Virginia Long-Term Care Clinician Network Monthly Forum

July 16, 2025

Welcome!

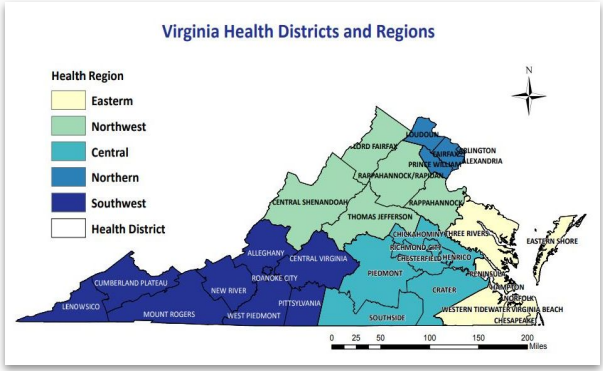
As you join, please turn on cameras and mic or unmute your phone and say hello to your Virginia colleagues.

Please use the chat box to introduce yourself.

Take a deep breath, hold and let it out….

Welcome New Members!

Emily Hicks - Central Region
Stephanie Zuo - Central Region
Ashley Hayes - Multiple Regions



Remind your work colleagues to attend so they can get education, support and CME!

309 Members Strong!

For great resources: look for previous slide sets and newsletters under *Forums & Events* and *Resources* on our website.

ltccn.vcu.edu

Minding the Gap, care transitions and communication

Laura Finch, GNP, MS, RN
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Network Members: If you are not currently seeing LTC residents, but have worked with transitions in the past, please go ahead and answer the discussion based on your experiences and role. Share any QAPI tools you have used in these situations.

Where do YOU see the Highest Risk During Transitions of Care

Waterfall question, type in the number or answer and wait for countdown

1. Medication errors
2. Fall, injury due to frailty or new setting, or other
3. Medications not advantageous to elderly/polypharmacy
4. Lack of clear communication between LTC staff and ED staff
5. Lack of mental status assessment (delirium v. dementia etc.)
6. Availability of knowledgeable liaison at each setting
7. Delayed discussion of end of life care (or no decision)
8. Lack of timely access to outpatient care (i.e. CT scan, transfusion)
9. Other

The strange black hole that takes paperwork between the LTC bedside and ED.

Poll: Screen to reduce readmissions

Does your facility use and communicate facility specific CMS readmission data with the clinicians? For example opioid drug event related readmissions

1. **Yes**
2. **No**
3. **Unsure**

CMS Data for One Virginia Facility showed Readmissions related to:

- Opioid drug events in long stay residents
- Facility acquired infections
- 30 day readmissions short stay
- Flu vaccine
- Pneumonia vaccine
- 30 day readmissions up with age 64 and less
- 30 day readmissions up with 85 and over
- Dually eligible increased readmits
- Men slightly more than women
- ESRD benefit increased readmis
- Dually eligible less likely than not dually eligible to readmit

Start with a Screen for: <65, >84, ESRD, dual eligible, missing advanced medical decisions and vaccinations

Questions from the Network

- How do we get the right information from the previous setting to treat?
- How can we communicate with clinicians in the community?
- Why doesn't anyone pick up the phone?
- I am on a secure texting system, but my colleagues are not - so how can I safely text them?
- How can we improve transitions and readmission rates using the systems we have?

Editorial | Free Access

A Moving Target—Medicare Beneficiaries Coming to the End of Long Lives

Joanne Lynn MD, MA, MS

First published: 09 May 2017 | https://doi.org/10.1111/jgs.14916 | Citations: 1

…..Instead, the United States is in the process of implementing ever-more-fragmented service delivery arrangements for Medicare beneficiaries living with progressive, eventually fatal, advanced illnesses and disabilities. Few outpatient physicians manage their hospitalized patients. New specialists in palliative care consult to settle goals of care and advise about symptom management, but they rarely provide ongoing primary care around the clock. Hospice promises to stay with the individual and family through death and bereavement—but hospice serves most enrollees only for 1 or 2 weeks. Hospice programs now often discharge very sick and disabled individuals when they live too long,8 thereby abrogating the promise of continuity……

…Outside of PACE and hospice, very sick and disabled people in their last phase of life usually see many different doctors, often in the emergency department and specialty consultation, without clear or comprehensive care plans and without the support that they and their families need.

