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Acute Care Management During a Pandemic

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ABSTRACT

Purpose/Objectives: During the global pandemic of Covid-19, the hospital setting transitional care management was challenged by the complexities of the rapidly changing health care environment, requiring the implementation of an innovative approach to hospital discharge planning. The purpose of this article is to review the experiences of an integrated urban health system, exploring the strategic tactics to ensure effective communication between team members, patient and family engagement in discharge planning, establishing and maintaining trust, connecting patients to appropriate next level of care services, and providing transitional care management support.

Primary Practice Settings: The Covid-19 pandemic response stimulated the rapid transformation of the acute care management model amidst the tremendous challenge of meeting the discharge planning needs of the hospitalized population in one large, urban, integrated health care system.

Findings/Conclusions: Patients transitioning to the community setting following discharge are vulnerable and at risk for adverse sequelae, and transitional care management that does not end when the patient leaves the hospital setting is integral to promoting positive patient outcomes (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011). The care management approach during the pandemic in one health care system precipitously shifted to an entirely virtual, remote model, and the team continued to provide transitional care support for hospitalized patients to avoid the common pitfalls that are associated with unfavorable outcomes.

Implications for Case Management Practice: The insights gleaned from one health system's experiences during the pandemic are transferable to other facets of care management in routine circumstances, with emphasis on the avoidance of the common care management snares that lead to less than optimal patient outcomes. The development and implementation of multifaceted interventions, with the goals of supporting health-promoting behavior changes and self-care capacity for at risk populations, are relevant in the current health care environment.

Key words: *acute care management, Covid-19, discharge planning, transitional care management*

The world is experiencing a global pandemic of Covid-19, posing challenges to hospital setting transitional care management and discharge planning. The purpose of this article is to review the experiences of an integrated urban health system and the strategic approach to applying innovation and technology to discharge planning for hospitalized patients in the acute care setting during the Covid-19 pandemic. Transitional care management in an acute hospital setting is a complex and individualized process, directly impacting throughput and readmission rates and aiming to ensure a supportive safety net of resources for the patients. The insights gleaned from one health system's experiences during the pandemic are transferable to other facets of care management in routine circumstances, with emphasis on the avoidance of the common care management pitfalls that lead to less than optimal patient outcomes through an innovative approach.

The Covid-19 pandemic response stimulated the rapid transformation of the acute care management model amidst the tremendous challenge of meeting the discharge planning needs of the hospitalized patient population. The incidence of confirmed Covid-19 cases was approaching 1.8 million people in the United States as of early June 2020 (Johns Hopkins University, 2020). In one integrated health system, the care management approach shifted to a remote, virtual model to contribute to the conservation of personal protective equipment and reduce the risk of exposure to the virus. The team leveraged technology and implemented virtual processes to maintain high standards of patient care and promote the provision of high-quality acute care management

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Prior research has identified recurring themes that represent discharge planning issues that lead to adverse consequences, including mistrust between older adults and health care team members, insufficient engagement of patients in self-care management activities, disintegration of care across the continuum, communication breakdown between care team members, and inadequate access to resources.

to the patient population served, mitigating the barriers associated with post-acute placements and connecting patients with resources.

Patients who are transitioned to the community setting following discharge are vulnerable and at risk for adverse sequelae, and transitional care management that does not end when the patient leaves the hospital setting is integral to promoting positive patient outcomes (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011). The care managers in the integrated health system ensured safe and smooth transitions of care for patients discharged from the emergency department (ED) and hospital settings in an intensive approach that was reflective of the paradigm that the care management does not begin and end with the acute care episode.

Virtual Health Care Management

The care management approach during the Covid-19 pandemic precipitously shifted to an entirely virtual, remote model for one integrated health care system. Prior research has identified recurring themes that represent discharge planning issues that lead to adverse consequences, including mistrust between older adults and health care team members, insufficient engagement of patients in self-care management activities, disintegration of care across the continuum, communication breakdown between care team members, and inadequate access to resources (Hansen, Young, Hinami, & Leung, 2011; Naylor et al., 2018). The care management team members provided transitional care support for hospitalized and discharged patients in an innovative approach to avoid the common pitfalls that are associated with unfavorable outcomes (see Figure 1).

