


# Veterans Health Administration Staff Perceptions of Overseeing Care in Community Nursing Homes During COVID-19

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## Abstract

**Introduction:** The Veterans Health Administration (VA) contracts with non-VA owned and operated community nursing homes (CNHs) to provide Veterans nursing home care. This study explored VA staffs' experiences coordinating care with CNH staff during the COVID-19 pandemic.

**Methods:** Qualitative study interviewing VA staff overseeing and coordinating care for CNH Veterans. Interviews were recorded, transcribed, and analyzed using inductive and deductive thematic analysis.

**Results:** Three themes influenced care coordination. (1) Pre-established working relationships strengthened trust in CNH staff and remote access to CNH electronic medical records (EMRs). (2) Remote oversight proved challenging as virtual visits did not fully capture Veterans' needs and Veterans experienced challenges due to cognitive status, hearing impairment, and discomfort with technology. (3) Partnerships strengthened as VA staff provided CNHs personal protective equipment, COVID-19 testing, infection control education, and emotional support.

**Discussion:** Despite pre-existing relationships and improved partnerships, most VA staff felt uncertain about the quality of oversight provided through remote monitoring and preferred in-person interactions. However, they found benefit in remote access to CNH EMRs and shared optimism with expanding virtual care.

**Conclusions:** Fostering strong partnerships between VAs and CNHs improve care coordination during crises like the COVID-19 pandemic and for daily care.

## Keywords

care coordination, nursing homes, Veterans, COVID-19

## Introduction

Nursing homes (NHs) have been hit hardest by the COVID-19 pandemic (Powell et al., 2020), with 38% of COVID-related deaths occurring in NHs (Lindsay & Sarita, 2021). NH staff have faced numerous challenges during the pandemic, including staffing shortages, inadequate supplies of personal protective equipment (PPE), and concerns about both the health of residents they care for and their own health and safety (Behrens & Naylor, 2020).

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In the Department of Veterans Affairs (VA) most NH care for Veterans is provided in community NHs (CNHs) rather than VA NHs, known as Community Living Centers (CLCs), as not all VA Medical Centers (VAMCs) have CLCs, but all VAMCs must have a CNH program (Miller et al., 2015). In 2018, 9808 Veterans received CNH care, and by 2037, the VA projects that the average daily census in CNHs will increase by 80% (GAO, 2020). VA CNH program staff collaborate with CNH staff to ensure Veterans in CNHs receive high-quality care. This proved critical during the pandemic when VAMCs and CNHs navigated policy changes restricting visitors to CNHs to increase safety of residents and staff and lower possibilities of virus transmission (VA Department of Veterans Affairs Memorandum, 2020). The objective of this research is to describe experiences of VA CNH program staff regarding oversight and care coordination for Veterans in CNHs during the pandemic.

## Methods

This study is an extension of a larger study of VA-CNH contracting practices. In September–October 2020, we invited VA CNH program staff that participated in interviews for our larger research study to participate in the current study. Participants were from four VAMCs and included CNH program coordinators, nurses, and social workers. We emailed program staff up to three invitations, and nine of the 12 VA CNH program staff members who participated in our larger study agreed to participate in the current study. Reasons for declining included leaving their role, being too busy, and not responding to invitations to participate. Table 1 shows participant demographics. Participants provided verbal consent to participate, and two researchers conducted semi-structured phone interviews with participants at a time convenient for them. We recorded, transcribed, and analyzed interviews using a content analysis approach (Elo et al., 2014). Two researchers (KM and LH) applied line-by-line coding to data using a combination inductive (codes emerged from the data) and deductive approach (codes were created a priori based on interview questions) and met regularly to reach consensus and discuss theme development. We developed themes by running queries of data based on consensus discussions using Atlas.ti analytic software. This allowed us to rigorously describe experiences of VA CNH staff coordinating care with CNHs during the pandemic. The study was approved by Blinded for Review Institutional Review Board (#18-XXXX).

