# UNMC College of Public Health ECHO

February 3, 2021

AHRQ ECHO National Nursing Home COVID-19 Action Network

# Welcome and Announcements

Deborah Levy

# Announcements

- Please type your ***name, email, and facility name*** in the chat box for us and ECHO Institute to capture your attendance
- Please type your questions in the chat box, and they will be addressed during the situation discussion and/or the Q&A
- The materials from the sessions are available for you to download from our website
- The recording of the sessions, which are required by AHRQ and ECHO Institute, are available only for special circumstances and a request must be made to Krista Brown
- Throughout the week, if you have questions, concerns, or issues to raise, please send Krista an email at Krista.Brown@unmc.edu
- Training Centers will receive a no notice audit – staff from the ECHO Institute will join one of our sessions between now and the end of the 16 weeks
- **Project ECHO is requesting feedback from facilities and training hubs through completion of the survey at this link by Friday February 5:**

▪ https://ctsctrials.health.unm.edu/redcap/surveys/?s=47DYDD4CXL

# CME and CNE Credits

- These sessions have been approved for both Physician and Nursing credits
- 1.5 credits will be awarded per session
- Approval is based on attending the 30 minutes of discussion and Q&A at the end of the formal 60 minutes
- You will be ***required to complete 2 evaluations*** to receive your continuing education credits
  - After the first 8 weeks
  - At the end of the 16 weeks
- You must type your ***name, email, and facility name*** in the chat box to be recognized as attending the session
- If you have questions or issues about these credits, please send Barbara Dodge an email at bdodge@unmc.edu

# Week 12 Agenda

| Time | Subject | Speaker/ Facilitator |
|---|---|---|
| 1200 - 1205 | Welcome and Announcements | Deborah Levy |
| 1205 - 1225 | Promoting Safe Care Transitions | Nancy Meier |
| 1225 -1255 | Case Study/Scenario Presentation and Discussion | Public Health Core Team |
| 1255 - 1300 | Weekly Poll | Krista Brown |
| 1300 - 1330 | Continued Discussion and Q&A | Public Health Core Team |

# 16-Week Curriculum Overview

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- Preventing and Limiting the Spread of COVID-19 in Nursing Homes ✓
- Guidance and Practical Approaches for Use of Personal Protective Equipment (PPE) during COVID-19 ✓
- Approaches to Cohorting during COVID-19 ✓
- Promoting Solutions for Making the Built Environment Safer during COVID-19 ✓
- Guidance for Cleaning & Disinfecting during COVID-19 ✓
- COVID-19 Testing for Nursing Homes ✓
- COVID-19 Community Transmission and Nursing Home Screening Strategies ✓
- Staff Returning to Work Safely during COVID-19 ✓

# Curriculum Continued

- Interprofessional Team Management of Mild Cases of COVID-19 ✓
- Advance Care Planning in the Time of COVID-19 ✓
- Promoting Safe Visitation and Nursing Home Re-opening during COVID-19 ✓
- **Promoting Safe Care Transitions during COVID-19: Admissions, Discharges, and Transfers**
- The Role of Certified Nursing Assistants (CNAs) in Managing and Supporting Residents and Families during COVID-19
- Managing Social Isolation during COVID 19: Perspectives on Staff and Residents
- Supporting the Emotional Well-being of Staff Caring for Residents during COVID-19
- Effective Leadership and Communication during COVID-19

# Promoting Safe Care Transitions during COVID-19 – Admissions, Discharges and Transfers

- Learning Objectives

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

# A Look Back

- **Key Elements of Safe Transfers**

- Pre-acute event goals of care
- During the event interprofessional (nursing, medicine, patient & family or surrogate) communication is essential
- Warm hand-off to receiving institution
- Transfer documentation that includes standard elements including COVID-19 history and COVID-19 vaccination status

# 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
  - O2 sat < by 3% or greater since last taken, 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?

# Cohorting

- Used CDC guidelines, State Health Department Guidelines and facility policies
- Cohort the admissions and readmission into 3 types of Units:
  - **COVID-19 unit:**
    - Private rooms if available (cohort based on exposure & risk)
    - Dedicated Staff required to use “full COVID” PPE
    - Move to general unit 7 days after first symptoms or positive test
  - **Admission/Observation Unit:**
    - Private rooms if available (cohort based on exposure & risk)
    - Dedicated Staff required to use “full COVID” PPE
    - 10 – 14 days: may or may not have test requirement before discharge into general care
  - **General/Standard COVID free Unit**

# Discharges

- Usual discharge instructions with explicit COVID infection and immunization status
- Any re-admission would require 14-day AOU stay regardless of the length of time since discharge

# Safe Transfer of COVID-19 Patient

- Guidelines used for Hospital to Nursing Home transfers:
- 1. Individuals who test positive for COVID-19 should not be discharged to a mainstream NH unless the facility can safely and effectively isolate the patient from other residents and has adequate infection control protocols and PPE for staff and residents
- 2. Transfer only if the facility has the ability to isolate or cohort the resident(s) separately from the rest of the com-munity and provide dedicated staff for people withCOVID-19
- 3. Such transfers should be in accordance with current CDC guidance

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# Key Safe Transfer Points

- Risk/Benefits of transfer
  - Evaluation of patient status
  - Risk of transmission
  - Mortality/morbidity of COVID-19
  - Resource limitations
- Communication
  - “warm handoff” conversation between medical providers at each care transition or change in site of care

