Nursing Home ECHO

COVID-19 Action Network

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

For educational and quality improvement purposes, we will be recording this video-session. By participating in this ECHO session you are consenting to be recorded. If you have questions or concerns, please email, nursinghome-echo@vcu.edu.

Project ECHO® collects registration, participation, questions/answers, chat comments, and poll responses for some teleECHO® programs. Your individual data will be kept confidential. These data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to inform new initiatives

Agency for Healthcare Research and Quality

Institute for Healthcare Improvement

Session 11

Promoting Safe Care Transitions During COVID-19:
Admissions, Discharges, & Transfers

Quality Improvement:
Moving to Action

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;

Accreditation Statement:

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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

ECHO is All Teach, All Learn

Session 11 Learning Objectives

Best Practices Briefing:

By the end of the session, participants will identify:

1. Describe safe nursing home admission process during COVID-19
2. Describe safe nursing home discharge process during COVID-19
3. Identify models that support reducing avoidable facility transfers

Quality Assurance-Performance Improvement:

By the end of the session, participants will:

1. Share successes & challenges
2. Identify 1 or more ideas to try
3. Plan for trying a new idea

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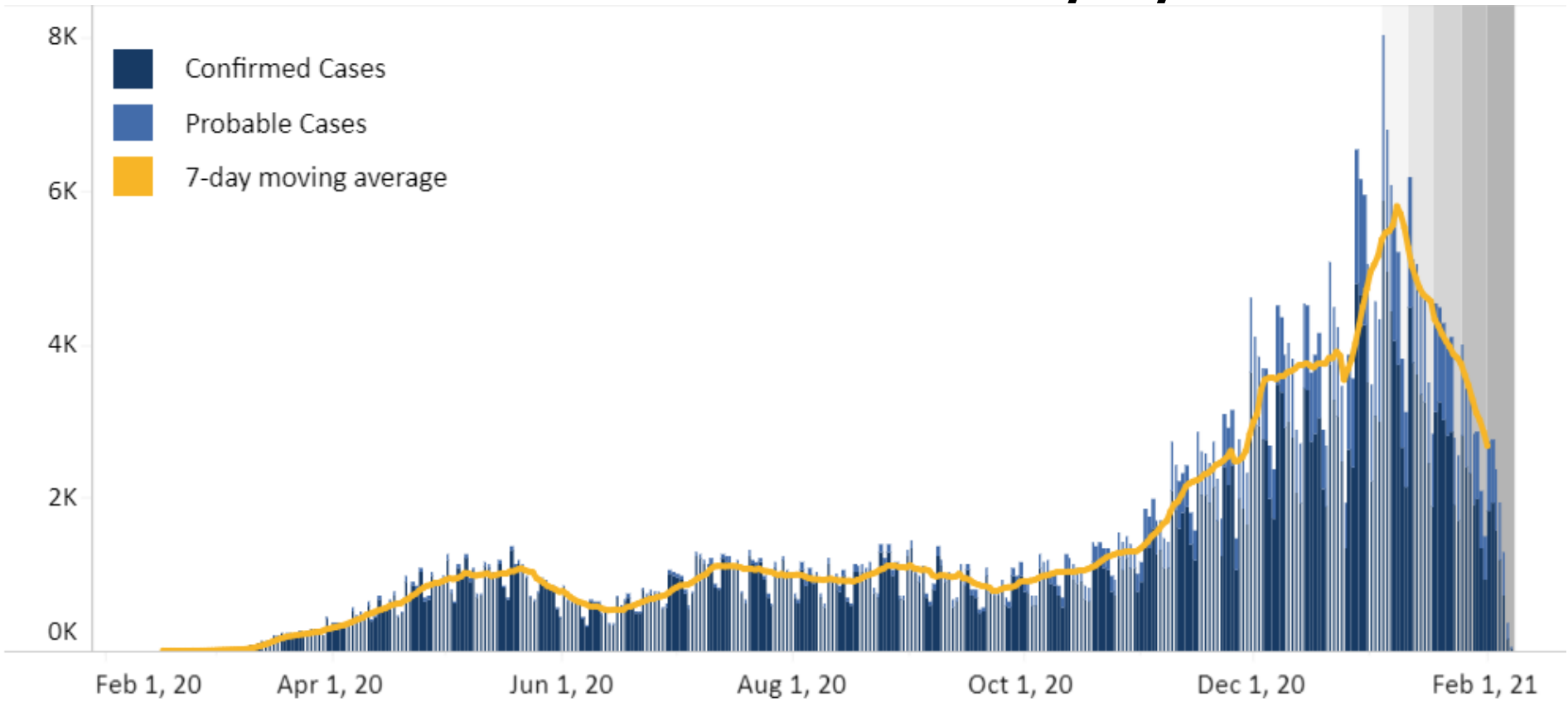
COVID 19 Incidence 2/8/21



* 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 Virgir
† 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/
Source: Cases - Virginia Electronic Disease Surveillance System (VEDSS), data entered by 5:00 PM the prior day.

7-day moving average
https://www.vdh.virginia.gov/coronavirus/coronavirus/covid-19-in-virginia-cases/

