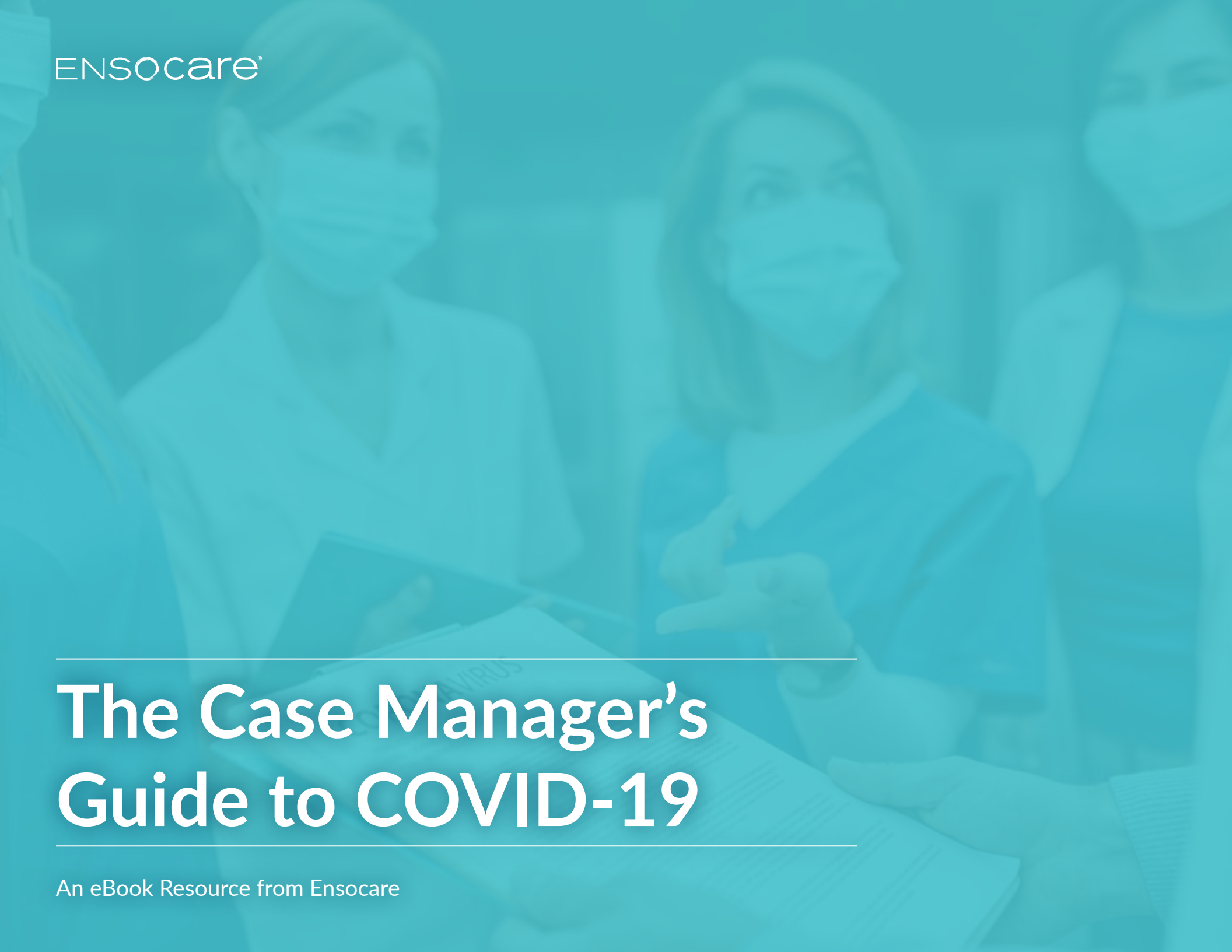

The Case Manager's Guide to COVID-19

An eBook Resource from Ensocare

Months into the pandemic and it seems like the stress and the strain will never end.

But there are positives. Because healthcare experts have also spent this unprecedented time conversing with other healthcare professionals, navigating a never-before-seen clinical environment, and learning new best practices that will set healthcare leaders up for success now and long after the pandemic is behind us.

In this Ensocare E-Book, you'll learn the many ways that COVID-19 has turned the role of the case manager upside-down, but you'll also see how hospitals have responded and adapted their policies to create an optimized patient experience.

Plus: you'll discover insights that can **help your own organization become more nimble, efficient and successful**.

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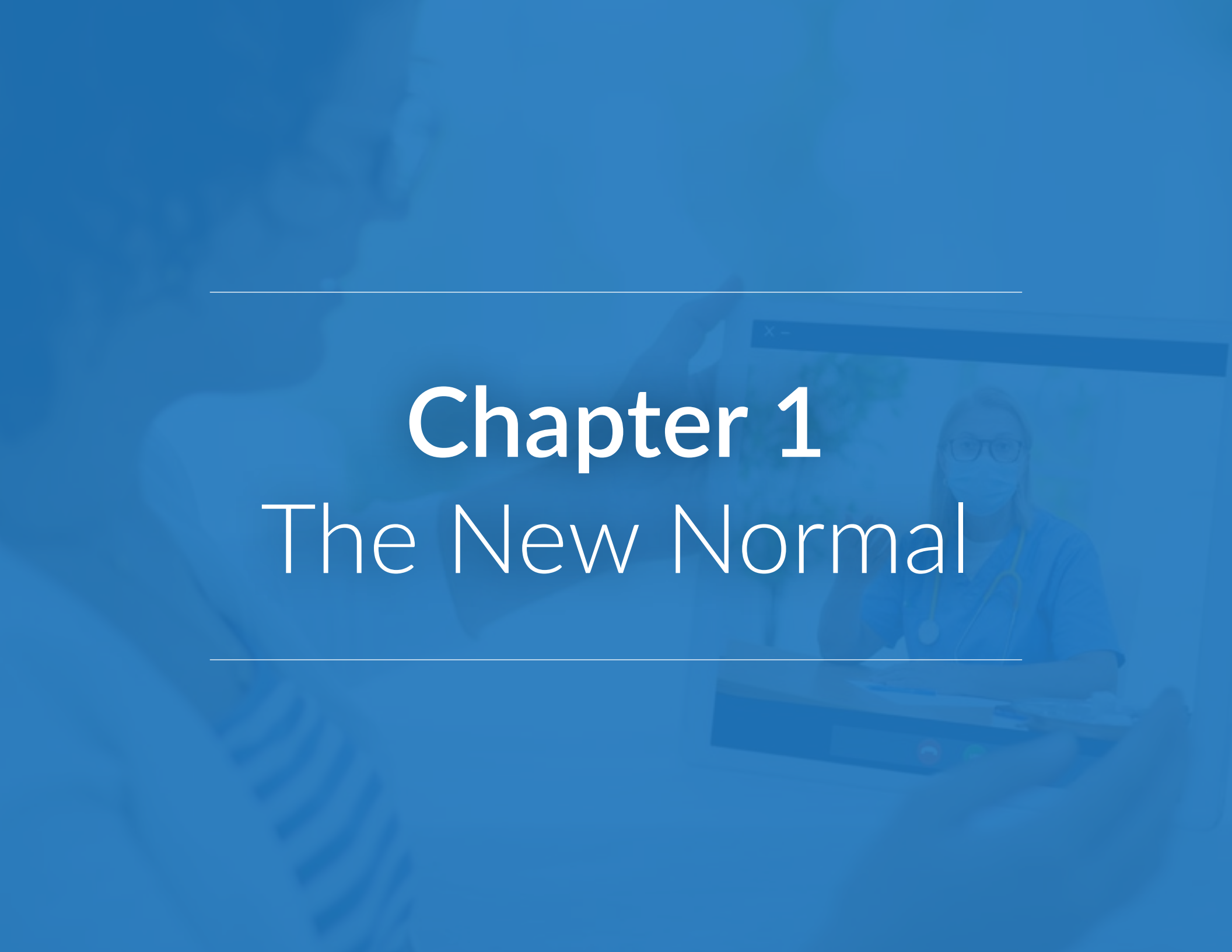
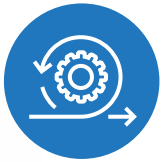


Chapter 1
The New Normal

Top Takeaways



Be Agile:
The ability to quickly adjust capacity on the fly will become one of the most important things a healthcare organization can accomplish moving forward.

Embrace New Technology:
Faxes and phone calls to post-acute providers waste valuable time and resources; case managers should use electronic communications to enable the quick transfer of patients.

Balance Staff Capabilities:
Cross-training among departments and disciplines will become more common as hospitals recognize the need to move clinical and non-clinical staff around the hospital to meet fluctuations in demand.

Revamp Crisis Training:
Crisis response will need to be baked into everything you do at your acute care facility. Annual training will no longer suffice.

Consider Expanding Your Preferred Network:
COVID-19 has shown that case managers may not be able to rely on organizations traditionally listed among patients' potential discharge locations. If an outbreak happens, alternate options will be crucial.

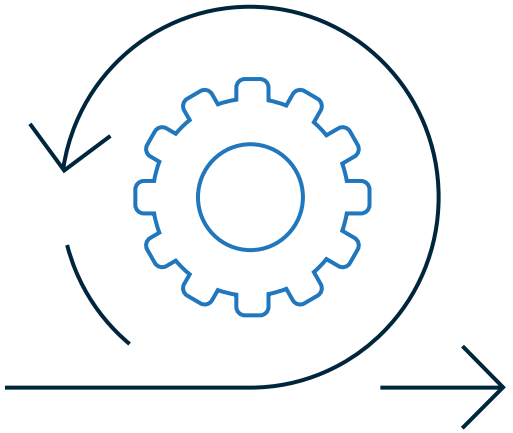
As the last few months of 2020 take shape, **hospitals around the country have reached a tenuous stabilization** in regard to the influx of COVID-19 cases.

As the last few months of 2020 take shape, hospitals around the country have reached a tenuous stabilization in regard to the influx of COVID-19 cases. For the most part, the United States has been able to avoid the widespread resource strain that was feared back in March, and most facilities have been able to delineate areas of the hospital designated for COVID patients and those designated for other patients.

Combined with all 50 states undergoing at least some form of an economic reopening, we've stepped into a new stage of combating the virus, one in which healthcare workers are cautiously looking ahead to what comes next. With elective procedures ramping back up and patients more comfortable with visiting their doctors, capacity is slowly filling back up.

However, this "new normal" is anything but, and how healthcare appears right now may look completely different from where we're at two months from now. After conversing with some of our hospital contacts and researching the types of processes taking place, the Ensocare team has some takeaways about what acute care providers ought to do now and how they can plan for the future.

The big takeaway? **That future might look unlike anything we've ever seen**.



Flex Space

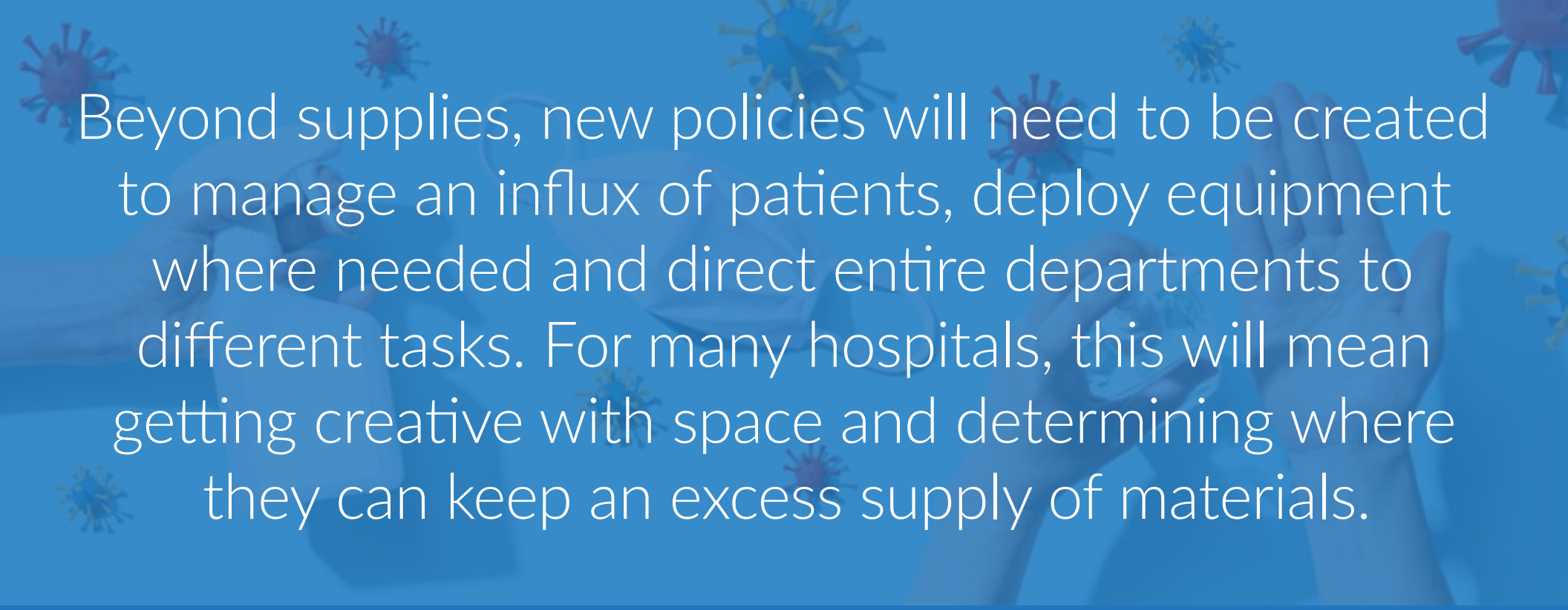
One thing that's rapidly become apparent as hospitals bring their acute care teams fully back online: the ability to quickly adjust capacity on the fly will become one of the most important things a healthcare organization can accomplish moving forward.

With states and even individual cities reopening in a multitude of different ways, from careful removal of lockdown procedures with strict social distancing to throwing the doors wide open to all businesses, it will be nearly impossible to predict a uniform rate of COVID cases over time. Hot spots will ebb and flow, affecting different areas for differing lengths of time.

As a result of this new, unpredictable world, healthcare providers will need to be agile.

So even as you bring back elective procedures and return to the standard provision of care you were used to pre-COVID, you need policies in place that allow you to quickly rope in additional resources for COVID patients if and when there's a spike in case numbers in your area.

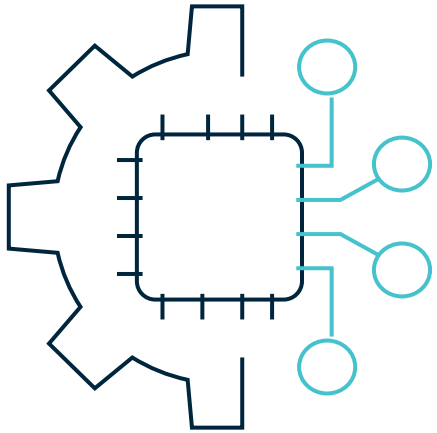
This completely alters the hospital revenue landscape, where the prevailing wisdom has long been to maximize resources and not let anything go to waste. **Now, however, you'll need an excess supply of PPE, ventilators, other medical equipment and, importantly, beds.** These might sit there unused for a long time, **but when you need them, you'll need them fast.**



Beyond supplies, new policies will need to be created to manage an influx of patients, deploy equipment where needed and direct entire departments to different tasks. For many hospitals, this will mean getting creative with space and determining where they can keep an excess supply of materials.

