

Essential Communication Strategies for Cross Continuum Infection Control: Lessons Learned

May 28th 2020

12:30 pm ET/ 11:30 am CT

Welcome!

- All lines are muted, so please ask your questions in chat
- For technical issues, chat to the 'Technical Support' Panelist
- Please actively participate in the evaluation "poll" that will pop up on the lower righthand side of your screen at the end of the presentation



We will get started shortly!

CMS Aims

Behavioral Health Outcomes and Opioid Misuse



- Promote opioid best practices
- Decrease high dose opioid prescribing and opioid adverse events in all settings
- Increase access to behavioral health services

Patient Safety



- Reduce risky medication combinations
- Reduce adverse drug events
- Reduce C. difficile in all settings

Chronic Disease Self-Management



- Increase performance on ABCS clinical quality measures (i.e. aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- Smoking cessation
- Identify patients at high-risk for developing kidney disease and improve outcomes
- Identify patients at high risk for diabetes –related complications and improve outcomes

Quality of Care Transitions



- Convene community coalitions
- Identify and promote optimal care for superutilizers
- Reduce community-based adverse drug events

Nursing Home Quality



- Improve the mean total quality score
- Develop national baselines for healthcare related infections in nursing homes
- Reduce emergency department visits and readmissions of short stay residents



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Objectives

- By the end of this session, you will be able to:
 - Discuss the importance of Best Practice Tools for Cross Continuum Communication and Care Management
 - Identify tools and resources for effective Infection Control Communication across Care Settings
 - Discuss lessons learned from the field for improved cross continuum care management of patients with Infections.

Richard Poveromo, LMSW, CCM, HEC-C

ASSISTANT VICE PRESIDENT TRANSITIONS OF CARE



Richard is the Assistant Vice President for Transitions of Care at Mather Memorial Hospital. He has a Master's degree in Social Work from Stony Brook University, with a specialization in Health and sub-specialization in alcohol and substance abuse. He has an Advanced Graduate Certificate in Health Care Management, a Certification in Case Management, and was one of the first Certified Healthcare Ethics Consultants in the United States.

Richard is a Co-Chair of the Mather Ethics Committee, member of the Readmissions Task Force, Palliative Medicine Committee, Length of Stay Task Force, Northwell SBIRT/NAL-SAT Workgroup and Leadership Development Team. With over 10 years as a medical social worker, director, and AVP he has implemented numerous strategies to address care transitions, evolving regulatory requirements, patient satisfaction, and care coordination for patients and families in the community.

rpoveromo@Northwell.edu

David Siskind, MD, CMD

CHIEF MEDICAL OFFICER

David Siskind, MD, CMD is the Chief Medical Officer at the Gurwin Jewish Nursing & Rehabilitation Center in Commack since December 2011. Prior to that, he was Medical Director for Our Lady of Consolation Nursing Home (West Islip) and Good Samaritan Nursing Home (Sayville). He attended Trinity College in Hartford, Connecticut where he received a B.A. in History and medical school at The Autonomous University of Guadalajara in Jalisco, Mexico. Dr. Siskind went on to complete an Internship in Surgery at Nassau County Medical Center and a Residency in Family Practice at South Nassau Communities Hospital. He is board certified in Family Practice and Hospice and Palliative Medicine and is a Certified Medical Director by the American Medical Director's Association. He is a Voluntary Clinical Assistant Professor in the Department of Medicine at the State University of New York at Stony Brook and Past-President of the New York Medical Director's Association. He serves on the Board of Directors of Long Island Select Healthcare, a Federally Qualified Health Center serving developmentally disabled children and adults and on the Education Committee of the American Medical Directors Association.



