

Essential Case Management Practices Amidst the Novel Coronavirus Disease 2019 (COVID-19) Crisis: Part 1

Tele-Case Management, Surge Capacity, Discharge Planning, and Transitions of Care

Hussein M. Tahan, PhD, RN, FAAN

ABSTRACT

Objectives: This is the first of a 2-part article that discusses essential case management practices and strategies amidst the novel coronavirus disease 2019 (COVID-19). The series showcases the potential professional case managers have in support of managing during a crisis such as this global pandemic. Part I discusses reenvisioned roles and responsibilities of case managers and leaders known to address patients' needs during a crisis, with a special focus on telehealth, tele-case management, surge capacity, redeployment, discharge planning, and transitions of care.

Primary Practice Settings: Applicable to the various case management practice settings across the continuum of health and human services, especially acute care.

Findings Conclusions: The COVID-19 global pandemic crisis has brought an unprecedented challenge to professional case managers and health care professionals. It also has provided opportunities for innovation and partnerships within and across health care organizations and the various care settings where patients/support systems access necessary services. Most importantly, it created a renewed interest in telehealth and facilitated a wider adoption of such approach to care delivery than ever before. This pandemic has also increased the use of nontraditional sites of care, most importantly those that operate virtually on electronic networks and health information system technologies such as remote visits, e-visits, virtual care, and tele-monitoring. Undoubtedly, these have provided new opportunities for tele-case management services and roles for professional case managers in the virtual world of health and human service delivery.

Implications for Case Management Practice: Professional case managers are integral members of interprofessional health care teams. Their roles are even more necessary during a global pandemic such as COVID-19. The practice of case management will forever change—for the better. The experience of this crisis in health care has brought about ever-lasting implications for case management professionals. It has raised awareness to sites of care never were as popular before, resulting in an increased need and recognition for tele-case management practice and virtual case managers. It has also forced partnerships and collaborations among the diverse contexts of health care organizations (public, private, or both) and other industries, regardless of whether directly involved in the delivery of care or having a support service role. These new and innovative approaches in the provision of care and case management services will without a doubt become routine expectations beyond the current pandemic period. Of special note are the enhanced roles of case managers in discharge planning and transitions of care.

Key words: COVID-19, discharge planning, long-term care, novel coronavirus disease 2019, pandemic, tele-case management, telehealth, tele-rounding, transitional planning

The current situation of the novel coronavirus disease 2019 (COVID-19) is an unprecedented time and experience for the United States and the world. The COVID-19 crisis is nothing like ever before; it has virtually impacted every aspect of modern life and each unique individual across the world. Although the experience of and lessons learned from

Address correspondence to Hussein M. Tahan, PhD, RN, FAAN, 10 Liberty Court, Secaucus, NJ 07094 (htahanrn@gmail.com).

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the global flu pandemic of the last century are beneficial, they are not entirely transferable to the current situation. This adds a degree of uncomfortable uncertainty to action planning and strategy execution in response to the current uncharted territory. Our society and its economic, sociopolitical, regulatory, and health dynamics are different today from those experienced during the 1918 global flu pandemic. Globalization, popularity of social and digital media, health care-related scientific and treatment advances, health information systems and technologies, and remote/virtual work settings are all different factors that affect today's pandemic compared with a century ago. On some level, these are advantageous strategies and may facilitate addressing the current crisis more effectively. On another level, these also may take an opposing juxtaposition and become barriers to curtailing the long-term impacts of this global pandemic concern.

The health care industry, practice environments, interprofessional care team members, and diverse care settings across the continuum of health and human services are all gravely challenged by the COVID-19 crisis. Locally, regionally, and globally, people are relying on their health care constituents to ensure timely access to services for those infected with COVID-19, enhance availability of safe care environments (i.e., prevention of exposure to this highly contagious infection) and resources especially for those who are not infected with the virus, and to stop or prevent the spread of the virus to other people and communities. All these challenges are occurring while maintaining one's own safety and well-being (Thalken, 2020). The reality, however, is that these health care stakeholders are not impacted alone. Other industries, whether health-related supply chain manufacturers, food industry companies, financial institutions, entertainment agencies, transportation providers, or religious institutions, among others, are all affected as well and in unique ways add to the complexity of this global pandemic and its consequences. This crisis necessitates unprecedented collaborations across various industries in creative, innovative, and adaptive ways. It also calls for essential and flexible partnerships between government and nongovernment agencies—locally, regionally, nationally, and globally. As health care professionals, therefore, we are to pay close attention to the

needs of both the healthy and well individuals and those who suffer from chronic health conditions, in the provision of health and human services—equally, fairly, and simultaneously.

Health care leaders, providers, payers, and advocacy organizations have a great responsibility toward the communities they serve, which impacts access to not only timely health and human services and resources but the public health safety and optimal outcomes as well. Case management leaders and professionals are no exception; in fact, they are poised to play an essential role in supporting health care organizations, providers, and other agents in their responses to the COVID-19 crisis. It is not an exaggeration to claim that COVID-19 has consumed the time and efforts of every leader and health care professional—daily and constantly—with no end in sight currently. Professional case managers, as core interprofessional health care team members, are the hub of care coordination and transitional care activities across the continuum of care and diverse health disciplines. With their educational backgrounds and knowledge, skills, and competencies in the provision of case management services, especially to the most vulnerable, they safeguard the public—the consumer of health services and their support systems—both in the usual conditions of care provision and in times of crisis. This two-part article series highlights several key strategies and areas of impact for the case management professionals and leaders whether directly or indirectly involved in the COVID-19 crisis. Discussing COVID-19 as a disease, diagnostic procedures, prevention strategies, and treatment options are not within the scope of this series. For such information, one may visit the Centers for Disease Control and Prevention (CDC) website where detailed guidance can be found (<https://www.cdc.gov/coronavirus/2019-ncov/index.html>).

Part I of the series reenvisions key roles and responsibilities of case managers and their leaders amidst the COVID-19 crisis. It addresses the provision of essential health and human services to meet the needs of patients and their support systems while ensuring their safety and attempting to limit potential exposure to this vicious infection or its transmission to others. It also highlights a renewed interest in the value of telehealth, telemedicine, and tele-case

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management. It does so by showcasing the importance of virtual and remote sites of care in meeting the health care needs of individuals when traditional primary care sites have faced unprecedented closures, requiring those in need for health and human services to find alternate care options. In addition, and unsurprisingly, Part I describes the impact of the pandemic (crisis) on the acute care/hospital setting where it is natural for those who need health care services to flood this care setting. This may result in an unusual rise in patient surge capacity that requires active involvement of professional case managers. Finally, this part features how redeployment of case management personnel, discharge planning activities, and transitions of care processes present an opportunity for case managers and leaders to play an integral role in meeting the demands of this crisis. Part II of the series continues to articulate the contributions of case management practice amidst the COVID-19 global pandemic. It highlights the role of palliative and end-of-life care, especially for patients who are critically ill, workers' compensation, and return to work due to increased exposure of health care workers to COVID-19, requiring quarantine, remote/virtual case managers' practice, and self-care and resilience due to the uncertainty of this infection and reports of health care workers feeling emotionally drained. This part ends with a brief view of legal and ethical case management practice.

A BRIEF HISTORICAL PERSPECTIVE AND BACKGROUND

The 1918 influenza pandemic was the most severe global pandemic in recent history. Although there was no universal consensus regarding where the virus originated, it spread worldwide during 1918–1919. In the United States, it was first identified in military personnel in the spring of 1918 before it became a major public health concern for the community at large. An estimated 500 million people or one third of the world's population then became infected with the virus, resulting in the death of approximately 50 million people worldwide, with about 675,000 occurring in the United States. A unique feature of the

pandemic was the high mortality rate in healthy people, including those 15–34 years of age (CDC, 2018).

As of May 2, 2020, the Coronavirus Resource Center at the Johns Hopkins University and Medicine (JHU) reports that nearly 3.4 million people worldwide have suffered from COVID-19 whereas about 240,650 individuals have died from the disease (mortality rate of 7.11%) (JHU, 2020). These data points reflect only the confirmed cases—primarily those who sought out health care services. Experts agree that the incidence of this infection must be much greater than the reported data based on concerns such as lack of enough testing for COVID-19 and the fundamental problems in self-reporting where some individuals may have felt their symptoms are controlled, never accessed a health care setting for care, and therefore their conditions have remained unreported. Experts also agree that the incidence of COVID-19 is continuing to rise globally in the absence of essential medical treatments such as vaccination and pharmaceuticals. In the United States, the reports as of this writing reflect more than 1,115,480 of confirmed cases and 65,298 deaths (mortality rate of 5.85%). The COVID-19 global pandemic has inflicted more than 200 countries as of this writing (JHU, 2020). Table 1 lists the top 20 countries of confirmed cases in the world and their corresponding deaths and mortality rates.

