Building Resilience: Maintaining Quality Care in Nursing Homes During COVID

University of Wyoming
Wyoming Center on Aging

UGEC
Utah Geriatric Education Consortium

Dakota Geriatrics

MTGEC
Montana Geriatric Education Center

Disclosure

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https://www.dakotageriatrics.org/great-plains-mountain-consortium

Recap of Last Week

- **Social Determinants of Health**

  Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.

  *Consider Unattended Microaggressions and Implicit Bias

  *Encourage Health Equity

- **Action Steps to QAPI:**
  - **Gather QAPI Data from multiple sources:** Resident and Family Satisfaction. Discharged Resident Surveys. Caregiver Satisfaction. Resident Council minutes
- Know and use your data sources
- Set goals
- Get your team involved

A CULTURE CHANGE CHALLENGE

CARMEN BOWMAN, REGULATOR TURNED EDUCATOR

"It would be nice if when a person moves into a nursing home, they ask him or her 'How do you want to live?' ... not just all that medical stuff."

-Person living in a nursing home

Sonya Barsness *Conversations in Culture Change with Carmen* guest
Sonya Barsness Consulting
sonya@sbcgerontology.com
www.beingheard.blog

Age-Friendly Health Systems

What would an Age – Friendly Health System look like in the Long Term Care setting ?

ZOOM PRE-KNOWLEDGE SURVEY

1) Older adults and family members commonly understand and
a) accurately estimate remaining life expectancy of the older adult
b) over estimate the remaining life expectancy of the older adult
c) under estimate the remaining life expectancy of the older adult

2) By better understanding What Matters to older adults, health care providers can
a) align health care
b) avoid futile health care
a) transition from curative to comfort care
b) all of the above

3) Certification as an Age Friendly Health Care facility
a) Improves older adult health outcomes
b) Lowers the cost of health care for older adults
c) Provides a consistent framework for providers to apply principles of Geriatric health care
d) all of the above

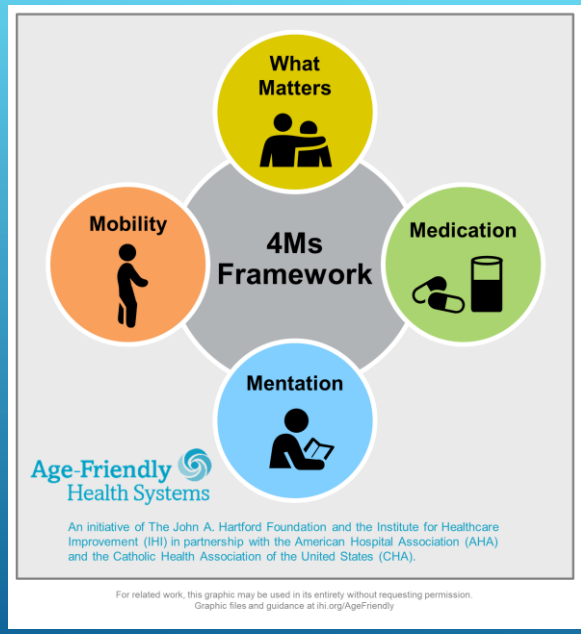
4) On average, how many years prior to death do older adults decline in function regardless of their age of death ?
a) 1 - 2 years
b) 2 - 3 years
c) 3 - 4 years
d) 4 - 5 years

