Building Resilience: Maintaining Quality Care in Nursing Homes During COVID

May 4th, 2022

Age-Friendly Case: Medications

Plan, Conduct, and Document PIPS

- Type your **name and facility name in the "chat box"**
- We ask that you have your **cameras turned on** in order to build a more engaging community of practice.
- Asking questions:
  - Unmute and ask the question
  - Utilize the chat feature to ask your question and the hosts will ask the question when there is a chance.
- Please remember to **mute your audio** when you're not speaking.

University of Wyoming
Wyoming Center on Aging

UGEC
Utah Geriatric Education Consortium

Dakota Geriatrics

MTGEC
Montana Geriatric Education Center

Disclosure

This study is sponsored by the Great Plains Mountain Consortium composed of Geriatrics Workforce Enhancement Programs from Montana, North Dakota, Utah, and Wyoming. Dakota Geriatrics is supported by funding from the Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling 3.75M with 15% financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by HRSA, HHS, or the U.S. Government.

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

Recap of Last Week

The Age-friendly Case – Mentation

- Understanding an individual's specific cognitive challenges and remaining abilities is essential to supporting person-centered care and 'what matters' to everyone.
- Become familiar with standardized tests and use them to support your diagnosis and guide care
- Effective interventions target the underlying cause & maximize physical, psychological & environmental support.

Step 9: Prioritize Quality Opportunities and Charter PIPs

A project charter clearly establishes the goals, scope, timing, milestones and team roles and responsibilities.

- The charter is developed by the QAPI team and then shared with a team designed to carry out the PIP.
- The charter helps a team stay focused but is not a workplan, the charter maps out goals and ensures the team is aware and focused on the solution at hand.

A Culture Change Challenge

Carmen Bowman, Regulator turned Educator

Ageism: prejudice or discrimination on the basis of a person's age.

Is there ageist language ***in the field of aging***?

Please enter in the Chat box…

4M of “Medication” and De-prescribing

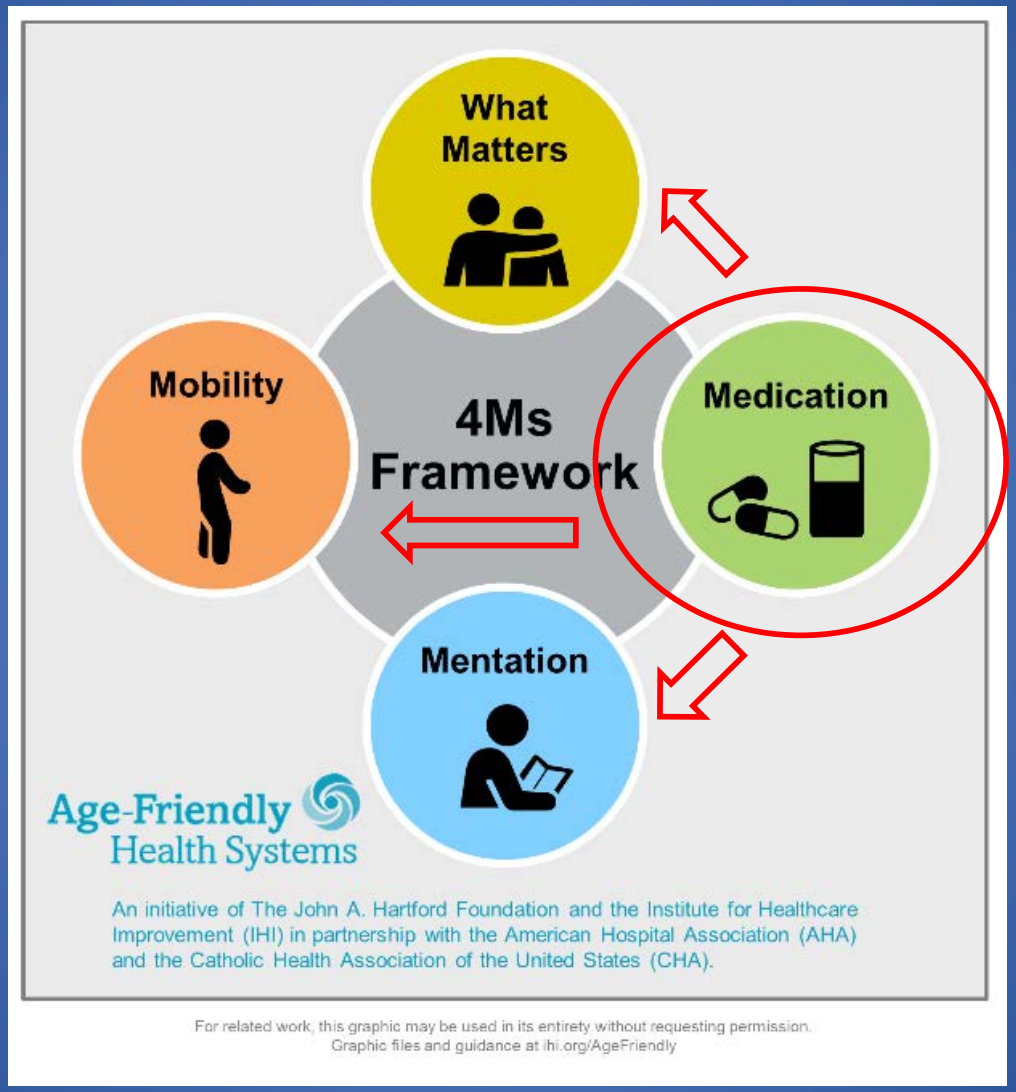
Donald Jurivich, D.O.
Department of Geriatrics
University of North Dakota
School of Medicine and Health Sciences

Pre-Didactic Questions (Zoom Poll)

1. The best clinical tool to recognize unsafe medications in older adults is
    a. Beers List
    b. Physician Desk Reference (PDR)
    c. Micromedex
    d. CAGE
2. Deprescribing medications in older adults
    a. gives time back to NH staff
    b. reduces drug - drug interactions
    c. reduces falls
    d. all of the above

Learning Objectives

- Report aging effects on pharmo-kinetics
- Recognize the dangers of Polypharmacy
- Effectively facilitate de-prescription

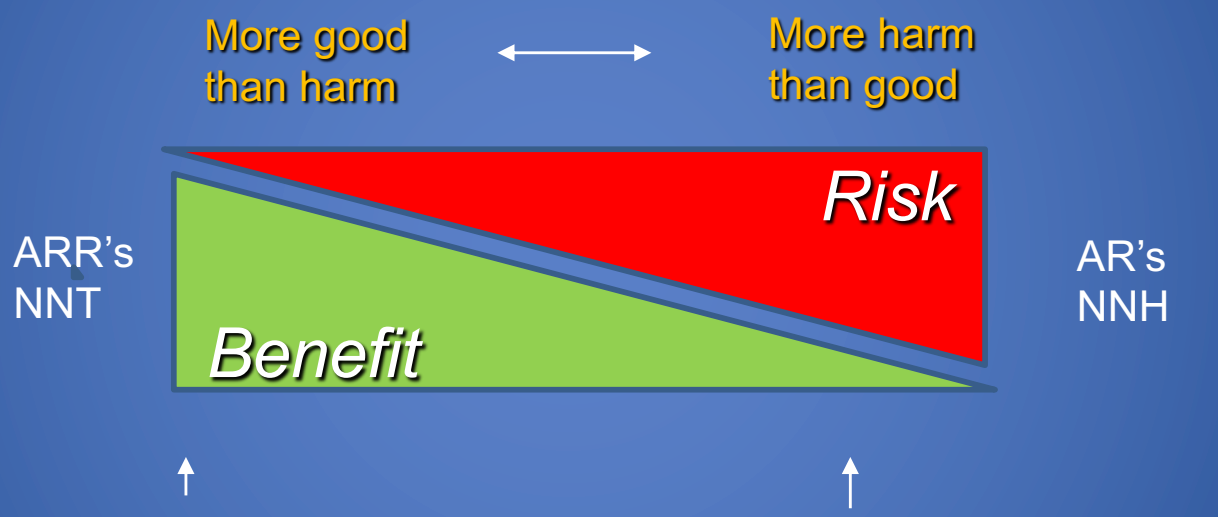

What Matters
Mobility
4Ms Framework
Medication
Mentation
Age-Friendly Health Systems
An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).
For related work, this graphic may be used in its entirety without requesting permission.
Graphic files and guidance at ihi.org/AgeFriendly