Like the 1918 flu pandemic, the properties that make the current COVID-19 global pandemic pervasive and devastating are still not well understood. Both pandemics are worldwide in spread, have no vaccine to protect against the infection, and no scientifically proven medications available to treat the associated infections. Necessary interventions to control or prevent the consequences of both global pandemics are socially based and rely on human behaviors, local community dynamics, and public health strategies. These consist of physical distancing, self-quarantine, personal and hand hygiene, personal protective equipment (PPE) such as a face mask, use of disinfectants, limitations of public gatherings, travel restrictions, consumption of nutritious diets, self-monitoring for symptoms of the disease, and ultimately pursuing early access to health care services.

TABLE 1**Top 20 Countries of Confirmed COVID-19 Cases and Their Respective Mortality Rates**

Country	Number of Confirmed Cases	Number of Deaths	Mortality Rate
1. United States	1,115,484	65,298	5.85%
2. Spain	213,435	24,543	11.50%
3. Italy	209,328	28,710	13.72%
4. United Kingdom	183,495	28,204	15.37%
5. France	167,305	24,597	14.70%
6. Germany	164,380	6,736	4.10%
7. Russia	124,054	1,222	0.99%
8. Turkey	122,392	3,258	2.66%
9. Iran	96,448	6,156	6.38%
10. Brazil	92,630	6,434	6.95%
11. China	83,959	4,637	5.52%
12. Canada	56,343	3,537	6.28%
13. Belgium	49,517	7,765	15.68%
14. Peru	40,459	1,124	2.78%
15. The Netherlands	40,434	5,003	12.37%
16. India	37,776	1,223	3.24%
17. Switzerland	29,817	1,760	5.90%
18. Ecuador	26,339	1,063	4.04%
19. Saudi Arabia	25,459	176	0.69%
20. Portugal	25,190	1,023	4.06%

Note. Mortality rates were calculated on the basis of the reported numbers of confirmed cases and deaths. From *COVID-19 Dashboard by the Center for Systems Science and Engineering*, by Johns Hopkins University and Medicine, Coronavirus Resource Center, 2020. Retrieved May 2, 2020, from <https://coronavirus.jhu.edu/map.html>

The global spread of COVID-19 and its resulting challenges have surpassed previous pandemics and epidemics, especially in the United States. Understanding the characteristics of this disease continues to be in flux. The CDC and the World Health Organization have been providing regular guidance about this disease and its control measures. However, their recommendations have been changing almost daily, which makes it more challenging for the public and health care providers alike, including professional case managers, to sustain their intervention plans and strategies and preventive measures. In addition, because of the uncertain nature of the disease and the ongoing changes in the control measures, these challenges are affecting the public at large perhaps to a greater extent. Therefore, the essential role professional case managers may play is invaluable for both the public and fellow health care professionals. Specific areas of utmost importance for case managers as discussed in this two-part article series include, but not limited to, telehealth, tele-case management, transitional and discharge planning, palliative and end-of-life care, long-term care and

skilled nursing facilities (SNFs), workers' compensation, remote practice, and self-care.

TELEHEALTH AND TELE-CASE MANAGEMENT

Telehealth and tele-case management are not new to the health care industry. Telehealth comprises the use of health communication networks and digital technology in the provision of health and human services to those in need. Specifically, it allows the exchange of medical and health-related information from one site of care or health professional to another through these electronic communication technologies for the purpose of enhancing a person's health status and well-being. In tele-case management, the services provided may relate to care coordination and transitions of care activities, brokering of services, triage and resource allocation, and communication with interprofessional care team members for the purpose of patient care planning. Most importantly, tele-case management services for the patient/support system usually focus on the provision of counseling, psychosocial support, health instructions for self-management, and preparation for safe transitions of care. Regardless whether tele-case management services involve the members of the interprofessional health care teams, the patient and support system, or both, the services involve professionals from not only the diverse care settings across the continuum but also the levels of care within an individual care setting.

Use of telehealth in the provision of case management services has for long been evident to occur in many ways such as traditional telephonic care coordination and demand management, use of remote monitoring of patients for enhanced engagement in own health and self-management, and in the application of digital communication technology for patient and family support, especially for coping with life-changing and complex health conditions. In the current COVID-19 crisis, however, telehealth is needed more than ever before, in nontraditional ways, in every practice setting, in new sites of care, and from diverse health professionals/disciplines across the continuum of care. Because of the increased vulnerability and risk of exposure to COVID-19, telehealth and tele-case management have been applied in more expanded ways across the health industry. Their use facilitates early access of patients/support systems to health and human services. It also promotes people's adherence to the physical distancing measures recommended for COVID-19 exposure risk reduction.

In this current COVID-19 crisis, it is necessary for case managers to expand the use of telehealth as a tool to provide timely care to patients and their support systems whether they are at home, in an acute care setting/hospital, or at another setting across

the continuum of care. This approach has quickly become a common and important method in caring for patients while preventing further exposure to COVID-19. The Centers for Medicare & Medicaid Services (CMS, 2020a) has loosened its regulations for telemedicine in support of such care delivery methods for Medicare beneficiaries under temporary and emergency basis. Since March 6, 2020, and under the released waiver, 1135 waiver authority, and the Coronavirus Preparedness and Response Supplemental Appropriation Act, Medicare started to pay for a provider's office, hospital, and other visits furnished via telehealth across the country and including in patients' places of residence. This has allowed a range of health care providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, to receive reimbursement for services offered via telehealth to their patients. This care approach supports the use of phones, smartphones, or laptops with a shared link to enable video communications, video chat applications (apps), or other electronic devices as vehicles for telemedicine. CMS telehealth waiver and expansion of reimbursable services have also expanded the methods and tools case managers may use to reach their existing and new patients (CMS, 2020a).

The spread of the coronavirus has contributed to the avoidance of those most vulnerable to access necessary health care services for fear of becoming infected because of direct or indirect contact with either suspected or confirmed COVID-19 patients. The uncertain dynamics of the coronavirus disease has made it more challenging for this population to engage with their health care providers, including case managers, even for needs that are unrelated to COVID-19. These most vulnerable individuals include persons with multiple chronic conditions, limited functional abilities, social determinants of health concerns, or suboptimal support systems. Under usual circumstances, these individuals require chronic disease management and experience planned encounters with their health care providers because of the need for frequent monitoring, follow-up care, and checkups as indicated by their conditions. Professional case managers are often routinely involved in the coordination and management of the services these individuals need on an ongoing and long-term basis—in the form of management of chronic illness practices. During the COVID-19 crisis, these vulnerable individuals have become a priority population requiring proactive attention (outreach) from case managers. Because direct in-person follow-up is not optimal, tele-case management has arisen as the desired answer. Although some tele-case management tools such as those described later may have

already been routinely used, the COVID-19 crisis has made these tools increasingly popular and the primary, if not the only, mode of care delivery.

Some examples of telehealth/tele-case management services professional case managers can either directly provide to or facilitate for their patients are discussed. These services help reduce the patients' risk for exposure to COVID-19, especially for those who are most vulnerable, ensure early identification of exposure, screening for needed care interventions, and coordinating the necessary services to ultimately prevent the need for, otherwise avoidable, acute care services.

Remote Home Care Visits

Remote home care visits occur by using videoconferencing technology and platforms. During these visits, case managers assess the patient's condition, offer counseling on self-care management activities as needed, provide health instructions, and coach the patient/support system in staying healthy at home while following necessary COVID-19 prevention strategies, if applicable. The case manager also can follow up on the plan of care, review medications, and assess the patient's progress as indicated on the basis of the patient's condition and care needs while in the community setting.