Institute *for* Healthcare Improvement

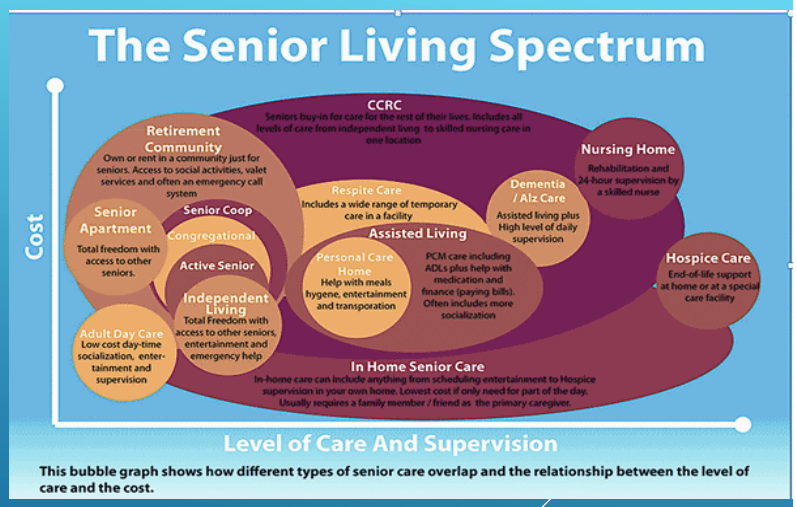
Care guided by evidence-based practices

Avoid harm

Focus on the Geriatric 4Ms



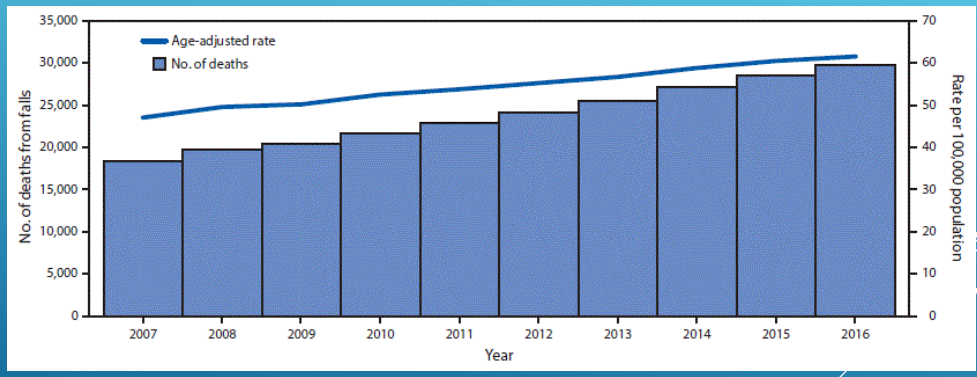
What Matters: Know and align care with each older adult's specific health outcome goals and care preferences



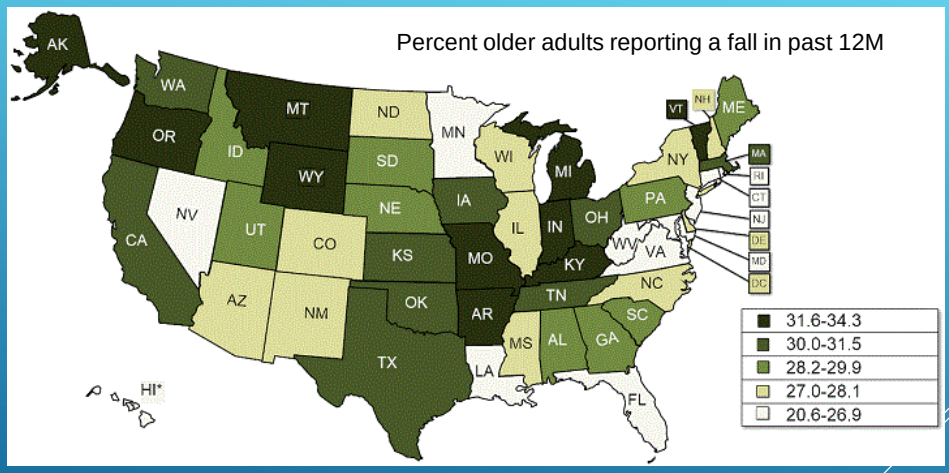
Medication: Avoid unsafe medications that interfere with What Matters to the older adult, Mobility, or Mentation.

Mentation: Prevent, identify, treat, and manage dementia, depression, and delirium.

Mobility: Ensure that older adults move safely every day in order to maintain function



Deaths from falls in older adults (CDC)



North and South Dakota have 1.4 X mortality from falls relative to average US rate

Steps to Becoming Age-Friendly

Ready…

- Learn about Age-Friendly Health Systems
- Inform IHI of interest in participating

Set…

- Identify an Age-Friendly champion
- Send IHI letter of commitment from senior leader
- Introduce teams to Age-Friendly framework

Go!

- Describe local application of the 4Ms
- Share your local description of the 4Ms with IHI
- Share count of patients receiving Age-Friendly care with IHI for at least three months

WHAT MATTERS

Miro

THE RANGE OF WHAT MATTERS TO OLDER ADULTS:

Highly functional

- Feeling strong and well enough to care for an active young grandchild

Frail

- Alleviating pain or being lucid enough to converse with family and friends

DIFFERENT ATTITUDES AND HEALTH GOALS

Highly invested

- Tight glucose control
- Strict blood pressure levels

Laissez faire

- Loose glucose levels
- Permissive blood pressure control

CARE PREFERENCES

- Health care activities that patients are willing and able to do or receive.
  - Medication regimen
  - Self-management tasks
  - Healthcare visits
  - Screening, testing, and procedures

IMPEDIMENTS TO WHAT MATTERS

Providers
&
Health Systems

Patients
&
Families

PITFALLS OF WHAT MATTERS FOR OLDER ADULTS ?