Communication Between Team Members

Maintaining effective communication and collaboration between health care team members is integral to the provision of care management for medically complex patient populations in the hospital setting and following discharge. Patient safety and the quality of care delivery are positively impacted by interprofessional collaboration, which is exemplified by open communication, clearly defined shared objectives, and routine discussion about plans of care and goals (Fox & Reeves, 2015). During the pandemic situation, the care management team reinforced efforts to remain in close contact with interdisciplinary care providers through the use of available technology such as

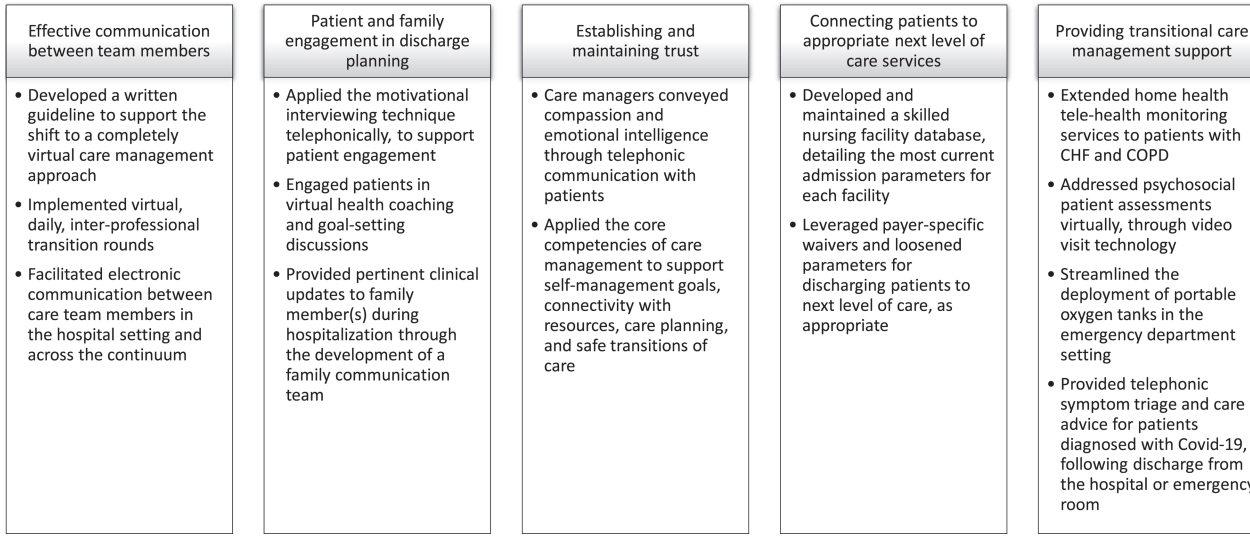

FIGURE 1
Avoiding the common pitfalls of discharge planning: A summary of the innovative approach to acute care management in one health system during the pandemic. CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease.

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the electronic health record and other secure telecommunications. Electronic forms and e-mail to fax functions were utilized to ensure patients and all next level of care service providers received all documents to support handoff communication, including clinical information, orders, and medication prescriptions.

The most illustrative example of interprofessional teamwork within the acute hospital setting during the pandemic situation was the implementation of virtual daily transition rounds. These telephonic meetings functioned with the goal of identifying, communicating, and mitigating the risk caused by barriers to safe and smooth transitions of care. Interprofessional communication and shared responsibility for decision making through the implementation of interprofessional transition rounds are associated with improved perception of collaboration between the team members and reduced potentially harmful patient outcomes (Urisman, Garcia, & Harris, 2018). The rounds involved a telephonic conference between interprofessional team members, including discharge planning, social work, utilization management, nursing, physicians, and, in some cases, specialists or therapists. The discussion of every hospitalized patient daily allowed each discipline the opportunity to provide insight into the assessment findings and data and to discuss potential barriers to self-care and successful transitions to the next level of care. Interprofessional rounding enhances communication and teamwork between the disciplines, serving as an effective strategy to avoid such breakdowns in the sharing of key clinical information between team members in the acute care setting (Ashcraft, 2017). The virtual transition rounds supported an environment that was conducive to supporting mutual respect between the health care staff members and the transparent sharing of ideas and insights.