Contact: dsiskind@gurwin.org

Anthony Dawson, RN, MSN

VICE PRESIDENT QUALITY AND CUSTOMER EXPERIENCE



Anthony is the Senior Clinical Expert at VNSNY, heading up the Clinical Expert Response Team (CERT). In his current role, he is responsible for leading the development of all clinical protocols regarding the care and treatment of COVID-positive, COVID-presumptive and traditional home care protocols during the COVID-19 Pandemic. In addition, he is responsible for the development of PPE protocols to protect the VNSNY staff and patients during this pandemic. These protocols allow the VNSNY staff to continue to provide exceptional safe care for some of the most vulnerable patients who are now discharged from hospitals and clinics following a Covid-19 illness. Previously at New York-Presbyterian Hospital, Tony is experienced at directing Clinical Operations and Patient Services. He is an expert in leading cross-functional teams across multiple specialties leading to improved patient satisfaction and quality of care. Tony has a successful track record in leading multidisciplinary teams, building nursing/physician relationships, leading and motivating staff. He is adept, at evaluating operations, strategic planning and leading development/implementation of short-and long-range goals. He has led many comprehensive initiatives to meet regulatory requirements including Department of Health, Centers for Medicare and Medicaid Services and The Joint Commission.

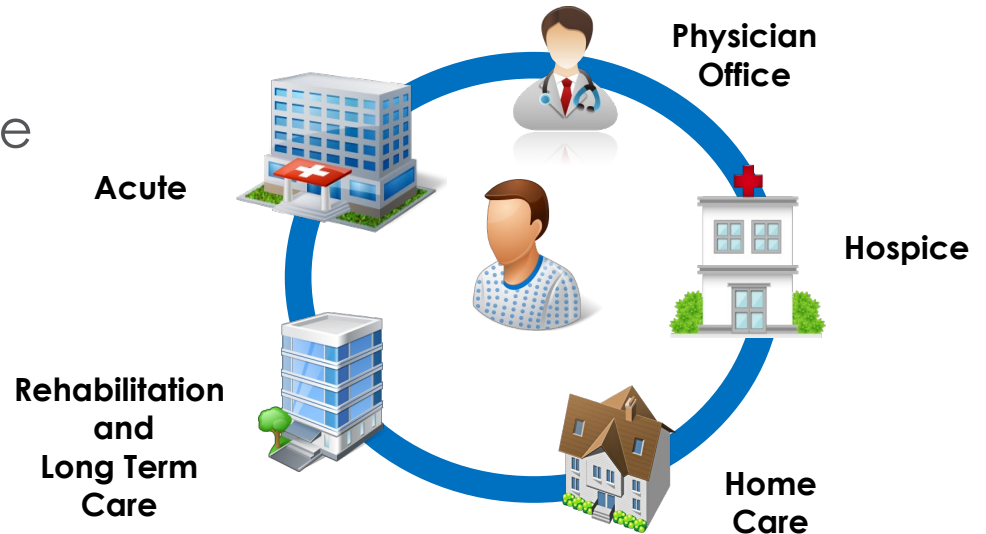
anthony.dawson@vnsny.org

Problem:

- How do we best manage communication across the care continuum to minimize exposure for patients and staff while maximizing care during a pandemic?

Post-Acute Services & Keeping Partners Notified

- Assess communication needs for ED and discharge
- Coordinate with stakeholders to set expectations
- Monitor changing regulations and guidelines
- **BE FLEXIBLE**



Discharge Planning Screen

To download this document please visit

<https://www.alliantquality.org/library-of-resources/>

ACM DOCUMENTATION FORM Discharge Planning COVID-19 Screen

Affix patient label

Criteria for 2019 Novel Coronavirus Discharge Screen

- | | | |
|--|------------------------------|-----------------------------|
| 1. The patient is considered a "Person Under Investigation" (PIU) for COVID-19 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. The patient been confirmed as positive for COVID-19 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Patient is being discharged with Home Care Services/Home Hospice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Did the patient meet criteria for testing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Guidance for Discharge to Home/Home with Home Care/Home Hospice Assessment and Patient Education

- | | | |
|--|------------------------------|---|
| 1. The patient is stable enough to receive care at home. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Appropriate caregivers are available as needed. | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Applicable |
| 3. As much as possible, instructions to stay in a specific room and away from other people in the home. Also, instructions to use a separate bathroom, if available. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Resources for access to food and other necessities are available. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. If patient is being discharged on anticoagulant, delivery address has been verified and if different than registration, task sent to Pharmacy. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. The patient and other household members have access to appropriate, recommended personal protective equipment (at a minimum gloves and facemask) and are capable of adhering to precautions recommended as part of home care or isolation (e.g. respiratory hygiene and cough etiquette, hand hygiene)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. There are household members who may be at increased risk of complications from 2019-nCoV infection (e.g. people > 65 years old, young children, pregnant women, people who are immunocompromised or who have chronic heart, lung, or kidney conditions)
<small>*see Care Coordination Progress Notes</small> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Guidance for Covid-19 Negative Patients Being Discharged Home Who Require Home Care Services

