CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

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As COVID-19 Pandemic Enters Second Phase, At-Risk Populations Remain Vulnerable

Case managers might need PPE and self-care

Case managers continue to work with their chronically ill patients throughout the stay-at-home orders, often through telemedicine or by taking more precautions for in-person encounters, such as wearing personal protective equipment (PPE).

The challenges case managers experience with helping homeless patients access care and resources became much more challenging in the face of the pandemic.

"What do we do with homeless COVID patients?" asks **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, senior director of care management nursing at Cleveland Clinic.

> THE CHALLENGES CASE MANAGERS EXPERIENCE WITH HELPING HOMELESS PATIENTS ACCESS CARE AND RESOURCES BECAME MUCH MORE CHALLENGING IN THE FACE OF THE PANDEMIC.

"We identified this would be a problem, before it became a problem," Davis says. "We are working with city and county governments to develop a plan with funding from all of these resources to discharge patients to a hotel as their home for the 14 days of isolation."

Follow-up phone visits also are part of the plan to keep homeless patients healthy. In some places, homeless shelters are kicking out people because

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AUTHOR: Melinda Young
EDITOR: Jill Drachenberg
EDITOR: Jonathan Springston
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS DIRECTOR: Amy M. Johnson, MSN, RN, CPN

they do not want to become COVID-19 hotspots, says **Robyn Golden**, LCSW, associate vice president of population health and aging in the department of social work and community health at Rush University Medical Center in Chicago.

"Rush created a shelter in the west side of Chicago just for people who have COVID-19, but don't need to be hospitalized," Golden says.

Because of the pandemic, there are a number of people who are newly homeless. Some in this population will need help with food and shelter for the long term, she adds.

"Rush is probably seeing around 25% of people in Illinois with COVID-19," Golden says. "It's been unbelievable in terms of how much we're doing to anticipate [problems] and get ready for all sorts of things."

The biggest gap that community case managers are seeing during the pandemic involves food, says **Bonnie Ewald**, MA, associate director of the Center for Health and Social Care Integration at Rush University Medical Center.

"Even if people were enrolled in SNAP [Supplemental Nutrition Assistance Program] recently or had an increase in SNAP benefits, we find they need food quicker," Ewald says. "We have a Rush program [that covers meal boxes for patients who can't afford it, and we have employees deliver that food."

The focus on food resources is in addition to traditional care and case management post-discharge, she notes.

"Those kinds of things are what our team is helping with," Ewald says. "There have been a lot of renewed and expanded food initiatives."

Rush has created a community command center that identifies the most pressing needs, how the team can fill them, and working with the city, she explains.

Rush's department of social work and community health provides phone support to patients after discharge, says **Elizabeth Cummings**, MSW, LCSW, manager of transitional care in the department of social work and community health. "Everything begins after someone goes home or leaves the clinic space," she adds.

Since the department always provided phone support, it was a fairly smooth transition when operations changed because of the pandemic, Cummings notes.

EXECUTIVE SUMMARY

Case managers faced many challenges in helping patients during the COVID-19 crisis, including connecting homeless patients to care and resources.

- Case managers can follow up via phone to help keep patients healthy and connected to care.
- Rush University Medical Center created a community command center in one part of Chicago for COVID-19 patients who do not need hospitalization.
- Nurse case managers and others need to practice self-care to help them through the crisis and deal with residual feelings and concerns after the pandemic.

"We can care for patients the way we always have, and it's been nice to get in touch with patients," she adds. "It's even easier now because patients have to stay home, and they're looking forward to our calls because we're providing some support for them to focus on their care goals."

Healthcare Staff Face More Stress, Trauma

Social workers provide one-on-one support to staff to address all of their emotional needs during the pandemic, Ewald notes. "We're calling people who test positive at Rush or who are negative, but have other psychosocial issues that come up."

Case managers and other staff have been dealing with patients experiencing traumatic losses at a time when they are unable to provide hands-on support, Golden says.

"I heard a story of a woman whose husband died of COVID-19, and he was alone at the hospital. Now, she's home with COVID-19," she laments. "I can't imagine these aspects of trauma our staff have never before experienced. I'm so worried they are burning out and becoming exhausted."

The psychosocial medical issues are within social worker case managers' wheelhouse, but they can be overwhelming — especially when they are helping staff as well as patients.

