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Healthcare Leaders Pay It Forward

Sharing Important Lessons in Care Transitions Learned During COVID-19

By B.J. Boyle, Vice President and GM, Post-Acute Insights at PointClickCare

What better way to have a hand in creating a new normal than to look at the lessons learned and actions taken by others during a crisis?

In the spirit of collaborating and paying it forward to craft a brighter future, we've asked leaders in senior healthcare to share their most valuable takeaways from the COVID-19 pandemic. Together, combining experience and newfound knowledge, we can provide better care for patients, protect our businesses, and prepare for what lies ahead.

Here are some of the most important lessons learned by senior healthcare leaders since the start of the pandemic:

Planning and Collaboration Are Critical to Our Success

Not surprisingly, preparation and infectious disease planning are on everyone's minds. Our leaders take hindsight a step further by providing fresh insights into what our plans need to look like:

Skelly Wingard,

Regional Director of Care Coordination and Placement at Kaiser Permanente

Wingard, says her biggest takeaway from the pandemic is the importance of being prepared for the unexpected by truly knowing your patient population in senior living and skilled nursing facilities (SNFs).

"We need chart level data to identify high-risk patients and the resources they need, and an understanding of our partners so we know who has resources – and a sophisticated model – to help," she says. "The more you understand that, the more equipped you are to react and intervene when tragedy strikes."

Wingard suggests approaching a preparedness plan by addressing what she calls the three S's: staffing, support, and supplies needed to ensure SNFs are equipped to be successful and to execute quickly.

"When patients are in our hospitals, we have that data and infection control at our fingertips, but SNFs are a step removed," says Wingard. "We need a disaster plan that accounts for them, provides a broad view, and includes key administrators, associations, departments of public health, local and county health services, health plans, med groups, and others. It also needs to dictate how these entities work together and align to be effective and efficient." Baker, agrees that collaboration between hospital systems and post-acute care systems is an important part of planning to ensure you're not operating in silos.

Lori Baker,

Director of Ambulatory Care Management and Senior Services/Post-Acute Care, at TriHealth

"COVID made us think about the importance of the patient experience, and ensuring team members at the skilled nursing facilities have as much time as possible to spend with patients to care for them," says Baker. "Both hospitals and skilled nursing facilities can get overwhelmed with volume, rapidly and repeatedly cycling patients from hospital to nursing facilities. It's important to minimize the amount of time spent on manually entering patient data to enable team members to spend time with patients. Preparation and electronic data exchange allows us to better collaborate without post-acute providers and ensure a more seamless transition."

To do that, Baker's teams have been a part of a community collaborative with other local hospitals and skilled nursing facilities to better address hotspots when they appear.

Successful Care Transitions and Patient Management Depends on Data

Data, which in this case includes who has been infected with COVID-19, their risks, and healthcare needs, is critical for care constituents to make informed decisions.

Dr. Tere Koenig

an internist geriatrician and Executive Vice President and Chief Medical Officer for Medical Mutual

Many organizations developed dashboards and assembled teams to gather, analyze, and share COVID-19 data. Dr. Tere Koenig, says her team quickly created a COVID dashboard. This dashboard allowed her team to look at who had been admitted with COVID or potential COVID and who needed high level care, such as ICU, so they could understand capacity needs and adjust resources, as well as provide state-required weekly updates on SNF cases.

"Had we had even more data and a way to share it across a continuum, we would have known where there is an open bed and we could have provided even better care transitions," she says.

Research and data could also help them understand why some facilities were ready – having zero COVID-related deaths – while others weren't.

Kaiser, too, pivoted quickly to the need for data around COVID, looking at patient populations across SNF settings and communicating and working together to proactively triage patients so they weren't sending patients with COVID back to acute care facilities.

The healthcare system launched a strike team to visit SNFs and teach them about appropriate transitions to avoid and mitigate risk.

