Care Planning for Successful Transitions During COVID-19

Welcome!

- All lines are muted, please ask your questions in Q&A
- For technical issues, chat to the 'Technical Support' Panelist
- Please actively participate in polling questions that will pop up on the lower righthand side of your screen

We will get started shortly!

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Care Planning for Successful Transitions During COVID-19

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Ms. Kazdan currently holds the position of Director, Health Care Quality Improvement for IPRO, the Medicare Quality Improvement Organization for New York State. Ms. Kazdan leads IPRO's work with Project ECHO® and serves as the Care Transitions Lead for Alliant Quality. Ms. Kazdan previously led the IPRO's work with the NYS Partnership for Patients and the Centers for Medicare & Medicaid Services (CMS) Special Innovation Project on Transforming End of Life Care in the Nassau and Suffolk County region of New York State. Prior to joining IPRO, Ms. Kazdan served as a Licensed Nursing Home Administrator and Interim Regional Director of Operations in skilled nursing facilities and Continuing Care Retirement Communities in New York, Pennsylvania, Ohio and Maryland. Ms. Kazdan has served as a senior examiner for the American Healthcare Association's National Quality Award Program, and currently serves on the MOLST Statewide Implementation team and Executive Committee. Ms. Kazdan was awarded a Master's Degree in Health Services Administration by The George Washington University.

Carolyn enjoys visiting her grandchildren, photography, crocheting, needlepoint, reading and being at the beach!

"I don't have to chase extraordinary moments to find happiness - it's right in front of me if I'm paying attention and practicing gratitude"
–Brene Brown

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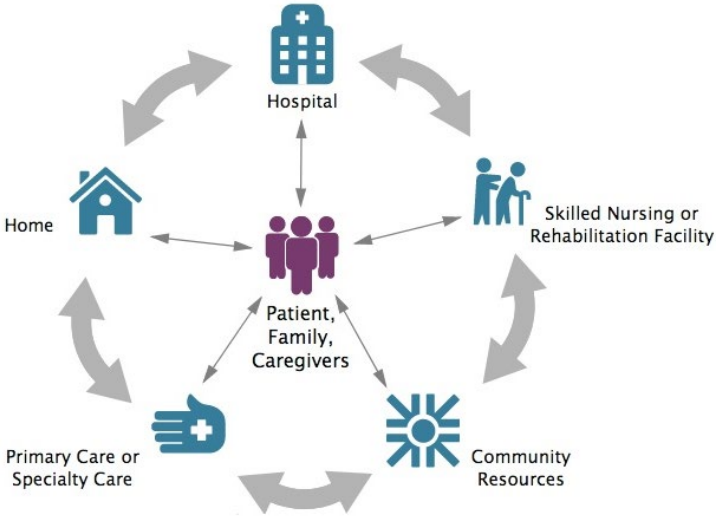
Objectives

- **Learn Today:**
  - Discuss components of effective facility to post-acute care and potential barriers imposed by COVID-19 protocols.
  - Describe challenges faced by family caregivers during the COVID-19 pandemic and their impacts on delivering effective transitional care.
  - Troubleshoot solutions to transitional care barriers associated with COVID-19
- **Use Tomorrow:**
  - Review your facility's transitional care processes impacted by COVID-19 and identify one strategy to implement that would improve your process.

Care Transition Defined

- Movement of patients from one setting or provider to another often as a result of an acute or chronic change in health status or care requirements.
  - Home-to hospital
  - Movement between care units
  - Hospital-to-home
  - Hospital-to-facility
  - Home-to-facility
  - Facility-to-home
  - Provider-to-home
  - From primary care to specialty care



https://www.pcori.org/topics/transitional-care/about-transitional-care

Care Essential Bundle: Interventions for Effective Care Transitions

- Medication management
- Transition planning
- Patient and family education
- Healthcare providers engagement
- Follow-up care
- Information transfer
- Shared accountability across providers and organizations

(National Transitions of Care Coalition)