- Rapid change in health status
- Chronic change, e.g. Alzheimer's Disease

OLDER ADULT IMPEDIMENTS TO WHAT MATTERS

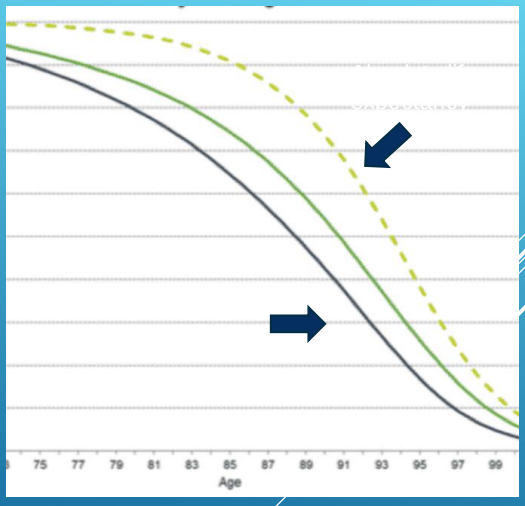
- Ambivalence
- Mood Disorders

OLDER ADULTS AND WHAT MATTERS

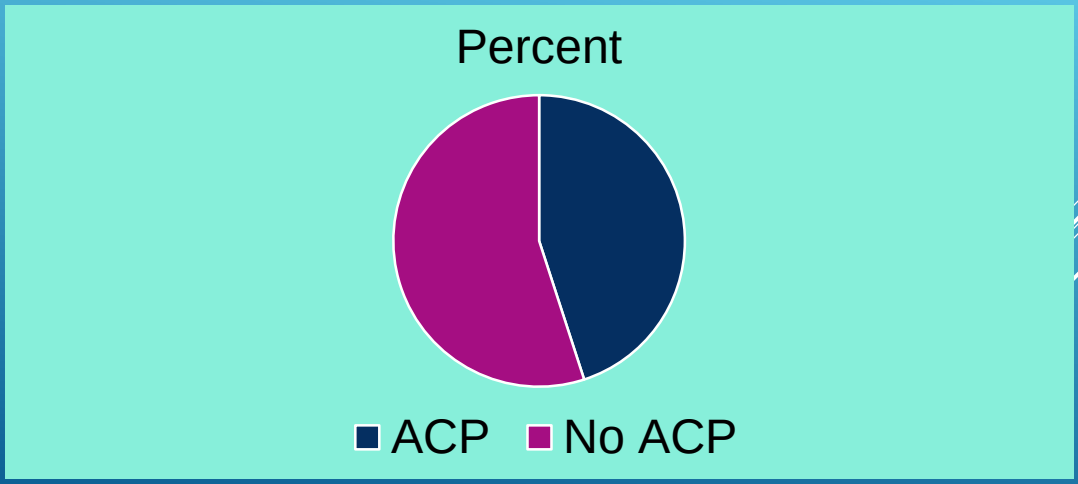
- Unaware of remaining life expectancy
- Cultural concerns: Don't want to evoke death spirit

OVER ESTIMATION OF REMAINING ACTIVE AND ABSOLUTE LIFE SPAN:

- Don't recognize 2 - 3 year functional decline prior to death
- Over estimate life expectancy by 5 – 6 years in heart failure and cancer



