ANCILLARY AND SUPPORT SERVICES

During the height of the COVID-19 pandemic, care for non-COVID-19 patients may have been postponed while physicians, nurses and other providers prepared for and cared for COVID-19 patients. As the incidence of COVID-19 in hospitals and health systems becomes more stable in many areas of the country, hospitals will begin to move into a "new normal" of caring for patients — some with COVID-19 and some without. Non-COVID-19 patients with medical needs requiring procedural care (surgeries and procedures), chronic disease management, and preventive services may have experienced delayed care during the initial response phase. Facilities that can do so safely can now resume providing care for these patients needing non-emergent, non-COVID-19 health care to prevent worsening of other health conditions or preventable deaths.

Many hospital functions straddle multiple clinical and non-clinical areas to enable the work of the entire organization. Some are referred to as ancillary services, and others are support services. Many ancillary and support functions also may have been scaled back or had resources redirected to activities related to COVID-19. Ancillary services — including therapeutic, care delivery and diagnostic services — are vital parts of care for patients. Support services — such as health information technology (IT), telehealth, quality and medical staff services — ensure the appropriate functioning of the organization, including care delivery, clinical services and revenue cycle management.

Temporary federal and state regulatory waivers that were intended to give hospitals more flexibility to respond to COVID-19 will likely evolve as the pandemic unfolds, and hospitals will need to monitor and respond to those changes.

To support hospitals and health systems in designing a "new normal" for various ancillary and support services, considerations for each are described below along with those that apply to resuming these services. As hospitals balance resuming services not related to COVID-19 with preserving capacity to handle surges of COVID-19 patients, these considerations can help guide your organization. Hospitals should be able to treat all patients without crisis standards of care. Maximum usage of telehealth modalities is strongly encouraged when possible to meet patients' needs and protect patients and caregivers.

CONSIDERATIONS FOR RESUMING ANCILLARY AND SUPPORT SERVICES

Beyond the decision about when to resume non-emergent and non-urgent procedures, hospitals also have to weigh which particular ancillary and support services can be resumed, and at what time it makes sense to resume them. Teams also should carefully consider how resuming services will affect the organization's readiness to provide care in case of a surge. It is important that hospitals closely monitor and adhere to requirements and guidance from the CDC[5] and other authorities[6]; any resumption should be authorized by the appropriate municipal, county and state health authorities and discussed with local emergency and COVID-19 response teams.

The following practices related to rigorous infection control and prevention impact all ancillary and support services, and should be considered:

- Establish non-COVID-19 care (NCC) zones.

- Establish screening and segregation protocols, following national and local guidelines, for all individuals entering the facility, including patients, visitors and staff.

- Implement social distancing in all staff, patient and public spaces.

- Routinely verify compliance with environmental cleaning protocols through rigorous assessment; retrain staff as necessary.

- Provide and require appropriate usage of PPE by all patients, visitors and staff.

- Provide volume-appropriate supplies of hand sanitizer and disinfectant for use by patients, visitors and staff.

- Modify visitation practices to enhance infection control and prevention while considering the needs of certain patient groups, e.g., maternity, end-of-life.

- Consider bringing back or recruiting volunteers for former as well as new assignments, e.g., wayfinding.

In addition, the impact of implementing these practices within each of the ancillary and support services outlined below also should be considered in light of:

- Incidence and trends for COVID-19 in the area.

- Medical necessity and time sensitivity of the care based on the clinical needs of the population.

- Available supply of PPE.

- Volume-appropriate supply of hand sanitizer and disinfectant.

- The extent to which the services can be resourced (appropriately credentialed and privileged staff, facilities, supplies and equipment) to resume operations; the impact of the draw on those resources that may be needed in treating COVID-19 patients, at various demand levels, such as critical care clinicians, ventilators and oxygen supply.

- The emotional health of staff members who have been under stress.

- Established lines of supervision for unlicensed or noncertified staff, students and volunteers, if applicable.

- Capacity to ensure adequate cleaning and disinfection of all spaces, facilities and equipment.

- Patient flow and workflow limitations related to the redesign of all areas of the hospital, including care delivery areas and waiting rooms, to enable social distancing and establish NCC zones.

While we have provided certain considerations for select clinical and support services, this framework for assessment can be applied for all operational areas.

CONSIDERATIONS FOR CLINICAL SUPPORT SERVICES

DIAGNOSTICS AND THERAPEUTICS

Reliable, accurate and timely diagnostic and therapeutic capabilities are at the core of hospital inpatient and outpatient services. At the height of the COVID-19 pandemic, the vast majority of hospital laboratory and imaging services, as well as therapeutic services, has been dedicated to urgent COVID-19 response needs. Many non-emergent and/or ambulatory diagnostic lab tests, imaging studies and therapies may have been dramatically scaled back — or even temporarily suspended — either to conserve PPE or due to a lack of demand.

