Making Community Connections: Supporting Safe Transitions During COVID-19

December 9, 2020 11am-11:45am

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Chat In

Please use the chat feature to share your name, organization, and state.

From Our Team to Yours…

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Thank you for your continued efforts to keep us safe!

Supporting New York, New Jersey, & Ohio

Sara Butterfield

Fred Ratto

Gail Gresko

Christine Stegel

Supporting New England

Lynne Chase

Kathleen Calandra

Gail Patry

Maureen Marsella

Lara Hollands

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Creating Connections to enhance Health Outcomes in your Community

- Increasing Access to Behavioral Health & Reducing Opioid Misuse
- Improving Patient Safety
- Preventing & Managing Chronic Disease
- Improving Care Transitions
- Enhancing Nursing Home Quality

But COVID-19?

Chat In

Please use the chat feature to let us know what you are hoping to learn and/or contribute to today’s session.

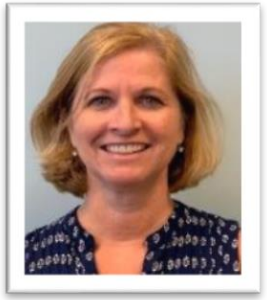
Session Objectives

- ✓ Recognize the power of provider coalitions
- ✓ Consider critical success factors for successful COVID-19 focused coalitions
- ✓ Identify initial areas to explore with cross-continuum providers

Today Speakers

Karen L. DeSantis, MSN, RN
Performance Manager
Post-Acute Services
Yale New Haven Health System

Nicole Garabedian, MSN, RN
Director of Clinical Operations and Throughput
Integrated Care Department
Lawrence General Hospital



Margie Hackett, BSN, RN
Transition Guide Nurse Manager
Care Coordination/Readmissions
Suburban Hospital, a member of Johns Hopkins Medicine

