April 27th, 2022

Age-Friendly Case: Mentation

Prioritize Quality Opportunities and Charter PIP

- 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

Age friendly Health Systems, by the Institute for Healthcare Improvement

- Care guided by evidence-based practices
- Avoid harm
- Focus on the Geriatric 4Ms: what matters, medication, mentation, mobility

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

Step 8: Identify Your Gaps and Opportunities

- Focuses caregivers on person-centered/ person-directed care
- The processes of an effective Quality Assurance and Performance Improvement (QAPI) plan contribute to the transformation that focuses us as caregivers on person-centered/person-directed care.
- Consider loneliness
- 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)

A CULTURE CHANGE CHALLENGE

Carmen Bowman, Regulator turned Educator

Avoid labels, even in federal regulations

CMS Tag F550 Resident Rights, treated with respect and dignity:

- Avoiding the use of labels for residents such as **"feeders"** ***or*** ***"walkers."***

- **What labels have you heard?** Please enter in the Chat box.

The Geriatric 4Ms: Towards Age Friendly Health Care

MIND - MENTATION

Caroline Stephens, PhD, RN, GNP-BC, FAAN
Helen Lowe Bamberger Colby Presidential Endowed Chair in Gerontological Nursing
Associate Professor
University of Utah College of Nursing

Goals

1. Apply mind-mentation assessment and management in the context of the Geriatric 4Ms
2. Prevent mentation problems in older adults
3. Utilize evidence - based tools for assessing mind-mentation
4. Use non - pharmacologic and pharmacologic interventions to address mind-mentation issues

Pre-test: What are the goals of addressing *mind-mentation*?

(Select all that apply)

A. Support cognitive functioning
B. Maximize independence & dignity
C. Ensure everyone is prescribed a cognitive enhancing drug, like Aricept
D. Identify & treat the 3 D's: depression, dementia and delirium
E. Prevent the 3 D's
F. All of the above

Case Study: Mrs. Jones

- 78F with PMH sig for mild-moderate dementia, hypertension, COPD, diabetes and left BKA.
- She has lived in the Shore Acres SNF community for 3 years and recently returned s/p 6 day hospitalization for pneumonia (incl. 2 days in the ICU).
- Previously able to roll her wheelchair around the facility & very engaged in activities, now she seems withdrawn, spends most of her time in bed sleeping and not participating in activities.
- Appetite is poor with 5# wt loss since readmission.
- She frequently falls asleep during meals
- Noc shift notes she's been up at night x 3, is restless, impulsively wanting to get out of bed without assistance.

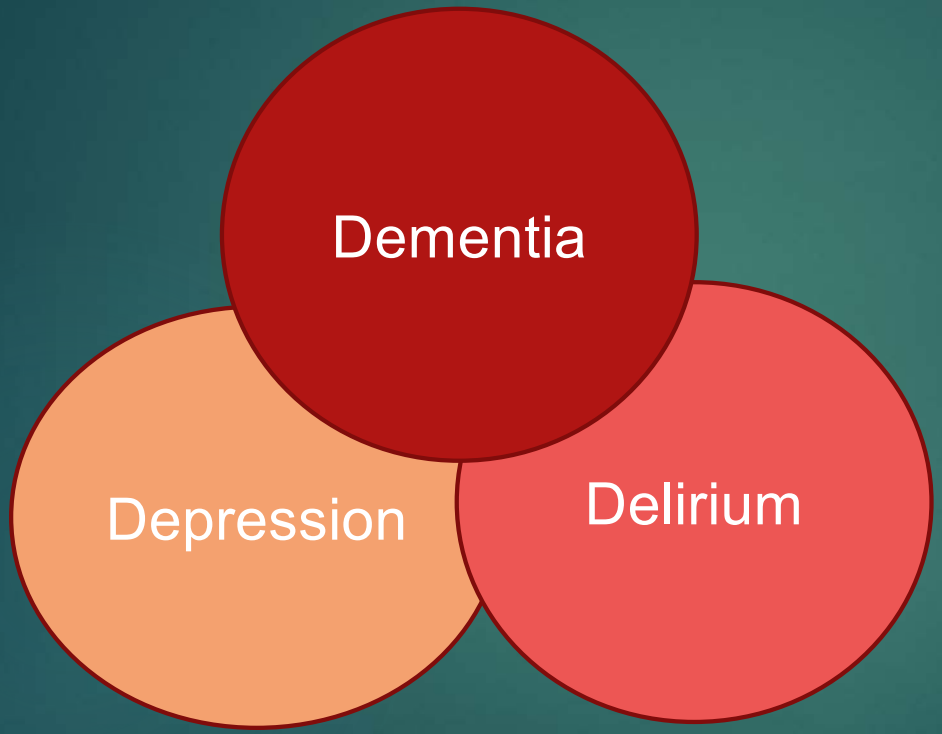
What's going on with Mrs. Jones?
(Zoom poll)

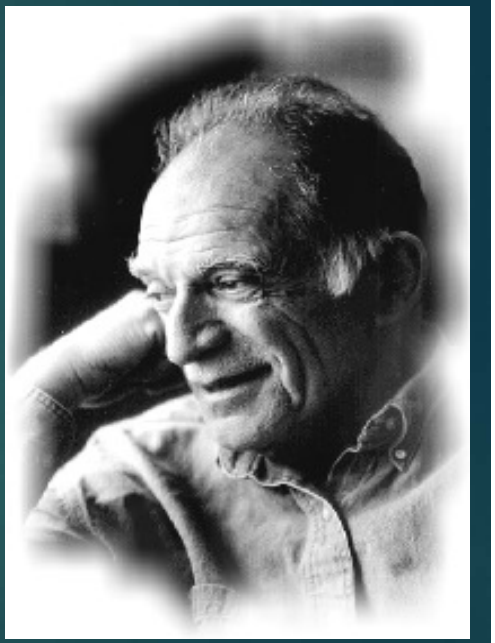
A. She is depressed that she cannot do what she once did and needs to be evaluated for an antidepressant
B. This is just 'sundowning' and worsening of her dementia
C. She may be experiencing delirium and needs to be evaluated for potential medical issues
D. She is having a lot of phantom limb pain from her left BKA and needs more pain medication
E. She needs an appetite stimulant
F. All of the above

What's going on with Mrs. Jones? (Answer)

A. She is depressed that she cannot do what she once did and needs to be evaluated for an antidepressant
B. This is just 'sundowning' and worsening of her dementia
C. She may be experiencing delirium and needs to be evaluated
D. She is having a lot of phantom limb pain from her left BKA and needs more pain medication
E. She needs an appetite stimulant
F. All of the above

What are the 3 D's of aging?





Dementia

"Chronic Confusion"

DEMENTIA

an umbrella term used to describe a set of symptoms that can include changes in:

and must be severe enough to interfere with a persons ability to function.