In alignment with the transitional care model paradigm, patients were not discharged but were transitioned to the next appropriate level of care during the Covid-19 pandemic. Information and communication breakdowns associated with insufficient documentation, unclear recommendations, and untimely updates on the progression of the discharge plan are perceived barriers to effective acute care management across the continuum of care (Pinelli, Stuckey, & Gonzalo, 2017). These inherent risks were mitigated during the pandemic through the electronic communication process, effectively closing the communication loop and providing pertinent details and information to support the clinical individualized discharge plan of care. The care management teams effectively facilitated communication across the continuum to virtually connect patients, family members, health care team members, health plan case managers, post-acute service providers, primary care provider, and specialists.

The transmission and exchange of important information between clinical team members and across the continuum of care were critical to the aim to limit the disruption to care management and safe, timely discharge planning throughout the Covid-19 pandemic. The relationships between the care team members were strengthened by the common sense of purpose that aligns both teams and their goals of promoting enhanced self-management.

Engaging Patients and Family Members in Discharge Planning

Care management is optimal when the patient is directly involved in the discharge planning process. Activation is defined as "an individual's knowledge, skill, and confidence for managing their health and health care" (Hibbard, Mahoney, Stockard, & Tusler,

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2005). Patient activation levels and participation in care lead to improved clinical outcomes and self-efficacy in behaviors supporting health and cost avoidance for patients managing chronic conditions (Coulter et al., 2015; Viau et al., 2016). Patient engagement in activities contributing to improved health and wellness was the central value to care management efforts during the Covid-19 pandemic.

The acute transitional care management team utilized the motivational interviewing therapeutic communication technique to actively listen and engage patients in their care, encouraging a high level of trust and activation. Motivational interviewing is defined as a collaborative communication style for eliciting an individual's own motivation and commitment to make health-promoting behavior changes (Miller & Rollnick, 2013). The technique is strengthened both through the demonstration of empathy and through the promotion of self-care (Beaulieu-Volk, 2015). During the Covid-19 pandemic, the care managers assumed a telephonic approach to assess the hospitalized patients' perceptions of the benefits of changing behavior and reflections on the opportunities for change, recognizing the patient as an active member of the health care team. The barriers and benefits of health-related behavior change were assessed, identified, and discussed, and the care manager facilitated the risk mitigation through the promotion of shared decision-making to develop the individualized plan of care, including discharge goals.

Knowledge gained through health coaching and goal-setting activities leads to improved patient assurance to participate in health promotion activities, patient activation, perceived self-efficacy, and improved clinical outcomes for patients (Hibbard, Greene, Sacks, Overton, & Parrotta, 2017). Self-care management capacity was strengthened through the provision of health-related education, including information relevant to Covid-19, to ensure patients and family members or caregivers were well informed on symptom and medication management and health-related care plans.

The hospital visitor restrictions contributed to a communication gap between the clinical care teams and the family members for the hospitalized patients. The care management department addressed the risk of fragmented communication with family members by developing a dedicated family communication team. Between the dates of April 6, 2020, and June 1, 2020, a team of ambulatory care nurses served in the role of bridging the gap in communication with family members. Four licensed practical nurses and registered nurses (RNs) were available to serve in this capacity, as their usual ambulatory roles were impacted by the decreased office visits and elective surgeries that were experienced during the pandemic. The hospital care managers sent referrals to the family communication team members through a secure messaging function in the electronic health record. The family communication nurses reviewed medical records and performed telephonic outreach to the family member or caregiver to provide pertinent clinical updates and ongoing support during the hospitalization. A template was used to guide the conversation, including the provision of updates on laboratory test results, tests, procedures, progress notes, and care plans (see Figure 2). The family communication team addressed more than 139 referrals over the course of 8 weeks, promoting the engagement of family members in care and discharge planning.