Evidence

Benefit

Uncertainty

Risk

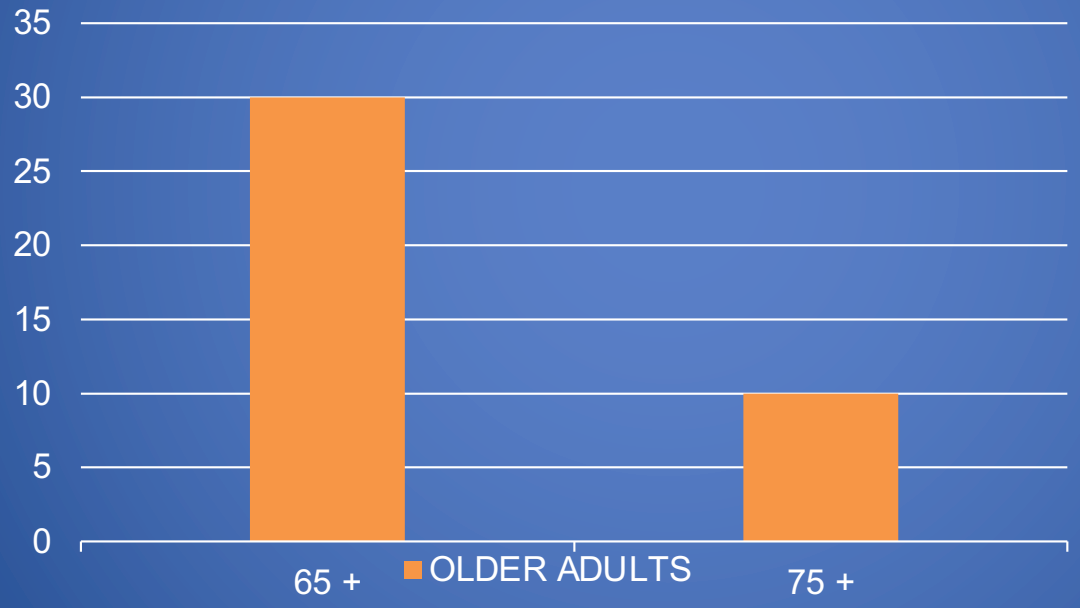


Conundrums

- Adults living longer and trained workforce shortage
- Drug safety concerns tend to be greatest in vulnerable older adults
- Drug prescribing guidance remains deficient
- Most clinical trials exclude frail patient populations
- Industry has little incentive to study at risk groups
- No clinical guidelines for multiple chronic conditions

Older adults under represented in clinical trials

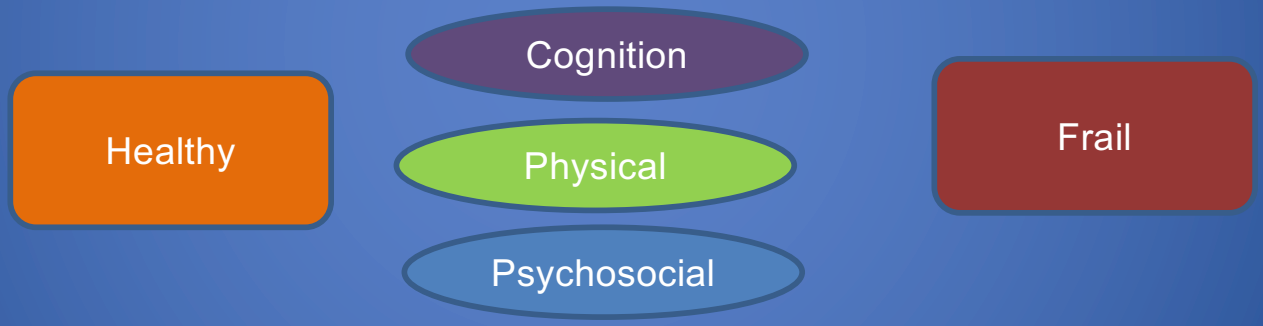
- New oncology trials enrollments



J Clin Oncology (2012) 30:2036

What makes medication use different for older adults ?

Heterogeneous group



Vulnerable to stressors

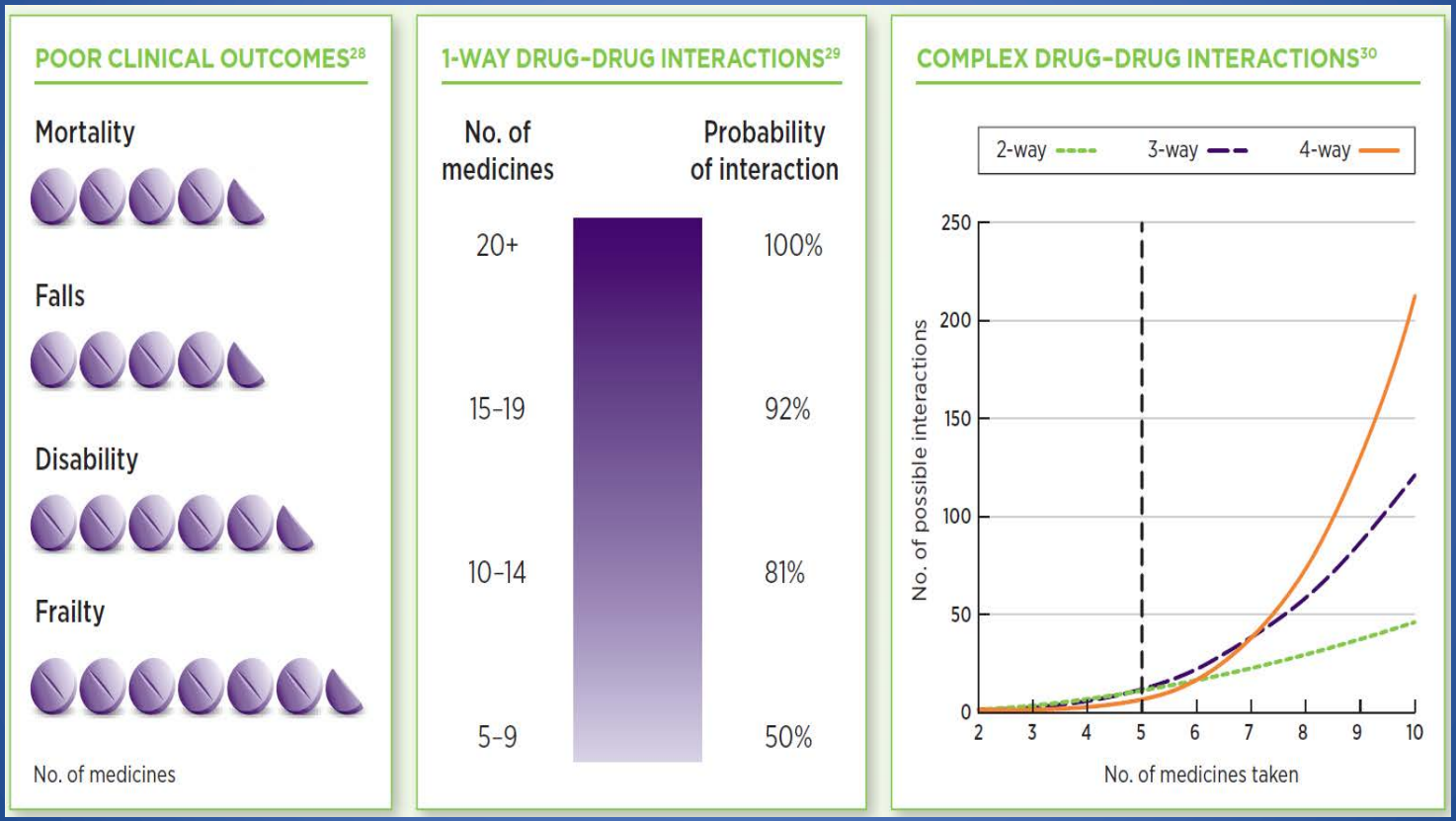
The dreaded (and sneaky) ADE

- Under recognized
- Attributed to disease
- More Rx to treat symptoms

What are ADE Risk factors ?

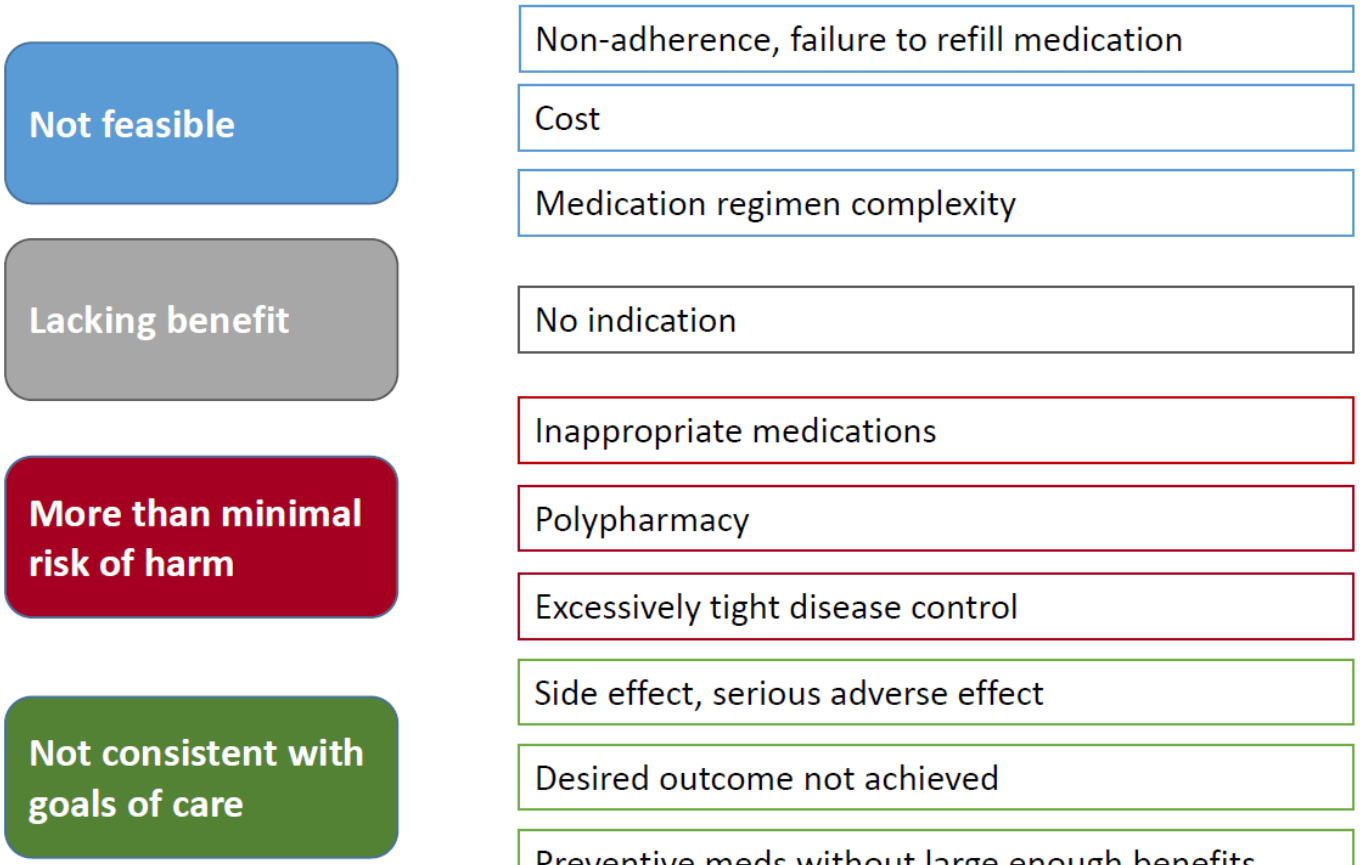
- Age (> 85)
- Polypharmacy (> 6 Rx)
- Low eGFR
- Multiple prescribers
- Low BMI
- MCC
- Blind adherence to guidelines
  - e.g., spironolactone for CHF
- High risk prescriptions
  - e.g., anti - cholinergics