While these sweeping changes may be overwhelming for many hospitals, one promising sign is CMS's willingness to accommodate flexibility, chiefly through the newly deployed Hospitals Without Walls program. Recognizing that space in an acute care facility may be at a premium in the foreseeable future, CMS has basically said that they'll extend reimbursement for acute care outside the hospital, eliminating a revenue hurdle that would have otherwise hindered appropriate provision of care when COVID cases exceed a hospital's supply of resources.

Acute care facilities ought to work with post-acute care organizations, both inside and outside their preferred network, to determine if they have capacity to accept COVID and non-COVID patients when they themselves have reached capacity. This will require rapid deployment of personnel and equipment to those facilities, so again, you must carefully think about how this might work. But in a pandemic, when time is of the essence and you need to be able to add additional capacity fast, having a release valve in the form of rehab facilities, skilled nursing homes, behavioral health facilities, etc., is crucial.



Communication

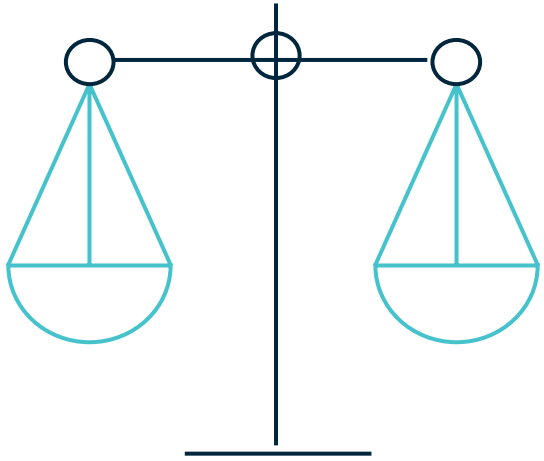
For case managers, the ability to communicate instantly between providers will become ever more important.

Reliance on your post-acute providers will be twofold: first, you need to know immediately if they're able to accept recovering COVID patients who no longer need acute care, as getting those patients discharged fast will help you free up beds and resources and maximize your staff. Second, if and when you do experience a surge in patients, instant communication will enable you to quickly set up acute care in a non-traditional setting among those post-acute partners who are willing to offer up that service.

Given what we know about the ebb and flow of patients you may experience, having the capability of coordinating the successful transition of these patients between locations and between levels of acuity is more important than it's ever been. While relying on fax machine and telephone communication may have worked before, those processes are too slow and eat up far too many resources to deal with the fast-changing dynamics of a pandemic.

Moving forward, case managers should **leverage new technology via electronic communication between providers**, which enables the quick acceptance of discharged patients and appropriate resource use at all levels.

Bringing Back Staff and Training Them Up



Hospitals that furloughed or let go of staff and need to rehire are beginning the process of bringing people back. But this is another tricky area, as you once again have to balance the need to earn profit with the reality of a surging and waning COVID-19 population. Balancing staffing capabilities with the needs of the incoming patient population may require rethinking your previous hiring practices.

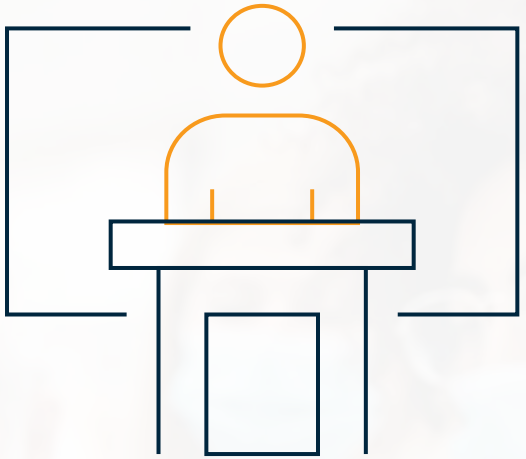
We expect cross-training among departments and disciplines to become a lot more common as **hospitals recognize the need to move clinical and non-clinical staff around the hospital** to meet fluctuations in demand.

Unfortunately, this could lead to some members of your team unable to work at top of license for periods of time, not the most ideal use of resources, but something that's hard to avoid in this scenario.

Another consideration might be to rethink where your teams are located and how they work. We previously explored how some facilities are moving to a remote case management workforce, and we expect these kinds of broad reconsideration of previous policy to only grow more common.

And make sure that, at all times, **staff is regularly trained on the newest policies**.

You may even have to hire some people exclusively to coordinate information and training among employees, knowing that up-to-date information can and will change regularly. Nowhere is this training more important than among new and furloughed staff, who will need to rapidly get up to speed on new infection control procedures, patient flow protocols and more.



Crisis Planning

Although most every hospital will have some form of crisis response and crisis communications plan in place, up until 2020, these processes probably didn't get a huge amount of attention among many staff members.

That changes now. Crisis response will need to be baked into everything you do at your acute care facility. Annual trainings will no longer suffice. Within every aspect of your facility, and among every team member, there needs to be a strict understanding of the procedures that need to be followed in a number of plausible scenarios resulting from the outbreak of COVID-19 or another public health emergency in the future.

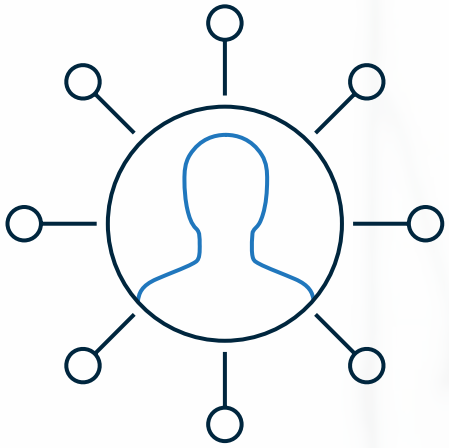
What to do when employees contract the virus? **What to do when ventilator space is limited**? How to deal with a belligerent family member who won't cooperate with new visitor policies?

These are just a few of the many questions and scenarios playing out in hospitals all across the country. Healthcare teams are encountering emergencies faster than crisis experts can come up with the best ways to respond to them. We're in brand new territory here and having a nimble team that understands the protocols for a wide variety of common crises is essential. This will require additional training and probably some additional hires you never had to make before.

You may even find yourself working more closely with the public relations arm of your organization as they coach team members through how to respond to media inquiries, who should be appointed to speak to the press when a crisis situation present itself, and more.

The best thing you can do when leading your team is to have a plan in place, regularly regroup to study and update the plan, and be honest that normalcy is probably pretty far away.

Opening Doors, Closing Doors



Given the huge economic toll the coronavirus has taken on the country, acute care facilities also need to realize that many of their post-acute partners might not survive. Simultaneously, brand new facilities may spring up to take their place.

We're already seeing how nursing homes, for example, can be decimated if they experience an outbreak of COVID-19 within their walls. Given the close quarters of residents, their medical needs and their at-risk status, the virus can spread rapidly at such facilities, devastating the population. This does a few things: it compromises that facility's ability to provide care to current residents, limits their ability to accept new residents and risks creating a public backlash that makes acquiring new residents even more difficult, if not impossible.

That's why there's never been a better time to take a closer look at your preferred network and look at expansion possibilities. You may not be able to rely on organizations you've traditionally listed among patients' potential discharge locations. If an outbreak happens, you need to quickly disperse that information to the relevant case management teams, and you need alternate options at the ready.

What's more, you need to keep your ear to the ground and keep tabs on new facilities opening up that will be able to take your post-acute (and, in a Hospitals-Without-Walls world, acute) patients. Some hospitals are even spearheading this effort themselves, working with other leaders within their ACOs and umbrella institutions to create new post-acute and acute locations that fit their needs.

Be Nimble

No one knows what happens next. For healthcare professionals who rely on certainty, that's a scary thought. But one thing we do know is that things are changing, they're changing fast, and you have to be nimble in order to change with them.

You can't prepare for every eventuality, but you can prepare your team to expect the unexpected. You can create a system that anticipates change and is agile enough to adapt to that change. Processes may need to be adjusted on the fly, and everyone should go into this summer with the understanding that what healthcare looked like in 2019 will never again be what healthcare looks like. If you set this expectation now, you'll have a much easier time getting through this than those institutions that insist on latching on to tried and true procedures that simply don't work in the current environment.

Chapter 2
Discharging Difficult-to-Place COVID Patients

Top Takeaways

Address Lack of Vacancies:

Due to the highly transmissible nature of COVID-19, many post-acute facilities that would traditionally accept patients are unwilling or unable to take on those recovering from the coronavirus.

List & Track COVID-19 Facilities:

Create and curate a list of all post-acute care (PAC) facilities currently accepting COVID patients. To avoid surprises, set up a process wherein you double-check their status on a weekly, biweekly or, at the very least, monthly basis.

Utilize an Electronic Database for Your PAC Network:

The increased demand of a public health crisis makes it imperative that case managers use a software tracking solution to increase the accuracy, speed and clarity of patient transfer.

Consider Home-Based Care:

While each state will have specific health parameters to follow, case managers should consider expanding qualifications for home health candidacy when possible.

It's happened to all of us in the case management field.

You have a patient who's ready to take the next step in their recovery. Their acute stay is complete, they've selected their preferred post-acute facilities, and you've begun the process of communicating with those providers to determine if they have the capacity to take on your patient.

Then you start receiving replies: **No**. **No**. **No**.

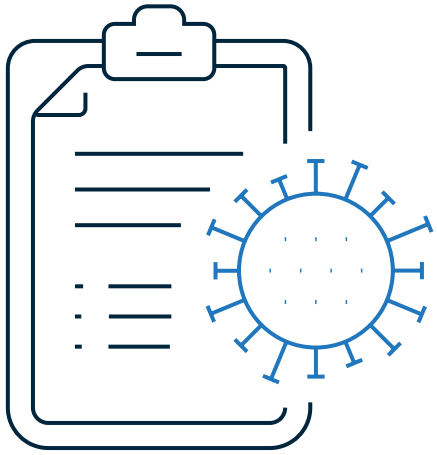
So you try again. You go back to the patient to apologize and tell them their initial choices aren't accepting patients. You create a new list of potential facilities and communicate with them.

No. **No**. **Maybe** (and then you follow up to find…no).

This is a frustrating situation at the best of times, but during the COVID-19 pandemic, it's particularly disheartening. COVID-19 is straining capacity of our nation's hospitals, and the highly transmissible nature of the virus also means many post-acute facilities that would traditionally accept patients are unwilling or unable to take on those recovering from the coronavirus. Hospitals end up with patients stuck in a bed even as waves upon waves of additional patients are coming in right behind them.

How do you resolve this dilemma? There's no perfect solution, but **you can follow a few best practices** to increase the chance that a patient is able to be discharged to the LTACH, SNF, IRF or any other facility where they'll be able to progress in their recovery.

Have a List of COVID-Ready Facilities…And Track Capacity



The best initial step you can take, if you haven't done so already, is to create and curate a list of all post-acute care (PAC) facilities that are currently accepting COVID patients.

This can itself be broken down into smaller steps. First, compile your list. Ideally, the solution you use to automate the discharge process has a feature that highlights whether or not a PAC is accepting COVID patients. If not, you have a lot more work ahead of you, as you'll have to reach out to these facilities on a regular basis to see their status and monitor if anything has changed.

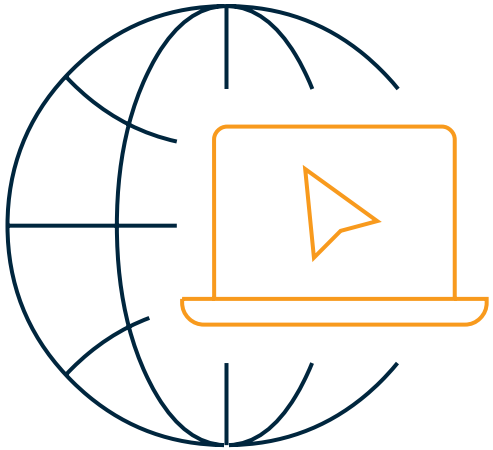
Once you have the list of PACs that accept COVID patients, set up a process wherein you double-check the status on a weekly, biweekly or, at the very least, monthly basis. To be at your most efficient, you don't want to have any surprises awaiting when you seek to place a patient.

As you go about placing patients, ask a PAC representative what their current capacity looks like. **Just because a facility can accept patients doesn't mean that they're always able to do so**.

They might have a relatively small number of beds in a separate unit set aside for COVID recovery cases. You'll want to know this number and be updated when they're almost full. Ideally, they would send a note to let you and other hospitals in the area know when they're at capacity, but that isn't always the case. You might have to be pretty proactive to track this information.

Finally, **keep a database that everyone on your discharge and case management teams can access** and edit as they discover more information.

Quickly Update Your PAC Network



Never before have hospitals' networks of potential post-acute facilities fluctuated so greatly in such a short period of time. As local governments and larger health systems respond to surges in cases by co-opting hotels, PACs and other buildings for the purpose of supporting the treatment and recovery of patients, your post-acute network is undergoing a level of change that case managers are unaccustomed to.

In order to have the best chance of discharging your patient to an appropriate setting, you need a running list of what settings are available. This certainly isn't easy, but you can do a few things to help your team out.

First, you need an electronic database of available organizations, which we've already mentioned. But more than that, **you need to be able to add and delete facilities on the fly. It's imperative that you have a software solution that accommodates this need**, otherwise you simply can't keep up with the demand of the current healthcare landscape.

Keep your finger on the pulse of the local news and the current pattern of COVID cases.

Hopefully, someone at your organization acts as a liaison to your city, county or state health departments. This role can relay information about new facilities, allowing you to update your catalogue accordingly. If not, communicate with hospital leadership the value in this proposition and how it can help you get patients out the door more quickly upon recovery.

This is also a great time to have a "hotlist" of preferred providers whom you know can reliably take on difficult-to-place COVID patients. This would be those organizations that have a great track record of safety, the appropriate infection control protocols and exceptionally high capacity.

Don’t Skip the Details

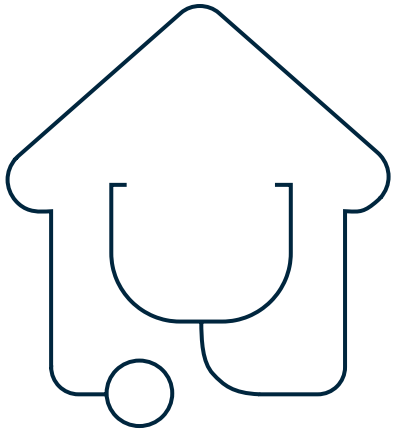
In some areas, standards have been set requiring, for instance, a patient to quarantine for two weeks at the PAC or to have a negative test result 48 hours prior to discharge. In other areas, these parameters might be piecemeal, with each individual PAC creating their own rules. And even in the areas with standards set by the Department of Health, the PACs might have additional rules that exceed those standards.

This scenario requires you to track a gigantic amount of information. The best way to do so could be to allow editing privileges to everyone on the team who has contact with PACs. That way, they can make notes and edit the PAC’s provider profile in your system. These notations can spell out things like testing requirements, capacity, transportation processes, infection control procedures, and other standards for accepting patients.

You might be sensing a pattern here: much of what we've listed as a best practice hinges on **carefully tracking and updating all available information so that your discharge team is working off the latest updates without having to manually track down** those details every single time.