Sufficient resources should be available to the facility across phases of care, including a healthy workforce, PPE, facilities, supplies, testing capacity, and post-acute care, without jeopardizing surge capacity.

IMAGING/RADIOLOGY

- Standardize protocols for decontaminating imaging rooms after caring for a COVID-19 patient, including one hour of downtime for passive air exchange; review and practice with staff.

- Evaluate numbers of staff involved in the care of each patient procedure, and limit to the smallest number possible for every visit when scheduling non-emergent procedures.

- Follow hospital screening, testing and isolation protocols for staff and patients, with attention to changes in these protocols as the hospital moves through the stages of the pandemic; educate staff routinely.

- Follow hospital visitation policies; ensure that staff are educated on these policies and that patient scheduling and registration procedures reflect current practices.

- Inform patients of established, predetermined visitor guidelines before they arrive for their exam; provide clear instructions for patient drivers; screen patients upon scheduling and arrival, if required for imaging procedures.

- Evaluate and streamline registration, check-in and check-out processes to limit the amount of time that patients are in the facility.

- Modify changing rooms and waiting area seating to meet social distancing guidelines.

- Adjust scheduling times to limit and monitor the number of patients in registration areas, waiting areas and changing areas for all modalities. Work with the centralized scheduling center to adjust patient load when working with shared areas for multiple modalities, such as computed tomography (CT), nuclear medicine, mammography, MRI, ultrasound and X-ray.

- Adjust scheduling times to allow for appropriate cleaning of imaging room and equipment.

- Allow for procedural recovery time, discharge instructions and patient ride considerations; designate location to accommodate patient drivers, while adhering to social distancing guidelines.

OUTPATIENT IMAGING RAMP-UP GUIDELINES:

Phase 1

A. Allow limited schedule slots when screening and diagnostic volume levels could be increased. Many radiology administrators are considering an initial increase of 25% to 50% over the volume experienced during COVID-19. Determining the phase 1 volume target should be in consultation with the incident command center and departmental physician leadership to ensure the increased volume can be managed safely, while also continuing to manage the needs for COVID-19 patients.

    i. This may include screening exams such as mammograms, DEXA (bone density) studies, CT lung screening, and CT coronary calcium scoring.

    ii. This may include routine diagnostics such as diagnostic cardiology, X-rays, CTs, ultrasounds, MRI, nuclear medicine and diagnostic mammography.

    iii. Invasive procedures should continue to be limited to only those performed in mammography.

B. Consider scheduling routine appointments that were previously deferred into these limited slots.

C. Pre-surgical testing should be prioritized to accommodate a return to non-emergent surgical procedures, even if those tests drive overall volume beyond levels anticipated above.

Phase 2: The same date that the facility resumes non-emergent outpatient surgical procedures.

A. Allow limited schedule slots for invasive procedure volume to be increased by 25% to 50% over the volume experienced during COVID-19.

B. Consider expanding hours/shifts to ensure that the additional volume is spaced out properly in this phase.

C. This may include invasive procedures such as:

    i. CT- and ultrasound-guided biopsies

    ii. Lung biopsies

    iii. Certain MRI that requires general anesthesia

    iv. Arthrograms (MRI, CT, etc.) procedures

    v. X-ray-guided joint aspiration procedures

    vi. Lumbar puncture procedures

    vii. Thyroid biopsies

D. Consider removing scheduling prioritization criteria put in place during the COVID-19 pandemic.

Phase 3: Timing undefined, evaluate at least every seven days; allow limited schedule slots for invasive procedure volume to be increased by 50% to 75% over the volume experienced during COVID-19.

Phase 4: Timing undefined, evaluate at least every seven days; allow limited schedule slots for invasive procedure volume to be increased by 75% to 100% over the volume experienced during COVID-19.

PATHOLOGY/LABORATORY

As hospitals consider broadening pathology and lab services to support increased patient volumes, planning should consider the following:

COVID-19 TESTING

- Maintain close contact with the hospital's overall plan for community, staff and inpatient testing; ensure adequate resources (e.g., staff, PPE, supplies, data analytics) to meet these plans.

- Ensure compliance with national and state reporting requirements.

- Evaluate the physical layout; consider options and appropriateness of segregation of COVID-19 sample collection and testing.

- Provide training/education on COVID-19 testing protocols and procedures for full staff.

STAFF

- Evaluate opportunities for continuing telepathology as allowed.

