From Pandemic to Panacea: Solutions that Sustained: COVID Inspired Continuum of Care Initiatives

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In early 2020, the Covid-19 virus swept through the world, causing a global pandemic. The onset of this unprecedented situation forced the health care system in this country to pivot and implement creative strategies to manage patient care and healthcare operations in the safest, most effective way possible to provide high-quality care. Care across the continuum had to be rendered in ways that were developed and implemented in a very short span of time. This article highlights several initiatives implemented which are currently being used in practice, with outcomes, as they demonstrated effectiveness in care coordination and health care operations.

Early in 2020 we began to hear rumblings on the news of a virus that was making its way from China to the United States. It was being reported that Coronavirus 19 (COVID-19) was a new virus for which we had no current treatment or vaccine. With the first patient arriving in Washington State, the alarm had not sounded for the general public. Health care organizations though, knew the potential impact of a virus like this. Did we though? Who could have imagined the magnitude of the impact on human life, daily life, and loss of life. By March of 2020 we had virtually closed the country, with words such as quarantine, unprecedented, personal protective equipment, and social distancing being uttered daily. Life as we knew it as healthcare professionals would never be the same. How could we sustain excellent, safe patient care when we were facing new and unknown challenges by the minute? It was through creativity, innovation, teamwork, and most of all effective communication that patient care and public health remained a top priority in ensuring safety and wellbeing.

As of June 2022, there have been 87,298,343 reported cases of COVID-19 nationally, with 1,012,767 deaths. Additional promising statistics include 222.3 million people who have been fully vaccinated in the nation, while 6,946,392 New Jerseyans are fully vaccinated.[1] Since COVID impacted individuals at home, assisted living, extended care, skilled nursing facilities, physician and provider offices, hospitals, and the streets, it was essential that identification and treatment occur where the people were. Many trial and error activities, whose goal was to keep patients/people out of the hospital and in their own "home" setting, have become new best practices for care throughout the continuum. Organizations such as the Organization for Nurse Leaders of New Jersey played a critical role is serving as a hub of communication and sharing these practices that made a difference in their organizations. The President of Organization for Nurse Leaders of New Jersey, Helene Burns, Chief Nursing Officer Jefferson Health, New Jersey, commented, "Our membership includes nursing leaders from across

KEY POINTS

- **The pandemic required health care organizations to quickly implement creative strategies to address the changing needs of patients and the environment.**
- **Essential to the success of these strategies was building relationships across the continuum of care and ensuring effective and timely communication.**
- **In order to sustain these strategies, the identification and collection of outcome data are an essential next step.**

the continuum of health care who have an opportunity to keep current on legislative issues, share best practices, network, and hear what others are doing." She continues that, "the ability to share and disseminate evidence-based practices, nursing research (and the many tests of change resulting from the COVID-19 health care environment) is truly the value of being a member." Through this article, COVID-19 inspired initiatives in the State of New Jersey will be shared, including examples that have sustained the test of time from acute care, transitions of care, subacute/extended care, and ambulatory/home care.

ACUTE CARE

Effective communication between care settings was the key to safe, smooth transitions. Burns noted, "the pandemic forced us (in a good way) to communicate more than we ever had, (on topics) such as current resources, staffing concerns, and bed availability. This facilitated further discussions on our shared patients on what is the most optimal location for their care."

Hospital at Home

Several years ago, Virtua Health, a comprehensive community health care system with 5 hospitals with more than 270 outpatient locations in South New Jersey and Philadelphia area, began to explore opportunities to expand acute care services outside of the traditional hospital setting. Virtua reviewed research over the past twenty plus years and noted successful outcomes with an emerging innovative program entitled, Hospital-at-Home (HAH.) As early as 1999, researchers from the Johns Hopkins University School of Medicine completed a study on the "The Hospital at Home" model which focused on acute care for older adults who transitioned from the hospital to home, to receive the same level of acute care services. The research revealed a safe, feasible, and cost-effective model of care for HAH patients. From 2000 to 2002, a National Demonstration and Evaluation Study evaluated this approach to care in 3 Medicare managed care organizations and 1 Veterans Affairs Medical Center. HAH quality performance standards were measured against those from the traditional hospital and found comparable results.[2] These included lower rates of mortality, use of sedative medication to manage delirium, restraints, falls, length of stay (LOS), and overall cost of care. In addition, higher patient and family satisfaction and functional outcomes were reported.[3]

