Safe Care Transitions During COVID 19

Cohort 6 Session 12

February 18, 2021

1-2:30 p.m. ET

Please note, Project ECHO collects registration, participation, questions/answers, chat comments, and poll responses for some ECHO 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.

AHRQ ECHO National Nursing Home COVID-19 Action Network

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Today's Agenda

Ice Breaker

Follow-up from Session 11 – Interprofessional Team Management and Monoclonal Antibody Treatment (5 min)

Safe Care Transitions

Case Study and Break Out Rooms

Performance Improvement Discussion

Wrap-up and Poll

Questions & Answers

What island country?

Chris Kenney, Administrator at Advocate Healthcare of East Boston

What state?

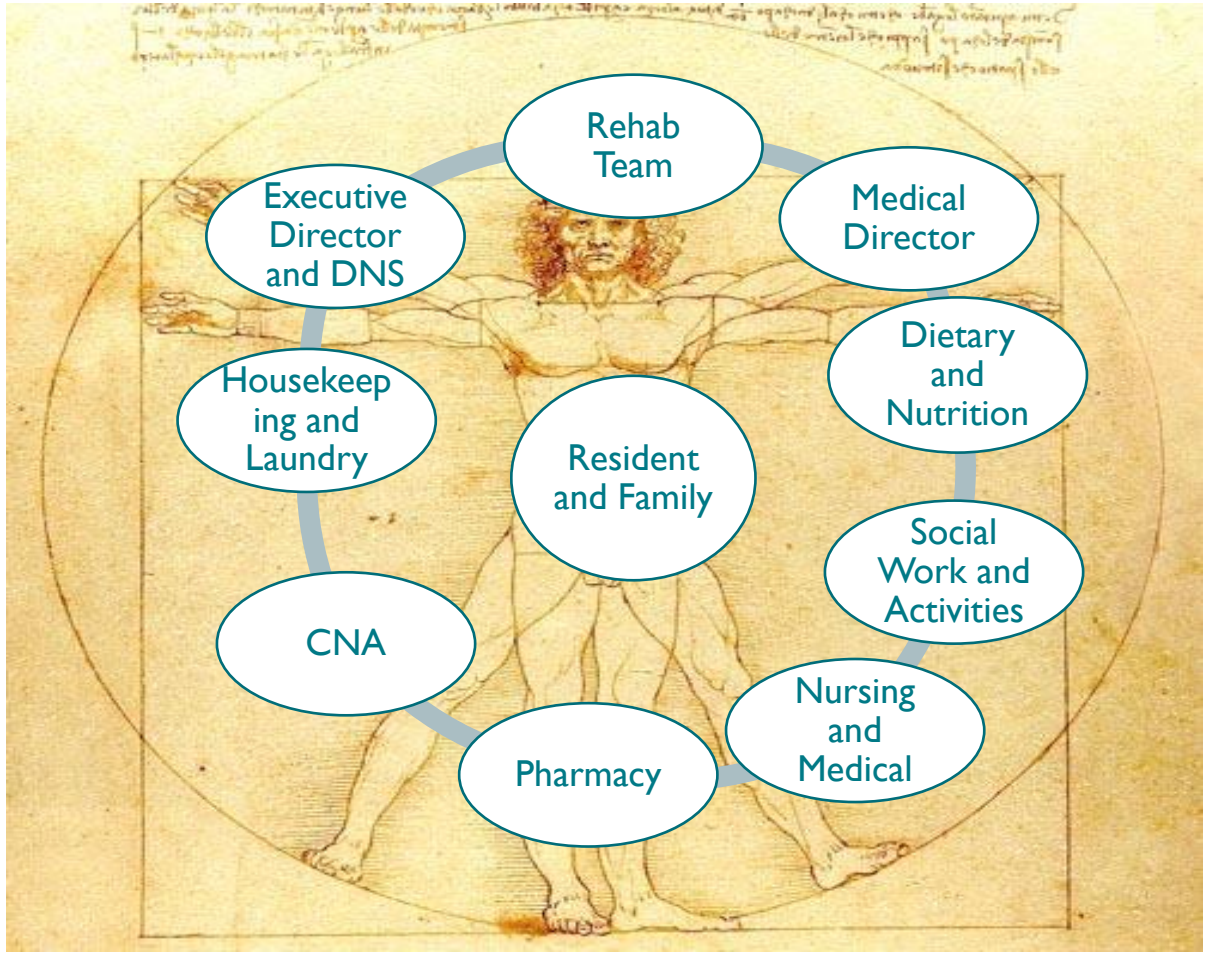
Sr. Maureen McDonough, Administrator at St. Patrick's Manor

What state?

