Swati Gaur, MD, MBA, CMD, AGSF

MEDICAL DIRECTOR, POST-ACUTE CARE
NORTHEAST GEORGIA HEALTH SYSTEM

Dr. Swati Gaur is the medical director of New Horizons Nursing Facilities with the Northeast Georgia Health System. She is also the CEO of Care Advances Through Technology, a technology innovation company. In addition, Dr. Gaur is on the EMR transition and implementation team for the health system, providing direction to the EMR entity to adapt to the LTC environment. She has also consulted with post-acute long-term care companies to optimize medical services in PALTC facilities, integrate medical directors and clinicians into the QAPI framework and create frameworks of interdisciplinary work in the organization.

Dr. Gaur established the palliative care service line at the Northeast Georgia Health System. She also is an attending physician in several nursing facilities. Prior to that, Dr. Gaur was a medical director at the LTC in Carl Vinson VA Medical Center and a member of the G&EC for VISN 7.
Making Health Care Better Together

About Alliant Health Solutions
Learning Objectives

• Examine how care transitions impact readmission rates and patient safety.

• Create an interdisciplinary system to improve processes for readmissions.

• Learn to establish a collaborative process with referring facilities that support safe resident admission.
All residents sent out

ED Admissions

Hospital readmissions

Discuss why?

<48 hours from admit

>48 hour to 30 days from admit
Medicare admission vs. All admissions

Hospital vs. Emergency Department admissions

Data fidelity

From 19 to ? in XXX months.

0 non-procedure ED admissions

Change in how we measure data

Programmatic evaluation
Clinical evaluation

Emergency Department Admissions

- Timeliness of assessment
- Incomplete assessment
- Inter-shift handoff
- Late clinician outreach
- Communication style to family
- Capability of stat labs
- Can’t do stat interventions
Interventions

Generating Confidence:

- Acute change in condition
- Communication to resident and family
- STOPANDWATCH
- Management plan
  - SBAR
    - Education
    - Formatted note
    - Escalate to DON

Creating capabilities:

- Capability of stat labs
- Starting IVs/clysis
- Supplies - IVs, tubes, eBox
- +/- Telehealth
The Story of Mrs. TOC

65-year-old PMH of CVA with right-sided residual weakness, aphasic, mostly bedbound, gastric cancer s/p subtotal gastrectomy, insulin-dependent type 2 diabetic, seizure disorder, HTN, GERD, hyperlipidemia, CAD brought to the ED by sister which she lives with because of patient having frequent falls and hypoglycemia.

ED: patient's vital signs WNL, WBC 14.9 UA negative for UTI, CT brain without contrast no acute pathology, CT pelvis without contrast no acute pathology, EKG NSR, cannot rule out anterior infarct, age undetermined. Initially, glucose 20s at presentation which jumped to 100s after treatment.

Abscess of the left third digit: minor abscess of the left third digit on 2/15. She was started on cephalexin with noted symptomatic improvement, I & D on 2/16/2023. No signs of continued infection.

