Nursing Home ECHO
COVID-19 Action Network

Virginia Nursing Homes * VCU Department of Gerontology
VCU Division of Geriatric Medicine * Virginia Center on Aging

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Session 9

Interprofessional Team Management of COVID-19

Quality Improvement- Thinking About AIMS

CE/CME Disclosures and Statements

Disclosure of Financial Relationships:

The following planners, moderators or speakers have the following financial relationship(s) with commercial interests to disclose:
Christian Bergman, MD – none; Dan Bluestein, MD – none; Joanne Coleman, FNP-none; Laura Finch, GNP - none; Tara Rouse, MA, CPHQ, CPXP, BCPA – none; Sharon Sheets-none;

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Session Agenda

- Acknowledgements & Announcements
- Best Practices Briefing
- Case Presentation
  - Hub Team response and recommendations
  - Spoke Sites response and recommendations
  - Facilitator summarizes recommendations
- Quality Assurance and Performance Improvement Booster
- Community Forum - Sharing Successes, Challenges and Solutions
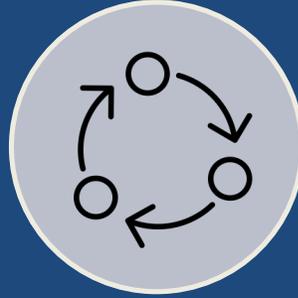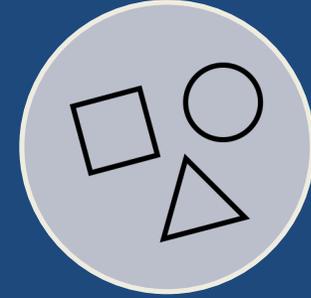
Icebreaker Breakout Discussion

Thinking back to your last NH outbreak, which of the following was the biggest challenge to management of COVID in your facility?

1. Availability/timeliness of lab services
2. Availability/Ability of staff to monitor for deterioration
3. Timely access to clinicians (MDS, NPs, PAs)
4. Conduct urgent Advance Care Planning
5. Prevent transmission to staff or other residents
6. Something else (specify)

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Session Learning Objectives

Best Practices Briefing:

By the end of the session, participants will identify:

1. Name nursing home challenges in preventing and treating COVID-19 outbreaks

2. Identify key aspects of preparation

3. Review navigating an outbreak – case study

4. Describe common clinical courses of nursing home residents with COVID-19

Quality Assurance-Performance Improvement:

By the end of the session, participants will:

1. Understand the importance of SMART Aims
2. Practice writing SMART Aims

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Interprofessional Team Management of COVID-19

Slides courtesy of:

AHRQ ECHO National Nursing Home COVID-19 Action Network

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National COVID-19 Impact on LTCF

- Nursing home residents are at high risk of getting COVID-19 and needing treatment and support.
- 80% of residents with COVID-19 will survive.
- About 15-20% of residents with COVID-19 will die. (100,000 deaths out of 500,000 cases; reminder 1.6 million LTCF residents in the US)
- Nationally, about 40% of deaths are nursing home residents.

VDH DATA as of 1/26/21

Dashboard Updated: 1/26/2021
Data entered by 5:00 PM the prior day.

Cases, Hospitalizations and Deaths

Total Cases*	Total Hospitalizations**	Total Deaths
483,326	**20,860**	**6,174**
(New Cases: 4,707)^		

Confirmed†	Probable†	Confirmed†	Probable†	Confirmed†	Probable†
389,259	94,067	19,996	864	5,442	732

* Includes both people with a positive test (Confirmed), and symptomatic with a known exposure to COVID-19 (Probable).
** Hospitalization of a case is captured at the time VDH performs case investigation. This underrepresents the total number of hospitalizations in Virginia.
^New cases represent the number of confirmed and probable cases reported to VDH in the past 24 hours.
† VDH adopted the updated CDC COVID-19 confirmed and probable surveillance case definitions on August 27, 2020. Found here: https://wwwn.cdc.gov/nndss/conditions/coronavirus-disease-2019-covid-19/case-definition/2020/08/05/

Outbreaks

Total Outbreaks*	Outbreak Associated Cases
2,249	**55,578**

* At least two (2) lab confirmed cases are required to classify an outbreak.