Care Essential Bundle: Medication Management

- Goal: Ensure safe use of medications by patients and their families

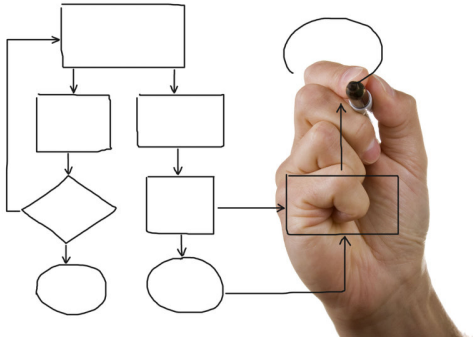
  - Assessment of medication use patterns
  - Patient and family education and counseling about medications
  - Development and implementation of a medication management plan
    - Medication reconciliation
    - Plan to acquire medications after discharge
    - Collaborative medication education
    - Team approach

    (National Transitions of Care Coalition)

Care Essential Bundle: Transition Planning

- Goal: Establish a formal process to support safe transitions of patients from one level of care to another.
  - Assigned professional with responsibility for transition process
  - Management of patient and family transition needs
  - Use of formal transition planning tools
    - Some are COVID specific
  - Development of transition summary which is transmitted to receiving provider/facility in a timely manner

(National Transitions of Care Coalition)



Care Essential Bundle: Patient/Family Education

- Goal: Educate patients and caregivers to support to enhance participation in self-management and decision making.

  - Patient and family knowledgeable of condition and plan of care including "red flags"
  - Patient and family-centered transition communication
    - "Real time patient- and family-centered handoff communication"
  - Development of effective self-management skills
    - Teach back techniques

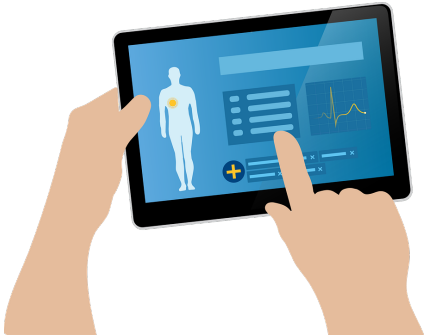
  (National Transitions of Care Coalition)

Care Essential Bundle: Information Transfer

- Goal: Share timely care information among patient, family/caregiver, and receiving healthcare providers in a timely and effective manner

  - Utilization of evidence-supported communication models.
  - Implementation of of formal communication tools
  - Assigned individual responsible for information transfers

  (National Transitions of Care Coalition)



Care Essential Bundle: Follow-up Care

- Goal: Execute follow-up care activities to support effective, safe transitions of care
  - Patients and family caregivers provided contact information for follow-up healthcare providers
    - Appointments for follow-visits with providers
    - Appointments for follow-up testing/diagnostics
    - 24-hour follow-up question line
    - Face-to-face visit within 48 hours of discharge
  - Communication of follow-up plan with patient, family caregiver, provider

(National Transitions of Care Coalition)

Care Essential Bundle: Healthcare Provider Engagement

- Goal: Demonstrate ownership and accountability for the care of the patient and family/caregiver at all times

  - Establishment with primary care provider
  - Use of evidence-supported practice guidelines
  - Patient and family education
  - Effective case management practices
  - Open, timely communication

  (National Transitions of Care Coalition)

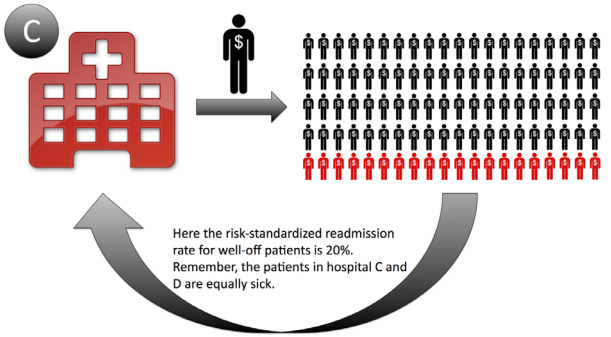
Care Essential Bundle: Shared Accountability

- Goal: Support care transition by demonstrating accountability for the patient's care by transitioning and receiving healthcare provider
  - Clear, timely communication of patient's plan
  - Effective communication between both providers/organizations
  - Assume responsibility for transition outcomes