- Evaluate physical layout to ensure social distancing.

- Evaluate staffing needs for maintaining inpatient testing needs and reopening outpatient testing.

OUTPATIENT TESTING

- Review historical lab schedule and consider impact of phased reopening of on-demand lab services.

- Prioritize testing for urgent, previously delayed care needs, such as biopsies.

THERAPY SERVICES

As hospitals begin to phase in non-COVID-19 services, therapy services should be reevaluated to ensure provision of high-quality care while maintaining the hospital's infection control and prevention practices. For all therapies, ensure that staff are trained on current hospital testing, use of PPE and social distancing policies. The following also should be considered:

SPEECH THERAPY AND AUDIOLOGY

- For outpatient services, determine whether to reopen some or all locations (which depends on demand for services, PPE, etc.).

- Communicate with referral networks about availability and scheduling.

PHYSICAL/OCCUPATIONAL THERAPY

For patients with COVID-19, physical therapists can provide critical assistance in positioning patients to improve oxygenation. In addition, these patients may be in the ICU for prolonged periods; therefore, during recovery, the exercise, mobility and rehabilitation services provided by a physical or occupational therapist are important to ensure the patient can safely transition home.

Inpatient considerations:

- Clean all equipment, devices and surfaces between each patient interaction, per CDC recommendations.

- Discontinue the use of equipment that cannot be or has not been cleaned and disinfected between patients.

- Create a designated area for all rolling stock equipment for cleaning and disinfection.

Outpatient considerations:

- Employ telehealth or other virtual tools to conduct patient assessments, make recommendations and provide care when possible.

- Evaluate treatment and waiting room space to practice social distancing. Communicate widely the revised space layout to minimize changes/reworking the space.

- Maintain contact with patients unable to attend regular sessions/appointments; provide coaching and instructions to minimize patient deconditioning.

- Adjust scheduling to minimize the number of patients waiting; consider asking patients to wait in their vehicles to ensure social distancing.

- Provide group therapy only when it can provided while practicing social distancing.

SPEECH PATHOLOGY

The CDC has recommended that each facility and practice setting complete a risk assessment to determine guidelines for speech language pathology services and explore alternatives to face-to-face visits.

Considerations:

- Reassess the scope of services to ensure all original characteristics of the program remain intact: patient population, age, activity limitations, cultural backgrounds, demographics and types of services needed.

- Evaluate the potential for increased volumes of certain tests and modifications of other treatment protocols as a result of COVID-19 prevalence, e.g., patient cognitive ability assessments after COVID-19 treatment.

RESPIRATORY THERAPY

During the COVID-19 pandemic, many respiratory therapists have been working in hospital ICUs and general units with patients who have breathing difficulties related to COVID-19. In some hospitals, respiratory therapists have been working in partnership with operating room technicians to provide sufficient support in the care of COVID-19 patients. As hospitals phase in non-COVID-19 care, operating room technicians will return to the operating rooms, leaving the respiratory therapy technicians to care for COVID-19 patients while providing routine support for non-COVID-19 patients.

Considerations:

- Establish a plan for addressing all patients with needs for breathing support in the event that a resurgence of COVID-19 occurs.

- Assess the current availability of critical breathing support supplies, such as suction tubing, suction canisters and metered dose inhalers, to ensure their availability before conducting non-emergent surgical procedures and also periodically as surgeries and other procedures continue to expand.

- Consider whether any of the care protocols that were developed during the COVID-19 crisis to assist patients with breathing difficulties were sufficiently effective that they should become a more routine part of hospital care protocols with appropriate approval from FDA. For example, strategies that were used to prevent the need for a patient to be put on a ventilator — such as the use of BiPAP machines or other, less invasive forms of breathing support — might be effective as part of a series of protocols for patient care.

- Document and validate sterilization of all respiratory equipment by the sterile processing department, processed in accordance with manufacturer instructions and facility policy.

PHARMACY

Pharmacy services provided during a patient's stay, upon discharge and in outpatient and clinic settings are critical components of providing safe and high-quality patient care while maintaining new post-COVID-19 standards for infection prevention and control.

Inpatient considerations:

- Use telehealth or other virtual tools to conduct medication history/reconciliation by pharmacists or pharmacy staff upon patient admission.

- Assess or reassess sedation medication supply and implementation guidelines accordingly.

- Consider outsourcing to external vendors when critical drugs are in shortage.

- Implement guidelines for limiting the reuse of certain medications to reduce possible contamination and spread, e.g. multidose insulin.

- Consider using metered dose inhalers (MDIs) with a spacer rather than nebulizers, which are aerosol-generating. Also assess MDI supply, which may be limited; if so, ask patients and families to bring in-home inhalers if possible.