PACE, hospice and LTC

(highlights added)

https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.14916

Case Study 1: Nobody Ever Does That

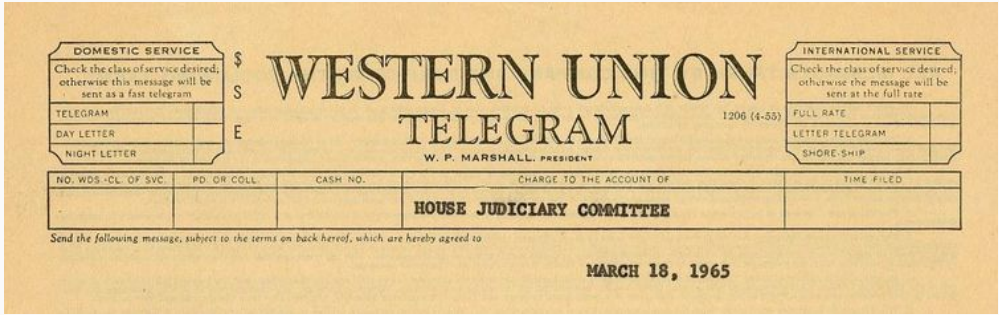
“Nobody ever does that,” said Dr. Grey to the nurse practitioner calling him. The NP had been working with a man at his home and sent him to hospital. He made it to the hospital, but succumbed to the cardiac event. She got word later from his family and called Dr. Grey to tell him know his patient had died due to a heart attack. Dr. Grey has been working as an internist over 45 years and was noting that **no one calls him when his patients are in the emergency room and have died.**

Dr. Grey has a primary care practice taking care of many vulnerable residents in the the city. He has taken care of generations of families.

Discussion

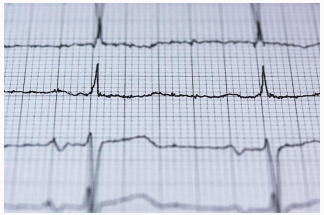
Do you or does the facility have a system for notifying colleagues of important changes such as hospitalization or death?
Please share how that is carried out.

A recent survey found a quarter of people aged 18 to 34 never answer the phone
-https://www.bbc.com/news/articles/crgklk3p70yo
Team helps college students with phone phobia
https://www.bbc.com/news/articles/cgm9klmzpjeo


DOMESTIC SERVICE
Check the class of service desired; otherwise this message will be sent as a fast telegram
TELEGRAM
DAY LETTER
NIGHT LETTER
$ S E
WESTERN UNION
TELEGRAM
W. P. MARSHALL, PRESIDENT
1206 (4-55)
INTERNATIONAL SERVICE
Check the class of service desired; otherwise the message will be sent at the full rate
FULL RATE
LETTER TELEGRAM
SHORE-SHIP
NO. WDS. | CL. OF SVC. | PD. OR COLL. | CASH NO. | CHARGE TO THE ACCOUNT OF | TIME FILED
HOUSE JUDICIARY COMMITTEE
Send the following message, subject to the terms on back hereof, which are hereby agreed to
MARCH 18, 1965

Case Study 2: Specialist Needed

Dr. Poy, a geriatrician, had Mrs. G, 85, in his office. She had been seeing several orthopedic specialists over time to try to improve her pain and mobility. Complicating things was a potential cardiac problem. The **messages weren't clear to her about next steps** and time was passing while she waited for answers from specialists. While she was in the office Dr. Poy called cardiology and was able to obtain and explain the next steps. He also called the orthopedist to get the plan. With this coordination of medical care, Mrs. G was able to move forward with hip replacement more quickly.