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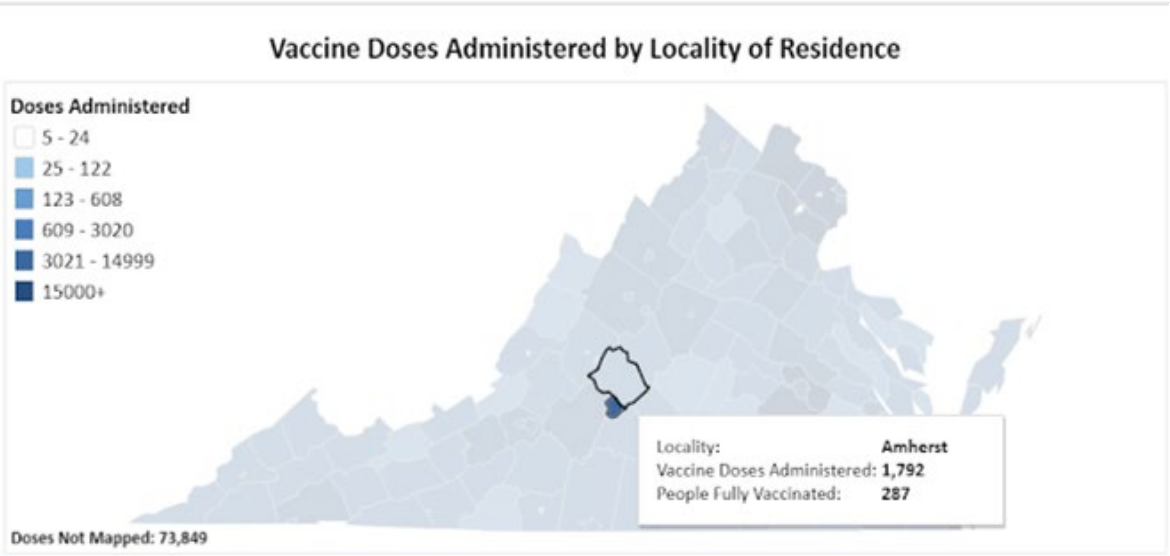
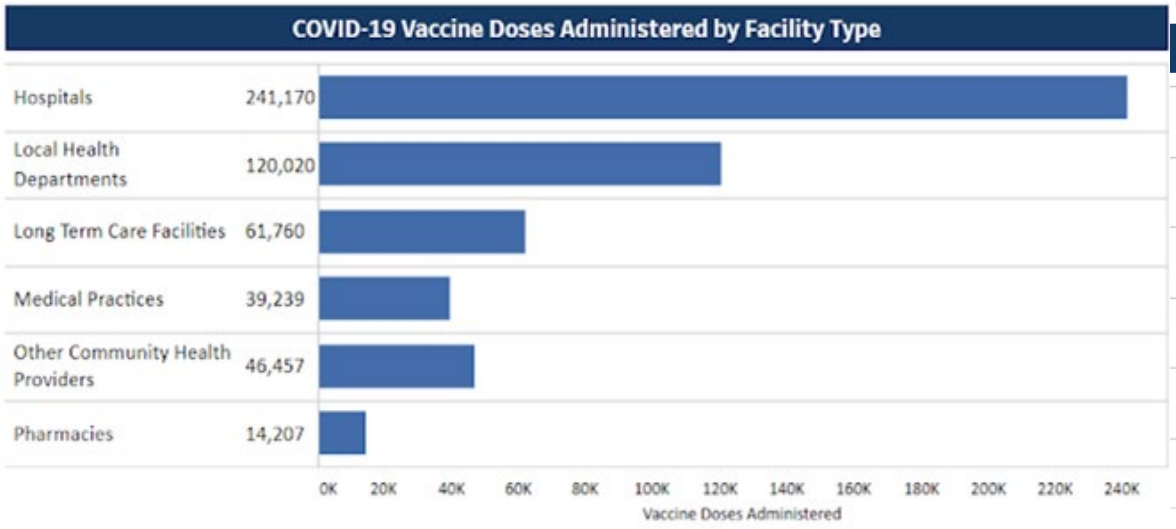
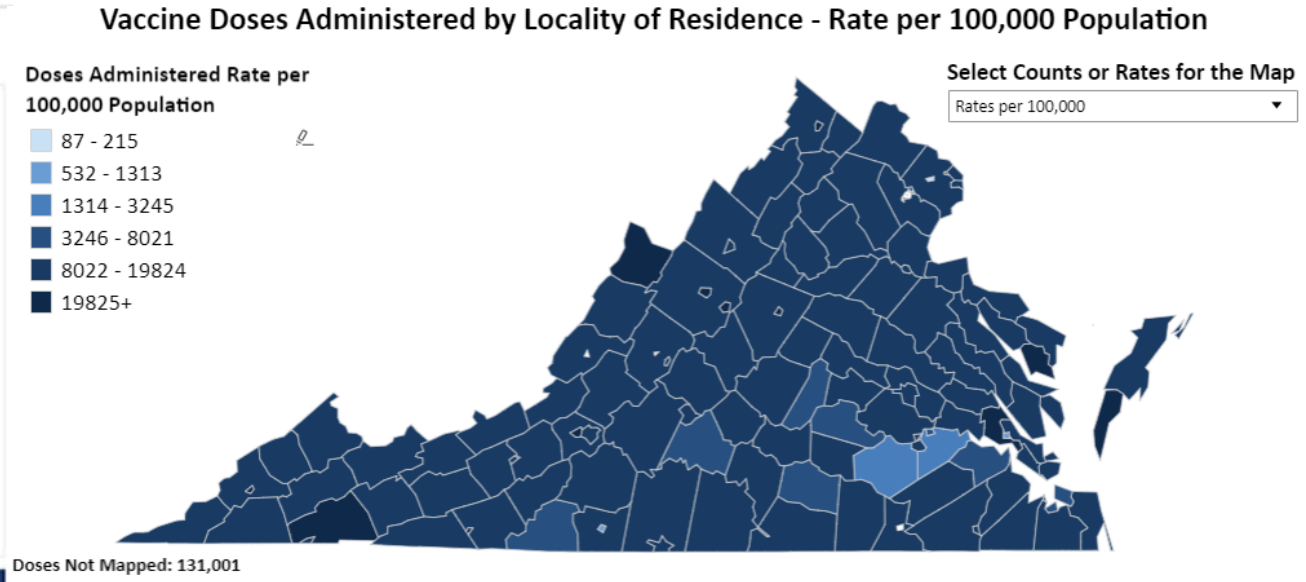
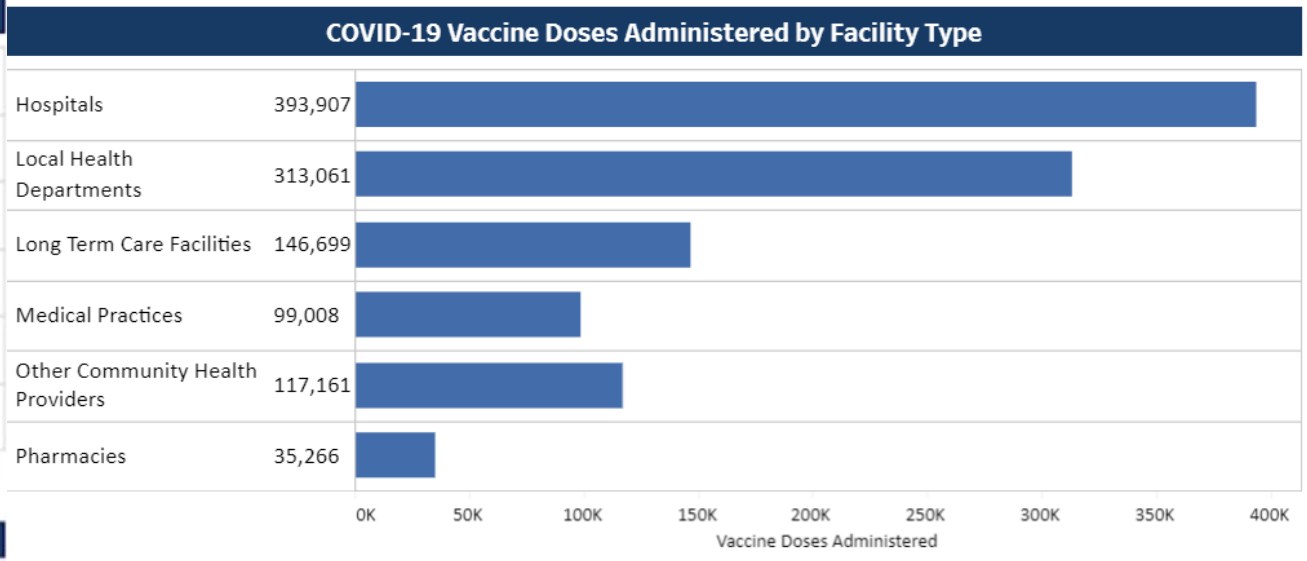
COVID-19 Vaccination Dashboard 1/26 vs 2/8









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Vaccinating Virginia

CVS and Walgreens Data (as of 2/8/21)

Activation	# Facilities Assigned	Total # vaccines administered 1st and or 2nd dose	First Dose	Second dose	
12-28-20	195 CVS	64,981	done	96% complete	
12-28-20	91 Walgreens	25,347	done	78% complete	

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Promoting Safe Care Transitions:

Admissions, Discharges & Transfers

Slides courtesy of Ellen Flaherty, Ph.D, APRN, AGSF
Director, Dartmouth Centers for Health & Aging