"It's important for nurses, managers, and all leaders to understand that, despite the barriers and challenges we currently face, empowering direct care nurses is essential to validating the meaning of their work," says **Caryl Goodyear**, PhD, RN, NEA-BC, CCRN-K, practice excellence programs manager with the American Association of Critical-Care Nurses. "These nurses are smart, intelligent, resourceful, and very creative. They know all too well what needs fixing, and have a lot of ideas about how to do that."

Case managers, social workers, and other healthcare workers need to support one another during these stressful times. A collaborative, supportive atmosphere can help people cope.

"What has been wonderful is how we come together as an institution from a medical center perspective," Cummings says. "We rally around and try to create a space for people to manage all of this uncertainty." This has been critical to helping staff and teams to support one another, she adds.

Case managers, social workers, and other healthcare professionals will need to engage in self-care so they can continue to be a support system to patients who are in crisis during the pandemic and an anticipated long recovery period.

"People are grappling with the effects of isolation, including boredom, loneliness, and mental health issues," Ewald says.

Healthcare workers are facing decision fatigue and stressors that they likely have never encountered before, says **Laurie Chaikind McNulty**, LCSW-C, wellness advisor in the Office of Intramural Training and Education at the National Institutes of Health. McNulty spoke at an April 14 webinar about managing stress during the COVID-19 pandemic, available online at: https://bit.ly/2VKGTOF.

Stress occurs when people experience a change in their physiological homeostasis or psychological well-being, McNulty says. Common stressors during the pandemic include uncertainty, scarcity of PPE, balancing work and family, financial issues, job security, unpredictability, helplessness, isolation, decision fatigue, information overload, disappointments and cancellations, and expectations from supervisors. People often have no control over these stressors, but they can ask for help when they need it and, also, allow themselves to fall short of their own expectations.

"We can say, 'This is something I'm struggling with and I might need a little extra help with it,'" McNulty suggests.

Also, as areas ease into the next phase of the pandemic and reopen public life, healthcare professionals need to put away expectations that they easily can bounce back to their pre-pandemic selves. "Bouncing back requires a lot of things," McNulty says. "It requires reaching out to people and collaborating."

It also requires resilience, which individuals can build within themselves through focusing on these six areas:

- **Vision:** Create a purpose and goals.
- **Composure:** Regulate emotions, watch out for interpretation bias, stay calm and in control.
- **Reasoning:** Engage in problem-solving, become resourceful, anticipate, and plan.
- **Health:** Practice good nutrition, sleep better, and exercise.
- **Tenacity:** Be persistent, set realistic optimism, and be open to bouncing back.
- **Collaboration:** Access support networks, look at social context, and manage perceptions.

Resilience is important for case managers when they help patients cope with anxiety and loneliness. They should remember that there

are some circumstances they cannot control and to focus on more of the things they can.

For instance, isolation and its effect on elderly patients is challenging, and case managers will not be able to solve this problem of the pandemic. But there are some tactics that healthcare institutions and individual healthcare workers can employ to at least help people with their loneliness. Wellness visits to people in some of the poorest communities served by Rush have shown that people are anxious and afraid to walk outside, Golden says.

"There is such an epidemic of isolation at this point," Golden adds. "It's a troublesome time. Suicide rates of older adults are going up and are predicted to go up."

One way to help patients cope with isolation and loneliness is through using teleconferencing apps so they can see and talk with healthcare providers, family, and friends.

Case managers can help patients use these apps by providing them simple instructions and back-up technical support for virtual events.

"Our whole team has translated all of those health lectures and self-management activities to happening virtually, which is not an easy task," Golden says. ■

Leaders Under Pressure Can Learn Decision-Making Tactics

Gather and use evidence as part of any plan

Leaders working in case management are under unforgiving time constraints, pressures, and resource constraints that make decision-making challenging.

The challenge relates to the way healthcare is moving and the speed with which change is occurring within organizations as they continue to change, form partnerships, and other issues, says **Joan Sevy Majers**, DNP, RN, FACHE, CENP, CCM, assistant professor and coordinator of the graduate programs in nursing administration at the University of Cincinnati.

"It is difficult to take time to figure out what are the best practices, and that's what evidence-based decision-making is all about," she says.