Triage Call Centers

As a participant in triage call centers, the case manager assesses the caller's situation and needs, identifies the best course of action necessary, and guides the caller on accessing health care services if indicated. In this case, for example, the case manager screens the caller's needs following specific algorithms that guide the telephonic assessment, identification of the key or priority problems requiring attention, and the decisions to be made regarding next steps or actions to be taken (i.e., interventions). The case manager then coordinates the necessary care interventions and services by facilitating an electronic clinic visit with a provider (i.e., virtual check-in, e-visit, or telehealth visit), assisting in the completion of an electronic prescription for a needed medication (refill), or coordinating a home delivery of needed medications or health care-related supplies.

From a COVID-19 crisis perspective, case managers (and other health care professionals) involved in these triage call centers may identify the caller's need for COVID-19 screening and testing and then direct the caller to where best to seek the needed follow-up including necessary testing. The screening, for example, comprises a special focus on the caller's travel history, home situation (e.g., living with someone who

is COVID-19-positive), potential or actual exposure to COVID-19, presence of symptoms, or other relevant health concerns. Case managers then use the gathered information to risk stratify the caller into the category of stay at home and continue to monitor health condition, high-risk exposure requiring testing for COVID-19, or a non-COVID-19-related health concern. Based on the classification, the case manager then advises the caller regarding next steps. In the case of stay at home, the case manager provides the caller with health instructions, especially concerning COVID-19 symptoms, red flags, and when to seek follow-up care; for the caller requiring testing, the case manager notifies the testing center and facilitates timely services; and for the callers with other health concerns, the case manager acts on the basis of usual triage protocols whether to follow up with primary care provider, to seek urgent care, or to transport immediately to acute care for attention to an emergent condition.

Virtual Services

In the virtual services provided via telehealth platforms, case managers collaborate with health care providers in ensuring patients receive timely and necessary services, including evaluation and management, mental health counseling, preventive health screenings, and routine checkups. As indicated by the patient's condition, triage protocol like the one used by the triage call centers may be followed. Based on the Medicare telehealth waiver (CMS, 2020a), this may occur in three ways:

1. *Virtual check-ins*, which are usually short and patient-initiated communications with the health care practitioner, often by telephone;
2. *e-Visits*, which are also patient-initiated communications with a health care practitioner, however, via an online portal and do not necessarily include a face-to-face interaction between the parties; and
3. *Telehealth visits*, where the use of telecommunications technology involves a real-time interactive audiovisual modality (bidirectional audio and video communication) between the patient and the health care practitioner. These are usually initiated by the practitioner.

Secure Digital Communications

The COVID-19 crisis has increased the need for case managers to use secure communication tools such as texting, telephone conversations, video chatting, and e-mail in sharing sensitive information with the patient/support systems or other health care providers. For example, they may reach out to patients

telephonically to inform them of positive COVID-19 test results and share instructions on self-care and quarantine. Another example is brokering of necessary services, whether community-based support resources (e.g., meal or grocery delivery to a COVID-19-positive patient) or health care services (e.g., referral for home care or to a consulting specialty care provider).

Telemonitoring Services

Telemonitoring services and remote management of a patient's symptoms are effective tools, especially in crisis situations such as COVID-19, which allow timely identification of concerns and implementation of necessary care interventions. For example, health care providers and case managers can remotely monitor a patient's temperature and symptoms and determine whether the patient can safely stay at home or should seek in-person care at a primary care clinic, an urgent care center, or an emergency care setting. These telemonitoring services may include follow-up on both patients who tested positive for COVID-19 but did not require hospitalization and patients with other chronic health conditions. In both cases, early and ongoing monitoring may prevent unnecessary need for face-to-face acute care services. The health care professionals involved in the telemonitoring services, including case managers, may also follow a decision-making approach to care decisions such as the one used by the triage call center and as indicated by the patient's condition implement necessary intervention.

A current popular innovation in electronic and telemonitoring of suspected or COVID-19-positive patients is the use of digital applications (apps) that allow for the tracking of symptoms, and through logistical and analytical models the technology triggers a red flag that signals the need for necessary follow-up. An example of such apps is the *chatbot*, a software application whereby individuals (e.g., patients) may use an online chat with others (e.g., health care provider such as a case manager) via a text-to-text or text-to-speech option in lieu of providing direct contact with a person. Such technology is not necessarily new; it has been used in online customer service support services in various industries. In the current COVID-19 situation, the use of chatbots or similar technologies has become increasingly popular. In this case, chatbots have been used as an acceptable strategy for meeting the increased demands for monitoring of individuals or provision of psychosocial counseling and support services, including patients and health care workers. It is also being used as a question-and-answer session providing health instruction, advice, and recommendations for appropriate or necessary care such as an e-visit

with a provider. The monitoring aspect comprises a secure online sharing of one's experience of COVID-19 symptoms (using a symptom checker tool within the app) with a health care professional (i.e., a case manager) whether before determining the need for testing, after testing positive but no immediate treatment or hospitalization was necessary, or postdischarge from a primary, acute, or urgent care encounter. For health care workers, it has been noted to enhance making timely decisions for return to work while avoiding the need for an in-person outreach contact. For other patients, it has been known to be a simple tool for the provision of emotional support, advice and counseling during quarantine, and answering questions regarding effective practices for the prevention and control of virus transmission.

Tele-Consults

Like under usual care delivery conditions, amidst the COVID-19 crisis, patients require consults with specialty care providers, especially when in the acute care/hospital setting. To limit the number of health care professionals directly involved in face-to-face care provision to the COVID-19-positive patient to the essential minimum and to avoid the risk of exposure of health care professionals to COVID-19, tele-consults have become increasingly popular. In this case, case managers may coordinate the consult and facilitate the opportunity for the consulting specialty provider to visit with the health care team and/or the patient via a telehealth platform inclusive of interactive audio and video communication technology. One most commonly used consult for the critically ill COVID-19-positive patients is palliative care. The consultant involved being a member of the health care provider organization often has direct or remote access to the patient's electronic health record through the provider organization's information technology network. The consultant then based on the patient's record review and the assessment completed using the telehealth approach may recommend necessary changes or additions to the patient's plan of care. The case manager, in turn, facilitates the patient's care progression and timely follow-up by the patient's interprofessional health care team.

Services provided during telemedicine/telehealth encounters are considered billable services if they are reimbursable under the payer's standards or based on available regulations such as the CMS (Medicare) expanded billable services via telemedicine/telehealth during the COVID-19 crisis based on the COVID-19 Public Health Emergency Act. From a utilization review perspective, case managers ensure that billing for these encounters and

their associated claims reflect same procedure codes as those the providers are eligible to bill for under normal care delivery circumstances or newly added COVID-19-related codes. For example, the expansion of telehealth waiver resulted in new billing codes for services rendered including the Current Procedural Terminology (CPT) codes 99421–99423 and Healthcare Common Procedure Coding System (HCPCS) codes G2061–G2063 for e-visits, HCPCS codes G2010 and G2012 for virtual checks, and CPT codes 99201–99205 for an office or telehealth visit or HCPCS codes G0425–G0427 for a telehealth consultation, emergency department, or initial inpatient visit, and G0406–G0408 for follow-up telehealth consultant for an inpatient or SNF resident (CMS, 2020a). In addition, the claims should reflect the required modifications, if any, that identify the claim as a bill for telehealth service provision.

Case managers, especially those involved in documentation improvement or revenue cycle initiatives, may play a key role in preventing any indication of potential fraud and abuse by ensuring the claims accurately reflect the billing codes that correspond to the services provided and method of care provision used. Case managers also have an increased opportunity to be patient advocates by facilitating timely access of the patient/support system to the right health care practitioner or support services by using telehealth and tele-case management platforms. In addition, they are invaluable for ensuring quality and safe practices during the provision of telehealth services (see Table 2).