If hospitals work as a team to acquire the most recent details, no matter how granular they may seem, and then you include that information in a database everyone has access to, you can save critical time and potentially get your patient out the door more quickly.

This issue requires systemic change and constant vigilance, but it will be worth it when it comes to keeping capacity as low as possible. And when this is all over, whenever that may be, you'll have an adaptable system set up well for the future.



Home Health

One scenario we haven't touched on yet is home health, which comes with its own complications. But if you take the proper precautions, this can be a good opportunity to free up bed space and improve the patient experience by giving your COVID patient the chance to recover in a setting where they'll be most comfortable.

You no doubt have parameters governing what qualifies an individual to continue their recovery at home rather than at the hospital or in a post-acute care setting. We certainly wouldn't presume to offer clinical guidance in that regard. But we would encourage you to think about what you could do to expand home health candidacy and make the experience as pleasant as possible for patients.

When assessing patient fit for home-based care, a case manager should consider a number of factors. For instance, what kinds of initiatives do you have in place to ensure the social determinants of health are being addressed for the patient? If that individual is in quarantine within their home, does he or she have a scheduled prescription delivery or access to a steady stream of groceries? Do they have a means of safely making it to appointments, or access to high-speed internet that makes telehealth possible?

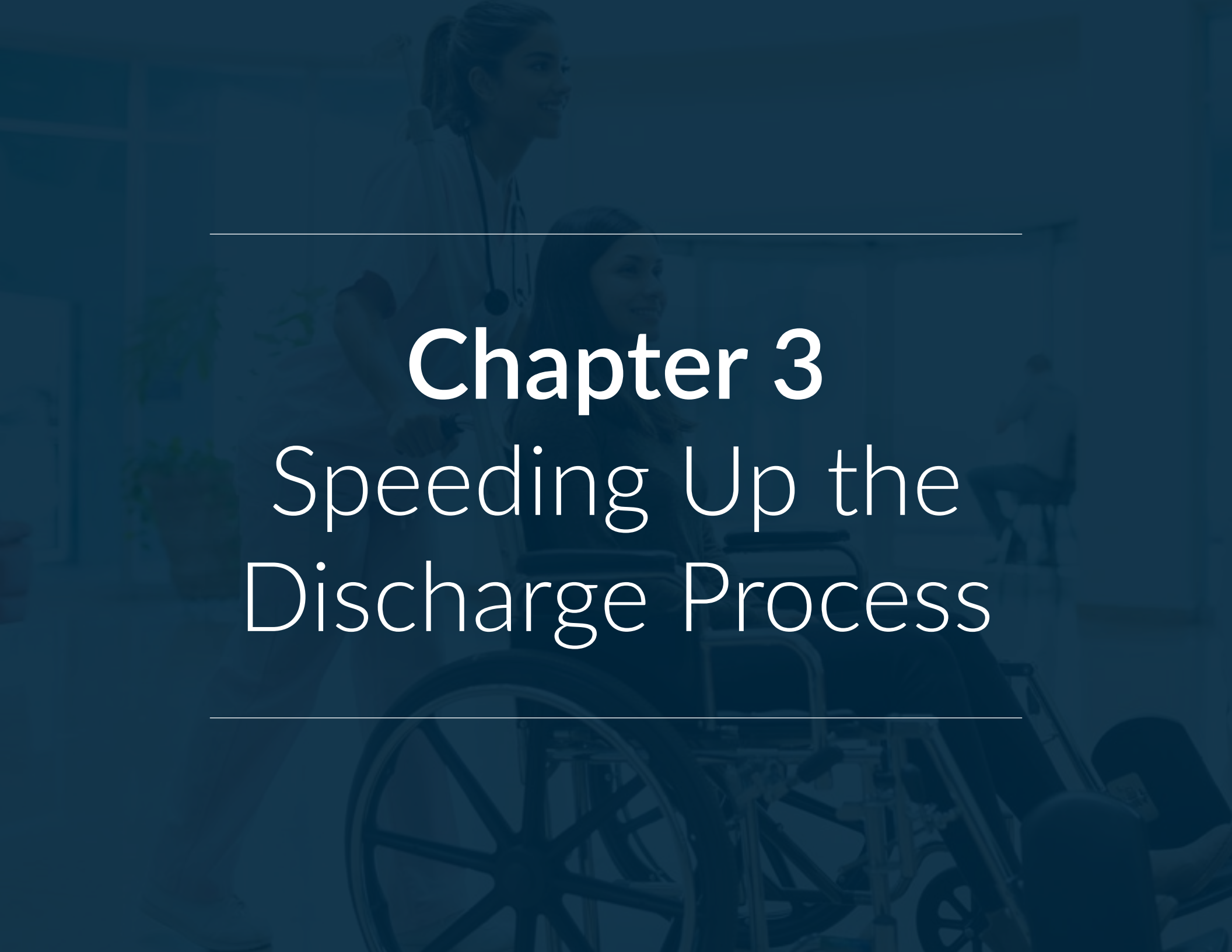
In some cases, if you can attend to the patient's needs, you might be able to take a patient who would otherwise have no choice but to stay in the hospital and allow them to recover at home. The cost of scheduling grocery delivery or setting up a telehealth app pales in comparison to the cost of that patient undergoing an extended hospital stay.

The past few years have seen plenty of talk about strategies that extend hospitals' purview beyond the hospital. COVID-19 has shown in great detail just **how important these initiatives can be for both recovery and revenue**.

As capacity becomes an issue, hospitals will no doubt get more creative than ever with determining which patients may qualify for home health, especially if a majority of PAC facilities are out of the question. Even if it requires additional staff or resources to check in on the patient and ensure they're progressing properly, this could be the right move for a number of patients who would otherwise be underserved in a hospital setting.

Ready, Set…Here We Go

We've all thrown around the word "unprecedented" a lot lately, but really, how else can you describe what's happening? **COVID-19 is causing all of us to rethink every process we have**, and discharge is no different, particularly when capacity is such a critical component of the proper provision of care.



Chapter 3
Speeding Up the Discharge Process

Top Takeaways

Narrow Networks Are Critical:
Reliance on and expansion of narrow networks is a key factor in fast-tracking patient discharge.

Network-Wide Communication:
Being able to send an electronic communication to the entire narrow network at one time can dramatically improve speed.

Team Training:
Catching team members up on new policies, and setting follow-up expectations with case managers, is crucial.

Among the many challenges hospitals faced amid the COVID-19 health crisis **were strained resources** due to patients' extended lengths of stay.

Unfortunately, it is often the burden of the case manager to keep stays as minimal and reasonable as possible.

That doesn't mean discharging patients earlier than would be medically sound, but it does require medical teams to assess patients on their individual conditions. Then, when the determination is made that they're stable enough to transition to post-acute care, that person must be transported out of the hospital quickly, thus freeing up the bed for the next incoming patient.

Without a productive discharge process, resources will become strained past the breaking point. In many areas, this is already happening. In order to help alleviate the stress on hospitals, you need to be able to communicate with post-acute care (PAC) providers quickly and efficiently.

These insights aim to help hospital staff, case managers in particular, **establish expedient and appropriate lines of communication** with their post-acute providers.

Embrace Electronic Communication

A fax or phone call-based discharge communication solution just doesn't cut it in a crisis. Taking the time to fax all of a patient's information, or setting aside critical personnel and countless labor hours so that a clinical team member can dial prospective post-acute care providers on a landline, can cost lives during the COVID-19 pandemic.

This scenario will only get worse as the lack of beds move "downstream," so to speak, and starts to impact the post-acute providers dealing with additional patients convalescing in quarantined areas. The number of PAC facilities that can safely take on COVID-19-positive patients is already extremely limited, and these facilities' own resources will only grow more constrained as more and more patients move through the system.

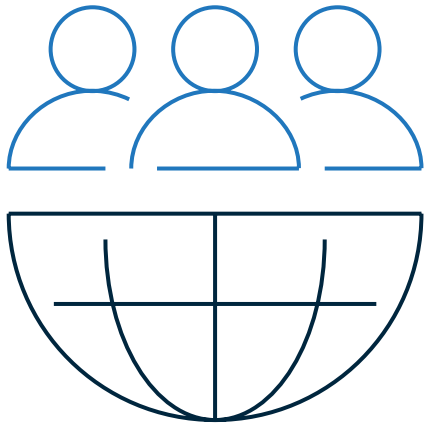
This will lead to a shortage of beds that can only be mitigated by a massive reduction in the time it takes to communicate with PACs. Instead of contacting two or three facilities, hospitals are faced with a scenario where they need to reach out to five, six, ten, etc., with those numbers escalating further depending on the locale.

No hospital can afford to have their essential staff spend hours upon hours each day calling and faxing. It's imperative that facilities invest in an electronic means of communication where they can send patient health information instantly. What's more, that same system should enable quick receipt (30 minutes or less median time) of a 'Yes' or 'No' answer as to whether the PAC can accept the patient.

One additional benefit of this type of E-system is its utilization of the cloud, which enables team members to access the discharge software safely and securely, wherever they are, on a mobile or desktop device.

Not only can this save critical time by not requiring team members to travel to specific work stations to initiate a discharge procedure, but it also **limits those remote workers' potential exposure to the virus**, since they don't necessarily have to be in the hospital to oversee patient transitions.

Harness Your Narrow Network



Your narrow network, the PAC facilities you've partnered with as part of an ACO, a payer arrangement or some other agreement, will be crucial during this pandemic.

Existing arrangements mean these facilities are able to establish a baseline of care, and because you keep in regular touch with them, you should have a pretty good idea of what their current resources are. Reach out to them now to see if their capacities have changed, if they're able to accept COVID-19 cases, and what their protocols are if so.

Now is the time to harness this narrow network to its maximum in order to ensure the patients being discharged will be taken care of appropriately. And if you don't have a narrow network? Start trying to come up with one, fast.

Consider Expanding Your Narrow Network

Okay, we just linked to an article all about how to narrow your network of PAC providers and explained why doing so is so important…BUT! In extraordinary times, it also might be worthwhile to explore the expansion of that network.

I don't mean that you want to cut corners when it comes to discharging people to areas where they'll receive appropriate care. However, in the interest of freeing up beds and getting COVID-19 patients to facilities where they'll be properly taken care of, it might be worth considering the creation of a new narrow network.

This could be an expansion of a current network or something else entirely. Basically, you would be planning which overrun facilities are able to take on your patients if your typical go-to providers are full or unresponsive.

We might be witnessing the creation of entirely new facilities set up in this emergency for the sole purpose of helping patients recover from COVID-19. As these come online, **consider plugging them into your hot lists of preferred providers so that you can quickly discharge patients as necessary**.

It's also important to note that, as you move to electronic communication, you'll want a discharge communication provider who's able to create profiles on the fly as they arise. If you don't already have this capability, or aren't sure if you do, please contact your current vendor, as this is a must-have in an emergency scenario where new, critical facilities are being set up in real time.

Communicate with Your Entire Network

We've heard from more than one hospital that has expressed a need to send a communication about the coronavirus and their patient influx to their entire post-acute network. Thankfully, Ensocare is more than equipped to enable this service, and we were able to work together with these hospital systems to ensure such a communication was deployed through our Transition software.

We would advise considering this kind of network-wide transmission yourself if you haven't done so already. If you're experiencing a sharp uptick in COVID-19 cases, or anything about your typical discharge patterns is about to change, it's in your best interest to let this be known to all of your potential post-acute partners at once.

In addition, this will **enable you to include questions within that communication about those PACs' own capabilities** if they haven't shared such information with you yet. This could be just the prod they need to explain what they've done to prepare for the rapid influx of patients.

Being proactive about these communications can help you plan as you deal with the ongoing pandemic.

Train New Team Members on Your Software

Just as important as having software in place to establish electronic communications with PACs is having staff capable of using that software to its utmost potential and standardizing your workflow.

Have your regular users immediately start to train anyone who could conceivably take on the responsibility of helping to discharge patients. If you're hiring more staff to help with the virus, that's great! This could even help you free up nurses typically responsible for the administrative tasks associated with discharge to do more clinical work while non-clinical staff take over discharge communication.

If you're not hiring more staff, then we'd still **encourage you to think about who could take on the additional duty**, particularly if your clinicians can be better deployed elsewhere.

Establish Follow-Up Parameters with Case Managers

Finally, you should have protocols in place for contacting patients and their post-acute care providers after they've been discharged from your facility.

The last thing you want in this scenario, where beds and personnel are at a premium, is to have a patient you discharged be readmitted to your hospital. If this happens in large numbers, it can make an already precarious situation even more dangerous.

Having case managers check in with PACs, patients and patients' family members at regular intervals can help you identify signs that the patient may be backsliding in their recovery path. In those situations, you can connect them with the prescriptions, medical devices, clinical experts and other resources they would need to prevent a readmission.

If you haven't done so already, figure out follow-up parameters and **be willing to adjust on the fly as patterns begin to emerge**.

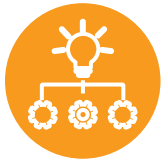
A Brave New World

We're all coming to terms with the impact the coronavirus is having on the healthcare system. But one step we can't ignore is the essential communication that must happen between acute and post-acute providers.

Hopefully, the above ideas will help you free up beds, decrease length of stay, and assist the highest number of patients in the best way possible.

Chapter 4
PAC Infection Control

Top Takeaways



Take Advantage of Existing Resources: :
The CDC and other agencies have released a wide variety of guides and suggested processes meant to help hospitals and PACs alike.

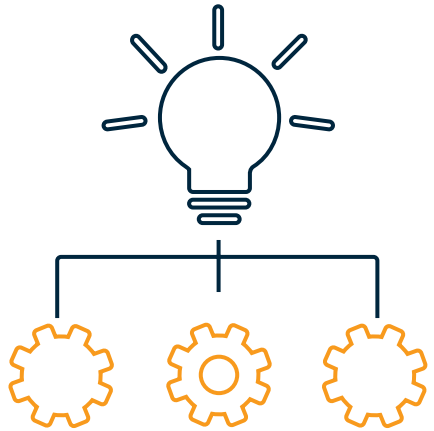
Establish New Patient Parameters:
PACs may be expected to take on acute care patients or form COVID wards, so ongoing preparation is essential.

Staff Infection Policies:
Having strict rules in regard to testing and illness procedures will protect patients and your own team from harm and liability.

In adapting to the COVID-19 pandemic, PAC providers had to embrace additional infection control procedures that, due to previous protocols and treatment capabilities, may not have been in place. These procedures are particularly important in PAC facilities now because the people within are the very same demographics most susceptible to complications deriving from COVID-19, particularly seniors in nursing homes and others whose underlying health conditions necessitate post-acute care.

Hospitals and other acute care providers can **help patients and expand their preferred network possibilities** by sharing resources PACs can utilize in order to bolster their infection control efforts.

Please note: The organizations that have put out this information are constantly revisiting best practices as we learn more and more about the coronavirus, and you and your facility should continue to check back often in order to make sure you're following the latest and most heavily vetted policies and procedures.



The CDC's Guidance

One of the first stops for developing policies related to infection control should be the Centers for Disease Control and Prevention (CDC). This government organization has already shared (and updated) a number of resources your team can use, everything from checklists to best practices and links to some of the most hot-button issues facing post-acute care facilities.

