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Editorial

Lessons in Collaboration from the Management of Pandemic in 2 Large Skilled Nursing Facility Chains

Arif Nazir MD [a,b,*], Annette Wenzler RN, MBA [b], JoAnne Reifsnyder PhD, MBA, MSN [c], Richard Feifer MD, MPH [c]

[a] Division of Family Medicine and Geriatrics, University of Louisville, Louisville, KY, USA
[b] Signature HealthCARE, Louisville, KY, USA
[c] Genesis HealthCare, Kennett Square, PA, USA

Interprofessional collaboration is defined as an active and ongoing partnership between professionals from diverse backgrounds with distinctive professional cultures and possibly representing different organizations or sectors working together in providing services for the benefit of health care users.[1] Effective collaboration that results in greater trust and engagement among interprofessional team members may appear simple but is no simple task.[2] The need for interprofessional collaborations among organizational team members and across organizations is not new but has intensified since the pandemic.

The COVID-19 pandemic fast-tracked many kinds of policy decisions and innovations (eg, telehealth) and demanded new channels of communication between various professionals within and across organizations—a key ingredient of collaboration.[3] But communication channels are not enough. Effective intra- and interorganizational collaboration requires a broader framework of enabling domains. A recent review provides one such framework that can be used to display many examples of collaboration that emerged in our 2 organizations to address critical quality of care issues in response to the pandemic.[4]

Framework for Effective Collaborations

Promoting a collaborative health care environment requires attention to 3 key domains: *bridging gaps* that may be professional, social, physical, or task-related; *negotiating overlaps* in roles and tasks; and *creating spaces* to support teamwork.[4] Teams can use this framework to design and then evaluate the effectiveness of their collaboration as part of normal operations or during a crisis, such as the recent pandemic.

- *Bridging gaps* in health care requires aligning professional perspectives on providing quality care. For example, gaps in beliefs, attitudes, and/or feelings needed to be addressed around such issues as cohorting patients. One approach to bridging such gaps is to share "communal stories; this helps diverse stakeholder groups [represented in the team] to develop a sense of what they have in common with each other."[5] Social gaps may also be closed by meaningful conversations—personal (eg, about families and vacations) or professional (eg, inadequate access to COVID-19 testing).[6] Use of pronouns such as "we" and "they" also builds a team culture.[7]

Overcoming communication gaps requires dissemination strategies tailored to various stakeholders, such as making sure that viral transmission knowledge and practices are accessible to all members of the care team. Finally, teams need to assure that tasks are shared when team members become overburdened during a crisis, such as nurse managers and rehabilitation therapists helping nurse aides to provide residents' dinner trays at meals.

- *Negotiating overlaps* applies to stakeholders within or across organizations and is about clarifying roles to keep individuals and groups from stepping on each other's toes. This happened in our organizations when referring hospitals and partnering SNFs came together to finalize COVID-19 testing protocols for patients being discharged to SNFs. Another important area to negotiate overlap is role clarity around individual care processes; for example, the role of social workers in advance care planning could be explicitly defined to supplement conversations by physicians and advanced practice providers.
- *Creating strategic spaces* to interact and intermingle is the final, intentional component of the framework for interprofessional collaboration.[4] These might include routine meetings, brief daily meetings of the entire care team on an SNF unit ("huddles"), and shared rounding opportunities (in-person or using virtual technologies) that are planned or convened ad hoc to prompt and facilitate engagement with medical or mental health providers. Effective collaboration requires stakeholders having ways to reach out to others, for example, physicians connecting with other professionals during annual and other meetings arranged by various professional associations either in-person or via virtual platforms.

During the COVID-19 pandemic, our organizations adopted a variety of tactics that involved and promoted collaboration, both within

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* Address correspondence to Arif Nazir, MD, Signature HealthCARE, 12201 Bluegrass pkwy, Louisville, KY 40207, USA.
E-mail address: Anazir@shccs.com (A. Nazir).

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Table 1
Examples of Collaboration Tactics in Various Domains of the Collaboration Framework: Based on the Experiences of 2 Large Post-Acute and Long-Term Care Organizations*