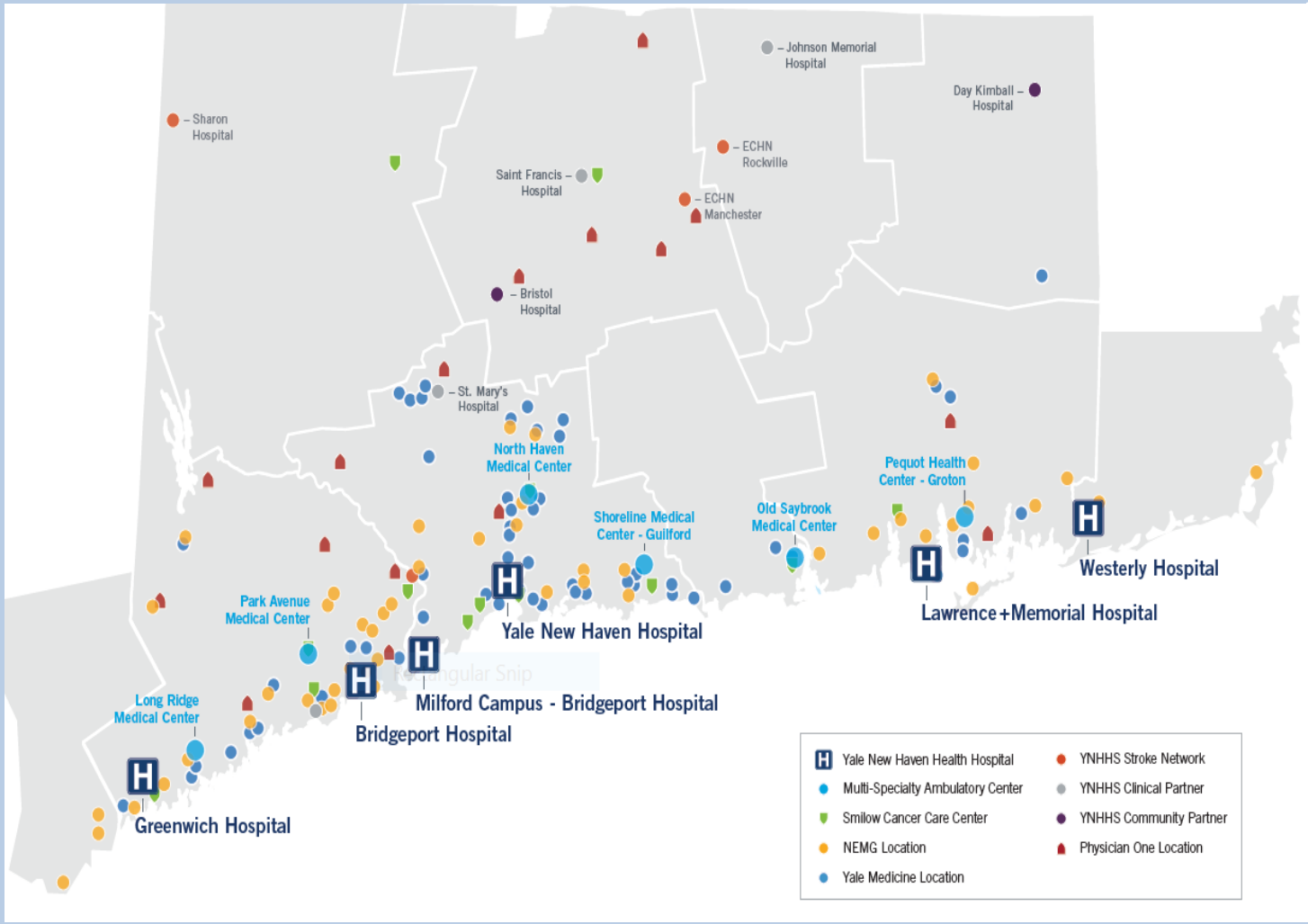
Yale NewHaven Health

Strategies During the First COVID-19 Surge

Karen L. DeSantis, MSN, RN
Performance Manager, Post-Acute Services

December 9, 2020

Yale New Haven Health System



Our Post Acute **Coordinated Care Network (CCN)** includes 40 Skilled Nursing Facilities and 56 Home Health Agencies.

Our Owned Facilities and agencies include:

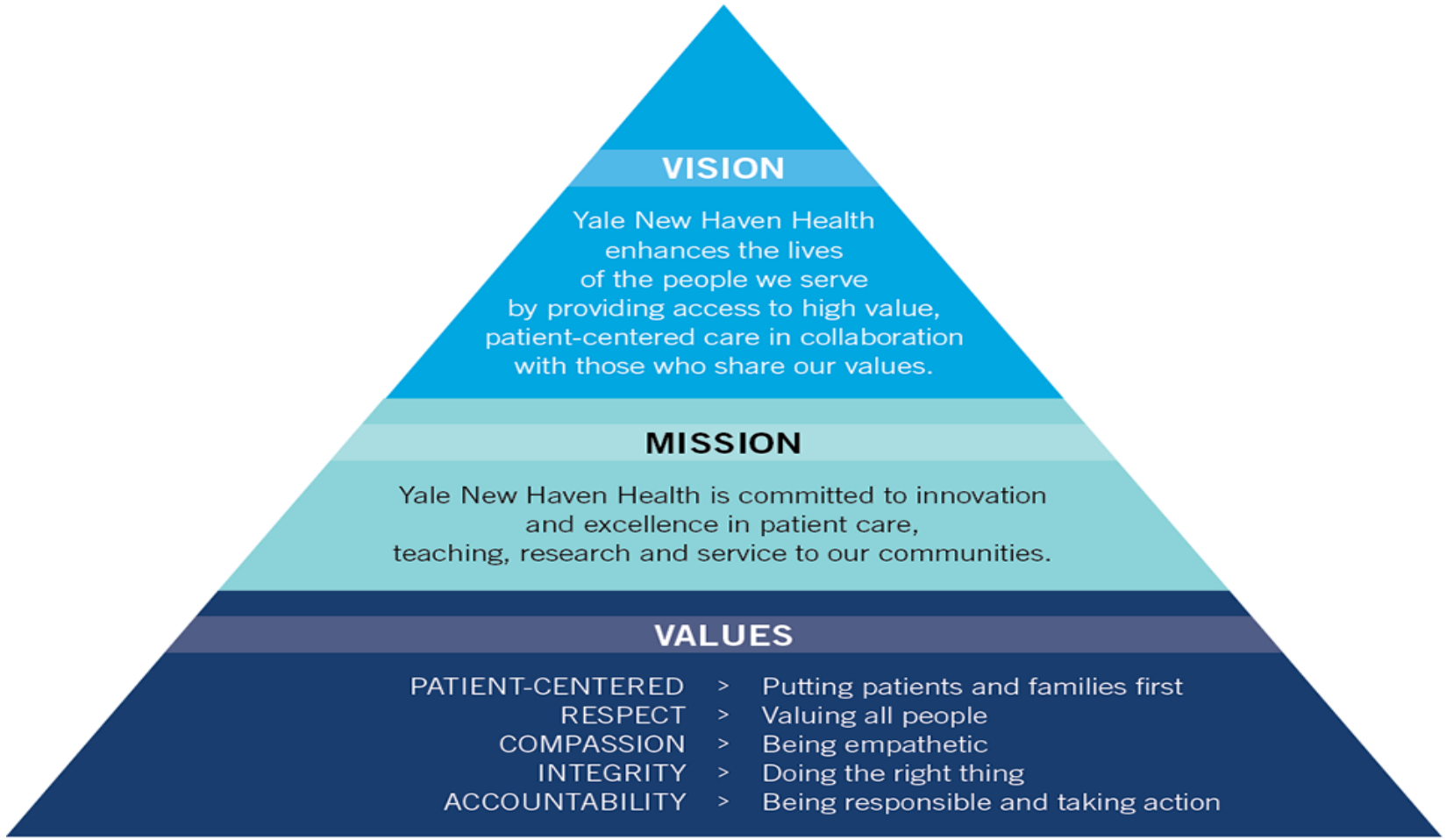
The Grimes Center New Haven

Home Care Plus
Milford

Home Care Plus SC
New Haven area

VNA Southeastern Waterford

VISION, MISSION AND VALUES



YaleNewHavenHealth

Bridgeport Hospital | Greenwich Hospital | Lawrence + Memorial Hospital | Westerly Hospital | Yale New Haven Hospital | Northeast Medical Group

Strategies During the First COVID-19 Surge

- Leadership meetings to discuss pertinent challenges and prioritization of initiatives.
  - The first intervention was to develop a tool that populated via survey questions. This helped our YNHHS inpatient Care Managers to identify which skilled nursing facilities had beds and what types of beds were available.
  - Initiated a weekly call with leadership of the large health systems in the state to share challenges and best practices. A representative from the DPH was added to the call when opportunities for improvement were identified.
  - **Development of a biweekly meeting with the Post- Acute Care community to help clarify and disseminate COVID-19 information in a timely and meaningful way.**
    - The first biweekly meeting was held on March 12, 2020. We decreased to one time weekly meetings by the end of April and discontinued the meetings at the end of May.
    - All local skilled nursing facilities and home health agencies were invited to attend regardless of affiliation with our CCN.

Yale NewHaven Health

Topics- “State of the State” and “State of the System”

- The state of COVID-19 in CT and RI
  - numbers of cases
  - number of mortalities
  - number of hospitalizations

- The State of YNHHS Hospitals and Communities
  - Locations of cases
  - Number of cases
  - Number of beds available
  - Ventilator status
  - Resource deployment to other Hospitals

Yale NewHaven Health

Topics- Providing Clarity and Guidance

- CDC and DPH guidance was frequently changing and confusing
  - Pulled out key takeaways from the websites or Blast Faxes and presented it in a clear concise way.
  - Modification of our information as it changed and informing the audience of changes.

- YNHHS COVID-19 education and tools were discussed and shared
  - PPE guidance
  - Swabbing guidance
  - Transition testing
  - Visitor policies
  - Isolation practices

Yale NewHaven Health

Topics- Q&A

- We offered a question and answer period at the end of each meeting.
  - Often a question in these sessions would lead us to focus on that topic for the next meeting.

- We shared the slides, with the attachments, a transcript of the Q&A and a presentation recording link to all participants after each meeting.