Tf. to LTC on 2/21
<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dosage/Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam</td>
<td>.5mg daily</td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>25mg nightly</td>
</tr>
<tr>
<td>Amlodipine</td>
<td>10mg daily</td>
</tr>
<tr>
<td>ASA</td>
<td></td>
</tr>
<tr>
<td>Cephalexin</td>
<td>500mg 4 times a day for 7 days</td>
</tr>
<tr>
<td>Pantoprazole</td>
<td>40 mg daily</td>
</tr>
<tr>
<td>Clopidogrel</td>
<td>75mg daily</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>300mg three times a day</td>
</tr>
<tr>
<td>Hydrocodone - APAP</td>
<td>10mg daily</td>
</tr>
<tr>
<td>Detemir insulin</td>
<td>10U twice a day</td>
</tr>
<tr>
<td>Levetiracetam</td>
<td>1000mg twice a day</td>
</tr>
<tr>
<td>Losartan</td>
<td>50 mg daily</td>
</tr>
<tr>
<td>Methocarbamol</td>
<td>500mg three times a day as needed</td>
</tr>
<tr>
<td>Polyethylene glycol</td>
<td>17gm daily</td>
</tr>
<tr>
<td>Pravastatin</td>
<td>40 mg daily</td>
</tr>
<tr>
<td>Sitagliptin</td>
<td>50 mg daily</td>
</tr>
<tr>
<td>Topiramate</td>
<td>25 mg twice daily</td>
</tr>
</tbody>
</table>
Hospital discharge: It’s one of the most dangerous periods for patients
<table>
<thead>
<tr>
<th>Meds on Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alprazolam 0.5mg daily</strong></td>
</tr>
<tr>
<td><strong>Amitriptyline 25mg nightly</strong></td>
</tr>
<tr>
<td><strong>Gabapentin 300mg three times a day</strong></td>
</tr>
<tr>
<td><strong>Methocarbamol 500mg three times a day as needed</strong></td>
</tr>
<tr>
<td><strong>Hydrocodone –APAP 10mg daily</strong></td>
</tr>
<tr>
<td><strong>Levetiracetam 1000mg twice a day</strong></td>
</tr>
<tr>
<td><strong>Topiramate 25 mg twice daily</strong></td>
</tr>
<tr>
<td><strong>Cephalexin 500mg 4 times a day for 7 days</strong></td>
</tr>
<tr>
<td><strong>Pantoprazole 40 mg daily</strong></td>
</tr>
<tr>
<td><strong>Detemir insulin 10U twice a day</strong></td>
</tr>
<tr>
<td><strong>Sitagliptin 50 mg daily</strong></td>
</tr>
<tr>
<td><strong>Amlodipine 10mg daily</strong></td>
</tr>
<tr>
<td><strong>Losartan 50 mg daily</strong></td>
</tr>
<tr>
<td><strong>ASA</strong></td>
</tr>
<tr>
<td><strong>Clopidogrel 75mg daily</strong></td>
</tr>
<tr>
<td><strong>Polyethylene glycol 17gm daily</strong></td>
</tr>
<tr>
<td><strong>Pravastatin 40 mg daily</strong></td>
</tr>
</tbody>
</table>
Process of Transition

Hospital Case manager sends request for admission

Admission team assesses and sends decision to accept

Discharge instructions sent to LTC

Patient arrives/meds arrive
- Assessed by MD
  Per reg within 30 days
- Meds assessed by consultant pharmacist within 3 days of admission

Faxed/sent to LTC pharmacy

Faxed/accessed by LTC admissions team
Process of Transition

**Hospital Case manager sends request for admission**
- Meet and educate

**Admission team assesses and sends decision to accept**
- Checklist of red flags
- Process of escalation

**Discharge instructions sent to LTC**
- Is this happening?

**Faxed/accessed by LTC admissions team**
- Who gets this?
  - Create an interdisciplinary team – Admitting nurse, consultant Pharmacist, Medical director

**Faxed/sent to LTC pharmacy**

**Patient arrives/meds arrive**
- Telehealth if prior to weekend
The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital

Alan J. Forster, MD, FRCPC, MSc; Harvey J. Murff, MD; Josh F. Peterson, MD; Tejal K. Gandhi, MD, MPH; and David W. Bates, MD, MSc

GOAL

66% med error
3% lab errors

Who is your team?
What are your capabilities?
Finding Common Ground

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7000 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

DATE: June 6, 2023

TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: Requirements for Hospital Discharges to Post-Acute Care Providers

CMS is committed to ensuring that the health and safety of patients are protected when discharges from hospitals and transfers to post-acute care providers occur. Therefore, we are providing the following information:

- Reminding state agencies (SA), accrediting organizations (AO), and hospitals of the regulatory requirements for discharges and transfers to post-acute care providers.
- Highlighting the risks to patients’ health and safety that can occur due to unsafe discharges.
- Recommendations that hospitals can leverage to improve their discharge policies and procedures to improve and protect patients’ health and safety.

Ref: QSO-23-16-Hospitals

CMS Hospital IQR Program Measures for the FY 2025 Payment Update

Details on measurement periods and Public Reporting Release dates are available on QualityNet in the FY 2025 Acute Care Hospital Quality Improvement Program Measures documents.