"More transitions means higher risk, including risks to paramedics, nurses and other care providers patients interact with during transit," says Wingard. "Data helped us use transitions sparingly and only when appropriate." Her teams are taught what it looks like when a patient needs to go to the hospital, and how to navigate the transition with a clear plan and a clear understanding of any directives, such as a DNR.

Data has been critical for Baker's team, too. For example, allowing TriHealth to quickly make visible COVID testing outcomes – those who were positive, pending, negative – to coordinate transitions back to nursing facilities and provide SNFs with visibility (patient COVID status) to effectively coordinate care before a patient arrives.

Data is also helping organizations make changes in the new reality. "We're slimming down our network, using data to help stratify and measure performance and choose the ones who have care models that support data sharing and outcomes," says Koenig.

What We Know Now and Wish We Had Known in January 2020

From a payer's perspective, Koenig says her team started talking about a possible pandemic in December 2019, and started planning in February. They conducted surge testing in the middle of March, an estimated seven days before their state's stay at home order was enacted. While it was a speedy response, she says she would have liked to better address health risks sooner and spend more time understanding the various changes that would be required.

Wingard and Baker go back to data and the importance of having it upfront and quickly, especially critical during a pandemic.

"We can't wait for a discharge summary from a clinician," says Baker. "We need to get data to the skilled nursing facilities sooner in order to plan admissions and successful care transitions."

"Having a better understanding of skilled nursing facilities and senior housing settings across regions, really knowing who they are, what their comorbidities are, and what their risks are if something tragic happens allows you to be prepared and ready to execute," says Wingard.

Other aspects of planning and execution she now knows is critical: "It's important to communicate a commitment to safety and provide regular updates to keep teams informed. One nurse calling in sick because she's scared of getting sick can collapse the whole system."

Her team, like many, used town hall meetings to communicate and keep tabs on their safety culture.

Long Term or Lasting Impacts on Care Transitions Brought About by COVID-19

An important takeaway that all of our interviewees conferred on is telehealth. As an industry, we've dabbled in telehealth and wondered if patients would embrace it and whether it could be done on a broad scale. Now we know. Since the start of the pandemic, the use of video visits has skyrocketed. Healthcare constituents across the continuum – from providers to payers – note its rise for assessing needs, delivering care, and informing healthcare decisions. They predict it's here to stay.

Another notable change with lasting impact is patients' expectations of when and how often they need to seek care. Koenig estimates a 30-40 percent drop in unnecessary visits during the crisis. She ties it to patients' fear of catching COVID-19, the elimination of elective procedures during quarantine periods, and limited availability, predicting the trend will continue.

"Patients are starting to come back, but only for that which is truly necessary," she says. "COVID has caused people to re-think whether care is really critical. They are rethinking whether follow-up care is truly necessary, and how often they need to see their physician."

As a payer, Koenig is looking ahead to what services and departments will likely see decreased traffic, predicting that ERs and expensive diagnostics are likely to be impacted. She worries COVID-19 will significantly set back the move to value-based care, as well as lower patient visits for high need patients which may result in some necessary care being avoided with eventual poor outcomes and higher costs.

From a provider perspective: "We've become successful in case managing patients in a remote way, but we need to be mindful of what that feels like for a patient over a longer term," says Wingard. "When they are not physically seeing their doctor or case manager, what is the customer experience?"

Perhaps, patient experience will become an important component of infectious disease planning playbooks. "Some of our dashboards and patient tracking methodologies will be scalable for anything," says Baker. "We now know how to track our data."

She also says there will be a new normal for case management and physician visits, as the industry leverages technology, including video, to optimize and accelerate the delivery of care.

Looking Ahead

We are still in the beginning stages of managing this pandemic, and readily responding as the situation unfolds. Challenges, and perhaps surprises, lie ahead, yet we can better prepare for them by learning from the lessons we're sharing along the way.

To learn about how Harmony is supporting care transitions through integrated care coordination, visit: www.pointclickcare.com/harmony