Feedback was 100% POSITIVE

Yale NewHaven Health

Lessons Learned

- Early engagement with our Community Collaborative was the cornerstone of our success.
- Bidirectional learning took place. We were able to understand their challenges and assist them in sifting through conflicting information that they were receiving.
- There was a need for Collaboration.
- Collaboration spread to other health systems and regulatory agencies.
- The structure for this program was utilized to stand up the SNF testing with our care partners.
- Included as part of our second wave planning, we have reinstituted these meetings on a weekly basis. They will go to biweekly if necessary.

Yale NewHaven Health

Yale NewHaven Health

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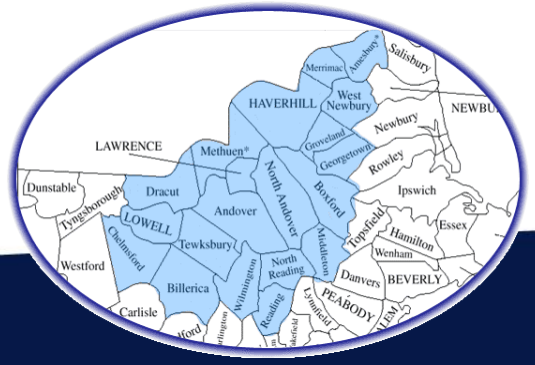
Lawrence General Hospital

Nicole Garabedian, MSN, RN
Director of Clinical Operations and Throughput

So good. So caring. So close.

Lawrence General Hospital

- Lawrence General Hospital is a 189 bed 41- bassinet private, non-profit community hospital providing care to Massachusetts' Merrimack Valley & Southern New Hampshire regions for nearly 140 years. Lawrence General Hospital is clinically affiliated with Beth Israel Deaconess Medical Center and Floating Hospital for Children at Tufts Medical Center.
  - Discharges are estimated at 13,000 for inpatients and 2,600 for observations annually.
  - Disproportionate share hospital with the second highest rate of low-income inpatient admissions.
  - Payer mix for the population is 70% government payers (Medicare/Medicaid)



Post Acute Incident Command Center

Participants:

- 2 Hospitals (different systems)
- 11 Skilled Nursing Facilities (SNFs) , 1 Acute Rehab (IRF), 1 Long Term Acute Care Hospital (LTAC)
- 8 Visiting Nurse Agencies (VNAs)/Hospice
- 8 Assisted Living Facilities (ALFs)
- 2 Physician Groups (SNFist)
- 1 Representative from the Quality Improvement Organizations (QIO)

Meeting Frequency:

- First Surge: Daily
- Second Surge: Twice a week

Top Three Initial Achievements

- Advance Care Planning/Goals of Care Discussions
- Testing
- Community Support

Preparing for the Second Surge

- Goal Evaluation and Assessment
- Early Flu Immunization
- Addition of ALF into Post Acute Network

The Future of the Post Acute Network

Agenda for Incident Command Meetings: Post Acute
1. Hospital Situational Update (Nicole) 2. External Situational Update (SNFist and QIO) 3. Organizational Report Outs: Any concerns from what is reported on the dashboard? Any needs or questions for the group?

Post Acute Incident Command Dashboard

	PPE	Visitors	Staffing	Overflow Areas Open	Patients in House w/Covid related barriers to discharge	Open Covid+ Unit	Number of Covid+ Patients	Concerns/Asks from the Group	Hospice/Palliative, Speciality Services expectations?
Lawrence General		Restrictions. Except MCH, Surgical Services, ICU and EOL.	Obtaining Travelers to assist with Overflow	4 Tele Beds and 4 MS beds on SDS 5 adult beds on pediatrics	15	Utilizing 1 MS unit for majority of Positive Patients	36 + 4 PUI 1 Keep	SNF Positive Units if Possible	

SNFs/IRFs/LTACs							
	PPE	Visitors	Staffing	Accepting Admissions	Bed Availability	Open Covid+ Unit	Number of Covid+ Patients
Example SNF/IRF/LTAC		Restrictions		Yes	2+ Open Bed		0

Home Health Agencies							
	PPE	Clean Team	Staffing	Ability to see patients within 24-48 hrs of d/c	Accepting New Patients	Accepting Covid + Patients	Number of Covid+ Patients
Example VNA		No		Yes	Yes	Yes	14