Measures Required to Meet Hospital IQR Program APR Requirements

**Short Name** | **Measure Name** | **Data Source** | **Specifications Link**
--- | --- | --- | ---
AMI Excess Days | Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction | Claims | Payment Methodology
AMI Payment | Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care | Claims | Payment Methodology
CMS PSI-04 | Death Rate among Surgical Inpatients with Serious Traumatic Complications (CMS Recalibrated Death Rate among Surgical Inpatients with Serious CMS PSI-04 Traumatic Complications) | Claims | PSI Resources
COMP-HF-KNEE | Hospital-Level Risk-Standardized Complication Rate Following Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty | Claims | Complications Methodology
HCAIPS | Hospital Consumer Assessment Of Healthcare Providers and Systems Survey | Patient Survey | Technical Specifications
HCH | Hospital Commitment to Health Equity | Web-based Submission | Assessment and Specifications
HCP COVID-19 Vaccination | COVID-19 Vaccination Coverage Among Health Care Personnel | NHIN | HPS Components
HCP Influenza Vaccination | Influenza Vaccination Coverage Among Healthcare Personnel | NHIN | HPS Components
HF Excess Days | Excess Days in Acute Care after Hospitalization for Heart Failure | Claims | Payment Methodology
HF Payment | Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure | Claims | Payment Methodology
MORT-30-STK | Hospital 30-Day All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke | Claims | Mortality Methodology
MSPII | Medicare Spending Per Beneficiary - Hospital | Claims | QIP MSPII Methodology
PC-40 | Electronic Delivery | Medical Record | PC-40 Specifications Manual
PN Excess Days | Excess Days in Acute Care after Hospitalization for Pneumonia | Claims | Payment Methodology
PN Payment | Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia | Claims | Payment Methodology
REARM-30-HWR | Hospital Wide All-Cause Unintended Readmission Measure | Claims | Unintended Readmission Methodology
THA/TKA Excess Days | Excess Days in Acute Care after Hospitalization for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty | Claims | Payment Methodology
THA/TKA Payment | Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty | Claims | Payment Methodology


A Warm Handoff
<table>
<thead>
<tr>
<th>Medication</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam</td>
<td>Avoid</td>
</tr>
<tr>
<td>Amiloride</td>
<td>Avoid if CrCl &lt;30 mL/min</td>
</tr>
<tr>
<td>Amiodarone</td>
<td>Avoid as first-line therapy for atrial fibrillation for most patients</td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>Avoid; has strong anticholinergic properties</td>
</tr>
<tr>
<td>Amobarbital</td>
<td>Avoid</td>
</tr>
<tr>
<td>Amoxapine</td>
<td>Avoid; has strong anticholinergic properties</td>
</tr>
<tr>
<td>Androgens</td>
<td>Avoid unless indicated for symptomatic hypogonadism</td>
</tr>
<tr>
<td>Apixaban</td>
<td>Avoid if CrCl &lt;25 mL/min</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>Avoid, except in some situations (e.g. bipolar disorder, schizophrenia, short-term chemotherapy)</td>
</tr>
<tr>
<td>Asenapine</td>
<td>Avoid, except in some situations (e.g. bipolar disorder, schizophrenia, short-term chemotherapy)</td>
</tr>
<tr>
<td>Aspirin</td>
<td>Use with caution for primary prevention of cardiovascular disease and colorectal cancer; Use with caution in adults ≥70 years; Avoid in most patients with history of gastric or duodenal ulcers; avoid chronic use with &gt;325 mg/day</td>
</tr>
<tr>
<td>Atropine (excludes ophthalmic)</td>
<td>Avoid; has strong anticholinergic properties</td>
</tr>
<tr>
<td>Belladonna alkaloids</td>
<td>Avoid; has strong anticholinergic properties</td>
</tr>
<tr>
<td>Benztrapine (oral)</td>
<td>Avoid; has strong anticholinergic properties</td>
</tr>
<tr>
<td>Brexiprazole</td>
<td>Avoid, except in some situations (e.g. bipolar disorder, schizophrenia, short-term chemotherapy)</td>
</tr>
<tr>
<td>Brompheniramine</td>
<td>Avoid; has strong anticholinergic properties</td>
</tr>
<tr>
<td>Butabarbital</td>
<td>Avoid</td>
</tr>
</tbody>
</table>
Choosing Wisely: From the Society for Post-Acute Long-Term Care Medicine

15. Don’t provide long-term opioid therapy for chronic non-cancer pain in the absence of clear and documented benefits to functional status and quality of life.