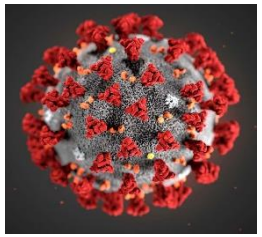
Amber Moore, Associate Inpatient Physician Director for Operations MGH

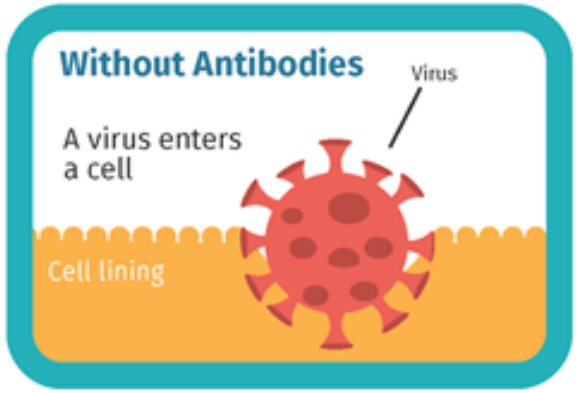
Session 11 Follow Up: Interprofessional Team

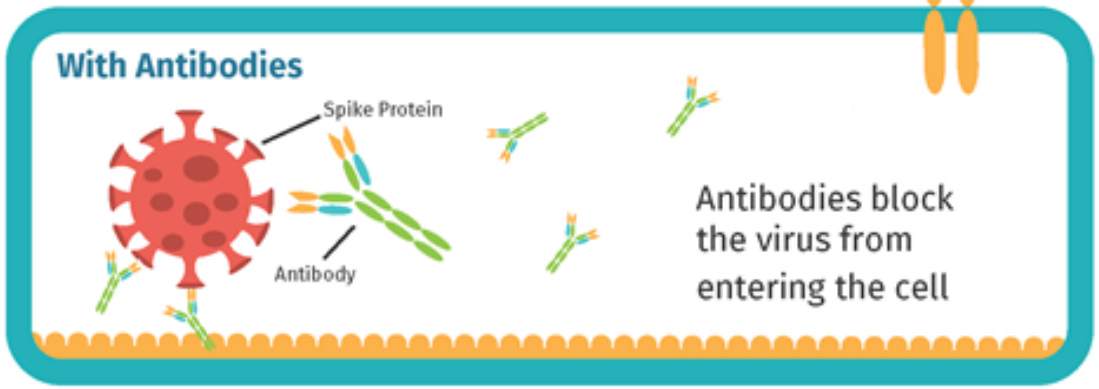
- Everybody plays a key role on the team in caring for the needs of the ENTIRE person



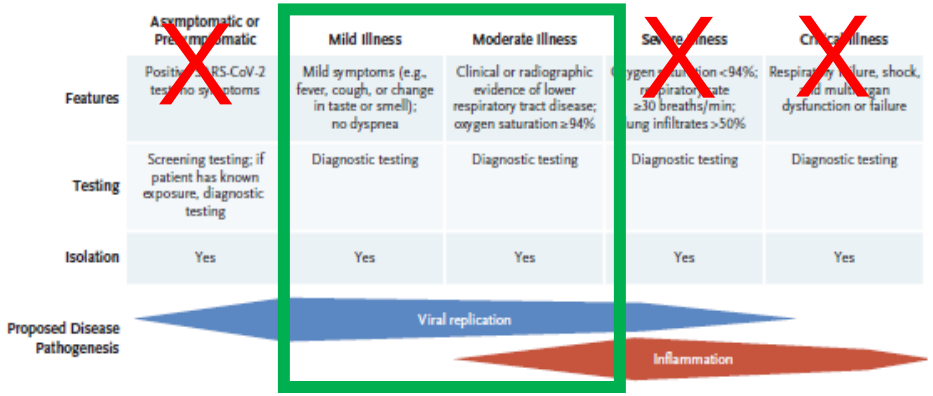
Session 11 Monoclonal Antibody (mAb) Therapy





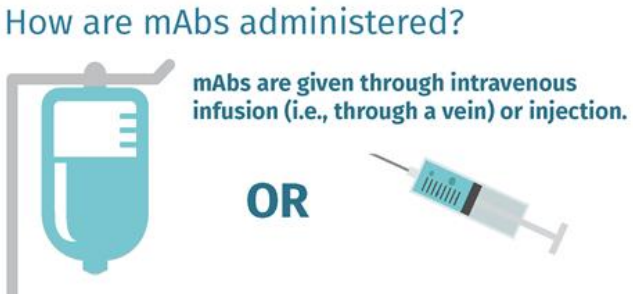


Monoclonal antibodies **(mAbs)** are antibodies developed in a laboratory to help our bodies fight infection.



There are now three FDA **EUA** approved mAbs

1. Bamlanivimab (BAM – Eli Lilly)
2. Casirivimab-Imdevimab (Regeneron)
3. BAM-Etesevimab (Eli Lilly)



Safe Care Transitions During COVID 19

Joining Us Today: Amber Moore, MD, MPH

Dr. Moore is a Hospitalist and the Associate Inpatient Physician Director for Operations in the Department of Medicine at MGH. As Co-Investigator of the ECHO Care Transitions (ECHO-CT) program at Beth Israel Deaconess Medical Center for the last 5 years, she has facilitated ECHO sessions and led operations and research related for the project, which is currently funded by a 3-year AHRQ grant.