- Consider implementing policies for remote medication order processing to maintain workforce capacity and limit exposure.

- Assess compounding procedures to ensure conservation of PPE;[7] include limiting the number of personnel conducting sterile compounding activities, reducing sterile compounding activities by reassessing the need for sterile compounded products and implementing procedures for remote/video verification of sterile compounding by the pharmacist.

- Establish social distancing practices in all pharmacy areas by spacing out workstations by 6 feet if possible.

- Use telehealth or other virtual tools to provide medication counseling by pharmacists upon discharge.

Outpatient/Ambulatory Pharmacy Services Considerations:

- Create a curbside pickup service for outpatient pharmacies to improve medication access and reduce exposure risk for individuals in pharmacies and in waiting areas.

- Consider using telehealth modalities for continuing ambulatory pharmacist visits such as warfarin clinics, which can optimize the critical management of chronic conditions, especially if patients are concerned about exposure and might skip clinic visits.

- Ensure enhanced cleaning of all waiting and treatment areas.

- Provide volume-appropriate supply of hand sanitizer and disinfectant for use between patients.

- Consider alternate methods, in addition to phone or electronic surveys, to assess patient engagement.

SOCIAL WORK

Social work services are a critical component of care delivery. As a member of the multidisciplinary care team, the social worker's role is well established as attending to the psychosocial needs of patients and families to promote overall well-being; this is especially important during periods of increased stress and worry, as associated with the COVID-19 crisis. Addressing the routine issues of discharge planning and patients' social needs is an additional and important area of focus for social workers and discharge planners. As hospitals resume non-emergent services, social workers and discharge planners will begin caring for non-COVID-19 patients in addition to COVID-19 patients.

In resuming care for non-COVID-19 patients, it is important to consider changes that have occurred in the field and how we can adapt practices and protocols.[8]

Considerations:

- **Staff**

  – Embrace social workers as essential workers who provide mental health services during this crisis to support patients, patients' families and colleagues.

  – Evaluate ability to provide social work services safely in-person or via remote technologies such as telemedicine to avoid COVID-19 exposure when possible.

  – For social work staff who serve as preceptors for social work students, determine if it is safe to resume field instruction.

- **Discharge planning**

  – Discharge planning should begin upon admission; visitor restrictions may limit patients' families or other support systems from engaging in discharge planning at the bedside, requiring additional communication (e.g., phone calls, emails) from discharge planning staff.

  – Evaluate changes to patient resources including family support, financial resources (including insurance, ability to pay) and transportation resources; if resources have changed, assess impact on discharge plan.

  – Consider patients' living environments and abilities to adhere to infection control and prevention recommendations, including isolation and transmission risk to and from household members.

  – Reassess relationships with community and additional providers within the health care continuum of care, including skilled and long-term nursing facilities, home care, hospice and palliative care, mental health services, substance abuse services, shelters, transport services and community centers.

  – Assess if frequently used resources are open, accepting new patients or have additional requirements.

  – Evaluate if there have been changes to referral, intake or admission processes.

  – Social work staff may need to supplement services typically offered by community services providers due to new priorities and/or closures from COVID-19.

- **Patient care**

  – Social work staff may be needed to provide additional counseling around grief and loss due to COVID-19.

  – Social work staff may need to spend additional time with patients and family members to review care plans and changes in care plans due to COVID-19.

  – Educate social workers on changes in policies and requirements to increase flexibility, including CMS waivers that require hospitals to provide a comprehensive list of or quality data on post-acute facilities, and CMS changes to telehealth policy.

  – Determine how social work can support the workforce during the COVID-19 crisis; empower social workers with tools and resources to lead debriefings and facilitate discussions around COVID-19.

- Create a partnership between social workers and staff support services to optimize emotional support services available.

- Determine how social work staff can partner with ethics or pastoral care staff to best support health care workers.

CONSIDERATIONS FOR ANCILLARY CARE DELIVERY SERVICES

Ancillary care delivery services include many hospital-based and freestanding skilled and long-term care nursing facilities, hospice and palliative care services, home health, dialysis and social work services — those that are part of the health system and those that are independent or community based. These services have played a vital role during the public health emergency, providing care for individuals who otherwise might have been hospitalized as well as for those with chronic conditions who require ongoing attention. Waivers of federal and state requirements enabled many of these practice sites and health care workers to provide services not routinely offered and to deliver care through new approaches, such as telehealth. As hospitals and health systems begin to return to offering non-COVID-19 care to patients, plans to reactivate these sites of service to support potential new surges must be maintained. All care delivery resources must remain prepared for any eventuality.

