Restarting “Regular” Health Care Will Be Hard: How Providers Can Prepare Now

written by Theresa Hush | April 30, 2020



As states across the country begin to loosen restrictions for the coronavirus pandemic and return to a modified version of normal life, how will our health care system get back to providing regular care? In particular, how can providers pivot from the scale and aftereffects of COVID-19, and bring their patients back? In hot spot areas, that task will also require healing their own organizations.

COVID-19 has upended traditional care delivery and revised priorities for patient care. It has changed status of providers and foisted enormous stress on front line staff, to the point of serious trauma and even suicide. With an enormous death toll of over 51,000 in less than a few months, models' higher predictions, sadly, seem reachable.

The virus has revealed huge gaps in the public health system, emergency preparedness, and health care capacity. It has

overwhelmed medical staffs and facility capacity—as well as capacity of nursing homes, rehab centers, and funeral homes. But COVID-19 has also unveiled widespread innovation, fierceness, and collaboration in health care. By many accounts of industry experts and medical staff, it has also opened opportunities for change. That change will be good for providers, health care systems, and future patients.

But here's something else that the latest data is showing: at least one-third of Americans have postponed routine health care during the pandemic. *Modern Healthcare* cites several recent studies of hospital claims, emergency room cases, and consumer polls that show double-digit declines in use of regular health care by consumers. And that is bad news.

Hidden by the Pandemic: Patients with Real Emergencies like Heart Attacks and Strokes

Back in March, CMS provided for expansion of telehealth services in lieu of personal medical visits, and then recommended delays in elective and other non-essential medical and dental services. Many state governments have used insurance and medical/hospital licensing authorization to reinforce these actions for private insurers as well as medical facilities.

Within weeks of the first COVID-19 surges in New York, these regular patients stayed home. Hospitals across the company furloughed employed physicians and other hospital clinical and administrative staff. Private practices were left without patients and are now financially threatened. Pediatricians, oncologists, surgeons, cardiologists—and other physicians dependent on physical exams and office or hospital procedures—have been sidelined.

There is a surprisingly sharp decline in the rate of reported STEMIs (the most serious kind of heart attack) and strokes during the pandemic—in Europe as well as in the U.S., from hundreds of cases to single digits. Independently, the Minnesota Heart Institute Foundation reported data that shows a 38 percent decline in cardiac catheterization lab activations for STEMIs across nine centers. *The New York Times* reported an informal survey of an online community of cardiologists on Twitter this month, estimating a 40 to 60 percent decline in admissions for heart attacks, with some reporting more than 60 percent.

So far, the reasons are unclear, but patients' fear of seeking care is suspected, along with financial concerns. There is also speculation that these medical events went undiagnosed during hospitalization of patents for COVID-19, because crisis management prevented taking full histories and the management of COVID-19 obscured other symptoms. And in some cases, COVID-19 has precipitated cardiac arrest or stroke.

While telemedicine has been effectively deployed in some areas hard-hit by COVID-19, use of telemedicine appointments has often been triggered by patients seeking medical attention and not, as a rule, by providers reaching out to high-risk patients. Those with cardiovascular symptoms who fear being told to come to a hospital may be unwilling to even schedule a telemedicine visit. Complicating the situation, provider continuity cannot be always maintained as physicians are reassigned to help on the front line, or furloughed, so that patients may lack trusted relationships during telemedicine appointments.

Cardiac experts expect a deluge of patients discovered to have had STEMI heart attacks at home as well as other heart emergencies. They fear that they will find advanced disease, damaged vessels, and organs that cannot be repaired.

Sidelined by the Pandemic: Patients with High Risk Factors

Beyond emergencies, almost all non-urgent care has been put on hold for two months. Measles vaccines have declined by 50 percent, and well child and regular visits for high-risk individuals have been postponed. Access to care under COVID-19 has been significantly reduced by a combination of factors, some patient- and some provider-driven, in order to preserve resources needed for fighting the virus.

Lack of access to care is strongly connected with negative long-term outcomes. In one recently published study on hypertension, loss of access to health care after Hurricane Sandy was associated with uncontrolled hypertension levels that persisted two years later.

Other studies also point to steep, dramatic increases in hospital admissions for diabetes and other chronic conditions that occurred after SARS between 2002 and 2004. The lack of ability to deal with highly complicated diabetes, behavioral health, intestinal issues such as Crohn’s Disease, and other illnesses may deluge providers reopening services after COVID-19 moves into another phase. Delays in laboratory services, alone, have put blinders on physicians’ ability to understand what is happening to these patients.

Cancer care has also gone on hold during the peaks of COVID-19.

Planned surgeries have been delayed, along with start of chemotherapies or other treatments. According to the Cancer Action Network, half of cancer patients have delayed or interrupted treatments. About a quarter of patients responding to surveys have delayed the start of treatment caused by closed access to care, along with 27 percent of patients who were in active treatment and have had to pause their care. Many have not learned when their treatments will be rescheduled. Oncology groups have issued guidance to clinicians to delay cancer care to avoid exposure of patients to the virus.

In addition to lack of access to treatment, cancer patients are stressed financially, having difficulty affording treatments. Thirty-eight respondents said that COVID-19 is financially affecting the affordability of treatment due to reduced job income.

How to Restart Health Care: Strategically Deploy Population Health and Other Tools

Regardless of how much we all want to get back to normal, it will not be easy to manage restarting regular health care, especially with COVID-19 cases still on the rise. State public health agencies have begun to issue guidance and directives to providers regarding how to restart actual services. California, for example, has defined the process of examining both when it is feasible to begin reopening care, dependent on the volume and curve of COVID-19 cases, and how those services should be delivered initially through telehealth rather than personal visits.

Beyond these parameters, however, we must answer the question of how to approach the sea of patients needing care now. We

suggest four steps:

- Use patient data to identify risk severity and stratify need for appointments and lab services. Identifying risk factors as well as uncontrolled clinical conditions will be essential to differentiate the effects of deferred care.
- Prepare patients for return to care with outreach. Patients will not have an understanding of what providers' process will be for reopening, or how safe that will be for them, unless it is clearly conveyed. To encourage patients to come, this communication should preferably come from their physicians. It will also be necessary to inform patients about how providers plan to communicate with them, especially if it will involve using the patient's portal into their systems.
- Use population health technology to facilitate scheduling of patients' telemedicine and lab services, prioritizing according to risk. This will enable analytics that show responsiveness, analytics by population segment, and effectiveness of outreach.
- Create analytics that tie deferred or delayed care to clinical status and outcomes. We know that COVID-19 will persist and go through waves; providers will need data that can be used in future planning and risk stratification to mitigate patient downward spirals caused by delayed care.

Providers will need to restore balance to regular patient health care while still battling COVID-19. The cost of deferral will be too high for patients, in the same way that a long-term economic shutdown is proving to be for the country. The use of telemedicine is a major feature that helps maintain some continuity of care and will remain a permanent fixture in

healthcare. But other ongoing elements of care must be now integrated to avoid catastrophic damage. Industry providers have shown remarkable courage and determination to fight COVID-19, and their technology vendors must rapidly develop data and solutions to help them breach the next front of the crisis.

To that end, Roji Health Intelligence has launched a population health registry to help providers track and communicate with patients at high risk for COVID -19 and other conditions that have been sidelined during the pandemic, at no charge to existing clients. Please click here for details.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Evgeni Tcherkasski