- | | | |
|---|---|--|
| 1. Do any household members meet the screening criteria for COVID-19 testing? | <input type="checkbox"/> Yes, contact Home Care/Hospice | |
| | <input type="checkbox"/> No, routine discharge | |

Screening Criteria for Discharge to Post-acute Facility

- | | | |
|--|------------------------------|---|
| 1. The patient is stable enough to receive care at home. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Appropriate caregivers are available as needed. | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Applicable |
| 3. As much as possible, instructions to stay in a specific room and away from other people in the home. Also, instructions to use a separate bathroom, if available. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Resources for access to food and other necessities are available. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. The patient and other household members have access to appropriate, recommended personal protective equipment (at a minimum gloves and facemask) and are capable of adhering to precautions recommended as part of home care or isolation (e.g. respiratory hygiene and cough etiquette, hand hygiene)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. There are household members who may be at increased risk of complications from 2019-nCoV infection (e.g. people > 65 years old, young children, pregnant women, people who are immunocompromised or who have chronic heart, lung, or kidney conditions)
<small>*see Care Coordination Progress Notes</small> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. It has been at least seven days since the initial positive test for COVID-19 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Resolution of fever, without use of antipyretic medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Improvement in illness signs and symptoms | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive sets of nasopharyngeal swabs specimens collected 24 hours apart. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Discharge Disposition Plan/Location

- | | | |
|---|------------------------------|-----------------------------|
| <input type="checkbox"/> Home/Home with Homecare/ Home Hospice services positive COVID-19 patient | | |
| COVID-19 Patient education materials provided | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Personal Protective Equipment (PPE) pack provided | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Certified Home Health Agency notified via warm handoff, if applicable | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Post-discharge address verified/communicated to Pharmacy (if applicable) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Home/Home with Homecare/ Home Hospice services for COVID-19 negative patient with COVID-19 positive household member | | |
| COVID-19 Patient education materials provided | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Personal Protective Equipment (PPE) pack provided | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Certified Home Health Agency notified via warm handoff, if applicable | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Home with Home Care routine discharge | | |
| <input type="checkbox"/> Post-Acute Facility | | |
| Sent documentation of criteria met with referral | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Post-Acute receiving facility contacted to provide warm handoff | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Staff Information

Print Name: _____ Title: _____
 Signature: _____
 Date/Time: _____ Phone Number: _____

GURWIN HEALTHCARE SYSTEM STRATEGIES

- The problem:
 - Rapidly, sometimes daily, changes in regulatory guidance, supply chain concerns, community prevalence data, etc.
 - Dissemination of information across multiple sites and agencies: Skilled Nursing, Assisted Living, Certified Home Health Agency and Licensed Home Care Agency

GURWIN HEALTHCARE SYSTEM STRATEGIES ₂

- The solution:
 - Weekly meetings (on-site and remote) of all senior level administrators and department heads
 - Meetings initially three times per week during early phase of the pandemic, now weekly and as needed
 - Review of data and trends both state and system wide
 - Review of latest pertinent regulatory guidance
 - Review of current patient management strategies (isolating, cohorting, etc.)
 - PPE availability and use

VNSNY Services Most Heavily Impacted by COVID-19



Service Line	Core Services	Typical Active Daily Patient Census
CHHA and Care Management Organization	Traditional Home Care , including telehealth and virtual care management.	~ 9,000 patients
Hospice	End-of-life and palliative care	~ 1,400 patients
Personal Care (Home Health Aide) Services	In-home support with activities of daily living for patients and members across VNSNY	~ 9,000 personal care workers
Medicaid Managed Long Term Care Program	A 'nursing home without walls' program serving individuals with ongoing in-home long-term care support needs, including personal care (home health aide) services	23,000 members Cared for by ~ 35,000 personal care workers (9,000 employed by VNSNY)
Community Mental Health	Behavioral health support and linkages for vulnerable individuals	Annually, 14,000 clients served