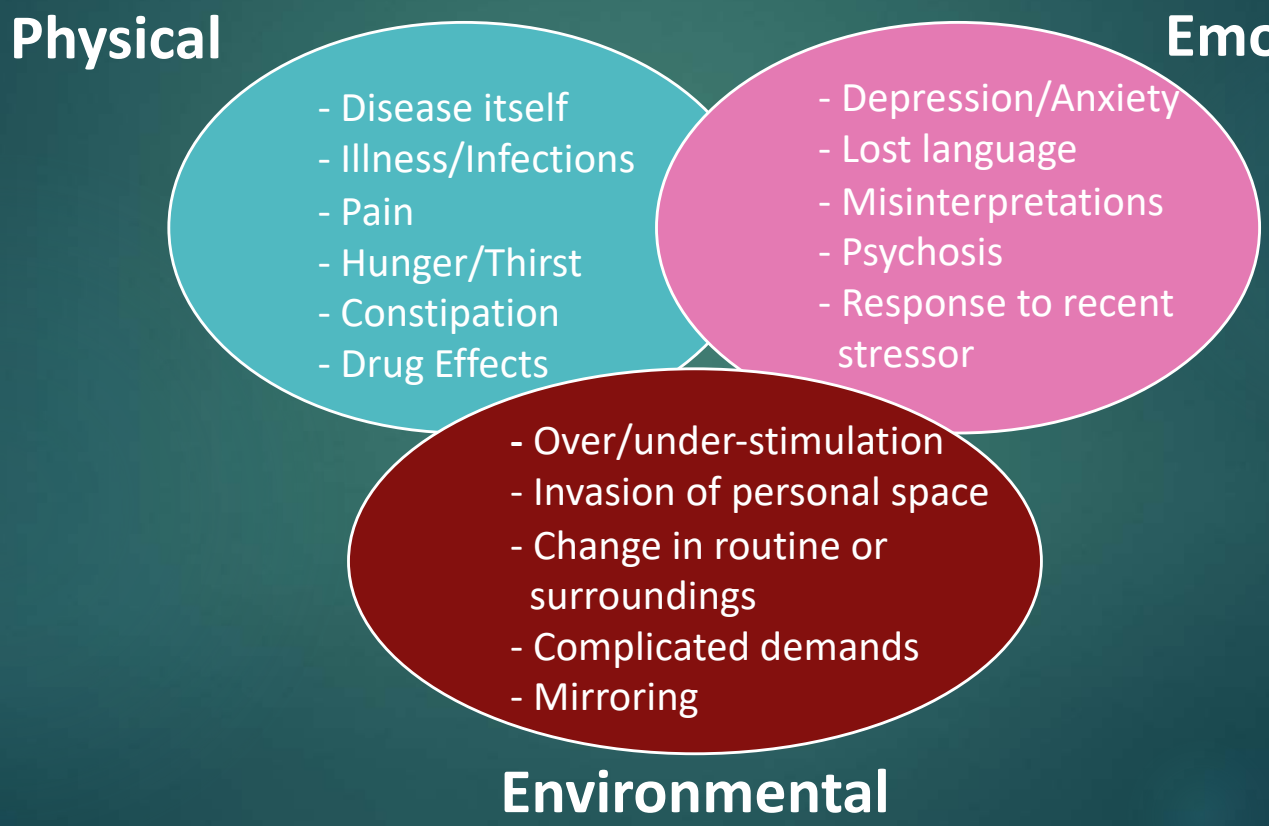
NORMAL AGING

PC: Neofect.com

Dementia

- # expected to triple from ~5 million to nearly 15 million people in next 25 years
- Affects nearly 60% of persons living in nursing homes
- #1 risk factor for developing delirium
- High prevalence of BPSD or *behavioral expressions in dementia* (78%)

What Factors Contribute to *Behavioral Expressions*?



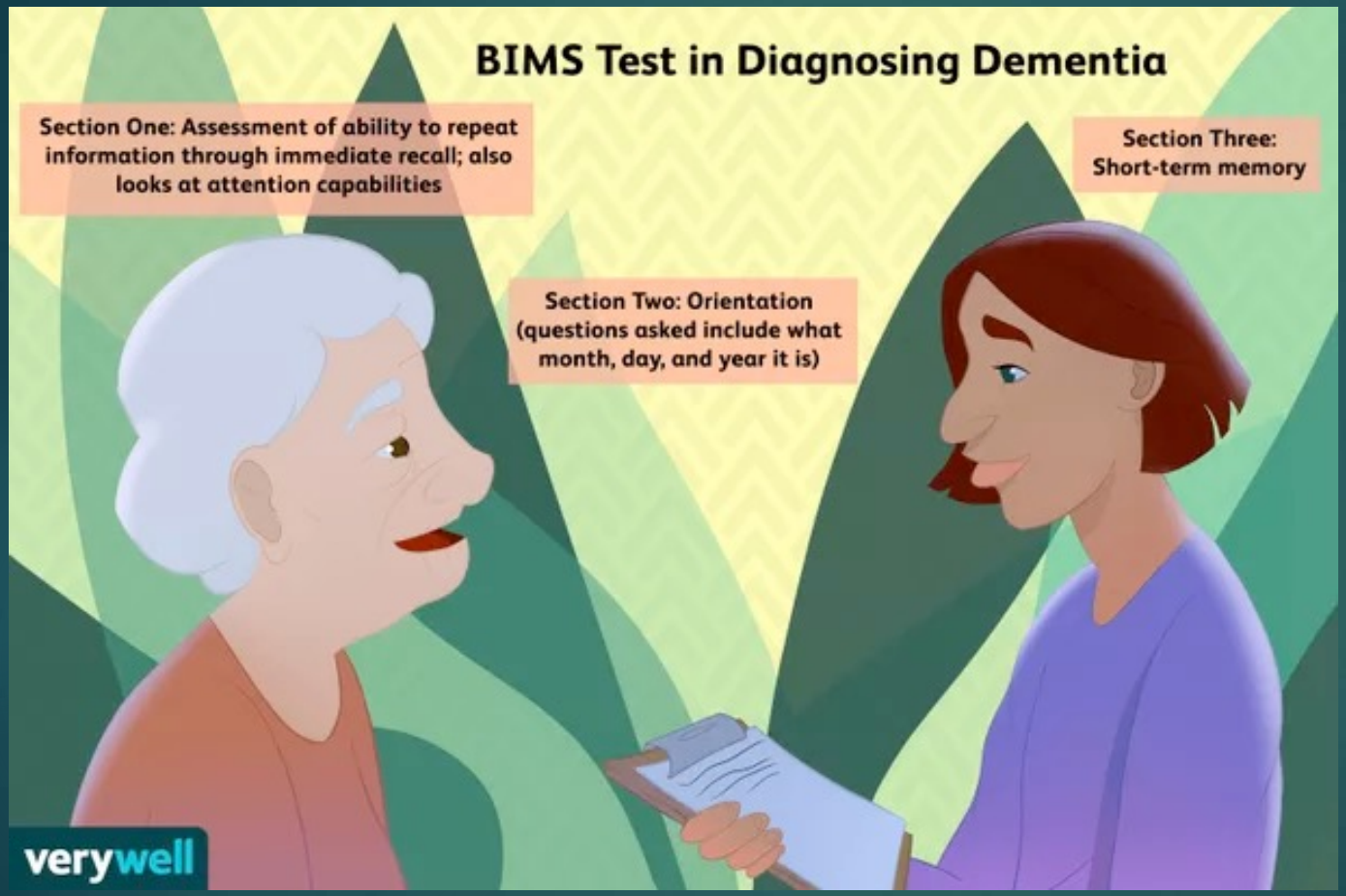
Stephens (2005)

Behaviors are NOT PROBLEMS

Behaviors represent *UNMET NEEDS*

ALL BEHAVIOR HAS MEANING!!!