PATIENT THROUGHPUT AND SURGE CAPACITY

Because the COVID-19 pandemic is new and there have been significant and continued rising numbers of incidences and patients' deaths across the globe, the uncertainty surrounding the treatment of patients and follow-up care options has presented health care professionals, including case managers, with unique and unprecedented challenges. It also has posed complex operational concerns for health care and case management leaders across the continuum of health and human services. In addition, it forced these leaders to confront many unknown and challenging situations, some of which relate to patient flow, throughput, and surge capacity. Enacted temporary federal and state waivers in conjunction with new and relaxed regulations have allowed for some flexibility in the sites of care, transitions of care, and reimbursement rules. Fortunately, these actions also have contributed to innovative opportunities for collaborations across health care organizations, regardless of type—private-for-profit, private-not-for-profit, fully public, joint public-private, or charitable—and

TABLE 2**Sample Contributions of Case Managers to Quality and Safe Telehealth and Tele-Case Management Practices During COVID-19 Crisis**

- Documentation of the patient's consent to receive telehealth services—verbal or written.
- Securing private and comfortable physical location for the provision of telehealth and tele-case management services for patients/support systems.
- Ensuring that availability and provision of services correlate to the scope of practice of the health care provider involved and to the setting(s) authorized on the basis of applicable laws and regulations. Practicing based on the professional licensure requirements of the respective jurisdiction where the patient/support system resides.
- Accountability for the same standard of care as otherwise present during a face-to-face health care encounter with a provider.
- Early identification of needs and concerns and acting on these concerns in a timely manner such as arranging for access to urgent care or emergency services as warranted.
- Adherence to utilization management standards and requirements stipulated by the payer and the health care provider organization; e.g., securing prior authorizations when indicated. If the payer has modified its requirements, then maintaining current knowledge and adhering to what remains applicable and relevant.
- Respecting confidentiality and privacy standards, including the Health Insurance Portability and Accountability Act (HIPAA); e.g., use of platforms that allow for end-to-end encryption and decryption functionality.
- Record keeping and documentation are reflective of quality and safety standards and support the services billed to the payer.
- Application of the usual ethical and legal standards, especially those that pertain to the use of technology and digital communication tools in care provision.

whether provider of care-based, payer-based, or support service agents from other industries such as supply chain.

Acute care/hospital settings remain the most accessed sites of care for COVID-19 patients, whether with a suspected or confirmed condition. In anticipation for increased volumes of patients needing care and as part of pandemic (or disaster) preparedness plans, one primary and essential action leaders may complete is the proactive determination of a health care organization's surge capacity. Often, based on the anticipated course of treatment and care requirements for the surge of patients, health care leaders and providers review their current capabilities, patient census, and potential expansion of capacity. They consider many factors in their decisions, including availability of health care personnel (i.e., providers, registered nurses, case managers, social workers, therapists, allied health clinicians, finance, supply chain, and other support staff), necessary supplies and at anticipated increased quantities (e.g., especially in this case, PPE, COVID-19 testing kits), diagnostic and therapeutic tests and procedures, medical equipment and devices (e.g., mechanical ventilators, infusion and feeding pumps), health information technology and devices (e.g., remote monitoring, telehealth), and considerations for opening new sites

of care when necessary (e.g., COVID-19 testing tents external to an organization or emergency department, virtual clinics). During these initial activities, professional case management leaders and case managers, the focus of this article, may assume (or participate in) key responsibilities relevant to patient capacity and throughput. For example:

- Leaders participate as chairpersons or members of key committees charged with establishing plans for increased bed capacity and efficient patient flow and throughput to meet the increasing demands for health care services and rising patient volumes.
- Case managers, whether nurses or social workers, review the care progress of the patients already in the hospital with special focus on the status of their case management plans of care and discharge/transitional plans. The main purpose of this activity is the feasibility of transitioning any patients to home or another level of care (e.g., long-term care) to ensure more beds become available for the actual or potential surge of COVID-19 patients.
- Case managers redeploy to assume roles in new sites of care or other departments such as virtual clinics and triage call centers.
- Case managers also assume leadership roles in bed management and assignment where they apply their clinical care skills and medical necessity knowledge (utilization management and allocation of resources). These make them effective decision makers for identifying the best level of care for patients and assist them in the assignment of beds accordingly.

It is common that in times of crisis, such as the COVID-19 pandemic, for acute care organizations to postpone patient admissions for elective procedures or routine services and shift to prioritize the use of resources for the care of patients with emergent needs whether due to their preexisting chronic conditions or related to the crisis. Having clear plans for the continued primary and acute care of the non-COVID-19 patients is also important. In addition, it is usual for case managers and leaders to contribute to the development of surge capacity and patient throughput plans. They may collaborate with other leaders from multiple departments, including physician practice groups, patient registration and bed management specialists, finance and reimbursement, health information and digital technology, operations, and administration. The surge capacity teams, for example, may gather essential information about the current capacity by bed type and determine the extent of a realistic increase in bed capacity for specific levels of care such as critical care based on anticipated demand and the health care organization's capability to continue to provide safe and

quality services. These teams may exercise special focus on other key activities and decisions such as, but not limited to, the following:

- Increase in the number of critical/intensive care versus step-down, intermediate care, and medical-surgical beds, isolation rooms with negative pressure, mechanical ventilation ready rooms, and dialysis ready rooms.
- Likelihood of converting private rooms to semi-private, non-critical care to critical care ready, and positive to negative air ventilation pressure rooms.
- Emergency department—possibility of increasing the number of available bays, consideration to move patient triage area to another location if necessary, readiness for surge in patients brought in by ambulance/emergency medical services.
- Availability of key equipment such as mechanical ventilators, resuscitation equipment, dialysis machines, physiological monitors, and portable health information technology.

The decisions made regarding any increase in surge capacity often have specific implications for case management services. For example, a change in the number of beds (e.g., expansion) or bed types (i.e., level of acuity, level of care, intensity of required resources based on the severity of the patient's condition) affects the role of case managers, especially those involved in patient flow and throughput (e.g., bed assignment and management, designation of a medical care team for the patient and clinical specialty). These decisions also impact the case managers responsible for the review of patients' conditions and treatment plans for the purpose of medical necessity for acute care/hospital stay admission versus observation status. Moreover, they potentially may increase the demand for case management services in some clinical areas (if bed expansion and rise in patient volume) while reducing (if bed contraction and decline in patient volume) it in others. The services most likely impacted include activities such as discharge planning, transitions of care, and health instructions for patient/support system self-care management postdischarge and while at home. An increase in patient surge naturally contributes to an increase in the volume of activities of these case managers, and the opposite is also true. Therefore, case management leaders may allocate additional resources as indicated, such as redeployment of professionals, to these functions in the specialties with high demand. It is common in a crisis that involves the community at large for case managers to be redeployed for roles in areas other than their existing practice environments; for example, in the community and in a setting(s) such as long-term care.

DISCHARGE AND TRANSITIONAL PLANNING

The issues of the COVID-19 global pandemic are not limited to the acute care settings and hospitals. Effective strategies to manage its complex consequences amidst uncertainty have demanded partnerships across the various care settings of the continuum of care (see Table 3). Case management leaders expeditiously complete, and deliberately monitor on an ongoing basis thereafter, a careful and thorough review of applicable enacted waivers and changes in CMS laws and regulations (see Table 4; CMS, 2020b) and any temporary modifications private and third-party payers may have made to the procedures and standards of discharge planning, utilization management, value-based care, and/or outcomes reporting. Of special interest are those that create flexibility in patient care operations, procedures of notification for admission, prior authorizations for care, and discharge notices. The CMS's decision to waive the select utilization review and management expectations during the COVID-19 public health emergency has provided case management professionals more time for other activities such as transitional planning and collaboration with post-acute care facilities/agencies. In addition, discharge planning waivers enacted by the CMS have contributed to flexibilities in transitional planning across the continuum of care, including to any newly added temporary transitional care sites.

Another consequential action is the reallocation of case management personnel to meet the demands caused by any changes made in bed capacity (e.g., increased number of critical and intermediate care beds), emergency department workflows (e.g., relocating the patient triage function perhaps to another adjacent location), and cohorting of patients admitted to the hospital/acute care settings (e.g., COVID-19-positive patients placed on the same unit and in semiprivate rooms). This activity may contribute to increased caseloads for the case managers coupled with other changes such as implementation of a prioritized set of responsibilities; for example, elimination of the routine screening of patients for case management needs, rather acting based on referrals from other health care team members or the patient/support system direct request. Regardless, however, social determinants of health factors and behavioral/mental health comorbidities (see Table 5) must remain a core component of patient assessment of needs, risk for readmission to acute care, and referrals for specialist care and case management or community support services. Patients with these concerns may experience increased vulnerability for decline in health status and well-being (i.e., physical, functional, cognitive, emotional, behavioral, mental) while in the community postdiagnosis of COVID-19 or after an

TABLE 3**Discharge Planning and Transitions of Care Strategies During The COVID-19 Crisis**