Polypharmacy Predicament



www.nps.org.au/older-people

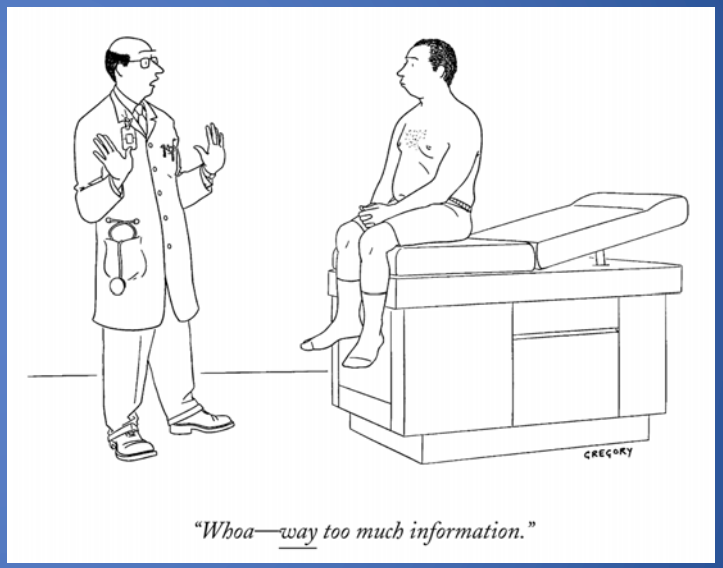
Medication Problems in Patients with Multiple Chronic Conditions



Adapted from Fried T *et al. BMC Geriatrics* 2016 16:67

Barriers to de - prescribing:

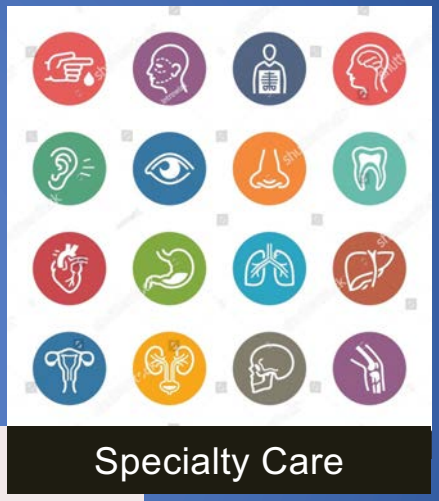
1. Lack of provider time
2. No formal education for providers
3. Disregard consultant Pharm D
4. Resident's request to maintain a specific medication
5. Resident taking a large number of medications
6. Difficulty communicating with other prescribers



"Whoa—way too much information."

Ramaswamy R. et al. J Eval Clin Pract 2011

Do providers have "prescriptive authority" to make medication treatment decisions for a patient?



Barriers to Routine Deprescribing

Myths and Pressures

- Global beliefs, attitudes, biases, prejudices
- Diagnostics, drug company, marketing and for profit pressures

Prescriber's Fears, Restraints, and Frustrations

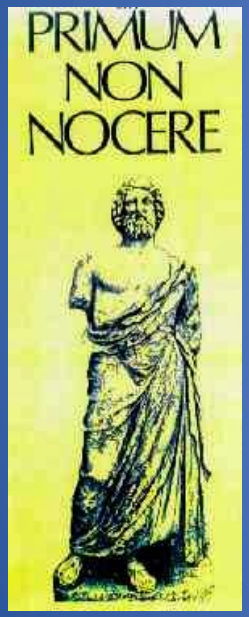
- Lack of evidence in EBM movement
- Fear of legal system, superiors, colleagues, peers, patients & families

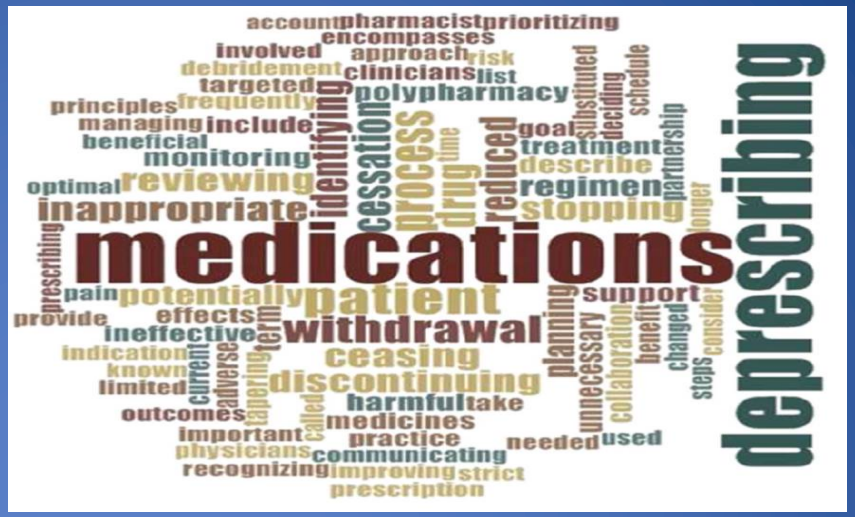
Patient Family Role and Pressures

- Give me something attitude
- "Expert prescribed" who are you to question
- Underappreciation of the scope drug related problems

What is the de-prescribing process ?

Deprescribing





"The process of withdrawal of an inappropriate medication, supervised by a health care professional with the goal of managing polypharmacy and improved outcomes."

Reeve E, et al. Br J Clin Pharmacol 80:6;1254-68.

Communication

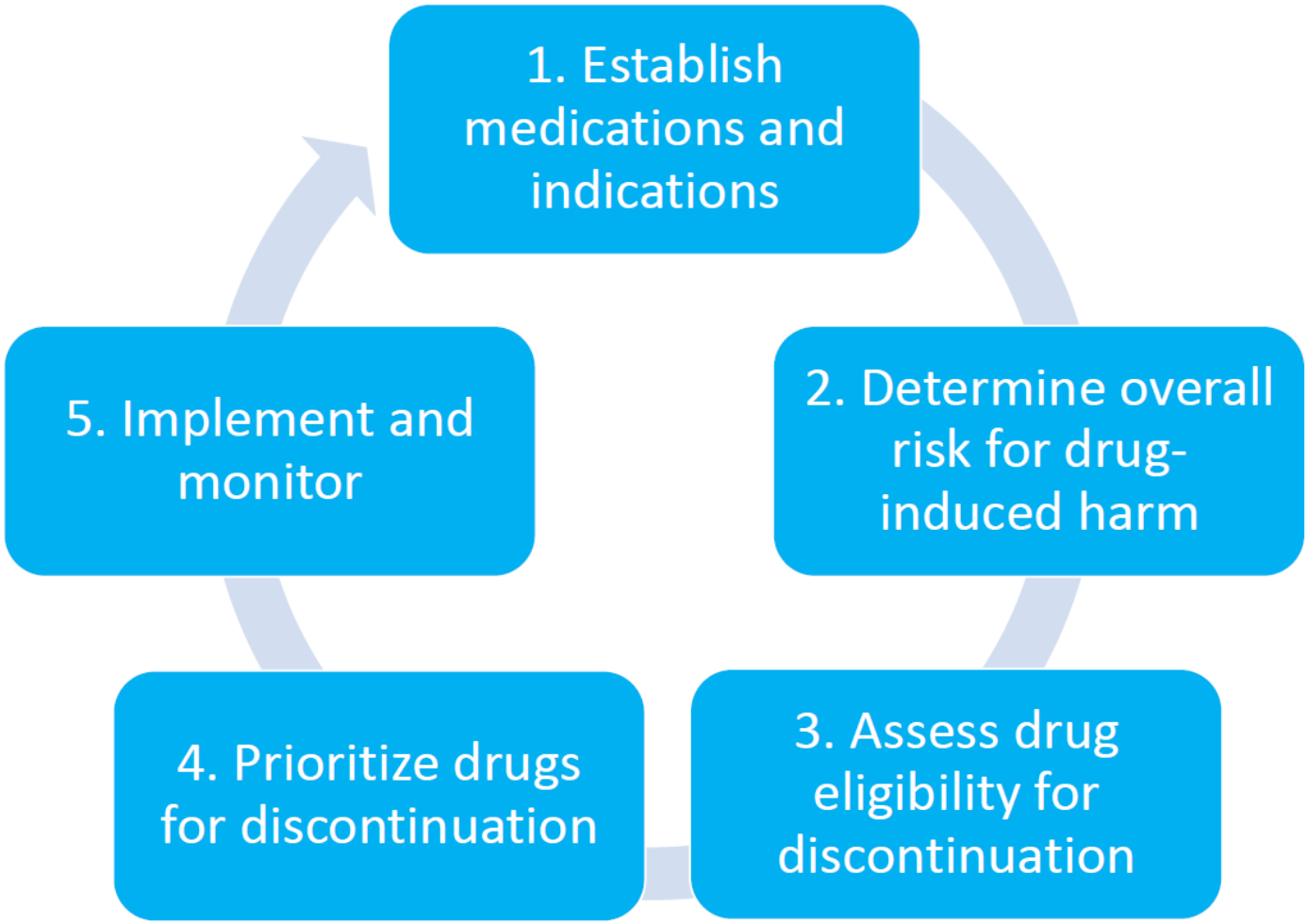
- Be aware of psychological connection to Rx
- Shared decision making
- Ice breaker: “How are these medications helping you ?”