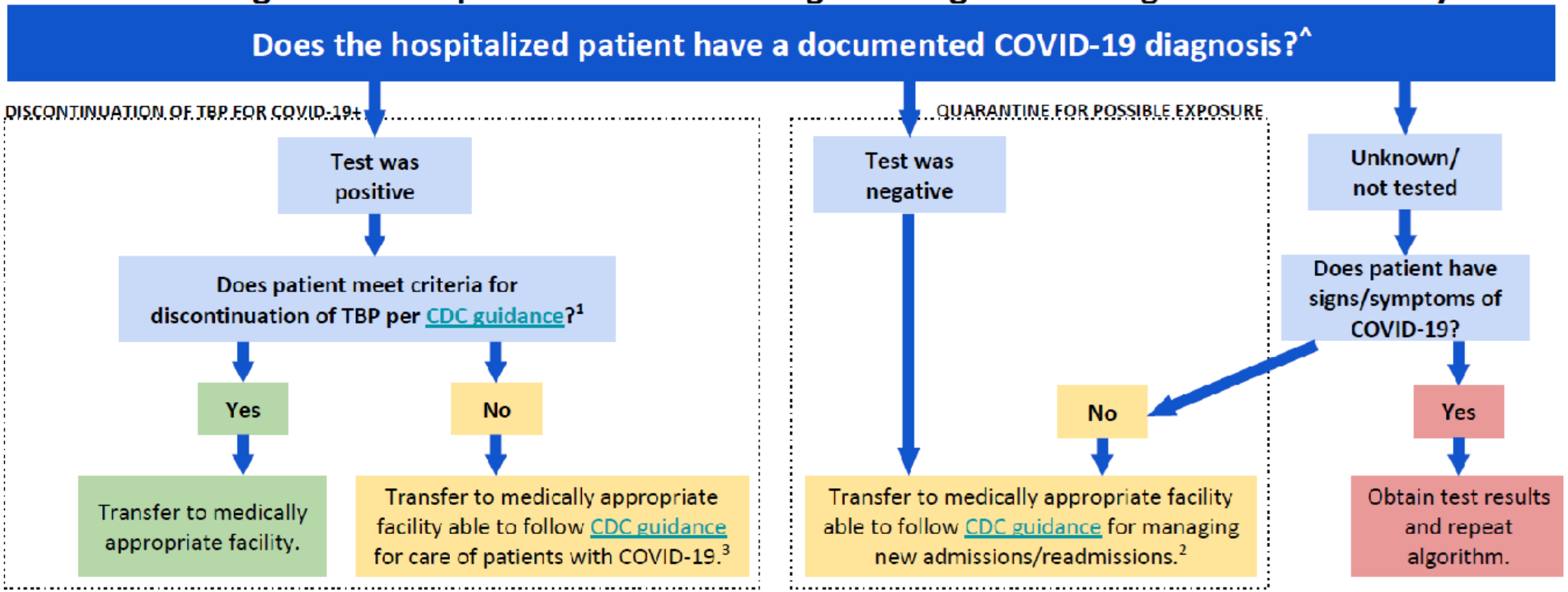
Pre-Admissions & Readmissions

Screening (to determine cohort)

Clinical Indicators/Symptoms: Fever of 99F or >, cough, runny nose, sore throat, nasal congestion, aches, shortness of breath, tachycardia, hypoxia (O2 saturation<94%), new onset of confusion, new onset of GI issues and general malaise

History of Exposure: Has the resident come in contact with a person with confirmed COVID-19 in the past 14 days?

Flow Diagram for Hospitalized Patients Being Discharged to a Long-Term Care Facility*



Discharge should be based on clinical status and the ability of an accepting facility to meet care needs and adhere to infection prevention and control practices.

1. Meeting criteria for discontinuation of **transmission-based precautions (TBP)** is not a prerequisite for discharge; CDC guidance on discontinuation of TBP for COVID-19 positive patients in healthcare settings is available here.
2. The ability to detect transmission is limited during the incubation phase; negative test results (any number) do not rule out COVID-19, and patients should still be placed on 14-days of TBP in a separate observation area or single-person room when transferred to long-term care. Testing is not required prior to transfer.
3. Discuss with facility to determine if patients who require aerosolizing procedures, e.g. nebulizer treatment, are appropriate for transfer.

*Nursing homes are licensed by the Virginia Department of Health, Office of Licensure and Certification. Assisted living facilities are licensed by the Virginia Department of Social Services. Consider discussing transfer concerns with licensing entity. ^Diagnosis should be via FDA-authorized direct viral assay to detect SARS-CoV-2.

Virginia Department of Health **8/24/2020**

https://www.vdh.virginia.gov/content/uploads/sites/182/2020/08/VDHTransferGuidance_8.24.2020.pdf

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Criteria to DC Transmission based precautions (per CDC)

A test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in prolonged isolation of patients who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

Symptom-Based Strategy for Discontinuing Transmission-Based Precautions.

Patients with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Note: For patients who are **not severely immunocompromised**[1] and who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.

Patients with severe to critical illness or who are severely immunocompromised[1]*:*

- At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- Consider consultation with infection control experts

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Cohorting Admissions & Readmissions (Post Screening)

Hospital Based Screening

1. Positive COVID test → COVID unit

1. No COVID Indicators (test negative, no symptoms) → Observation Unit (warm/yellow zone)

Observation Unit

- Private rooms if available (cohort based on exposure & risk)
- Dedicated Staff required to use “full COVID” PPE; no extended use PPE
- 14 days isolation
- No test requirement in asymptomatic individuals before transfer out of warm zone.

COVID Unit

- Private rooms if available (cohort based on exposure & risk)
- Dedicated Staff required to use “full COVID” PPE
- Can have extended use PPE in hallway within COVID unit
- Ok to transfer out once discontinuation criteria for transmission based precautions have been met (10-20 days), no test requirement, symptoms must have improved and remain afebrile.

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Personal Protective Equipment (PPE) and COVID-19 in LTCF

Indications for PPE when NO COVID-19 Outbreak (Standard Precautions)	Hand Hygiene	Facemask	Gloves	Gown	Eye Protection	Fit-tested Respirator
All residents, all the time	X	X				
Within resident room or care area	X	X	X			
High contact activity	X	X	X	X	X	
Splash/spray possible	X	X	X	X	X	
Aerosol-generating procedure[1]	X	X	X	X	X	X[2]
Indications for PPE During COVID-19 Outbreak	**Hand Hygiene**	**Facemask**	**Gloves**	**Gown**	**Eye Protection**	**Fit-tested Respirator**
All residents, all the time[3] on Cold, Warm, and Hot Units/Areas	X	X	X	X	X	X[2]
Cold Unit/Area	Designated unit/area for **current, healthy, asymptomatic residents**.					
Warm Unit/Area	Designated unit/area for managing **new admissions and readmissions** whose COVID-19 status is unknown, **symptomatic residents who tested negative for COVID-19,** and **residents/roommates who may have been exposed** to someone with COVID-19.					
Hot Unit/Area	Designated unit/area for care of residents with **confirmed COVID-19** (those who test positive), who have not met criteria for discontinuation of transmission-based precautions.					

https://www.vdh.virginia.gov/content/uploads/sites/182/2020/12/PPE-Chart.pdf

12-20-2020

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Discharges from Facility

- 2 types of discharges
  - Back to community
  - Back to hospital
- Usual discharge instructions with explicit COVID infection and immunization status
- Any re-admission would require 14 day Observation Unit stay regardless of the length of time since discharge

Prior to COVID-19, Remember Key Steps for Successful Discharge Planning

1. Ascertain need for and obtain language assistance.
2. Make appointments for followup care (e.g., medical appointments, postdischarge tests/labs).
3. Plan for the followup of results from tests or labs that are pending at discharge.
4. Organize postdischarge outpatient services and medical equipment.
5. Identify the correct medicines and a plan for the patient to obtain them.
6. Reconcile the discharge plan with national guidelines.
7. Teach a written discharge plan the patient can understand.
8. Educate the patient about his or her diagnosis and medicines.
9. Review with the patient what to do if a problem arises.
10. Assess the degree of the patient's understanding of the discharge plan.
11. Expedite transmission of the discharge summary to clinicians accepting care of the patient.
12. Provide telephone reinforcement of the discharge plan.