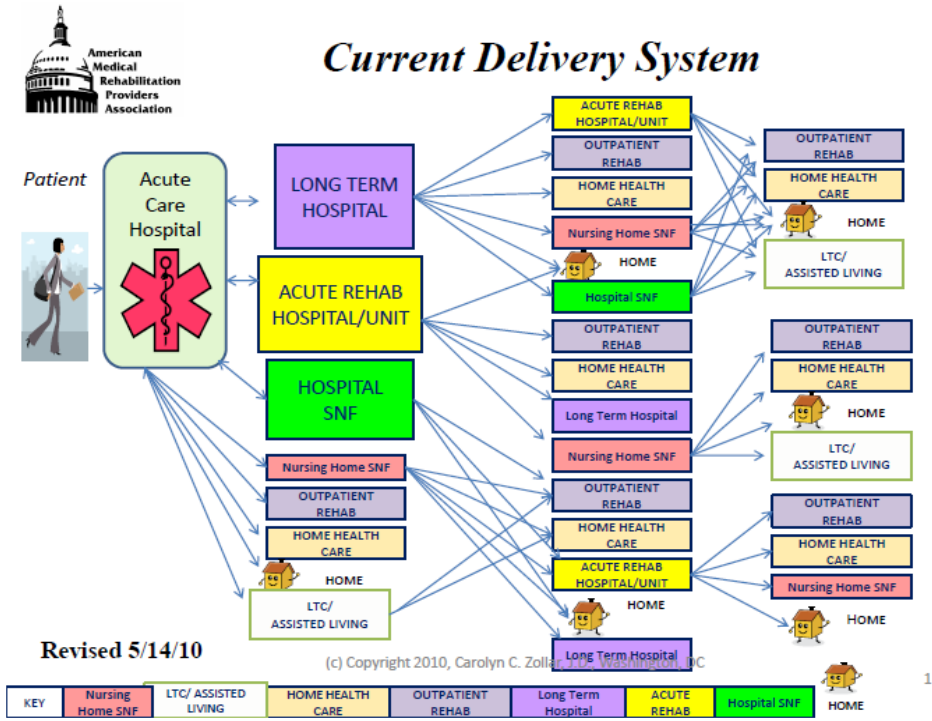
Transition of Care Defined

- A transition of care is defined as the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
  - Center for Medicaid and Medicare Services

- Hospital to SNF
- SNF to Hospital
- SNF to Home
- SNF to SNF
- Between Units

The 'Burden' of Care Transitions: Sobering Facts

- 15% of hospitalized patients 65 or older are discharged to another inpatient facility (SNF) for post-acute care.
  - Up to 45% for pts 85 or older
- **25%** of medicare SNF pts are readmitted to the hospital within 30 days of discharge from an acute hospitalization.
- Individuals with chronic conditions may see up to16 physicians in one year.
- Between 42 – 70% of medicare patients admitted for hospital care in 2003 received care from > 10 physicians during their stay.
- Adverse health outcomes are tied to poor-quality transitions, including inconsistencies with medications and follow-up care



Kessler et al. Clin Geriatr Med. 2013.

ECHO-CT Transition of Care Events

- 675 patients experiencing 743 hospitalizations over 2 years
- 139 transition of care events in 132 patients (20% of patients)
  - 41% communication-related
  - 37% medication-related
- Extrapolating these results to 140m Medicare discharges between 2000-2015= 5.5 million TCEs over a 15-year period

Gonzalez et al, JHM Jan 20,2021

Effective Care Transitions Matter – 'Just Talk!'

https://www.youtube.com/watch?v=eDjlGiLFiAs&ab_channel=Marcel%27sPromos%26CommercialsChannel

Benefits of Improved Transitions of Care

- 40% decreased risk of readmission
- Decreased SNF LOS by 5.5 days
- Decreased 30-day costs by $2,600 per patient

Moore et al, AJM May, 2017

Why Effective Communication During Care Transitions Matter

- **Resident Outcomes**
  - Hospital Admission or Readmission
  - Falls
  - Medication Errors
  - Delirium
- **Facility Outcomes**
  - Survey implications
  - Quality Measures
  - Health Care System partnerships

Components of an Effective Care Transition

- Transfer of complete & accurate patient care Information

AND

- Transfer of responsibility & Ownership for the patient's care.

The Ownership Problem:

There was an important job to be done and **Everybody** was sure that **Somebody** would do it. **Anybody** could have done it, but **Nobody** did it… **Everybody** blamed **Somebody** when **Nobody** did what **Anybody** could have done.