In March 2020, Centers for Medicare and Medicaid Services (CMS) announced the "Hospitals Without Walls" program for hospitals to provide acute care services in locations beyond their existing hospital walls. In late 2020, at the urging of the American Hospital Association due to the extraordinary surge of COVID-19 patient acute care volume, the CMS launched the "Acute Hospital Care at Home program," which provided authorized hospitals with "unprecedented regulatory flexibilities" to provide acute care services to patients in their homes. Essentially, this allowed hospitals to expand their capacity in response to the COVID-19 pandemic crisis.[4]

Hospitals participating in the HAH program must first be approved by the CMS. According to the CMS (2021) requirements of participation include the following:

- Appropriate screening protocols before care at home begins to assess both medical and non-medical factors, including working utilities, assessment of physical barriers, and screenings for domestic violence concerns.
- Medicare beneficiaries will only be admitted from emergency departments or transferred from inpatient hospital beds.
- In-person physician evaluation is required prior to starting care at home.
- A registered nurse (RN) will evaluate each patient once daily either in person or remotely.
- Two in-person visits will occur daily by either RNs or mobile integrated health paramedics, based on the patient's nursing plan and hospital policies.

The services provided by the HAH program clearly differentiates care provided by home health care services. In addition to the physician and nursing services provided in the home, laboratory and radiology services are available as well as pharmaceuticals and meal delivery.

In early 2021, during the winter surge of the COVID-19 pandemic, all 5 Virtua Health acute care hospitals were struggling with high patient volume, similar to all health care organizations in New Jersey. Although Virtua Health had been researching HAH prior to the COVID-19 pandemic, efforts to develop and execute a strategic plan to implement HAH intensified. Virtua Health Voorhees Hospital was chosen as the pilot hospital for the organization to launch HAH. In late 2021, Virtua Health received approval by the CMS to be a participating provider in the HAH program. As part of Virtua Health's mission to orient to the consumer and transform its delivery models, the HAH program would provide the option for certain patient populations to have the hospital brought directly to their home.[4]

On January 19, 2022, Virtua Health Voorhees Hospital successfully transferred its first patient to their HAH program. Initially, the HAH program was focused on patients with COVID; however, it soon expanded to include chronic obstructive pulmonary disease, pneumonia, urinary tract infection, congestive heart failure, and cellulitis. Patients are screened for HAH eligibility by a Virtua Health HAH Care Coordinator through 2 different workflows as follows: evaluation of inpatients and emergency department patients (See *Table 1* HAH Workflows).

Table 1. Virtua Health Hospital-at-Home Workflows

Patient Type	Workflow
Inpatient Department	• HAH care coordinator meets with IP interprofessional team comprised of registered nurses, physicians /licensed independent practitioners, respiratory therapists, physician therapists, case managers, and pharmacists during daily nursing department "patient progression rounds." • Team reviews all IPs to discuss progression of care and eligibility for HAH • HAH care coordinator discusses eligibility with attending LIP and patient/family to determine interest in participating in the program. • Patient agrees to participate in HAH • Nursing and other departments begin the process to transfer the patient to HAH, similar to an internal transfer within the hospital.
Emergency Department (ED)	• ED physician orders inpatient admission • HAH care coordinator meets with ED physician and if indicated, the HAH inpatient physician, to determine HAH eligibility • HAH care coordinator discusses eligibility with patient/family to determine interest in participating in the program. • Patient offered and agrees to participate in HAH • Nursing and other departments begin the process to transfer the patient to HAH

ED, emergency department; HAH, hospital-at-home; IP, inpatient; LIP, licensed independent practitioners.

As the Virtua Health HAH continues to grow, it is anticipated that this will provide additional inpatient beds as patients transfer to HAH. This is especially significant during periods of high inpatient and emergency department volume.[5]

Virtua Health HAH performance measures of success are identical to those in the organization's acute care measures such as hospital-acquired infections, falls, falls with injury, LOS as well as customer satisfaction. Additionally, Virtua Health HAH debriefs and analyzes all patient transfers back to the hospital to determine reason and opportunities for improvement. From January 2022 to September 2022, with 166 patients transferred to the HAH program, only 4.8% required transfer back to the hospital which is less than Virtua Health's internal benchmark goal, based on the national median, of 5.5%.[6]