## Results

The danger of spreading the COVID-19 virus in CNHs led to rapid changes in VA CNH program operations (VA Department of Veterans Affairs Memorandum, 2020). VA Central Office (VACO) mandated VA CNH program staff halt monthly in-person visits and switch to remote VA oversight and virtual care. We identified three themes influencing care coordination and oversight between VA CNH teams and

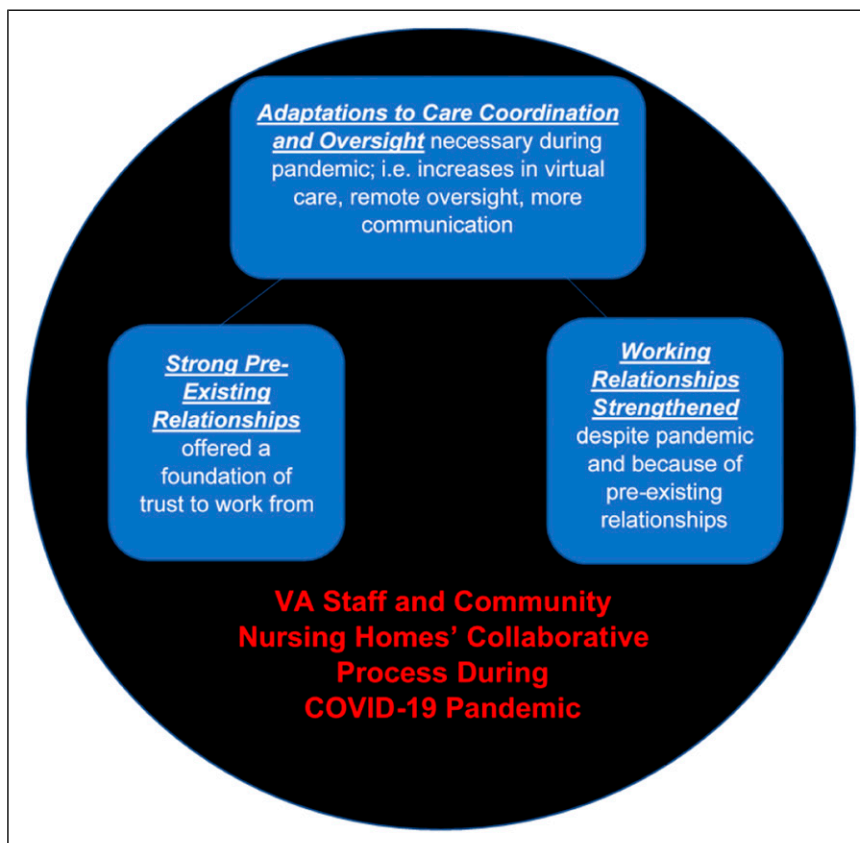
**Table 1.** Participant Demographics (N = 9).

Gender	N
Female	8
Male	1
Race	
White	1
Multiracial	8
Ethnicity	
Non-Hispanic	9
Education	
Bachelor's degree	2
Master's degree	7
Age (years)	
30–39	1
40–49	3
50–59	3
60–69	2
Role	
CNH coordinator	4
VA social worker	2
VA nurse	3
Time in role (years)	
0–3	4
4–7	3
≥8	2
Location of associated VAMCs (n = 4)	
Site A	3
Site B	2
Site C	2
Site D	2

CNHs: 1) value of pre-existing relationships; 2) adaptations to overseeing and coordinating care; and the 3) strengthening of working relationships. (Figure 1)

### Value of pre-existing relationships

Participants described how pre-existing relationships between themselves and CNH staff facilitated care coordination and oversight during the pandemic. All participants interviewed had been visiting NHs regularly at least every 45 days, and from the four VA CNH programs we studied, the number of NH contracts ranged from 11 to 36 (Department of Veterans Affairs Sharepoint, 2020). In the VA CNH program, the same VA social worker and nurse visit contracted NHs at each visit, and participants described that regularity of visits allowed CNH staff and VA staff to build relationships. Pre-existing relationships allowed them to continue oversight through early, regular, and transparent communication and trust between themselves and CNHs. One participant noted, “When we walk into the room, people [CNH staff] know who we are, they are happy to see us, they talk with us, they realize that we are there to help” (Site A, 129). *Established Channels for Communication*



**Figure 1.** Veterans Health Administration staff and community nursing homes' collaborative process during COVID-19 pandemic.

Participants described well-established channels of communication with CNH staff due to pre-pandemic working relationships and regular in-person visits to CNHs. Prior regular email, phone, and in-person communication between participants and CNH staff assisted in making easier transitions to remote monitoring of care. Participants highlighted how, thanks to pre-existing relationships, CNH staff had a VA point of contact during the pandemic, "Once I could not go in at all, they [CNH staff] knew who I was, the ones I had already formed relationships with, and they knew they could call me" (Site D, 102).