- Anonymous

Care Transitions Programs and Toolkits

- BOOST (Hospital Based)
- ProjectRED (Hospital Based)
- INTERACT (Nursing Home Based)
- OPTIMISTIC (Nursing Home Based)
- RAFT (Nursing Home Based)
- I-PASS (Universal Signout Tool)

Effective Communication

I-PASS

BETTER HANDOFFS. SAFER CARE.

I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Time line and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

OK, this resident seems quite stable

She's an 84 yo LTC resident with Diabetes, Afib and Dementia and she tested COVID positive during surveillance testing yesterday. She's never been COVID positive before and so we have to move her to the COVID unit. Has no known exposures. She's a fall risk and has a small skin tear to her right arm from a fall 2 weeks ago.

We're planning on bringing her over within the ½ hour. Here are the to do's: Meds are due this evening; toilet her before her bedtime Needs window side bed side rail up during the night

She has a MOLST which is DNR/DNI but OK to hospitalize. Her HCP is her son who is supportive and wants to be notified asap 24/7 with any change in condition

OK, so this is what I heard….

DPH Regulations: Hospital to Nursing Home

- When a resident is transferred to a hospital for evaluation of any condition must accept the resident's return to the facility when the resident no longer requires hospital level of care.
- Shall not condition admission or return to the facility on COVID-19 testing or COVID-19 test results.
- If a test is not performed before discharge, facility should test the resident upon admission, if a test is available.
- Awaiting the test results should not delay discharge from the hospital to the long-term care
- Newly admitted or readmitted residents returning from any setting outside of the facility who are not recovered from COVID-19 within the previous six months
  - should be quarantined in a private room or, if unavailable, placed in a room with another resident who is recovered (less than six months from infection), in a dedicated quarantine space
  - monitored for symptoms of COVID-19 for fourteen days after admission

DPH Admission Freezes

- Does not apply to a resident transferred from the facility to a hospital or other healthcare facility.

CMS Regulations

Hospital to Nursing Home

- Can accept a resident diagnosed with COVID-19 and still under Transmission Based Precautions for COVID-19
- Should admit any individuals that they would normally admit to their facility
- If possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital.
- Quarantine 14 days with no symptoms

Nursing Home to Hospital

- Residents who require transfer to a hospital - facility alerts EMS and hospital of the resident's diagnosis (suspected or confirmed COVID-19) and precautions to be taken by transferring and receiving staff

Case Study: Mr Jones

- Mr. Jones was admitted to a facility in June 2020 with a Stage 3 pressure ulcer, COPD, depression, morbid obesity, and osteoarthritis. He was admitted due to severe debility, requiring assistance with care needs and mobility.
- There was a physician's order on 6/19/2020 for bilateral upper side rails on the bed and ide rails were recommended as part of the plan of care.
- A side rail consent was signed by resident on 6/29/20 to use bilateral upper side rails as an enabler.
- Reassessment of use of side rails was completed on 12/10/20.
- Mr. Jones left the facility on Christmas, 12/25/20, on a social leave and upon his return was **transferred to the quarantine unit.**
- During personal care by the CNA on 12/28/20, resident attempted to roll onto his side in bed by throwing his leg over but because of weight, he lost control and fell of the bed. **During the facility investigation, it was noted that resident's bed in the quarantine unit did not have bilateral upper side rails.**

QI: Safe Care Transitions Process

Nizar Wehbi, MD, MPH, MBA

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Breakout Session: (15 minutes)

How Might We: Improve Communication When There Is A Care Transition During COVID 19?

- Group 1: SNF to Hospital Transition
- Group 2: Hospital to SNF Transition
- Group 3: Unit to Unit Transition