Questions/Chat/Open Mic

- Are you able to get in touch with specialists to assist you with your patients and how do you do it?
- What happens when you call, for example, urology or cardiology for help?
- Do you work with particular specialists you get a call back from or have their cell number?

Example of a text: *“A pt of mine at your facility whose name rhymes with a pink muppet character, needs XX followed up”*
Is this secure enough?

Case 3: Orders Placed Post Discharge

A clinical nurse specialist working in a transitional care program to reduce readmissions of NH transfers noted on Friday a patient had been **discharged with incorrect cardiac medications**. She quickly reviewed the chart realizing the cardiologist saw the patient after the patient's discharge orders had been placed. She notified the NP on the transitions team Friday after 5 pm. The NP was able to contact the cardiologist Friday evening using secure texting, the cardiologist then called the NP and they had a conversation about his medication intentions. She then secure texted the nursing home clinician to get the medications communicated and the patient got them on schedule the next day.

Discussion

- How often and how are you dealing with after discharge consult orders?
- Do you have access to the EHR at the hospitals?
- Do you have staff who know the hospital staff well enough to call?
- Do you have relationships with people, a friend, a former colleague, in the hospital who can help you after hours?
- Do family have access to the resident's hospital portal or other medical records to send a message?

To Aid in Improvements: QAPI tools

https://hqin.org/wp-content/uploads/2021/05/HQIN-Fishbone-Diagram_508-1.pdf

https://hqin.org/resource/five-whys-worksheet/

EHR by Hospital and Region

Sentara: Epic
Riverside: Epic
EVMS: Oracle Cerner
VCU: Epic
HCA: Meditech
Veterans Affairs: Oracle Cerner
Encompass: Oracle Cerner
Bon Secours Mercy: Epic
UVA: Epic
Valley Health: Epic
Inova: Epic
Carilion:Epic
Augusta Health: Expanse (6/25)
Kingsport Tn (used by SW Virginia)

Data from VHHA

Medical Records and Technology Issues - Virginia

- Offenders within the VADOC system are transported to different prisons when they get too ill to be cared for where they are located. Offenders referred to VCU-HS for treatment are sent to Greenville, Powhatan or Deep Meadow as part of a "step down" treatment process on their way back into the general prison population.
- The constant movement of offenders requires medical charts to be moved. None of the health care record systems operated by the jails, regional jails or the prisons are integrated. Long term offenders moved from one prison to another may have between 1 and 8 boxes filled with paper medical charts that are moved too.
- VADOC telemedicine services are often with VCU-HS. Some of the physicians want medical records faxed to them, some allow for electronic transfer of scanned records.
- VADOC health care providers can look up health information on an offender through the VCU-HS "web based patient portal" but they do not have the ability to enter data on offenders in their care.
- VADOC health records system needs to be updated and upgraded to include electronic health records available to all facilities. In addition, at a minimum, regional jails need to be able to access the system.
- A coordinated system between VADOC and VCU-HS allowing VADOC medical staff to access and update patient records when offenders remain under the care of a VCU-HS physician or receive tele-medicine services can improve efficiency and reduce the potential for errors.