COVID-19 Progressive Care Unit

During the pandemic, it was evident that creative approaches to staffing and care models were needed. According to one organization, "leadership determined that the new model should optimize all bedside nurses' ability to practice at the top of their license while receiving support from nonnursing staff." Key elements of this model included frequent rounding, huddles, and role reassignment from the operating room, cardiac catheterization lab, and the gastrointestinal procedural unit.[7] Inspira Health, a multicampus health care facility in South Jersey, implemented an innovative nursing model for the higher acuity needs of COVID patients. With this increased acuity and higher intensity of nursing care required, a collaborative, interdisciplinary approach was established in this new Progressive Care Unit (PCU). This model of care aided in bridging the gap between traditional step-down units and medical surgical units by creating one blended PCU, which served the patients until discharge. Essential to the success of this model were the key stakeholders including nursing, providers, case management, and operations, to ensure effective communication, relationship building, and appropriate care referrals through the continuum. The nurse to patient ratio was established at a consistent 1:4 and all nurses received critical care training. Several measures of success were identified (See *Table 2*-Performance Measures). According to organizational leaders, the impetus for this approach was to decrease transitions and handoffs, and to improve quality and patient safety.

Kimberly Talley, Vice President of Patient Care Services, described the model as "an interdisciplinary planned approach where patients are the priority. When you build trust with the patient, overall compliance will increase leading to improved health

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Table 2. COVID-19 Progressive Care Unit Performance Measures

Metric	Baseline 1/1/21- 3/31/21	Pilot 1/1/22-3/31/22	Improvement
Throughput			
Bed assigned to complete	100 min	77 min	23%
Bed request to complete	204 min	188 min	8%
Discharges prior to 1400	16% discharged	22% discharged	38%
EVS TAT – Request to complete	186 min	84 min	55%
Patient satisfaction			
Willingness to recommend	52.70	70.59	25%
Rate the hospital: 0-10	57.14	88.33	31%
Nursing communication	76.69	88.89	14%
Physician communication	72.30	87.04	17%
Communication of medications	54.20	73.08	26%
Care transitions	37.10	60.19	38%
Financial			
Case mix index	1.51	1.61	6%

outcomes. The PCU is truly a team model with the patient at the core of all we do."

An essential element of success to this care model focused on the discharge plan, and the most timely and appropriate next level of care. The RN case manager is a critical team member in facilitating a discharge that reduces 30-day readmissions. The case management model is a dyad approach, utilizing both RN case managers and social workers. There is an RN case manager assigned to all patients, and when high risk needs are identified, such as undocumented, uninsured/ underinsured, placement issues, and abuse/ neglect, a social worker is consulted to facilitate the psychosocial aspects of the discharge plan. The majority of these patients were discharged to home with homecare, then to subacute rehab as the COVID-19 environment allowed. The case manager engaged with patients and their families early in the admission, which facilitated making connections and referrals to the next level of care in a timelier manner. This allowed for these facilities and agencies to partner with the inpatient care management team in identifying their discharge needs. Also, the case management associate staff was able to pick up these needs and report to the RN in a timely way. The overall focus of the case management team is to build relationships and promote comradery among patients and families. This consistent oversight by the RN case manager and synergy with the social worker helps to develop a patient centered plan of care that addresses both the medical and psychosocial needs, thus reducing the risk of readmission and preventing delays.

From a nursing perspective, the model promotes a consistent continuum of care in the acute care setting, which results in decrease of patient harm. Continuity of care and relationships with patients and families is consistent. Subtle changes in patient behavior or symptoms are caught earlier because of the consistent care, and negative outcomes are prevented. The nurses get to know their patients resulting in earlier identification of change in patient condition.

This model afforded improved nursing and staff satisfaction and engagement. There is a consistent nurse to patient ratio of 1:4 and staff remarked that this allowed for improved overall communication, more time to spend with patients and family, and safer care. Comments obtained during leadership rounds from patients included, "the communication is clear and I feel safe. I know my nurse and they know me." This is supported by patient engagement data which demonstrated an increase of 25% in "willingness to recommend."

Another benefit of this model, noted by Betty Sheridan, COO, is improved satisfaction of the physician leaders. Aspects of provider satisfaction include the interdisciplinary team approach, continuity of care, and the promotion of joy in the workplace.