Testing (PCR Only)

Testing Encounters PCR Only*	Current 7-Day Positivity Rate PCR Only**
5,079,311	**12.5%**

* PCR" refers to "Reverse transcriptase polymerase chain reaction laboratory testing."
** Lab reports may not have been received yet. Percent positivity is not calculated for days with incomplete data.

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COVID -19 Outbreaks in Virginia as of 1/26/2021

All Health Districts Total Outbreaks	All Health Districts Outbreak Associated Cases	All Health Districts Cases in Healthcare Workers
2,249	55,578	21,311

Current Selection: All Health Districts

Number of Outbreaks by Facility Type

Long Term Care Facilities	844
Congregate Setting	780
Correctional Facility	136
Healthcare Setting	195
Child Care	117
College / University	59
K-12	118

Number of Outbreaks
- 8-15
- 16-25
- 26-35
- 36-45
- 46+

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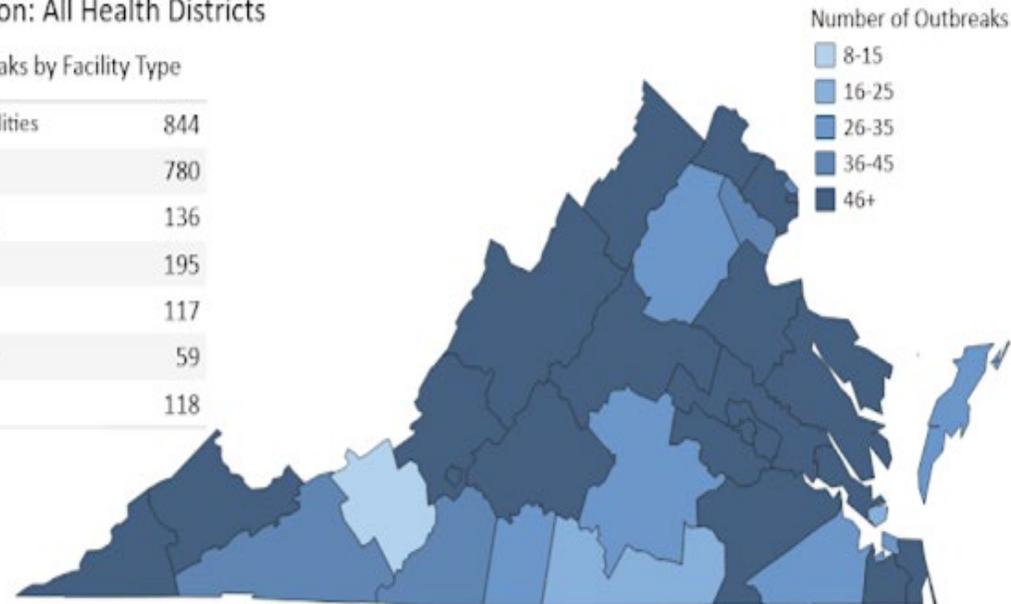
COVID 19 Data Outbreak as of 1/26/21
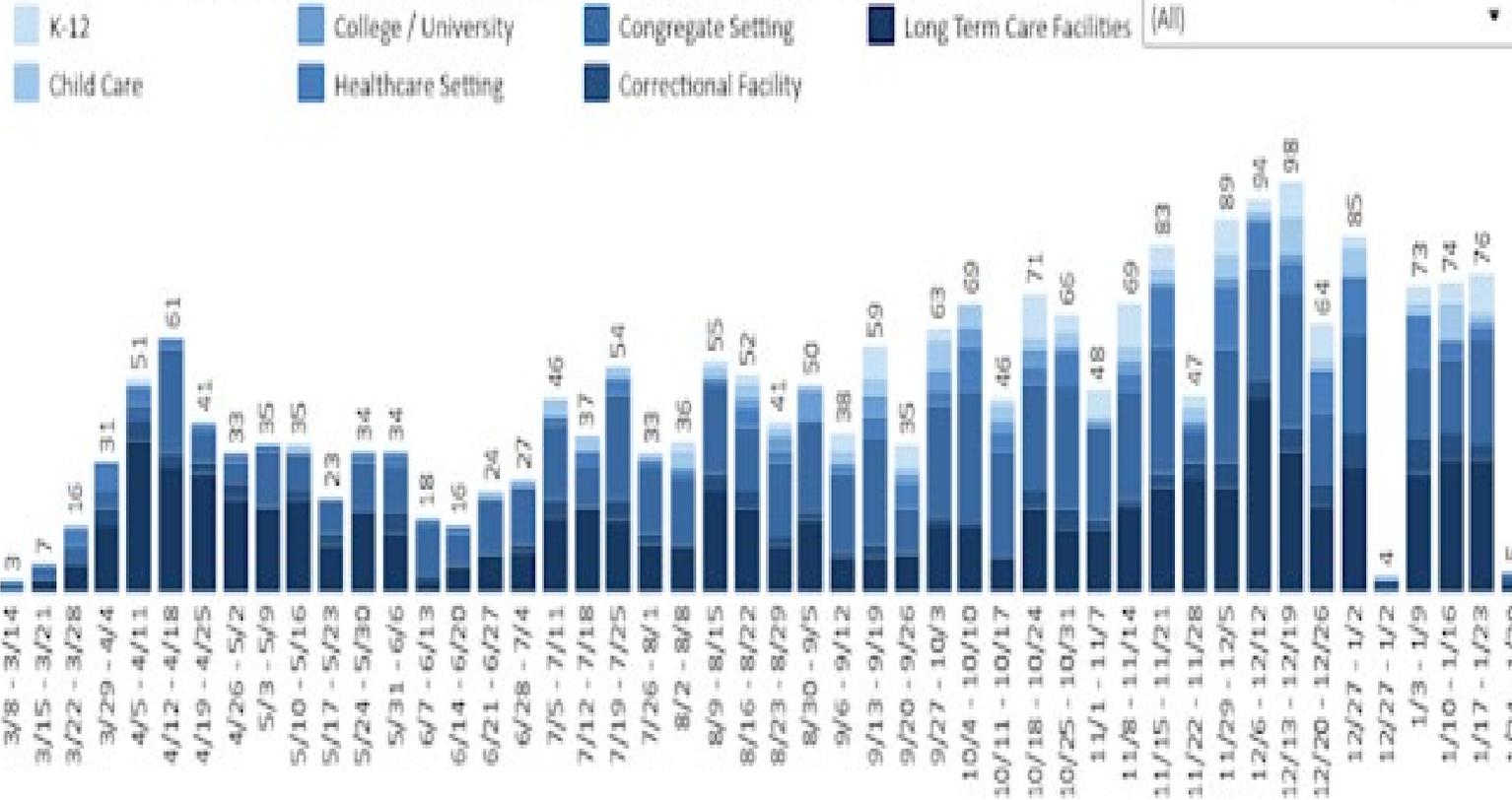
COVID-19 Vaccination Dashboard
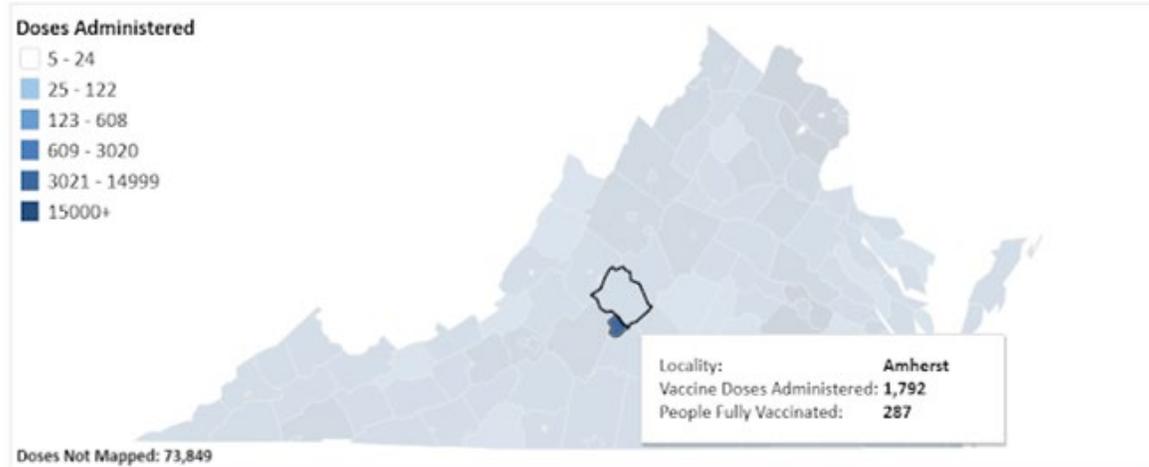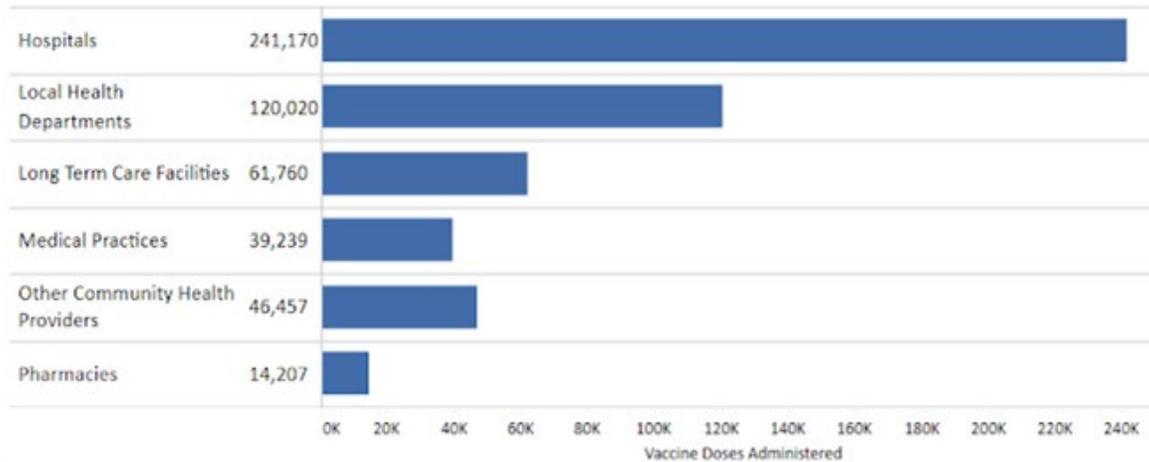
VDH COVID 19 Vaccination Summary as of 1/25/21