IT'S UP TO US TO FIGURE OUT WHAT IT MEANS!!

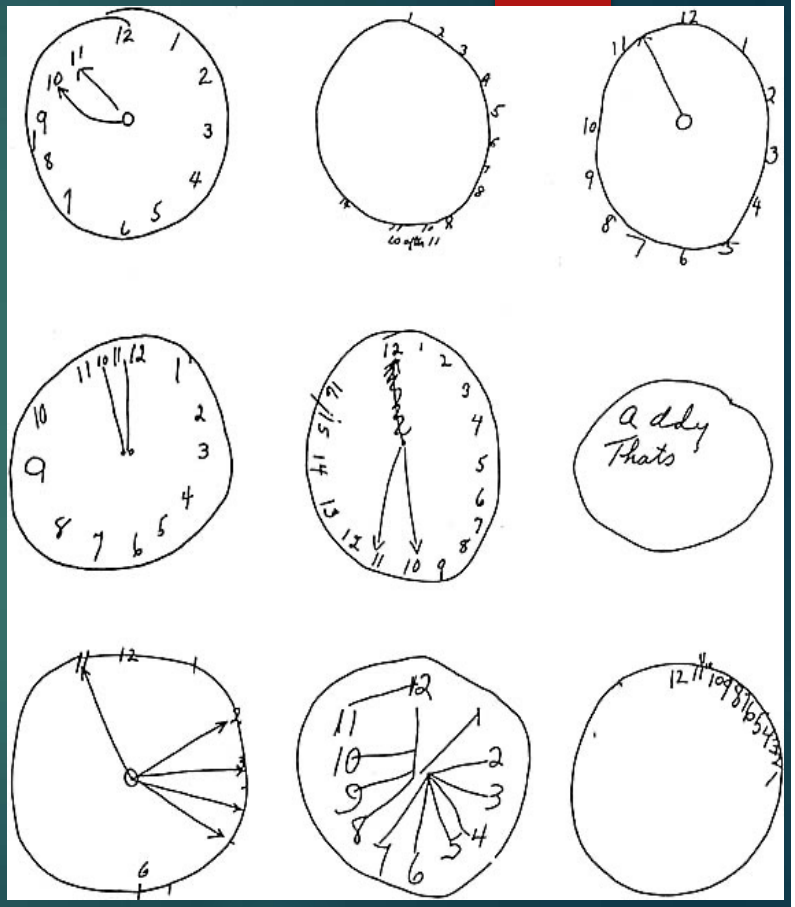


Scoring

- 13-15 points: Intact cognition
- 8-12 points: Moderately impaired cognition
- 0-7 points: Severely impaired cognition

Dementia Assessment Tools

- Mini-Mental Status Exam (MMSE)
  - Scrutinize if <27
- Montreal Cognitive Assessment (MoCA)
- Mini-Cog
- Dementia Severity Rating Scale
- Global Deterioration Scale

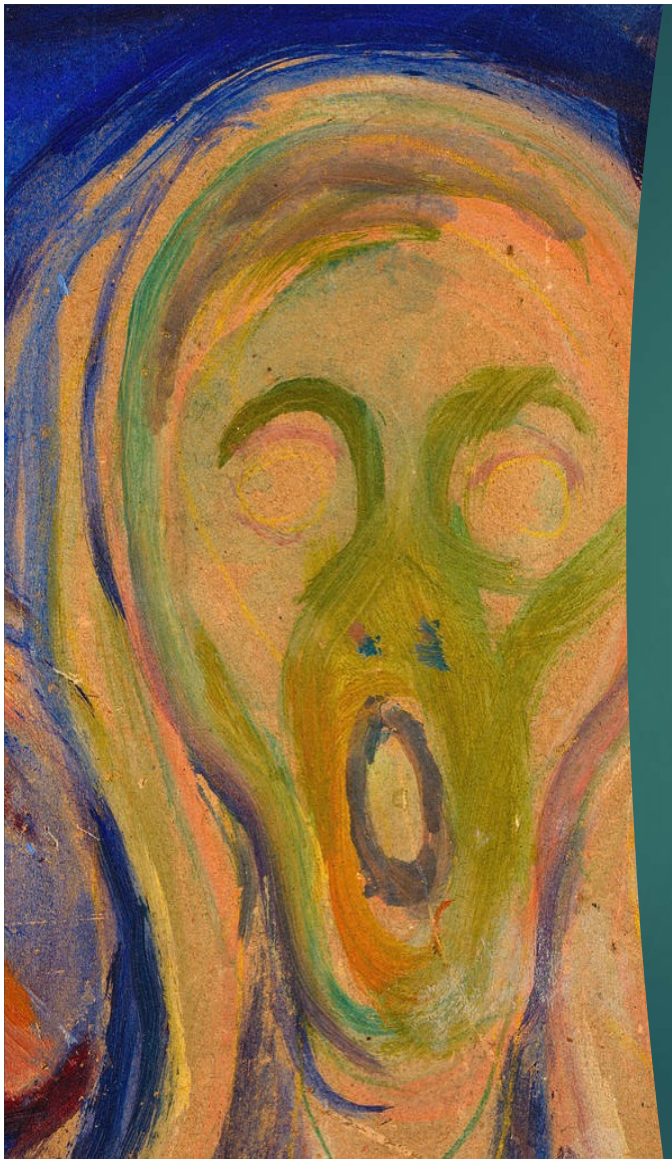


Mobilize existing comprehensive interprofessional assessments to….

- Not only to identify dementia-related symptoms, but more importantly to *identify preserved cognitive abilities* that can be supported through:
  - modification of the environment
  - task adaptations
  - use of communication & cueing strategies that facilitate engagement and participation.
  - Facilitating smooth care transitions across settings

Understanding an individual's specific cognitive challenges and remaining abilities is essential to supporting person-centered care and 'what matters' to each individual.

Edelman et al, 2021



Delirium

"Acute Confusion"
or
"Acute Brain Failure"

NORMAL AGING

Delirium

- Delirium is a syndrome characterized by disturbed attention and orientation that develops acutely and fluctuates.
- It is accompanied by cognitive deficits, such as disturbances in memory, language, perception, or consciousness.