The Psychological Connection to Medications

Patients' Perception
Inconsistent advice leading to difficulties with trust
"But my other doctor told me I should never stop this drug. Are you saying (s)he was wrong? Do you know what you are doing?"
Further confrontation with mortality
"I was told to take this until I die. Are you saying I'm about to die?"
Feelings of abandonment by the medical world
"So it's not worthwhile treating me anymore."
Exposure to the complication of the medical condition
"But won't I get sick without the tablet?"
A sense of futility of previous efforts with compliance
"So why did I bother with jabbing my finger and eating rabbit food for the last twenty years?"

BMJ. 2004 Oct 16;329(7471):909-12.

The Process of Deprescribing



Adapted from Scott, *et al., JAMA Internal Medicine*, 2015

When and for Whom is deprescribing appropriate?

www..nps.org.au/older-people. Medicine Wise News September 2013

OBJECTIVES

What is the efficacy of de-prescribing ?

De-prescribing evidence

- 116 studies
- 34,143 enrollees
- Australian study: 2.0 +/- 0.9 fewer meds
    - Plos One (2016)

Evidence of de-prescribing

- Comprehensive Geriatric Assessment
  - Average 4.0 fewer medications
  - 88% better QOL
- Anti – psychotic reduction in LTC (n=7 studies)
  - 80% residents had no increase in symptoms
  - Reduced falls
  - Improved cognition

Geriatrician consensus on which therapies can be discontinued

Rank	Drug	Number of participants (%)
#1	Benzodiazepines	43/47 (91%)
#2	Atypical antipsychotics	38/47 (81%)
#3	Statins	22/47 (47%)
#4	Tricyclic antidepressants	21/47 (45%)
#5	Proton-pump inhibitors	20/47 (43%)
#6	Urinary anticholinergics	17/47 (36%)
#7	Typical antipsychotics	16/47 (34%)
#8	Cholinesterase inhibitors	16/47 (34%)
#9	Opioids	12/47 (26%)
#10	Selective serotonin reuptake inhibitors	9/47 (19%)
#11	Bisphosphonates	8/47 (17%)
#12	Anticonvulsants	7/47 (15%)
#13	Beta-blockers	3/47 (6%)
#14	Antiplatelets	3/47 (6%)

PLoS ONE 10(4):e012246. (n=65 Canadian Geriatric Experts- 36 pharmacists, 19 MDs, 10 NP's). 3 round delphi, 67% response

Strategies to Facilitate Deprescribing in Clinical Practice

Tools

- Beer's List
- Anticholinergic Risk (ARS)
- Drug Burden index
- OBRA Guidelines
- TRIM

Ther Adv Drug Saf 2015;6(6):212-233
JAMA Intern Med 2015:175(5):829
CMAJ 2014;186(18):1372

Target meds

- Benzos
- Anti – psychotics
- Sulfonylureas
- Vitamin E
- MVI
- Bisphosphonates
- PPIs

Post-Didactic Questions (Zoom Poll)

1. The best clinical tool to recognize unsafe medications in older adults is
   a. Beers List
   b. Physician Desk Reference (PDR)
   c. Micromedex
   d. CAGE

2. Deprescribing medications in older adults
   a. gives time back to NH staff
   b. reduces drug - drug interactions
   c. reduces falls
   d. all of the above

Conclusion

- Create a PIP to reduce unsafe medication burden of residents
- Use specific tools to monitor progress
  - e.g., use Neuropsych Inventory (NPI) to verify no change in behavior when deprescribing antipsychotics
  - e.g., use Beers List and have consultant Pharm D create monthly recommendations for deprescribing

ACTION STEPS TO QAPI

STEP 10: PLAN, CONDUCT, AND DOCUMENT PIPS

Jenifer Lauckner, RN

Quality Improvement Specialist

Quality Health Associates of ND

May 4, 2022

FOLLOW UP FROM LAST WEEK

- Have you used the QAPI prioritization tool?
- What areas did you prioritize?
- Share your experience developing a PIP charter?

PRE-QAPI (ZOOM POLL)

Your PIP Charter can:

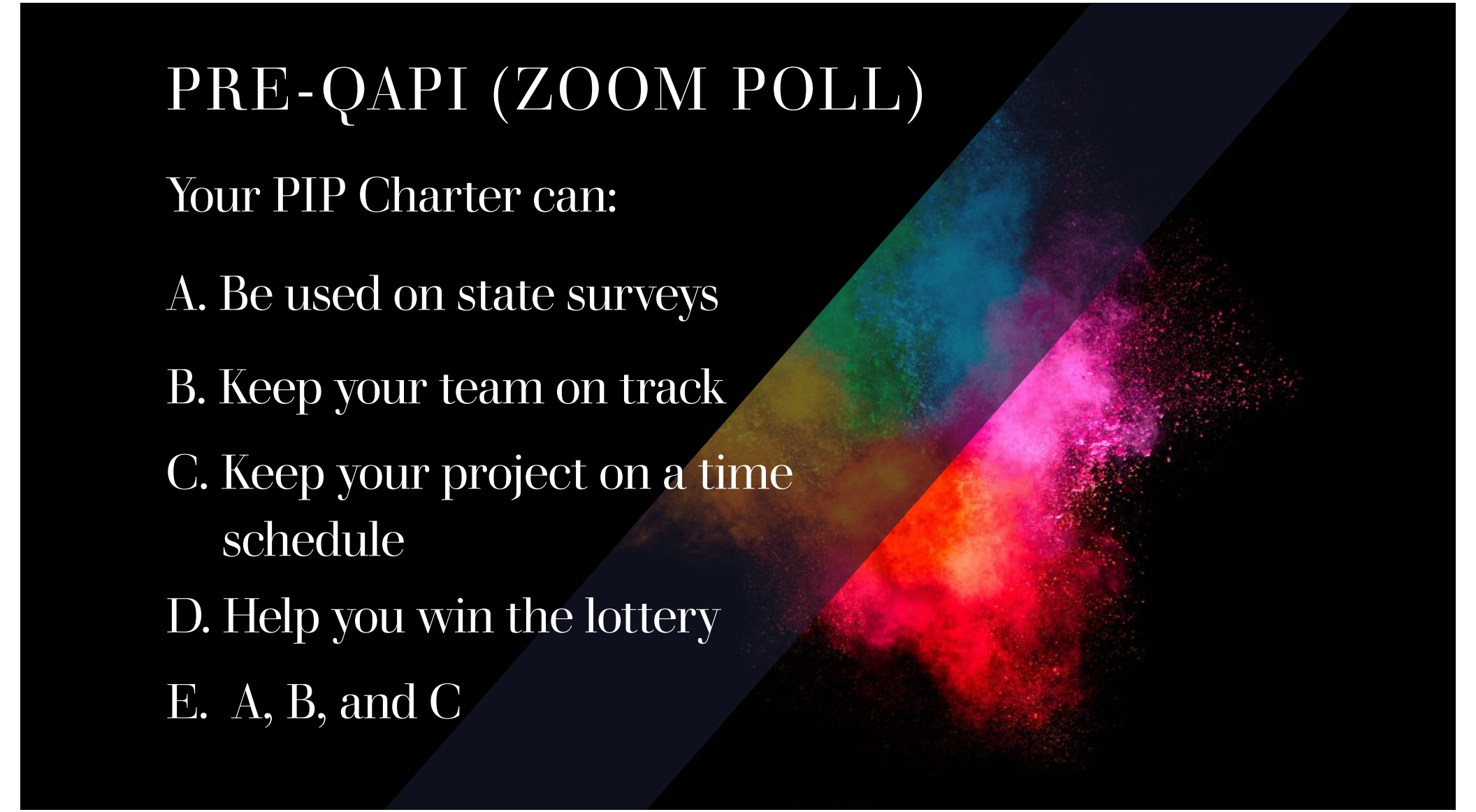
A. Be used on state surveys

B. Keep your team on track

C. Keep your project on a time schedule

D. Help you win the lottery

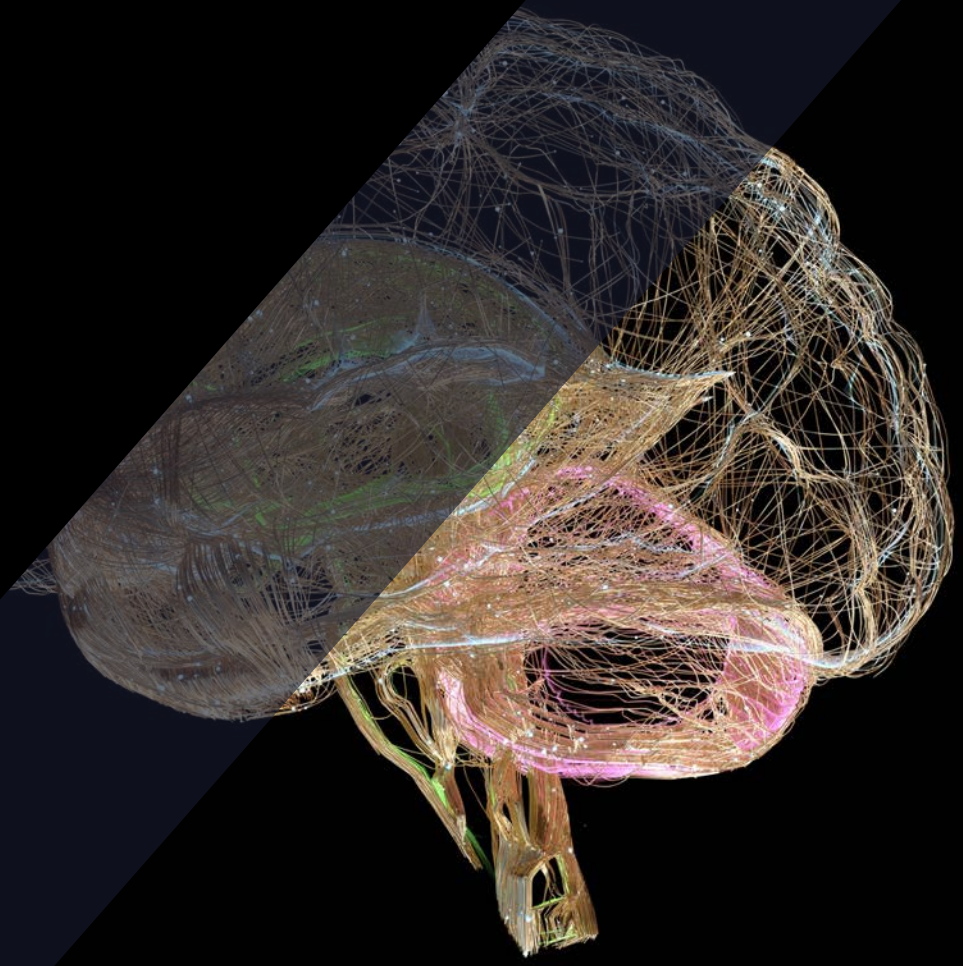
E. A, B, and C



STEP 10: PLAN, CONDUCT, AND DOCUMENT PIPS

Think SMART

- Specific
- Measurable
- Attainable
- Relevant
- Time-Bound



Specific

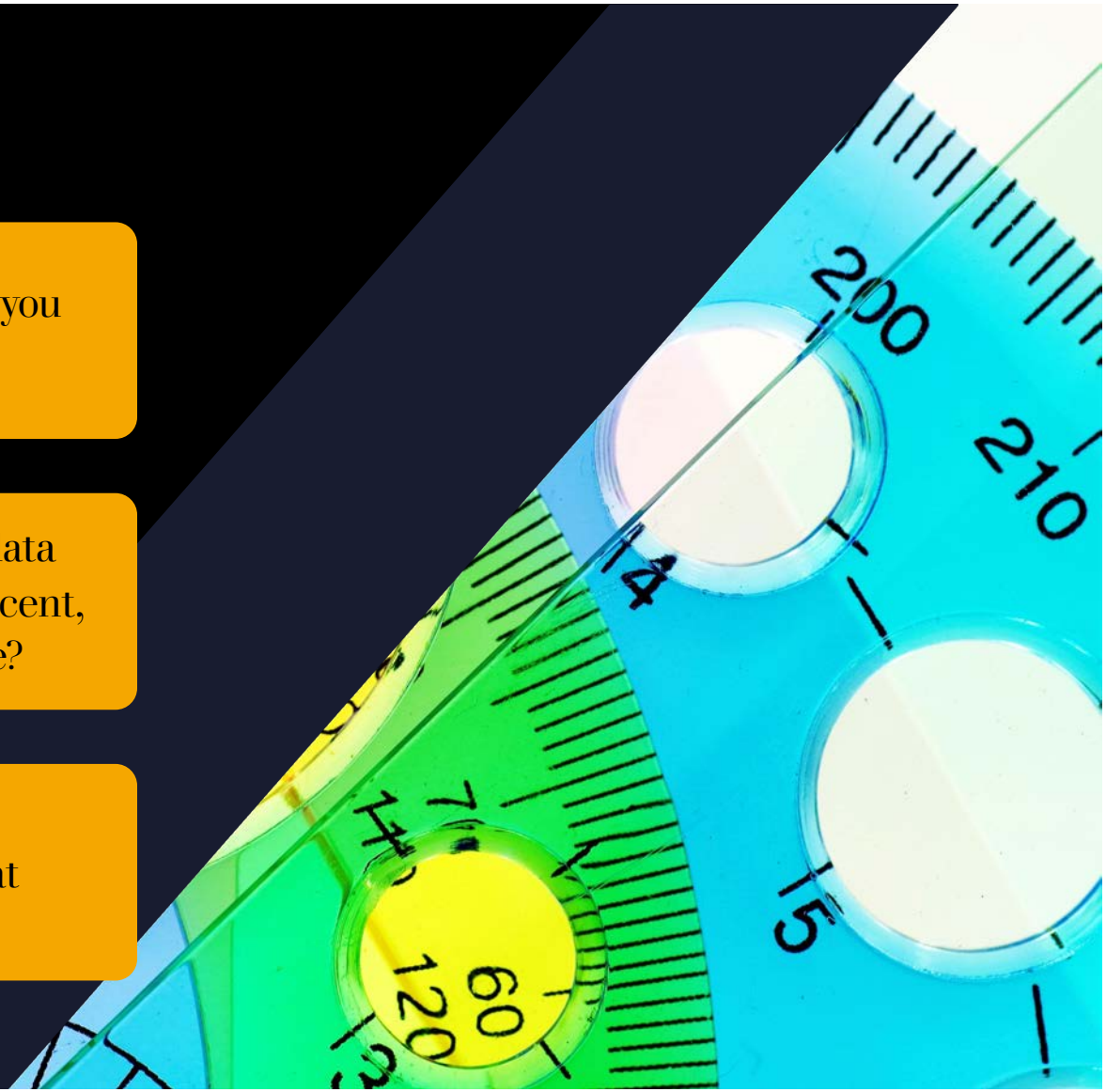
- What do we want to accomplish?
- Who will be involved/affected?
- Where will it take place?

Measurable

What is the measure you will use?

What is the current data figure (i.e., count, percent, rate) for that measure?

What do you want to increase/decrease that number to?



Attainable

Did you base the measure figure you want to attain on a particular best practice/average score/benchmark?

Is the goal measure set too low that it is not challenging enough?

Does the goal measure require a stretch without being too unreasonable?

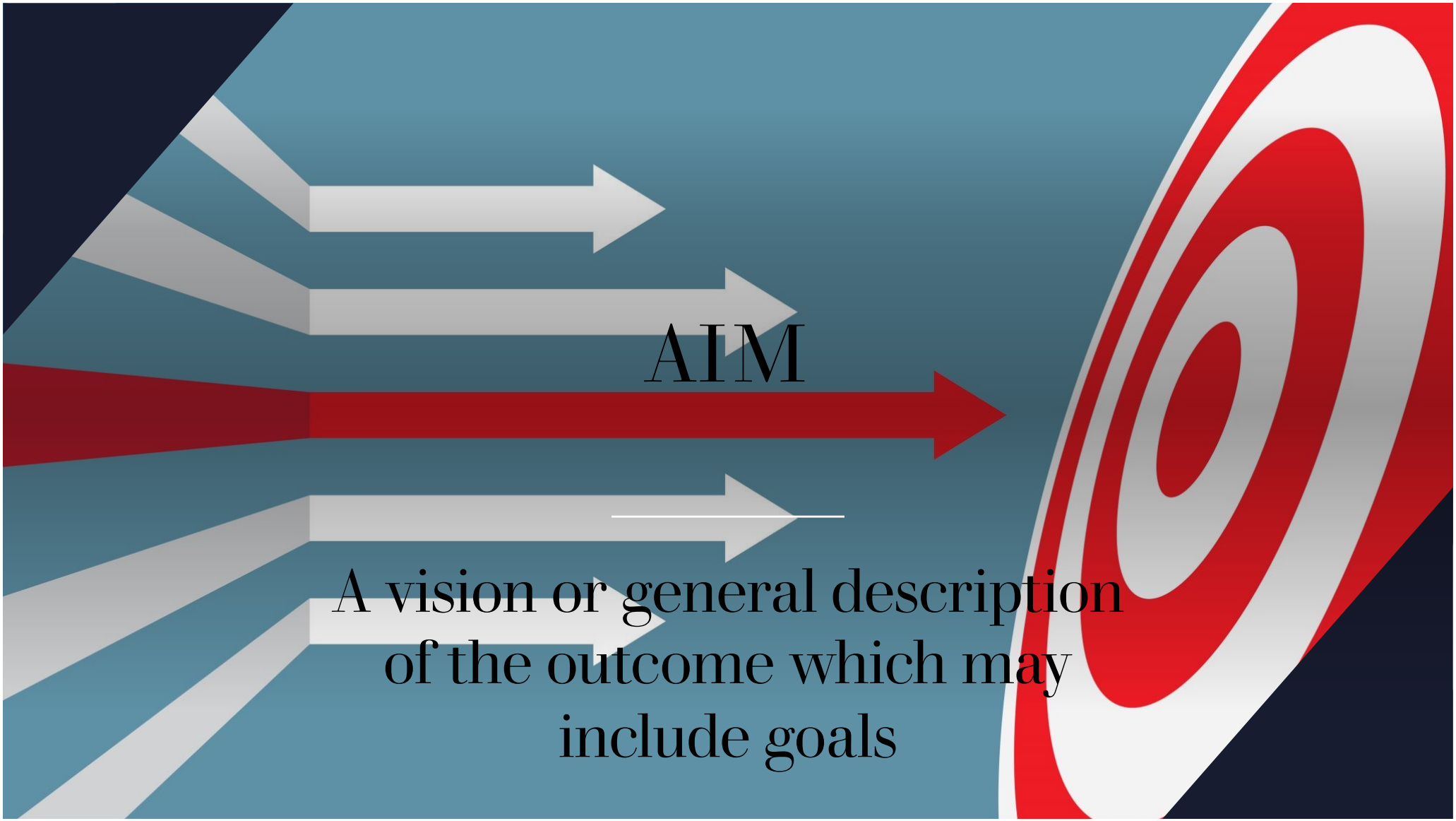
RELEVANT

Briefly describe how the goal being set will address the business problem stated above.