Perhaps the best starting point when sifting through the CDC's many resources is their page entitled "Preparing for COVID-19: Long-term Care Facilities, Nursing Homes." As you might guess from the title, this acts as an indispensable guide to some of the basic precautions PACs ought to take in order to mitigate the threat of infection.

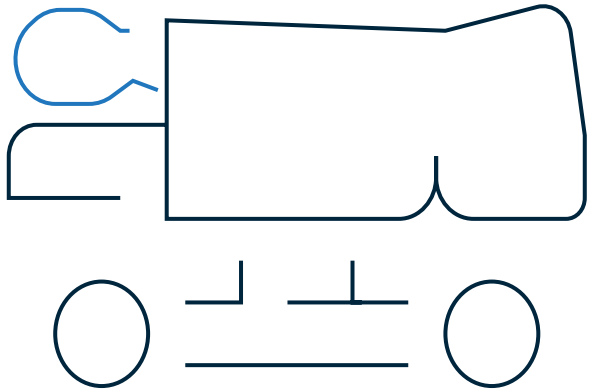
But it's not necessarily just Long-Term Acute Care facilities (LTACs) and nursing homes that can benefit from this information. The guide's preparedness checklist is a **fantastic starting point for anyone whose care organization might come into contact with a COVID-19 patient or that might be preparing to take on this responsibility in order to deal with escalating demand**. And with subsection titles like "Things Facilities Should Do Now" and "Policies and Procedures for Visitors," these detailed resources really do an excellent job outlining precautions.

That's far from the only CDC web resource to consult in order to guide your actions. Here are a few others PACs may find useful:

- **Infection Control** – Guidance for safely caring for confirmed and suspected COVID-19 patients, collecting post-mortem specimens and guidance related to personal protective equipment (PPE).
- **Infection Prevention Training** - Online coursework you can take and share with team members in order to ensure everyone at your organization is prepared for the additional infection control responsibilities expected of them.
- **Prevention Tools** – Checklists you can follow to improve your infection control methods, core elements of infection prevention in nursing homes specifically and links to a variety of other tools that will help you in your progress.

Please remember, of course, that these are guidelines and **should really act as a base effort to infection control efforts**, and that the **CDC has many additional resources** you can and should consult.

Understand the New Normal



We're seeing many rules swept away as our nation's healthcare agencies get creative in addressing the challenges posed by the COVID-19 pandemic.

On March 30, 2020, the so-called "hospitals without walls" program was unveiled by the Centers for Medicare & Medicaid Services (CMS). This paved the way for hospitals to essentially expand their ability to provide acute services to facilities that previously would have been prohibited from offering that level of care.

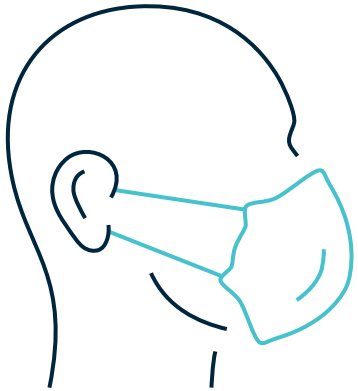
As part of this rule, it's conceivable that LTACs, rehab centers and other non-acute settings may soon find themselves being asked to work with hospitals to establish acute capabilities. This poses additional infection control challenges that need to be addressed, and it will be up to PAC stakeholders, staff members and their hospital counterparts to work together to figure out the contours of these potential new partnerships.

But even among those PACs that aren't expected to provide hospital-like care, you may soon see an influx of COVID-19 patients that have to be sectioned off from the rest of your population. Even this requires a substantial rethink of current processes. The Advisory Board has an excellent resource tackling this very topic among nursing homes, and we'd recommend consulting it for tips on infection control and coordinating with hospitals.

All of this provides an opportunity for post-acute organizations to accept more patients and fill beds that otherwise might sit empty, but it certainly requires a substantial time and resource commitment. If your organization is in this situation, it's important to stay versed in the latest rules.

In these unprecedented times, communication absolutely has to be stellar between hospitals, skilled nursing facilities, home health care agencies and all other PACs, with the lines of communication open at all times. With the risk as high as it is right now, **keeping in touch and knowing where your facility partners stand is of paramount importance**.

Staff Infection, Staff Ejection



Finally, the Advisory Board has put together another great resource tackling one of the biggest challenges confronting nursing homes (and, indeed, all manner of PACs): staffing.

As they point out, staffing challenges unique to PACs actually have the potential to make infection risks more prevalent. These challenges are manifold, having to do with heightened direct care staff turnover in comparison with a hospital environment and a greater presence of unlicensed team members.

But even these challenges can be addressed with the right mindset and a willingness to tackle the issue. Perhaps the most important thing PACs can do is ensure they have a strict training regimen that all personnel are subjected to. This should go hand in hand with the provision of viable protective equipment (after all, training won't suffice if it isn't paired with the tools necessary to prevent further contagion).

It's also worth pointing out what might be Advisory Board's best point: leaning on hospital partners for assistance. **During this pandemic, we're all learning as we go along, and hospitals today are dealing with the volume and challenges that PACs will confront tomorrow**. Hospitals owe it to their PACS to offer insights, best practices and lessons learned.

One other thing to note, and something that's also mentioned in the CDC's aforementioned resource guide:

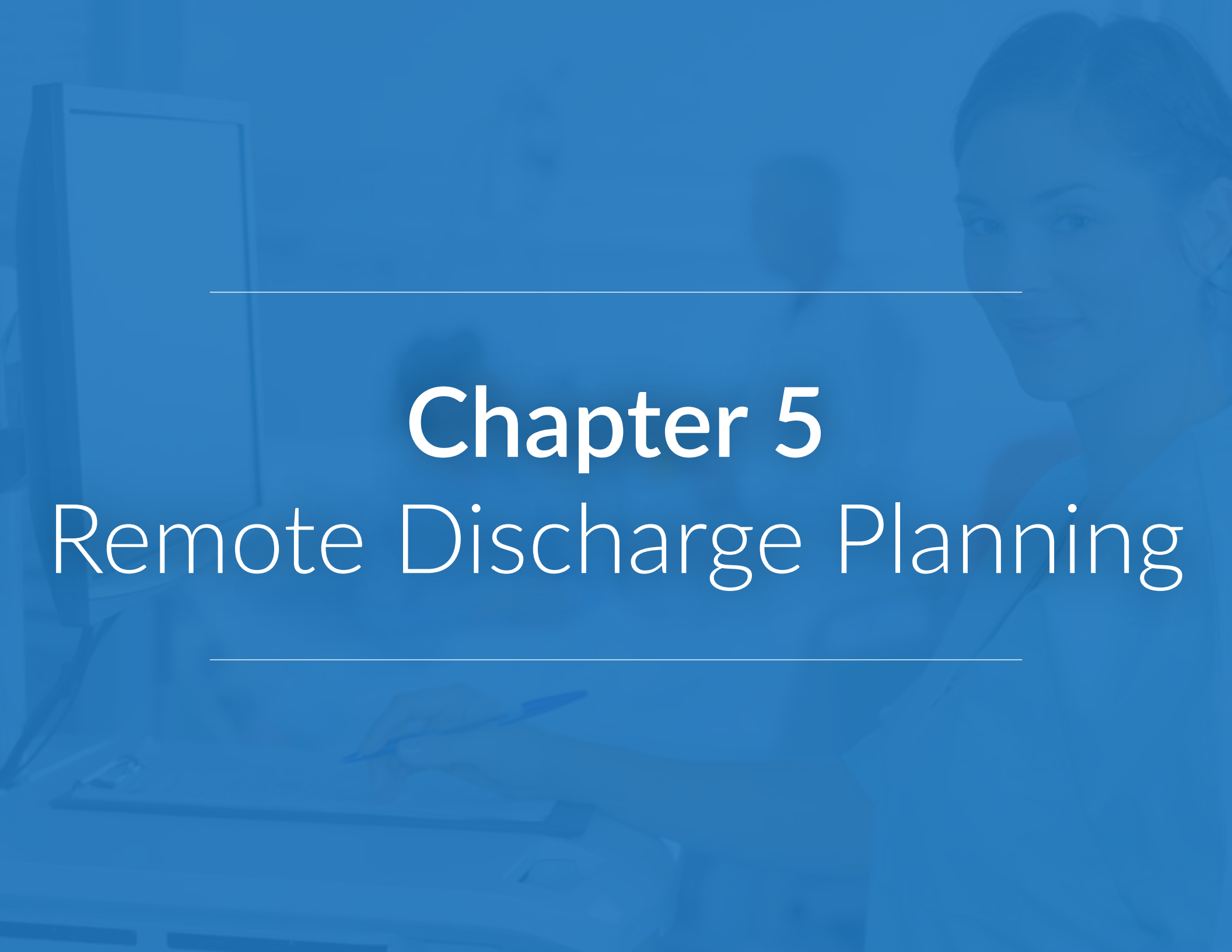
even though consistency and licensure of staff may be one of your facility's greatest challenges, the drive to shore up staff **must also be paired with vigilance toward the care of those same staff members**.

PACs must be open with team members and have policies in place that allow them to stay away from the facility when they themselves begin to exhibit symptoms of COVID-19. If a team member feels pressured to work, either for financial reasons or something else, and they show up for a shift, they can make an already precarious situation substantially worse, particularly if that staff member is around non-COVID patients.

It's certainly a balancing act, but one we must all work on to prevent the further spread of this virus.

Resource Intensive

We hope the above resources provide a good start, and there's plenty more where they came from, with the CDC and others updating their guidance frequently. The Agency for Healthcare Research and Quality has another excellent guide on infection prevention for long-term care staff which you can check out as well, and some of the other leading resources, entities like the WHO, CMS and more, are only a click away.



Chapter 5
Remote Discharge Planning

Top Takeaways

Three Must-Haves:
Hardware, software and security have made a remote workforce a distinct possibility for many hospitals.

On-Site Staff:
Determine who will need to be on site in order to act as a de facto patient liaison.

Remote Training:
A remote workforce requires very different training and touch-base considerations, and you may find yourself establishing policies that are dissimilar from what an in-person discharge planning team would experience.

The COVID-19 pandemic has caused everyone in the healthcare field to rethink previous policies and consider new ways of doing things. Some of these may be temporary adjustments that help get us through the crisis, while other, more transformational processes may stick around.

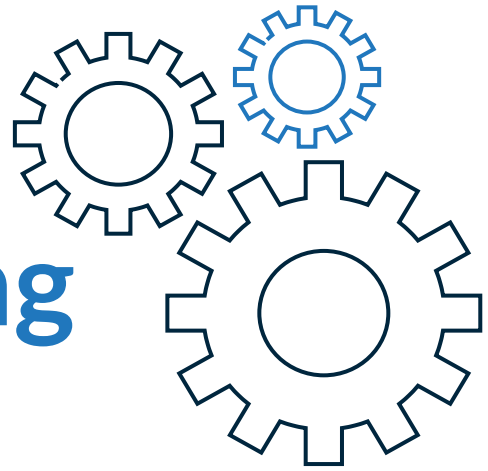
Case in point: the number of team members and organizations that have been forced to switch to a remote work structure. At no point in history have so many people worked from home at one time, and we at Ensocare are no exception.

But if there's one field resistant to such a work setup, it would be the interactive, people-centric act of caregiving. It's true that telehealth has made some basic appointments possible over the internet, but **when it comes to coordinating care within the walls of the hospital, that work must necessarily be done by people on site**.

However, we've slowly been seeing institutions get creative with how they approach staffing during this pandemic, particularly in the areas of discharge planning and case management. Hospitals are rethinking the idea that these teams need to be within the hospital in order to accomplish their goals. Some hospitals had moved to this type of system already with their case managers, having transferred responsibility of those functions to an outside call center, but the patient coordination and discharge sectors are where we've seen organizations become truly innovative in their approach.

If your organization would like to **protect employees and patients alike by reducing the number of people on site, thus limiting potential exposure to the coronavirus**, case management and discharge planning are great areas to consider. But there are certain tools you'll need to have in place.

Three Must-Haves for Remote Discharge Planning and Case Management



The first hurdle you'll need to clear in order to set up a remote workforce is simply having the technology in place to make such a transition possible.

When determining if you could even begin the process, there are three factors to consider:

Hardware

Do your case managers, nurses and social workers have access to smartphones and computers that would enable them to accomplish the same work they do in the hospital? Is this something your IT teams could conceivably provide in in a reasonable span of time?

Software

If your team members do have access to the hardware necessary to accomplish their jobs, do they also have access to the same apps they would use in the hospital? Will those apps work properly outside your facility, or are they geofenced in some way for security purposes? Which leads to the final consideration...

Security

HIPAA regulations and data protection haven't gone away during the pandemic. In fact, security protocols are arguably more important outside the hospital, where, for instance, your team may not have the same network protections they would within the facility.

Security: A Closer Look

For the purposes of this article, we're going to assume you're able to connect your workforce to the right hardware and software.

For many facilities, the bigger challenge lies with security. You'll need to work with your IT team to make sure the electronic health data that flows in and out of remote workstations is safe.

These are some of the things that will make doing so possible:

VPN:
A Virtual Private Network can offer an additional level of protection to all internet activity moving through a location. These are available at the consumer level for a relatively low price.

Two-Factor Authentication:
This provides an additional layer of protection to all interactions. When your team member logs into a given app or system remotely, he or she should be prompted with an email or text message that includes a code they can enter, thus ensuring that even if a password has been compromised, account access won't be.

Protected Desktop Access:
If your team members will need to log into a system stored within the hospital, i.e. mirroring their work desktop on their home computer, your IT team will no doubt need to use some type of software to enable this process.

Cloud Security:
Rather than have data stored centrally in one location, cloud-based data provides even more of a security boost to your remote employees. This has the added benefit of improved team access to necessary data, because it's not stored in a physical location requiring on-site interaction.

If you can receive assurances surrounding these things, or your IT personnel have otherwise given you the green light, then you're basically at the starting point for a remote case management workforce transition. [For more on cybersecurity, check out the next chapter]

So…what now?

Product Choice

In order to have a case manager or discharge planner continue their work outside the hospital, you need software that can function in that kind of setting as well.

That leaves manual processes out of the question. If you're expecting an employee to communicate with post-acute providers in order to discharge patients to the appropriate care setting, that person needs to be able to do their work electronically. Faxing protected health data or making phone calls to various care settings, then making additional calls and faxes to report those statuses to the hospital, simply won't cut it.

You thus need to rely on a product that lets you electronically communicate and coordinate discharge with post-acute providers, patients and family members.

Decide If You Need a Staff Member On-Site to Interact with Patients

There's one component of patient discharge that's a little harder to manage remotely, and that's the actual interaction with the patient.

At some point along the line, a nurse or some other team member must present the patient and their family with their post-acute care options. Typically, this happens right in the room. But one consideration you could make is having your discharge team members use an online meeting platform like Zoom or GoToMeeting to interact with the patient through the screen.

Access to video conferencing with screen sharing capabilities makes it possible to present the patient with their potential choices without actually entering the room. They can make their choice, the case manager can record it in the documentation software, and then the case manager can coordinate with the on-site clinical team to execute the successful discharge of that patient.

As a sidenote: making the actual documentation of patient choice electronic is something Ensocare has been adamant about for years. **We've long encouraged hospital staff to use tablets to showcase PACs in a far more visually appealing manner, highlighting reviews, CMS scores, photos and location intuitively**. Thus, the teleconferencing technology we're recommending here is an extension of that, **making the process seamless for your patients while protecting team members** who don't need to be on site.