From ProjectRED; orange highlights esp. pertinent to LTC DC Planning

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Transfers

Key Elements of Safe Transfers

- Remember Advance Care Planning and Goals of Care
- Interprofessional (nursing, medicine, patient & family or surrogate) communication is essential
- Warm hand-off
- Transfer documentation that includes COVID-19 history and vaccination status

Reducing Nursing Home Transfers

- BOOST (Hospital Based)
- ProjectRED (Hospital Based)
- INTERACT (Nursing Home Based)
- OPTIMISTIC (Nursing Home Based)
- RAFT (Nursing Home Based)

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INTERACT (Nursing Home Based)

INTERACT® (Interventions to Reduce Acute Care Transfers)

Quality improvement program that focuses on:

- Management of acute change in resident condition
- Uses clinical and educational tools and strategies

Tools and guidance available at:

https://pathway-interact.com/

What are the INTERACT® Tools?

There are four basic types of tools:

1. Quality Improvement tools
2. Communication tools
3. Decision Support tools
4. Advance Care Planning tools

The specific tools are designed for use by selected members of the care team. However, in order for the INTERACT® team to be successful, all members of the care team should be aware of all of the tools and their uses. The INTERACT® project champion will assist your team in using the tools on a daily basis. The tools have been designed to help staff improve care, but not increase unnecessary paperwork. **To view and download, go to INTERACT® Tools >**

OPTIMISTIC (Nursing Home Based)

OPTIMISTIC (Optimizing Patient Transfers, Impacting Medical Quality and Improving Symptoms: Transforming Institutional Care)

- Ongoing CMS project focusing on avoiding unnecessary hospitalizations
- Project staff are embedded into each facility to extend clinical resources by mentoring nursing staff, implementing evidence-based tools to improve care and communication, and leading efforts in advance care planning

https://www.optimistic-care.org/

Access to RN & NP
Closed to enrollment
May hear more about in future

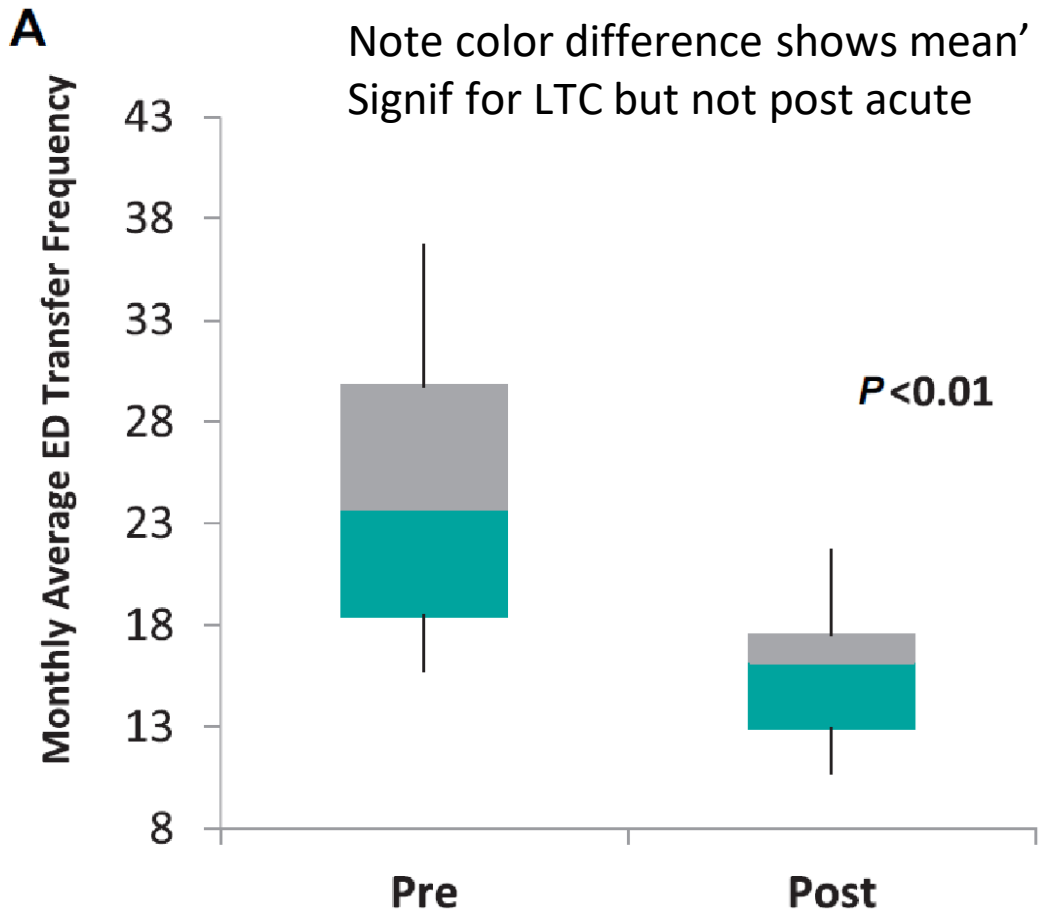
RAFT (Nursing Home Based)

RAFT (Reducing Avoidable Facility Transfers)

Quality Improvement model focusing on:

- Eliciting goals of care pre-acute event (“What Matters Most”)
- Acute event management by trained on-call clinicians
- Post transfer debrief

https://www.jamda.com/article/S1525-8610(19)30297-X/fulltext



SBAR

SBAR-Transitions

Situation:

New admission from the hospital.

Background:

65 year old male without prior medical history who tested positive for COVID-19 with PCR 21 days ago and was treated in the hospital for pneumonia. He is sent to your facility for rehabilitation for his weakness and muscle atrophy after being bedridden for 2 weeks. He has no difficulty breathing. VS- T 98, BP 130/70. HR 72, O2 sat 97% on room air. His PCR test yesterday came back negative.

SBAR, continued

Assessment:

- Patient was admitted to the green/cold zone overnight.
- Should have been admitted to observation unit (yellow/warm zone).
- What should we do?

Recommendation:

Who will make the decision on which unit this patient is admitted to?

Who is on your “admission team during the pandemic”?

What if any is your protocol for determining which unit to admit this patient to?

Let’s Poll It Up!