Assisted Living Facilities							
	PPE	Visitors	Staffing	Accepting New Residents?	Plan for accepting Covid + Residents back	Number of Covid+ Residents	Patients at LGH
Example ALF		scheduled with screening/PPE		Yes	Yes, individualized plan would be determined	0	2

Discussions/Themes	
Topic	Recommendations
In Home Testing (11/19/20)	testing services from that organization to assist. For example, many have onsite testing capabilities and might be able to send a nurse to the patients home and/or coordinate with the patient's VNA to obtain the swab and send it off for testing. Working with individual PCP offices and the labs they utilize for testing. Board of Healths in different towns have been providing testing and may be able to assist.
Transportation Options	Nurse Care in Methuen (approx. $50 for one way trip and they have chair vans): http://www.nursecaretransportation.org/ Uber Health https://www.uberhealth.com/ Gogo Grandparent https://gogograndparent.com/
Positive Family Members	VNA is reporting that they are discovering post discharge that the patient either lives with or has been exposed to a Covid+ patient. This then puts the nurse out on leave as they quarantine and test.
VNA Patient Discharges	VNAs are reporting that patients over the last week have been refusing home health services post discharge not wanting staff in their homes. This has caused the need for a lot of re-education and support to patients.
Positive Patients Post Discharge	One facility reported that they had three patients with negative tests then test positive via PCR 3 days after coming into the facility.

Structured…. Shared Data Dashboard… Clear Outcomes

Lawrence General Hospital

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SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

Managing COVID19 Pandemic in a Community Hospital

Margie Hackett, RN, BSN, BC-Gerontology

Transition Guide Nurse Manager

Suburban Hospital, A Member of Johns Hopkins Medicine

SUBURBAN HOSPITAL
Bethesda, MD

- Founded in 1943
- 228-bed acute care
- Patient population resides principally in Montgomery County, MD, and Northwest Washington, DC
- 11,880 admissions (FY 2020)
- 41,725 emergency department visits
- 1,124 trauma visits

Transition Guide Nursing at Suburban

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

- Transition Guide Nurse - focus 30 days post hospitalization
  - Post DC calls and home visits
  - Reinforcement of DC instructions
  - Connections and linkage to post acute referrals
- Who is served by TGNs?
  - Those identified as readmission risk
  - INPATIENTS ONLY
  - No Patients with Home Health or SNF dispositions (i.e. only those going home with self care)
  - COVID + patients – OBS and IP
- SNF Collaboratives
  - Hopkins
  - Nexus
  - Medical Directors
- Home Health Collaborative
- Special initiatives:
  - Mobile Medical Care referrals and coverage for hospital services
  - Hospital to Home and Private Duty
  - Remote Patient Monitoring for all Heart Failure Patients and other initiatives around Total Cost of Care for Maryland Care Redesign Programs

Changes in Transition Guide Nurse Role

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- COVID HOTLINE
- Community COVID Testing Site
- Go Teams for COVID Testing in the SNFs
- RPM Oximetry Program
- Post hospitalization call -coordination with nursing units and CRNP in ED
- PPE deliveries to SNFs and ALFs
- Communication with SNFs, ALFs, HHAs
- More Collaboration within internal Care Coordination Leadership and Teams
- CRISP SNF Capacity Report – daily reporting

Care Coordination Communication- steps

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

- COVID Rounds – daily 11:45 am with CM/SW teams, hospitalists, Care Coordination leadership
- Daily Completion of COVID Expectations of DC Disposition and Identification to potential barriers to discharge
- Hospitalist meeting – weekly Thursdays
- Daily Huddle COVID updates
- Daily afternoon COVID updates
- Johns Hopkins and Suburban each has its own Covid Information Portal
- Care Coordination Leadership Team Meetings- Weekly, sometimes daily
- Post Acute Calls started 3/31- 2 times weekly through end of June with plans to restart in the fall