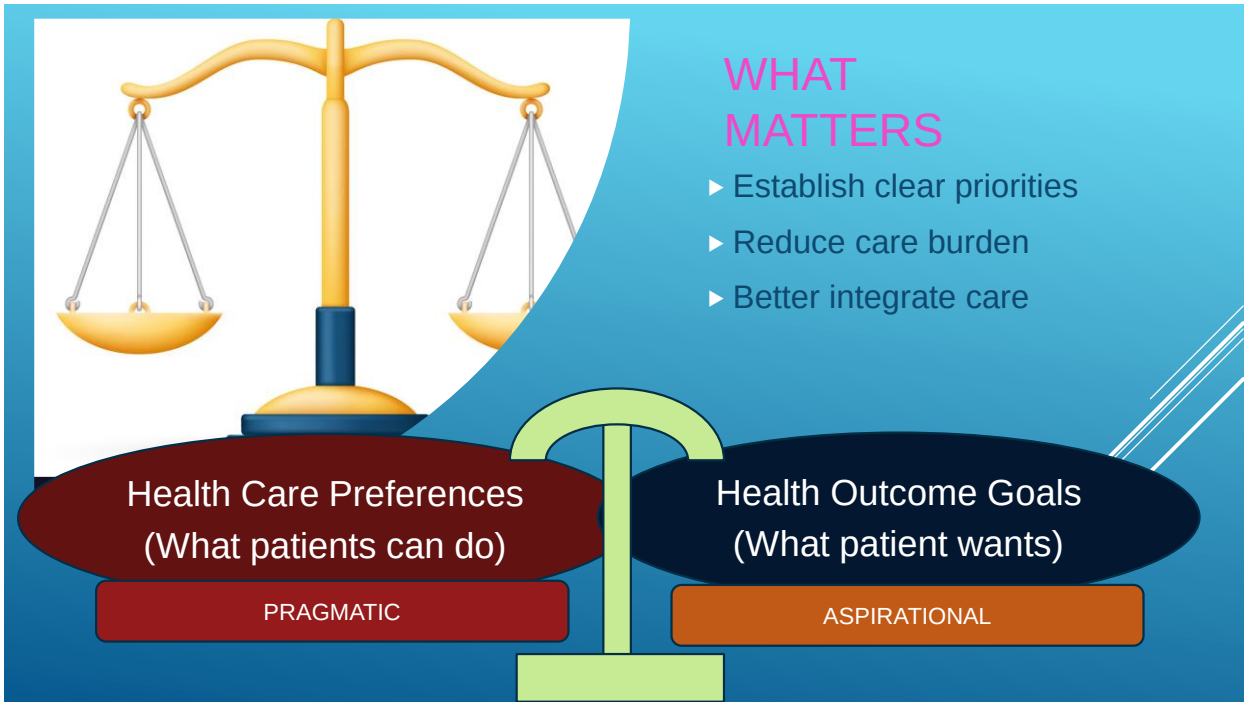
POOR DOCUMENTATION OF WHAT MATTERS

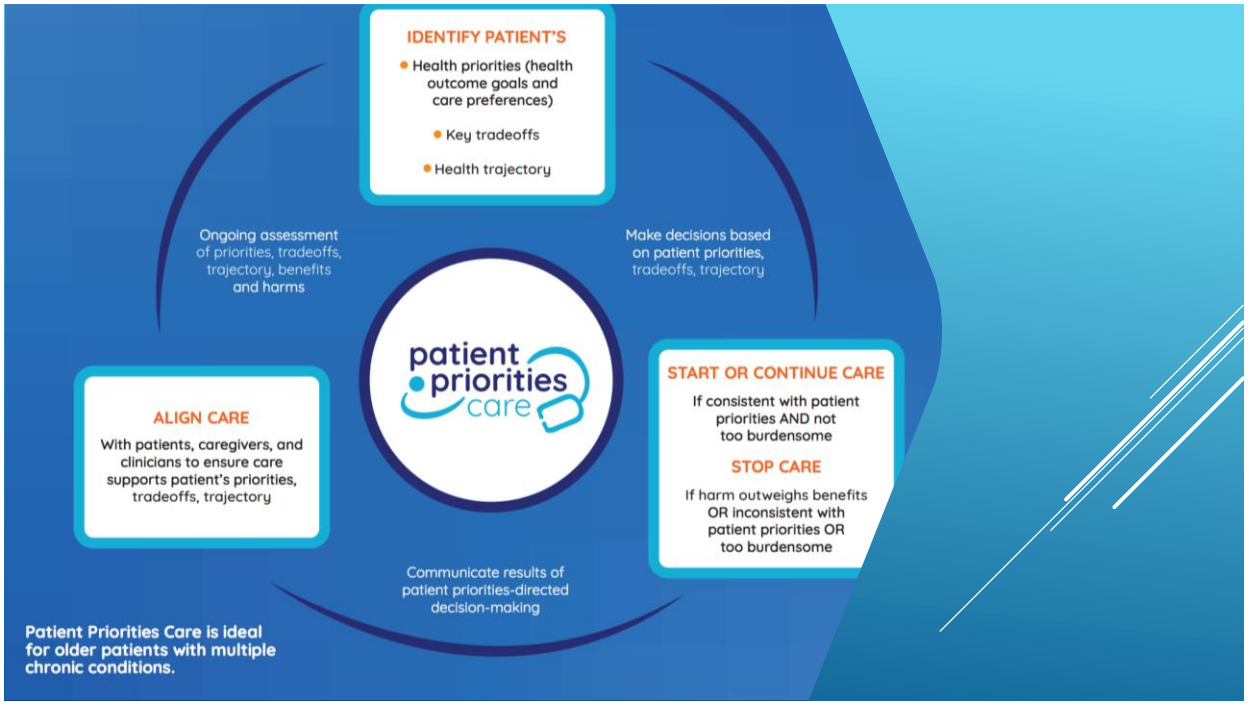


WHAT IS THE CONCEPTUAL FRAMEWORK FOR WHAT MATTERS ?