Leave in Action - Reflections

- 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

Thinking About Measurement

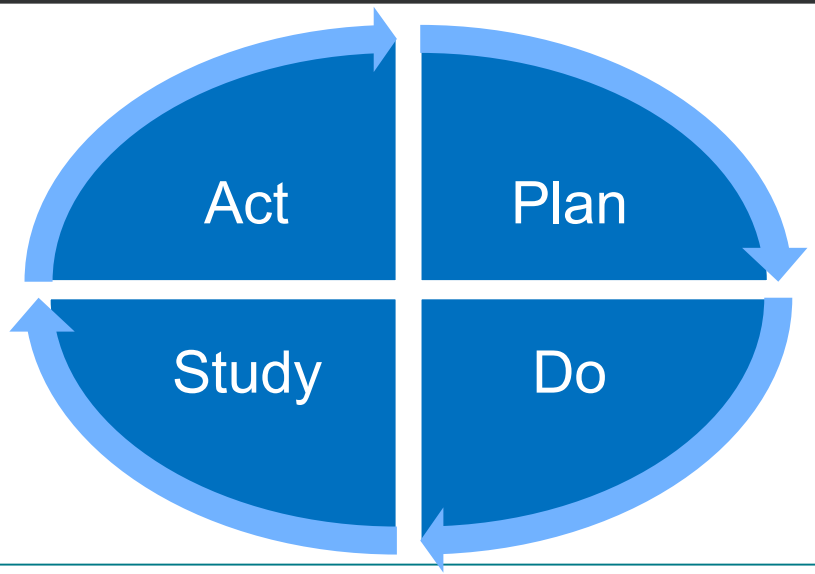
What is something you measure on a regular basis?

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?



The Improvement Guide, API, 2009

Measurement

Types of Measures

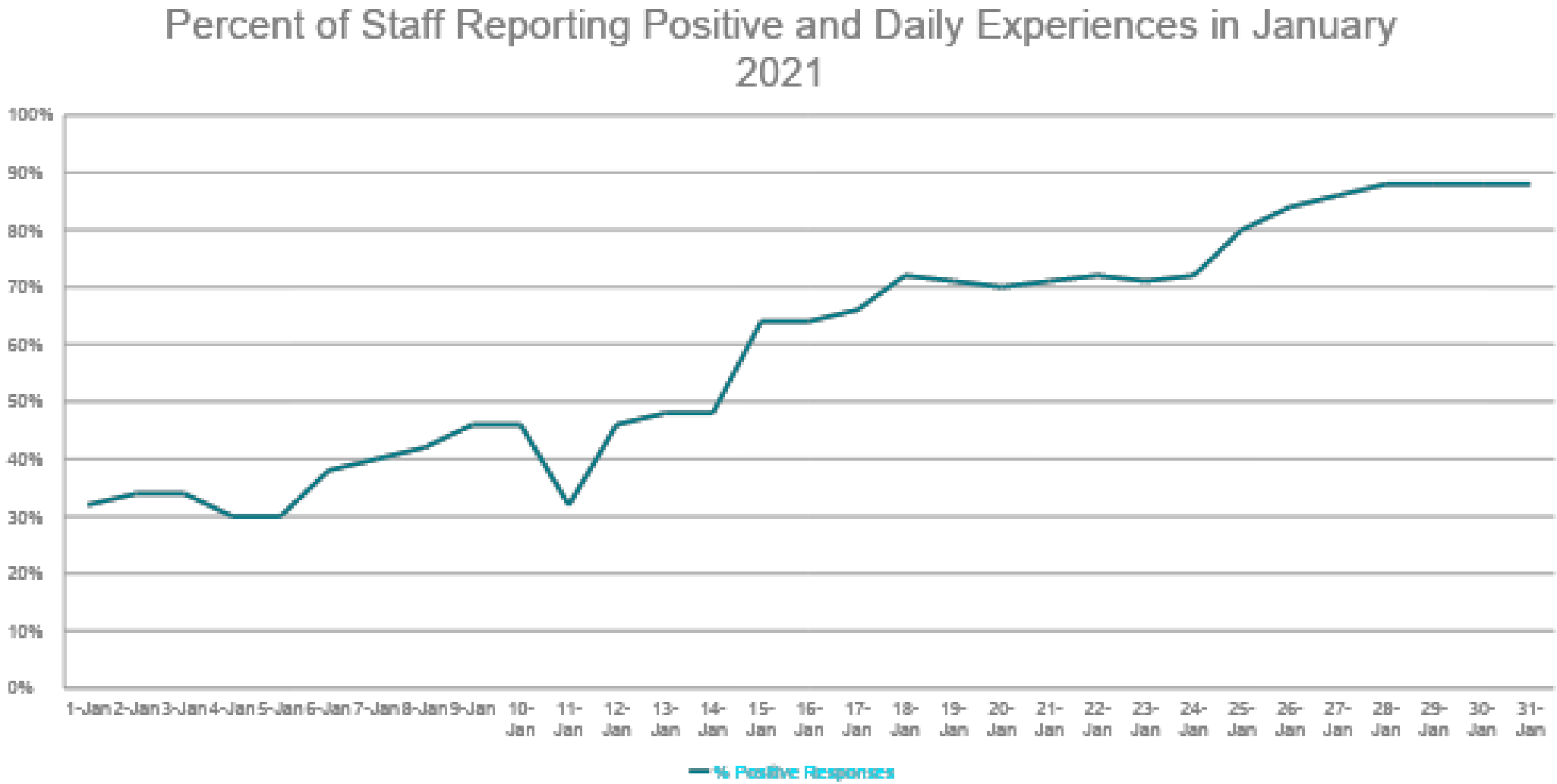
- **Outcome Measures** – Where are we ultimately trying to go?
- **Process Measures** – Are we doing the right things to get there?
- **Balancing Measures** – Are the changes we are making to one part of the system causing problems in other parts of the system?