This is an excellent time to further develop relationships and partnerships between hospitals and independent care providers along the continuum of care. Post-COVID-19 assessments of patient flow and decision criteria are recommended.

Hospitals and health systems should consider the following in their planning and next phase of service approaches:

SKILLED NURSING AND LONG-TERM CARE FACILITIES

Skilled nursing and long-term care facilities provide important services as part of the continuum of care delivery. During the pandemic, this includes treating confirmed and suspected COVID-19 cases, as well as supporting other providers that refer non-COVID-19 patients to other nursing and care facilities to create additional acute care space to treat COVID-19 patients. These facilities treat a wide array of conditions. Skilled nursing facilities focus on patients requiring a higher-level of nursing and rehabilitation to restore or prevent deterioration of function. Long-term care facilities are more residential in nature but also offer dietary, social and therapy services. In assessing services post-COVID-19, consider recommendations from the CDC[9] as well as the following:

- Determine needed staffing and other resources as the clinical needs of patients being referred to skilled nursing and long-term care facilities evolve.

- Evaluate staff wellness and revisit employee health practices.

- In collaboration with the acute care and emergency medical transport providers, review and update acute care discharge and transfer criteria for confirmed and suspected COVID-19 patients.

- Evaluate infection control and prevention policies and practices including social distancing, screening, testing, surveillance and isolation; ensure all resources (appropriately credentialed and trained workforce, supplies, space) are available to comply with these policies and practices.

- Implement ongoing use of telehealth for patients with COVID-19 and other diseases.[10]

- Develop new scheduling strategies to limit staff and exposure to patients with infectious diseases.

- Communicate with patients and their families about changed practices and policies.

- Provide patient and family education on best practices on infectious disease mitigation.

HOSPICE/PALLIATIVE CARE

Careful planning is required to resume inpatient and home care of palliative patients and those at end of life.[11,12,13,14,15] Considerations include:

- Establish protocols for safe delivery of home care when possible, including screening patients and families for COVID-19 and provisions for prescribing practices; using functional virtual care and telehealth platforms is recommended whenever possible.

- Develop protocols for engaging patients, families and caregivers in conversations around care plans and advanced directives.

- Assess community care partners that have delivered services in the past, such as Meals on Wheels. Are their services interrupted? Do they have the resources needed? Can partnerships be strengthened to assure continued services?

- Can new resources be mobilized, such as ministers or other volunteers who might make calls?

- Communicate with patients and their patient families about changed practices and policies.

- Provide patient and patient-family education on best practices on infectious disease mitigation.

HOME HEALTH

Home care services may be provided as part of a health care system or may be an independent entity. Every effort should be made to ensure that home care plans that were in place prior to the current quarantining protocols are implemented. Particular communication by the home health provider with patients and families will be necessary to build confidence that their safety is being protected so these patients do not refuse care at this time. New home health patient populations also are emerging, including patients who would previously have been admitted for non-emergent care, i.e., patients who are medically stable and can receive care at home.

Home health providers are encouraged to create policies and procedures that reflect their own operations, capabilities and community/patient needs, including lessons learned from the pandemic experience to date, which can serve to improve home care services into the future.[16] The following also should be considered:

- Provide PPE for the patient and patient's family.

- Develop protocols for engaging patients, families and caregivers in conversations around care plans and advanced directives.

- Assess community care partners which have delivered services in the past, e.g., Meals on Wheels. Are their services interrupted? Do they have the resources needed? Can partnerships be strengthened to assure continued services?

- Can new resources be mobilized, such as ministers or other volunteers who might make calls?

- Continue to collect acuity and other data to assist with planning for staffing requirements, e.g., therapies, nursing, dietary, etc., and to ensure the patient meets eligibility requirements for home health services.

- Develop appropriate protocols and policies to guide testing and contact tracing when resources become available.

- Develop an assessment protocol for accepting COVID-19-positive patients, to include at least:

  – household availability of necessary PPE and ability to follow precautions (hand hygiene, respiratory hygiene and isolation needs)

  – availability of separate bedroom and bathroom

  – availability of appropriately skilled and trained caregivers in the home

  – food and other necessary resources

- Establish a process for conducting a screening call prior to a home visit to a COVID-19 patient to determine:

  – clinical status of the patient and other household members

  – needed PPE, medical supplies

  – recent travel and visitor history for patient and household members

- Communicate with patients and their families about changed practices and policies.

- Provide patient and family education on best practices on infectious disease mitigation.

- Conduct a continuous assessment of staff wellness.

- Consider potential modifications of scheduling protocols to enhance infection control and prevention, such as scheduling COVID-19-positive patients at the end of the day.