- Understand functional trajectories
- Estimate life expectancy
- Know when medical care is futile
- Assess decisional making capacity
- La mission de la vida: “What’s your mission ?”

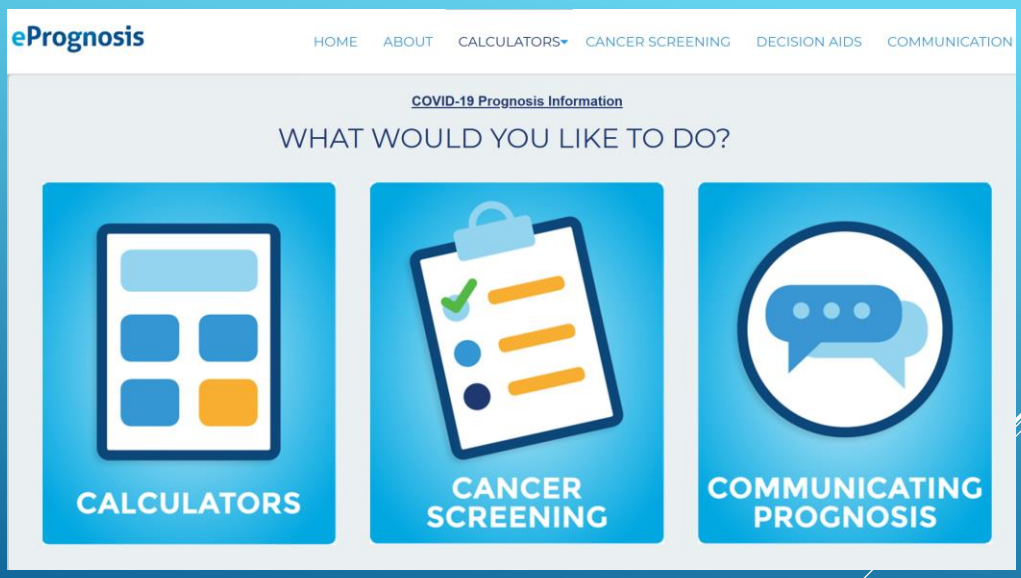
Leonard Nimoy


WHAT MATTERS
Establish clear priorities
Reduce care burden
Better integrate care
Health Care Preferences
(What patients can do)
PRAGMATIC
Health Outcome Goals
(What patient wants)
ASPIRATIONAL


IDENTIFY PATIENT'S
Health priorities (health outcome goals and care preferences)
Key tradeoffs
Health trajectory
Make decisions based on patient priorities, tradeoffs, trajectory
START OR CONTINUE CARE
If consistent with patient priorities AND not too burdensome
STOP CARE
If harm outweighs benefits OR inconsistent with patient priorities OR too burdensome
Communicate results of patient priorities-directed decision-making
ALIGN CARE
With patients, caregivers, and clinicians to ensure care supports patient's priorities, tradeoffs, trajectory
Ongoing assessment of priorities, tradeoffs, trajectory, benefits and harms
patient priorities care
Patient Priorities Care is ideal for older patients with multiple chronic conditions.

PROVIDER ASSESSMENT

- Prognosis
  - Does patient look younger or older than chronological age ?
  - E – prognosis
  - Chronic disease calculator
- Functional assessment
  - ADL
  - IADLs
- Decisional making capacity



Guiding Questions: Anchoring Treatment in Goals and Preferences

- What is the one thing about your health care you most want to focus on so that you can do [fill in desired activity] more often or more easily?
- What are your most important goals now and as you think about the future with your health?
- What concerns you most when you think about your health and health care in the future?
- What are your fears or concerns for your family?
- What are your most important goals if your health situation worsens?
- What things about your health care do you think aren't helping you and you find too bothersome or difficult?
- Is there anyone who should be part of this conversation with us?

