

CORONAVIRUS DISEASE 2019 [COVID-19]



April 14, 2020

PLANNING FOR COVID-19 HOSPITALIZATIONS IN SUPPORTIVE HOUSING

This document summarizes care team roles and key recommendations specific to tenants whose symptoms are severe enough to require hospitalization.

KEY ROLES

- **Tenant:** Everyone on the care team should be centering on the tenant, including their recovery and support needs. This includes ensuring each tenant understands and is actively involved in making the care plan.
- **Hospital Social Worker/Discharge Planner:** The hospital social worker/discharge planner ensures a discharge plan is in place ensuring the patient has the resources necessary to recover. Discharge plans should include where the tenant will be discharged to post hospitalization; any aftercare they will require with details on who will be providing the care; and an updated medication list.
- **Care Coordinator:** Care Coordinators may be from a Medicaid managed care organization or a primary care clinic. Their role is to help tenants navigate the health care system and to understand and adhere to hospital discharge plans. They generally meet with patients by phone, however some care coordination models do have staff who will see the patient in the community. Care Coordinators conduct health risk assessments, make care plans, ensure communication between different providers on the care team, assist with referrals, prior authorizations, and transportation to medical appointments.
- **Case Manager:** The case manager is an advocate for the tenant, supports the tenant in maintaining housing stability, and assists the tenant in understanding and following the clinical care plan. People with disabilities, people of color, under or uninsured, and people with low literacy or limited English proficiency often face implicit bias, discrimination and barriers in the health system. Tenants impacted by implicit bias may need additional advocacy on their behalf to ensure they are getting needed care, treatment, and appropriate discharge planning.

- **Public Health Department Staff:** Some communities may have public health department staff directly involved in monitoring those who are confirmed COVID-19 positive. Supportive housing providers should check with their local public health department for guidance. Hospitals and health care for the homeless providers are in direct communications with local public health COVID-19 response.

PREPARING FOR HOSPITALIZATION AND DISCHARGE

1. **Symptoms:** Anyone experiencing COVID-19 symptoms should connect with their primary care provider. If a tenant is feeling ill, experiencing symptoms, or you are concerned they might need hospitalization, support them in being prepared as best they can.
2. **Key Information to Gather:** In the case of severe symptoms requiring hospitalization, tenants will need to bring key information with them to the hospital, such as information in the [Client COVID-19 Advocacy Form](#). **This information is best gathered prior to severe illness.** This critical information is helpful to the tenant's care team and lets them know the patient has a network of people who are concerned for and care about the tenant.
3. **Hospital Location:** If hospitalization is required and the tenant is transported by an ambulance, onsite staff should confirm which hospital the patient will be transported to. If the tenant informs you they are going to the hospital on their own or with a friend/family member, find out which hospital. Some hospitals may be overloaded and you can't assume the patient will be able to go to the closest emergency department. Once you know which hospital, the care coordinator needs to be informed.
4. **Discharge Planning:** The hospital social worker/discharge planner should reach out to the patient's case manager as soon as possible to plan for an appropriate discharge plan, however they may not be aware the patient has a case manager. If the patient has a care coordinator who is actively involved, connect with them for discharge planning. If there isn't a care coordinator, reach out to the social worker or discharge planner.
5. **Discharge Planning Meeting:** Supportive housing case managers usually know more about tenants than hospital staff. Advocate for a discharge planning meeting with the hospital care team before the tenant is discharged back to the residence. The discharge planning meeting should include the case manager, care coordinator, discharge planner, and any other key community based clinical services (such as ACT team). Include all relevant team members and address strengths, resources,

and barriers to discharge plan adherence. Discharge planning meeting should include:

- a) Is the tenant still infectious? If yes, can their isolation needs can be met in their home? If no, what should they expect for recovery? Will they still need to self-isolate and for how long? If the tenant lives with others (children or adults), can they be safely discharged to a shared home environment, or is there any remaining risk to those in their household or building? How will they access food and transportation for any follow up appointments?
 - b) What medical/clinical follow up is needed? Can these needs be met in their home? Are there specialty care or rehab referrals? If the tenant will be referred to respite or a rehabilitation facility for additional clinical support, where are they being transferred and when? Initiate contact shortly after transition to respite/rehab to begin planning for the eventual transition home.
 - c) Does the tenant have behavioral health needs to address in the care plan?
 - d) Are there any new medications or medication changes? Is the tenant able to get all prescribed medications?
 - e) Will the tenant have additional support needs during the recovery process? How is the tenant getting food, household supplies, and medications if they need extra support but aren't infectious?
 - f) Which symptoms indicate the need to call the primary care provider or return to the hospital?
 - g) What cleaning and safety procedures need to be in place for property management and ongoing case management?
 - h) If the tenant is uninsured, has the hospital applied for their Medicaid? If they won't be eligible, did the social worker initiate charity care applications?
6. **After the Discharge Planning Meeting:** Ensure you have a copy of the discharge plan. Ask the discharge planner and care coordinator additional follow up questions as needed

KEY RECOMMENDATIONS FOR SUPPORTIVE HOUSING CASE MANAGERS

- Tenants experiencing symptoms or who test positive for COVID-19 will not be able to have visitors. This is true during both self-isolation and hospitalization. This is likely an extremely stressful and frightening time for them. Support them in being connected to family and friends as best they can or as desired. It helps tenants

when the hospital care team sees there are concerned, caring individuals involved in their life.

- Case managers should have access to local public health department protocols for people who have COVID-19 symptoms as well as people who have been tested and are COVID-19 positive. When tenants are experiencing symptoms and accessing care, are local protocols and best practices being followed for the tenant?
- Ask the tenant what their discharge plan is, prior to discharge. Use open ended questions rather than simply asking yes/no questions. Share information, and support the tenant in asking questions so they have the information they need about their discharge plan.
- Considerations for supportive housing providers: how often are you meeting with the tenant to check in? Are meetings virtual or in person? If virtual, plan for how you will assess access to food, medications, and any other regular/ongoing case management needs. If meeting in person, how will you ensure staff and tenant safety?