Vaccinating Virginia
CVS and Walgreens Data

Activation	# Facilities Assigned	Total # vaccines administered 1st and or 2nd dose	First Dose	Second dose	
12-28-20	195 CVS	39,733	done	43% complete	
12-28-20	92 Walgreens	11,270	done	Not available	

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Multiple Challenges

- PPE – supplies and training

- Off-site labs, time to receive COVID-19 results

- Access to providers – in person and role of telehealth

- Personal care requiring prolonged exposure

- Staffing

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JUST THE FACTS: WHAT CAUSED COVID-19 OUTBREAK IN NURSING HOMES

Location of a nursing home, asymptomatic spread and availability of testing – not quality ratings, infection citations or staffing – were determining factors in COVID-19 outbreaks according to independent analyses by leading academic and health care experts. A new study from Harvard University, with support from the National Institute on Aging and National Institutes of Health, examined COVID-19 outbreaks in New York, Detroit and Cleveland, and found that the intensity of COVID-19 outbreaks in nursing homes mirrored the rate of spread among the general population. These findings are consistent with research conducted by the American Health Care Association and National Center for Assisted Living (AHCA/NCAL), which examined recent data from the Centers for Medicare and Medicaid Services (CMS) on COVID-19 outbreaks in nursing homes.

KEY FINDINGS	HARVARD MEDICAL SCHOOL — DAVID GRABOWSKI, PHD, *Professor Of Health Care Policy*	BROWN Public Health — VINCENT MOR, PHD, *Professor, Health Services And Policy*	THE UNIVERSITY OF CHICAGO — R. TAMARA KONETZKA, PHD, *Professor Of Health Services Research*
LOCATION OF FACILITY DETERMINED OUTBREAKS	"According to preliminary research presented, larger facilities located in urban areas with large populations, particularly in counties with a higher prevalence of COVID-19 cases, were more likely to have reported cases." [1]	Mor: "If you're in an environment where there are a lot of people in the community who have COVID, the patients in the building are more likely to have COVID." [1]	"Outbreaks of COVID-19 in nursing homes are often a signal of the communities into which the virus is spreading." [4]
ASYMPTOMIC SPREAD AND AVAILABILITY OF TESTING WAS A KEY FACTOR	Grabowski: "It is spreading via asymptomatic and pre-symptomatic cases…We're not going to get a handle on COVID-19 until we get a systematic testing and surveillance system." [1]	"COVID-19's ability to hide in plain sight will continue to crush expectations of halting its spread unless more and quicker testing at nursing homes sweeps the country, said a top U.S. researcher (Mor)." [3]	"Given asymptomatic spread and inadequate testing, staff often do not know which residents are infected. With policymakers and the public initially focused on the spread of infection within hospital settings, nursing homes often lost that competition." [4]
QUALITY RATING OF FACILITY AND PREVIOUS CITATIONS WERE NOT A FACTOR IN OUTBREAKS	"COVID-19 cases in nursing homes are related to facility location and size and not traditional quality metrics such as star rating and prior infection control citations." [2]	"He (Mor) added that counter to some assertions, regression analyses show that infection rates are unrelated to quality rankings…" [3]	"We found no meaningful relationship between nursing home quality and the probability of at least one COVID-19 case or death…Indeed, the first death reported was from a nursing home in Washington State that had a 5-star rating." [4] Senator Susan Collins: "Testing should be conducted at all nursing homes, as Dr. Konetzka's research finds no correlation between CMS' quality ratings of nursing homes and the probability of at least one COVID-19 case. One of the worst outbreaks in Maine was at a nursing home that had five stars, the highest rating."[5]
NO SIGNIFICANT DIFFERENCE BETWEEN FOR- OR NOT-FOR-PROFITS IN THE CHANCE OF AN OUTBREAK	"Characteristics that were not associated with a facility having a COVID case included… whether it was for-profit, part of a chain... These factors had no correlation with whether the facility had cases of COVID-19." [1]	N/A	"We found no significant differences in the probability of COVID-19 cases by profit status, with for-profit nursing homes and not-for-profit nursing homes being equally likely to have cases." [4]

[1] *Provider Magazine*, 5/11/20
[2] "Characteristics Of U.S. Nursing Homes With COVID -19 Cases," 6/2/20

[1] *Provider Magazine*, 5/11/20
[3] *McKnight's Long Term Care News*, 5/11/20

[4] *Testimony* To United States Senate Special Committee On Aging, 5/21/20
[5] *Op-ed*, Senator Susan Collins, The Portland Press Herald, 6/15/20

Team Management of COVID-19

- Who is doing what?
- Think about:
  - Team Leader
  - Communication (with families and shift work-handoff)
  - Clinical protocols
  - Severity of Illness (what should I be looking for in disease progression?)