Training and Regular Check-In

Finally, you might have the infrastructure in place, but it's also important to be cognizant of the very real human challenges that come along with maintaining a remote workforce.

Not only will you need to train your discharge planning and case management teams on the processes inherent to their new roles, but you'll need a management structure in place to monitor progress and adjust as necessary. Having a team that works from home will present you with challenges that never would have occurred in the clinical setting. Productivity, connectivity issues, burnout: all are very real issues, and they require the steady hand of leadership in order to identify and solve when managing a remote staff.

Your teams should be meeting regularly to touch base about best practices, challenges and lessons learned. Additionally, you should continue to analyze the new workflow and identify areas of opportunity and difficulty. At all times, thought should be given to clinical outcomes, specifically if the switch to remote work is having a positive or negative impact on your patients' recovery after they've left acute care.

Remote or Bust

As you've no doubt surmised, transitioning to a remote case management and discharge planning workforce is no easy feat. It requires careful coordination and planning to get such an effort off the ground. However, once you have the pieces in place, you have the opportunity to witness innovative, transformational care delivery, the type that benefits patients and your own caregivers.

Chapter 6
Cybersecurity

Top Takeaways

Staff Empowerment:
People throughout your organization should have the means to report potential vulnerabilities, as well as a documented process for doing so.

Extra Diligence:
An increasingly remote workforce requires additional care and investigation from healthcare IT teams.

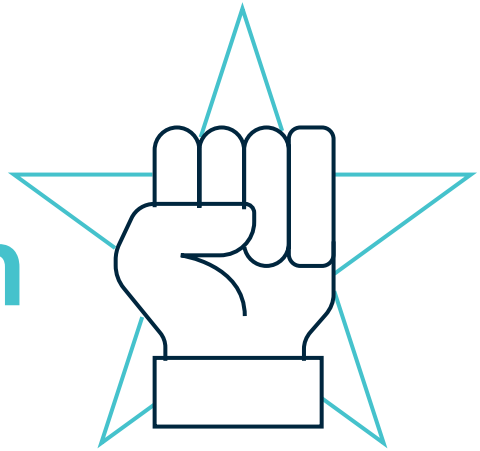
Additional Precautions:
Two-factor authentication and VPNs are a must to protect healthcare data.

In March, 2020, the Office for Civil Rights (OCR) at the U.S Department of Health and Human Services (HHS) issued COVID-19 HIPAA waivers to promote data sharing and telehealth, relaxing laws over the good faith use and disclosures of protected health information (PHI). The explosion of COVID-19 demonstrates that providers need fast access to tools that identify, collect, track and exchange data on the flux of infected patients.

Protecting the privacy and security of patient data is the health IT industry's fundamental civic duty during a nationwide public health crisis. While a hospital's core competency has never been and will never be information technology (IT), taking care of patients is.

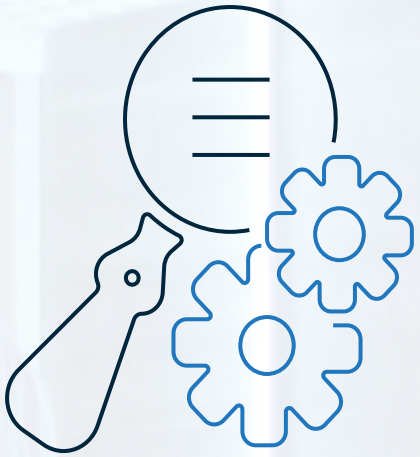
Here are five strategies to help you protect and secure your organization's patient data and network from cyber attacks:

Make sure your escalation procedures are sound



A healthcare worker who spots a questionable issue must be free to report their concern so it can be addressed swiftly. Most every IT department has in place a reporting process, either a formal ticketing system or an on-call employee who accepts personnel's phone calls. Once the IT staffer quickly escalates the issue to the appropriate leader or medical professional, the healthcare worker can resume their day job. Whether the issues are coronavirus-related or basic security breaches, e.g., an email phishing attack from an unfamiliar source, all team members, even those on the clinical side, should be empowered to bring up potential dangers to the appropriate parties.

Instruct your IT team to be extra diligent investigating unknown emails, links and websites

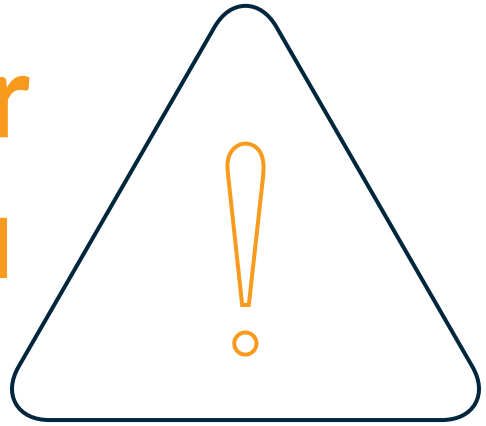


Cyberattacks targeting hospitals, practices and healthcare organizations are on the rise dramatically, a rise that can at least partially be attributed to the exploitation of the coronavirus.

Unfortunately, remote workers are also being singled out. A recent McAfee report uncovered a correlation between the increased use of cloud services and collaboration tools during the COVID-19 pandemic, along with an increase in cyberattacks targeting the cloud. External attacks on cloud accounts grew 630 percent from January, 2020 to April, 2020. Cisco WebEx, Zoom, Microsoft Teams and Slack saw an increase of up to 600 percent in usage over the same period.

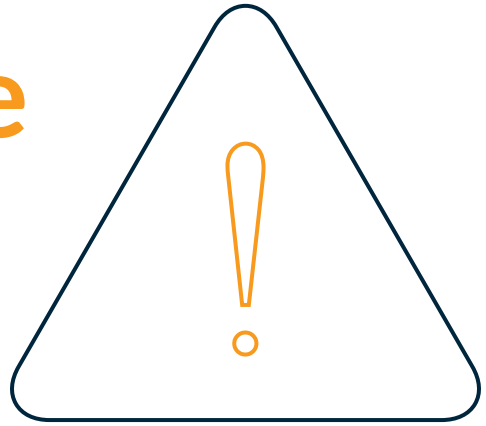
Healthcare staff members working remotely are more vulnerable and understandably distracted supporting COVID-19 patient care — which could make them easy prey for cybercriminals. The pandemic represents a huge opportunity for bad actors to compromise your systems with things like phishing emails that include faulty links and websites, ransomware attacks, and intrusions on sensitive data. Regularly remind your remote workforce to report suspicious activities by following your organization's security protocols.

Review your intrusion detection strategy (IDS) or continue to monitor if you already have one



An IDS is a network security technology originally built for detecting vulnerability exploits against a target application or computer. Intrusion Prevention Systems(IPS) add the ability to block threats in addition to detecting them and have become the dominant deployment option for IDS technologies. More broadly, think of intrusion protection as personal computer security, but in a format that can look between different servers and flag suspicious activity. You should be reviewing and updating your technology and strategy regularly to ensure you've kept up with all applicable best practices.

Ensure your remote employees have corporate VPN and two-factor authentication services



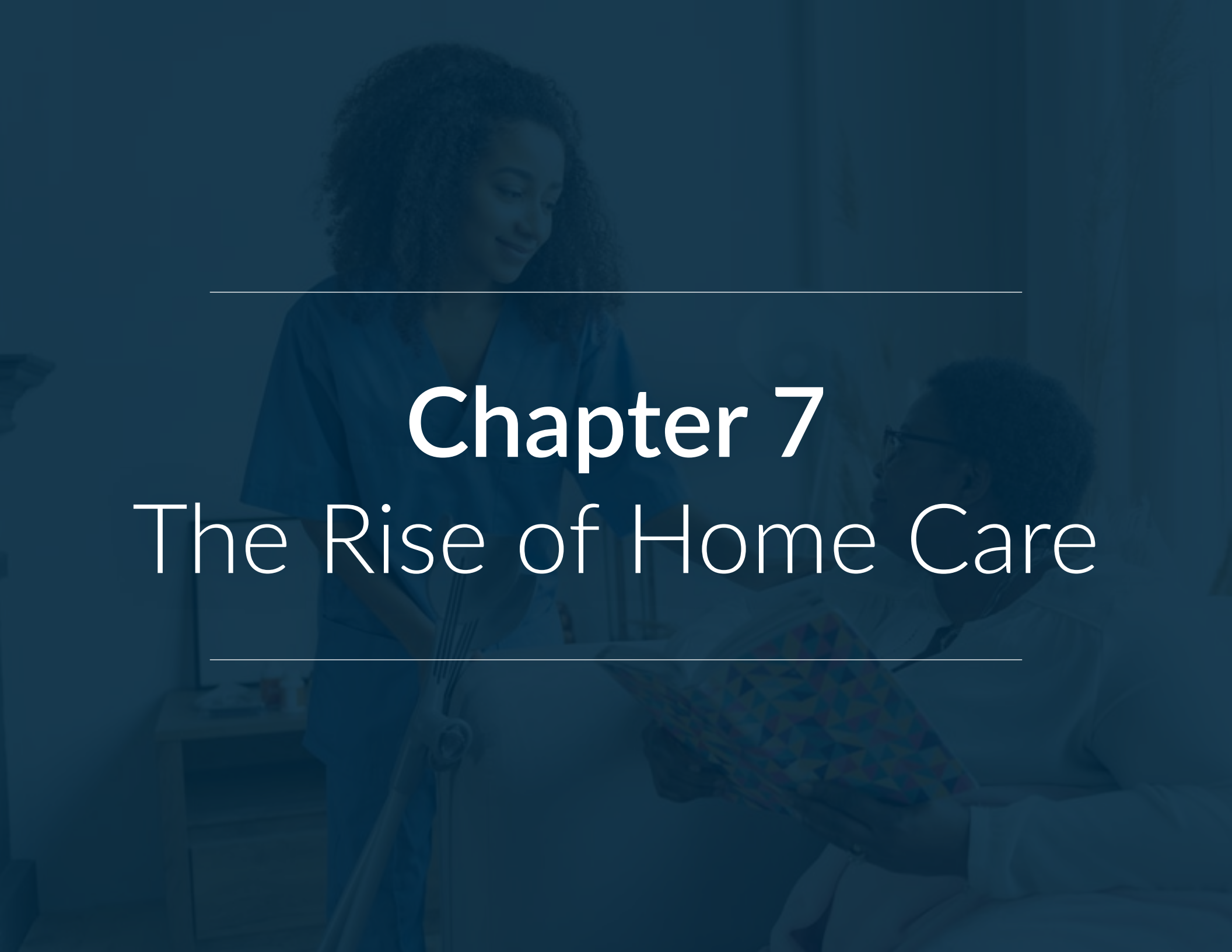
This telework protocol should already be part of your business continuity plan. It should be reviewed and updated periodically to ensure traffic is handled securely.

Home internet networks simply are not as secure as your office network. VPN and two-factor authentication services are recommended for remote connection to support the goal of making remote work as seamless as possible. Be aware that, short of completing mission-critical projects, at-home internet outages will not necessarily cause a security issue. A larger issue is whether the remote worker has the right modem installed to handle many different in-home users.

Last point: Encourage employees to use corporate laptops with encrypted hard drives that are not shared with family members.

Keep doing all of the good things you were doing before the pandemic

Everything in your systems security plan is still valid with some possible changes for critical business continuity that should be maintained and exercised. HIPAA compliance might be relaxed, but security protocols remain doubly important in our current health crisis.



Chapter 7
The Rise of Home Care

Top Takeaways

Freeing Up Bed Space:

Increased reliance on home care is a great way to free up bed space in an acute care setting, assuming a patient meets the clinical threshold for a home-based recovery environment.

Caregiver Considerations:

Guaranteeing the presence of a qualified caregiver is a must, whether that individual is a medical professional or a family member educated on the patient's recovery plan.

Getting Resourceful:

A patient should only be discharged to the home if case managers can verify their access to food, transportation, medication and other resources.

The path to recovery from COVID-19 can be long and difficult, made even more so when patients are forced by lack of post-acute capacity and other extenuating circumstances to stay within the hospital for longer than is clinically necessary.

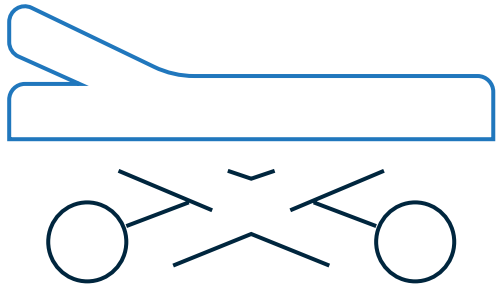
That's where, in select cases, discharge to the home can play a prominent role [as discussed in Chapter 2]. Particularly if you reside in an area in which there's a shortage of PACs capable of taking on your recovering patients, a careful review of whether or not the patient's condition supports a transition to the home becomes crucial in solving for capacity issues.

When the evidence of the patient's recovery journey supports a discharge to the home, the successful transition of that individual benefits multiple parties. The patient, of course, gets to be more comfortable because they're in their own space, so their experience improves while the risk of hospital-acquired infections is reduced. Your hospital benefits because it gets to free up bed space (and thus reduce length of stay) at a time when those same beds may be at a premium due to rising COVID case counts. And post-acute care providers gain because they themselves save on critical bed capacity that might otherwise be under-utilized by a patient who could have continued recovery in the safety of their own home.

Home-based care is less resource-intensive, reduces infection spread in downstream settings and clears up hospital capacity. However, patients refusing care, limits on telehealth visits, and gaps in scaling staff to meet new clinical needs mean home health can't supplement the full scope of post-discharge needs. As a start, models like hospital-at-home or offering custodial support with skilled home health increases the range of patients that can receive care in the home, reducing inpatient utilization.

Let's look more closely at the **important role home health plays in our nation's pandemic efforts**, including how to assess patients' ability to successfully progress and how to ensure they remain on the path to recovery.