For instance, when case management leaders need evidence-based methods for keeping patients safe, they could address ways to improve safety during transitions.

Sevy Majers teaches graduate students about how to create a framework for making decisions. The goal of decision-making is to come up with the best solution possible under the circumstances, she says.

Use these steps to build a decision-making framework:

• **Identify stakeholders.** "We often forget there may be other stakeholders important to this decision," Sevy Majers says.

Stakeholders include physicians, medical directors, and payer sources.

• **Look for internal evidence.** Identify what information is available to you, internally, she says.

"This is where it becomes difficult, sometimes," Sevy Majers says. "There may be data, so find out what's available to you. Not every organization is the same."

Ask these questions to find internal evidence:

- Which patients are at high risk for readmissions?
- Where are you going to put your most important efforts?
- Can you get that information?
- What are your quality indicators?
- Are any items falling through the cracks?

"There is information that might be outside your area, and you need

EXECUTIVE SUMMARY

Case management leaders experience many daily challenges, including time constraints, resource limitations, and other decision-making pressures.

• One way to help leaders make the best decisions is by building a decision-making framework that includes identifying stakeholders, looking for internal evidence, and other actions.

• Leaders can identify patients at high risk for readmission and figure out where to put their biggest efforts.

• In assessing evidence to find the best solutions, leaders can look for resources, such as the Critical Appraisal App that helps people judge the trustworthiness of a study.

to get that information that will help you with whatever decision you make," Sevy Majers says.

• **Use external evidence.** "This is where it becomes a challenge," she says. "If you don't have [other] resources, maybe there are external resources in the literature."

Case management leaders can decide when looking at studies whether these questions apply to the hospital's patient population:

- Is this a good study?
- Is the sample size big enough to think about?

"Evaluate that study to see if it's worth considering," Sevy Majers says.

• **Identify the correct decision-makers.** Whether the decision is for strategic or operational purposes, case management leaders need to identify the decision-makers in the health system.

For example, a case management problem might involve obstacles to bed turnover. In some hospitals with high-acuity patients, the emergency department could be overcrowded as people wait for beds that are occupied by patients ready for transfer, but are held up for nonmedical reasons. A leader will identify decision-makers who can help take a solution proposal and turn it into an operational change or a pilot project.

"The PACU is holding patients overnight. They can't get inpatients discharged, and they can't get new patients into those beds," Sevy Majers says.

One solution would be to develop huddles that bring different disciplines together to discuss discharge obstacles. This method could lead to a central command center for transfers and discharges, and improve throughput, she says. With information technology support, patient discharge information and bed availability could be automated, making it easy for hospital staff to see where beds are open.

Case manager leaders can develop a process like this through an evidence-based framework, Sevy Majers says.

• **Handle logistics.** Making the best decision takes time. "How does a case management leader fit this into everything they have to do?" Sevy Majers asks. "Time is a constraint. Do I have the resources to support me?"

Leaders need help, so they must identify reliable partners. They also should know how to evaluate evidence.

"Do you work in an organization that supports this kind of approach?" she says. "Is the culture such that they're interested in seeing a significant operational or strategic issue from this approach? Do we have a culture that supports this?"

• **Assess evidence.** Create a performance improvement committee, Sevy Majers suggests. "If there is a robust performance improvement process within the organization, this certainly is an option to bring forward as a tool to be used."

Leaders can find resources, such as the Critically Appraisal Topic (CAT) Manager app that helps people judge the trustworthiness of a study. *(More information is available at: https://bit.ly/2VnT9mL.)* For instance, the CAT Manager will show whether a study is qualitative, which might include weaker evidence than a study that used a randomized, controlled clinical trial, which contains among the highest-level of evidence, Sevy Majers says.

"Performance improvement projects frequently are qualitative," she adds. "Most hospitals don't have the money or energy to do randomized, controlled trials for management studies, which are frequently used for oncology research, drug trials, and other clinical trials."

There also are some good, higher-quality studies with methods for discharging patients that will not fit every organization, she notes.

"That doesn't mean they don't have some use in some organizations," Sevy Majers says. "They may have the best evidence for some organizations." ■

Researchers Study Link Between Diabetes and COVID-19 Deaths

Encouraging self-care helps

Obesity and diabetes are important risk factors for severity of COVID-19, according to the results of a new study.

