Systemness across the care continuum

Providing a consistent experience for patients and employees has never been a higher priority

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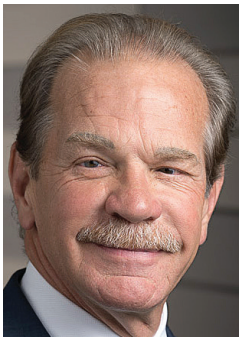

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Systemness can improve the patient experience, lower costs, reduce risk and provide insights into a range of care and management issues. But aligning services and practices across a wide range of facilities, employees and care can be a challenge. There's no questioning the priority that systemness holds for today's hospitals and health systems—especially in this era of COVID-19. But what are the perceived benefits and obstacles? And what is needed to continue to move the process forward successfully?

Fawn Lopez, publisher of Modern Healthcare and vice president of Crain Communications, sat down with leaders in healthcare to discuss systemness and the paths they've taken in their current positions, as well as the road ahead.

Fawn Lopez: What are the perceived benefits of systemness, on a short-term and long-term basis? And especially now with COVID-19?

Joseph Cacchione: During COVID, systemness has really helped us have a coordinated response. The access to and moving PPE to where markets request it was critical. We've actually even helped other health systems with PPE. I think there were a couple of sleepless nights around gowns, but beyond that, we really did not have shortages of any PPE, including drugs, especially drugs for sedation.

We had begun our journey into virtual care, but we've obviously doubled down on that very quickly and had the infrastructure in place. We've now done about 1.5 million virtual visits since March.

And we're not only reaching the 30-something-year old with broadband; we're also reaching the poor and vulnerable populations. The elderly are using virtual services — 8% of our virtual visits were with people over 80 and 32% were with those over age 65. So we're reaching the Medicare-age populations in different ways across our system. We're getting our physicians licensed in multiple states now, so they can deliver care into other

markets. We're also supporting some of our smaller markets with access to specialty care that they previously would not have had through virtual.

Michael Slubowski: If there was ever a time to demonstrate the value of systemness it's during a pandemic. We started with what we called an incident response team. Now it's our COVID-19 response team. Having a central command center, but also mirror command centers in each of our markets to leverage the things that we needed to handle, whether it was supplies, equipment, drugs or staff. So we have a program called FirstChoice where we recruit nurses and respiratory therapists who can respond or travel; even within markets; it's an alternative to hiring an external agency. But all those things came to bear during this pandemic. And so it's a real opportunity to highlight the benefit of being able to work together.

We have a 450,000-square-foot warehouse in Fort Wayne, Indiana, that trucked materials to 22 states during the pandemic. These are examples of where the value of systemness is demonstrated—when we're able to leverage our skill, scale and knowledge across multiple venues and initiatives, whether it's with our work on Alternative Payment Models and accountable health, or whether it's our work on community health and well-being.

Randy Oostra: I think if you ever saw the advantage of being part of systemness, it was during COVID-19 from our Incident Command Center. Having infectious disease doctors support hospitals across the system, including our nursing homes all across the country, that's just not something that you normally have in a lot of facilities. As we think about safety and quality, we have seen the benefit, especially as we look at social determinants and how senior care has been positively impacted.

Where I think that's taking us all is to this ability to paint more of a holistic idea that a system can think about, not only when we do need to take care of somebody clinically but much more of a consumer-based idea about giving people the tools and control for their health. And that's what we all want, giving some individual control.

Telehealth is such a broad category, it's hard to describe. We do a lot of visits, but the categories of visits have radically changed from what we think of as just a typical visit to much more than that. Whether it's supporting diabetes groups, or OB cohorts, or supporting ICUs or maternal-fetal medicine in rural communities, the list just keeps going on. So really it's fascinating, we've opened the door now. I think long-term where you'll see systemness shifting is to more of a consumer-centric model where people are going to be able to access services in different ways.

FL: What lessons have you learned about telehealth during the pandemic?