Limitations of health care records include sites such as the correctional system

Case 4: Holiday Discharge

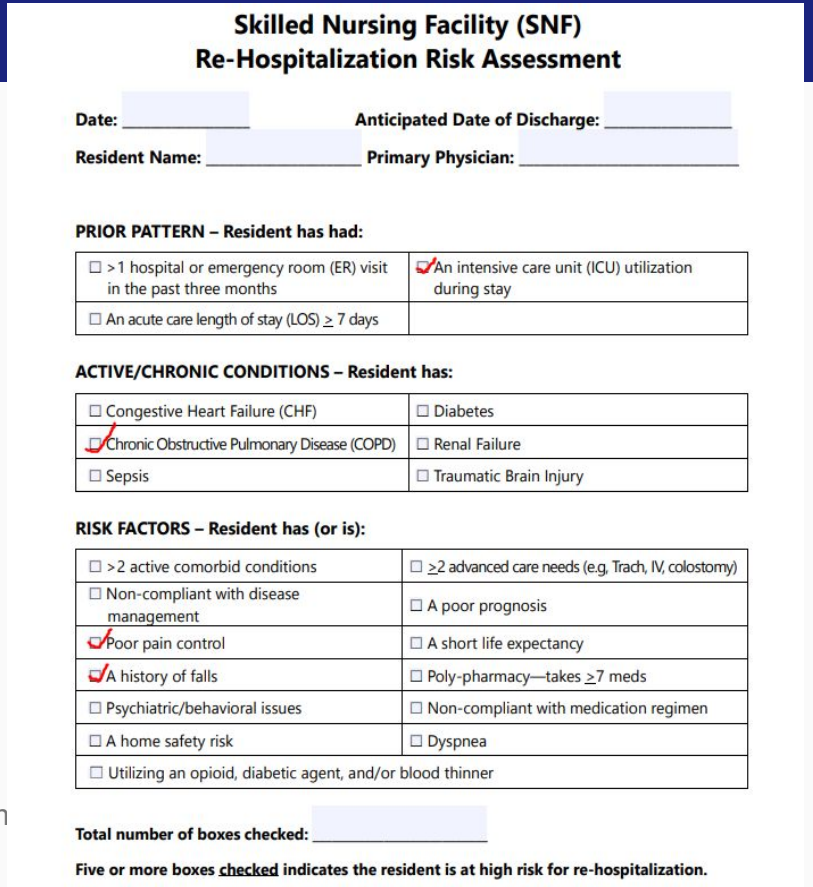
Mrs. Jacobs, 84, hx COPD, AF, had been living home alone independently, She got up at night to use the bathroom, slipped down the bed to the floor and was found hours later by her adult child.
PTA: independent with walker, driving, cooking, lives alone in condo
Post Fall: Right sided multiple broken ribs and clavicle. Blood thinner stopped with shared decision-making at hospital
12/24 d/c plan: inpatient rehab from ICU. That night instead discharged to a nursing home near her adult child. D/C A&O with O2, prn inhalers, prn pain med, prn constipation med, etc.
12/27 the medical director admitted her. 12/29 in pain, no BM in a week, asking for inhalers at beside, pulse ox and VS not being checked regularly. 1/6 CVA, to hospital, thrombectomy didn't help, family followed their mother's comfort care wishes

https://www.mdcalc.com/calc/801/cha2ds2-vasc-score-atrial-fibrillation-stroke-risk
https://www.acc.org/Tools-and-Practice-Support/Mobile-Resources/Features/Anticoag-Evaluator
https://www.google.com/url?q=https://www.sparctool.com/&sa=D&source=editors&ust=1744736192870449&usg=AOvVaw1tXKlLyooivO4FRp9m5bcg

Share what could have made this transition better

- NP visit with MD not being available within 48h
- PT/OT
- Evaluate/revisit need for O2
- Schedule pain medication for recent fractures
- Scheduled constipation medication
- Revisit blood thinner use
- What else?

https://hqin.org/wp-content/uploads/2023/07/Reh
ospitalization-Risk-Assessment_508.pdf



Skilled Nursing Facility (SNF)
Re-Hospitalization Risk Assessment

Date: _____ **Anticipated Date of Discharge:** _____

Resident Name: _____ **Primary Physician:** _____

PRIOR PATTERN – Resident has had:

☐ >1 hospital or emergency room (ER) visit in the past three months	☑ An intensive care unit (ICU) utilization during stay
☐ An acute care length of stay (LOS) ≥ 7 days	