The study also revealed that patients with diabetes and coronavirus infections need continuous glucose monitoring and insulin to better manage both their chronic illness and their infection. These findings suggest that case management of diabetic patients is extremely important during the pandemic, given the additional risks it poses to these patients' health. *(The study is available online at: https://bit.ly/3b8SP0U.)*

"We find extensive shared pathways between genes and proteins important for the pathophysiology and treatment of diabetes, and the mechanisms used by coronaviruses for infection and inflammation," says **Daniel J. Drucker**, senior scientist, Lunenfeld-Tanenbaum Research Institute at Mt. Sinai Hospital in Toronto.

Drucker suggests that case management and self-management of patients at risk of COVID-19 might include:

- Patients staying in regular contact with their healthcare providers;
- Patients keeping a detailed list of their medications;
- Contacting their provider and increase glucose monitoring if they are not eating normally;
- If hospitalized for COVID-19, making their doctors aware of their diabetes, medications, and any adjustments to their usual diabetes care regimen.

Keep in mind that there is no evidence that any diabetes medication is helpful or harmful against coronavirus infection. "However, some medicines may need to be adjusted or discontinued in ill patients admitted to the hospital, or in people at home who are not eating and drinking normally," Drucker says.

"There are indicators that simple measures, such as taking temperature daily, recording heart rate, or examination of changes in patterns of blood glucose measurements, can be useful in detecting signs of early infection," Drucker adds. ■

Remote and Live Group Lifestyle Interventions Work for Diabetes Management

Researchers found that both an in-person and phone group lifestyle intervention can lead to weight loss among patients with type 2 diabetes.[1]

"The two interventions were the same intervention, but delivery was different," says **Linda Delahanty,** MS, LDN, RD, associate professor of medicine at Harvard Medical School. "One was in-person, group sessions, and the other had phone conference calls with four to 12 people in groups."

The one-hour to 1.5-hour sessions focused on skill-building, nutrition, and various other activities. Participants learned lifestyle skills, such as how to lose weight and increase activity — both of which are important for diabetes management, Delahanty says.

"They encouraged portion-controlled foods, in the form of shakes, bars, and prepackaged entrees," she adds.

Both Interventions Equally Effective

Both the in-person sessions and the conference call group sessions were equally effective, achieving 5% weight loss, Delahanty says. The mean percent weight loss at 12 months was 4.6% for the in-person lifestyle intervention and 4.8% for the conference call intervention.

"More than 15% of participants achieved at least a 10% weight loss," Delahanty adds.

Attendance also was similar in both groups: The average attendance was 18 sessions out of 25 sessions in the first year.

"The people on the phone self-reported their weight, but they came into the site for outcome assessments," Delahanty says. "They came in at six months and 12 months and were officially weighed."

Many participants lost some weight after the intervention, but

EXECUTIVE SUMMARY

A new study revealed equally positive results for a diabetes management intervention delivered in a group setting in person and via phone.

- Participants learned lifestyle skills involving weight loss and exercise.
- More than 15% of participants lost at least 10% of their weight.
- All participants improved their glycemic control.

some were less successful in reaching at least a 5% weight loss, she says.

"These programs are not a fit for everyone," she explains. "Some people might fare better with individual treatment therapy." Before the intervention, researchers asked people what type of help they would prefer, and some indicated a preference for one-on-one counseling, Delahanty says.

The group interventions were successful in helping people improve their glycemic control: "Everyone improved their glycemic control, and there was no difference between the two lifestyle interventions on medical nutrition therapy," she says. "Many of the participants were able to reduce diabetes medications or come off some of their medications."

The lifestyle skills training included label-reading, problem-solving, behavioral goal-setting, managing stress-related eating, and learning how to reframe negative thinking into positive thinking and cognitive restructuring, Delahanty says.

Participants met weekly for 14 weeks, then met every other week for 10 weeks and monthly after that.

"During the sessions, participants were able to discuss and share strategies for how they applied these into their daily lives and help each other solve barriers to weight loss activities and goals," Delahanty says. "It's a low-tech intervention. We found we were doing it in a socioeconomically diverse community, where not everyone has computer access and skills. We gave people workbooks whether they met in-person or on the phone.