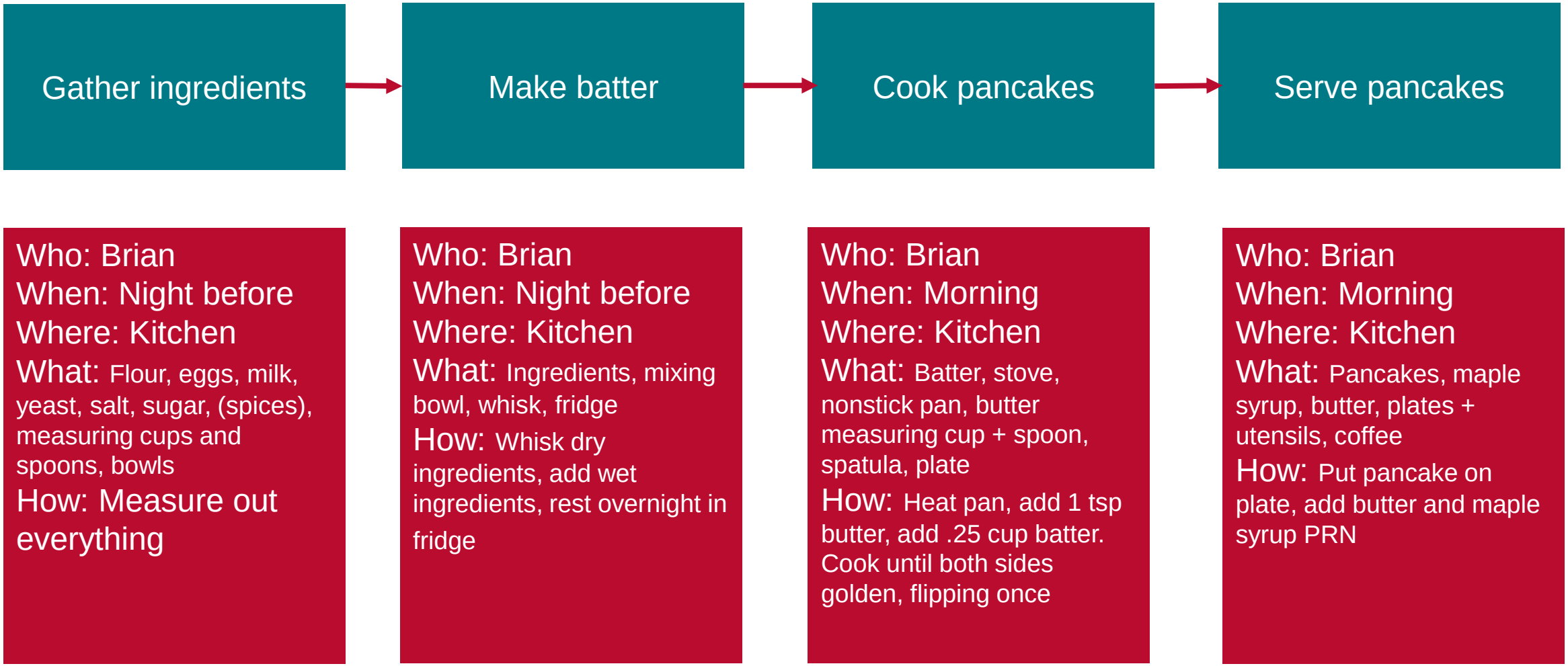
Describing a process

https://www.youtube.com/watch?v=Ct-lOOUqmyY

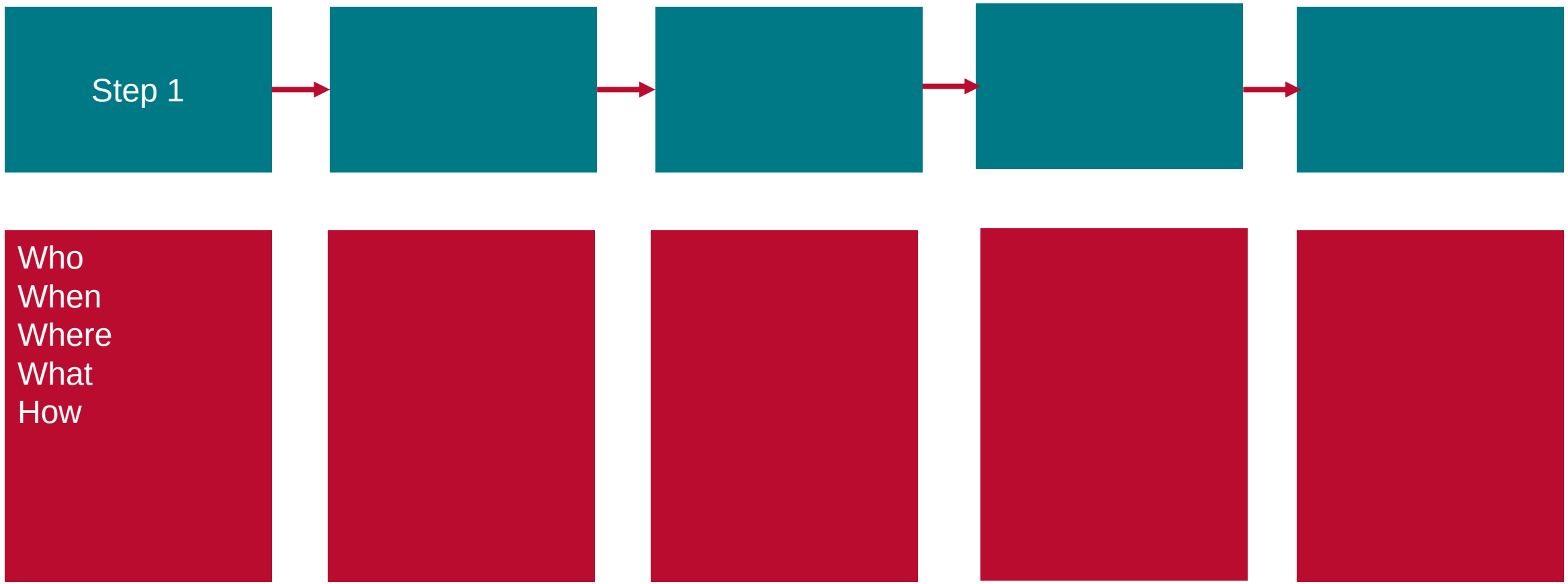
Breakout Session Activity

- Describe the process for information transfer between settings/units
  - High Level Flowchart
- Answer the 5 Questions
  - Who
  - When
  - Where
  - What
  - How