**Transparency.** Several participants detailed how relationships with CNH staff allowed for transparent communication about needs during the pandemic without fear of negative responses from the VA. One participant noted, "Building these relationships, it builds trust, and by being able to do that, they [CNH Staff] are more forthcoming" (Site B, 140). Another participant shared how pre-existing partnerships allowed for "more honesty and more transparency...our community partners [can] contact us and have some of those difficult conversations" like discussing COVID-19 outbreaks with residents (Site C, 112).

**Trusting CNH staff.** Participants noted that trusting information shared by CNH staff proved integral to coordinating and

overseeing Veterans' care as they "did not know [how] things were going unless they [CNH Staff] decided to call and let me know or I saw something in the chart review" (Site D, 102). VA staff underscored the importance of trusting updates provided by CNH staff about Veterans' well-being and needs given they could not visit NHs, they were, "Getting the staff's side of the information for the most part, what they write in the chart, and not really getting the Veteran's perspective" (Site A, 122).

#### *Adapting to Overseeing and Coordinating Care*

Participants shared positive, negative, and mixed feelings about changes to oversight and care coordination.

#### *Silver linings: VA staff received remote access to Veterans' CNH medical records facilitating improved communication*

Participants shared the most positive change during the pandemic was accessing Veterans' CNH electronic medical records (EMR) remotely, which allowed for continued care coordination and oversight. While not a replacement to laying eyes on Veterans, gaining remote access to CNH EMRs acted

as a welcome substitute. Accessing records allowed VA staff to provide health status updates to Veterans' family members. In addition, switching to remote oversight allowed VA staff more time to communicate with VA colleagues and CNH staff. One participant noted their colleagues were, "available all the time on their computers, so I think that that's really provided the opportunity to do a lot more and, and in some cases, quicker coordination because of the ability to communicate instantly through instant messaging" (Site C, 112). Another participant (Site B, 140) noted this made their VA team closer, allowing them to check in on CNH short-stay Veterans more regularly. This participant also noted CNH staff were more responsive to VA phone calls compared to pre-pandemic.

### *Challenges from lack of face-to-face interactions*

With monthly in-person visits stopped, VA staff checked in with fewer Veterans, some stating they checked in with less than 10% of their caseload, despite attempts to reach them repeatedly by phone. Many shared wanting to "turn back the clock to before COVID and get back into the building" because they disliked virtual case management and felt "removed from the Veterans" (Site D, 101). Another participant described that pre-pandemic they were "better able to assess their [CNH Veterans'] stress levels or their needs, all through verbal and facial interactions and...it is much harder to feel like I am really understanding what they are going through and what they need [during the pandemic]" (Site D, 102).

Some participants felt care was de-personalized and more administrative, and they were gathering "information for spreadsheets" (Site A, 122). One participant noted, "when you are there and you are walking around together seeing folks, it gives you opportunities to think of things that you need and I think it does make a closer collaboration on patient care" (Site A, 121). A participant from the same VA noted that lack of visiting CNHs had "taken a lot of the joy out of the work" and they missed "an important piece of how they are [Veterans] doing, and I know that the nursing staff is struggling, too...this does not feel like it is as good as it used to be" (Site A, 122).

*Telehealth: challenges and optimism.* While video and phone telehealth to CNHs increased, one participant described telehealth as in its infancy (Site C, 112), especially since VAMCs had high demand to begin or expand telehealth for many VA specialties during the pandemic. Other participants described how CNH Veterans' age and confusion using technology (Site B, 129), as well as lack of interest in video visits, proved challenging (Site D, 101). Several participants felt video visits added extra burden to already over-stretched CNH staff and they thus had reservations about relying on CNH staff to facilitate visits. However, at one VAMC, a participant noted optimism due to conducting virtual visits with CNH Veterans' primary care providers, and how that will improve access to care going forward (Site A, 122).

The VA provided iPads to CNHs in this case to conduct these visits.

### *Strengthening Working Relationships*

When asked how the pandemic affected relationships with CNHs, several participants shared they were strengthened due to support provided by VA staff. One VA staff member shared, "Nursing homes are seeing us more as partners, and I think before COVID, there was a lot more of seeing us as a referral source and as a payer source" (Site A, 121). Due to this change, the same participant believed CNHs were more likely to ask VA staff for assistance, and communicate needs, going forward.

VA staff supported CNH staff through instrumental, informational, and emotional support.

### *Instrumental support*

All participants described providing instrumental support to CNH staff by providing PPE to CNHs without adequate supplies. One participant mentioned conducting and processing COVID-19 tests for Veterans in the CNH because "early on, nursing homes here could not get tests" (Site A, 121). Another participant reported helping CNHs by increasing VA payment for Veterans' care: "We did alter the rates that we pay them [CNHs] to the higher rate while they had to put them in private rooms to protect them [Veterans] from the outbreak," (Site A, 122).

