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** | **Patient Safety** | **Chronic Disease Self-Management** | **Quality of Care Transitions** | **Nursing Home Quality** |
| - Promote opioid best practices | - Reduce risky medication combinations | - Increase performance on ABCS clinical quality measures (i.e. aspirin use, blood pressure control, cholesterol management, cardiac rehab) | - Convene community coalitions | - Improve the mean total quality score |
| - Decrease high dose opioid prescribing and opioid adverse events in all settings | - Reduce adverse drug events | - Smoking cessation | - Identify and promote optimal care for superutilizers | - Develop national baselines for healthcare related infections in nursing homes |
| - Increase access to behavioral health services | - Reduce C. difficile in all settings | - Identify patients at high-risk for developing kidney disease and improve outcomes | - Reduce community-based adverse drug events | - Reduce emergency department visits and readmissions of short stay residents |

**Making Health Care Better Together**

ALABAMA • FLORIDA • GEORGIA • KENTUCKY • LOUISIANA • NORTH CAROLINA • TENNESSEE
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.dawnson@vnsny.org
Problem:

• How do we best manage communication across the care continuum to minimize exposure for patients a 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/
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

• 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

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

May 11th: 178,766 cases

Phase I: Surveillance and Prep
**Priorities:**
- Staff/patient screening, beginning with travel monitoring
- Emergency planning

Phase II: Mobilization
**Priorities:**
- Protect Patients/Staff
- Secure PPE
- Move to Tele-Work

Phase III: Emergency Response
**Priorities:**
- 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)

**Supplies & PPE Procurement and Management**
2x/week calls

**Workforce and Human Resources**
Daily calls

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

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

**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, conference 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

This presentation contains guidance as of April 14, 2020, and is subject to change.

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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

<table>
<thead>
<tr>
<th>Critical Care Equipment Requirements</th>
<th>Caregiver in place</th>
<th>Medication Access</th>
<th>Physician Outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All equipment and supplies should be in the home on day of discharge</td>
<td>• Patients must have a caregiver, unless they are independent and can care for themselves, able to get medications, etc.</td>
<td>• 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)</td>
<td>• Patients must have a physician who is available to coordinate care during this time.</td>
</tr>
<tr>
<td>• Verify whether pulse oximeter is being sent home with patient</td>
<td></td>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td>• Verify whether there are any aerosol treatments involved (and if available, whether patient is independent or not with aerosol treatments)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Protocol A Patient (positive, lower-risk, less PPE)</th>
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<tbody>
<tr>
<td>- At least <strong>7 days</strong> since onset of symptoms <strong>AND</strong></td>
</tr>
<tr>
<td>- At least <strong>48-72 hours since fever is resolved</strong> without the use of fever-reducing medications and improvement <strong>AND</strong></td>
</tr>
<tr>
<td>- <strong>Overall improvement in illness</strong> (e.g. improving cough, shortness of breath)</td>
</tr>
<tr>
<td>- * HHA – <strong>REGULAR HOURS</strong></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Protocol B Patient (positive, higher-risk, more PPE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Evaluated/diagnosed/treated as COVID-19 in the Emergency Room or Clinic, Hospital and released home <strong>(Treat and Release)</strong></td>
</tr>
<tr>
<td>- Patients report symptoms on <strong>Pre-visit Screening</strong> (positive Pre-visit screen)</td>
</tr>
<tr>
<td>- Diagnosed with COVID-19 while on service</td>
</tr>
<tr>
<td>- 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.</td>
</tr>
<tr>
<td>- Gown/DC per A</td>
</tr>
<tr>
<td>- * HHA <strong>RESTRICTED HOURS</strong></td>
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<td></td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Protocol Patient (negative, but household member positive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 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).</td>
</tr>
<tr>
<td>• Clinicians should ask symptomatic household member to stay in a separate room or maintain distance of &gt;6 feet for the duration of the home visit.</td>
</tr>
<tr>
<td>• *HHA RESTRICTED HOURS MAXIMUM TWO HOURS if symptomatic household member cannot be isolated in another room.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protocol C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial home care and hospice visits, clinicians should follow Droplet and Contact Precautions:</td>
</tr>
<tr>
<td>– Surgical mask</td>
</tr>
<tr>
<td>– Gown</td>
</tr>
<tr>
<td>– Gloves</td>
</tr>
<tr>
<td>– Shoe Cover When Available</td>
</tr>
<tr>
<td>– Head Cover When Available</td>
</tr>
<tr>
<td>For subsequent visits, screen the patient for COVID-19 symptoms. If the screening is positive, follow protocol B.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protocol D Patient (negative, lower-risk, less PPE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patients without Covid-19 diagnosis or symptoms (fever, cough/shortness of breath).</td>
</tr>
<tr>
<td>• Or the patient has a past medical history of Covid-19 diagnosis and are now asymptomatic.</td>
</tr>
<tr>
<td>• (14 days have passed from 1st day of diagnosis and the patient has no Covid-19 symptoms).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protocol D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial home care and hospice visits, clinicians should follow wear:</td>
</tr>
<tr>
<td>• Surgical mask</td>
</tr>
<tr>
<td>• Gloves</td>
</tr>
<tr>
<td>• Gown When Available</td>
</tr>
<tr>
<td>For subsequent visits, screen the patient for COVID-19 symptoms. If the screening is positive, follow protocol B.</td>
</tr>
</tbody>
</table>
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)
- Protocol for the Limited Reuse and Extended Use of N95 Respirators and Face Shields (April 28, 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 patients 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
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Jeana Partington
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### Upcoming Events

<table>
<thead>
<tr>
<th>Nursing Homes</th>
<th>Community Coalitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesdays, 2pm ET/1pm CT</td>
<td>Thursdays, 12:30 pm ET/11:30am CT</td>
</tr>
<tr>
<td><strong>June 16th, 2020:</strong> Assessing and Reducing Opioid Prescribing in Long Term Care</td>
<td><strong>June 25th, 2020:</strong> Partnering Across the Healthcare Continuum for the Complex Chronic Care Population</td>
</tr>
<tr>
<td><strong>July 21st, 2020:</strong> Managing Behavioral Challenges In Long Term Care to Prevent Hospitalization</td>
<td><strong>July 30th, 2020:</strong> Population Health Assessments: Identifying Hidden Risks</td>
</tr>
<tr>
<td><strong>August 18th, 2020:</strong> Initiating an Effective Medication Reconciliation Program</td>
<td><strong>August 27th, 2020:</strong> Using SBIRT for Effective Screening and Referral to Treatment</td>
</tr>
<tr>
<td><strong>September 15th, 2020:</strong> High risk medication use and quality practices to prevent ADE</td>
<td><strong>September 24th, 2020:</strong> Opioid Use in the Aging Population</td>
</tr>
<tr>
<td><strong>October 20th, 2020:</strong> Understanding and using QAPI elements in day to day care processes</td>
<td><strong>October 29th, 2020:</strong> Blood Glucose Targets And Adapting Treatment Goals For Special Populations</td>
</tr>
</tbody>
</table>
This material was prepared by Alliant Quality with the help of the Visiting Nurse Service Of New York. Alliant Quality is the quality improvement group of Alliant Health Solutions (AHS), the Medicare Quality Innovation Network - Quality Improvement Organization for Alabama, Florida, Georgia, Kentucky, Louisiana, North Carolina, and Tennessee, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 12SOW-AHSQIN-QIO-TO1CC-20-206