Delirium = *Acute Brain Failure*

Why is it significant?

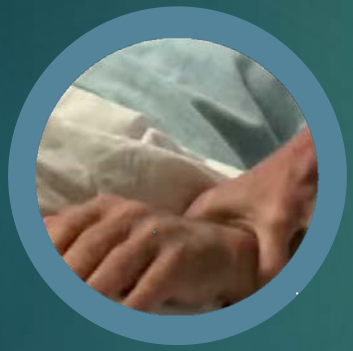
- Increased morbidity & mortality
- Higher rates of complications & prolonged hospital stays
- Delayed rehabilitation
- Increased rehospitalizations
- Increased rates of nursing home placement
- Annual Medicare expenses >$4billion

Unfortunately…

- ***Delirium is poorly recognized & managed***

- Overlooked, misdiagnosed, misattributed to "normal aging"
- 30-50% not recognized by staff
- 88% of patients with delirium superimposed on dementia went unrecognized

There are 3 types of delirium that present differently based on psychomotor (cognitive + motor) activity:



HYPERACTIVE

HYPOACTIVE

MIXED

Hyperactive Delirium

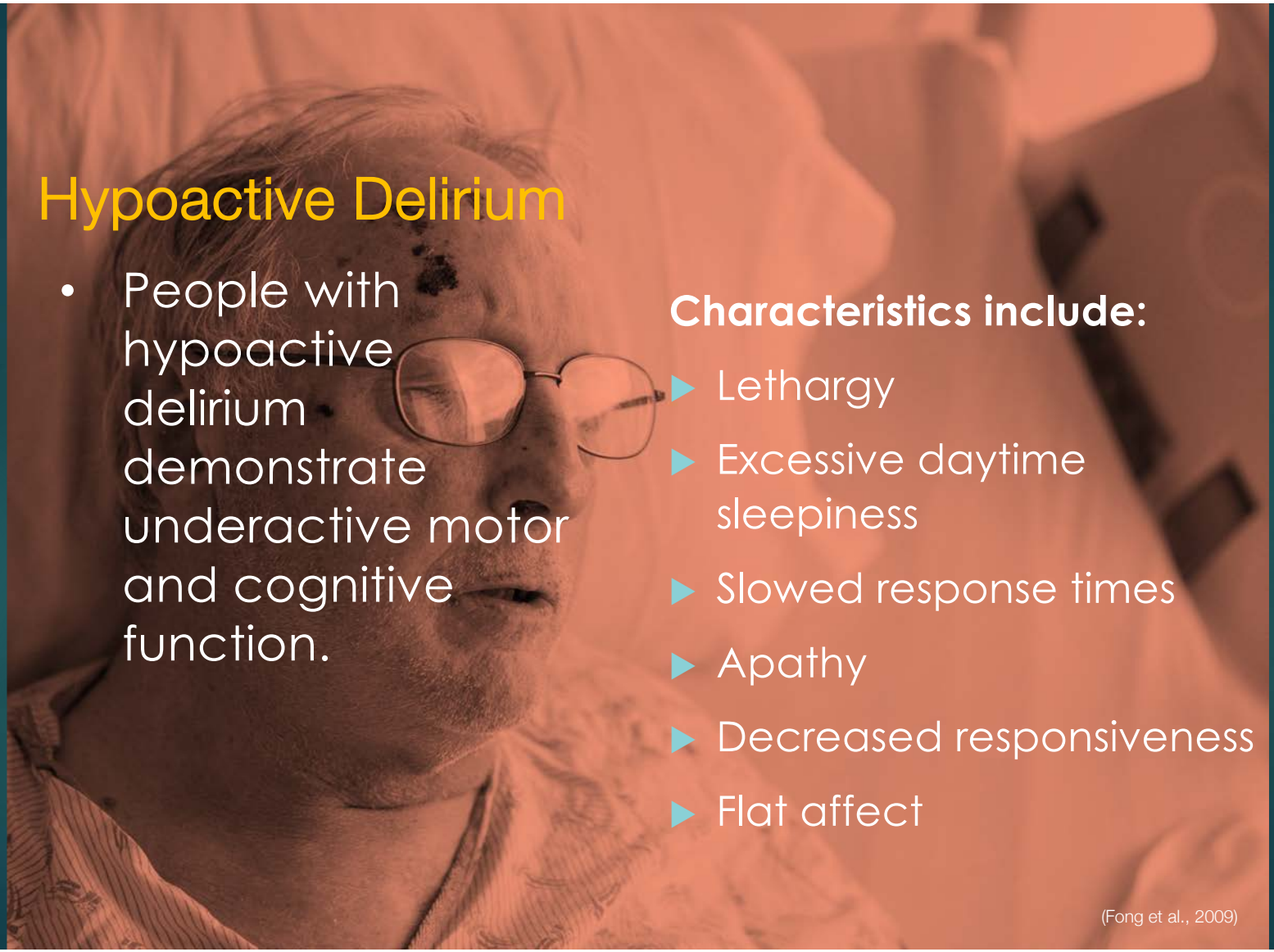
- demonstrate overactive motor and cognitive function.

Characteristics include:

- Delusions, hallucinations
- Restlessness, fidgeting
- Hypervigilance
- Paranoia
- Agitation

(Fong et al., 2009)

Credit: UCSF



Hypoactive Delirium

- People with hypoactive delirium demonstrate underactive motor and cognitive function.

Characteristics include:

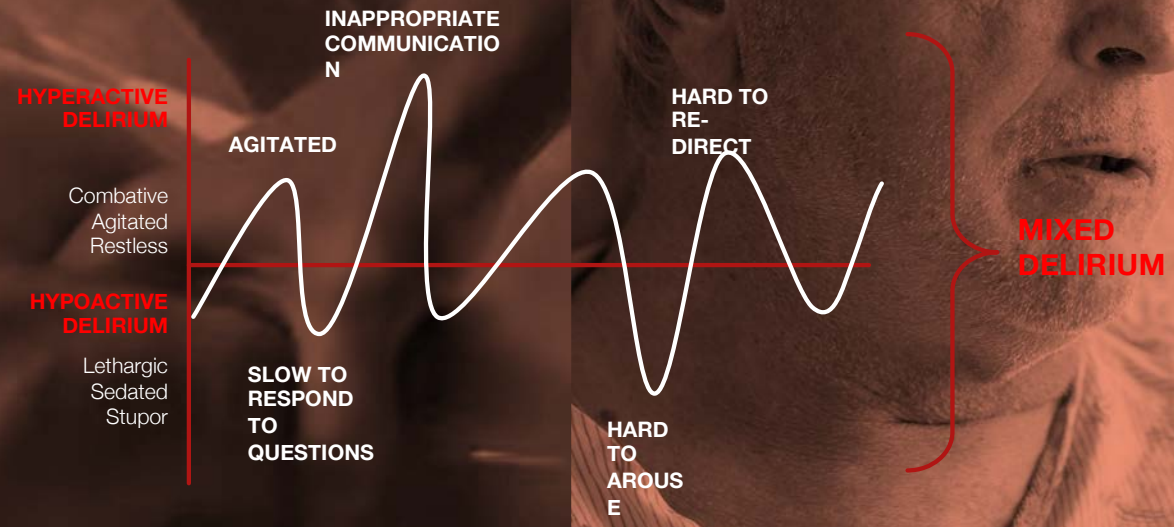
- Lethargy
- Excessive daytime sleepiness
- Slowed response times
- Apathy
- Decreased responsiveness
- Flat affect

(Fong et al., 2009)

Credit: UCSF

Mixed

- People can exhibit characteristics of both hyperactive and hypoactive delirium across the day.