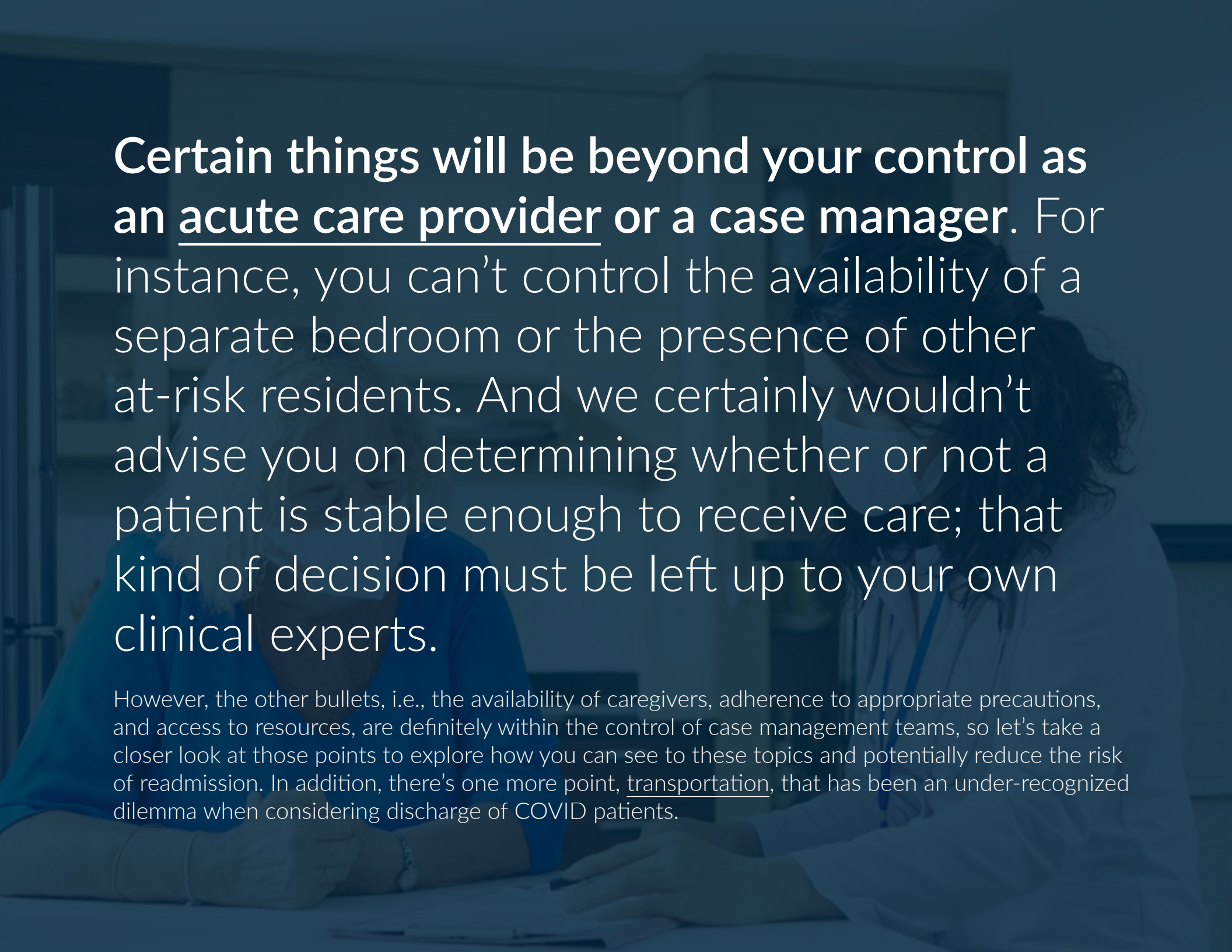
Suitability for Home Care



First, understand the CDC's guidance on gauging suitability for discharge to a residential setting. They provide six considerations that will determine whether or not home healthcare will be appropriate for that individual:

- The patient is stable enough to receive care at home.
- Appropriate caregivers are available at home.
- There is a separate bedroom where the patient can recover without sharing immediate space with others.
- Resources for access to food and other necessities are available.
- The patient and other household members are capable of adhering to precautions recommended as part of home care or isolation.
- There are household members who may be at increased risk of severe illness from COVID-19 infection.

The first five bullets explain the five things that should be in place in order for a home referral to be considered, while the last bullet is something that might actually cause you to rethink home discharge.



Certain things will be beyond your control as an acute care provider or a case manager. For instance, you can't control the availability of a separate bedroom or the presence of other at-risk residents. And we certainly wouldn't advise you on determining whether or not a patient is stable enough to receive care; that kind of decision must be left up to your own clinical experts.

However, the other bullets, i.e., the availability of caregivers, adherence to appropriate precautions, and access to resources, are definitely within the control of case management teams, so let's take a closer look at those points to explore how you can see to these topics and potentially reduce the risk of readmission. In addition, there's one more point, transportation, that has been an under-recognized dilemma when considering discharge of COVID patients.

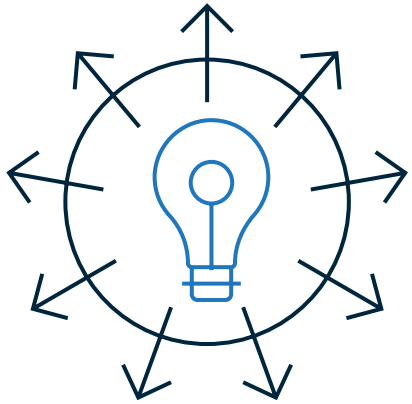
Caregiver Availability

Eligibility for home healthcare will hinge on not just the person's health, but their ability to continue on the prescribed recovery regimen. For that, it is important to identify if someone will be available to intervene when necessary.

If a family member or some other in-home caretaker is available, your case management team will need to brief them on the care plan and make sure all parties within the home understand that plan. Included within this plan should be information about hygiene procedures to prevent further infections.

If a family member isn't readily available, it's up to your case management team to coordinate with in-home health agencies to ensure the patient's care needs are seen to. Determine whether the caretaker will be in-home 24/7 or if the patient's condition is stable enough (and the risk of backsliding small enough) that the caregiver can visit on a set schedule for regular check-ins.

It's also important to have open lines of communication between the caregiver and the rest of the patient's care team. If a medication isn't working as assumed, or if the patient backslides, you'll want visibility into this so an intervention can take place and the risk of readmission can be reduced.

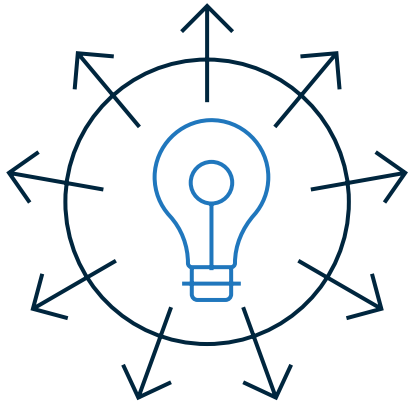


Resource Access

Working with the in-home caregiver also involves a careful determination of the patient's socioeconomic needs and making sure that those are addressed as well.

The social determinants of health play a massive role in COVID recovery. Because the individual will be under quarantine, they need to be in a space where they'll have private access to amenities such as a restroom, laundry and more. They need a supply of healthy food that will provide a balanced diet during their recovery, a diet that's overseen by a nutrition expert and adjusted depending on the individual's needs. They also need access to whatever medications have been prescribed, whether via delivery or pick-up, and a means to order additional prescriptions depending on the progress of their recovery.

A careful analysis of all these things and more will be essential prior to discharge to the home, and continued review of these social determinants is critical. The caretaker involved in the patient's recovery should check in regularly to determine if the patient has everything they could conceivably need, and you should communicate with this person regularly to monitor the patient's status. [More on the Social Determinants of Health in the next chapter]



Transportation

One social determinant that requires special attention is that of transportation. Too often, especially when we're focused on discharging the patient and freeing up a bed, it's easy to put blinders on and only think about scheduling transport from the hospital to the post-acute setting.

But with home COVID recovery especially, transportation can play a far bigger role. If the patient has in-person, non-telehealth appointments, he or she needs a means of getting there. It's a good idea to look ahead and set up transportation early on, ideally with the very same NEMT providers you scheduled for drop-off at home.

Also coordinate with your in-home caregivers when thinking about how transportation can be used in other ways. NEMT can be involved in grocery and prescription delivery as well as the shipping of any other items that can make the patient's life better and their recovery more assured. [More on transportation in Chapter 9]

Knowledge Is Power

Finally, you must work diligently to ensure the patient and anyone else within the home understands both the care plan and the precautions necessary to prevent further COVID spread.

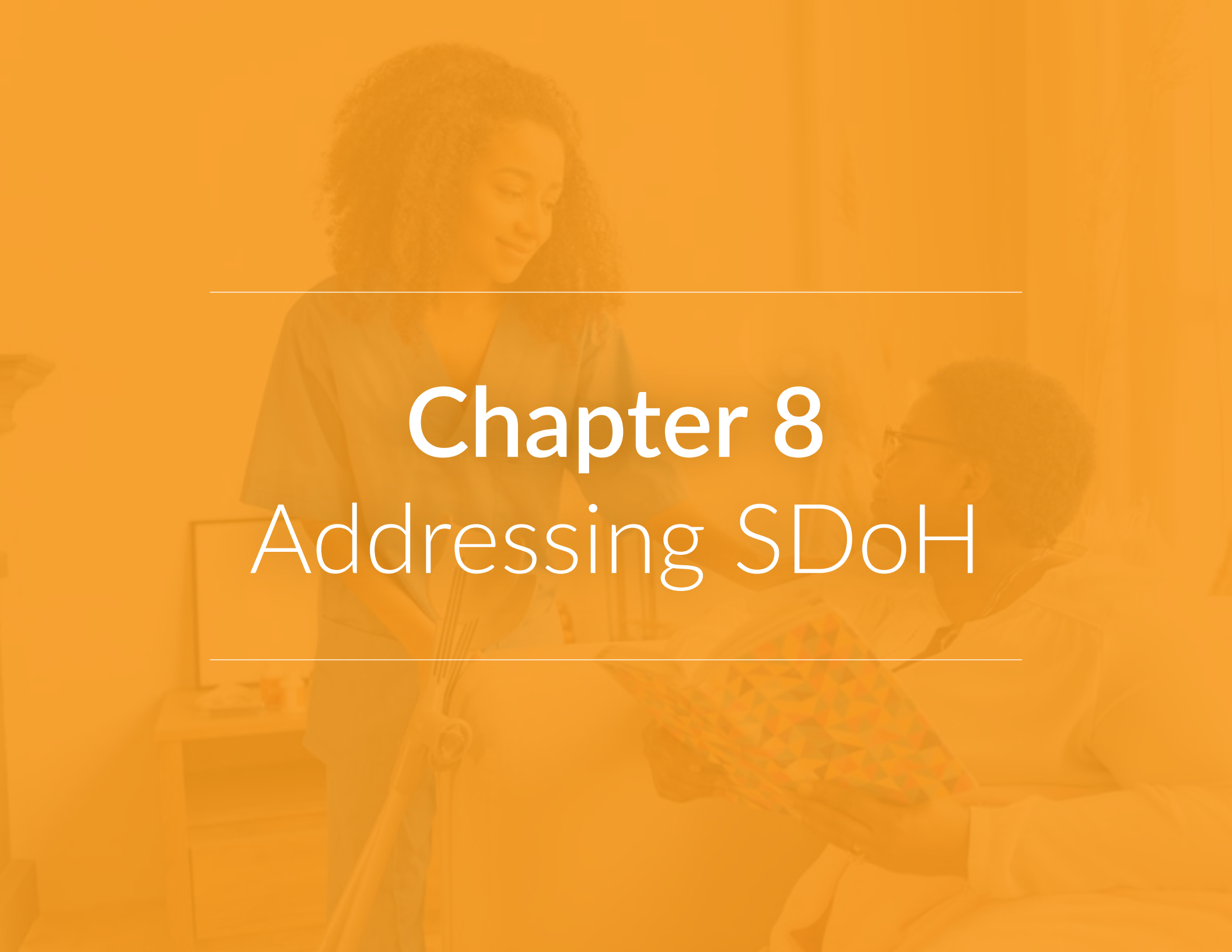
This begins at discharge. You will no doubt have a team member thoroughly review the care plan and what patients can expect from their in-home caregivers as they continue their recovery. Make sure, ideally using the teach-back method, that the patient understands the expectations and the progress markers to graduate to the next step in recovery.

Once the patient is out of the hospital, continue to follow up to see how they're progressing and gauge their ongoing understanding of their care plan. Not only does the patient and everyone within the home need to know the care plan, they also need to know proper quarantine procedures. This complicates case managers' work, as they now have additional items they need to cover when they check in. But that work is necessary to boost recovery chances.

Home Is Where the Start Is

After the patient is able to go back home, their recovery can truly begin. But that doesn't mean we can let our guard down.

By adhering to CDC guidelines and continuing to work with in-home caregivers and patients themselves, you can **reduce the risk of readmission and ensure that discharge to the home is as successful as it could possibly be**.



Chapter 8
Addressing SDoH

Top Takeaways

Combating Readmission:
To ensure continued recovery, acute care settings must ensure patient needs beyond their medical conditions are assessed and addressed.

Supply the Demand:
Because a patient may need to quarantine for weeks, ensure he or she is stocked up on the necessary groceries, medications and more.

The Human Element:
Loneliness can be an overlooked aspect of the pandemic, and hospitals may combat this with regular outreach and even a socially distanced visit from a case manager.

The highly infectious nature of the coronavirus has led many to make the claim that COVID-19 doesn't discriminate.

But that's not entirely true.

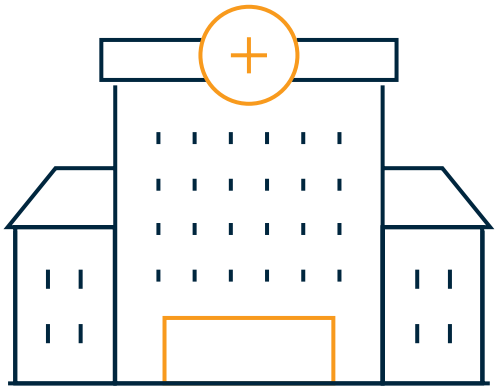
We know, for instance, that while anyone can contract the virus, socioeconomic factors actually play a critical role in determining the likelihood of exposure. Anyone whose job by necessity dictates that they work in close quarters or in a retail setting where they're making regular contact with outside parties, is at far greater risk of contraction than someone who is able to work remotely, in isolation.

Similarly, socioeconomic factors can play a role in continued transmission and access to care. Homes with large families living in close quarters can be a super-spreader event all their own. Among those who become ill, persons with insurance, access to high-quality care, and the proper support system are going to generally fare better than those who don't have those things.

There's yet another area where the social determinants of health play a role, and that's in discharge. Someone with employer-sponsored health insurance coverage, transportation, a large home and a remote work situation is far easier to discharge than an individual who has none of those things. The social determinants of health have an outsized impact not just on COVID transmission and treatment, but in your ability to transition patients to the next step in their care journey.

Case managers who solve for the social determinants of health **can therefore remove barriers to discharge, freeing up bed space and enabling the patient to progress in his or her recovery**. Here's how to tear down some of those impediments to success.

Shelter



Perhaps the biggest roadblock to a successful discharge is the availability of a care setting that can accept that patient.

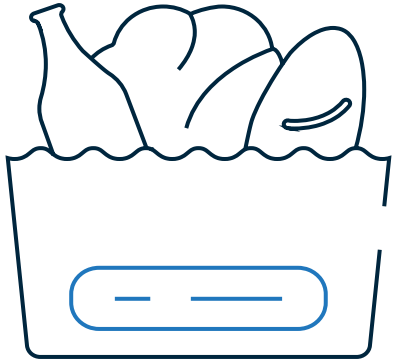
This can primarily happen in two ways. First is if the patient has recovered sufficiently to be discharged but still needs some type of post-acute care. You could be prevented from a successful referral due to a lack of available facilities with bed space, PACs' inability to treat COVID patients, insurance incompatibility, a patchwork series of rules and regulations regarding COVID discharge in your area, or some combination of all of the above.

The second issue is if the patient is deemed clinically eligible to recover at home but they actually don't have a home acceptable for COVID recovery. For instance, if they're homeless, live in a shelter or share a small space with a large number of other people, home discharge gets much more difficult. After all, recovering COVID patients should have their own habitable space, including a bed and bathroom.

The first issue mentioned can be solved by working with your post-acute providers to gauge their ability to accept COVID patients and establish a real-time look at the number of beds available. When this still isn't sufficient, some hospitals have turned to essentially creating their own post-acute spaces out of existing facilities, a move made possible thanks to recent flexibility from CMS.