Establishing and Maintaining Trust in a Virtual Environment

Trust between patients and health care team members exemplifies the belief in another's good intentions and will, which were demonstrated consistently during the Covid-19 pandemic through virtual interactions that conveyed empathy and high levels of emotional intelligence. The emotionally intelligent care manager remains self-reflective to understand and effectively manage central emotions and demonstrates an appreciation of the emotions of others through the empathetic expression of respect and awareness (Yekta & Abdolrahimi, 2016). Through conveying compassion and emotional intelligence telephonically, the acute care managers established trusting relationships with hospitalized patients during the pandemic.

The engagement of patients through the therapeutic motivational interviewing approach was integral to the sustained trusting connections maintained by the care managers. Gaining an understanding of an individual's motivation to make health-related behavior changes is a critical element in the promotion of self-care management. The individual's desire to engage in behavior change is elicited through active listening, resisting the

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S	**Situation:** What is the situation you are calling about?	Hi, my name is [redacted] and I'm a nurse calling from the [redacted] Health System. I am on a team that is calling family members to provide updates about their loved ones' care and progress in the hospital. We realize this is a difficult time for you and your family, and we want to be sure that we are communicating important updates with you. The nurse has asked me to call you to share updates about (*patient's name*) and his/her care. Is this a good time for you to talk for a few minutes?
B	**Background:** Pertinent background information related to the situation could include the following: • The admitting diagnosis and date of admission • List of current medications, allergies, IV fluids, and labs • Most recent vital signs • Lab results: provide the date and time test was done and results of previous tests for comparison • Other clinical information	I am sharing information that I have learned by reviewing the patient's chart, as I am not in the hospital providing direct care for him/her. (*Patient's name*) was admitted on _____, and the diagnosis is _____. The physicians and care teams are taking great care of him/her. Provide an overview the hospital stay and treatment to date, including: Lab results Recent vital signs Clinical information and current treatment (nutrition, activity, meds, etc.) Testing completed
A	**Assessment:** What is the nurse's assessment of the situation?	I reviewed the nurses' notes, and wanted to share the assessment information from the nursing perspective, including: Pain control Systems review (cardio, pulm, uro, GI, etc.) Nursing care plans and goals
R	**Recommendation:** What is the nurse's recommendation or what does he/she want?	Thank you for trusting [redacted] to care for your loved one during this challenging time. I can ensure you that we have a passionate team of caregivers providing care for (*Patient's name*). Do you have any questions about any of the information I shared with you?

FIGURE 2
Template to guide the family communication team's conversations with hospitalized patients' family members in order to provide pertinent updates.

urge to correct a problem, and providing suggestions to support the patient's development of individualized discharge plans and goals. The core competencies of care management are well aligned to support these aims, as the primary purpose is to activate patients to become better managers of their own health (Agency for Healthcare Research and Quality, 2016). These competencies include supporting self-management goals, connecting with resources, developing a care plan, providing education, and ensuring safe transitions of care (Agency for Healthcare Research and Quality, 2016). Sustaining a virtual environment for the patient and the care manager to communicate in an authentic and transparent manner about goals of care was intuitive for the care managers during the pandemic, establishing trust in the virtual context.

Post-Acute Care

Mitigating the challenges and barriers associated with managing post-acute service placements for patients during the Covid-19 pandemic presented unique challenges for the care management team in one health system. Although Medicare and many managed care payers waived or loosened precertification requirements to aid in timely patient discharges to the next appropriate setting of care, post-acute care setting nuances and complexities drove significant delays in throughput. Skilled nursing facilities (SNFs) imposed parameters and requirements that varied by facility and were constantly changing. The care management team navigated these complexities in support of the aim to ensure the right level of care at the right time for patients.