Credit: UCSF

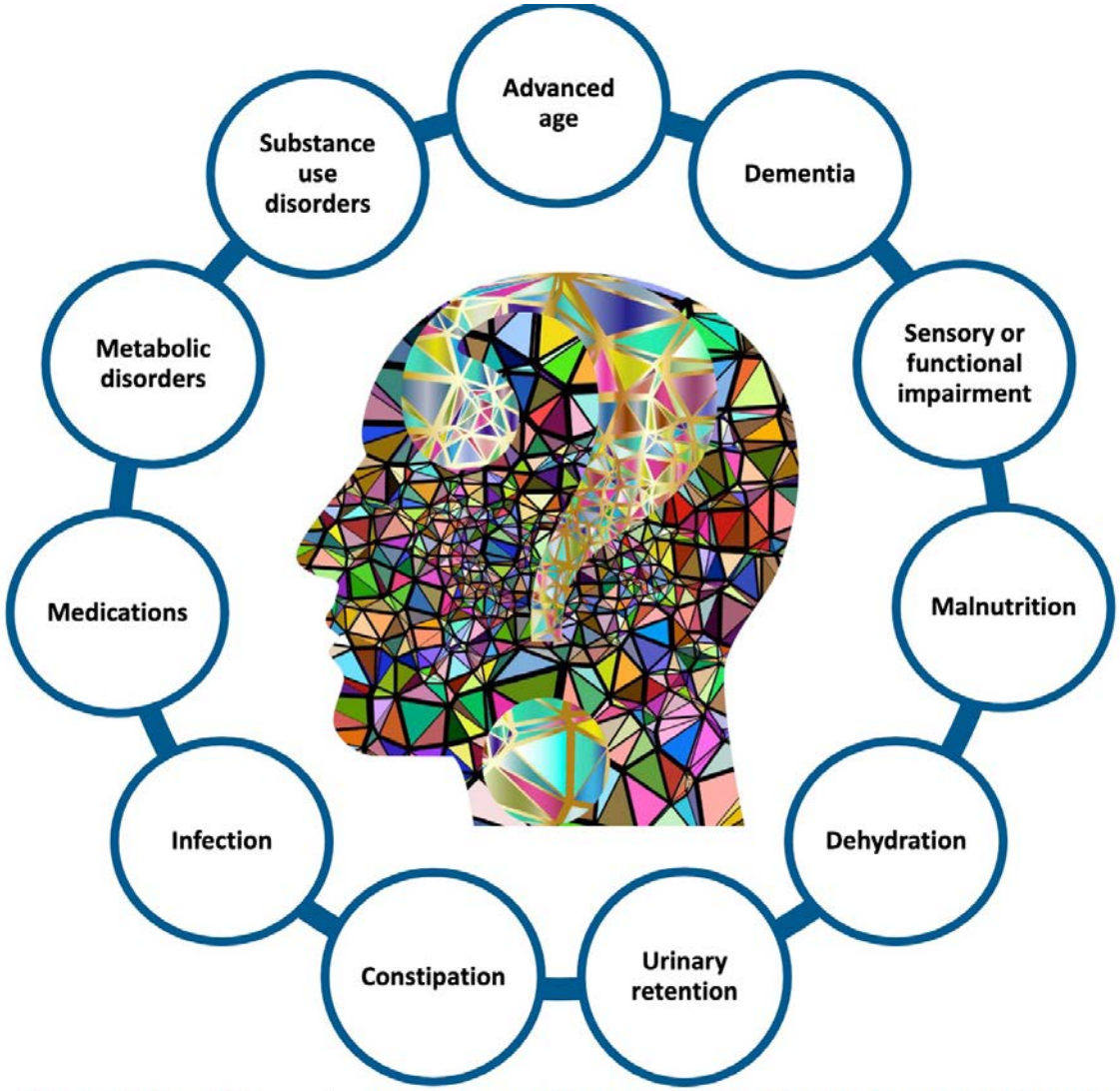
Answer in Zoom chat:

Most delirium presents as hyperactive.

TRUE FALSE

False

- While most providers associate delirium with the hyperactive presentation (because they present "behavioral problems", only 25% of delirium cases are hyperactive. Most cases of delirium are hypoactive or mixed.
- Hypoactive delirium is associated with the highest mortality rate and higher rates of pressure ulcers and hospital-acquired infections.



For more information, see the Assessment and Management in Delirium Patients Quick Reference Card *(Canadian Coalition for Seniors' Mental Health, 2010)*[4]