RO: It's physicians realizing that, 'Hey, I can be much more effective. I can provide much better access. I don't need to see every single person. I don't need to touch every patient.' We were able to use our physician group to support our senior facilities across the country. An example: a nurse in Naples, Florida, has a patient who has a vascular wound, and being able to talk to a vascular surgeon in Ohio, asking, 'What do you think of this? What should I do?' That is the sort of thing we have seen some real excitement and synergy around.

MS: Within our EHR software, we added a module that connects clinical care to social services in the community. So we used our community health workers to reach out to those that we knew had risk factors, lacked resources and were most vulnerable—and we were able to make the connection between their clinical care and social care needs.

JC: It's the people, the experience of the people and then technology. And so that's why we are big on digital literacy and why we are trying to simplify the access through our digital means to make digital literacy an important piece of what we do.

Lisbeth Votruba: I think telehealth is thought of as just a visit replacement; that's not really transformational, but it's when you can leverage the data that's inevitably created, it becomes transformational. I feel ethically obligated to share some of the learnings, qualitatively, that we get from data. For example, workplace violence incidents are being witnessed and documented across our whole customer base. So we're able to capture data from hundreds of hospitals. We can show types of verbal abuse that are happening in patient rooms from vulgar language to demeaning language to actual threats. We published this data, just so nurses can learn from it. And it carries the conversation forward about workplace violence.

FL: From a metrics and measurement standpoint, what does systemness success look like to you?

MS: We keep a "system scorecard"—a balanced scorecard of measures. Quality, safety, care experience/satisfaction, alignment with our clinicians, growth, financial stewardship, diversity and inclusion and measures of our community health and well-being impact. So, we try to hit all the dimensions of what would constitute a balanced way to look at our performance.

RO: To support our physician groups, our patient engagement folks educated our clinicians on the ABCs of how to conduct a telehealth visit—the type of things to focus on. I'd love to say we have it all figured out, but we pretty much had been using traditional metrics. And now we're asking ourselves, just what is our metric? How are we going to look at that on telehealth? And is it different than an in-person metric? I think it's a work in progress.

FL: Maintaining consistent systemness is tough enough across hospitals. Now that you're delivering more care outside of the hospital, what are some of the challenges you've experienced creating systemness?

MS: If you don't have the common platforms to be able to manage care across the continuum, it is a large challenge. We are accomplishing this in waves across our 22 states. I would say for Trinity Health, one of my concerns in returning to the organization three and a half years ago was we hadn't made the decision to standardize on the EMR platform five or six years ago, like many other organizations. We had a "Heinz 57" variety of EMR platforms in place. So we're playing catch-up, but will get there in a few years.

JC: I think the biggest issue is making sure it transcends the hospital. Most experienced measures have been hospital-based, so we need to expand the measurement of experience. How do we measure people's experience across the entire spectrum of care? Having the data that's actionable and timely to feed back to our frontline providers and to make decisions based on solid data is going to be critically important. In the meantime, we've done a lot of standardization around access, and expanded access. We have set expectations for our providers, and we can measure some of those improvements in access.

But I still think the measurement science throughout the entire continuum of care is lagging behind, and that's something we all need to improve. So the measurement science has to catch up. Our strategy is about longitudinal care delivery across the entire continuum, yet we only capture small bits and pieces of the patient experience across that continuum.

FL: Would you agree that telehealth, especially during the pandemic, was the tipping point to achieving systemness?

JC: I wouldn't say it was a tipping point for us, but I would say it was an accelerator. I think it really just accelerated our systemness. I think we're closer from a system standpoint, but I think there's nothing like a crisis to galvanize a community to bring them together in a way that is completely different. And I think there's a stronger sense of community across Ascension today than there was before. Probably the best story is how we brought in Ascension Living, which is our nursing homes. They were so exposed during the pandemic that we had to be mindful of what was going on there in a more purposeful way. That was a great example of how the pandemic really pulled in a part of the organization that didn't always feel like it was totally connected. The spirit of "One Ascension" has never been stronger.

RO: It was a tipping point, I believe, to have telehealth adopted across the whole industry. That, I think, is true. And I think part of our struggle is that we had a so many doctors adopt this approach early because they had to. The numbers started to go back down. Some specialists went back to office visits, some are doing telehealth, some aren't, so consistency is a bit of a struggle. We also started with the environment. Especially at home, you're using technology in a variety of environments, in a whole different way. So, yes, I think it is systemness.

