

Aiming for System Improvement While Transitioning to the New Normal

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As we transition out of the Omicron surge, the lessons we've learned from the prior surges carry forward and add to our knowledge foundation. Medical journals have published numerous research and perspectives manuscripts on all aspects of COVID-19 over the past 2 years, adding much-needed knowledge to our clinical practice during the pandemic. However, the story does not stop there, as the pandemic has impacted the usual, non-COVID-19 clinical care we provide. The value-based health care delivery model accounts for both COVID-19 clinical care and the usual care we provide our patients every day. Clinicians, administrators, and health care workers will need to know how to balance both worlds in the years to come.

In this issue of *JCOM*, the work of balancing the demands of COVID-19 care with those of system improvement continues. Two original research articles address the former, with Liesching et al¹ reporting data on improving clinical outcomes of patients with COVID-19 through acute care oxygen therapies, and Ali et al² explaining the impact of COVID-19 on STEMI care delivery models. Liesching et al's study showed that patients admitted for COVID-19 after the first surge were more likely to receive high-flow nasal cannula and had better outcomes, while Ali et al showed that patients with STEMI yet again experienced worse outcomes during the first wave.

On the system improvement front, Cusick et al³ report on a quality improvement (QI) project that addressed acute disease management of heparin-induced thrombocytopenia (HIT) during hospitalization, Sosa et al⁴ discuss efforts to improve comorbidity capture at their institution, and Uche et al⁵ present the results of a nonpharmacologic initiative to improve management of chronic pain among veterans. Cusick et al's QI project showed that a HIT testing strategy could be safely implemented through an evidence-based process to nudge resource utilization using specific management pathways. While capturing and measuring the complexity of diseases and comorbidities can be challenging, accurate capture is essential, as patient acuity has implications for reimbursement and quality comparisons for hospitals and physicians; Sosa et al describe a series of initiatives implemented at their institution that improved comorbidity capture. Furthermore, Uche et al report on a 10-week complementary and integrative health program for veterans with noncancer chronic pain that reduced pain intensity and improved quality

of life for its participants. These QI reports show that, though the health care landscape has changed over the past 2 years, the aim remains the same: to provide the best care for patients regardless of the diagnosis, location, or time.

Conducting QI projects during the COVID-19 pandemic has been difficult, especially in terms of implementing consistent processes and management pathways while contending with staff and supply shortages. The pandemic, however, has highlighted the importance of continuing QI efforts, specifically around infectious disease prevention and good clinical practices. Moreover, the recent continuous learning and implementation around COVID-19 patient care has been a significant achievement, as clinicians and administrators worked continuously to understand and improve processes, create a supporting culture, and redesign care delivery on the fly. The management of both COVID-19 care and our usual care QI efforts should incorporate the lessons learned from the pandemic and leverage system redesign for future steps. As we've seen, survival in COVID-19 improved dramatically since the beginning of the pandemic, as clinical trials became more adaptive and efficient and system upgrades like telemedicine and digital technologies in the public health response led to major advancements. The work to improve the care provided in the clinic and at the bedside will continue through one collective approach in the new normal.

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