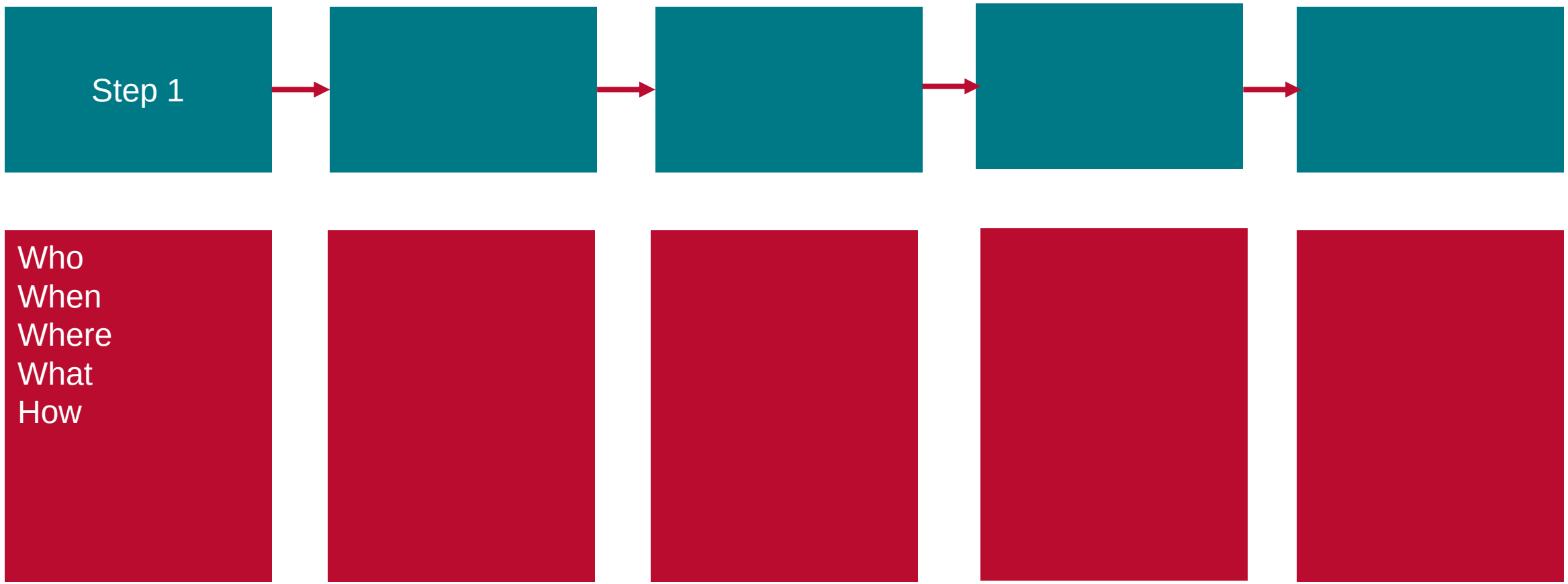
Make pancakes for breakfast



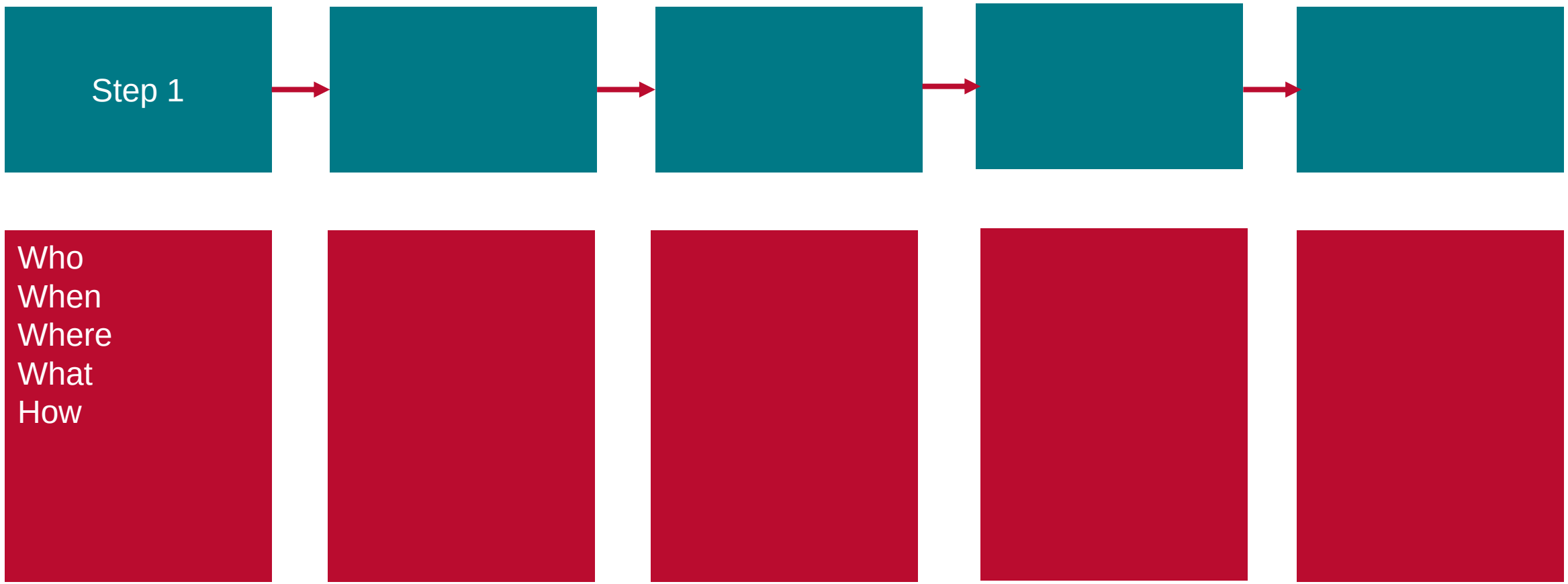
Safe transition from SNF to hospital



Safe transition from Hospital to SNF



Safe transition from Unit to Unit



Safe transition from Unit to Unit

Determine the ability to move off the unit	Notifications	Prepare room in receiving unit	Warm Hand-off	Transfer Patient
Who - IPCO When –at 14 days Where – quarantine unit What – negative test results How -	Who – resident, HCP, roommate, receiving unit, MDs (to and from) When- before the move Where – receiving unit/room What - Meds, chart	Who – maintenance dept What – protocols for cleaning; ensure proper equipment When – prior to move Where – How -	Who – clinical nurse, CNA What – ADL status, special equipment, diet needs, precautions, meds When – right before transfer Where – prior to transfer How – communication board & in-person/verbal	Who – receiving unit staff – nurse, CNA What – make sure hallways are clear, provide mask Where – receiving unit What – How -

Report Out

- How did you do?


Maureen McDonough, St. Patrick’s Manor

What to expect next…

Next Session: **February 25, 2021**

Topics:

- Session 13: Safe Visitation and Reopening

Send best practices/challenges to Marina (mrenton@maseniorcare.org)

Wrap Up and Poll

- Please watch your screen and respond to our 2 poll questions as they launch

Questions?

Case Study: Mr. Doe

- Resident (Mr. Doe) currently hospitalized at a local hospital after a fall on a Friday night - **Feb. 12th**.
- Mr. Doe tested positive for COVID on a rapid test in their ER on Saturday – **Feb. 13th**.
- Resident has had no signs or symptoms and the test was performed as part of routine screening.
- Resident tested negative at LTC facility screening the day prior, **Feb. 12th**, as residents are tested twice weekly.