Facilitating transitions for patients from the hospital to post-acute care facilities was simplified when the Centers for Medicare & Medicaid Services (CMS) and managed care payers reduced the administrative burden on care management by enacting waivers and loosening the parameters for discharging to the next level of care. On March 13, 2020, the CMS communicated an emergency declaration that (at least temporarily) waived the requirement for the 3-day prior hospitalization for patients to become eligible for coverage of an SNF stay (CMS, 2020a). The CMS 3-night stay waiver and the relaxing of the usually stringent precertification requirements by managed health plans were enacted to support throughput for patients to the appropriate level of care during the pandemic, promoting safe and smooth transitions of care for patients as they discharge from the hospital setting. The care managers were empowered to help patients transition from the hospital setting without the usual payer-related barriers to throughput during the pandemic.

Skilled nursing facilities analyzed referrals for patients to admit to the facility, imposing parameters and requirements that varied by facility and were perpetually being changed. The CMS (2020b)

issued guidance on April 2, 2020, for SNFs to isolate patients with unknown Covid-19 status for 14 days. Many facilities had limited geographical ability to isolate new admissions or returns from the general population or had limited supplies of personal protective equipment to safely implement the guidance. Post-acute service providers and the acute care management team members worked in collaboration to support the patient's choice of discharge disposition, maintaining strong collegial working relationships to mitigate the risk of exposure and to ensure high-quality, safe, and continuous transitions of care for all patients. The hospital care management team created and maintained an SNF database, updating the document with the most current admission parameters for each facility in the geographic regions in proximity to the hospitals. The length of stay index for the month of April 2020 for patients discharging to the SNF level of care revealed a 0.08 increase from the prior year, reflecting the challenges relative to discharging to facilities during the pandemic.

Access to Resources

The development and implementation of multifaceted interventions to support the self-care management capacity and health of high-risk populations were imperative in the changing health care environment. Complex chronic illnesses and social determinants of health issues present challenges to effective self-management for the expanding aging population (Cacchione, 2018). The care transition team developed and implemented rapid change projects during the Covid-19 pandemic to address and mitigate identified needs for high-risk patient populations. Three of these innovation solutions aiming to improve the access to resources included:

1. A tele-monitoring service for patients with heart failure (HF) and chronic obstructive pulmonary disease (COPD);
2. The completion of virtual social work psychiatric-related assessments in the ED; and
3. The implementation of a process to discharge patients with oxygen directly from the ED.

The home health tele-health monitoring platform was extended to support the at-risk HF and COPD patient populations, especially during the pandemic, when access to routine primary and specialty care was often disrupted. The tele-monitoring programs were monitored by experienced RNs who monitor daily biometrics and vital signs, escalating positive triggers and early warning signs to providers. There was an assurance of medication adherence through ongoing monitoring and improved virtual connectivity between the nurse, patient, and provider through this platform. The implications for practice are considerable, as the core concepts of the project are applicable to addressing the health of other high-risk populations.

Addressing psychosocial assessments for patients in a virtual approach was augmented through the leveraging of video visit technology in the ED setting. Virtual psychiatric-focused specialty social work assessments were initiated in the system EDs through an electronic platform, enabling audio and visual connectivity with this vulnerable population. This social worker provided a remote psychiatric assessment, providing recommendations for care and connecting the patient with appropriate resources to mitigate further risk. This technology allowed the system to optimize the effective and efficient use of the specialized social work resources, promoting sensitive, individualized care for at-risk patients across multiple EDs.