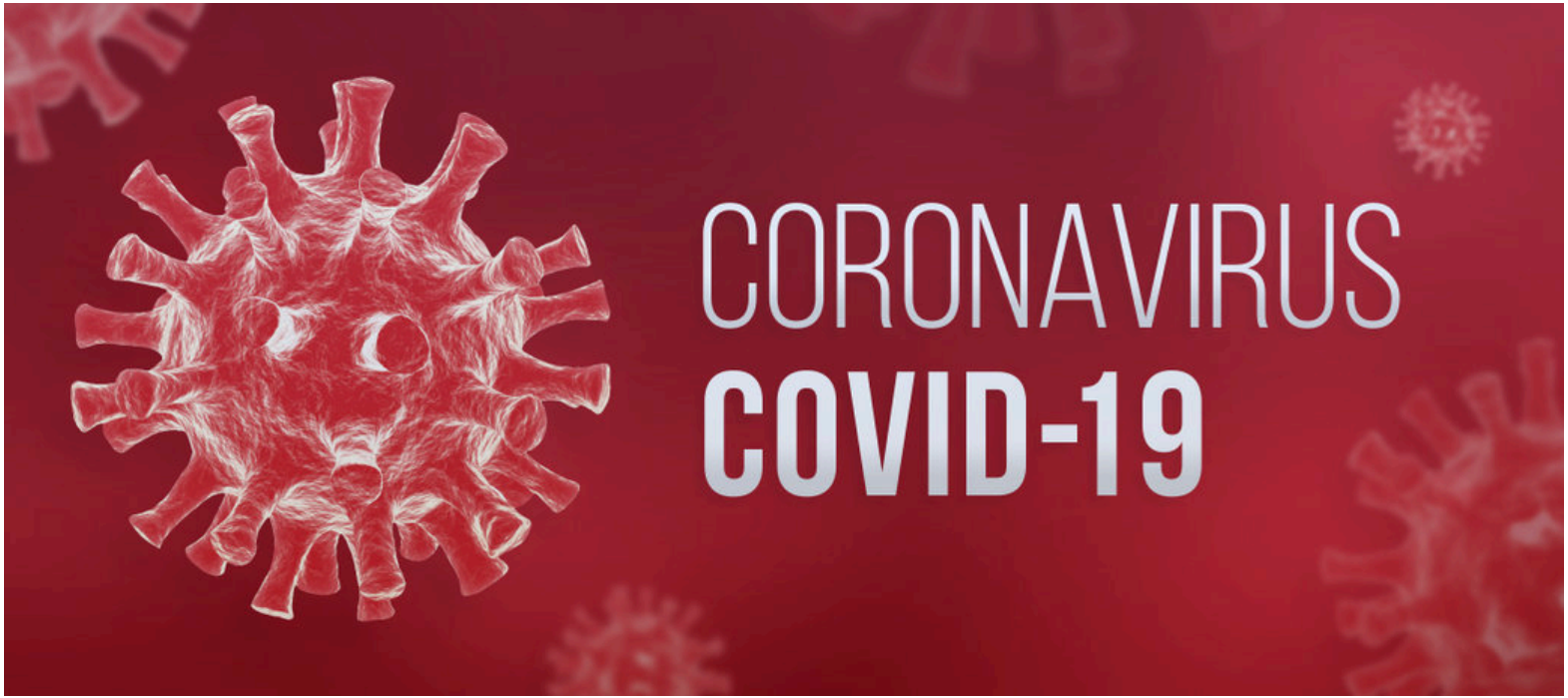
  (National Transitions of Care Coalition)

Common Transition Difficulties

- Medication management
  - Reconciliation
  - Self-management
  - Timely acquisition
- Timely information exchange
- Poor inclusion of patient and family caregiver in decision making
- Inadequate patient education
  - Red flags
- Timely, accurate exchange of information
- Timely access to follow-up



The Problem of COVID-19 Transitions



The Problem of COVID-19 Transitions

- Potential for rapid deterioration in ambulatory management
- 20% of COVID-infected individuals will develop severe disease
  - Cancer
  - Cerebrovascular disease
  - Chronic kidney disease
  - COPD
  - Diabetes
  - Hypertension
  - Cardiac disorders
  - Obesity
  - Pregnancy or recent pregnancy
  - Smoker, current and former