TIME-BOUND

What is the target date for achieving this goal?

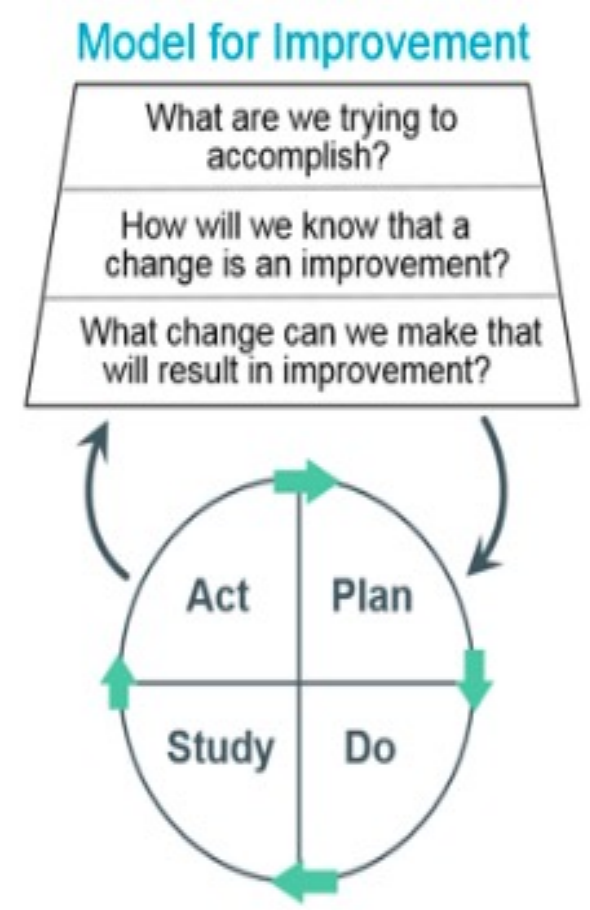

AIM
VS.
GOAL
Should not be confused
with one another


AIM
A vision or general description
of the outcome which may
include goals

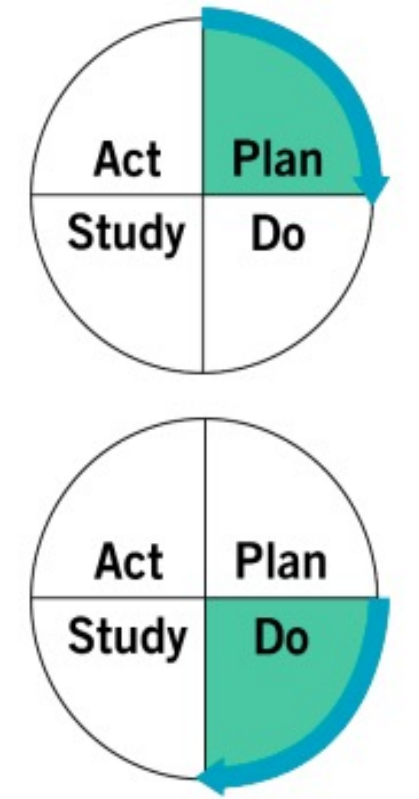
GOAL

Specific and measurable outcome.

PLAN
DO
STUDY
ACT



Plan, Do, Study, Act (PDSA)



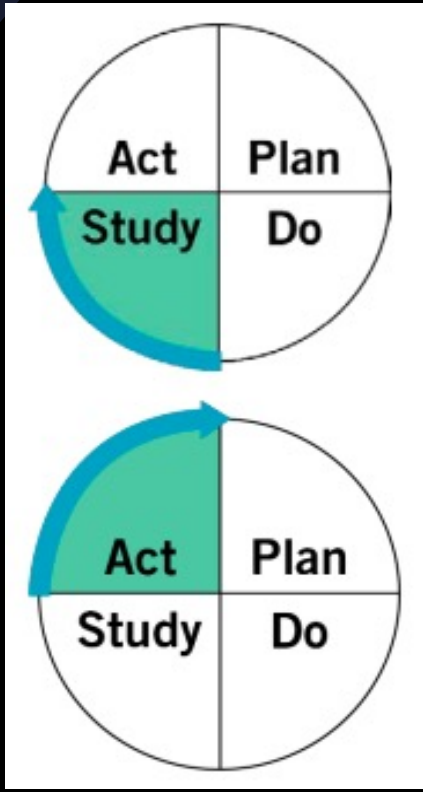
Plan: Plan the test, including a plan for collecting data

- State the question you want to answer and make a prediction about what you think will happen.
- Develop a plan to test the change. (Who? What? When? Where?)
- Identify what data you will need to collect.

Do: Run the test on a small scale

- Carry out the test.
- Document problems and unexpected observations.
- Collect and begin to analyze the data.

Plan, Do, Study, Act (PDSA)



Study: Analyze the results and compare them to your predictions.

- Complete, as a team, if possible, your analysis of the data.
- Compare the data to your prediction.
- Summarize and reflect on what you learned.

Act: Based on what you learned from the test, make a plan for your next step.

- Adapt (make modifications and run another test), adopt (test the change on a larger scale), or abandon (don't do another test on this change idea).
- Prepare a plan for the next PDSA.

Performance Improvement Project (PIP) Guide

Start Date	Review Date(s)	Complete Date	PIP Squad Members
7/1/2018	Monthly	Ongoing	1. Julie M. Titus, CNP (psych provider) 2. Michelle Carter, RN 3. Angela Johnson, RN 4. Mark Greenstad, RN 5. Erik Tamborino, Pharm Tech 6. Sara Stapleton, Pharm Tech 7. Click or tap here to enter text.
Project Leader **Jonah Jones, RPH**	Click or tap to enter a date.	Click or tap to enter a date.	
Key Area for Improvement	Broadening Gradual Dose Reductions from antipsychotics only to now including ALL psychoactive medications. These include antidepressants, antianxiety, sleep aids, and memory enhancers. These GDR's will be flagged twice in the first year of initiation and once yearly after that unless contraindicated. These reviews will be correlated to the MDS schedule.		
Goal: Specific Measurable Action-Oriented Realistic Time Bound	These GDR flags will be initiated monthly following the MDS schedule. Our target threshold is to have the psych provider address 70% of the GDR flags by 12/31/18. The addressed flags will include acted upon GDR flags and those flags with written justification for providers decision.		

What is the Root Cause(s) for the problem? Ask 'Why is this happening?' 5 times. If you removed the root cause, would this event have been prevented?

The root cause of this undertaking is the broadening of CMS guidelines in relation to psychoactive medications. Also, this PIP deals with F329, unnecessary drugs because the flags that are generated will "hopefully" trigger trial GDRs which will then justify the medication's continued use in therapy. Also, the increased scrutiny of the GDR flags will address inappropriate (or off-label) use of many of the therapies by calling the stated diagnoses into scrutiny by the pharmacist/DON/medical officer.

Barriers:

1. Provider buy-in to the whole GDR process and scope.
2. Electronic charting makes it more difficult to ascertain medication start dates d/t to meds all being updated on re-admit etc.
3. Electronic charting makes some record keeping cumbersome or difficult to find later OR review later.
4. Follow up charting (or outcome charting) is an ongoing difficulty
5. Lag time in the provider making changes in the flagged GDR's does skew data.

Brainstorm possible solutions and start your PDSA [PLAN DO STUDY ACT] Cycle
Brainstorm: 1. Continue to improve and increase pharmacist/provider communication 2. With increased use electronic record keeping becomes less cumbersome and somewhat more streamlined. 3. Throw out duplicated GDR's that haven't been acted on yet

Plan	Do			Study and Act	
List the tasks to be done	**Responsible Team Member**	**Start Date**	**Actual Completion Date**	**Comments/Lessons Learned**	**Adopt/Adapt/Abandon**
Generated MDS schedule	Michelle, Angela, and Mark	07/01/18	07/01/18	**Patients come up on MDS quarterly, so schedule works well.**	Adopt
Generate GDR flags of all psychoactive medications from MDS schedule	Jonah	07/01/18	07/27/18	**Pass GDR flags to provider in smaller increments.**	Adopt
Action/Response to GDR flag by provider	J. Titus, CNP	07/27/18	Ongoing	Click or tap here to enter text.	Click or tap here to enter text.