Many patients with a Covid-19 diagnosis were able to be safely discharged from the ED setting, with instructions for self-management at home. The health care system implemented a process to streamline the deployment of portable oxygen tanks in the ED setting, supporting transitions to home for patients in need of home oxygen supplies. The durable medical equipment supplier provided each ED with a supply of portable, ready oxygen tanks on consignment. The provider identified a patient in need of oxygen and appropriate for discharge, communicating this resource need to the care manager to expedite the ordering process. A dedicated care management team member completed the referral process, enabling the patient to receive an oxygen tank on demand in the ED, and a concentrator that would be delivered to the home. The medical equipment company deployed a staff member to provide education on oxygen use and care in partnership with a home health care agency in the home setting. This process enabled the potential avoidance of unnecessary hospitalization, improving access to needed medical equipment to support clinical outcomes while remaining in the home.

Transitional Care Support

The transition of care for patients from the hospital to the community setting was supported through care management efforts that were integrated across the continuum of care. Patients who receive transitional care management services experience decreased adverse outcomes and costs following an index hospital episode of care (Bindman & Cox, 2018). The care managers engaged discharged Covid-19-positive patients in an intensive cadence and approach to support transitional care management in the home setting. Nurses provided outreach to patients within

24 hr of ED or hospital discharge and then daily between Days of Illness 8 and 14. They leveraged an electronic nursing triage platform and Covid-19 triage guidelines, based on emerging evidence, to assess symptoms, providing individualized care advice and education. Scripting was used to support the engagement of Covid-19-positive or recovered patients in the convalescent plasma donation program. The care managers described the plasma donation opportunity and asked for the patient's permission for a program representative to outreach to provide further information about the prospect of donating plasma. The care management team provided 7 day per week support to Covid-19-positive or suspected patients, promoting transitional care management and effective self-management.

Conclusion

The common pitfalls for acute care management and discharge planning were mitigated through a comprehensive, progressive, innovative approach during the Covid-19 pandemic. The care management strategies may be transferable to other health care systems or acute care settings. The development and implementation of multifaceted interventions, with the goals of supporting health-promoting behavior changes and self-care capacity for patient populations are relevant in the current health care environment. The innovative approach to acute care management supported effective communication between team members, patient and family engagement in discharge planning, establishing and maintaining trust in a virtual environment, connecting patients to appropriate next level of care services, and transitional care management support for patients discharging from the hospital.

The evaluation of the implementation of these interventions will ensue following the pandemic situation. The qualitative feedback from the interprofessional team members, care managers, patients, and family members has been overwhelmingly positive. The hospital unit staff members acknowledged that the in-person approach to collaboration with care management is preferable for relationship-building purposes; however, there was limited disruption experienced for the transitional care communication and processes. The care management leaders are committed to studying the quantitative impact of the transitional care management interventions on the outcomes of hospital length of stay, readmission rates, and patient satisfaction scores. The results of the analysis will be used to inform future strategic approaches to acute care management for the health system.

The conversion of care management to a remote and virtual approach during the Covid-19 pandemic drove one integrated health system to rapidly develop and implement an innovative, progressive model by implementing processes and an approach that are transferable to general care management practice. The creation and deployment of these plans enabled this team to provide high-quality, comprehensive transitional care planning and management, mitigating the risk posed by the common pitfalls through an integrated approach that does not start and end during the hospitalization.

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Nicole R. Howard, BSN, RN, is the System Educator for Acute Care Navigation at ProMedica Health System, where she designs and provides a structured and integrated curriculum for acute care management onboarding and continuous education programs. Nicole provides direct education and is considered a systems expert regarding post-acute resources and transitional care management needs across the continuum. Onboarding new employees, and empowering them to work at the top of licensure, is a critical facet of her position and providing these new team members with the resources and knowledge necessary to drive an integrated transitional care practice in the hospital setting. She is the manager of a team of clerical support staff members in the Care Navigation Resource Center, who manage referrals and all post-acute needs. Nicole is a passionate leader/educator and encourages growth through continuous education and goal setting. Nicole has 12 years of progressive nursing experience in the areas of education, transitional care management, hospice case manager, home health care administrator, and acute nursing. She earned a Bachelor of Science in Nursing degree from Lourdes University in 2008 and is currently applying for a Master of Science in Nursing program. Nicole plans to pursue a Doctorate in Nursing Practice in the future.

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