- Mr. Doe had COVID last spring and finished the 2nd round of vaccination Tuesday – **Feb. 9th.**
- A CNA on his unit tested positive on Friday – **Feb. 12th** (CT value in the low 30s), but that CNA was not assigned to resident. A second CNA who worked with him had non-specific symptoms on Sunday but tested negative on their last swab on Thursday – **Feb. 11th**.

Case Study: Mr. Doe, continued

- Before the CNA COVID-19 positive staff member, the LTC facility had not had a staff case in long-term care in over 2 weeks. Moreover, the LTC facility have not had a long-term care resident test positive since last summer.
- Even still, our staff wears full PPE for all patient care, including N95s, gown, gloves, and eye protection. Subsequent PCR testing on Sunday – **Feb. 13th** - in all the residents on floors worked by the staff member this week were negative. There were no positives thus far among the staff who could have been contacts.
- Based on these factors above, hospital staff agreed to re-test Sunday – **Feb. 14th** - and that was reportedly negative. However, their infection control now maintains that Mr. Doe should not have been re-tested and, by hospital protocol, the new positive test >180 days after initial infection should be considered a **new infection, regardless**.

Questions To Ponder?

- Who do you call for help?
- What should I do now?
- How is this reasonable?
- Why does this always happen on a weekend?

Unattended Consequences

- Outbreak status extended
- Family visitations impacted
- Because of the need for a precautions will be a potential disruption to this resident and others (including moving their rooms to meet the need for isolation)
- Not having a more definitive diagnosis, with consideration of the particular clinical circumstances of the situation, as opposed to unmovable decisions determined by protocol.
- Additional clinical workup (i.e., x-rays, medications, labs, etc.)

