Challenges and Opportunities Programs Face in Reopening to Elective Procedures

In this month's article, **Anne Beekman, Senior Manager, Care Pathway Solutions, Terumo Business Edge**, describes the insight and learning she and her team gained from working with programs during the Covid-19 crisis. Anne possesses a wide body of knowledge in cardiology, and her experiences, coupled with the guidelines that have come out from Centers for Disease Control (CDC), Society for Cardiovascular Angiography and Interventions (SCAI), and other organizations, has helped prepare her to assist programs through these troubling times. What Anne describes below in many ways only scratches the surface of what programs must do in order to prepare for the future, certainly as it relates to care redesign and the move to value-based care.

— Gary Clifton, Vice President, Terumo Business Edge

When we are faced with a new problem or a situation where we don't have any personal experience to lean on, it is common to reach out to an expert or an individual with experience. Unfortunately, that tried-and-true method was not on the table when it came to Covid-19. Opening procedural programs post Covid has presented leaders with a multitude of challenges. Compounding the situation is the lack of consistent data and lived expertise to guide leaders through these tough decisions. Part of the work done by Terumo Business Edge as an industry partner is to communicate best practices and insights from our customers. Restarting your cardiovascular (CV) program during Covid requires careful planning, frequent adjustments, and paying a tremendous amount of attention to monitoring metrics. In addition to these immediate leadership needs, there is a powerful opportunity to redesign care. Below are three areas in Covid reopening that are challenging for procedural programs: (1) Covid testing, along with if and when to perform the test; (2) patient messaging/restoring patient confidence, and (3) visitor policies.

At the forefront for all leaders as they attempt to restart elective procedures is opening safely, and eliminating the spread of Covid to patients and staff. A discussion around what defines "elective procedures" can be a whole article in itself, so for our purposes, we will consider patients coming in from home as elective. All programs we interviewed and observed are performing temperature checks and interviews on Covid exposure.

How do you pick the right Covid-19 testing strategy for your program? Below are examples of current practices being utilized in programs:

Covid testing only if airway management and general anesthesia is expected:

- **Pro** - Reduces complexity of scheduling and no patient quarantine is needed.
- **Con** - Risk of a Covid-positive patient having an elective procedure.

Covid testing prior to arrival for procedure:

- **Pro** - Prevents bringing a potentially positive patient into the hospital setting.
- **Con** - Requires patient to self-quarantine.
- **Con** - Need test results to be available in 72 hours.

Covid testing on arrival to hospital:

- **Pro** - Combines testing with procedure.
- **Pro** - No need to self-quarantine.
- **Con** - May bring a Covid-positive patient into the hospital setting.
- **Con** - If patient is Covid-positive, the cancellation is difficult to fill.

These Covid testing practices are focused around procedural patients coming from home, but even greater variability is seen with the inpatient procedural patients. Although many positive Covid patients have no symptoms, including an increased temperature, inpatients are often not tested if asymptomatic and are not planned to receive anesthesia as part of their procedure. This is a potential gap in many programs we work with.

Suggestions

• Ensure your Covid testing policy does not become a barrier to care.

Some programs have very complicated steps and timing surrounding Covid testing prior to the procedure. These processes can be hard for clinical office settings to understand and schedule. The testing process can be overwhelming to some patients, and result in no-shows or the patient arriving the day of the procedure without proper testing.

There are many steps needed to safely reopen, but testing practices seem to be a universal challenge and create a great deal of discussion and review. Considering the options above, it is important to weigh the current state of positive Covid tests in your community and the communit(ies) you serve. In some areas, patients can and will self-isolate; in other areas, that may not be realistic. In addition, your program must be willing to adjust screening if your community experiences a Covid spike.

• Once program leaders land on testing requirements, the next challenge is customer confidence and patients' willingness to return to the hospital.

Making sure a program has a sensible, safe plan for operationally supporting the clinical team when reopening to patients is an expectation of all programs. Innovative programs will go deeper.

Many programs are using advertising to assure patients it is safe to come back to the hospital. If your program has a solid plan to safely restart and has marketed a message of safety but patient volumes still remain low, following are some areas to consider.

What staff or departmental role is responsible for contacting the patient? In many programs, a front-line staff member (someone who cannot discuss risks in delaying care) is the main point of contact. If this describes your program, and volumes are not returning, you may need a clinical person versed in the patient's individual risks to reach out to the patient. In some programs, it does require the physician to educate the patient on the risks of delaying care and the safety of the hospital in order for the patient to feel comfortable with scheduling care. You may also want to look at the use of telehealth for discussing invasive procedures such as a diagnostic catheterization. Although telehealth has been a critical tool in keeping patients and providers connected during the pandemic, some patients need that face-to-face connection as they work to understand and prepare for more complex care such as invasive procedures.

• Is your visitor policy too restrictive to caregivers?