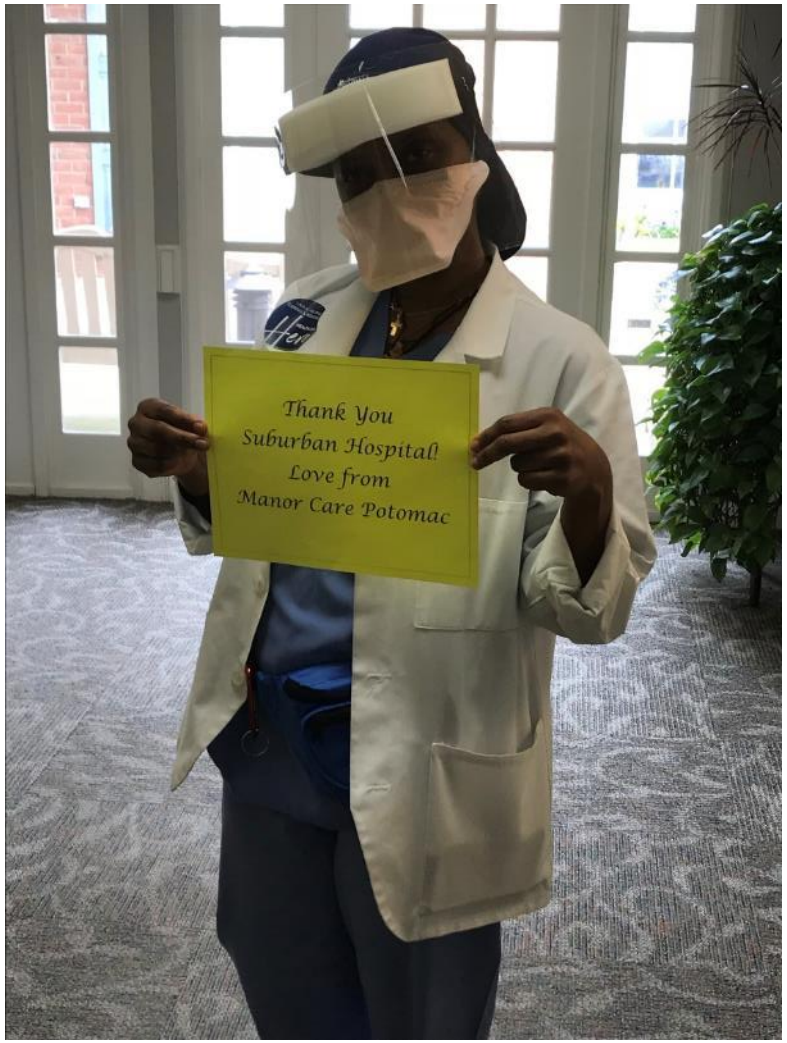
Information shared during Post Acute Calls

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

SUBURBAN HOSPITAL CENSUS – 5/5/20

- Covid-19: 75
  - →ICU: 11
  - →Stepdown: 13
- Non-Covid-19: 96
  - →ICU: 16
- BH: 12
- Total: 183

(Hospital licensed for 228 beds)



Information Shared during Post Acute Calls

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TOTAL COVID-19 Discharges from 3/18/20 through 5/4/20

SNF/LTC/ALF	Home	Johns Hopkins Hospital	NIH trial	Expired	Hospice	AMA	Total
56	104	31	7	57	7	1	263

EXPECTED DISCHARGES for 5/5/20

Hospice	Return to SNF/ALF	New SNF	Withdrawal of care	Home	JHH	Expired	Total
1 at LTC	2	1? Private pay		2 (1?)		1	6 (2?)

FUTURE DISCHARGES 5/5/20 AND BEYOND

Likely expire	Hospice	TBD	Return to SNF/LTC/Alf	Needs new SNF	AR	Home	JHH
1		8	36	8	1	16	1