> "IT'S TRUE THAT ONE SIZE DOES NOT FIT ALL FOR ANY LIFESTYLE AND NUTRITIONAL PROGRAM, SO WE NEED TO HAVE DIFFERENT TYPES OF PROGRAMS FOR PEOPLE WITH VARYING NEEDS."

There were no computer visuals for the in-person sessions, so the delivery formats were very similar."

This also made the program scalable. When researchers started the study, they thought the in-person group program would work better than the conference calls, Delahanty notes.

"At the outset of the study, many participants believed they needed in-person group accountability to be successful with weight loss, and we also thought, potentially, the in-person group program would be better," she says. "But we were pleased to see how well the phone intervention worked in helping them lose weight and manage diabetes."

Calls Offer Time, Financial Benefits

The patients who attended the conference calls also were pleased with not having to travel to be part of the program. "There is the potential for broader reach and removing barriers through the telephone conference calls," Delahanty says. "This really offers a great potential for scaling up these programs across the country."

The financial benefit of conference calls chiefly went to patients. "The cost of the lifestyle intervention was the same for in-person and conference calls," Delahanty says. "The idea of comparing the two treatment arms is because in recruiting people for these programs, we found a major barrier was transportation." People did not want to drive into the city and give up the time the travel entailed.

The next step is to evaluate weight loss and sustainability of an intervention like this and to better predict who does best with in-person, phone, and other methods.

"It's true that one size does not fit all for any lifestyle and nutritional program, so we need to have different types of programs for people with varying needs," Delahanty says. ■

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Hospitals Use Telemedicine to Limit Exposures, Preserve PPE, Guide Patients to Right Setting

In October 2019, Bergen New Bridge Medical Center in Paramus, NJ, began using telemedicine to check in with patients who are discharged from the emergency department (ED) and ensure appropriate follow-up appointments are in place.

As it turns out, the timing of its implementation was fortuitous, because the hospital has been able to quickly expand its telehealth platform to help with patients who might have contracted COVID-19.

"It is really for anyone who feels they have been exposed or has symptoms that suggest they could be a COVID-19 patient," explains **Deborah Visconi**, MHA, president and CEO at Bergen New Bridge Medical Center. She adds the service is available to anyone in the community who wants to speak to a clinician without going to a hospital.

The Health Insurance Portability and Accountability Act (HIPAA)-compliant service is designed to help identify patients with the virus, expedite care to them while limiting community exposure, and ease potential burdens on the ED or urgent care centers. Visconi is hopeful the telemedicine service also will encourage people to seek early care and evaluation, and ease fears about the pandemic.

To access the service, patients call a hotline that will connect them with a nurse via two-way video hookup. The nurse will screen patients based on the latest guidelines from the Centers for Disease Control and Prevention (CDC) for evaluating persons under investigation for COVID-19. *(For more information about these CDC guidelines, visit: http://bit.ly/2uxf6q1.)*

A primary care or emergency medicine physician will conduct an assessment. If that provider determines the patient should be seen by an infectious disease physician, he or she can receive that assessment right away via the telemedicine hookup or at a later time, depending on availability, Visconi explains.

"If the infectious disease provider is available, and the patient is available, we will do that [assessment] right away," she says. "Sometimes, we have to make that arrangement after the initial telemedicine call."

The infectious disease providers involved with the telemedicine service can arrange for COVID-19 testing in cases where they believe it is appropriate. Visconi acknowledges the health system has struggled to access testing services just like other hospitals around the country. She expects that problem to ease as commercial labs are allowed to conduct testing for the virus. "We are hoping soon that hospital labs will have access to those test kits, and we can test right here in our medical center," she adds.

Start Simple

Primary care offices, urgent care centers, and EDs in the community are referring patients to the service as a first point of contact for patients with concerns or symptoms. "Initially, we didn't get a lot of calls, but as things are evolving ... and there is a lot of movement with the viral spread, we are getting at least 10 calls a day, if not more, into the telehealth platform," Visconi observes.

The health system continues its efforts to spread the word about the virtual visits through media and other efforts. It also has posted information about the telemedicine option for patients concerned about COVID-19 on the front page of the medical center's website. Further, while some insurance companies are paying for the virtual visits, the option is available to anyone in the community regardless of their ability to pay.

"We are absorbing the cost," Visconi says. "We are a safety net hospital, and we don't worry about people's ability to pay for services."