	Study and Act				
Benchmarks/metrics [how will we measure progress?]	**Baseline Date**	**First Measurement Date**	**Second Measurement Date**	**Final Measurement Date**	**Comments**
Was Action Taken on GDR Request?	Click or tap here to enter text.	**June to Dec. 2018**	**6/18 to 3/19**	**6/18 to 5/19**	Click or tap here to enter text.
	Click or tap here to enter text.	**(28/35) 80.00%**	**(46/49) 94%**	**(59/66) 89%**	

This material was prepared the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for North Dakota and South Dakota, 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. 12SOW-GPQIN-13/0320

Performance Improvement Project (PIP) Guide

Start Date	Review Date(s)	Complete Date	PIP Squad Members
3/16/2022	4/20/2022	Click or tap to enter a date.	**1. Emily Schneider RN/ADON/IP** **2. Mandy Robinson OT** **3. Sara Farrell PT** **4. Abby Staiger RN, RCC** **5. Lisa Conlon LPN, RCC** **6. Jeanne Miller, RN RCC** **7. Emily Dakken RN/DON**
Project Leader E Schneider RN/ADON/ICP	Click or tap to enter a date.	Click or tap to enter a date.	
Key Area for Improvement	Routine Repositioning of Residents		
Goal: Specific Measurable Action-Oriented Realistic Time Bound	Reduce the risk of future pressure sore development by increasing nursing staff compliance with repositioning of at-risk residents that use their bed as their primary sleep furniture to a rate of 90% by October 16 2022.		

What is the Root Cause(s) for the problem? Ask 'Why is this happening?' 5 times. If you removed the root cause, would this event have been prevented?

Lack of cues and materials in resident room. Misunderstanding of understanding/lapse of education regarding position changes.

Barriers:

Staff compliance, need extra materials placed in rooms to make project successful

Brainstorm possible solutions and start your PDSA [PLAN DO STUDY ACT] Cycle

Brainstorm:

Education Inservice meeting regarding importance of repositioning needs to be held – pillows to be introduced
Repositioning time sheet needed in room as reference
Observations and audits need to be done

Plan	Do			Study and Act	
List the tasks to be done	**Responsible Team Member**	**Start Date**	**Actual Completion Date**	**Comments/Lessons Learned**	**Adopt/Adapt/Abandon**
Staff education regarding repositioning and reference card with repositioning times needed in resident room	Mandy Robinson OT Sara Farrell PT	3/16/22	3/16/22	Don't take basic education for granted – staff need reminders	Nursing staff indicated they want a different stay room repositioning card – PT did redo the reference card to staff liking
Red pillows introduced and placed in resident's rooms for use	Emily Schneider, ADON Emily Dakken DON	3/16/22	3/16/22	If pillows are not in room staff often will not go and retrieve per self	Extra pillows retrieved from storage area, and red pillow cases placed so was ready for staff use
Audits/observations of repositioning compliance	Emily Schneider, ADON Emily Dakken DON Lisa Conlon LPN/RCC Abby Staiger RN/RCC Jeanne Miller RN/RCC	3/8-3/14 -pre-ed 3/17-3/23 – one week post ed 3/24-4/15/22 – 2 to 4 weeks post ed Goal is daily audits-M-F as staff are able for the 1st month	3/8/22-3/14/22 3/17/22-3/23/22 3/24/22-4/15/22 Continued ongoing audits	Noted increase in repositioning after education session and with the placement of the red pillows in the room	Will continue to monitor after the one-month mark – will decrease audits to 2x weekly vs daily M-F

	Study and Act				
Benchmarks/metrics [how will we measure progress?]	Baseline Date	First Measurement Date	Second Measurement Date	Final Measurement Date	Comments
Audits/observations with results that are logged in excel spreadsheets and graphs	3/8-3/14/22 -pre-education data	3/17-3/23 – one week post ed	3/24-4/15/22 – 2 to 4 weeks post ed	Click or tap here to enter text.	After one month mark will monitor progress monthly (biweekly for two months) then depending on results may go monthly audits only
	Pre-education % of staff using reposition pillow during audit observation was 15%	1 week post-ed results = 69% reposition pillow used during observation/auditing	1-month post-education results = 75% reposition pillow used during observation/auditing	Click or tap here to enter text.	

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Project Leader Click or tap here to enter text.	Click or tap to enter a date.	Click or tap to enter a date.	
Key Area for Improvement	Click or tap here to enter text.		
Goal: Specific Measurable Action-Oriented Realistic Time Bound	Click or tap here to enter text.		
What is the Root Cause(s) for the problem? Ask 'Why is this happening?' 5 times. If you removed the root cause, would this event have been prevented?			
Click or tap here to enter text.			
Barriers: Click or tap here to enter text.			
Brainstorm possible solutions and start your PDSA [PLAN DO STUDY ACT] Cycle - see page 2			

Plan	Do			Study and Act	
List the tasks to be done	**Responsible Team Member**	**Start Date**	**Actual Completion Date**	**Comments/Lessons Learned**	**Adopt/Adapt/Abandon**
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Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

	Study and Act				
Benchmarks/metrics [how will we measure progress?]	**Baseline Date**	**First Measurement Date**	**Second Measurement Date**	**Final Measurement Date**	**Comments**
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	

This material was prepared the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for North Dakota and South Dakota, 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. 12SOW-GPQIN-13/0320

Please Answer in the Chat...

- What one thing so far in this ECHO series has sparked excitement for you to create your PIP?


Please Answer in the chat...
• What challenges have you faced while developing your PIP?

POST-QAPI (ZOOM POLL)

Your PIP Charter can:

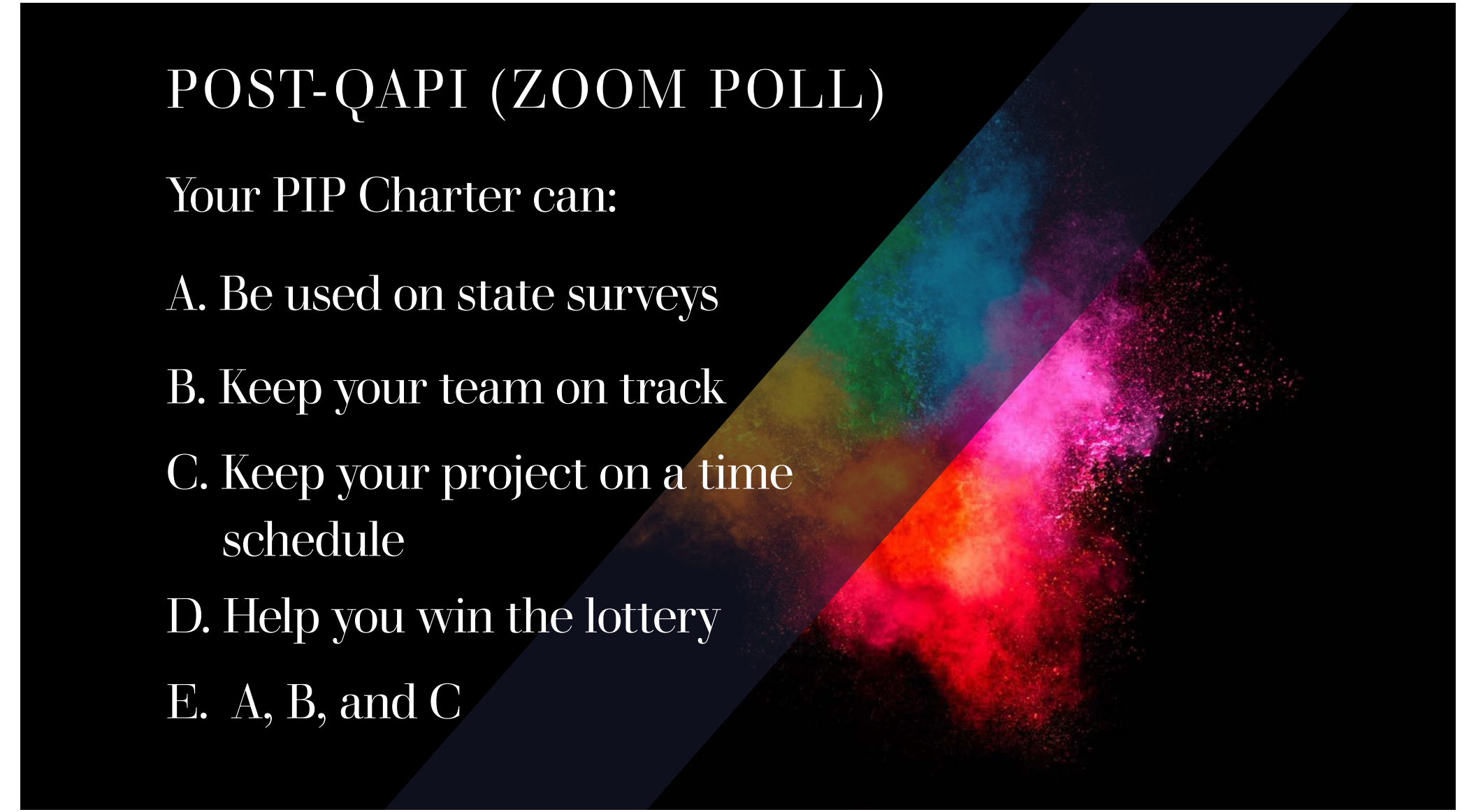
A. Be used on state surveys

B. Keep your team on track

C. Keep your project on a time schedule

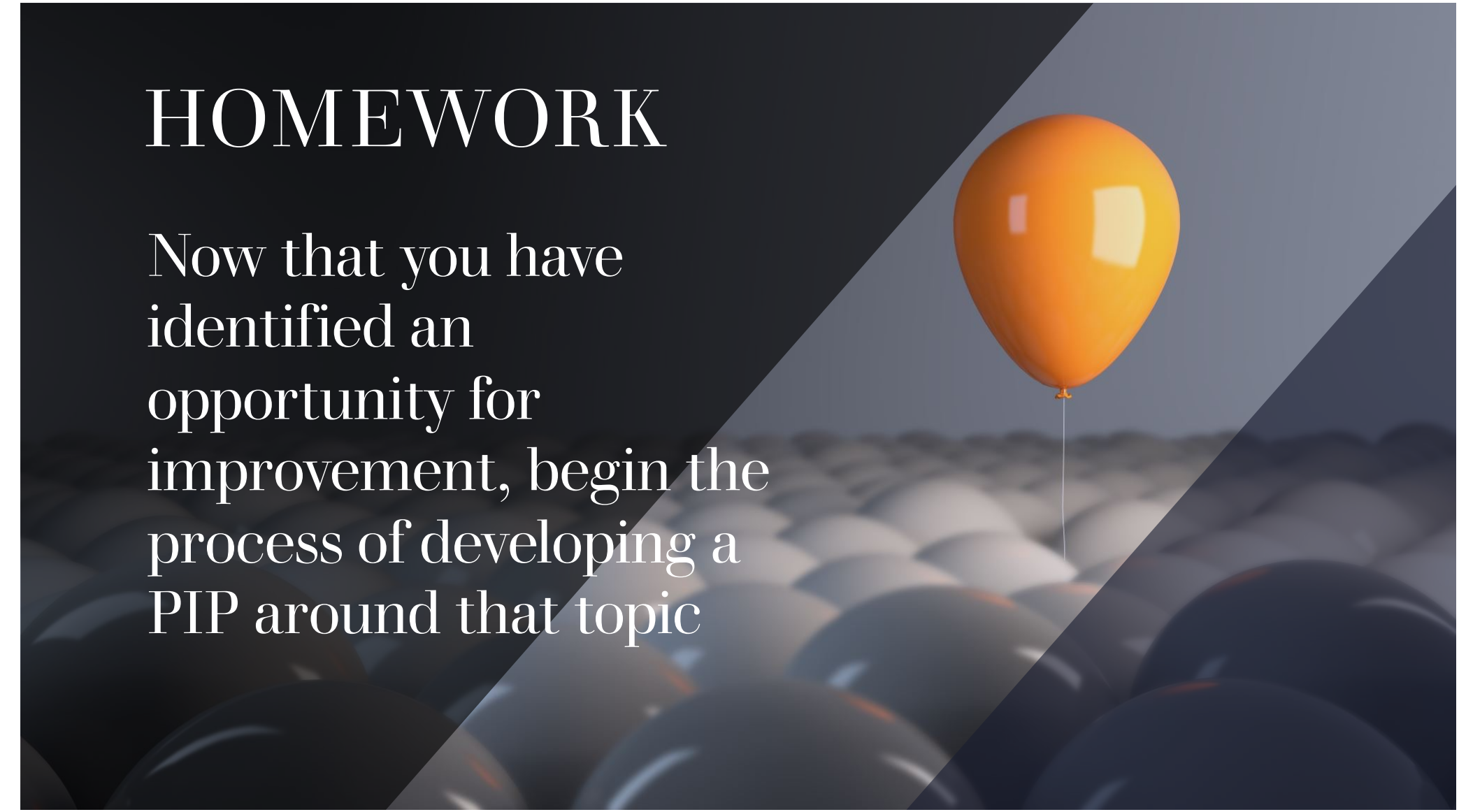
D. Help you win the lottery

E. A, B, and C



HOMEWORK

Now that you have identified an opportunity for improvement, begin the process of developing a PIP around that topic




Questions?


Thank You

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701-989-6228

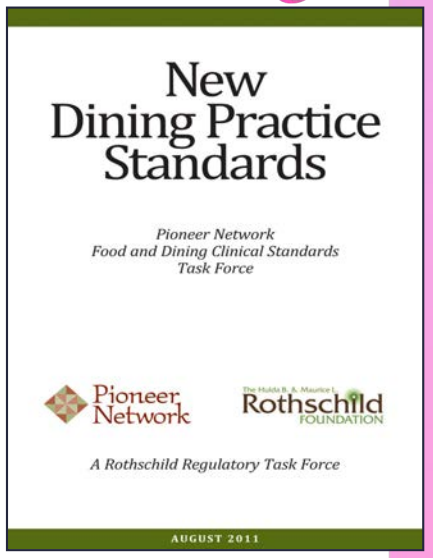
Beware of subtle pejorative language disparaging, derogatory, deprecatory, patronizing

Examples:

- We <u>let</u> our residents sleep in.
- We <u>allow</u> them to have a pet.
- We <u>permit</u> them to go outside.

Consider instead:

- We **support**…
- We **honor**…
- We **encourage**…

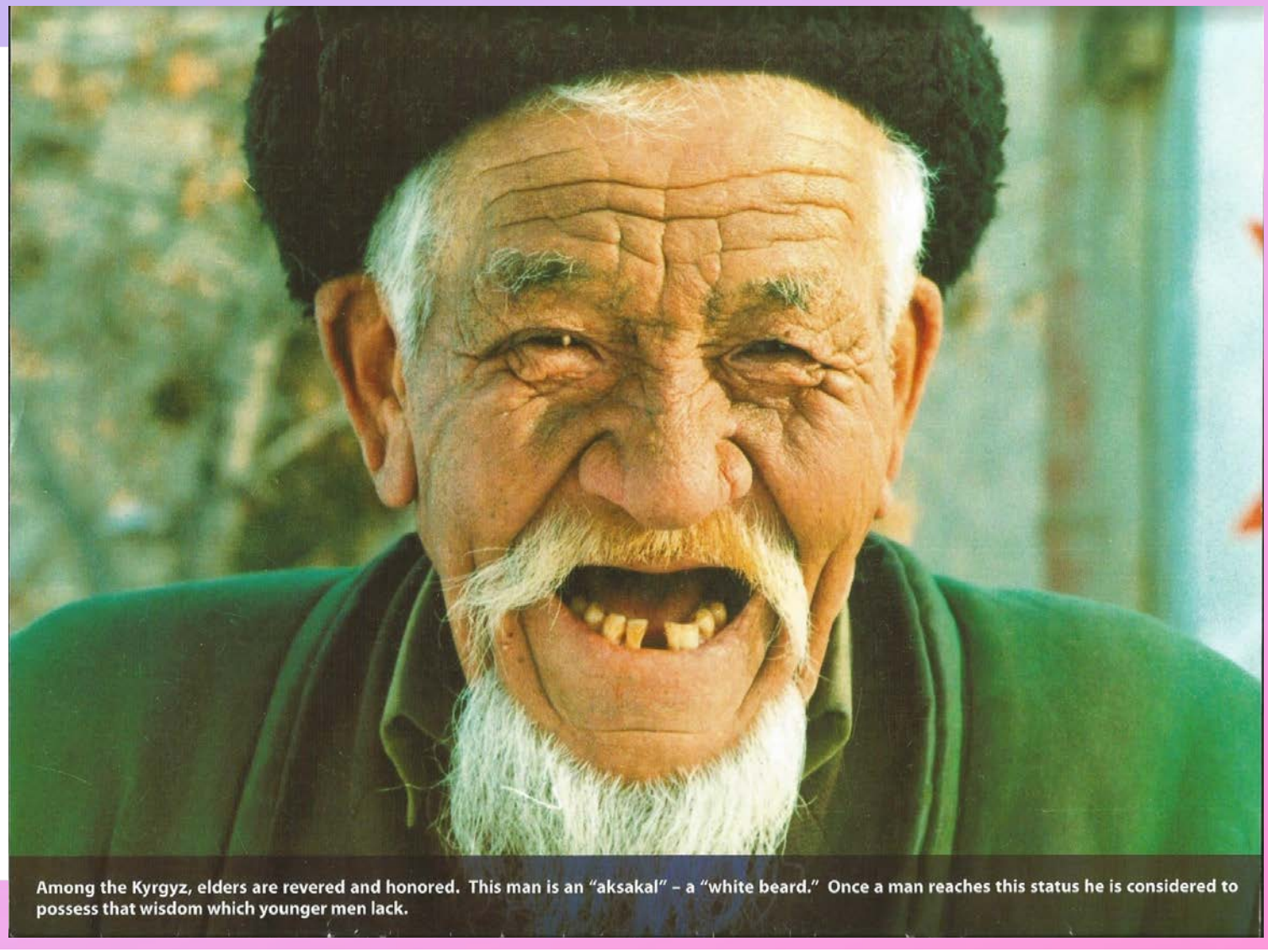


Shifting Traditional Professional Control to Support Self Directed Living
(from the New Dining Practice Standards at pioneernetwork.net)

Do we value, revere, and honor older age?

Do you proudly say your age?

Are you proud of your grey hair?



Among the Kyrgyz, elders are revered and honored. This man is an "aksakal" – a "white beard." Once a man reaches this status he is considered to possess that wisdom which younger men lack.

Aging: good or bad?

ANTI-AGING
What is the message?

Popular to look **older** in some cultures, some **dye their hair grey**

How do ***we*** talk about getting older?

"I'm having a senior moment."

"Thanks for putting up with us *old people*."

"We're going to AT&T with phone questions, I can see those kids rolling their eyes now!! Haha."

"You're my longest friend - but I won't say for how long."

https://www.tandfonline.com/doi/full/10.1080/01924788.2021.1992712

Satisfaction Survey

PLEASE TAKE A MOMENT TO COMPLETE THE ZOOM POLL.

USE THE CHAT TO SHARE ANY ADDITIONAL COMMENTS/THOUGHTS ON TODAY'S SESSION.

Thank you,
See you next week!

May 11th, 2022:

- Age – Friendly Case: Mobility
- Step 11: Getting to the "Root" of the Problem

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