URGENT/CONVENIENT CARE

Non-COVID-19 care as provided by urgent or convenient care centers can be offered to patients as clinically appropriate, when state and local authorities allow and when providers have the necessary resources to provide such care without interfering with the ability to respond to a potential surge in COVID-19 cases.[17] The following considerations should be part of the planning process for activating such care:

- Communicate with patients about changed practices and policies.

- Provide patient education on best practices on infectious disease.

- Evaluate services provided, overall need for care and availability of resources (credentialed and trained staff, space and supplies) to restart needed activities.

- Ensure adequate access to PPE, testing supplies, medications and other medical supplies for anticipated patient load.

- Can the facility accommodate segregation of care based on COVID-19 positive or suspected positive status? If so, should staffing plans accommodate best practices for infection control and prevention?

RETAIL CARE

Non-COVID-19 care as provided in retail centers can be offered to patients as clinically appropriate when state and local authorities allow and when providers have the necessary resources to provide such care without interfering with the ability to respond to a potential surge in COVID-19 cases.[18] The following considerations should be part of the planning process for activating such care:

- Maximum use of all telehealth modalities is strongly encouraged and/or restricted opening to only needed services based on facility capabilities and local conditions.

- Evaluate services provided, overall need for care and availability of resources (credentialed and trained staff, space and supplies) to restart needed activities.

- Can the facility accommodate segregation of care based on COVID-19 positive or suspected positive status? If so, should staffing plans accommodate best practices for infection control and prevention?

- Allow for social distancing in waiting areas; minimize wait times, keep chairs 6 feet apart and maintain low patient volumes.

- Practice current best practices for infection control and prevention, for staff and patients.

- Consider recommending that older adults over age 65, those with underlying health conditions and other individuals with higher risk for COVID-19 seek care outside of a retail space.

DIALYSIS

There are two types of dialysis, hemodialysis and peritoneal dialysis. Peritoneal dialysis is either continuous ambulatory (CAPD) or automated (APD). While hemodialysis can be done in a hospital, in a dialysis center that is not part of a hospital or at home, peritoneal dialysis is generally done at home. The following considerations should be part of planning for services provided in dialysis centers, whether part of a hospital or an independent center.[19] For home dialysis services, please refer to the Home Care section of this document.

Considerations:

- Can the facility accommodate segregation of care based on COVID-19 positive or suspected positive status? If so, should staffing plans accommodate best practices for infection control and prevention?

- Allow for social distancing in waiting areas; minimize wait times, keep chairs 6 feet apart and maintain low patient volumes.

- Practice current best practices for infection control and prevention for staff and patients, including social distancing in all waiting areas and encouraging patients to wait in their vehicles until their treatment room is available.

- Consider having patients call ahead and triage patients with fever or respiratory symptoms, with additional screening upon arrival at the center.

- Communicate with patients about changed practices and policies.

- Provide patient education on best practices on infectious disease.

- Ensure adequate access to PPE, testing supplies, medications and other medical supplies for anticipated patient load.

- Assess the number and placement of isolation rooms not being used for hepatitis B patients.

- Use isolation rooms when possible; if none are available, consider a designated dialysis station away from the main flow of traffic to cohort patients with suspected or confirmed COVID-19 patients.

- Minimize the number of health care providers in the isolation rooms or designated stations.

- Assess policies regarding those who might accompany patients for their treatment, considering best practices for infection control and prevention.

CONSIDERATIONS FOR GENERAL SUPPORT SERVICES

INFORMATION TECHNOLOGY

Hospital and health system IT departments have played a critical role in the COVID-19 response. Departments have redirected resources to meet COVID-19 needs for increased telehealth, temporary sites of service, data reporting and emerging needs for testing and tracing. As departments consider how to return to normal operations, considerations should include:

- Evaluate IT staffing to ensure there is sufficient staff to support normal patient care operations and respond, if needed, to supporting additional surges of COVID-19 patients, especially in continuing to support telehealth capacity.

- Prioritize and plan to make routine maintenance, patches and updates that were planned but delayed due to the strain on IT services during COVID-19.

- Reassess potential cyber vulnerabilities of new technologies rapidly deployed to support COVID-19 response, such as telehealth and telework platforms.

- Plan, prioritize and undertake the necessary work to reinstate system enhancements, and new release changes; consider resuming projects that were in progress but then suspended, including regulatory mandates that require IT system changes.

- Reconfigure systems to provide support for rescheduling and managing any patient backlogs.

- Collect data for metrics that are important to national and state COVID-19 tracking.