Many other hospitals and EDs are in the process of rolling out similar services to respond to the virus. Visconi's advice is to start simple. "Get a team in place that can serve as your frontline providers," she says. "We [also] needed to get infectious disease physicians lined up. That was different than the initial rollout [of the telemedicine service in October]. We had to make sure we had providers on board who were willing to be part of this process."

Consider Options

A virtual service like the one unveiled at Bergen New Bridge is just one way telemedicine is leveraged to address the virus. Other hospitals, such as Providence Regional Medical Center in Everett, WA, and Massachusetts General Hospital in Boston, are placing iPads or telemedicine carts in patient rooms so at least some staff-patient interactions can take place without in-person contact. In addition to

limiting the potential for exposure, such approaches also can help preserve supplies of N95 respirators and other personal protective equipment.

Health systems are leveraging virtual triage techniques, too, and some are developing automated chat boxes in which patients can report their symptoms and receive general advice on how to proceed. The idea behind the chat option is to help ease the concerns of the "worried well" so they do not present unnecessarily to EDs or other settings that are dealing with large caseloads.

Some health systems with robust telemedicine infrastructures are trying to convert scheduled in-person visits into video visits, when possible. This approach has received added impetus of late as the Centers for Medicare & Medicaid Services (CMS) has significantly eased restrictions on the use of telemedicine services in the care of senior patients. The move enables seniors to visit their physicians via phone or videoconference, even using platforms such as FaceTime or Skype to do so.

Further, CMS pledges penalties will not be imposed on providers who use telehealth in ways that are not compliant with HIPAA requirements. Clinicians can bill for telemedicine visits with reimbursement rates on par with in-person visits.

Such moves should be beneficial for patients who are immunosuppressed or live with other underlying conditions that put them at higher risk of complications from the virus. In a statement, the American Medical Association (AMA) applauded CMS for its actions.

"The use of telemedicine and remote care services are critical to the management of COVID-19, while also ensuring uninterrupted care for 100 million Americans with chronic conditions," the group said. "The AMA encourages any private payers that are not already covering telehealth services to remove those limitations now."

Additionally, the American College of Emergency Physicians reports that in response to its advocacy, CMS will be revising its Emergency Medical Treatment & Labor Act guidance to allow medical screening exams to be delivered via telehealth, too. *(Read more about this at: https://bit.ly/3bqkbQH.)*

The AMA has been vocal on this issue. It unveiled a "quick guide to telemedicine practice," a resource that includes implementation advice and other tips to help providers start in this area. The guide provides links to other resources that can assist providers who are ramping up their telemedicine capabilities to respond to the virus and minimize exposures. *(Read more at: https://bit.ly/3bCglV1.)*

Other public health agencies are encouraging the use of telemedicine wherever possible. For instance, the CDC is directing health systems to consider virtual techniques to guide patients to the right setting for care. Further, lawmakers have signaled strong support for efforts to fully leverage telemedicine during the outbreak. In March, Congress passed legislation that includes $500 million in emergency funds for telemedicine services. ■

Healthcare Workers' Well-Being Is Ethical Concern During Pandemic

Half of 1,257 healthcare workers caring for COVID-19 patients in 34 hospitals in China reported depression, 45% reported anxiety, 34% reported insomnia, and 71.5% reported psychological distress, according to a recent study.[1]

These findings point to significant ethical concerns regarding clinicians' well-being. "Society depends on healthcare workers who use their skills to provide for the best interests of patients," says **James G. Adams**, MD, senior vice president and chief medical officer at Northwestern Medicine in Chicago.

Clinicians always face some risk as they carry out routine duties, including acquiring infection or sustaining injury. However, the pandemic has significantly increased these risks, with healthcare providers around the world acquiring the infection at work.

"Importantly, healthcare workers have transmitted the virus to others, including family members, co-workers, and other patients who were previously uninfected," Adams notes. Many healthcare workers have recovered, but some have died. "In this context, there is an obligation to ensure that the healthcare workers are protected," Adams says. There are a few relevant ethical considerations:

- Inadequate protection could result in insufficient numbers of healthcare workers.
- Healthcare workers are not ethically obligated to assume undue,

excessive risk of harm to carry out their professional duties.

• There is a duty to protect healthcare workers to prevent harm to others (family members, colleagues, and other patients for whom they provide care).