Pantoprazole

13. Don’t routinely prescribe or continue sedative hypnotics such as Restoril or Ambien, diphenhydramine (Benadryl), benzodiazepines, or Serotonin Modulators (Trazadone) for long-term treatment of sleep disorders in geriatric populations. Consider the use of nonpharmacological interventions (e.g., physical activity, a regular schedule or cognitive behavioral therapy.)

Hydrocodone- APAP 10mg daily

11. Don’t continue hospital-prescribed stress ulcer prophylaxis with Proton-Pump Inhibitor (PPI) therapy in the absence of an appropriate diagnosis in the post-acute and long-term care (PALTC) population.

Alprazolam
13.4 Because older adults with diabetes have a greater risk of hypoglycemia than younger adults, episodes of hypoglycemia should be ascertained and addressed at routine visits. B

<table>
<thead>
<tr>
<th>Patient characteristics/health status</th>
<th>Rationale</th>
<th>Reasonable A1C goal‡</th>
<th>Fasting or preprandial glucose</th>
<th>Bedtime glucose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex/intermediate (multiple coexisting chronic illnesses* or 2+ instrumental ADL impairments or mild-to-moderate cognitive impairment)</td>
<td>Intermediate remaining life expectancy, high treatment burden, hypoglycemia vulnerability, fall risk</td>
<td>&lt;8.0% (64 mmol/mol)</td>
<td>90–150 mg/dL (5.0–8.3 mmol/L)</td>
<td>100–180 mg/dL (5.6–10.0 mmol/L)</td>
</tr>
<tr>
<td>Very complex/poor health (LTC or end-stage chronic illnesses** or moderate-to-severe cognitive impairment or 2+ ADL impairments)</td>
<td>Limited remaining life expectancy makes benefit uncertain</td>
<td>Avoid reliance on A1C; glucose control decisions should be based on avoiding symptomatic hyperglycemia</td>
<td>100–180 mg/dL (5.6–10.0 mmol/L)</td>
<td>110–200 mg/dL (6.1–11.1 mmol/L)</td>
</tr>
</tbody>
</table>
Questions?
Nursing Home and Partnership for Community Health: CMS 12th SOW GOALS

**OPIOID UTILIZATION AND MISUSE**
- Promote opioid best practices
- Reduce opioid adverse drug events in all settings

**PATIENT SAFETY**
- Reduce hospitalizations due to c. diff
- Reduce adverse drug events
- Reduce facility acquired infections

**CHRONIC DISEASE SELF-MANAGEMENT**
- Increase instances of adequately diagnosed and controlled hypertension
- Increase use of cardiac rehabilitation programs
- Reduce instances of uncontrolled diabetes
- Identify patients at high-risk for kidney disease and improve outcomes

**CARE COORDINATION**
- Convene community coalitions
- Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits
- Identify and promote optimal care for super utilizers

**COVID-19**
- Support nursing homes by establishing a safe visitor policy and cohort plan
- Provide virtual events to support infection control and prevention
- Support nursing homes and community coalitions with emergency preparedness plans

**IMMUNIZATION**
- Increase influenza, pneumococcal, and COVID-19 vaccination rates

**TRAINING**
- Encourage completion of infection control and prevention trainings by front line clinical and management staff
Scan the QR codes or Click the Links to Complete the Assessments!

CMS requested Alliant Health Solutions, your QIN-QIO, to work with select nursing homes to understand emerging healthcare needs in nursing homes. Alliant Health Solutions is engaging nursing home leadership in this key area to ensure plans are in place to achieve and maintain health quality and equity!

Please scan the QR code below and complete the assessment.

Nursing Home Infection Prevention (NHIP) Initiative Training Assessment

Making Health Care Better Together

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

Julie Kueker
Julie.Kueker@AlliantHealth.org
Alabama, Florida and Louisiana

Program Directors