COVID-19 in Older Adults

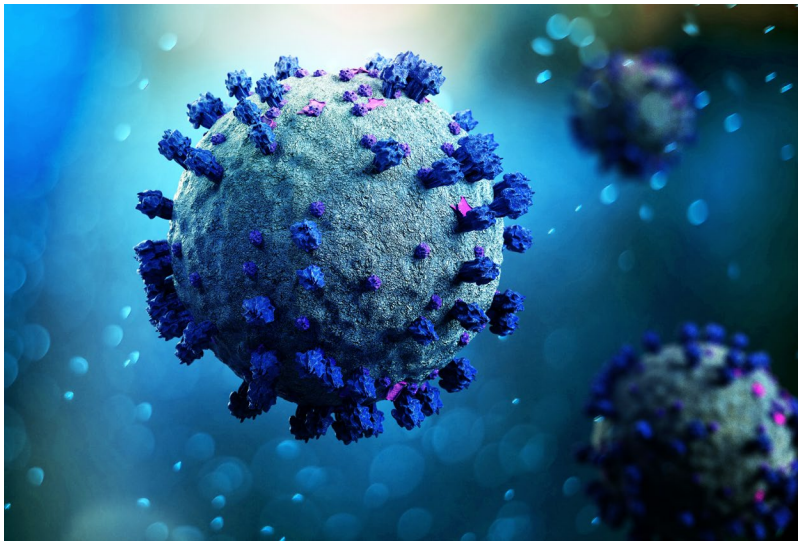
- Survivors of hospitalization return home with new or worsened health challenges
  - Worsening of existing, multiple chronic conditions
  - Residual COVID-related health problems
  - Post-intensive care syndrome (PICS)
    - Physical strength deficits, cognitive decline, and mental health disturbances after discharge from critical care
    - Persist for a protracted amount of time
    - May affect substantial numbers of COVID-19 survivors requiring ICU care
    - Conditions increasing risk:
      - Diabetes, hypertension, asthma, COPD, prolonged mechanical ventilation
      - Frailty
      - Prolonged isolation

COVID-19 in Older Adults

- Post-intensive care syndrome (PICS) in COVID-19
  - Mobility and Functional Decline (28-87%)
    - Deterioration in walk test persisting more than 12 months
    - Partial dependence for at least one ADL at least 12 months (33%)
    - ICU-acquired weakness (30 to 50% of ICU patients)
  - Cognitive Impairment (20-57%)
    - Affects 40 of ICU patients 3 to 6 months after illness
    - Memory*, executive function*, attention/concentration, mental processing speed
  - Mental health problems (6-60%)
    - Anxiety, depression
    - May persist for a year
  - Family stress

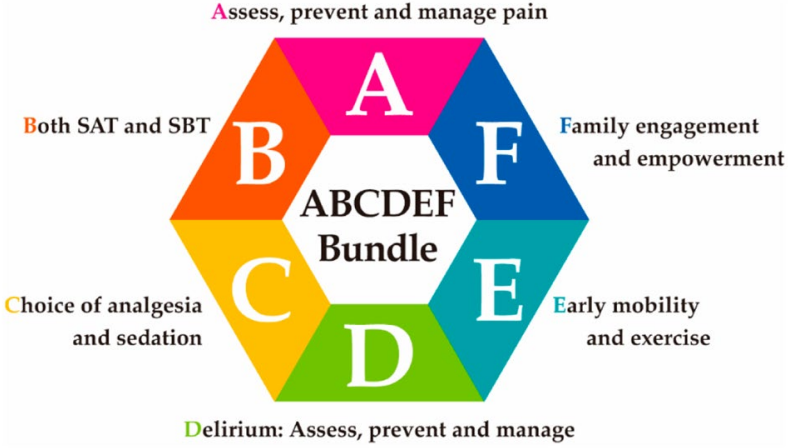
COVID-19 in Older Adults

- Post-COVID-19 Syndrome or Long-COVID
  - Fatigue or muscle weakness
  - Sleep difficulties
  - Anxiety
  - Depression



COVID-19 in Older Adults

- Implications
  - Assess for PICS 2 to 4 weeks after discharge
  - Integrate ABCDEF interventions to prevent delirium in ICU
    - Difficult with COVID patients



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Transition Complications in COVID-19 Care

- Consider that confirmatory diagnosis to home is a transition
  - Support and supervision required
  - Identification of red flags for deterioration
  - Ongoing care needs
  - Quarantine and isolation
  - Follow-up difficulties

Transition Complications in COVID-19 Care

- Difficulty with full-implementation of evidence-supported transition models
  - Visitation limitations
  - Communication by phone, video and texts
  - Skill training is difficult
  - Difficulty creating patient/family caregiver/provider partnership especially when providers change frequently
  - Difficulty in team coordination
  - Symptom management may be complicated especially when family has not had direct contact with patient
  - Telehealth limitations
  - Access to SNF's, homecare, timely provider follow-up
  - Families may lack full understanding of the needs of the care recipient
  - Competing demands of caregiver

Don't Forget the Caregivers!