Types of Measures: An Example

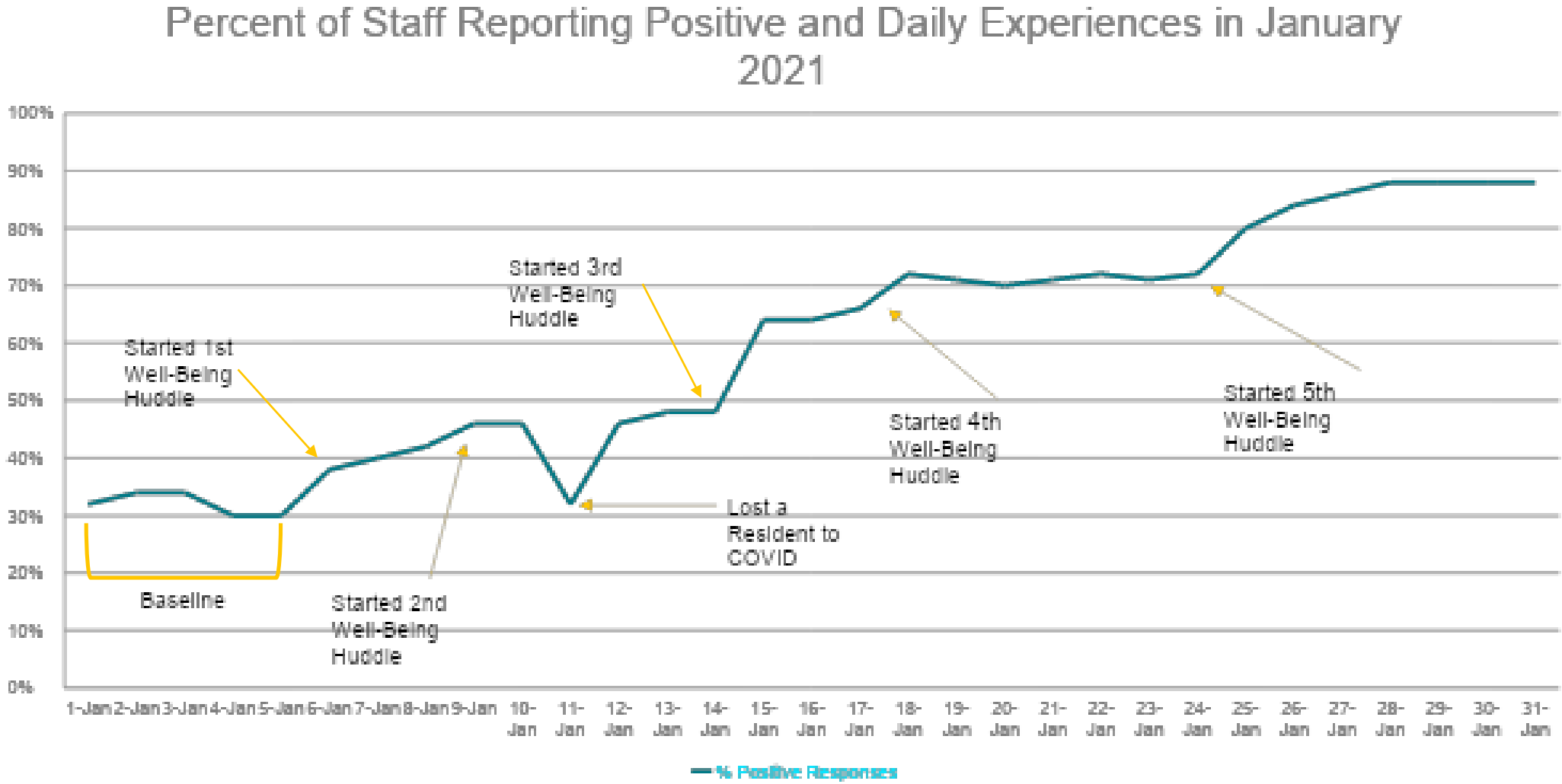
By March 15, 2021, we will improve the use of well-being huddles for all full time and part time staff in our facility by offering at least 5 well-being huddles weekly, ensuring that 80% of all staff attend at least one per week.

- **Outcome Measures** – Where are we ultimately trying to go?
  - Annual staff retention rate
  - Annual staff turnover rate
- **Process Measures** – Are we doing the right things to get there?
  - Number of well-being huddles per week
  - Percent of staff attending well-being huddles per week
  - Percent of staff reporting a positive experience for the day
- **Balancing Measures** – Are the changes we are making to one part of the system causing problems in other parts of the system?
  - Time needed to complete a huddle
  - Percent of staff reporting a negative experience for the day

Tracking Data – Run Charts



Tracking Data – Run Charts



Tracking Data – Run Charts

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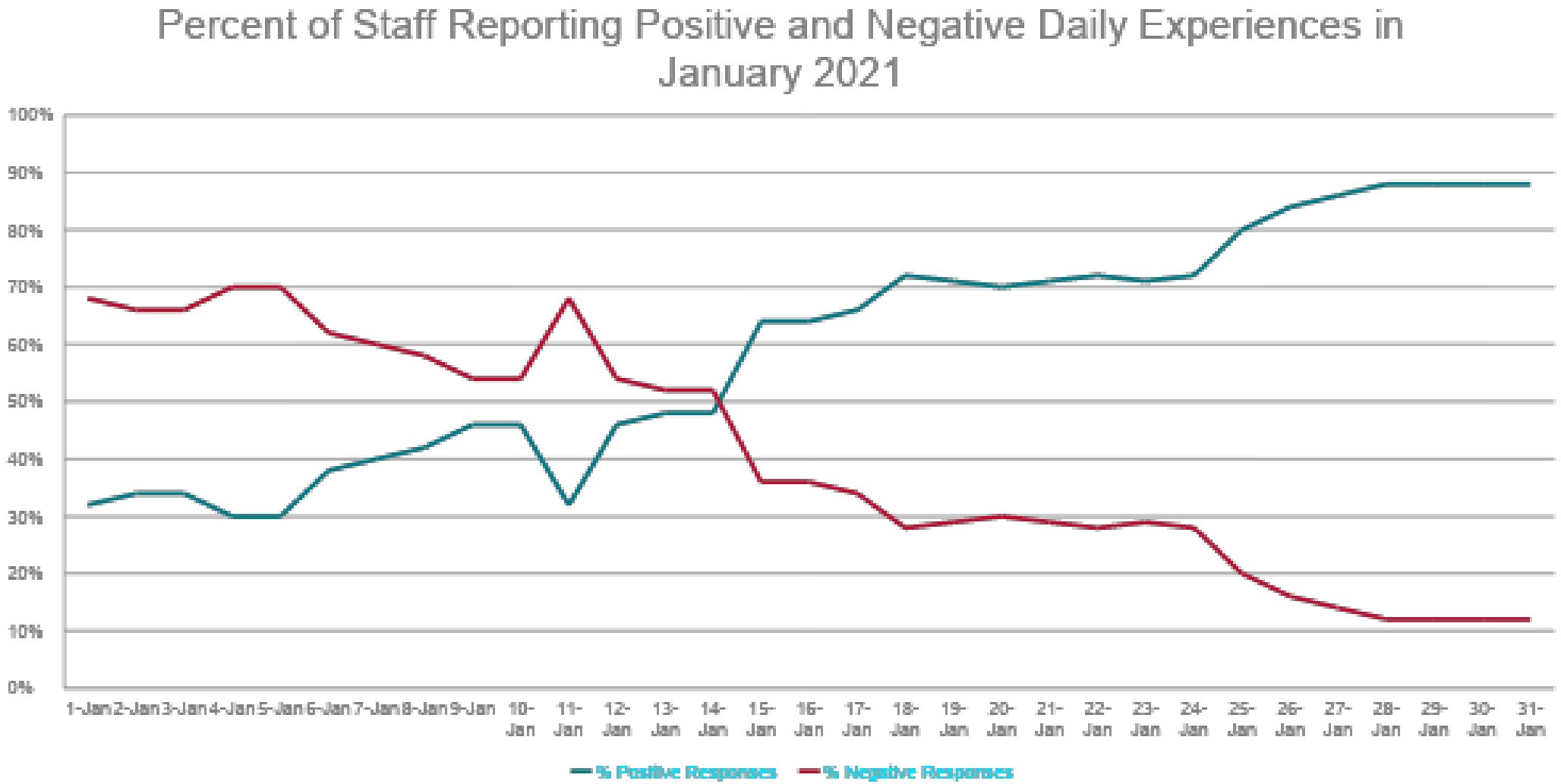

"All improvement will require change, but not all change will result in improvement"

G. Langley, et al *The Improvement Guide.* Jossey-Bass Publishers,
San Francisco, 1996: xxi.

Let's Try One Together! **Falls**

- **Outcome Measures** – Where are we ultimately trying to go?
  - Falls Rate per 1000 Resident Days
  - Percentage of Falls Causing Injury
- **Process Measures** – Are we doing the right things to get there?
  - Percentage of Residents with Completed Falls Risk Assessment
  - Percentage of "At Risk" Residents with a Documented Falls Prevention/Injury Plan
  - Percentage of Residents Designated "At Risk" and Status Communicated
- **Balancing Measures** – Are the changes we are making to one part of the system causing problems in other parts of the system?
  - Resident Bed Days
  - Costs Associated with Falls/Falls Prevention

Leave in Action

- Consider an Aim your team is working towards
- Identify the measures that will let you know if your hard work is paying off:
  - What are your **outcome** measures?
  - What are your **process** measures?
  - What are your **balancing** measures?