VNSNY's COVID-19 Response Planning Framework



- **Guiding principles** for VNSNY's COVID-19 emergency response:
 1. **Protect our patients and staff**
 2. **Address NYC's pressing public health need by supporting decompression of local inpatient facilities**
 3. **Mitigate impact to the organization where possible**

- **These principles have guided our response in 7 key areas:**
 - A. Shift of office-based staff to remote-work
 - B. Employee communication
 - C. HR Policies and Employee Support
 - D. Supplies and PPE Procurement and Management
 - E. Volume Impact and Financial Tracking
 - F. Clinical Response and Service Delivery (CHHA, Hospice, Personal Care Services)
 - A. Transition to Virtual Care
 - B. Home Care Criteria
 - C. Hospice-specific Considerations
 - D. PPE Protocols
 - G. Regulatory Considerations and Advocacy Priorities

The VNSNY COVID-19 Response Timeline: 3 Phases

NYC Confirmed

Cases

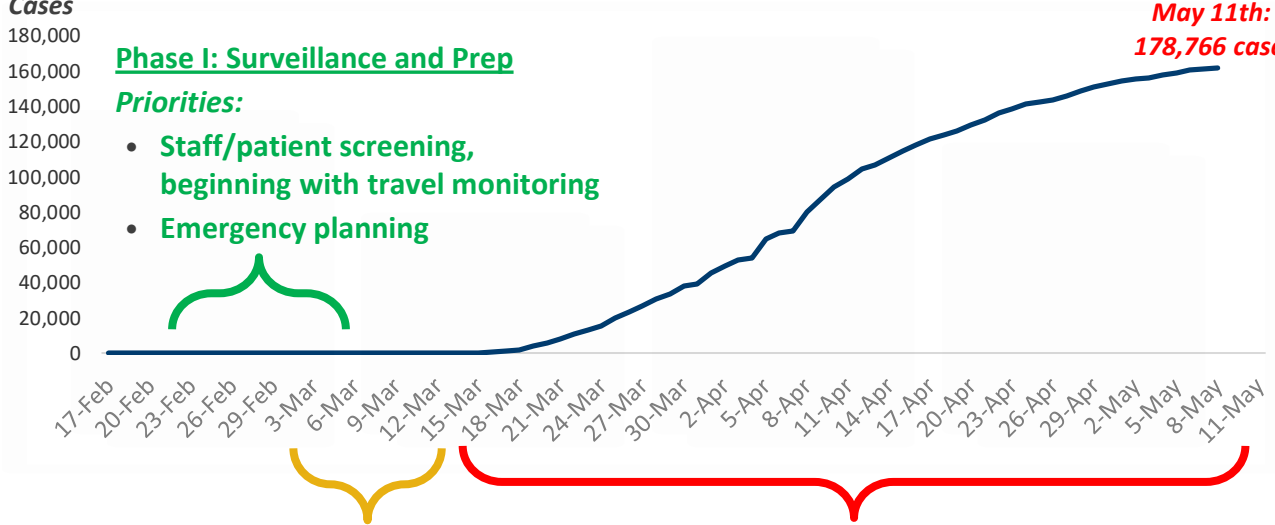
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0

Phase I: Surveillance and Prep

Priorities:

- Staff/patient screening, beginning with travel monitoring
- Emergency planning

May 11th:
178,766 cases



Phase II: Mobilization

Priorities:

- Protect Patients/Staff
- Secure PPE
- Move to Tele-Work

Priorities:

Phase III: Emergency Response

- Protect Patients/Staff
- Decompress overwhelmed hospital systems
- Care for COVID19-positive patients
- Strengthen PPE Pipeline
- Advocate for emergency regulatory relief
- Manage acute staffing shortages

VNSNY's COVID-19 Response Governance Structure



VNSNY Executive Team

(7 leaders- daily 8:30am COVID-19 virtual-huddles)

Emergency Response Planning Team

(45 leaders- daily 9am calls)

Clinical/Infection Control Leadership Team *(daily 10am calls)*

Clinical Emergency Response Hotline Team (CERT): *available 7 days/week*

Supplies & PPE Procurement and Management

2x/week calls

Workforce and Human Resources

Daily calls

Regulatory Affairs and Compliance

Daily calls/updates

Financial Tracking and Metrics

*Several new dashboards
developed*

Communications (Internal & External)