ACTIVE/CHRONIC CONDITIONS – Resident has:

☐ Congestive Heart Failure (CHF)	☐ Diabetes
☑ Chronic Obstructive Pulmonary Disease (COPD)	☐ Renal Failure
☐ Sepsis	☐ Traumatic Brain Injury

RISK FACTORS – Resident has (or is):

☐ >2 active comorbid conditions	☐ ≥2 advanced care needs (e.g, Trach, IV, colostomy)
☐ Non-compliant with disease management	☐ A poor prognosis
☑ Poor pain control	☐ A short life expectancy
☑ A history of falls	☐ Poly-pharmacy—takes ≥7 meds
☐ Psychiatric/behavioral issues	☐ Non-compliant with medication regimen
☐ A home safety risk	☐ Dyspnea
☐ Utilizing an opioid, diabetic agent, and/or blood thinner	

Total number of boxes checked: _____

Five or more boxes checked indicates the resident is at high risk for re-hospitalization.

NP Visit prior to MD admission

- **Can depend on model of practice, is the driver billing or reducing readmissions**
- **Is it medically necessary for a clinician to see a new admission**
  - **Case by case? or Always? When do residents usually get readmitted?**
- Billing issues
  - If a patient is in a SNF under a Part A stay (POS 31), the NP can see the patient prior to the physician and bill for it, but per regulatory guidance by CMS, the physician must complete the admission H&P and see the patient at least every 30 days during the first 90 days of admission.
  - The NP visit prior to this would have to be billed with a subsequent visit code of 99307-99310 (it isn't technically a subsequent visit, but it is the regulation).
  - Per CMS, in states where NPs are allowed under scope of practice to conduct admission history and physicals in the SNF/NF setting (POS 32), an NP can conduct and bill for the admission history and physical, 99304-99306. I am not aware of any states that do not allow the NPs to conduct the admission H&P during a POS 32 stay.
  - During Covid, there was a waiver regarding this which allowed the NPs to conduct the admission H&Ps in the skilled setting, but this waiver expired May 7, 2022.

Frequency and diagnoses associated with 7- and 30-day readmission of skilled nursing facility patients to a nonteaching community hospital

F697 Pain Management Revised

§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

INTENT
Based on the comprehensive assessment of a resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management.

"Acute Pain" *refers to pain that is usually sudden in onset and time-limited with a duration of less than 1 month and often is caused by injury, trauma, or medical treatments such as surgery. (From the Centers for Disease Control and Prevention (CDC)).*

"Adverse Consequence" *refers to* an unpleasant symptom or event that is due to or associated with a medication, such as impairment or decline in a resident's mental or physical condition or functional or psychosocial status. It may include various types of adverse drug reactions and interactions (e.g., medication-medication, medication-food, and medication-disease).

Are scheduled meds compliant in this resident?

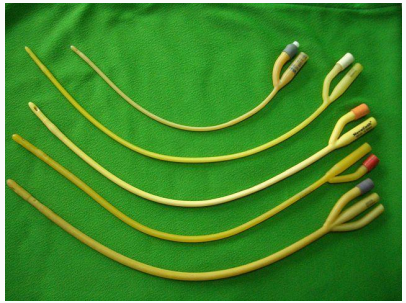
F757 Unnecessary Drugs-General

F757 (Rev.) §483.45(d) Unnecessary Drugs—General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used— §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or Advance Copy §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section

How do you assess unnecessary duration and other measures for potentially unnecessary drugs?

Case 5: Facility Capabilities

Facility NP called NP at ED to say they were sending a resident who **only needed their indwelling catheter replaced**, that the resident was already on IV fluids and antibiotics, they had lab results and they had the capability and guardian's agreement to manage his care. The facility NP would be available to readmit the resident from the ED. They had been unable to secure a urologist visit to replace the catheter.
Patient to ED, catheter replaced, resident admitted to hospital. He did not get the rehabilitation in hospital that was planned at facility and he declined. Resident was discharged eventually back to facility.