The second issue requires a little more creativity. In some areas, local governments and community organizations have turned hotels into de facto recovery spaces, where COVID patients without the proper shelter can go to quarantine. Look into the options that exist in your area to see if this might be a possibility for some of your patients that have nowhere else to go.

Nutrition and Medication



I'm grouping nutrition and medication together because they share very similar DNA.

In order for an individual to be discharged either home or to a post-acute setting, they need to have a steady supply of both food and prescribed medications. Because the patient will be unable to go to the grocery store or a pharmacy given their condition and need to quarantine, it's essential that something be done to help them procure these essential items.

Case managers can and should communicate with local businesses, such as grocers and pharmacies (or online providers of food delivery and prescriptions), in order to have items ready for the patient when they arrive at their next care setting and to set up delivery of these items on a set schedule.

One important thing to note: with the cutbacks that have taken place at the United States Postal Service, it's more important than ever to get an ETA on item delivery and to follow up to ensure the delivery occurred. This is an added step for care managers, but it's essential in order to keep the patient's recovery on track. A missed prescription or food drop-off could lead the individual to break their quarantine or even suffer a lapse that leads to readmission, so make sure every part of the plan is executed as it should be.

Transportation

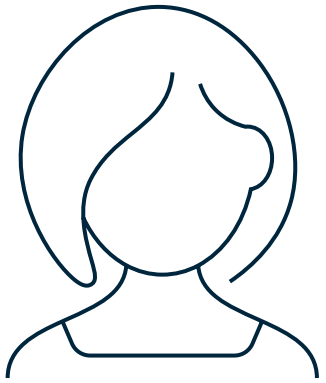
If a patient doesn't have the proper transportation, their discharge can be delayed, they're at greater risk of missing follow-up appointments, and their ability to secure other resources, such as the aforementioned food and prescriptions, is compromised.

Case managers can work with local transportation providers to solve for some of these issues. First, you should have a program in place to schedule pick-ups and drop-offs with patients who need them. Ideally, you would be able to do this instantly from a secure online portal that offers a real-time view into where the transportation provider is, how long until arrival, any check-ins that need to occur along the way, etc.

But don't stop there. If you know your patient is under quarantine or otherwise unable to secure their own transportation, then case managers can look ahead to upcoming appointments and set up pick-ups accordingly. This requires quite a bit of follow-up and even some handholding, but that's always going to be better than readmission. And when it comes to connecting the patient with other resources, there might be transportation options in your area that can also handle grocery and prescription pick-up and drop-off.

Programs like these can help you **reduce the risk of readmission and further transmission of the virus**. [Read the next chapter for an in-depth look at transportation]

Support Systems



Finally, one social determinant that absolutely can't go overlooked is human connection.

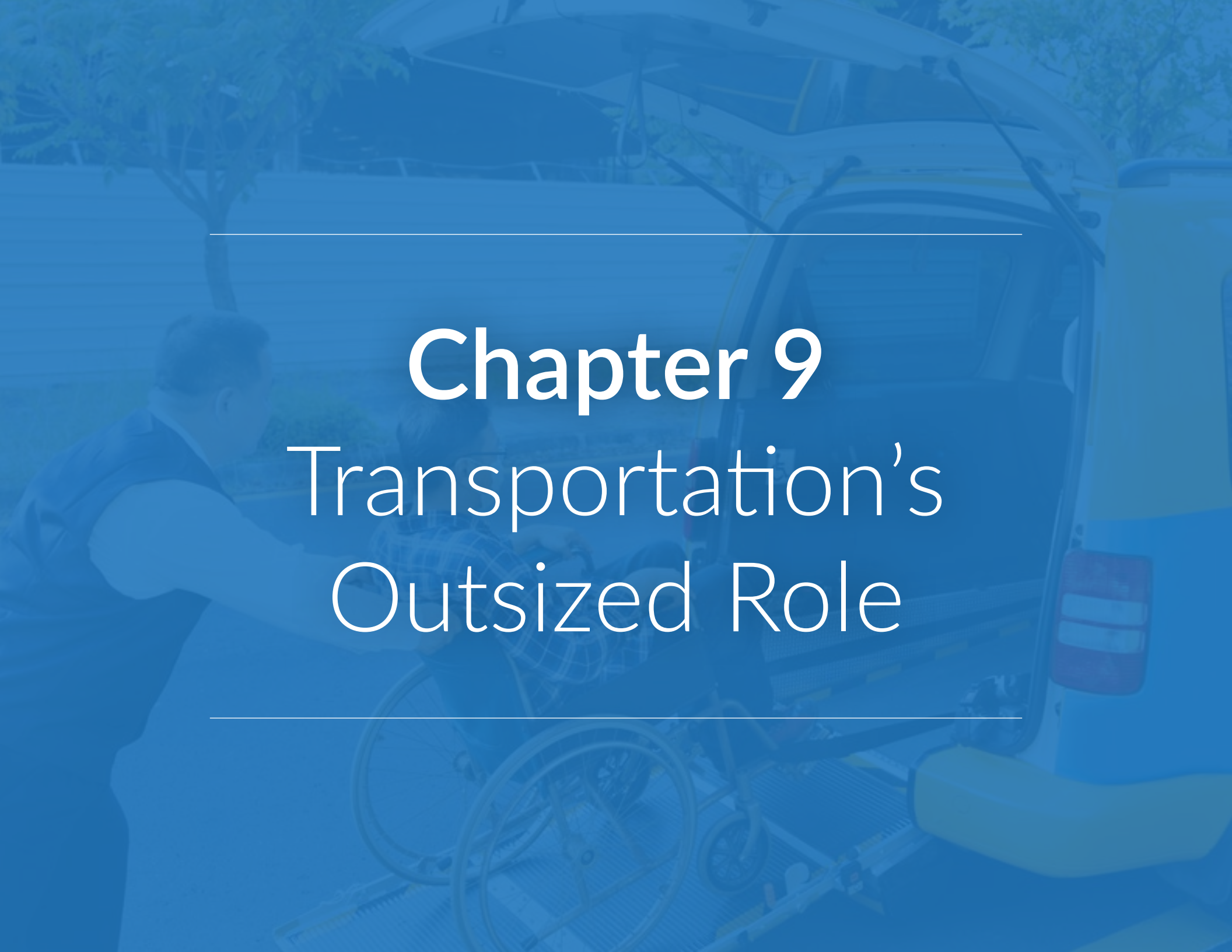
COVID is a lonely disease. The very companionship we crave when we're ill is impossible when the act of being near family, friends and community can lead to a dangerous retransmission of the virus.

When quarantine is a fact of life for the foreseeable future, you can still make a real difference as a caregiver. Whether it be setting up Zoom for an elderly patient who wants to be able to connect with her social circle, teaching someone who wants to go to church just what a Facebook Live stream is, or explaining and scheduling telehealth or even telepsychiatry appointments, you can do so much to treat the "loneliness" aspect of COVID-19.

In addition, a simple check-in by an in-home caregiver can be enough to brighten an individual's day. You would obviously want to take precautions (masks, disinfectant, PPE, etc.), but looking in on a patient can ensure they're continuing on the path to recovery, are sticking to prescribed guidelines from the physician and are just generally doing okay.

Addressing the social determinants of health is a step we cannot overlook during the COVID-19 pandemic. Case management teams have a variety of tools at their disposal to ensure discharged patients don't turn into readmitted patients.

By solving for these problems ahead of time, you can even speed up discharge and patient referrals, thereby reducing avoidable days and creating a win-win scenario



Chapter 9
Transportation's Outsized Role

Top Takeaways

A Shortage of Transporters:
Hospitals must reckon with a dearth of vehicles capable of safely transporting recovering COVID patients out of the hospital.

Infection Control Support:
Acute care teams are uniquely positioned to help transportation providers boost their infection control procedures.

More Than Just Discharge Assistance:
Transportation providers can also be relied upon to provide grocery and medication delivery, appointment pickup and drop-off, and more.

More widespread availability of non-emergency medical transportation (NEMT) for COVID patients has the potential to save lives, reserve emergency resources for those who need them and provide safe pathways to primary care for the chronically ill.

Let's talk about how contracting with NEMT providers for various services can positively affect your facility and **reduce the possibility that patients boomerang back to the hospital upon discharge**.

Transporting Patients

The most obvious benefit of an NEMT partnership is the ability to transport patients to and from the hospitals and between varying levels of acuity.

When a COVID-19 patient needs transportation to the hospital, it's typically because of a deterioration of condition or a lack of adequate personal transportation. Because those patients also can't rely on public transportation given the viral transmission risk, most incoming hospital traffic will arrive via ambulance.

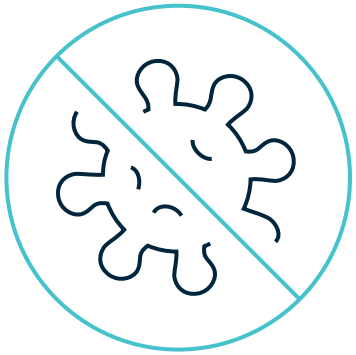
NEMT providers come into play once the patient has stabilized and is ready to be discharged from the hospital. And to be perfectly blunt, there is a downright lack of vehicles with the expertise, personal protective equipment and infection control procedures available to ensure safe, appropriate transport of a stabilized COVID-19 patient.

Prior to the pandemic, much was made of partnerships between healthcare systems and ride-share companies like Uber and Lyft. These partnerships were a great idea that sought to address one of the key social determinants of health, that of transportation.

But the onset of the pandemic led to a multitude of rideshare vehicles shutting down. And even if they weren't taken out of commission, those vehicles certainly weren't capable of the types of infection control necessary to protect drivers. In fact, many NEMT vehicles, not just those related to rideshare partnerships, lack those kinds of precautions.

What this means is that patients who are technically recovered enough to leave an acute care setting, but who don't have someone to transport them, become stuck in a hospital for much longer than they otherwise would need to be. **This creates capacity issues, particularly if your area experiences a spike in COVID cases, and it ultimately presents patient recovery risks and revenue shortfalls for your organization**.

Getting Where You Need to Be on Infection Control



In your area, there may actually be a number of NEMT providers who want to be part of the solution but simply haven't encountered a situation quite like this (who has?). In these instances, and where the regulatory landscape allows, some hospitals have actually found success by working closely with NEMT providers to offer their insights and guidance into things like infection control in order to get those services back online.

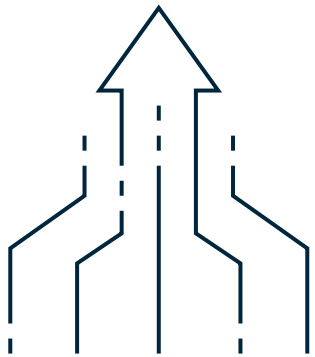
Acute care providers are uniquely positioned to provide guidance on the steps NEMT providers will need to take in order to protect themselves and patients during transportation. The first step should be ensuring providers are staying up to date on the latest guidelines from healthcare authorities. The CDC has a fantastic guide to disinfecting non-emergency transport vehicles. Many states have also released their own resources targeted toward this information.

Your own experience is its own valuable resource. Consider scheduling an informational webinar where you talk about the types of infection control procedures you use at the hospital and that could be adopted to a vehicle. Alternately, reach out individually to NEMT agencies you've utilized in the past to see where they stand with infection control procedures and offer your consultative services to get them to a point where they're capable of accepting your COVID patients. Consider a certification program where those transport companies, who may also be feeling a financial pinch because of COVID-19, can meet certain thresholds to demonstrate their capabilities and get on your hotlist of preferred providers.

Being able to rely on NEMT providers for the transportation of stabilized COVID patients has a lot of upside for your organization. It frees up emergency resources, such as ambulances, for those patients truly in need. It has the potential to reduce length of stay and free up bed space, as you won't have to wait 14 days to ensure the patient is no longer contagious.

This then creates a better patient experience, as they get where they need to go without a substantial wait in an acute space.

Addressing the Social Determinants



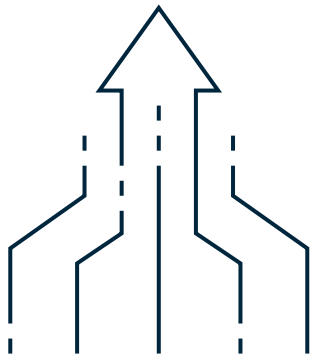
Just as important as transport out of the hospital is ensuring the patient's condition doesn't worsen to the point where they need to be readmitted. And this is yet another way NEMT can be enlisted to aid your organization's fight against COVID.

Proper deployment of NEMT resources can help patients stay healthy by targeting social determinants of health. As noted in Chapter 8, transportation is a critical social determinant of health. NEMT, specifically, can be relied upon to ensure the delivery of things like groceries, medical supplies, prescriptions and other items that can make a large difference in a patient's recovery. Some states won't even allow you to discharge a patient if they don't have two weeks of groceries available, and leaning on NEMT to guarantee this access can remove that barrier.

Even if your NEMT providers don't have the protocols in place to transport COVID patients, they can help you solve for disparities in social determinants of health. It's become clear that the very people most at risk for COVID-19 are those who also don't have access to resources others might take for granted, and by addressing these, you can boost the path to recovery beyond what would otherwise be possible.

Consider working with NEMT providers to schedule pick-ups and deliveries on those basics that will help the patient recover. Doing so can **massively reduce the risk of readmission**.

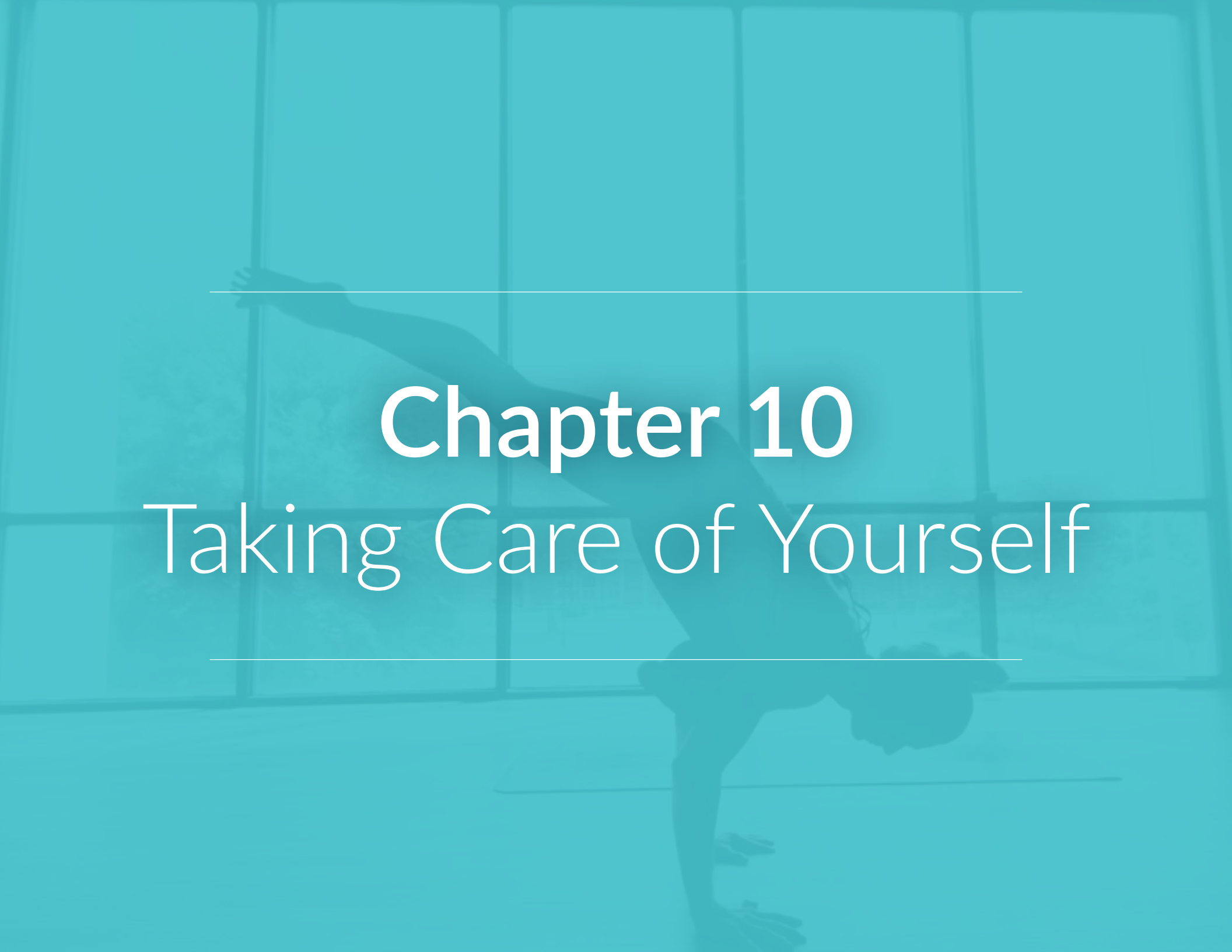
Communication



We've emphasized previously how important it is to regularly interact with your post-acute network to gauge their capacity and their ability to accept COVID-19 patients. This is just as true for NEMT providers, whether those transporting patients or those providing services aimed at addressing the social determinants of health.