MS: I think the rapid roll-out of telehealth is an example of how the pandemic forced us to think about more possibilities. How do we take the momentum from what we've learned during this period—opening our minds to new ways of getting things accomplished quickly and by using people differently? Really, healthcare is an industry in which people always perform well in a crisis. Our people who work in emergency rooms or in the intensive care units, they always rise to the occasion. So this has been a situation where we've asked everyone to rise to the occasion to leverage our skill, scale and learnings on a national basis.

FL: What advice can you share for leaders looking to implement systemness across their own health systems?

JC: Take care of the patients, take care of the associates. Don't worry about the balance sheet, don't worry about operating performance.

RO: When you think about how we started and grew as leaders, from a very traditional perspective, there was a certain path most of us took. Then you look at what we are facing today—the pandemic, loneliness, depression, systemic racism, food insecurity, the anger around the election, people working from home—it's a different focus now as we think about people more holistically. In our case, we are thinking about individuals from a larger lens, and markets that we've not thought about before. You still come back to some basics; back to the reasons why we exist; our purpose, what we're about, the role we play in the communities we serve, and painting that notion of vision, trying to keep people connected, trying to help people understand why they have chosen the field they have.

MS: We're organizing differently to solve problems and we want to continue that effort through what we're calling "Emergence Teams," making that a permanent part of our leadership model and engaging our regional leaders and system leaders together differently. The best companies don't subscribe to "holding company" or "operating company" model. They are a hybrid. They figure out how to leverage the skill, scale and learnings of being a larger or a national or a multi-market organization. They also recognize the unique differences in each community, and they leverage the strengths of talented people that they place in those communities to act and meet unique community needs.

LV: You have to find that sweet spot where the technology supports what the human can do. My ex-husband is a radiologist, and he is not encouraging our daughters to join that field because a lot of what he does will probably be one of the first to get supplemented by technology, but not completely replaced. So, with the radiologist expertise on one end of the spectrum, the other end of this spectrum is TeleSitting, which is unlicensed nursing assistants that have been traditionally one-to-one sitting, 24/7. One nursing assistant assigned to the bedside of a patient. This is what we've been doing for 10 years, making that more efficient. But what I've seen in this last year I would never have imagined when I joined the company, that something like what Trinity is doing, covering all their hospitals with two hubs in the United States. And I think Ascension has one hub per state. That's the direction of the systemness and centralization. That's a good case study.

FL: What are your goals and expectations for what your system will look like in the future?

JC: I would say a more comprehensive approach to the continuum of care, and to have migrated away from an asset-heavy hospital-based system to a real integrated system that is delivering care in multiple venues anywhere in the continuum of the consumer journey of how they will access healthcare; it could be in the home, it could be on their phone, it could be in the hospital, it could be in any number of venues. We should support payment models that help drive and create leverage to be more effective in delivering care in a holistic way, versus in a fragmented, episodic way that we've done up until now.

LV: We have a mission statement that is going to stay standing and that is, "we help people keep people safe." We want to continue to do that, and also meet consumer expectations. Kent Hospital recently published a press release about one of their patients who kept saying, "Alexa, play Roy Orbison, Alexa." The CNA overseeing the TeleSitter system made sure to play Roy Orbison over the communication speaker to console the patient. I'm hoping to consistently get to that level of meeting member, patient, consumer and resident expectations.

MS: As a faith-based health system, our vision statement is to be the national leader in improving the health of our communities and each person we serve- and being the most trusted partner for life. We've expanded that to include our "brand promise" of providing care for all in body, mind and spirit by listening, partnering and making it easy. In addition, we aspire to be the safest health system in America. We're going to grow— but it will be disciplined growth. We will be much further along on having common platforms in place so that we can truly leverage our skill, learning and scale in a more comprehensive way.

RO: We want to build a diversified health and well-being model that integrates the physical and social needs of people at every stage of life. When we think about being diversified, that gets back to moving toward a consumer-focused model. When we look back, five, ten years from now, we want to say that we've done things in some new and unique ways.