NON-COVID-19 Discharges - 5/4/20 - 24

SNF – 3
Home 17
Expired – 1
Acute Rehab – 1
From Behavioral Health – 2 to home

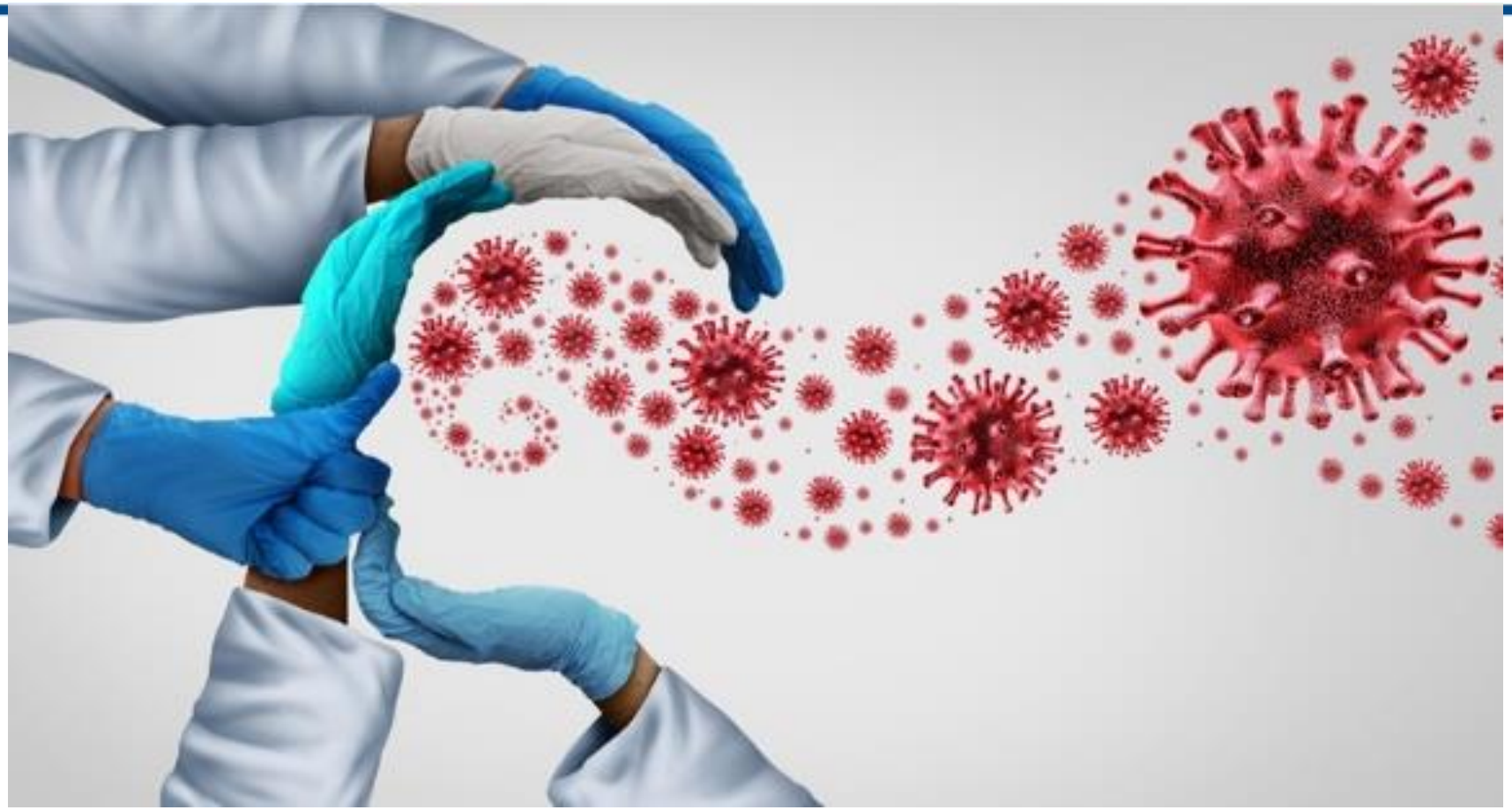
CURRENT CONCERNS

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

- Patients refusing post acute care
  - Refusing recommendations for a SNF rehab stay
  - Not allowing home health nurses and therapists in the home
  - Media coverage of SNFs is very negative
  - Not ready for end of life conversations

TEAMS against COVID

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE



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Facilitated Panel Discussion

Moderated by:

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Fred Ratto, IPRO, a member of the IPRO QIN-QIO

Panelists

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Before you go… we invite you to

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Create Connections
to enhance Health Outcomes In Your Community

This material was prepared by the IPRO QIN-QIO, a collaboration of Healthcentric Advisors, Qlarant and IPRO, serving as the Medicare Quality Innovation Network-Quality Improvement Organization for the New England states, NY, NJ, OH, DE, MD, and the District of Columbia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 12SOW-IPRO-QIN-T2-A4-20-239