Naturally, programs in Covid hot spots need to restrict traffic in the hospital, and this means limitations on visitors or no visitors. For some patients, this is a dealbreaker to scheduling care. Patients might be willing to go solo for an echocardiogram, but feel that a diagnostic heart catherization requires the emotional or physical support of a family member. One program, faced with the need to heavily restrict visitors due to a rapid spike in Covid cases, has adapted the hospital's concierge program to help patients navigate the hospital and keep patients connected with loved ones. This has been such a huge success that the program intends to keep this concierge role in place once the Covid pandemic subsides.

Recognizing Opportunities for a Care Redesign

As your program looks back on its efforts during the Covid pandemic, how will you evaluate the opportunity of this crisis? Will you see that your

program was able to continue functioning in much the same way while testing patients, providing emergent care, and restarting elective procedures? Or will your program have created a safe restart while also leveraging the Covid crisis into an opportunity for a much-needed care redesign?

Innovative programs are using the massive disruption Covid has created as a catalyst for needed care redesign. There has never been a time where patients, families, staff and physicians are expecting care to look different. How are some programs using the extreme challenges of Covid to create something positive?

The first and most obvious push is for reducing length of stay. This has long been on the radar for many programs facing challenges with both cost and capacity, but now patients do not want to be admitted in the hospital and certainly do not want to overnight unless absolutely medically necessary. Many hospitals have patients sign disclaimers that while in the hospital they may be exposed to Covid. Doesn't it make more sense to mitigate the actual risk and eliminate the overnight stay if possible? The body of peer-reviewed information on the safety and effectiveness of same-day discharge practices for elective percutaneous coronary intervention (PCI), as well as the reduced length of stay for certain cohorts of non-ST-elevation myocardial infarction (NSTEMI) and STEMI patients, is strong.[1-5]

Another interesting trend is reducing patient movement and touchpoints with staff. This is not only useful for reducing exposure to Covid, but both a patient satisfier and an operational win. Examples include: (1) the patient activating their registration when in their car or staff doing bedside registration; (2) moving the patient less often (consider placing leadless remote monitoring devices at the bedside for inpatients, or in the prep area for outpatients); (3) reducing rotating staff out of procedure rooms and minimizing the use of transport when able. In our observations, these activities are reducing patient-staff touchpoints from an average of 20 staff members to less than 10 staff members for an elective procedure. This is a great practice for the Covid environment, but also a patient satisfier, and streamlining care can maintain or reduce cost. Reducing interactions also improves the utilization of the electronic medical record (EMR), because every time a program introduces a new staff member to the patient, they repeat non-essential questions and often reenter the same data on a paper form or the EMR. This is a patient dissatisfier and a waste of time, but for some staff it is a habit and/or they only trust information they collect themselves. Eliminating the excessive staff touchpoints can eliminate the waste.

Lastly, if you have been waiting for the shift from volume to value and thinking it would be driven by a value-based payment structure, you are partly right. Covid has further exposed the deficiencies of a solely relative value unit (RVU)-based model. There is no doubt that programs need procedural volume for financial health, but if that is the only measure of a program's value, the Covid crisis will be especially challenging. Covid has become another reason to look at how we measure and pay for care.

Making sure a program has a sensible, safe plan for operationally supporting the clinical team when reopening to patients is an expectation of all programs. Innovative programs will go deeper. Your program can choose to redesign care for the better by learning from and purposefully responding to the opportunities presented by the Covid pandemic. Recognizing and making use of this opportunity is a critical step for the future.

References

1. Amin AP, Patterson M, House JA, et al. Costs associated with access site and same-day discharge among Medicare beneficiaries undergoing percutaneous coronary intervention: an evaluation of the current percutaneous coronary intervention care pathways in the United States. *JACC Cardiovasc Interv.* 2017; 10(4): 342-351. doi:10.1016/j.jcin.2016.11.049
2. Amin AP, Crimmins-Reda P, Miller S, et al. Novel patient-centered approach to facilitate same-day discharge in patients undergoing elective percutaneous coronary intervention. *J Am Heart Assoc.* 2018; 7(4): e005733. doi:10.1161/JAHA.117.005733
3. Amin AP, Pinto D, House JA, et al. Association of same-day discharge after elective percutaneous coronary intervention in the United States with costs and outcomes. *JAMA Cardiol.* 2018; 3(11): 1041-1049. doi:10.1001/jamacardio.2018.3029
4. Kwok CS, Rao SV, Gilchrist IC Sr, et al. Relation of length of stay to unplanned readmissions for patients who undergo elective percutaneous coronary intervention. *Am J Cardiol.* 2019; 123(1): 33-43. doi:10.1016/j.amjcard.2018.09.028
5. Rodriguez-Araujo G, Cilingiroglu M, Mego D, et al. Same versus next day discharge after elective transradial PCI: the RAdial SAme Day DischArge after PCI trial. (The RASADDA-PCI trial). *Cardiovasc Revasc Med.* 2018; 19(6S): 7-11. doi:10.1016/j.carrev.2018.05.020

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