POLST

physician orders for life-sustaining treatment paradigm

- Indicate preferences for
  - resuscitation
  - intubation
  - intravenous antibiotics
  - feeding tubes
- POLST is primarily for use among patients with life-expectancies of one year or less.
- Dynamic document: most older adults change within 2 years of death

Stanford MEDICINE | Letter Project

My name

What Matters Most to Me
Examples: Being at home, doing gardening, going to church, playing with my grandchildren

My important future life milestones:
Examples: my 10th wedding anniversary, my grandson high school graduation, birth of my granddaughter

Here is how we prefer to handle bad news in my family
Examples: We talk openly about it, we shield the children from it, we do not like to talk about it, we do not tell the patient

Here is how we make medical decisions in our family
Examples: I make the decision myself, my entire family has to agree on major decisions about me, my daughter who is a nurse makes the decisions etc.

PATIENT EDUCATION

- Advise about remaining life expectancy
- ACP consult if available
- ACP packet
- POLST copy
- Stanford letter web site

ZOOM POST-KNOWLEDGE SURVEY

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SUMMARY

- What Matters is a continuous conversation
  - annual, major life events, or changes in health status
- Coordinated among all team members

SUMMARY

- Pursue What Matters keeping in mind patient cognition, health status, lifespan, and identity
- Need organizational change to operationalize What Matters
  - Training older adults, staff, providers
  - Clinical workflows (pre – clinic visit, EMR surveys, etc)

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Mountain-Pacific Quality Health

Step 8: Identify Your Gaps and Opportunities

Dana Mitchell, RN, CPHQ
Mountain-Pacific Quality Health

April 20, 2022

Homework (from 4.13.22)

Share some successful strategies for collecting QAPI data

Share a successful story of how you have used your QAPI data

Follow up from last week's session

Check out resources, including *QAPI at a Glance*.

Share your success!

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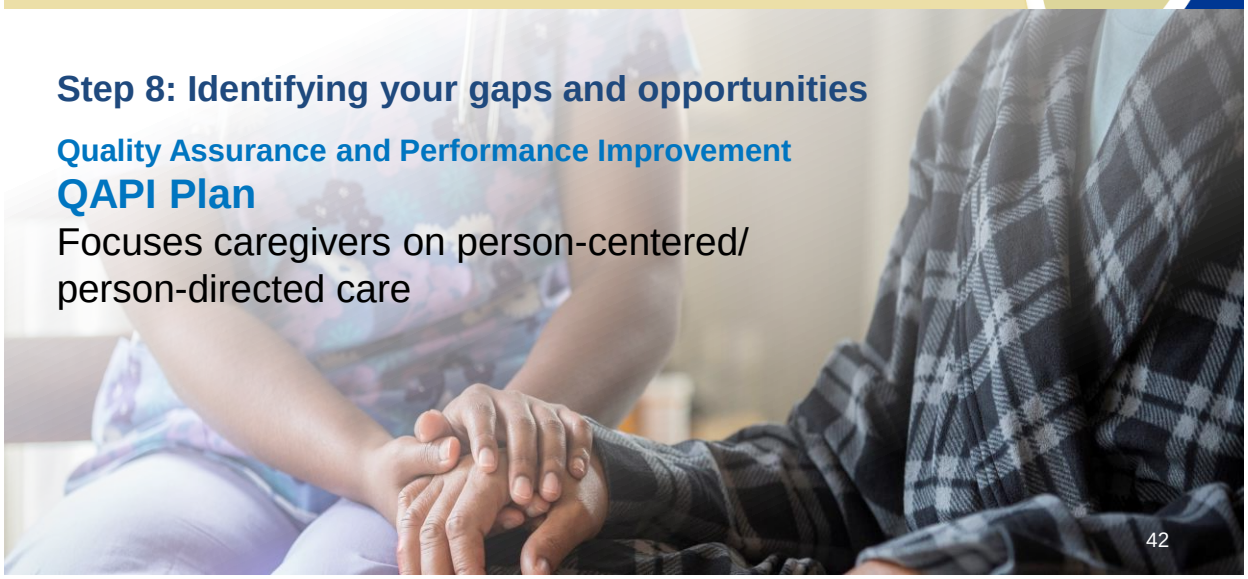
Transforming the lives of nursing home residents through continuous attention to quality of care and quality of life.