Facility Capabilities

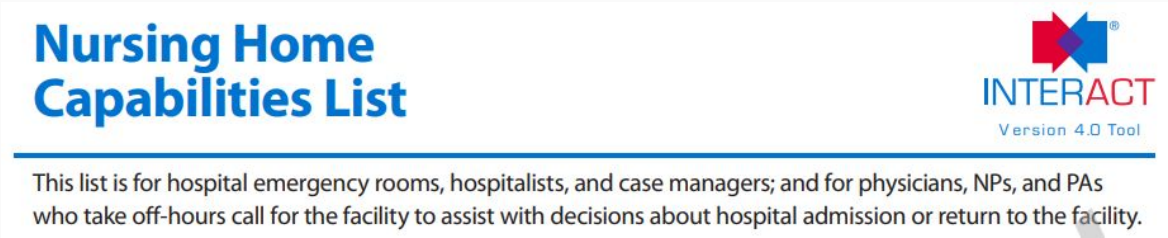
Has this happened at your facility despite best efforts?

How are capabilities and ED transfers communicated?

Does your team have an inpatient clinician who can check on residents?

One ED Doctor's Request for LTC

- **Code status**
- **Legal next of kin/guardian**
- **List of Medications**
- **How to get the patient back to the facility (including rules of return, etc.)**



Current Considerations with Transitions to Community

- Free clinics unable to provide services
- Veterans Affairs reductions decreased home care services
- Community health workers cuts
- Capital Area Network cuts
- VDH work pauses and changes
- Share other news that might affect transitions

Resources

https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.14916

https://geripal.org/churning-patients-through-care-settings/

https://pathway-interact.com/about/what-is-interact/

https://hqin.org/wp-content/uploads/2023/07/Readmissions-Self-Assessment.pdf

https://www.decisionguide.org/

Open Forum

Any questions or ideas from the talk?

Free Emergency Preparedness Trainings

- There are many free and low-cost training resources available
  - www.ready.gov
  - FEMA free online training classes (https://training.fema.gov/is/crslist.aspx);
  - American Red Cross Ready Rating programs for businesses and schools (http://www.readyrating.org/The-Red-Cross-Ready-Rating-Program)
  - National Disaster Life Support Programs for HC professionals (http://www.ndlsf.org)
  - Asst. Sect. for Preparedness and Response/HHS (http://ASPRtracie.hhs.gov). Email: askasprtracie@hhs.gov
  - *How to Prepare for Anything* by Aaron Titus

Accreditation

	In support of improving patient care, VCU Health Continuing Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
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Disclosure of Commercial Support:

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1. *If you have **not participated in a VCU Health CE program** in the past:*
   a. Go to vcu.cloud-cme.com to create an account – make sure to add your cell phone number
2. Once you have registered or if you **have participated before:**
   a. Text the course code to (804) 625-4041.
   b. The course code for today's event is: **######** *within **5** days of the event*

Complete Evaluation & Claim Credit, *(within 60 days of the event)*

1) Go to https://vcu.cloud-cme.com
2) Sign in using email address used above
3) Click "My CE"
4) Click "Evaluations and Certificates"

OR

1) Open the CloudCME app on your device
2) Click "My Evaluations"
3) Click the name of the activity to complete evaluation

Need help? ceinfo@vcuhealth.org

Thank you for joining us!

Updates and News - See News Updates via email

Next Monthly Forum: **Wednesday, August 20, 4-5 pm - Dr Stephanie Zuo from UVA, will be speaking on urogynecology in the older adult, send us any questions**

Your Calendar Link - In the Zoom Registration Confirmation email you received today, there's a calendar link to update your calendar for future meetings.

On your way out of our meeting today, kindly answer a brief feedback survey.

Stay in touch! Email us at vcoa@vcu.edu

Invite your colleagues! They can register at ltccn.vcu.edu