Reducing the number of handoffs during the patient stay promotes safety. Transfers within the organization from critical care, to step down and then to active care were almost 200 per week prior to implementation of this model. Since the inception of the model, there have been 3 transfers, which are investigated as "failures." Less transfers result in reduced handoffs and reduced opportunities for error. Other improvements include, but not limited to, increased throughput, improved transportation times, decreased

turnaround time for bed cleaning, and decreased "left without being seen" in the emergency department (See *Table 2* Performance Measures)

The PCU Model of Care has resulted in many positive outcomes, such as a reduction in falls. Opportunities moving forward include defining the leadership roles of charge nurse and assistant nurse manager. This care model is summed up by Talley as she states, "We improved in all predetermined metrics during the pilot phase and will expand to other areas. When patients are at the center of what we do, the entire team wins!"

Innovations in Orientation - Lessons Learned from Covid

Ensuring effective orientation experiences for nursing was just one more challenge created by the pandemic. An organization from Australia sought to provide the learning experience by creating a virtual explorer tool "to support student success in the simulated clinical environment, to prepare students for work integrated learning, and to assist in informing students about the reality of the physical space, health and safety challenges, and clinical practice elements of the simulated clinical environment."[8] The Valley Hospital, in northeast New Jersey, created an orientation tool to facilitate the care of a broader demographic of patients on the cardiac surgery unit. The initiative was started in the Cardiac Surgical Intensive Care Unit (CSICU) unit during the COVID-19 pandemic as a result of the decrease in cardiac surgery patients. It was observed that the unit was no longer caring for only cardiac surgery patients and the nurses had to be quickly trained to care for different types of patients. The team felt that the orientation process had become fragmented as a result of inconsistency of preceptors based on several factors including nurses becoming ill and/or leaving the unit, or resigning.

The goal-based orientation progress tool was developed to provide continuity to the nurses during the orientation period. It is an objective tool that looks at the weekly progress and is used in real time. It serves as an organized way to train preceptors and sets clear objectives, broken down by orientation week number and clinical milestones. These clinical milestones are preset into the tool-based CSICU nursing practice and are reflective of the advancing competence of the new nurse orientee. During the biweekly progress meetings, the nurse orientee and nurse preceptor come to an agreement on the progress of the nurse orientee. This progress is measured and recorded in percentages using the following scale:

- 0%-25%, dependent on nurse preceptor to meet requirements
- 25%-50%, demonstrates some autonomy from nurse preceptor to meet requirements
- 50%-75%, mostly independent but seeks guidance from nurse preceptor when needed
- 75%-100%, completes requirements with minimal to no assistance from nurse preceptor

Table 3. Registered Nurse Cardiac Surgical Intensive Care Unit Turnover Rate

Time Frame	Turnover Rate
April 2020-April 2021	13%
April 2021-April 2022	7%

The use of this tool continues for CSICU orientation and will be used for future critical care opportunities. The tool served to identify strategies to move from traditional learning resulting in new, innovative, and creative approaches.

With the movement of nurses during COVID due to a change in venue, retirement, or leaving the organization, the team at the Valley Hospital identified reducing turnover rate as an outcome measure (See *Table 3* RN CSICU Turnover Rate).

A survey was given to the current cohort of CSICU nurse residents (new to the CSICU) and their primary preceptors to explore and measure the effectiveness of the goal-based orientation progress tool and to evaluate its original intent and purpose. The nurse preceptors and nurse residents were asked identical questions with the exception of one question asking the nurse preceptors to compare the tool to previous practice. (See *Table 4*, Nurses Preceptors/ Nurse Residents Satisfaction with Tool).

Table 4. Nurses Preceptors/Nurse Residents Satisfaction with Tool

Question	Result
Was effective in comparison to past practice	100%
Was effective in identifying learning needs	100%
Was effective in tracking and monitoring progress	100%
Was effective in measuring critical thinking	86%
Was effective in measuring clinical decision skills	86%

COVID-19 Response Resilience Team

The burden that COVID 19 placed on the health care team was great. One organization recognized the significant stress that the pandemic has put on health care professionals and essential workers by implemented strategies to enhance resilience such as a Health Care Worker Assist Program, which provides all health care workers with rapid access to services that provide skills that enhance resilience and reduce symptom burden.[9] The Valley Hospital took this another step further through the development and implementation of a *Resilience Team.* In the spring of 2020, the Resilience Team, comprised of the spiritual care supervisor, patient experience officer, and holistic practitioners, was created to address the trauma, stress, and challenges presented in caring for a COVID-19 population. Nurse's health and well-being were supported by providing in-house and community assistance including presentations, individual counseling, team-based resilience sessions (resilience lounges), critical incident stress management, spiritual care, the Integrative Healing Arts Academy, mindfulness programs, and Integrative Healing Practitioners.