Communications



- Initially, centralization of messaging critical to ensuring accuracy
- Move to more department-specific comms over time
- Use multiple channels to expand reach

(a) Conveying of information

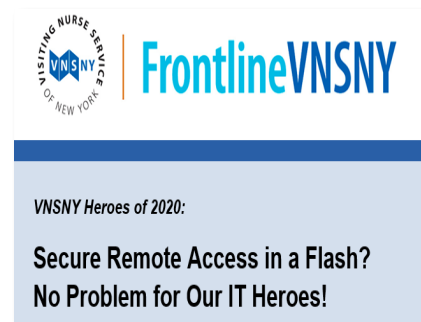
- Used “branded” template for all email; placed content on COVID-19 Intranet Hub; texts, videos, conf calls, audio messages
 - Primary information categories:
 - FAQs, Clinical Advisories, Business Advisories, Clinical Protocols
 - Weekly email updates to Board of Directors

(b) Engaging staff through other channels

- Daily inspirational audio messages sent by the CEO to all staff
- Weekly all-staff conference calls with the CEO + video message
- Weekly all-staff conference calls *by business unit*
- Heroic field staff stories; staff pictures/videos working remotely

Lesson learned:

- Create a mechanism for two-way communication so staff are heard
- Need to communicate clinical information and that is complex and evolving, *while also* communicating supportive, empathetic information. Staff may well be anxious and need some level of reassurance.



Clinical Response and Service Delivery:

Disclaimer on Clinical Guidance Presented Here



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Clinical Response and Service Delivery: *Virtual Care*



We transitioned CHHA and Hospice to virtual care where possible

- **Developed new patient triage methodology** to identify which visits could be replaced with virtual encounters, in order to minimize in-person exposures
- **Updated admission criteria** to effectively triage patients during intake
- **Created virtual visit guidelines and workflows** for clinicians to collaborate with ordering physicians, document updates to plans of care as appropriate
- **Allowed for temporary use of various available virtual visit technologies**, consistent with CMS guidance (including FaceTime, WhatsApp, etc.)
- **Tightened Interdisciplinary process** to ensure no duplication of service across disciplines

Clinical Response and Service Delivery: *Home Care Admission Criteria*



Given acute staffing shortages, we adapted our service delivery criteria to ensure we prioritized:

- 1) **Protection of patients and clinical staff** from COVID-19 exposure
- 2) **VNSNY's role in supporting local hospitals** to decompress inpatient beds, including admission of COVID-19 positive patients
- 3) **Preservation of scarce PPE**

These criteria prioritized admissions considered essential, i.e. admissions that:

- A. **Are absolutely required** to prevent significant medical decline, or prevent a hospital admission
- B. **Enable patients (especially COVID19-positive) to be discharged from a hospital** to free-up beds, or prevent an admission to the hospital

Note on timing of COVID19-positive admissions: given acute lack of sufficient PPE until mid-March, VNSNY began admitting COVID19-positive patients into our CHHA and Hospice *only after* receiving an initial emergency supply from the NYC Office of Emergency Management

Clinical Response and Service Delivery: *Additional Home Care Admission Criteria*



Critical Care Equipment Requirements	Caregiver in place	Medication Access	Physician Outreach
<ul style="list-style-type: none">• All equipment and supplies should be in the home on day of discharge• Verify whether pulse oximeter is being sent home with patient• Verify whether there are any aerosol treatments involved (and if available, whether patient is independent or not with aerosol treatments)	<ul style="list-style-type: none">• Patients must have a caregiver, unless they are independent and can care for themselves, able to get medications, etc.	<ul style="list-style-type: none">• Ensure that patients have a means of receiving their medications (either by picking it up themselves, having a caregiver deliver to them, or whether a pharmacy will deliver to them)	<ul style="list-style-type: none">• Patients must have a physician who is available to coordinate care during this time.• If a patient's physician is not available during this time, there must be an alternate physician, PA (Physician Assistant), or NP (Nurse Practitioner) available to provide and sign orders to the field clinicians.