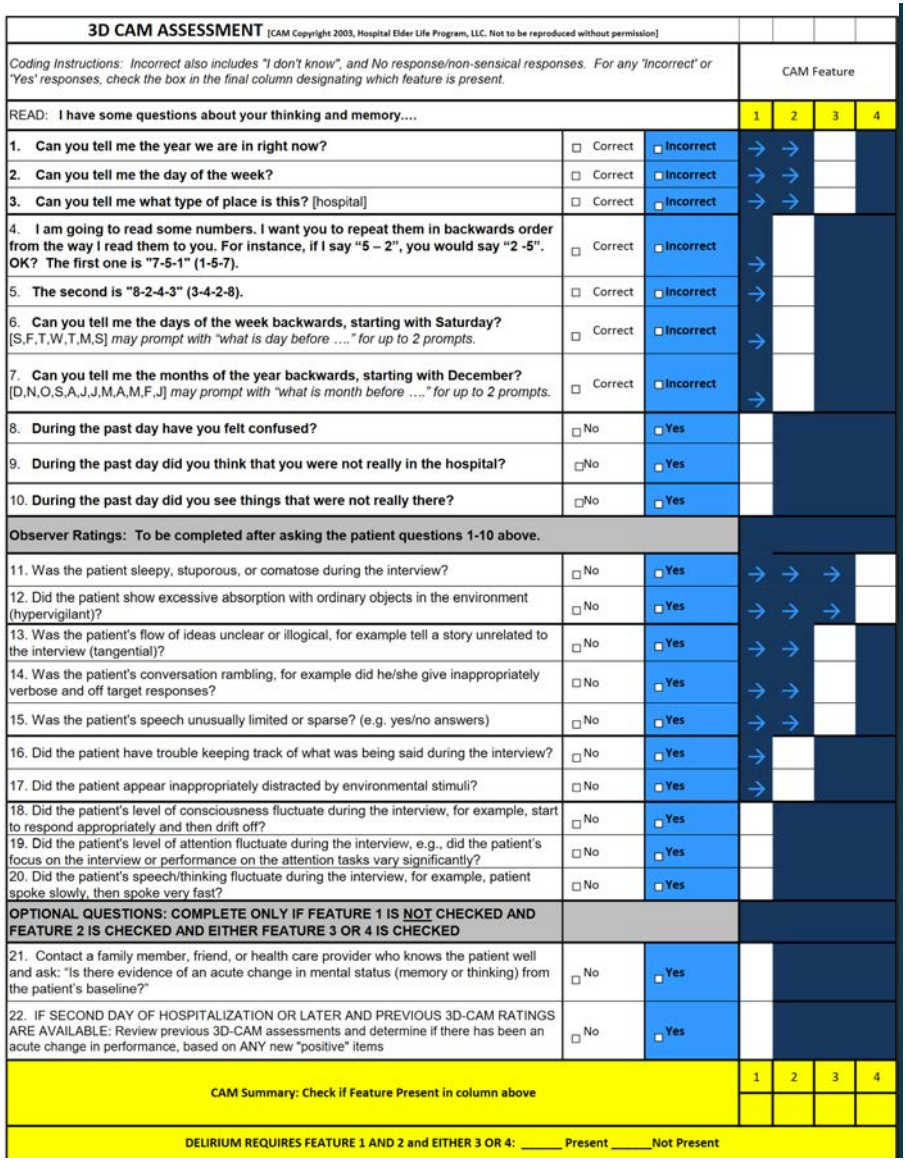
Predictors of delirium in NH

- Dementia
- Infection
- Anticholinergic medications
- Pain
- Depression
- Urinary incontinence

3D CAM

1. Provider asks patients questions
2. Provider records observations
3. Corroborate with family
4. Compare to other assessments

Positive score if one item in section 1 and 2 along with items either 3 or 4



3D CAM ASSESSMENT [CAM Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission]

Coding Instructions: Incorrect also includes "I don't know", and No response/non-sensical responses. For any 'Incorrect' or 'Yes' responses, check the box in the final column designating which feature is present.

CAM Feature

READ: **I have some questions about your thinking and memory....**			1	2	3	4
1. Can you tell me the year we are in right now?	☐ Correct	☐ **Incorrect**	→	→		
2. Can you tell me the day of the week?	☐ Correct	☐ **Incorrect**	→	→		
3. Can you tell me what type of place is this? [hospital]	☐ Correct	☐ **Incorrect**	→	→		
4. **I am going to read some numbers. I want you to repeat them in backwards order from the way I read them to you. For instance, if I say "5 – 2", you would say "2 -5". OK? The first one is "7-5-1" (1-5-7).**	☐ Correct	☐ **Incorrect**	→			
5. **The second is "8-2-4-3" (3-4-2-8).**	☐ Correct	☐ **Incorrect**	→			
6. **Can you tell me the days of the week backwards, starting with Saturday?** [S,F,T,W,T,M,S] *may prompt with "what is day before …." for up to 2 prompts.*	☐ Correct	☐ **Incorrect**	→			
7. **Can you tell me the months of the year backwards, starting with December?** [D,N,O,S,A,J,J,M,A,M,F,J] *may prompt with "what is month before …." for up to 2 prompts.*	☐ Correct	☐ **Incorrect**	→			
8. **During the past day have you felt confused?**	☐ No	☐ **Yes**				
9. **During the past day did you think that you were not really in the hospital?**	☐ No	☐ **Yes**				
10. **During the past day did you see things that were not really there?**	☐ No	☐ **Yes**				
Observer Ratings: To be completed after asking the patient questions 1-10 above.						
11. Was the patient sleepy, stuporous, or comatose during the interview?	☐ No	☐ **Yes**	→	→	→	
12. Did the patient show excessive absorption with ordinary objects in the environment (hypervigilant)?	☐ No	☐ **Yes**	→	→	→	
13. Was the patient's flow of ideas unclear or illogical, for example tell a story unrelated to the interview (tangential)?	☐ No	☐ **Yes**	→	→		
14. Was the patient's conversation rambling, for example did he/she give inappropriately verbose and off target responses?	☐ No	☐ **Yes**	→	→		
15. Was the patient's speech unusually limited or sparse? (e.g. yes/no answers)	☐ No	☐ **Yes**	→	→		
16. Did the patient have trouble keeping track of what was being said during the interview?	☐ No	☐ **Yes**	→			
17. Did the patient appear inappropriately distracted by environmental stimuli?	☐ No	☐ **Yes**	→			
18. Did the patient's level of consciousness fluctuate during the interview, for example, start to respond appropriately and then drift off?	☐ No	☐ **Yes**				
19. Did the patient's level of attention fluctuate during the interview, e.g., did the patient's focus on the interview or performance on the attention tasks vary significantly?	☐ No	☐ **Yes**				
20. Did the patient's speech/thinking fluctuate during the interview, for example, patient spoke slowly, then spoke very fast?	☐ No	☐ **Yes**				
OPTIONAL QUESTIONS: COMPLETE ONLY IF FEATURE 1 IS NOT CHECKED AND FEATURE 2 IS CHECKED AND EITHER FEATURE 3 OR 4 IS CHECKED						
21. Contact a family member, friend, or health care provider who knows the patient well and ask: "Is there evidence of an acute change in mental status (memory or thinking) from the patient's baseline?"	☐ No	☐ **Yes**				
22. IF SECOND DAY OF HOSPITALIZATION OR LATER AND PREVIOUS 3D-CAM RATINGS ARE AVAILABLE: Review previous 3D-CAM assessments and determine if there has been an acute change in performance, based on ANY new "positive" items	☐ No	☐ **Yes**				
CAM Summary: Check if Feature Present in column above			1	2	3	4

DELIRIUM REQUIRES FEATURE 1 AND 2 and EITHER 3 OR 4: _____ Present _____Not Present

Delirium Management

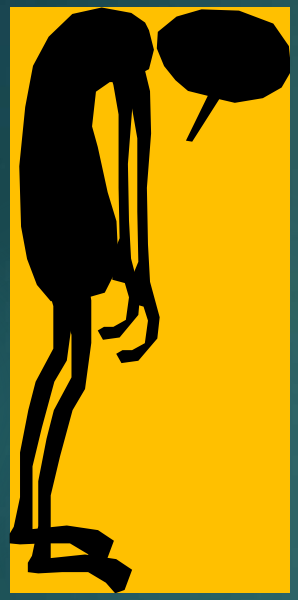
- Treat the underlying cause
- Use behavioral management techniques
  - Go with the flow
  - Positive tone and facial expression

Think
PINCHES ME
kindly

- ***One third to one half of delirium can be prevented by addressing these risk factors***

Depression

"Down in the Dumps"



Depression is ….