NIH COVID-19 Illness Categories

- Asymptomatic or Presymptomatic Infection
  - Individuals who test positive for SARS-CoV-2 by virologic testing using a molecular diagnostic (e.g., polymerase chain reaction) or antigen test, but have no symptoms.
- Mild Illness:
  - Individuals who have any of the various signs and symptoms of COVID 19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.
- Moderate Illness:
  - Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) ≥94% on room air at sea level.
- Severe Illness:
  - Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level, ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
- Critical Illness:
  - Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Team management of COVID-19: General

- Encourage hydration
- Baseline labs: CBC, CMP (no routine indication for ESR, CRP, coagulation studies, or ferritin)
- Baseline imaging: chest x-ray
- Check vitals (T,HR,BP,RR,O2sat) every 4 hours for first 48 hours, then every 8 hours for day 3-7 days, followed by every shift for 7 days
- Frequent repositioning, early ambulation when possible
- Early Goals of Care conversations with family (focus on what to do if clinical deterioration, ie when to hospitalize? Prior advance care wishes? Code Status? Visitor guidance?)

Team management of COVID-19: Medication

- Severity of disease determined by NIH criteria, see above
- Discontinue NSAIDs, nebulized treatments
- Use antipyretics
- Do not discontinue statin therapy
- Do not stop ACE/ARB unless hypotension
- Symptomatic medications: cough medications
- Reduce burden of non-essential medications, ie consider 14 day hold (vitamins, etc.)
- Consider IV fluids for acute kidney injury
- Consider respiratory oral antibiotics for clinical evidence of superimposed bacterial pneumonia
- Other medications that may be indicated pending on availability:
  - Monoclonal antibody therapy (Regeneron, Eli Lily), convalescent plasma, Remdesivir and other anti-virals
- Medications not routinely recommended:
  - Azithromycin, hydroxychloroquine, ivermectin

Disease Severity based on NIH	Vitamin C/zinc (optional)	Dexamethasone**	Anticoagulation	Monoclonal Antibody
Negative but in NH outbreak	1000 mg / 100 mg daily	Not indicated	Not indicated	Not Indicated
Asymptomatic (no sxs)	1000 mg / 100 mg daily	Not indicated	Not indicated	Indicated
Mild (no resp sxs)	1000 mg / 100 mg daily	Not indicated	Not indicated	Indicated
Moderate* (resp sxs, O2>94 on RA)	1000 mg / 100 mg daily	Consider use	VTE ppx (SQH or lovenox)	Indicated
Severe* (resp sx, O2<94 or RR >30)	1000 mg / 100 mg daily	Dexamethasone 6 mg daily for 10 days	VTE treatment dose (lovenox or OAC)	Not indicated
Critical*	1000 mg / 100 mg daily	Dexamethasone 6 mg daily for 10 days	VTE treatment dose (lovenox or OAC)	Not indicated

* Transfer if rapid progression of disease symptoms with respiratory symptoms (moderate severity) or with severe/critical disease.

** dexamethasone 6 mg PO/IV = 32 mg methylprednisolone = 40 mg prednisone

When to Hospitalize

- Confirmed goals of care are consistent with hospitalization
- Vitals become unstable despite interventions
- Urgent need for diagnostics and therapeutic

Safe Transitions

- Safe Transitions
- WARM hand-off – provider to provider conversation
- Communicate COVID-19 concern clearly
- POLST(physician orders for life sustaining treatment), code status communication
- Family contact information clear
- Place mask on patient
- Nursing facility notifies EMS of COVID-19 +/exposure

Key points

- Multiple challenges inherent in the nursing home setting which we must navigate
- Advance care planning is a skill and is critical before and during an outbreak
- Infection control practices are necessary and require significant vigilance and effort over time
- Even if you do the right things, outbreaks can occur and require a plan for managing staff and residents and transitions of care
- Nursing home residents may experience a variety of clinical courses with COVID-19

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SBAR

S: Staff members are very stressed.