Clinical Response and Service Delivery: Hospice-specific Considerations and Challenges



VNSNY Hospice Care Core Values of Empathy, Agility and Integrity guided our response to COVID–19 pandemic

Hospice-specific Challenges

- VNSNY’s Hospice program experienced the organization’s **first admissions** of confirmed COVID19-positive patients (initially GIP)
- **High-risk end-of-life procedures** for COVID19-positive patients, requiring highest-levels of PPE for staff (including N95 respirators)
- **IDG Team Members** played a critical role to provide service delivery to our patients
- **Hospice Physicians** played a key role in ePrescribing medications to our patients and also in certifying deaths
- Online **Social Work** support provided to the entire VNSNY enterprise
- **Critical staffing** shortages at the Epicenter required utilizing triage skills of our **After Hours** staff to assist
- **Body removal. Due to the** high numbers of deaths in NYC, local funeral homes have begun to refuse or delay body removal, requiring VNSNY to partner with City Medical Examiner’s office for alternative solutions to remove bodies from homes
- **Bereavement Services** – grief and the impact of COVID-19

PPE Protocols: Protocols A and B

We created four patient protocols to guide clinicians on PPE usage:

Protocol A Patient (positive, lower-risk, less PPE)

- At least **7 days** since onset of symptoms **AND**
- At least **48-72 hours since fever is resolved** without the use of fever-reducing medications and improvement **AND**
- **Overall improvement in illness** (e.g. improving cough, shortness of breath)
- * **HHA – REGULAR HOURS**

Protocol A

Clinicians must follow Contact and Droplet Precautions:

- Surgical mask
- Gown
- Gloves
- Shoe Cover When Available
- Head Cover When Available
- Gown may be discontinued after 7 days of home care admission **AND** overall improvement in illness (e.g. improving cough, shortness of breath). Then continue Standard Precautions, including surgical mask and gloves for this patient population.

Protocol B Patient (positive, higher-risk, more PPE)

- **Evaluated/diagnosed/treated as COVID-19** in the Emergency Room or Clinic, Hospital and released home (Treat and Release)
- **Patients report symptoms on Pre-visit Screening** (positive Pre-visit screen)
- **Diagnosed with COVID-19 while on service**
- Referred from the following institutions, nursing homes, adult care facilities, and certain other congregate living facilities (that are not COVID positive or symptomatic) – Switch to Protocol A after 7 days from SOC without symptoms for this population.
- Gown/DC per A
- * **HHA RESTRICTED HOURS
MAXIMUM TWO HOURS**

Protocol B

Initial home care and hospice visits, clinicians use Contact, Droplet, and N95:

- N95 Respirator
- Cover N95 Respirator with Surgical mask OR Face shield to prevent droplet contamination of the N95 (discard surgical mask after the visit, face shield may be discarded if unable to clean between patients)
- Gown
- Gloves
- Eye protection (face shield or goggles)
- Shoe Cover When Available
- Head Cover When Available

PPE Protocols: Protocols C and D

We created four patient protocols to guide clinicians on PPE usage:

Protocol Patient (negative, but household member positive)

- Patients without Covid-19 diagnosis or symptoms but who have a household member/family/home care companion living in the same home with lab-confirmed COVID-19 OR COVID-19 symptoms (fever, cough/shortness of breath).
- Clinicians should ask symptomatic household member to stay in a separate room or maintain distance of >6 feet for the duration of the home visit.
- *HHA RESTRICTED HOURS MAXIMUM **TWO** HOURS if symptomatic household member cannot be isolated in another room.

Protocol C

Initial home care and hospice visits, clinicians should follow Droplet and Contact Precautions

- Surgical mask
- Gown
- Gloves
- Shoe Cover When Available
- Head Cover When Available

For subsequent visits, screen the patient for COVID-19 symptoms. If the screening is positive, follow protocol B.

Gown may be discontinued after 7 days of household member's isolation AND overall improvement in illness (e.g. improving cough, shortness of breath) and Clinician and HHA must then follow Standard Precautions, including surgical mask and gloves for this patient population and HHA CAN START OR RESUME REGULAR HOURS.

Protocol D Patient (negative, lower-risk, less PPE)

- Patients without Covid-19 diagnosis or symptoms (fever, cough/shortness of breath).
- Or the patient has a past medical history of Covid-19 diagnosis and are now asymptomatic.
- (14 days have passed from 1st day of diagnosis and the patient has no Covid-19 symptoms).