NOT **a normal part of aging!!**

Depression Among Older Adults

- Under-recognized
- Under-diagnosed
- Under-treated

20 - 30% of people with Alzheimer's will develop a Major Depression

What does depression look like???

- Depressed mood
- Tearfulness
- Irritability/ Anger/ Verbal agitation
- Loss of interest
- Feelings of guilt or worthlessness
- Changes in sleep patterns
- Lack of energy
- Changes in appetite
- Feeling either agitated or slowed down
- Difficulty thinking and concentrating
- Suicidal thoughts

Recognizing Depression in Older Adults with Dementia

- May manifest in "*atypical*" ways:
  - new onset agitation
  - wandering
  - apathy
  - crying out
  - insomnia
  - change in functional status
  - sexually inappropriate behavior

Assessing Suicide Risk in Older Adults

- **S** ex, male
- **A** ge, advanced
- **D** epression, possibly recurrent

- **P** revious suicide attempts
- **E** thanol abuse
- **R** ational thinking loss
- **S** **ocial isolation**
- **O** rganized plan to commit suicide
- **N** o spouse
- **S** ickness

DEPRESSION SCREENING

9-Item Patient Health Questionnaire (PHQ-9)

- 9 items cover diagnostic criteria for major depressive disorder
- Initial 2 questions (PHQ-2) can be used for screening
- Serial administrations can be used to reliably assess response to treatment

PHQ-9 Scoring

PHQ-9 score	Depression severity	Clinician response
1–4	None	None
5–9	Mild to moderate	If not currently treated, rescreen in 2 weeks. If currently treated, optimize antidepressant and rescreen in 2 weeks
10–14	Major depressive disorder	Start antidepressant therapy
≥15	Major depressive disorder	Start antidepressant therapy; obtain psychiatric consultation if suicidality or psychosis suspected

Case Study REVISITED: Mrs. Jones

- 78F with PMH sig for mild-moderate dementia, hypertension, COPD, diabetes and left BKA.
- She has lived in the Shore Acres SNF community for 3 years and recently returned s/p 6 day hospitalization for pneumonia (incl. 2 days in the ICU).
- Previously able to roll her wheelchair around the facility & very engaged in activities, now she seems withdrawn, spends most of her time in bed sleeping and not participating in activities.
- Appetite is poor with 5# wt loss since readmission.
- She frequently falls asleep during meals
- Noc shift notes she's been up at night x 3, is restless, impulsively wanting to get out of bed without assistance.

Take Home Messages

- Understanding an individual's specific cognitive challenges and remaining abilities is essential to supporting person-centered care and 'what matters' to each individual.
- The 3 D's of Aging often overlap & more than one illness can be present in an older adult at the same time.
- Become familiar with standardized tests and use them to support your diagnosis and guide care.

Take Home Messages (Continued)

- Recognition of risk factors and routine screening for delirium should be part of comprehensive nursing care of older adults.
- Effective interventions target the underlying cause & maximize physical, psychological & environmental support.

Post-test: What are the goals of addressing *mind-mentation*?

(Select all that apply)

A. Early identification of mentation problems
B. Ensure everyone is prescribed a cognitive enhancing drug, like Aricept
C. Effectively treat and manage depression, dementia and delirium
D. Prevent the 3 D's
E. All of the above

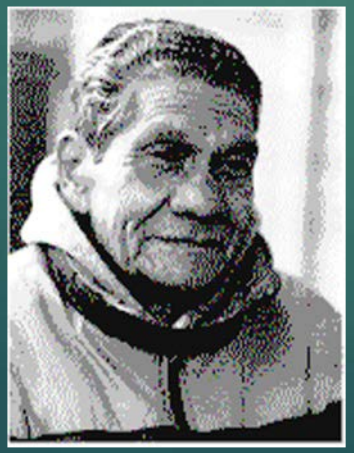
Post-test: What are the goals of addressing *mind-mentation*?

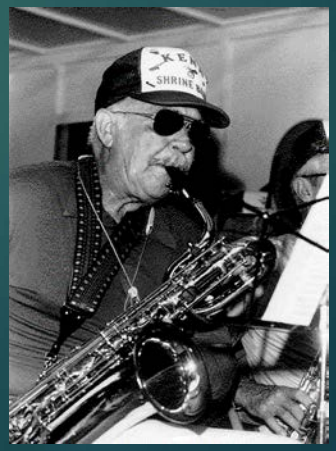
(Select all that apply)

A. Early identification of mentation problems
B. Ensure everyone is prescribed a cognitive enhancing drug, like Aricept
C. Effectively treat and manage depression, dementia and delirium
D. Prevent the 3 D's
E. All of the above

Wrinkles should merely indicate where smiles have been.

- Mark Twain




Thank
you!

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Step 9: Prioritize Quality Opportunities and Charter PIPs

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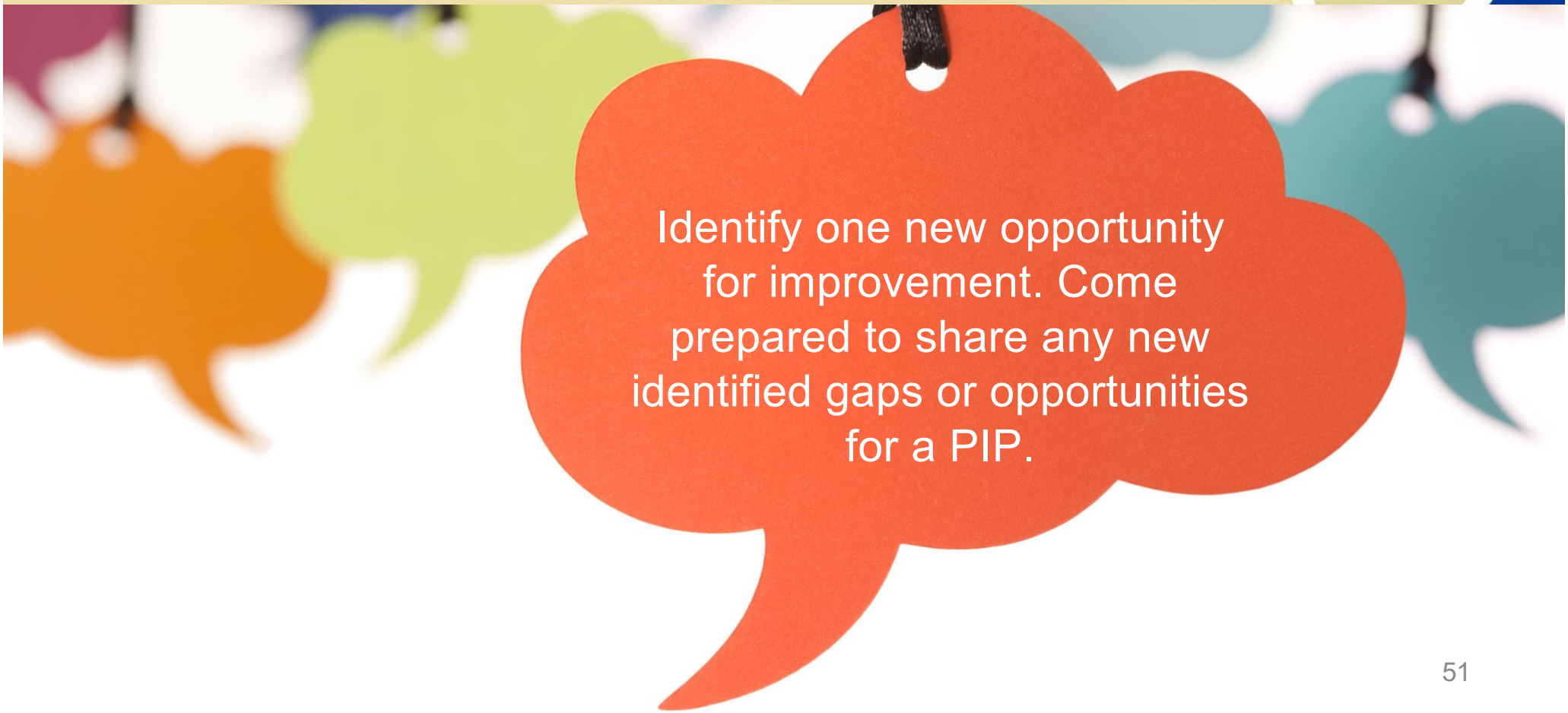
Adrienne Butterwick, MPH, CHES