Step 8: Identifying your gaps and opportunities

Quality Assurance and Performance Improvement

QAPI Plan

Focuses caregivers on person-centered/ person-directed care

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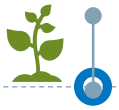
QAPI in Our Nursing Homes

19th Century
QAPI seeds planted



England and America
Quality management incorporated in health care systems

Affordable Care Act 2010
QAPI plan required for nursing homes

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Key Differences between QA and PI
QA+PI = QAPI

	Quality Assurance	Performance Improvement
Motivation	Measuring compliance with standards	Continuously improving processes to meet standards
Means	Inspection	Prevention
Attitude	Required, reactive	Chose, proactive
Focus	Outliers; “bad apples;” individuals	Processes or systems
Scope	Medical provider	Resident care
Responsibility	Few	All

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Briefly, Remember…

Element 1: Design and Scope	**Element 2:** Governance and Leadership	**Element 3:** Feedback, Data Systems and Monitoring	**Element 4:** Performance Improvement Projects (PIPs)	**Element 5:** Systematic Analysis and Systemic Action
• Ongoing, comprehensive • Safe, high-quality care • Emphasizes resident autonomy/ choice in daily life	• Fosters culture where QAPI is inherently team effort • Governing body responsible for setting expectations	• Uses PI to monitor wide range of care processes and outcomes • Uses benchmarks and targets	• Conducts PIPs to examine and improve care and focus on areas where PI is needed and/or desired	• Organized processes/actions • Developed policies and procedures (P&Ps) to support QAPI • Root-case analyses (RCAs) expected for events/missed harm

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Step 8: Identifying Gaps and Opportunities

More Traditional Areas

- Minimum Data Set (MDS) data
- Patterns of caregiver turnover, absences, gaps in certain shifts, overuse of emergency department and/or hospital transfers
- Trends in complaints, family and resident satisfaction, survey results
- Nursing Home Compare and CASPER reports
- Analysis of last 3 annual health surveys – repeat or related citations
- Compliance with written POCs (survey plans of correction)
- People!
- Resident and family council

Keep the resident in focus

Person-centered

Person-directed

This is their home

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Step 8: Identifying Gaps and Opportunities
The Keys to Success

- Discuss themes, trends or patterns identified by residents, caregivers and family
- Focus on high-risk, high-volume and/or problem-prone areas
- Celebrate gains, wins and successes
- Continue setting priorities for improvement

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Step 8: Identifying Gaps and Opportunities
Loneliness during COVID-19

Loneliness is even more common in long-term care institutions.

JAMDA
https://www.jamda.com/article/S1525-8610(20)30373-X/fulltext

Loneliness has a greater impact on health than smoking 15 cigarettes daily or obesity.

Julianne Holt-Lunstad
Brigham Young University
https://www.mcknights.com/blogs/the-world-according-to-dr-el/the-minister-for-loneliness-in-ltc/

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Closing Didactic

Katie Martin, RN, BSN, WCC, QCP
Assistant Director of Nursing
South Peninsula Hospital Long Term Care (Alaska)

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Final Thoughts/Homework

Identify one new opportunity for improvement. Come prepared to share any new identified gaps or opportunities for a PIP.

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Mountain-Pacific Quality Health

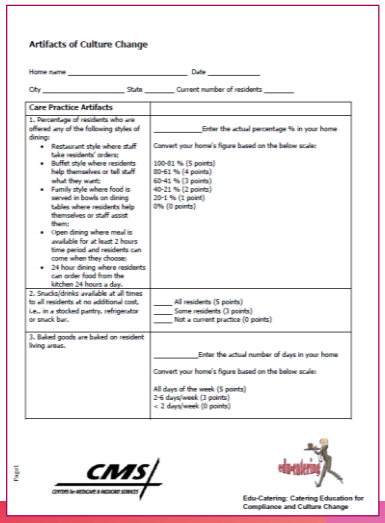
All process improvement is a journey. Teamwork • Engagement • Resident-centered

Thank you!

Questions?

This material was prepared by Mountain-Pacific Quality Health, a Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO), under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW-MPQHF-AS-NH-04/22-129

ARTIFACTS OF CULTURE CHANGE



Artifacts of Culture Change

Home name _____ Date _____

City _____ State _____ Current number of residents _____

Care Practice Artifacts	
1. Percentage of residents who are offered any of the following styles of dining: • Restaurant style where staff take residents' orders; • Buffet style where residents help themselves or tell staff what they want; • Family style where food is served in bowls on dining tables where residents help themselves or staff assist them; • Open dining where meal is available for at least 2 hours time period and residents can come when they choose; • 24 hour dining where residents can order food from the kitchen 24 hours a day.	_____Enter the actual percentage % in your home Convert your home's figure based on the below scale: 100-81 % (5 points) 80-61 % (4 points) 60-41 % (3 points) 40-21 % (2 points) 20-1 % (1 point) 0% (0 points)
2. Snacks/drinks available at all times to all residents at no additional cost, i.e., in a stocked pantry, refrigerator or snack bar.	____ All residents (5 points) ____ Some residents (3 points) ____ Not a current practice (0 points)
3. Baked goods are baked on resident living areas.	_____Enter the actual number of days in your home Convert your home's figure based on the below scale: All days of the week (5 points) 2-6 days/week (3 points) < 2 days/week (0 points)