Resilience Lounges

These were virtual support sessions held weekly to support staff and give them a place to share their concerns, as well as learn some new techniques in dealing with their reactions and responses to the situation. Each week presented various themes from the participants ranging from shock, anger, a loss of control, insomnia, and anxiety just to name a few. The facilitators of the sessions used a simple structure to conduct the sessions, with time at the end for some instruction and coping skill techniques for the unique issues that presented during each session. Generally, the sessions were structured by the following format:

- Sessions always started with a song and music
- Next were a series of questions
  - "what are you struggling with this week"
  - "what is going well this week"
  - "what are you doing that is working and not working."

These sessions were held regularly for many months, paused for a while and reactivated several more times over the course of the pandemic as needed. Participants voiced feeling better and had better coping skills, and a sense of not being alone with peer support after sessions. Total participants included over 700 from all entities of the organization.

The Integrative Healing Practitioners rounded on units to provide emotional support, guidance, and therapeutic modalities such as aromatherapy to all clinical staff. During rounds they brought lavender aromatherapy sniffers, snacks, lotions, and handmade masks to the staff to encourage stress management. Today their focus has shifted to provide department specific support as they have been called upon to provide stress reducing strategies such as music, Reiki, touch therapy in both group and one-to-one sessions with staff. They also began to announce a daily intention over the hospital intercom system each morning to encourage staff to pause and focus on the intention as they started the day. These daily intentions continue even today.

Team-based resilience sessions (Resilience Lounges) continue to be available upon request to any work area experiencing higher than normal levels of stress. Resilience experts join the team virtually, offer space to process difficult emotions, and share practical tips for building resilience. These lounges are restarted when needs arise, and the sessions are ongoing, addressing specific unit's needs.

The resilience team, along with employee health, made a decision to add a resilience component to the 2021 "It's Your Move Program" through the employee Health Department. This program encourages health care workers to make positive changes to their health and well-being. Employees must complete a 30-minute resilience education session and commit to a personal resilience plan. These initiatives are still ongoing, and through post-education surveys, the team determined the efficacy of the modules.

Three classes were offered a month that focused on resilience, self-care and stress reduction, and joy. Along with these 30-minute educational sessions, participants were encouraged to commit and utilize resources as part of a personal resilience plan. This intervention reached 500 employees.

Additional presentations offered by the resilience team are included as follows:

1. Strategies of emotional and mental health well-being.
2. Striking a Balance between work and home.
3. Practicing decompression and disconnecting from work.
4. Positivity, a spiritual practice of resilience.
5. Stress management strategies and gratitude for improved well-being.

Nurses can use information included in the presentations to reduce stress and improve well-being. Through post-education surveys, we determined efficacy of the modules.

Table 5. SNFist Key Indicators – 2021 (Blue = Exceeds Target; Green = At Target)

Key Indicators	Target	Baseline	1Q	2Q	3Q	4Q
30-day readmission rate	<27%	30.4%	22%	8%	15%	14%
% with completed AD/ POLST	85%	NA	96%	100%	86%	90%
SNF LOS	21 d	24.6	13.2	21	14.8	19
APN visits/d	8	4	14	14	12	10

AD, advance directive; LOS, length of stay; NA, not applicable; POLST, physician orders for life sustaining treatment.

TRANSITIONS OF CARE/ SKILLED NURSING FACILITIES

SNFist Model of Care

In February of 2021 AtlantiCare embarked on another initiative during the pandemic, known as the "SNFist" model of care. The goal of this model was to decrease the LOS in a skilled nursing facilities (SNF) setting and the prevention or reduction of 30-day readmissions to acute care. This model utilized advanced practice nurses (APNs) to conducts assessments, rounding, and education in the subacute setting. Although a physician still has to complete the history and physical within 48 hours of admission to a SNF, the APN conducted rounding and patient assessments within 24 hours of patient discharge from acute care. Rounding occurs on a daily basis which allows the APN to identify early, and complications or change in patient condition that previously may have resulted in a readmission.

The APN created a collaborative relationship with the nursing staff in the facility, and provided education to the staff on topics such as identification and treatment of congestive heart failure. They also provided fecal immunochemical test testing, Infection Prevention and Control education, and COVID-19 vaccinations to the staff, which enhanced the relationship between SNFist and nursing staff. Additional responsibilities of the SNFist include renewing patient medications conducting weekly meetings with the care team, communicating and collaborating with ambulatory care management, and participation in utilization review meetings. In addition to the daily rounding, they are on call on the weekend for new admissions to the SNF.