- Transition existing patients to the next level of care or home, as appropriate.
 - Review new/pending admissions and patients already hospitalized for necessity of acute care stay and possibility of expedited transfer to another level of care.
 - Assess for stability and discharge as many patients to home as clinically appropriate. Discharge to home as a priority option helps reduce the risk of COVID-19 transmission to another facility such as an SNF or inpatient rehabilitation. With the closure of schools and businesses, patients' support systems may have become more available to care for patients postdischarge from the acute care setting and while at home.
- Leverage the federal, state, and private health insurance waivers enacted regarding UR, discharge planning, and transitions of care.
 - Take advantage of the waivers eliminating the need for prior authorization of postdischarge services and levels of care.
 - Partner with state agencies on resolving discharge/transition of care concerns of existing patients; e.g., homeless patients and no availability of shelters, guardianships, pending Medicaid application, and others.
- Collaborate with post-acute service providers and agents.
 - Gather information about the preparedness of the post-acute care facilities to receive additional patients from acute care settings/hospitals. Complete this daily.
 - Share key information with the post-acute service providers, especially regarding changes in hospital admissions criteria, bed capacity, and staffing challenges.
 - Secure durable medical equipment, especially oxygen therapy that is known to increase in demand due to COVID-19 being a pulmonary system-related disease.
 - Communicate the discharge planning and transitions of care surge expectations to the post-acute service providers; stress test the efficiency of meeting the increased service demands. Seek the input of these providers on the plans.
 - Implement a system for any required testing of the patient's COVID-19 status as part of the discharge/transition planning process for patients transitioned to long-term care facilities, including SNFs, inpatient rehabilitation, group homes, and nursing homes.
 - Communication of the test results to the health care team at the next level of care.
 - Ensure long-term care facility receiving the patient can provide infection prevention and transmission-based precautions.
 - Case managers must address this requirement in their transitions of care workflows and documentation.
 - Hold daily calls (or more regularly if necessary) with various post-acute service providers and discuss status of plans, address challenges, and seek to understand the mutual expectations.
 - Share discharge instructions developed for the suspected and confirmed COVID-19 patients. These are helpful for both home health and long-term care facilities.
 - Inquire about any changes in admission criteria/practices and capacity your post-acute service provider partners may have made. It is likely that SNFs decline to admit patients with COVID-19 because of their limited ability to care for patients needing droplet isolation precautions. Proactively address the implications of these changes on transitions of care plans.

Note. SNF = skilled nursing facility.

episode of acute care hospitalization. It also has been noted so far that older individuals suffering from multiple, preexisting, complex, and chronic health conditions are at a higher risk for COVID-19 and increased chances that they may require hospitalization in the critical or intermediate care setting, often for acute respiratory insufficiency. Conditions such as cardiac illness, chronic obstructive pulmonary disease, diabetes, hypertension, and renal insufficiency present heightened concerns.

Emergent conditions such as the COVID-19 pandemic require diligent care coordination and transitions of care efforts. They also demand interprofessional/interdisciplinary collaboration within and across

health care organizations and support service providers. The COVID-19 pandemic has reduced the availability of primary care settings and patients' access to these services, therefore prompting those in need for care to access emergency departments, urgent care centers, and acute care hospitals. Fortunately, there has been a grave increase in the availability of telehealth (i.e., e-visits and remote visits) to counter this situation. This has provided an opportunity for individuals with lower acuity health conditions (e.g., fever, cough, sore throat, need a prescription refill) to access needed services while staying safe in their own homes. For these patients, case managers may provide triage services, health instructions, especially

Emergent conditions such as the COVID-19 pandemic require diligent care coordination and transitions of care efforts. They also demand interprofessional/interdisciplinary collaboration within and across health care organizations and support service providers. The COVID-19 pandemic has reduced the availability of primary care settings and patients' access to these services, therefore prompting those in need for care to access emergency departments, urgent care centers, and acute care hospitals.

TABLE 4**Flexibilities Issued by the Centers for Medicare & Medicaid Services in Postdischarge Needs as a Result of the COVID-19 Crisis (CDC, 2020b)**

- Waiving the requirements related to post-acute services to expedite the safe discharge and movement of patients among care settings.
 - Maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate care setting with the necessary medical information and goals of care.
 - Eliminating the need to share a list of post-acute care facilities or HHAs, inform the patient/support system of the freedom to choose, and obligation to disclose financial interests.
 - Offering flexibility in patient self-determination act requirements that pertain to need to provide patients with information about advance directive policies.
- Home health agencies:
 - Provision of more services to Medicare beneficiaries using telehealth within the 30-day episode of care if it is part of the patient's plan of care and does not replace needed in-person visits.
 - Extension of "homebound" definition to include need to stay at home due to confirmed or suspected COVID-19 diagnosis.
 - Certification and recertification of patients' plans of care and eligibility for home health services no longer limited to physicians; nurse practitioners, clinical nurse specialists, and physician assistants can prescribe the need for home care and sign the plan of care.
 - Completion of initial home assessments remotely or based on a review of the patient medical or health record.
 - Accelerated and advance payments in order to increase cash flow for the HHA during the pandemic crisis.
 - Relief on reporting; extension of the 5-day completion requirement for the comprehensive assessment (OASIS) and waiving the 30-day OASIS submission requirement.
 - Extension of the time period for filing an appeal in Medicare fee for service, advantage plans, and Part D.
- Durable medical equipment:
 - Prior authorizations of DMEPOS are paused for certain items.
 - No requirement of accreditation for newly enrolling DMEPOS; extension of any expiring supplier accreditation for 90 days.
 - Waiving the requirements of the face-to-face assessment, medical necessity documentation, and new physician order, for lost, destroyed, irreparable, or otherwise rendered unusable DMEPOS.
 - Removing the need for signature and proof of delivery requirements for Medicare Part B drugs and DME when a signature cannot be obtained; documentation of delivery and inability to obtain signature required.
 - Accelerated and advance payments in order to increase cash flow for the DME providers during the pandemic crisis.
 - Extension of the time period for filing an appeal in Medicare fee for service, advantage plans, and Part D.
- Long-term care facilities—SNFs and NFs:
 - Waiving the requirement of the 3-day prior hospitalization for coverage of an SNF transfer and stay.
 - Removal of the need for a preadmission screening and annual resident review. Suspension of the assessment of new residents for 30 days; thereafter, residents admitted with a mental illness or intellectual disability require an assessment as soon as resources become available.
 - No requirement of residents' participation in groups, given the recommendation of physical distancing and limitation of the size of groups/gatherings.
 - Extending physician and nonphysician visits to nursing home residents to include telehealth options.
 - Waiving the requirements under 42 C.F.R. §843.90 to allow for a non-SNF building to be temporarily certified as and available for use by an SNF in the event there is a need for isolation of COVID-19 residents that may not be feasible in the existing SNF structure. This assumes the state has approved the location as sufficiently safe and comfortable for patients and staff.
 - Waiving certain conditions of participation and certification requirements for opening an NF if the state determines there is a need to quickly stand up a temporary COVID-19 isolation and treatment location. Other flexibilities are also made about increasing number of certified beds if the additional beds are considered safe for patients and staff such as converting conference and activity rooms for use as resident rooms.
 - Loosening the rules surrounding interfacility transfers to allow one LTC to move residents within a facility or to transfer residents to another LTC for the purpose of cohorting and separating residents with from without COVID-19.
 - Providing relief concerning required reporting on the minimum data sets and staffing data.
 - Offering temporary Medicare Part A billing privileges for providers and suppliers establishing isolation facilities.
 - Accelerated and advance payments in order to increase cash flow for the LTC providers during the pandemic crisis.
 - Extension of the time period for filing an appeal in Medicare fee for service, advantage plans, and Part D.
- Prospective payment systems:
 - Waivers for prospective payment systems offered for inpatient acute care hospitals, LTCHs, and IRFs based on the provisions of the Coronavirus Aid, Relief, and Economic Security (CARES) Act.
 - Increasing the weighting factor of the assigned diagnosis-related group by 20% for an individual diagnosed with COVID-19 and discharged during the COVID-19 public health emergency period—inpatient prospective payment system (IPPS). ICD-10-CM codes are B97.29 for discharges prior to April 1, 2020, and U07.1 thereafter.
 - Waiving the site neutral payment rate provisions for LTCHs and the payment adjustment for LTCHs that do not have discharge payment percentage for the period that is at least 50% during the COVID-19 period and public health emergency period.
 - Waiving the requirement, under Medicare Part A, fee-for-service patients, of the need to participate in at least 3 hr of intensive therapy daily or 15 hr weekly, during the COVID-19 public health emergency period for IRFs.
 - Waiving the entire UR conditions of participation that results in eliminating the need to have an UR plan and committee to allow for more focus on direct patient care provision.