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# Reducing Nursing Home Transfers

- Many models for reducing nursing home transfers:
    - Hospital based:
        - Evaluating criteria for ED admissions
        - Discharge from hospital to nursing home
    - Nursing home based:
    - INTERACT:
        - Managing acute care patients
        - Avoiding unnecessary hospitalizations
    - OPTIMISTIC: https://www.optimistic-care.org/
        - Focus on staff support
    - RAFT (Reducing Avoidable Facility Transfers)

# RAFT

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

# Safe Transfer of COVID-19 Patients

- **Key Considerations for transfer from Nursing home to Hospital:**

(1) Whether the resident's **goals of care** have been discussed, including completion of a Patient Orders for Life-SustainingTreatment or **advance directive**;

(2) What the resident's medical needs are, as determined by the NH clinical staff and attending physician; and

(3) Whether the NH will be able to provide the resident's medical care in place

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# Advance Care Planning & Communication of Plan

- Explanation and discussion of advance directives
  - includes completion of such forms **IF** preformed

- Discussion with Patient, family, and/**OR SURROGATE**
  - Communication is most critical in nursing home patients with advanced disease and frailty and/or life-limiting disease (such as advanced dementia, heart failure or metastatic cancer)
  - Given the significant morbidity and mortality of COVID-19 in this population, information regarding advanced care planning is crucial for all providers and facilities when transferring COVID-19 patients

# Patient and Family Communication

- A patient with advanced dementia who develops COVID-19 may not be able to remain in her semi-private room in the nursing home, even if that is the family's preference
- Similarly, if triage protocols are implemented, it may not be possible to honor patient preferences for full intervention
- This is because other criteria such as mitigation of transmission risk, take priority in decisions regarding access to a scarce resource

# Impact on Resources and Staffing

- Caring for clients with COVID-19 in nursing facilities involves:
  - Dedicated teams, leaders and staff
  - Up-to-date on resources, equipment
  - Providing acute care to individuals with co-morbid and complex issues
  - Takes an emotional and mental health toll; physical impact on staff, families and patient

# Improving COVID-19 Outcomes

- **Use of Standard Orders once patient tests positive**:
  - Use of standard order sets for nursing home residents to try to prevent or mitigate the effects of COVID-19
- **Two examples are listed below**:
- **Standard Order Set #1:**
  - Labs - CBC, CMP, CRP, Ferritin daily for 3 days then weekly when recovered
  - Medications: thiamine, zinc, quercetin, melatonin, vitamin D, vitamin C, methylprednisolone
- **Standard Order Set #2**:
  - Medications: mirtazapine, famotidine, melatonin, azithromycin, dexamethasone, vitamin C, vitamin D, zinc and enteric-coated aspirin

# All Teach All Learn Case Study/Situation Presentation and Discussion

UNMC Public Health Core Team

# Resource Links

- **Content Resource Links**
- *Video:* Session 12_Presentation_Safe Care Transitions:
- https://www.youtube.com/watch?v=lygp0gsKK3c&feature=youtu.be

- **Vaccine Information**

  Capitol Hill Steering Committee on Pandemic Preparedness and Health Security

- https://www.centerforhealthsecurity.org/ourwork/CapitolHillSteeringCommittee/

- MMWR – allergic reactions after first dose of Moderna vaccine
- https://www.cdc.gov/mmwr/volumes/70/wr/mm7004e1.htm?s_cid=mm7004e1_e&ACSTrackingID=USCDC_921-DM47045&ACSTrackingLabel=MMWR%20Early%20Release%20-%20Vol.%2070%2C%20January%2022%2C%202021&deliveryName=USCDC_921-DM47045

# Resource Links

- **Additional Information**
- Mary D. Naylor , Karen B. Hirschman & Kathleen McCauley (2020) Meeting the Transitional Care Needs of Older Adults with COVID-19, Journal of Aging & Social Policy, 32:4-5, 387-395, DOI: 10.1080/08959420.2020.1773189 To link to this article: https://doi.org/10.1080/08959420.2020.1773189
- Stacie Levine, MD, Alice Bonner PhD, RN, FAAN, Adam Perry, MD, Donald Melady, MSc Ed, MD, Kathleen T Unroe, MD. (2020). COVID-19 in Older Adults: Transfers Between Nursing Homes and Hospitals. Journal of Geriatric Emergency Medicine, 1(5)
- Ellen Flaherty. (2021). Promoting Safe Care Transitions: Admissions, Discharges and Transfers. AHRQ ECHO National Nursing Home COVID-19 Action Network

# Resource Links

- **Additional Information**
- https://hsc.unm.edu/echo/institute-programs/covid-19-response/us-covid19/hhs-aspr/miniseries.html [hsc.unm.edu]
- https://www.centerforhealthsecurity.org/resources/COVID-19/COVID-19-SituationReports.html
- https://hsc.unm.edu/echo/institute-programs/covid-19-response/us-covid19/hhs-aspr/ [hsc.unm.edu]
- https://hsc.unm.edu/echo/institute-programs/covid-19-response/us-covid19/hhs-aspr/miniseries.html [hsc.unm.edu]
- https://www.nih.gov/news-events/news-releases/severe-covid-19-pregnancy-associated-preterm-birth-other-complications

# Weekly Poll

Krista Brown

# Continued Discussion and Q&A

UNMC Public Health Core Team

University of Nebraska Medical Center

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