B: Garden Nursing Home has 80 long term care residents and 10 post-acute care residents. During the peak of the pandemic in their county, community COVID-19 transmission rates rose to 11%. Over a few months, there were 24 positive COVID cases and 17 deaths at the center. Many of those residents had lived there for more than a year and staff were 'like family' to them. Since family/care partner visits had been severely limited, staff often provided palliative, end-of-life care and support with residents. Many staff have expressed sadness, anxiety, and high rates of stress due to the loss of their residents.

A: We found that staff have experienced high rates of stress as a result of losing multiple residents in a short period of time.

R: Leaders, supervisors, and owners need to do more to support staff by creating a quiet room for staff, food and supplies for staff in need, referrals to mental health providers, team huddles, what else do you recommend?

Let's Poll It Up!

Leave in Action: Reflections

In the past week, did you…

- Identify or create opportunities to hear from your community regarding vaccines?

- Use "Ask-Tell-Ask" or other Motivational Interviewing Techniques to address hesitancy?

- Identify at least one potential innovator?

- Invite innovators to help lead the charge re: vaccinations?

Tell Us!
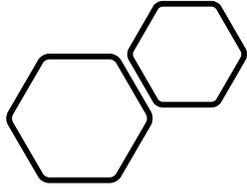
What do you want by the end of March?

"Every system is perfectly designed to get the results it gets."

- Paul Batalden

Quality Improvement

The Model for Improvement

What are we trying to accomplish?

How will we know a change is an improvement?

What changes can we make that will result in improvement?

Act | Plan

Study | Do

The Improvement Guide, API, 2009
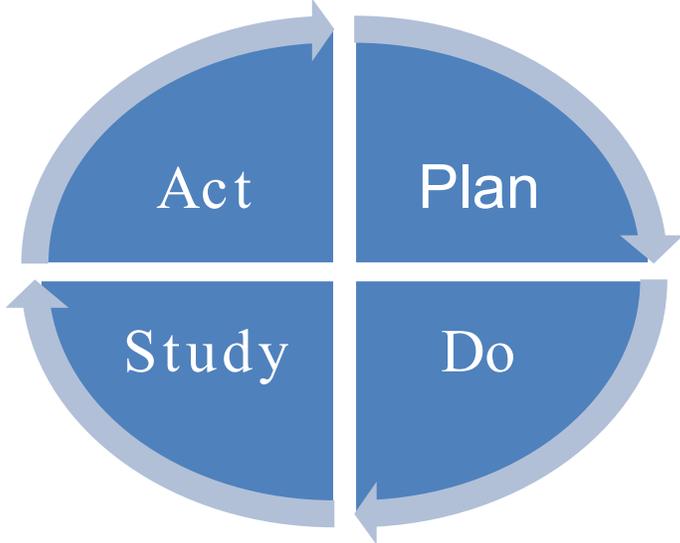
What are we trying to accomplish?

SMART AIM
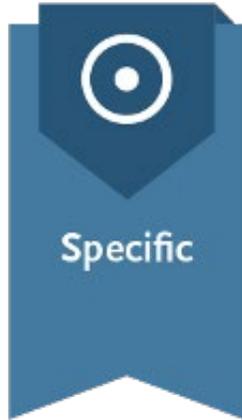
S	**M**	**A**	**R**	**T**
Specific	Measurable	Attainable	Relevant	Time Based
What exactly is it you want to achieve?	How can you measure and track the progress of the goal?	Is it actually attainable in the given time frame?	Is it something that you really want to do? Will it directly benefit you?	When do you want to achieve this goal by?
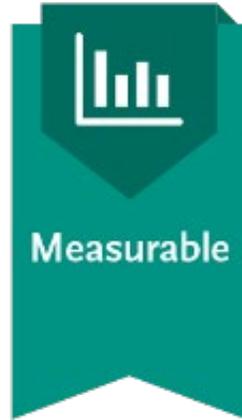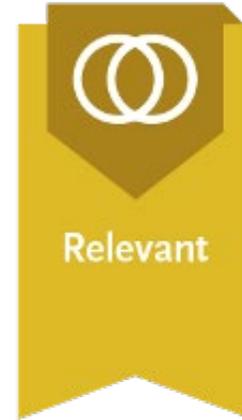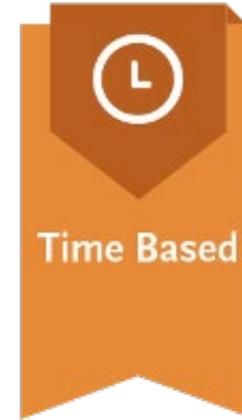
A Template for Writing a SMART Aim Statement