You should communicate regularly with your providers, and you should have a system in place that lets you quickly schedule pick-up and drop-off of patients and the supplies they need to continue on their path to recovery. Ideally, you'd be able to monitor these rides in real-time and use the data to make even more strongly informed decisions about your NEMT providers in the future.

Transportation is a struggle in the COVID-19 era, but hospitals are getting creative with how they're safely discharging patients. I hope these tips will help you as you evaluate NEMT and its role at your organization.



Chapter 10
Taking Care of Yourself

Top Takeaways

Your Best You:
It's impossible to provide an optimum level of care to patients if healthcare workers don't take time to take care of themselves.

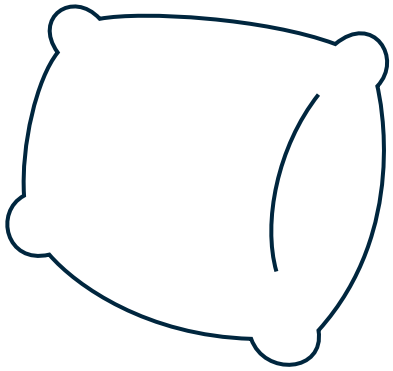
Don't Overlook Sleep:
Difficult as it may sometimes seem, getting the requisite seven to eight hours of sleep per night can make a big difference in your alertness and capabilities.

Family Time and "Me" Time:
Spending time with and reaching out to those you love provides huge mental health benefits, but so does knowing when you need some time to yourself.

This book wouldn't be complete without at least a partial focus on an aspect of the pandemic that's been tragically overlooked: self-care.

Many healthcare workers are likely struggling to find the energy to do anything more than report in to work each and every day, but you still need to make time for yourself. **When you're at your best, your patients receive the best care**.

To that end, here are some tips to consider when it comes to taking care of yourself even as you spend an inordinate amount of time taking care of others.

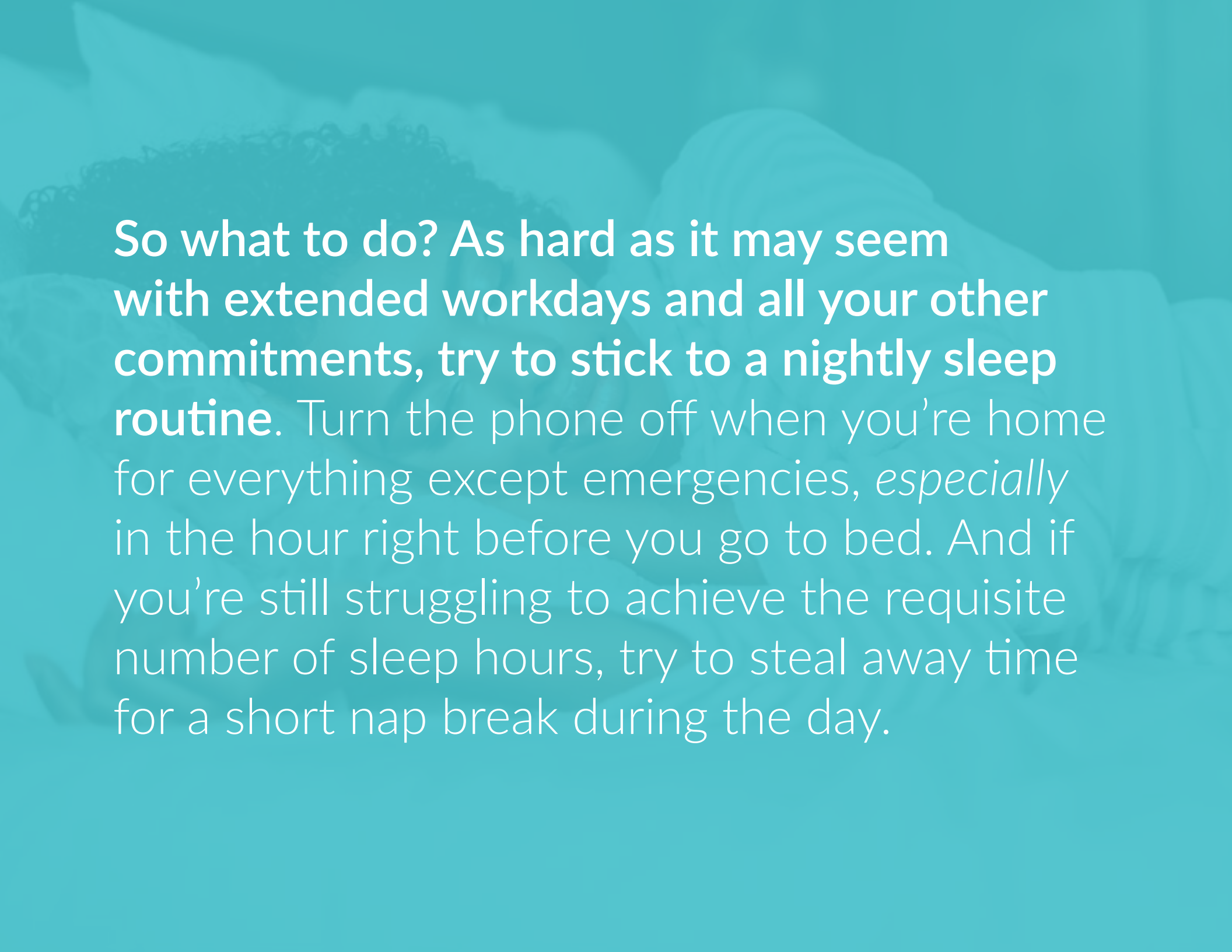


Sleep

This is the big one. Even though it probably seems like there's not enough time in the day to do all the things you have to do as an employee, a spouse, a parent, etc., it's critical to make time for the requisite amount of sleep in your day.

What's the requisite amount? **Seven hours or more**. Some of you may be laughing right now given all of the demands you have to meet in a given day, but this can't be emphasized enough.

If you're not getting enough sleep, your body isn't equipped to stay healthy. You have a higher risk of making mistakes. Your response time is diminished. And perhaps the scariest part: after extended bouts of not getting sufficient sleep, you may not even realize how tired you are or the decrease in your abilities.



So what to do? As hard as it may seem with extended workdays and all your other commitments, try to stick to a nightly sleep routine. Turn the phone off when you're home for everything except emergencies, *especially* in the hour right before you go to bed. And if you're still struggling to achieve the requisite number of sleep hours, try to steal away time for a short nap break during the day.

Family Time

Those working from home right now are likely reeling from an overabundance of family time. Healthcare workers face the opposite problem. It's easy to feel like you're missing valuable time with your loved ones when you're spending 12+ hours per day in a stressful clinical environment.

That makes the time you do have with your loved ones that much more important. Make sure to lean on and spend time with those closest to you. If they're your immediate family, still take the time to play games, have dinner, and do all the things you would normally do around the house. If you have loved ones outside your own home, particularly elderly parents who probably crave a connection right now too, reach out to them regularly for conversation.

And if the weather cooperates in your area, grab the whole family and get outside. This may seem counter-intuitive in a quarantine environment, but most jurisdictions at this point in time are encouraging people to go for walks or explore parks, so long as you still practice the social distancing etiquette that's so important to halting the spread of COVID-19.

(one thing to note: if you have kids, think more nature parks than playgrounds. Getting in the outdoors to explore is much safer than touching a bunch of playground equipment).

Me Time

On the other end of the spectrum, you also should continue doing the things that bring you joy. That means carving out time for the hobbies you love and the pastimes that are uniquely you.

These are probably the easiest things to let slide during an emergency situation, but without them, it's easy to sink into a malaise. The risk is greatest if you find yourself falling into a routine of going to work, where you worry about patients' needs, and then coming home and worrying exclusively about loved ones' needs.

You have to recognize that you have needs too, and one of the best ways to do that is to treat yourself to the things you love.

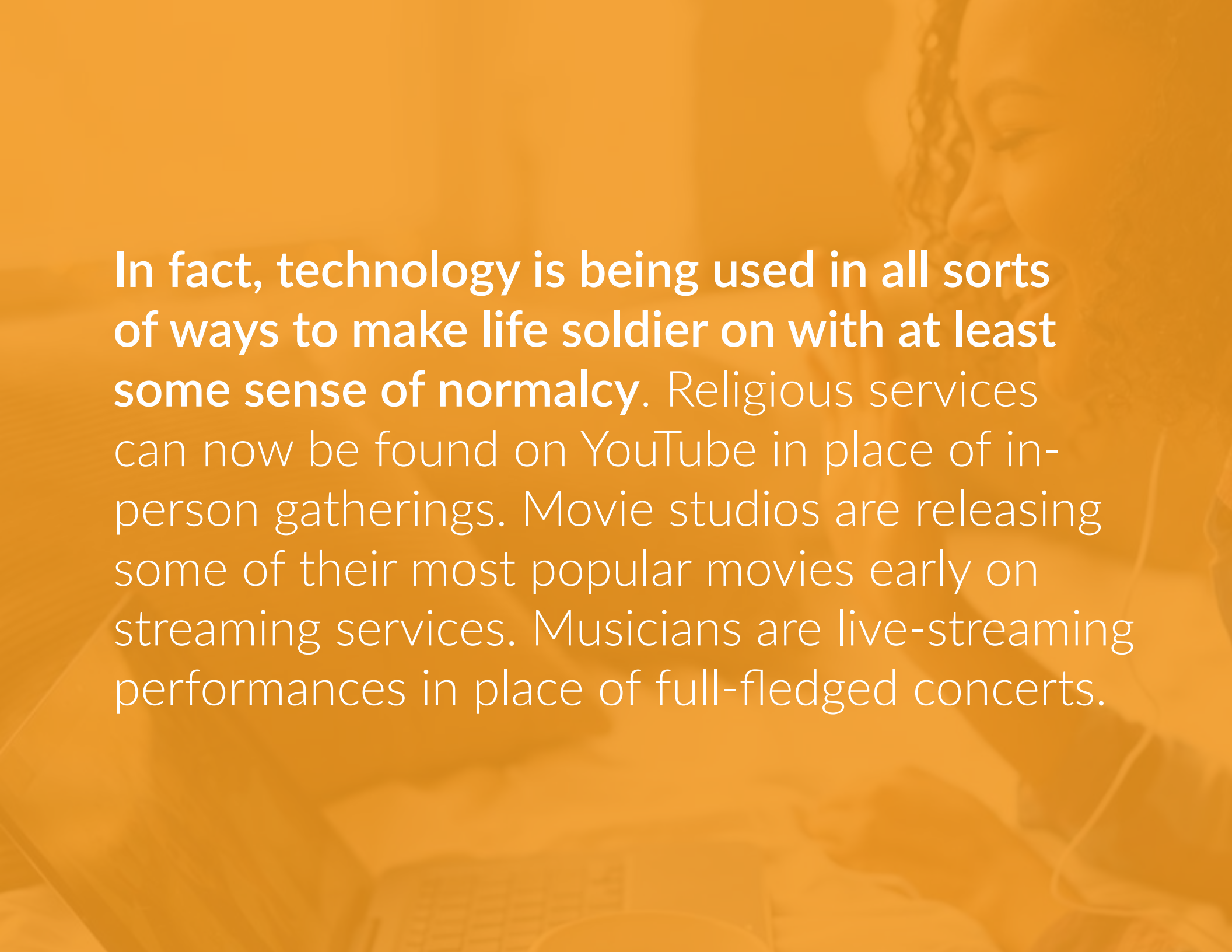
Sometimes, that could mean taking 15 minutes at the end of the day to read a book or watch a show you enjoy. It could mean setting boundaries with your loved ones to tell them that, on your day off, while you very much look forward to spending quality time with them, you're also going to **take two hours to go for a run, to work on a craft project or do whatever else fills your bucket**.

Face to Face

One of the biggest threats facing healthcare workers is something that's a little harder to define, but no less serious: loneliness.

True, you may spend your day interacting with patients and members of your team. But that's no replacement for human contact, especially if a quarantine order has you staying far away from those you want to see the most.

There are no easy answers in this situation, but modern technology has eased the burden somewhat. Apps like Skype and FaceTime enable you to have face-to-face communication with those you care about, and I can guarantee that, in these difficult times, the people you reach out to will be just as grateful for the human contact as you. We've gotten so used to texting and communicating via GIF and Emoji, but there really is no replacement for seeing someone's face or hearing their voice, especially if you've gone weeks without that sort of contact.



In fact, technology is being used in all sorts of ways to make life soldier on with at least some sense of normalcy. Religious services can now be found on YouTube in place of in-person gatherings. Movie studios are releasing some of their most popular movies early on streaming services. Musicians are live-streaming performances in place of full-fledged concerts.

Take Care

There's no limit to human ingenuity, and there's no better proof of that than the healthcare professionals who continue to dip into reserves of boundless enthusiasm and dedication to help patients in need. But make sure to save at least some of that creativity for you. Doing so will have a positive impact not just on you, but on the entire world around you.

Epilogue

And that does it! It's a lot of information to take in, but our hope is that you've discovered something useful that will help your own case management and patient referral processes.

Thanks for reading!

About **Ensocare**

Ensocare is a cloud-based solution suite that makes transitions of care more efficient. Transition, Ensocare's care placement and referral software, automates the discharge process and effectively transitions patients between care settings and enables coordinated care across the continuum. A growing portfolio of services designed to identify and fill gaps in patient care transitions complement Ensocare's overall mission to make discharge more efficient, engage patients and hospital staff, and positively influence outcomes.

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