Jean C. Lyon, PhD, APRN

Final Thoughts/Homework from April 20th



Recap from last week – Step 8: *Identify Your Gaps and Opportunities*

- At the end of last week's session you were asked to consider gaps and opportunities in your QAPI program.
- Please share your findings with us, in chat.

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Step 9: Prioritize Quality Opportunities and Charter PIPs

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Pre-QAPI Poll:

Which of the following clearly establishes a project's charter?

A: Goals and scope

B: Timing and milestones

C: Team roles and responsibilities

D: All the above

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QAPI Prioritization

- Now that you've reviewed sources of information to identify gaps and opportunities, it's time to *prioritize them and take action!*
- Priorities should be set based on the needs of the residents and organization.
- Other factors to consider include high-risk, high-volume, or problem-prone areas that affect health outcomes and quality of care.

Prioritization Worksheet for Performance Improvement Projects

Directions: This tool will assist in choosing which potential areas for improvement are the highest priority based on the needs of the residents and the organization. Follow this systematic assessment process below to identify potential areas for PIPs. This process will consider such factors as high-risk, high-volume, or problem-prone areas that affect health outcomes and quality of care. This tool is intended to be completed and used by the QAPI team that determines which areas to select for PIPs. Begin by listing potential areas for improvement in the left-hand column. Then score each area in the following columns based on a rating system of 1 to 5 as defined below:

1 = very low	2 = low	3 = medium	4 = high	5 = very high

Rating is subjective and is meant to be a guide and to stimulate discussion. Finally, add the scores across the row and tally in the final column. Potential improvement areas with a higher score indicate a higher priority.

POTENTIAL AREAS FOR IMPROVEMENT Consider areas identified through: Dashboard(s) Feedback from staff, families, residents, other Incidents, near misses, unsafe conditions Survey deficiencies	PREVALENCE The frequency at which this issue arises in our organization.	RISK The level to which this issue poses a risk to the well-being of our residents.	COST The cost incurred by our organization each time this issue occurs.	RELEVANCE The extent to which addressing this issue would affect resident quality of life and/or quality of care.	RESPONSIVENESS The likelihood an initiative on this issue would address a need expressed by residents, family and/or staff.	FEASIBILITY The ability of our organization to implement a PIP on this issue, given current resources.	CONTINUITY The level to which an initiative on this issue would support our organizational goals and priorities.	TOTAL SCORE TALLY

Additional factors to take into account:

1. What existing standards or guidelines are available to provide direction for this initiative?
2. What measures can be used to monitor progress?
3. Is the topic publicly reported on Nursing Home Compare?
4. Which type of changes primarily will be involved (i.e., system changes, environmental changes, staffing changes)?
5. Which staff will be most affected by the initiative? What training needs will this initiative present?
6. Is there an identified champion(s) for this initiative?

Chartering Performance Improvement Projects (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.

Putting a Charter in Action

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Post-QAPI Poll:

Which of the following clearly establishes a project's charter?

A: Goals and scope

B: Timing and milestones

C: Team roles and responsibilities

D: All the above

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Post-QAPI Poll (Answer):

Which of the following clearly establishes a project's charter?

A: Goals and scope

B: Timing and milestones

C: Team roles and responsibilities

D: All the above

Discussion / Next Week's Follow Up

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

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Thank You!

Person First Language

What it is:

- Person first language **puts the person *before* the disability**.
- Person first language **describes what a person *has*, not who a person *is***.

Examples

- Diabetic or a person with diabetes?
  Diabetic is actually a label even though commonly used.
- Interesting example, we don't refer to people as myopic. Instead, we say a person wears glasses. Let's all follow this example.

Person First Language

People are not a disease causing a problem

- Paraplegic
- The dementia patients/residents

People are human beings with needs who require assistance

- Someone who has paraplegia
- People who have dementia

  Old language now:
  suffers from dementia,
  living with dementia

THE MOST APPROPRIATE LABEL IS

ONLY ONE LABEL NEEDED EVER

Including Chat Box

Other Labels

- Screamer, wetter, isolator, hoarder, wanderer, frequent faller, repeat offender, complainer → **person's name and describe**
- The quad, the Alzheimer's, the CVA → **avoid**
- The "get ups," the "put downs" → **avoiding the practice by honoring sleep and natural awakening**
- 300B, Room 28 Bed A - **avoid**
- Memory Care – violates HIPPA

Look through the  of HOME

- Try ***person/individual/neighbor*** (instead of patient/resident)
- Try ***home/community/the name of the place*** (instead of facility)
- Try ***neighborhood*** (instead of unit/ward/station/floor)
- Try ***team*** (instead of department)
- Try ***team member*** (instead of staff)
- Try ***checking in with/check ins*** (instead of rounds/rounding)
- Try ***approach/individualized approach*** (instead of intervention)
- Try avoiding program: program is the mark of an institution & causes us to "check out"
- Try **move in/move out** (instead of admit and discharge)
- Try ***use bathroom*** (instead of toilet, toileting)

Carmen Bowman, Regulator turned Educator
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Thank you,
See you next week!

May 4th, 2022:

- Age – Friendly Case: Medications
- Plan, Conduct, and Document PIPs

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