Protocol D

Initial home care and hospice visits, clinicians should follow wear:

- Surgical mask
- Gloves
- Gown When Available

For subsequent visits, screen the patient for COVID-19 symptoms. If the screening is positive, follow protocol B.

PPE Protocols: COVID-19 Kit Contents



COVID-19 Positive *Start of Care* Kit: for CHHA Starts of Care Only

- N95 Respirator (for Protocol B only)
- Surgical face masks
- Gowns
- Face shields
- Head cover
- Paper bag for mask re-use
- Shoe covers
- Plastic bags for disposal of PPE
- Alcohol Wipes
- Thermometer
- Blood Pressure Cuff
- Stethoscope

COVID19-Positive Standard Kit (CHHA Follow-up Visits, Hospice, Personal Care Workers)

- N95 Respirator (for Protocol B only)
- Surgical face masks
- Gowns
- Face shields
- Head cover
- Paper bag for mask re-use
- Shoe covers
- Plastic bags for disposal of PPE
- Alcohol Wipes

Note: For all staff, including personal care workers (home health aides), we have limited the length of visits requiring COVID-19 PPE to a maximum of 2 hours

Resources on our home page

<https://www.vnsny.org/coronavirus-covid-19/covid-19-professional-resources/>

- Protocol for Donning and Doffing of Personal Protective Equipment (UPDATED: May 6, 2020)
- Patient Care Protocol for COVID-19 Positive/Suspect Patients and COVID-19 Negative Patients: Home Care and Hospice (UPDATED: April 28, 2020)
- Protocol for the Limited Reuse and Extended Use of N95 Respirators and Face Shields (April 28, 2020)
- COVID-19 Personal Protective Equipment (PPE) Guidelines (April 16, 2020)
- Personal Protective Equipment (PPE) Competency Checklist (April 2, 2020)
- Personal Protective Equipment (PPE) Guidelines for Home Health Aides
- COVID-19 PPE Guidelines for Home Health Aides (April 22, 2020)
- COVID-19 PPE Guidelines for Home Health Aides – IN SPANISH (April 22, 2020)
- COVID-19 PPE Guidelines for Home Health Aides – IN CHINESE (April 22, 2020)

Training Videos

- How to Don and Doff PPE for COVID-19+ Recovering Patient (April 3, 2020)
- How to Don and Doff PPE (March 31, 2020)

Things to think about - we have been doing this for 127 years



- ✓ Daily employee screening and monitoring that data
- ✓ CERT Team to support your other teams- although we are large we have a relatively small number of staff in EHS/HR – track and trend data over time
- ✓ Keeping EE and patients safe, not seeing positive covid-19 patents until we had sufficient and appropriate PPE
- ✓ Full PPE for Hospice pts – high risk
- ✓ PPE distribution WWW
- ✓ PPE and HIPAA –Training /dist. centers and managers with embedded D&D Protocols
- ✓ 7000 HHA PPE donning and doffing
- ✓ Rapid discharge from Hospital ER because they were stressed to the max – walking well sent home with underlying conditions – COPD, CHF, HF
- ✓ D/C from SNF, LTCF
- ✓ Transport to and from work – crowded subways – homeless and reduced service
- ✓ Parking passes for staff so they could drive to see patients vs taking public transportation
- ✓ Future business – Hospitals Systems becoming Covid+ only
- ✓ Elective and urgent surgeries
- ✓ Next phases testing and tracing
- ✓ Preparing for the Fall
- ✓ Preparing for audits and inspections

Questions:

- Please enter your questions in the Chat



Contact Information:



Richard Poveromo

LMSW, CCM, HEC-C

Assistant Vice President
Transitions of Care

rpoveromo@Northwell.edu

David Siskind

MD, CMD

Chief Medical Officer

dsiskind@gurwin.org



Anthony Dawson

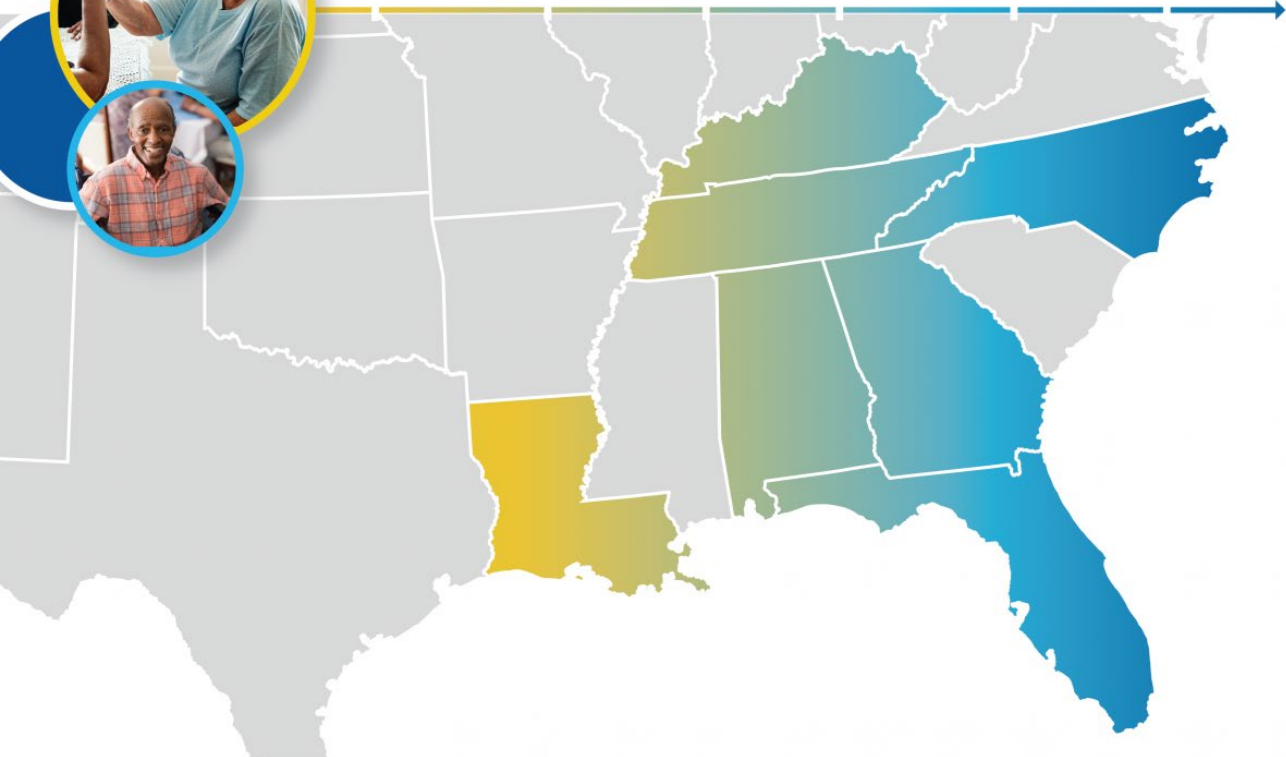
RN, MSN

Vice President Quality
and Customer Experience

anthony.dawson@vnsny.org



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Georgia, Kentucky, North
Carolina, or Tennessee
Leighann Sauls
Leighann.Sauls@AlliantHealth.org



Alabama, Florida, or Louisiana
Jeana Partington
Jeana.Partington@AlliantHealth.org

Program Directors



Upcoming Events

Nursing Homes

Tuesdays, 2pm ET/1pm CT

Community Coalitions

Thursdays, 12:30 pm ET/11:30am CT

June 16 th , 2020: Assessing and Reducing Opioid Prescribing in Long Term Care	June 25 th , 2020: Partnering Across the Healthcare Continuum for the Complex Chronic Care Population
July 21 st , 2020: Managing Behavioral Challenges In Long Term Care to Prevent Hospitalization	July 30 th , 2020: Population Health Assessments: Identifying Hidden Risks
August 18 th , 2020: Initiating an Effective Medication Reconciliation Program	August 27 th , 2020: Using SBIRT for Effective Screening and Referral to Treatment
September 15 th , 2020: High risk medication use and quality practices to prevent ADE	September 24 th , 2020: Opioid Use in the Aging Population
October 20 th , 2020: Understanding and using QAPI elements in day to day care processes	October 29 th , 2020: Blood Glucose Targets And Adapting Treatment Goals For Special Populations

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