Note. DME = durable medical equipment; DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies; HHS = home health agency; ICD-10-CM = *International Classification of Diseases, Tenth Revision, Clinical Modification*; IRF = inpatient rehabilitation facility; LTC = long-term care; LTCH = long-term care hospital; NF = nursing facility; OASIS = outcome and assessment information set; SNF = skilled nursing facility; UR = utilization review. Compiled from *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*, by the Centers for Medicare & Medicaid Services, 2020. Retrieved from <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>

TABLE 5**Social Determinants of Health and Behavioral Health Conditions—Special Concerns for the COVID-19 and Non-COVID-19 Patients During the Pandemic Crisis**

Factor	Examples of Concerns for the Patient/Support System
Social	<ul style="list-style-type: none"> • Living alone; no support system available • Limited access (or no access at all) to community support services due to closure such as Meals on Wheels, senior day centers • Homelessness; concern for unsafe discharge/disposition delaying ability for discharge
Economic	<ul style="list-style-type: none"> • Employer closed business—no income • Unemployment due to furloughs; no temporary job opportunities • Limited or inconsistent support from charitable organizations • School closure and “home schooling” requirements may not be feasible
Physical living environment	<ul style="list-style-type: none"> • One room impeding ability to adhere to exposure prevention measures such as physical distancing • Lack of disinfectants and other cleaning supplies • No public transportation methods • Quarantine procedures limiting access to parks and outdoor activities such as walking and jogging • Inconsistent practices of exposure precautions at grocery stores and food shops, prompting individuals not to access these stores for fear of exposure • Closure of stores and shops • COVID-19 “hot spots”; a high number of individuals testing positive in the immediate community
Health behaviors	<ul style="list-style-type: none"> • Low health literacy level contributing to lack of understanding of precaution procedures and inability to adhere to the essential health instructions provided • Holding off on activity and exercise routines due to lockdown and “stay-at-home” expectations • Inability to adhere to “special diet” due to limited access to food; food insecurity • Self-management and health engagement concerns such as no support system, resulting in lack of adherence to health regimen
Clinical care	<ul style="list-style-type: none"> • Concern that health care facilities are dedicated to caring for COVID-19 patients, therefore opting to delay access to services • Limited or no access to technology that facilitates e-visits, tele-visits, or virtual visits with primary care providers or urgent care • Difficulty refilling prescriptions for essential medications • Reluctance to access health care services for fear of exposure to COVID-19 • COVID-19 testing sites and services not available in the area, or limited availability • Need for urgent or emergent care as a result of deterioration in condition due to lack of adherence to health regimen—suboptimal health engagement and self-care management
Coexisting behavioral or mental health conditions	<ul style="list-style-type: none"> • Suicide ideation and potential action • Homicidal ideation and potential action • Rationing of prescribed medications for fear of running out and inability to refill prescription • Emotional disturbance as a response to COVID-19 • Hallucination remaining unmanaged • Fear of stigma resulting in avoidance of health care (mental or behavioral) services

regarding COVID-19 precautions, counseling and emotional support, and simple care coordination of resources to prevent unnecessary visits to acute care.

Professional case managers in the acute care and hospital settings during the COVID-19 pandemic have focused on key discharge/transitional planning activities and have engaged in addressing barriers that may have arisen resulting in delays in patients’ transition to the next level of care. They also have continued their care coordination and management rounding with the interprofessional health care team while adhering to infection prevention procedures such as physical distancing and ongoing use of face masks despite the added challenges in practice. Tele-rounding has arisen as a desirable option as well, allowing the care team to round and discuss patients’ plans of care while maintaining one’s own safety. *Tele-rounding* is described as the use of interactive telecommunication digital technology (whether audio, video, or

both) as a remote tool that allows various members of interprofessional and interdisciplinary health care team members to engage in synchronous discussion about a specific patient situation for the purpose of care planning and resolution, without needing to be physically present in a unified location. It enhances transparency, open communication, timely information sharing, and collaborative decision-making for the purpose of patient-focused care and safe and quality outcomes.

Tele-rounding has also extended to communication with postdischarge care providers such as SNFs and home health care agents. Case managers from these care settings may use tele-rounding digital platforms to connect with their counterparts from the acute care setting for the purpose of transitions of care planning and confirmation of the patient’s disposition. They may also use this technology to connect remotely with the patient to conduct an interview, if necessary, and complete other necessary preadmission screening and

Use of such [tele-rounding] technology has provided case managers an opportunity to practice physical distancing and minimize the risk of exposure, while continuing to provide timely transitions of care services and the patient's transfer to the necessary next level of care.

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Because COVID-19 affects the person's pulmonary function resulting in shortness of breath and low oxygenation, the need for oxygen therapy and supplies at home has increased exponentially, resulting in unforeseen shortages and often causing delays in the patient's discharge from the acute care setting. Tele-rounding with case managers from other care settings or representatives of support service providers has allowed timely discussion of this need and implementation of proactive strategies to ensure availability of oxygen therapy within an acceptable time period—one that prevents any delay in the patient's transition. A “rule of thumb” case managers have continued to apply in their practice when deciding about a patient's discharge plan and its timely execution, which are essential regardless of the crisis condition, is the *patient's safe discharge and transition always first*. Despite the CMS enacted waivers for discharge planning, the regulations continue to require the following regardless of the COVID-19 crisis—safety first:

- The “*decision to discharge a patient from the hospital should be made based on the clinical condition of the patient. If [COVID-19] Transmission-Based Precautions must be continued in the subsequent setting [or level of care], the receiving facility must be able to implement all recommended infection prevention and control recommendations.*” (CMS, 2020c, p. 4)
- Hospitals must “*assess the patient's needs for post-hospital services. And the availability of such services. When a patient is discharged, all necessary medical information (including communicable diseases) must be provided to any post-acute service providers ... and to the healthcare transport personnel.*” (CMS, 2020c, p. 4)

These two requirements present a potential challenge for both the discharging and receiving

facilities where case managers are helpful in managing while collaborating with other personnel at both facilities. The receiving facility (e.g., SNF) may not accommodate the isolation precautions because of inability to adhere to these requirements whether due to limited supply of PPE or lack of knowledge, skills, and competency in PPE use by the receiving facility's personnel. Undoubtedly, these concerns have escalated during the COVID-19 pandemic, especially in the long-term care facilities that are not used to such a high demand for these patient care requirements. They also have presented a serious issue because of PPE supply shortages and lack of training resources such as expert clinicians to oversee the necessary training programs. Concurrently, however, the discharging facility (often an acute care hospital) may experience an increased patient surge requiring more availability of inpatient beds, prompting the need to expedite the patient's discharge or transfer.

One discharge setting that has been prioritized and has pressured careful consideration is the patient's home setting. Regardless of the present crisis, acute care case managers must continue to consider the patient's home as a discharge/disposition option, facilitate such decision with the interprofessional health care team, and examine the home's suitability and safety while evaluating the patient's ability to adhere to the home isolation precaution requirements. They also evaluate the need for home health services and coordinate its availability based on the patient's condition irrespective of diagnosis. It has been noted that suspected or confirmed COVID-19 patients benefit from home care services even if for a limited time period. To facilitate a patient's discharge with home health services, the CMS has expanded the definition of homebound to include COVID-19-related home quarantine as described as follows:

A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19. As a result, if a

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beneficiary is homebound due to COVID-19 and needs skilled services, an HHA [home health agency] can provide those services under the Medicare Home Health benefit. (CMS, 2020d, p. 1)

The CDC has also provided important guidance on hospital discharge criteria and instructions for suspected or confirmed COVID-19 patients (CDC, 2020; CMS, 2020d). These are a must for the professional case managers (both nurses and social workers) who may review and consider in the development of discharge standards and health instructions written at a grade level that is appropriate to patient/support system needs and meets health literacy standards. Leading a group on this matter is a necessary case management activity. Use of impactful health instruction tools enhances continued patient engagement postdischarge to home and promotes effective self-care management. It is likely that patients and their support systems express fear, anxiety, other concerns, or discomfort about adherence to the required quarantine and procedures of infection prevention while at home, perhaps, mostly fear of transmitting the infection to friends and family members. When developing COVID-19-related discharge criteria and health instructions, remember to address the following:

- *Hospital discharge criteria, whether to home or another facility/level of care:* Address stability of the patient's (1) respiratory status including oxygen saturation on ambient air; (2) hemodynamic (e.g., heart rate, blood pressure) stability or return to baseline; (3) absence of fever without medications; (4) mobility such as ambulation; (5) food tolerance; (6) level of dependence in activities of daily living; and (7) stability of other identified symptoms or concerns. As is usually the case in discharge planning, criteria for transfer to an SNF or discharge to the home setting with home health services are also applied while considering enacted flexibilities in the regulations. Case managers may continue to collaborate with the providers/physicians in deciding the best disposition option for their patients based on needs and availability of resources including remote monitoring and telehealth.
- *Discharge health instructions, especially to the home setting:* Instruct the patient regarding self-care management with special focus on (1) self-monitoring of changes in COVID-19 symptoms (i.e., fever, cough, shortness of breath, vomiting, changes in mental status, and loss of taste or smell) including frequency; (2) addressing red flags such as increased shortness of breath; (3) precautions related to transmission of COVID-19 (e.g., physical distancing, use of a separate room at home, hand washing/hygiene, disinfection of surfaces, when to wear a face mask, handling of coughing and sneeze, and no sharing of personal items); (4) follow-up care, especially use of telehealth and virtual care visits; (5) when to stop isolation precautions; (6) need for retesting for COVID-19; and (7) self-care including rest, ability to manage basic needs, and guidelines for returning to normal life activities/routines. It is important to individualize the instructions based on the condition of the patient being discharged; for example, suspected versus confirmed COVID-19 disease and other needed instructions determined on the basis of existing comorbidities/chronic health conditions.

It is recommended that professional case managers design and implement protocols for the completion of post-transitions of care calls to suspected or confirmed COVID-19 patients who are discharged to the home setting, regardless of whether these patients were expected to receive home care services from a home health agency. The logistics of these post-transition calls are the same as those may have already been in practice prior to the pandemic, however, applying a COVID-19-specific guidance in conjunction with the routine follow-up expectations. Because the postdischarge services are planned during the inpatient acute care stay and in collaboration with other interdisciplinary health care team members, it is necessary for the case managers to first confirm that the patient's home is a safe and feasible disposition. Table 6 describes effective activities for this discharge process and post-transition calls to COVID-19 patients and their support systems. In these processes, professional case managers must continue to assess the patient's state of social determinants of health and any coexisting behavioral or mental health condition, especially

TABLE 6**Suggestions for Discharge to Home and Postdischarge Calls Processes of Suspected or Confirmed COVID-19 Patients**

- Suitability for the patient's discharge/transition to the patient's home
 - Collaborate with the interdisciplinary health care team in identifying patients appropriate for discharge to home.
 - Establish criteria for the patient's discharge to home based on the COVID-19 guidelines from the Centers for Disease Control and Prevention. For example, ability to continue to isolate at home, adhere to infection prevention procedures, and have an engaged support system.
 - Consider transition to another level of care such as a temporary assisted living or rehabilitation facility if home is found to present safety and readmission risks.
 - Assess the patient's risk for readmission. Consider the social determinants of health in this assessment and ability for self-care management and health engagement.
 - Communicate to the patient and family the discharge to home plan and ensure safe home environment.
 - Coordinate necessary postdischarge services such as need for home health, community health worker, food delivery services, or charity support.
 - Provide patient and support system with necessary health instructions, including care expectations related to COVID-19.
- Readmission risk classification system specific to COVID-19 patients.
 - Establish a readmission risk classification system; if possible, apply same categories as you may already have established prior to the COVID-19 pandemic and have been routinely using. For example, low-, moderate-, and high-risk categories; include a very high-risk category if your current system is of four levels. Not all criteria must be met as cited in each of the following categories:
 - Very high risk: Intensive care unit hospital stay; intubation for mechanical ventilation during stay; age >75 years; four or more chronic health conditions, one of which is a pulmonary condition; social determinants of health concerns, especially in the living situation aspect; requiring home health services; and high readmission risk score.
 - High risk: Intensive care unit hospital stay; age >70 years; three or more chronic health conditions, one of which is autoimmune or resulting in immunosuppression; social determinants of health concerns, especially in the living situation aspect; requiring home health services; and high readmission risk score.
 - Moderate risk: Extended hospital stay (e.g., ≥10 days); age >65 years; fewer than three chronic health conditions and requiring oxygen therapy at home; social determinants of health concerns, especially in the living situation aspect; and moderate readmission risk score.
 - Low risk: Short hospital stay; age <65 years; multiple comorbidities; no chronic health condition and no need for oxygen therapy at home; no social determinants of health concerns; and low readmission risk score.
 - Link the readmission risk category to specific expected actions such as involvement of a transitions of care case manager in the postdischarge calls with a clear pattern by readmission risk category. Be clear about the expectations of the call—review of symptoms, status of postdischarge services, needs assessment, and answering questions. An example of calls frequency is as follows:
 - Very high risk: Call within 24 hr of discharge and another follow-up call within 27 hr, if necessary, by a case manager; also receiving home care services
 - High risk: Call within 24 hr of discharge and another follow-up call within 72 hr, if necessary, by a case manager; also receiving home care services
 - Moderate risk: Call within 24 hr of discharge and another follow-up call within 96 hr by case manager
 - Low risk: Call within 24 hr of discharge by a nurse, community health worker, or a case manager
- Follow-up postdischarge and transition to home
 - Establish an automated/electronic process to identify patients requiring calls postdischarge or transition to home. Use electronic health record documentation for this process.
 - Develop and implement a workflow with clear roles, responsibilities, and expectations for key professionals involved, including case managers. Maintain existing postdischarge workflows, if possible, to enhance success.
 - Differentiate between patients requiring a call within 24 hr of discharge vs those appropriate for 48 hr.
 - Establish a COVID-19-related standard review process to guide the postdischarge call. Be clear on the escalation process if concerns were identified during the postdischarge calls.
 - Refer the patient to a community health worker, a pharmacist for medication reconciliation and safety review, or social services as indicated, especially based on findings from an assessment of the patient's social determinants of health, self-care, and engagement in own health.

depression. This focus is of increased importance due to COVID-19 where more patients may be found to be of increased vulnerability requiring careful postdischarge attention.

LONG-TERM CARE AND CASE MANAGEMENT

Professional case managers assist patients and their support systems navigate across the continuum of health and human services, guiding them to the next level of care and coordinating the services they need postdischarge or transition from an episode of care. This responsibility is not any different during a crisis such as the COVID-19 global pandemic. However,

the context of successfully executing this function is challenged by the constraints imposed upon case managers due to the changes demanded from a public health perspective on the society at large. The changes comprise, for example, physical (social) distancing, home quarantine, personal and hand hygiene, practice of infection transmission precautions, closure of businesses, and the uncertain patterns of transmission of this highly contagious infection. These social dynamics and individual personal behaviors have affected the health care industry, and long-term care providers and residents/patients are no exception, including home health agencies, SNFs, and nursing homes.

The current COVID-19 experiences of SNFs and nursing homes have resulted in serious challenges, mostly characterized like the dynamics of an “outbreak” and leading to crises within these facilities. It has been reported that some health care facilities, especially those located in certain areas referred to as “hot spots” (a commonly used term that refers to a community or facility with a concentrated and high incidence of the disease) for the COVID-19 pandemic around the country, have suffered outbreaks, requiring them to activate their disaster plans. These experiences have also attracted the attention of local and state government agencies, other health care providers in the area such as regional health care systems, and, to some degree, the national guards and Federal Emergency Management Agency (FEMA)—prompting direct involvement in containing these situations. Primary goals of these efforts have focused on stopping the spread of COVID-19 and offering support in the provision of necessary health care services to the patients (residents) who have experienced changes in their health conditions, regardless of whether related to COVID-19. The involved parties have resorted to a “shelter-in-place” approach, especially due to bed capacity constraints at the area acute care hospitals and the increased patient surges requiring competing services and resources at these hospitals. Experts have also advocated for this approach as an effective strategy for and safest option to contain the spread of COVID-19 while facilitating a treatment-in-place care model (see Table 7). These situations have offered case management professionals (leaders and those at the front lines) an opportunity to exercise their expertise in care coordination and transitions of care and to assume key roles in strategizing how best to meet the needs of the affected patients/residents and the SNFs/nursing homes. Regardless of the practice or employment setting, case managers and leaders from across the continuum of care, most importantly hospitals, however, have needed to extend their services to these patients and facilities.