• As healthcare workers care for patients, it is reasonable for society to ensure these people are protected. "Without a sense of reciprocal obligation, the social compact between healthcare workers and patients will weaken," Adams cautions.

People understand well healthcare workers' professional obligations to patients. The reverse is not. "The obligation of society and the hospital to healthcare workers is not clear, and is not explicitly and broadly recognized," Adams adds. ■

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Early 2020 Quality Data May Need 'Compassionate Surveying'

The first half of 2020 was an extraordinary time for the United States. Quality leaders are beginning to assess how the COVID-19 pandemic response will affect the quality metrics of hospitals for months after the emergency subsides. What will those metrics look like?

They may not look great, and accreditors might be prompted to use a form of "compassionate surveying" when it comes to revelations of noncompliance during this period.

Even after the pandemic winds down, the experience is likely to leave a significant and lasting effect on quality metrics, says **Lauren Patrick**, founder and president of Healthmonix, a healthcare analytics company based in Malvern, PA.

There are several components to the effect on quality metrics, she says. First, what will the quality metrics show in terms of quality of care? Will quality, measured via the clinical quality measures that are reported, remain at the same level?

"Changes in the performance of clinical quality metrics may be affected in a variety of ways," Patrick says. "Chronic care management and prventive care measures may suffer due to missed appointments, clinical transformations, and providers' focus on immediate issues during the initial period. Focusing on urgent care, first and foremost, may impact the focus on nonemergent care."

Secondly, there will be two factors that contribute to a change in the metrics, Patrick says. Depending on how well the quality protocols and standards of care are embedded in a practice at the beginning of the pandemic, there may be a temporary or longer-term decrease in those numbers, she explains.

"A decrease may be due to high-priority urgent care needs that cause a lack of focus on the quality actions that are normally included. A decrease may also be temporarily seen by physicians who are transforming their clinical practices to accommodate new strategies and protocols so swiftly," Patrick notes. "As physicians quickly move to telehealth or shift roles due to layoffs or urgent care needs, workflows may need to be redesigned to accommodate the changes and ensure that outcomes continue to be achieved and documented."

The Centers for Medicare & Medicaid Services (CMS) has not released revisions to the quality measure reporting requirements for 2020, Patrick notes. CMS issued guidance for completing 2019 reporting since it was due at the onset of the pandemic. Still, even in Registry Kick-Off meetings with CMS, there was little guidance as to what changes may occur for 2020, Patrick says.

"So far, we have heard that there will be one new addition to the quality payment program [QPP] for 2020, which is credit for participating in clinical trials connected to COVID-19. We do know that CMS is considering changes for 2020 reporting," Patrick says. "To date, CMS has remained tight-lipped on what those changes may be. When we have asked them directly, the response is that we will hear something 'very soon.'"

In the addition to the QPP, CMS announced clinicians may earn credit in the Merit-based Incentive Payment System (MIPS), the performance-based tracker that incentivizes quality and value, for participation in COVID-19 clinical trials.

To receive credit, CMS says clinicians must participate in a COVID-19 clinical trial using a drug or biological product and report their findings through a clinical data repository or clinical data registry.

"The new improvement activity provides flexibility in the type of

clinical trial, which could include the traditional double-blind, placebo-controlled trial to an adaptive or pragmatic design that flexes to workflow and clinical practice. It also carries a high weight from a scoring perspective," CMS announced. "This means that clinicians who report this activity will automatically earn half of the total credit needed to earn a maximum score in the MIPS improvement activities performance category, which counts as 15% of the MIPS final score." *(Learn more at: https://go.cms.gov/3cWgp2r.)*

Patrick says the fact that CMS is not requiring reporting of some metrics for a while could produce negative effects. The saying "what gets measured gets done" may apply here.

"If we are not requiring the metrics to be tracked and reported, many may not receive the attention they have in the past, and the outcomes and processes that are being measured could decrease," she says. "If we essentially give a two-year pass to providers — 2019 and 2020 — and then attempt to reinstate the program again after that, we may lose the gains made over the program's history. Providers could be less likely to participate in the process of quality reporting."

Similar concerns about what quality data will look like when surveyors look back on the pandemic period months from now come from **Patrick Horine**, chief executive officer at DNV GL Healthcare in Milford, OH, which offers hospital accreditation integrating ISO 9001 with the Medicare Conditions of Participation.

