COVID 19 Impact on Patient Flow: The Critical Need for Case Management

Bonnie Geld, President, The Center for Case Management

As health Systems come back "on-line", continuing to be occupied with COVID19 patients, access to care and the risk of volume surges will continue to impact and challenge health systems. This will become even more complicated in the fall with both the return of Influenza and COVID19.

Before the COVID19 crisis, hospital flow had already become a challenge for most hospitals across the nation. Many organizations have been searching for solutions to tame the volumes and manage capacity. Case Management is one significant strategy in capacity management and will become even more critical in the days and months to come.

The role of Case Management is to identify and provide appropriate interventions in addressing the patients immediate and transitional needs. The Case Manager serves as a primary point of contact, assisting the patient and their family in coordinating necessary services and resources to address their crisis recovery needs and re-establish a sense of normalcy that will allow them to begin and maintain their recovery. It is also important that the RN Case Manager, in partnership with the social worker and other providers, ensure that the patient is engaged and actively participating in the plan.

The window to ensure there is an effective case management process that supports and influences improved capacity, is beginning to open this summer and may quickly close again in the Fall when the system will likely, again, be compromised. Case Management remains a solution to ensure the right patients are managed as inpatients and outpatients and are effectively steered to the proper level and sites of care.

As capacity continues to be at a premium, decreasing length of stay to ensure bed availability for all will be mission critical. Additionally, there will likely be a spike in homelessness, Medicaid beneficiaries and the uninsured. All of these issues will impact the health system and demand efficient care. Case Managers will be required to keep their eye to appropriate admissions, length of stay, quickly address new and even more compromising Social Determinants of Health.

Rebounding and New Volumes

As patient volumes and patient populations return to pre COVID medical care will now include:

- delayed surgeries and preventive care
- deferred medical care
- COVID19 patients
- Influenza season in the Fall.

This will creat increased demands to manage patients at the entry points and transitions points.

Case managers must work closely with bed management and patient insurance verification to ensure timely authorizations and bed availability. Additionally, post-acute care facilities will become less available due to higher volumes of COVID-19 patient influx and this must be addressed. It will be important to avoid "bed wars" between case managers, vying for the same limited beds. New strategies and collaboratives in discharge planning with all post-acute providers will be imperative

Case Management & Social Work will solve many issues within 2 Frameworks:

1.Managing the Access Points

Access to care inside the hospital is reflected in 3 types of status and 4 entry points (5 including internal transfers). A patient can be identified as an inpatient, an observation patient or an outpatient (in a bed). Case Management, with the aid of evidence-based tools and criteria, is widely recognized as the authority in determining appropriate status and has garnered support and strong clinical partnerships with physicians during the admission decision making period.

To better understand the significance of Access Point (entry point) surveillance, it is important to identify where they are:

Emergency Department	Scheduled Admissions	Transfers	Direct Admissions	Internal Transfers
Patients who present in the emergency department for care and need a hospital bed	Patients who have been scheduled for surgery or a procedure	Admissions requested by other hospitals who do not have available resources for the patients level of needs	Patient's referred from an outpatient site	• Acute to ICU • ICU to Acute • ICU to Step Down • Wrong Acute Bed

2. Proactive Discharge Planning

Case Managers and Social Workers must be positioned to utilize their clinical skills to comprehensively assess patient's needs (including post COVID19 patient needs) and develop a solid, but timely care plan for transitions. Better understanding the patient and their "nexus of care needs" (clinical, financial and psychosocial), will prepare the team to develop a better plan and the patient/family to be more participative.

Action Steps in Discharge Planning

- ✓ Development of a comprehensive care plan for transitions and follow up through well-coordinated assessments, partnerships and patient engagement
- ✓ Community Advocacy to identify and connect patients to services that will provide for psychosocial needs and social determinants of health
- ✓ Connecting high risk patients to ambulatory case managers, primary care physicians, and specialists
- ✓ Collaborating with post-acute care facilities for timely transfers
- ✓ Engagement of patients and families in recovery and next steps through patient communicationsand patient education

In hospitals today, the competition for beds is coming from several different sources. This creates an even more critical need to ensure the right patients are in the right bed. Now is the time to ensure your Case Management strategy is leveraged to manage capacity.