What?	
For whom?	
By when?	
How much?	
Full Statement	

What?	
For whom?	
By when?	
How much?	
Full Statement	

A Template for Writing a SMART Aim Statement

What?	
For whom?	
By when?	
How much?	
Full Statement	

What?	Improved use of well-being huddles
For whom?	
By when?	
How much?	
Full Statement	

A Template for Writing a SMART Aim Statement

What?	
For whom?	
By when?	
How much?	
Full Statement	

What?	Improved use of well-being huddles
For whom?	All full time and part time staff at our facility
By when?	
How much?	
Full Statement	

A Template for Writing a SMART Aim Statement

What?	
For whom?	
By when?	
How much?	
Full Statement	

What?	Improved use of well-being huddles
For whom?	All full time and part time staff at our facility
By when?	March 15, 2021
How much?	
Full Statement	

A Template for Writing a SMART Aim Statement

What?	
For whom?	
By when?	
How much?	
Full Statement	

What?	Improved use of well-being huddles
For whom?	All full time and part time staff at our facility
By when?	March 15, 2021
How much?	• At least 5 well-being huddles will be offered per week
Full Statement	

A Template for Writing a SMART Aim Statement

What?	
For whom?	
By when?	
How much?	
Full Statement	

What?	Improved use of well-being huddles
For whom?	All full time and part time staff at our facility
By when?	March 15, 2021
How much?	• At least 5 well-being huddles will be offered per week • 80% of staff will attend well-being huddles at least once per week
Full Statement	

A Template for Writing a SMART Aim Statement

What?	
For whom?	
By when?	
How much?	
Full Statement	

What?	Improved use of well-being huddles
For whom?	All full time and part time staff at our facility
By when?	March 15, 2021
How much?	• At least 5 well-being huddles will be offered per week • 80% of staff will attend well-being huddles at least once per week
Full Statement	By March 15, 2021, we will improve the use of well-being huddles for all full time and part time staff in our facility by offering at least 5 well-being huddles weekly, ensuring that 80% of all staff attend at least one per week.

Let's Try It Together!

What do you want to accomplish?

For whom?

By when?

How much?

Leave in Action

- Create a SMART Aim Statement for some aspect of your COVID efforts

- Don't forget to address:
  - WHAT you want to do
  - FOR WHOM do you want to do it
  - By WHEN
  - By HOW MUCH

Unless **SOMEONE LIKE** **YOU CARES** a whole awful lot, nothing is **GOING** to get **BETTER** **IT'S NOT.**

-Dr. Seuss-

Honoring the Work

Accordius Health of Waverly – Halloween Carnival

Break slide

NEXT UP – WRAP UP & NEXT STEPS

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Announcements

Next Week: Advance Care Planning

CE Activity Code

Within 7 days of this meeting, **text the attendance code to (804) 625-4041.**

Questions? email ceinfo@vcuhealth.org

Attendance

Because attendance rewards and CE credit are dependent upon your ECHO attendance, contact us at nursinghome-echo@vcu.edu if you have a conflict.

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Break slide

RESOURCES

Resources

https://www.vcuhealth.org/NursingHomeEcho Jan. 2021