Let’s Poll It Up Again!

Break slide

NEXT UP – WRAP UP & NEXT STEPS

Announcements

Next Week: Ethics and Managing Social Isolation During COVID-19: Perspectives on Staff and Residents

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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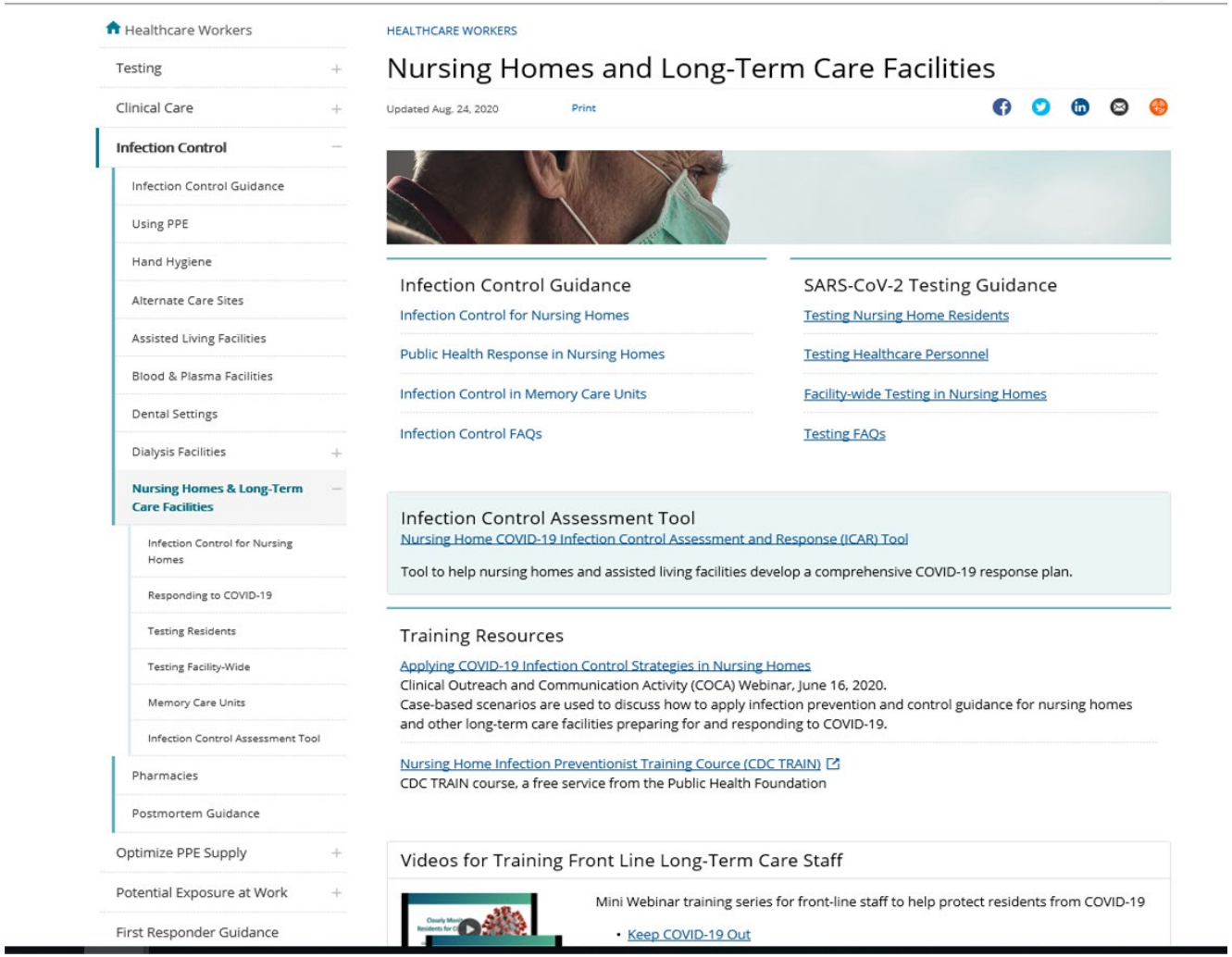
Break slide

RESOURCES

COVID-19 Resources for Nursing Homes

https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-home-long-term-care.html



- Infection Control Guidance
- SARS-CoV-2 Testing Guidance
- Assessment tools
- Training resources

Discontinuation of Transmission-Based Precautions for Patients with Confirmed SARS-CoV-2 Infection

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html Date Aug 10, 2020

https://www.vdh.virginia.gov/content/uploads/sites/182/2020/05/VirginiaLongTermCareFacilityTaskForceCOVIDPlaybook.pdf VDH LTC playbook 1-21-2021

Considerations:

- Symptom-based, not test-based strategy
- Severity of illness dictates duration (10 vs 20 day interval)