Page1

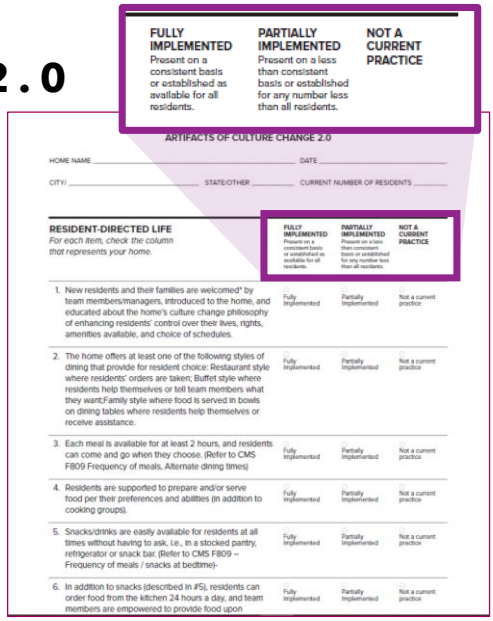
CMS

Edu-Catering: Catering Education for Compliance and Culture Change

- Funded by CMS
- First debuted 2006
- Represents the philosophy of changing from institution to home reflected in practices.
- A tool:
  - Educational
  - Inspirational
  - Self-assessment
  - Benchmarking
  - Gauge progress

ARTIFACTS OF CULTURE CHANGE 2.0

- Debuted Feb. 2021
- Clear indication of practices



FULLY IMPLEMENTED Present on a consistent basis or established as available for all residents.

PARTIALLY IMPLEMENTED Present on a less than consistent basis or established for any number less than all residents.

NOT A CURRENT PRACTICE

ARTIFACTS OF CULTURE CHANGE 2.0

HOME NAME _____ DATE _____

CITY/ _____ STATE/OTHER _____ CURRENT NUMBER OF RESIDENTS _____

RESIDENT-DIRECTED LIFE *For each item, check the column that represents your home.*	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	NOT A CURRENT PRACTICE
1. New residents and their families are welcomed* by team members/managers, introduced to the home, and educated about the home's culture change philosophy of enhancing residents' control over their lives, rights, amenities available, and choice of schedules.	Fully Implemented	Partially Implemented	Not a current practice
2. The home offers at least one of the following styles of dining that provide for resident choice: Restaurant style where residents' orders are taken; Buffet style where residents help themselves or tell team members what they want;Family style where food is served in bowls on dining tables where residents help themselves or receive assistance.	Fully Implemented	Partially Implemented	Not a current practice
3. Each meal is available for at least 2 hours, and residents can come and go when they choose. (Refer to CMS F809 Frequency of meals, Alternate dining times)	Fully Implemented	Partially Implemented	Not a current practice
4. Residents are supported to prepare and/or serve food per their preferences and abilities (in addition to cooking groups).	Fully Implemented	Partially Implemented	Not a current practice
5. Snacks/drinks are easily available for residents at all times without having to ask, i.e., in a stocked pantry, refrigerator or snack bar. (Refer to CMS F809 – Frequency of meals / snacks at bedtime)-	Fully Implemented	Partially Implemented	Not a current practice
6. In addition to snacks (described in #5), residents can order food from the kitchen 24 hours a day, and team members are empowered to provide food upon	Fully Implemented	Partially Implemented	Not a current practice

Artifact #133.

The home uses **non-institutional language** in **all document**s (clinical charting, job descriptions, policies and procedures) **and verbal interactions**, and provides **periodic training** to **all team members** to **remove institutional language.**

https://www.pioneernetwork.net/artifacts-culture-change/

"GET THE WORD OUT"

Star Valley Health in Afton, WY

Culture Change Project 2021-2022

Implemented 10 practices/Artifacts

Chose language as one practice

Positive reinforcement game

Hear someone using new language, their name goes into the jar for a drawing.

Great Plains - Mountain GWEP Consortium

Thank you,
See you next week!

April 27th, 2022:
- Prioritize Quality Opportunities and Charter PIP
- Age-Friendly Case - Mentation
https://www.dakotageriatrics.org/great-plains-mountain-consortium