"One of the things I'm really concerned about when we go back out and do our on-site surveys, in light of the waivers and the concentrated focus on COVID-19 — there are going to be a lot of issues that are demonstrated noncompliance in a lot of different areas," Horine says. "It's probably going to require some level of compassionate surveying because there is going to be a lot of noncompliance issues that hospitals might otherwise have been more strict in following. We're going to want to see that there are corrective action plans put in place in short order to address immediate concerns, and then plans for long-term correction."

In particular, Horine is curious to see the effects on infection control during the pandemic. With the increased use of personal protective equipment, heightened awareness of hand hygiene, and the reduction in patient volume in many hospitals, some facilities could see a reduction in infections, he says.

"One would think their overall infections would be reduced in light of the enhanced practices, but it could be the opposite if all those precautions were just keeping their heads above water while the infection rates were going up," Horine offers.

Horine also wonders about the impact on value-based purchasing programs. CMS is providing waivers that ease the burden during the pandemic response, he says, but what is going to happen later when hospitals do not meet the expectations of value-based purchasing agreements?

"There are going to be a lot of challenges for hospitals and for CMS. Are they going to look at a different data collection period for assessment of that value-based purchasing?" Horine asks. "Will they forgo any penalties during this time with the hospitals so impacted? I don't think there is an easy answer, but it is going to have an impact no matter which way they go."

On a positive note, Patrick says hospitals and providers have done a tremendous job of adapting. Facilities have rapidly and aggressively adopted telemedicine, changed hospital and provider protocols to address COVID-19 needs, and prioritized urgent care while re-engineering a significant portion of the standard way they deliver healthcare services, she says.

The number of eligible cases for quality metrics will be down for this period, Patrick notes. Elective surgeries and procedures have been suspended. There has been a dramatic decrease in office visits, and routine care and preventive testing have taken a back seat to more urgent needs. That will mean lower populations are included in the measures. "While we may pause capturing some outcomes [as] we adapt to the new normal, hospitals should ensure that as the crisis subsides, we pick these back up. There may be new workflows that need to be created, and we may need to ensure that documentation is up to date," Patrick says. "New tools that have been adopted during this time will need to incorporate the quality metrics so that we don't place undue burden on physicians as we move forward."

Patrick suggests this is an opportunity to assess how ingrained the quality practices are within any organization. Consider an audit moving forward to ensure there are no lost processes in the urgency and transition. Assess gaps that have arisen, and institute appropriate improvement processes to bridge any gaps.

"Reviewing quality metrics from this period will show the extent to which quality practices are ingrained into the workflows, even at a time of crisis and change," Patrick says. "Comparing metrics and root cause analyses of these changes, or lack of changes, will certainly inform our practices going forward." ■

CASE MANAGEMENT ADVISOR™

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CE QUESTIONS

1. **According to Bonnie Ewald, MA, which is the biggest gap that community case managers are seeing during the pandemic when they are engaged with urban populations?**

   a. Access to critical care beds for COVID-19 patients
   b. Food access
   c. Urgent care access
   d. COVID-19 testing

2. **A study about COVID-19 patients with diabetes revealed:**

   a. they experienced better outcomes when hospitalized with COVID-19 than did non-diabetic patients.
   b. they experienced better outcomes when case managers assisted them with care transitions.
   c. they needed higher levels of insulin than did diabetic patients without COVID-19.
   d. they needed continuous glucose monitoring and insulin to better manage both their chronic illness and their infection.

3. **Which is an important question to ask when a case management leader is searching for internal evidence, according to Joan Sevy Majers, DNP, FACHE, CCM?**

   a. Where are you going to put your most important efforts?
   b. Which patients can be discharged easily into the community?
   c. How much of the local population is estimated to have been infected with COVID-19?
   d. How quickly could you build a larger staff?

4. **Which was a finding of a study of in-person and conference call group lifestyle interventions for people with type 2 diabetes?**

   a. Both the in-person sessions and the conference call sessions were equally effective.
   b. The in-person sessions achieved twice the weight loss as the conference call sessions.
   c. The conference call sessions were better able to help patients achieve optimal glycemic levels.
   d. The in-person sessions produced the widest weight loss range.