### *Informational support*

Several participants described providing CNH staff information about managing COVID-19. One participant recommended CNH staff "create a COVID unit ahead of time for COVID positive patients" and shared best practices for infection control (Site A, 121). Another participant shared information about where to obtain PPE from sources besides the VA (Site A, 123).

### *Emotional support*

A few participants described offering emotional support to CNH staff by showing compassion and providing "moral support [by] sending out emails... saying thank you for all of your [CNH staff] attention and concern to our community members" (Site B, 129). Another participant expressed empathy and understanding about challenges of caring for CNH residents during the pandemic by "having some compassion for the staff... [communicating] that you have an understanding of how difficult this is for them" (Site A, 121).

## **Discussion**

Our study highlighted how positive, pre-existing relationships between health systems and NHs can facilitate

adaptations to care coordination during crises, ultimately strengthening partnerships. Thanks to pre-pandemic relationships, VA staff provided tangible and emotional support to CNHs. As NHs rebound from the shock and devastation COVID-19 wielded, it is critical to consider the importance of such partnerships and the value of clear communication and collaboration when caring for NH residents. The partnerships described in our study, in which VA and CNH staff shared goals and information, had mutual respect, exercised improved communication, and solved problems related to caring for CNH Veterans during the pandemic, reflect care coordination literature. Specifically, these domains are central to relational coordination theory, in which high-quality communication supports effective care coordination (Bolton et al., 2021).

Recent studies echo our findings and underscore the importance of relationships between NHs and health systems during the pandemic (Archbald-Pannone et al., 2020; Kim et al., 2020). One study of an academic health system's post-acute care network shows that rapid dissemination of a COVID-19 response plan, and subsequent successful care coordination is facilitated by existing partnerships with NHs (Kim et al., 2020). Moreover, established partnerships between health systems and NH staff allow for timely provision of resources like PPE and information about infection control.

As partnerships proved critical in managing care for NH residents during the pandemic, our hope is that our findings that showed VA's ability to effectively partner with CNHs can inform how other healthcare systems collaborate with NHs (Unroe, 2021). One important change that facilitated care coordination and oversight during the pandemic in our study was CNHs providing remote EMR access to VA staff. This change, if sustained, has the potential to improve care coordination by allowing for a hybrid model of in-person visits and remote monitoring of the CNHs' EMRs by VA CNH staff, which will present itself in real time as in-person visits began again per a VA directive issued in November 2021 (VA Department of Veterans Affairs Memorandum, 2021). While VA staff often are granted remote access to the CNH medical record, CNH staff do not have similar access to the VA EMR. Accessing Veterans' VA records often involves an employee at a CNH to become a without compensation (WOC) federal employee, and that can take several months and often only allows for read-only access. Research shows that community providers continue to experience challenges accessing Veterans' VA records and integrating community records into the VA EMR (Haverhals 2018; Nevedal et al., 2019; Miller et al., 2021; Townsend & Kolchugina, 2006). If such partnerships can be improved between the VA and CNHs, this could also be extended to NHs providing information about residents to families in a timely and clear manner, especially during crises (Feder et al., 2021). Recent research suggests that communication is essential between NHs and families during the pandemic when loved ones were dying and focusing on clear communication between family caregivers

and NHs during future crises have been proposed (Hado & Friss Feinberg, 2020).

Finally, studies of NH staff's experiences during the pandemic report that staff are over-burdened and experiencing high levels of stress while managing staff shortages (White et al., 2021). Our findings also showed how VA CNH staff experienced stress and understaffing, but the strength of these partnerships facilitated collaboration with and support of CNHs by providing instrumental, informational, and emotional support, despite shifting roles on both sides.

Study limitations include sampling VA CNH staff from only four VAMCs and not gathering perspectives from CNH staff, which would contribute to a fuller picture of partnerships between CNH and VA staff. Additionally, our study did not interview Veterans living in CNHs, and interviewing them would have added important information on the care they received during the COVID-19 pandemic.

## Conclusion

We found that the established, prior relationships VA staff had with CNH staff acted as a solid foundation to continue to deliver quality oversight and care coordination to CNH Veterans during crises. Our description of how VA staff coordinated care with CNHs will act as a basis for future partnerships in understanding what CNH partners' value. Future research is necessary to assist in identifying the best tools to build effective relationships between health care systems and NHs and offer support beyond the COVID-19 pandemic.

## Declaration of conflicting interests

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