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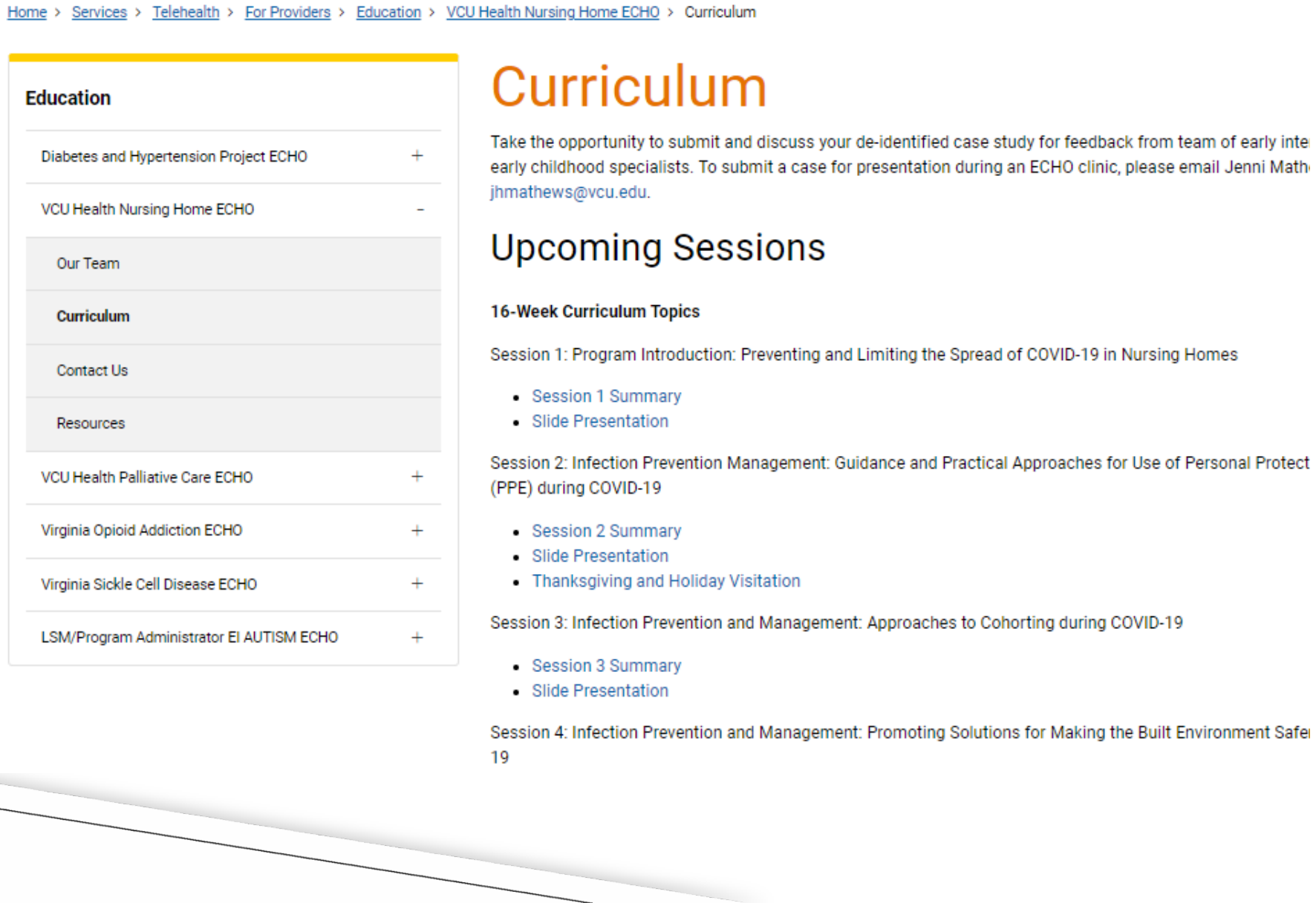
Resources

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



Home › Services › Telehealth › For Providers › Education › VCU Health Nursing Home ECHO › Curriculum

Education

- Diabetes and Hypertension Project ECHO +
- VCU Health Nursing Home ECHO –
  - Our Team
  - **Curriculum**
  - Contact Us
  - Resources
- VCU Health Palliative Care ECHO +
- Virginia Opioid Addiction ECHO +
- Virginia Sickle Cell Disease ECHO +
- LSM/Program Administrator El AUTISM ECHO +

Curriculum

Take the opportunity to submit and discuss your de-identified case study for feedback from team of early inte
early childhood specialists. To submit a case for presentation during an ECHO clinic, please email Jenni Math
jhmathews@vcu.edu.

Upcoming Sessions

16-Week Curriculum Topics

Session 1: Program Introduction: Preventing and Limiting the Spread of COVID-19 in Nursing Homes

- Session 1 Summary
- Slide Presentation

Session 2: Infection Prevention Management: Guidance and Practical Approaches for Use of Personal Protect
(PPE) during COVID-19

- Session 2 Summary
- Slide Presentation
- Thanksgiving and Holiday Visitation

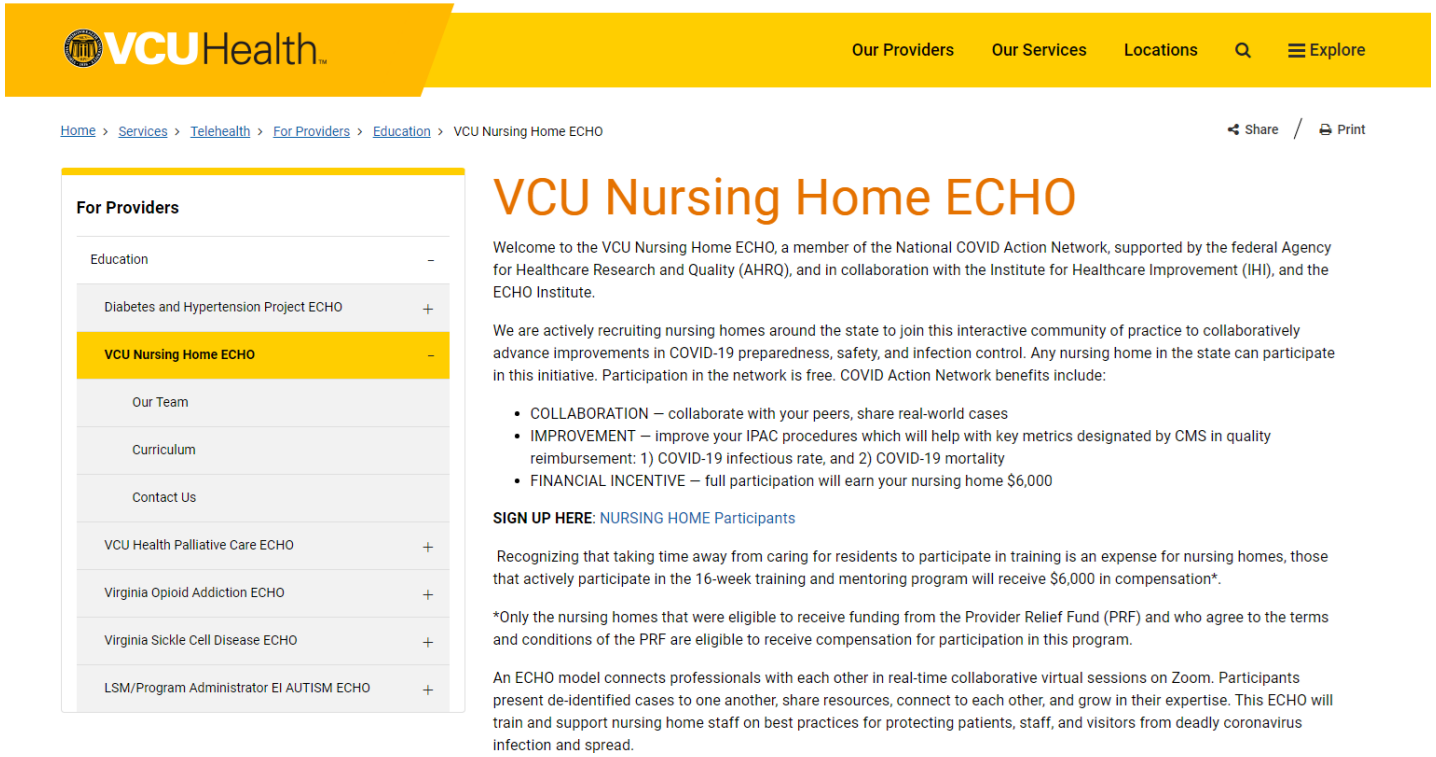
Session 3: Infection Prevention and Management: Approaches to Cohorting during COVID-19

- Session 3 Summary
- Slide Presentation

Session 4: Infection Prevention and Management: Promoting Solutions for Making the Built Environment Safe
19

VCU Nursing Home ECHO Website

- Team members
- Curriculum content
- Handouts-Don't forget your 1-Pager!
- Contact information



https://www.vcuhealth.org/NursingHomeEcho