A second SNFist was added in March of 2022, allowing for coverage of 4 facilities, with an additional 2 in the near future. The face-to-face interactions between the SNFist and the patient were essential to the successful outcomes (See *Table 5*: SNFist Key Indicators). "Once the patients transitioned to subacute rehabilitation, we faced challenges with communication updates to the care plan, notification of discharges back to the community, and access to follow-up care. This model helped to bridge the gap in post-acute care, with the SNFist acting in the role of attending provider at the facility, while improving handoffs to primary care providers," commented Lauren Cooke, Corporate Director of Care Coordination.

AMBULATORY CARE

SNF at Home

In addition to the SNFist model, the organization also implemented a SNF at home program, which brings the services of the skilled nursing facility to the home. Many patients are reluctant to stay in a SNF, fearful of COVID-19 exposure and do not want to be

Table 6. SNF at Home Key Indicators – 2021 (Blue = Exceeds Target; Green = At Target; Yellow = Progressing to arget)

Metric	Target	Q1	Q2	Q3	Q4
30 Day readmission rate	13%	16%	14%	20%	0%
% with advanced care planning Conversations	85%	84%	100%	90%	92%
SNF at home patient volume (cumulative)	30	6	14	24	27

SNF, skilled nursing facility.

isolated from their loved ones. In this pilot, all patients are part of the organizational accountable care organization program (ACO), whose acuity is at the skilled nursing facility level. This added benefit to the Medicare Shared Saving Program/accountable care organization members was made available through the Medicare waivers enacted during the pandemic. Specifically, the waiver covered the cost of meals and private duty nurses, which mimics the level of service a patient would receive in a SNF, while RN and rehab services were covered by a partner home care agency.[10,11] When needed, physical and occupational therapists deliver daily sessions. The doctor or nurse practitioner visits weekly. Help with personal care and meals are also available. With SNF at Home, patients will be allowed to recover in their homes with all of the same services that are provided within the SNF facility.

An APN conducts an initial assessment of the patient in their home and visits at least weekly ongoing. They are working to the top of their license as they are the primary care giver during the 30-day SNF at home period. At this time the care is then turned over to their primary care provider.

Savings is realized through the Medicare Shared Savings Program, by keeping them in a less costly care setting. Referrals are made to SNF at Home by the transitional care nurse, inpatient care management, ambulatory care management, or primary care. The following are criteria for inclusion into the program:

- DRG's including congestive heart failure, Chronic obstructive pulmonary disease, wound care, hip/knee replacement)
- Intravenous antibiotic treatment
- AMPAC (Activity Measure for Post-Acute Care) score of at least 15

Exclusions to the program included:

- Patients on dialysis.
- Patients with no caregiver at home.
- Past medical history of behavioral health issues.
- Past medical history of addiction.

Services include:

- Physical, occupational and speech therapists
- Social Services/care management
- Home visiting APN
- Medication delivery
- Vital signs
- Wound care
- Infusion therapy
- Nonemergent transportation
- Private duty care
- Directorate of Medical Education/surgical supplies

Outcome measures for this initiative included goals of care discussions, 30-day readmissions, and SNF at home visit volume (See *Table 6*: SNF at home metrics)

As we continue this life journey side-by-side with COVID-19, it is evident that there are a few silver linings. Overall safe hygiene practices have improved, thus improving the long-term health of our population. Improved communication has strengthened the patient experience through the continuum, placing the patient as the center of focus. Finally, stronger relationships have developed with health care partners in different care settings.

CONCLUSION

As evidenced in this article, 2 key components of successful initiatives are effective communication and relationship building throughout the care continuum, and establishing outcome metrics. It is essential that health care leaders broaden their lens, viewing the patient as the center of everything, rather than any one organization or care setting. According to Burns, "as we rely more on face-to-face communication for providers (and caregivers), including ZOOM, we have become less dependent on documentation. Smart technology, such as secure chatting has allowed for improved (and timely) communication." These approaches, hardwired during the pandemic phase of COVID-19, will continue to provide access to patient information at all points of care.

Finally, as we further identify measures of success, these COVID inspired initiatives will become the best evidenced-based practices of the future. It is important for organizations to adopt consistent metrics for broader comparison (locally, regionally, and nationally) including COVID-19 readmission rates, sepsis readmissions, and patient/family satisfaction/staff engagement.

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