Lessons Learned – Solving the Puzzle Together

- In line with DPH guidance for recovered individuals in long-term care settings (10/16/20), isolation is not recommended for this individual based on the 2/13 positive result.
- DPH Guidance, October 16
  - https://www.mass.gov/doc/considerations-for-caring-for-covid-19-recovered-residents/download

PPE Refresher

Your staff is providing direct care to a newly admitted patient from the hospital requiring short-term post-acute care (e.g. “quarantined”).

Which of the following is the <u>most</u> correct use of PPE for this situation?

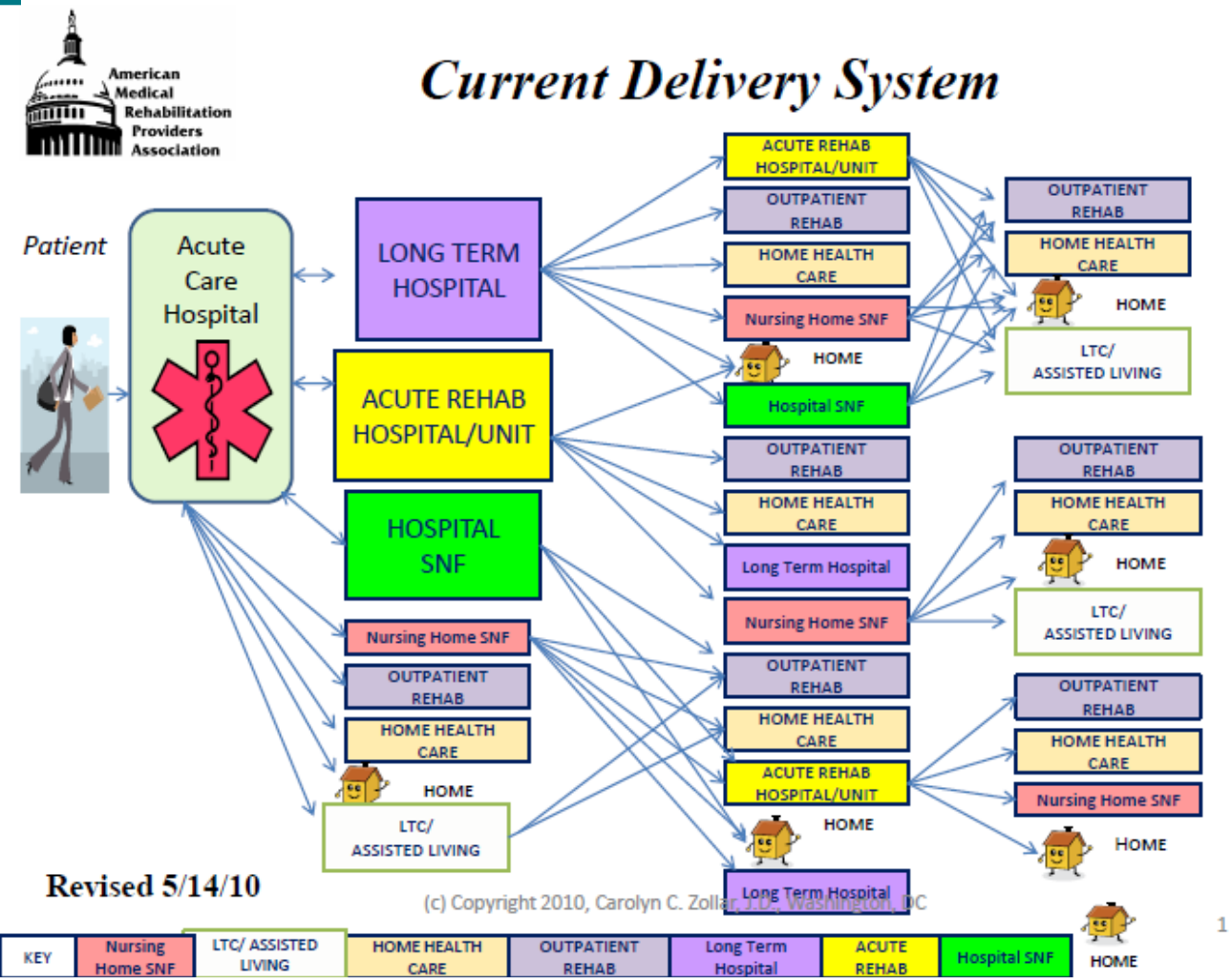
A

B

C

D

The Burden of Transitions



Care Transitions: One of the Most Common (and dangerous) Clinical 'Procedures'

- PHS Hospitals ~ALOS 5 days
- ~3 shifts/day each for MD/RN
- ~150,000 admissions/yr

- 5 days
- X 6 = 30 hand-offs/adm
- X 150,000

= **4,500,000**

- ~250,000 consulting team hand-offs
- ~75,000 discharges to post acute
- ~100,000 discharges to the PCP
- ~75,000 from post acute

- \+ 250,000
- \+ 75,000
- \+ 100,000
- \+ 75,000

= 5 MILLION