TELEHEALTH

There has been a dramatic increase in telehealth flexibilities for COVID-19 and other care during the public health emergency. In response, hospitals and health systems have moved a significant portion of in-person visits to virtual platforms and created new ways of connecting patients with providers. While it is still unclear which of these flexibilities will remain in place after the pandemic, CMS has indicated its interest in preserving the ability to treat patients via telehealth. **See the Ancillary and Support Services Appendix for the impact of telehealth waiver options.** As CMS determines how to do so, hospitals and health systems should:

- **Monitor federal and state requirements for the use of telehealth for both COVID-19-related and other care.** Hospitals and health systems should take careful note of CMS' and states' treatment of telehealth

services, including originating and geographic site restrictions, HIPAA privacy and security requirements, cost-sharing and consent for telehealth services and remote patient monitoring (RPM), using telehealth to fulfill certain face-to-face requirements; using virtual check-ins and e-visits for new patients, and using RPM for acute conditions.

- **Monitor federal and state licensure requirements.** Today, there exists a patchwork of state licensure rules that, to varying degrees, allow providers licensed in one state to provide care via telehealth in another state. Hospitals and health systems should stay up to date with each state's limits on out-of-state practice as well as any federal developments on this issue.

- **Evaluate telehealth capacity to meet current and future demand for virtual services.** Even after the current emergency ends, patients may be wary of returning to in-person visits. Additionally, there will be high demand for telehealth services during any subsequent waves of COVID-19 outbreaks. Hospitals and health systems should take stock of their telehealth infrastructure and any areas where they may need to increase telehealth capacity, including equipment and workforce. Specifically, hospitals and health systems may need to train additional providers and support staff to deliver services via telehealth. Acquisition of new equipment to connect with patients and new devices to enable patients to send information to their providers also may need to be acquired. Hospitals also should consider mechanisms to track quality/outcomes for patients receiving services via telehealth.

- **Mitigate cybersecurity risks.** In scaling up capacity, hospitals and health systems should pay close attention to cybersecurity weaknesses and work to close those gaps. Cyber adversaries may look for hardware, software and/or network technical vulnerabilities in these platforms to capture and steal protected health information or other sensitive information in transit during telehealth visits. They also may look for telehealth vulnerabilities and network connections to penetrate main hospital networks and electronic medical records to steal data, launch ransomware attacks and/or conduct espionage operations targeting medical research. As such, hospitals are required to ensure proper security design features are in place. Based on the most current risk assessment, this may include encryption in transit and at rest, and multifactor authentication and network segmentation to mitigate risk to patient safety, security and privacy of patient data.

- **Determine which services each and every payer will reimburse when delivered via telehealth.** CMS has added over 80 new services to the list of Medicare telehealth services in Section 1834(m) of the Social Security Act, but it is not clear whether these changes will become permanent. Moreover, Medicare, Medicaid and commercial insurers may cover different sets of telehealth services and may make changes to those coverage rules over time.

QUALITY AND PATIENT SAFETY

There is wide variation in the scope and composition of hospitals' central quality and patient safety offices. Prior to the pandemic, these offices generally focused on meeting federal and state quality measure reporting requirements, preparing hospitals for CMS and accrediting organization surveys, conducting patient safety event investigation/mitigation, and supporting high-priority quality improvement projects. Because of the pandemic, many of these departments had to refocus their activities on supporting their organization's COVID-19 planning and response. As hospitals resume a fuller set of services, these departments can:

- **Monitor federal and state requirements/requests for reporting of COVID-19-related and other quality and safety data.** At the federal level, hospitals have been asked to report certain data daily,[20] and quality departments may help support this activity. At the same time, CMS has suspended required reporting in its

quality/value programs for the first two quarters of 2020. This exception could be extended, depending on the pandemic's progression. Hospitals and health systems should plan now for reestablishing these reporting requirements.

- **Monitor federal and state requirements related to accrediting organizations/Conditions of Participation and state surveys.** CMS and accrediting organizations have largely suspended on-site survey activities, but those activities will resume in the future. In addition, your state may have its own requirements/schedules for survey activity.

- **Evaluate and reprioritize previously identified improvement priorities.** Pandemic response may mean deferring some improvement initiatives, or redeploying process improvement/data collection expertise to supporting safe practices in areas of the hospital where services are resuming. For example, quality staff may help with monitoring infection control practices.

- **Ensure flexible and timely safety event reporting and investigation processes.** As services resume, hospital staff may encounter unexpected issues. A mechanism to quickly identify and respond to these issues will ensure services resume as safely as possible.