Primary factors that have contributed to the COVID-19 crisis in nursing homes and SNFs comprise lack of enough resources to meet the unexpected increase in care demands (trained personnel, equipment, and PPE supplies) at these facilities, limited availability of COVID-19 testing and inability for these facilities to perform the necessary tests internally, and patient surge at the neighboring acute care hospitals shrinking the potential number of inpatient beds available for residents from the affected facilities. It is likely that these concerns have also extended to assisted living facilities and group homes where use of PPE and availability of infection prevention resources and supplies are usually an uncommon necessity in these care settings.

Case management professionals from both the acute/hospital and long-term care settings may collaborate with the leaders and providers from their respective health care organizations on the development and implementation of protocols for the triage of care needs of residents/patients at the long-term care facilities and transfer to the acute care setting for further care as indicated. For example, the triage and transfer protocol may include a classification system based on specific criteria such as the following guidance:

- *High risk*: Serious and uncontrolled symptoms related to deterioration in an existing health condition warranting immediate attention, however, not manageable to the long-term care facility. For example, respiratory distress requiring intubation and mechanical ventilation or a serious change in heart condition requiring initiation of vasoactive drugs. Transfer to acute care or emergency services is indicated.
- *Moderate risk*: Moderate and controlled symptoms pertaining to an existing chronic health condition requiring an in-person assessment and intervention by a provider; however, the condition remains manageable at the long-term facility with follow-up support by the redeployed treatment-in-place care team (see Table 7) in conjunction with telehealth/telemedicine. For example, a symptomatic change in blood glucose level (high) requiring temporary treatment with an insulin injection, need for oxygen therapy due to shortness of breath, or presence of symptoms indicative of COVID-19 and necessitating a specimen collection for testing and isolation precautions pending test result. No transfer to acute care or emergency services.
- *Low/no risk*: Mild symptoms that are manageable at the long-term care facility with existing or redeployed resources. For example, initiation of intravenous fluid therapy, collection of specimens for further evaluation, and offering remote services via a telehealth platform. No transfer to acute care or emergency services.

The role of professional case managers in the application of the triage and transfer protocol may comprise screening of the resident’s care needs, identification of needs and coordination of indicated services, engagement of the appropriate health care providers (e.g., physician services whether physically deployed to the long-term care facility or via telehealth), arranging for the resident’s transport to the acute care setting if necessary, and follow-up on the plan of care as necessary. The role also extends to transitions of care activities that aim to return the resident/patient who may

TABLE 7**Collaborative Case Management Strategies With Long-Term Care Providers—Treatment-in-Place Care Approach Amidst the COVID-19 Crisis**

- Collaborate with local government agencies (e.g., state department of health, national guards) overseeing the treatment-in-place approach for the long-term care facilities.
 - Participate in the local or state-level forums established to oversee the needs of the long-term care facilities and remain apprised of requirements and procedures.
 - Interface directly with the government-designated group charged with oversight responsibility for the treatment-in-place care approach.
 - Assist in the assessment of the long-term facility needs and resources, if appropriate. Contribute to the design of an action plan for effective and timely response.
- Designate appropriate resources to assist in the “treatment-in-place” care model in support of the long-term care facilities and providers affected by the COVID-19 pandemic, most importantly those identified as “hot spots.”
 - Maintain awareness of the challenges and care needs the long-term care providers are facing in your community; these may include skilled nursing facilities, assisted living facilities, nursing homes, group homes, and others.
 - Engage appropriate leaders for the endorsement of the treatment-in-place team to be redeployed, e.g., senior leader(s), financial officer, human resources leader, and case management program executive.
 - Identify the key personnel resources to redeploy for care provision at these facilities. Design a health care team (response team) approach. For example, geriatrics care providers and specialists, professional case managers (nurses and social workers), therapists (physical and occupational), and necessary administrative support personnel.
- Share guidelines developed regarding use of PPE and conservation, COVID-19 patient isolation and cohorting, standard of nasopharyngeal swab specimen collection and testing, discharge to home criteria, and health instructions, especially postdischarge.
- Determine the role boundaries of the treatment-in-place team. For example:
 - Augment the personnel resources available at the long-term care facility. Allocate expert clinicians to participate in the response team; for example, physicians, clinical nurses, and case managers.
 - Complete COVID-19 testing; communicate results; provide guidance on procedures for infection prevention, resident isolation, and transmission precautions.
 - Provide rapid assessment and stabilization of the residents (patients) experiencing a change in condition.
 - Triage for the need of services at another level of care; initiate the resident’s transfer to emergency services and acute care hospital if warranted.
 - Implement indicated treatment interventions as feasible such as intravenous fluid and oxygen therapy.
 - Manage the resident’s care needs to the extent appropriate to avoid a transfer to already overburdened acute care hospitals. Implement palliative care services if appropriate.
 - Coordinate telehealth/telemedicine services where indicated to enhance the on-site care team capabilities.
 - Train the long-term care facilities’ staff on infection control, prevention, and use of PPE, COVID-19 signs and symptoms, and management of condition (diagnostic and therapeutic), as needed.
- Establish a process for the redeployment of the team.
 - Be clear on the conditions of team redeployment: hours of operations, reporting structure, appointment of a team leader, and other important logistics.
 - Develop explicit roles and responsibilities for each team member.
 - Provide an orientation to the team members as necessary.
- Evaluate the collaborative case management strategies, treatment-in-place health care team process and experience, and outcomes of the engagement.

Note. PPE = personal protective equipment.

have been transferred to the acute care hospital setting for further treatment back to the long-term care facility. An effective case management strategy to ensure resident/patient safety and timely access to services is the ongoing collaboration and communication among the case managers from the various care sites. Another is the need for case managers to demonstrate comfort

in the use of remote and digital technology to facilitate the resident’s timely access to telemedicine and tele-case management services that are useful options for the evaluation of residents and provision of necessary specialty and consulting services. In fact, telehealth (telemedicine, tele-case management) has become a desirable and valuable method of triaging care needs

Early participants in addressing this pandemic without hesitation and regardless of its uncertain and complex dynamics have demonstrated inspirational leadership skills and commitment to serving others. They also have capitalized on the opportunity to be innovators and out-of-the-box thinkers. These health care professionals have gained the titles of transformational leaders and role models. Most importantly, however, they possess future thinking skills that have allowed them to envision a brighter horizon for case management practice and professional case managers’ roles.

and coordinating necessary services for anyone regardless of location or care setting. Case managers involved in addressing the needs of the long-term care facilities and their residents are invaluable in enhancing residents' safety, well-being, and quality outcomes.

CONCLUSION

The COVID-19 pandemic is a unique crisis that has required special skills from health care professionals and leaders, including those in case management. Early participants in addressing this pandemic without hesitation and regardless of its uncertain and complex dynamics have demonstrated inspirational leadership skills and commitment to serving others. They also have capitalized on the opportunity to be innovators and out-of-the-box thinkers. These health care professionals have gained the titles of transformational leaders and role models. Most importantly, however, they possess future thinking skills that have allowed them to envision a brighter horizon for case management practice and professional case managers' roles. The experience so far in managing during the COVID-19 crisis has required the creation of "order amidst chaos" and sense of "comfort amidst feelings of fear, anxiety, and apprehension." What we have learned to date from this global pandemic is that our practice of case management will never be the same—in fact, it will be better and more impactful. The innovative care sites and collaborative approaches to care provision, which have been built on true and deliberate partnerships across the various care settings and diverse professionals across the continuum of health and human services, are going to serve the advanced specialty practice of case management very well. *The future is bright—for all involved: consumers, providers, payers, advocates, and other stakeholders.*

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Hussein M. Tahan, PhD, RN, FAAN, is a case management consultant, expert, author, and researcher. Dr. Tahan has nearly 30 years of experience in hospital management and operations and professional case management practice; is a member of the editorial advisory board of *Professional Case Management*; author of multiple textbooks, including the CMSA's Core Curriculum for Case Management and *Case Management: A Practical Guide for Education and Practice*; is the chief knowledge editor of the *Case Management Body of Knowledge* online portal sponsored by the Commission for Case Manager Certification; and the recipient of CMSA's 2016 Lifetime Achievement Award for his contributions to the field of case management.