- Family caregiver concerns during COVID-19 (Lightfoot, et al., 2021)
  - Social isolation of care recipient and caregiver
  - Decline in mental health of care recipient
  - Decline in physical and cognitive function of care recipient
  - Protecting the care recipient from COVID-19/guilt
  - Lack of caregiving support
    - Most often from family or informal networks
  - Caregiver stress
    - Anxiety, depression, sleep disorders
    - Greater risk: female, having COVID contact, prior mental health problem (Li et al., 2021)

Adapted Transitional Care Models

- Adapted Care Transition Model (Naylor, Hirschman, & McCauley, 2021)
- VA transitional care model (Driver et al., 2020)
  - RN led – assessment, monitoring equipment, protocol, phone-based follow-up and symptom monitoring, provider contact
- Care Coordination and Transitions Management (Landor, Schroeder, & Thompson, 2020)
  - RN/SW model in partnership with primary care and hospitalists post discharge
- Hospitalization diversion program for ED patients (Borgen et al., 2021)
  - Home oxygen, expanded home care, daily telemedicine visits, protocol-based telenursing
- Consider community health worker models

Resources to Support Post-COVID Transitions

- National Transitions of Care Coalition
  - Safe and Effective COVID-19 Transitions of Care CE offering
    - Checklist for Home Recovery from COVID 19
      - Establish with health provider
      - Home oxygen monitoring – parameters requiring follow-up
      - Review "Red Flags" requiring immediate follow-up
      - Quarantine and isolation guidelines
      - Environmental controls
    - COVID-19 Care Card for Safe Return to In-person Care
    - Leverage telehealth
    - Identify consistent point person for family
    - Consider decision making and personal beliefs on limits to treatment

Resources to Support Post-COVID Transitions

- National Transitions of Care Coalition
  - Discharge Management Protocols
    - Promote patient readiness for home recovery
      - Verify support at home
      - Assess functional status including fall risk
      - Home monitoring, duration, isolation
    - Review measures to prevention family infection
    - Accurate electronic record transfer
    - Medication update specifying changes
    - Medication counseling
    - Communicate changes to pharmacy
    - Provider checklist (example NTOCC Point-of-Care Checklist)

Resources to Support Post-COVID Transitions

- National Transitions of Care Coalition
  - NTOCC Point-of-Care Checklist for Transitions of Care Assessment
    - Assessment of Medical Issues
      - Understanding of COVID-19 and symptoms
      - Medication list and adherence assessment
      - Assessment for substance use disorder
      - Instructions and appointment for follow-up labs, care and appointments
      - Establish viability of technology to support telehealth or RPM if to be used
      - Educate patient and family of conduct of a virtual follow-up visit

Resources to Support Post-COVID Transitions

- National Transitions of Care Coalition
  - NTOCC Point-of-Care Checklist for Transitions of Care Assessment
    - Medication Assessment
      - Review of all prescribed medications
      - Teach back on medication plan
      - Information on COVID-19 follow-up vaccine
      - Establish plan for prescription transfer to pharmacy and plans to acquire medication and for refills
      - Plan for DME if required
    - Health Literacy and Linguistic Assessment
      - Patient and caregiver
      - Capacity of both to understand information

Resources to Support Post-COVID Transitions

- National Transitions of Care Coalition
  - NTOCC Point-of-Care Checklist for Transitions of Care Assessment
    - Social Factor Assessment
      - Barriers to accessing care (virtual or in-person) and medications
      - BADL's and IADL's
      - Understanding of people living in home and their health/risk profile
      - Technology access and ability to use (internet, computer, tablet, SMART phone)
      - Presence of caregiver and other supports
      - Safe housing
      - Food security

Resources to Support Post-COVID Transitions

- National Transitions of Care Coalition
  - NTOCC Point-of-Care Checklist for Transitions of Care Assessment
    - Continuity/Coordination of Care
      - Name and availability of PCP
      - Name and availability specialty providers
      - Home care/DME referrals
      - Appointment/referrals

Final Thoughts

- COVID-19 adds complexity in transitions of infected patients but also in meeting needs of patients with other diagnoses.

- Creative models of care are emerging that embed protocol driven, frequent follow-up and telehealth/telemedicine .
- Resources to support process development are available.