- **Ensure a high-functioning quality management system.** Make sure that leadership is in alignment and that guidance is quickly communicated throughout the hospital and health system. No matter the size of your organization, in times of crisis it is even more important for leaders to be able to come together quickly, make decisions swiftly and communicate and follow-up on needed actions expediently.

REVENUE CYCLE MANAGEMENT

As hospitals begin to scale up services that may have been suspended due to the pandemic, many revenue cycle practices should be reviewed to assure compliance with individual governmental and commercial insurer requirements as well as modified workflow imperatives. For example, coding and billing requirements have been altered to reflect new treatment and diagnostic care modalities.

Additionally, many hospitals may have held back claims for the initial surge of COVID-19 patients, due to strained administrative capabilities and ever-changing insurer billing instructions. To navigate these challenges, hospitals should consider:

- **Monitor policy updates of major insurers.** As a result of the strain that the pandemic placed on the health care delivery system, CMS and many other payers removed a significant number of reimbursement requirements for patient care. As providers begin to increase services and return to providing a wide spectrum of services, they should expect insurers to begin retracting waivers or readjusting care requirements. To ensure that care is provided in the appropriate manner to receive payment, providers need to closely monitor insurer information regarding policy changes.

- **Track billing rules and requirements related to the location where patients obtain care.** Many of the traditional payment rules and billing requirements related to the setting in which a service takes place have been altered as a result of the pandemic (e.g., inpatient care allowed at off-site locations). Payers have varied in both the services allowed and methods of billing for care performed at non-traditional settings, and hospitals should ensure that they are billing appropriately based on insurer policies to receive optimal reimbursement.

- **Monitor and apply rapidly changing coding/billing instructions.** Hospitals and clinics should stay apprised of the latest coding/billing instructions, including new ICD-10-CM, CPT or HCPCS codes and modifiers, National Uniform Billing Committee announcements and other instructions. Coding professionals should

follow the ICD-10-CM Official Coding Guidelines for COVID-19 and monitor the ICD-10-CM frequently asked questions for COVID-19 for reliable interpretation of ICD-10-CM codes and guidelines approved by the AHA and AHIMA.[21] Ensure that you have the necessary codes to bill for COVID-19 testing. Multiple methods of testing for COVID-19 have been developed. Hospitals and clinics should ensure that they are using the appropriate CPT/HCPCS code(s) for the type(s) of COVID-19test(s) being conducted and that individuals responsible for charge capture are aware of the differences among the tests.

- **Develop a process for flagging positive COVID-19 test results for coding professionals if results are not available at the time of coding.** Often, COVID-19 tests are inserted into a billing system prior to the results of the test being known. To ensure appropriate codes are applied, hospitals should develop an internal method of flagging positive test results for coding professionals as waivers and payments can be based on the coding of confirmed diagnoses of COVID-19.

- **Be prepared for accelerated payment withholdings.** If your health system received any CMS accelerated payments, ensure that your billing systems and accounting staff prepare for and document the withholdings on CMS claims payments occurring 120 days or more from the date of the initial payment. These withholdings will be reflected in remittance information in the PLB segment.

- **Update utilization management protocol.** Many insurers have suspended or changed utilization management/prior authorization requirements for services, the specifics of which are largely dependent on the insurer. As providers begin to perform a broader range of services, they should check with relevant insurers regarding any utilization management requirements that may have suspended so as to avoid delays in care due to unnecessary pre-care procedures.

PROVIDER STAFF SERVICES

As hospitals and health systems return to full operations, waivers related to licensing, supervision and collaboration requirements will expire, accreditation surveys will resume and credentialing and re-credentialing schedules will need to be updated. Hospitals and health systems will need to develop a coordinated plan for returning to full credentialing and privileging while providing support and education to the provider staff.[22] Considerations include:

- Review licensure, collaboration and supervision requirement waivers:

  – www.fsmb.org/siteassets/advocacy/pdf/states-expediting-licensure-for-inactive-retired-licensees-in-response-to-covid19.pdf

  – NCSBN | List: Nursing Licensure Waivers in Response to COVID-19

- Review accreditation requirement waiver sunset dates.

- Review appropriate privileging for telehealth (see Telehealth section of this document).

- Update records to prepare for resumed accreditation surveys.

- Identify protocols and prioritization for resuming full credentialing functions.

- Update (cancel or continue) any disaster privileges granted.

- Identify and share education and resources for providers on requirements for maintenance of certification, licensing, continuing education and supervision agreement changes.

- Consider interactions with providers via multiple channels, e.g., town halls, intranet postings, department/section meetings, etc.

- Consider inclusion of well-being resources in re-credentialing materials.

Also refer to the Workforce section of this document for considerations regarding telework and social distancing.