Focus Areas	Domains for Effective Collaboration		
	Bridging Gaps	Negotiating Overlaps	Creating Spaces
Medical, clinical, and operational partnerships	Regular interactions, leveraging videoconferencing Communication as a necessity, not a formality Sharing of knowledge and regulatory updates Shared decision making around operational and clinical issues	Multiple conversations and debates regarding operationalizing recommendations from the Centers for Disease Control and Prevention (CDC) and state/local public health departments	Daily meetings of varying length that were flexibly scheduled depending on the agenda items, and the availability of busy team members
Infection control	Interprofessional committees created at corporate and facility levels Weekly calls and facility huddles for knowledge dissemination Infection control education messaged differently for different levels and disciplines Appointment of Infection Prevention "designees" on all shifts to ensure consistent implementation of practices	Clear delineation of infection preventionist's responsibilities New infection control responsibilities for various disciplines (operations, legal, compliance teams)	COVID-19 units to provide safe and efficient care in SNFs with outbreaks Dashboards for cases, outbreaks, supplies etc. Daily and weekly written updates and broadcasts directly from executives to facility leaders Direct participation of chief medical, clinical, and operational leaders at facility-level and regional "outbreak management" action planning meetings Virtual "rounds" to observe and coach facility staff on infection control practices
Collaboration with public health officials and the CDC	Establishing communication with various state departments of health and task forces Contribution to various states' COVID-19 taskforces Regular meetings with the CDC	Providing insights to new protocols around testing and cohorting Collaborating with hospital partners on COVID-19 discharges to SNFs	Serving on state-level advisory committees, charged with supporting pandemic policy making for nursing homes
Medical Director Partnerships	Frequent communications with medical directors on mutual learning of clinical and policy matters Medical director sharing pandemic-related information from other parts of the health care system, eg, acute care Medical director direct engagement with families	Ensuring medical director is engaged in-person or virtually Stronger medical director and infection preventionist partnership and role in staff education Assisting medical directors with telehealth visits	Setting frequent calls with medical directors at corporate and facility level Frequent memos and newsletters for medical director education Inviting medical directors to educational meetings and webinars by professional associations Sharing educational resources through a medical director digital app
Research collaboration between provider, pharmaceutical and academic settings	Facilitating contacts between pharma and academic researchers and SNF leaders by meaningful messaging on value of COVID-19–related research Collaborate with researchers while being minimally disruptive to clinical operations	Helping with practical research designs on several aspects of COVID-19 management, eg, efficacy of monoclonal antibodies and antiviral medications, understanding serologic responses to COVID-19 infections	Regularly scheduled dialog to establish research priorities for SNFs Participating with external collaborators to consider and design clinical trial networks to support post-pandemic research in PALTC Partner in research presentations and publications

*These tactics are suggested, experience-based courses of action only and are *not* intended to be viewed, interpreted, or relied on as required standards or standards of care for the health care industry.

our organizations and with others across the health care system. These tactics are listed in Table 1, with a description of how each fit within the 3 key domains of collaboration.

Key Lessons Learned About Effective Collaborations During the Pandemic

The tactics described in Table 1 reflect approaches that positively contributed to teamwork and partnerships, but pursuing these tactics was not easy or without challenges. Within each of the 3 domains, we experienced and addressed barriers. Here we share some of the valuable lessons learned with the hope that they will help other organizations and policy makers in the future.

A key barrier to collaboration was in bridging gaps between our organizations and public health officials in early months of the pandemic. Such collaboration was unprecedented, and no effective structures or platforms for such collaboration were available. Even the most basic steps, like identifying key stakeholders and obtaining contact information, were difficult.

Negotiating overlaps was a challenge regarding infection control and pandemic management, because of the health care industry's dearth of experience with COVID-19. Many well-intentioned experts and officials initially put their best thinking into new policy recommendations, but these sometimes conflicted. In one specific case, adjacent states were providing conflicting guidance on cohorting requirements to the various SNFs belonging to the same post-acute care

organization. As pandemic management evidence continued to develop on this and many other topics, frequent open dialog was required, as we sought the best way to protect and care for residents, as well as influence health policy decisions that affected all providers.

Creating spaces was also initially difficult, particularly across organizations, because our industry lacked sufficient pre-existing collaboration platforms, settings, and processes for engagement. Leaders needed to be identified, list servers needed to be created, weekly meetings needed to be established, and processes needed to be modified or created. All of this was possible and was achieved, but precious days and weeks were sometimes required before these collaboration spaces were fully functional.

Although there were many challenges to creating collaborations, many factors were extremely helpful. Most importantly, the majority of long-term care staff displayed unprecedented courage and flexibility toward an "all hands on deck" approach. When needed, departmental lines or silos dissolved, as team members readily adopted new roles. For example, business office personnel aided with personal protective equipment supply management; regional and corporate team members moved equipment and beds to create special units; and local communities supported the staff in many ways, such as holding appreciation parades and donating food items. Timely federal health care waivers created efficiencies and allowed access to needed resources. For example, waiving the 3-day hospital stay for skilled care allowed services to be rendered in place at the SNF, so that staff could use their skills and competencies to avoid burdening the already overloaded acute care systems. Similarly, room change notification requirements were modified to expedite moves for isolation and cohorting with creation of COVID-19 units.

Recommendations

To conclude, we share key recommendations that may help foster smoother and faster collaborations and prepare post-acute and long-term care (PALTC) providers for a better response in a future crisis:

- PALTC leaders should have a formal seat at the table in the policy-making aspects of the broader health care system, both at the federal and state levels. Similarly, hospital systems should work toward closer relationships and meaningful ongoing collaborations with local SNFs in their markets.
- PALTC leaders should establish ongoing formal connections with key federal bodies such as Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, Departments of Health and Human Services, and others.
- The PALTC community should develop and promote a common vision around the role of medical directors as administrative leaders both during day-to-day and during emergency operations.
- PALTC organizations should implement training of frontline teams on systems for effective in-facility teamwork (eg, grand rounding processes and informal or ad hoc huddles), augment existing (or create new) leadership training that incorporates key lessons from recent crisis management, and establish formal networks to facilitate and encourage collaboration between organizations. For example, industry stakeholders should build on initiatives like the ECHO program for ongoing interprofessional and cross-setting learning.[8]

In summary, the COVID-19 pandemic has been an unprecedented challenge. Health care institutions of all types and the public at large have sought a prompt understanding of practices to support infection control in PALTC. Our SNF organizations prioritized nimble intra- and extraorganizational collaborations that not only bridged internal and external gaps, negotiated and resolved overlaps in roles and tasks, and created new spaces for essential teamwork but also provided much needed operational and clinical clarity for other providers.

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