Objectives Check In!

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Closing Survey

Help Us Help You!

- Please turn your attention to the poll that has popped up in your lower right-hand side of your screen
- Completion of this survey will help us steer our topics to better cater to your needs

CMS 12th SOW Goals

Behavioral Health Outcomes & 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. diff in all settings

Chronic Disease Self-Management

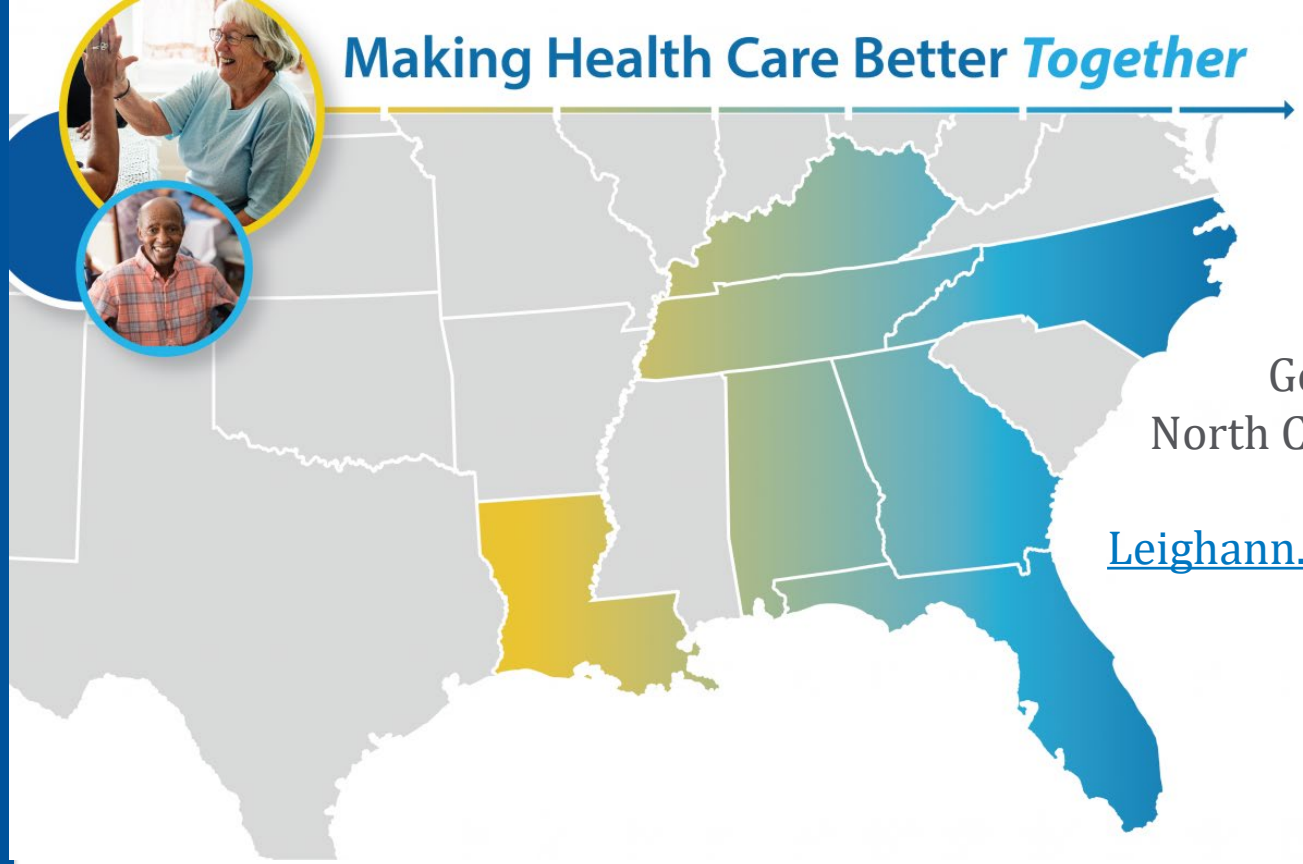
- ✓ Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- ✓ Identify patients at high-risk for developing kidney disease & improve outcomes
- ✓ Identify patients at high risk for diabetes-related complications & improve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

Quality of Care Transitions

- ✓ Convene community coalitions
- ✓ Identify and promote optical care for super utilizers
- ✓ 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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