



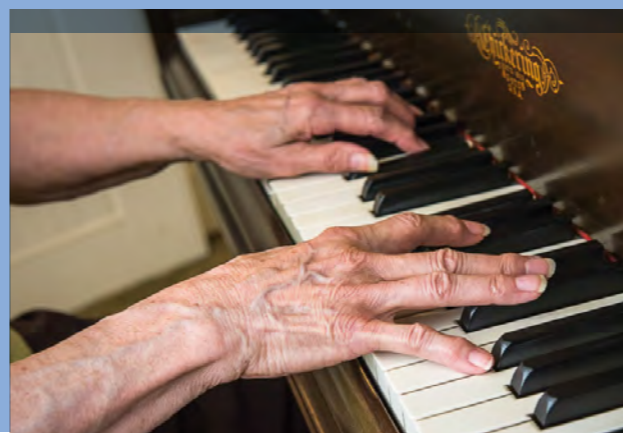
**HELPING  
SENIORS  
PRESERVE  
THEIR  
PHYSICAL,  
MENTAL,  
AND  
SOCIAL  
WELL-BEING**

# LONGER LIVES BETTER HEALTH



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# ROOTS

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This **ROOTS** is intended to celebrate the work the Foundation has done with many good partners to re-envision aging. By addressing the physical, social, technological, and environmental factors that minimize disability and foster prevention, we aim to change the trajectories of decline and dependence.

But our aspirations go further. We believe that the years post-65 can be truly golden. Worries and challenges of youth and middle age are in the past. There can and should be much joy in the present. But our systems of care must change to better meet the needs of those who want independent living and community engagement.

My hope is that this **ROOTS** will inspire others to join us in enhancing the well-being of older adults. And I encourage other foundations — if not already engaged — to contemplate the satisfactions of an aging agenda. If we do it right, while advances in medicine and technology are adding years to life, we can also add life to years.

KAREN WOLK FEINSTEIN, PhD  
President and CEO



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## **DEDICATION**

*We dedicate this issue of ROOTS to our intrepid and long-standing JHF board member Dick Simon, whose vitality and insight are ageless. Overall, Dick has logged 60 consecutive years of service on the Montefiore and now JHF Boards.*



# INTRODUCTION

The Jewish Healthcare Foundation (JHF) was established in 1990 to support and foster the provision of healthcare services, education, and research. Its founding board tasked the Foundation with responding to the health-related needs of the elderly, indigent, and underserved populations in western Pennsylvania.

Over the years, JHF's health reform efforts have evolved, driven by research, revelations, policy developments, and the opportunities to test new models of care, but it has never deviated from the promise to care for vulnerable seniors in western Pennsylvania.

## EARLY AGING AGENDA INCLUDES FOCUS ON HEALTHY AGING

In 1992, JHF began developing a continuum of care for the elderly in western Pennsylvania. "Our goal," says Karen Wolk Feinstein, PhD, the Foundation's founding president and CEO, who continues to lead the Foundation, "was to create an integrated delivery system that helped seniors preserve their physical, mental, and social well-being, that coordinated assistance when they became vulnerable, and that provided comprehensive services for all seniors—from the most independent to the most frail."

The Foundation challenged conventional wisdom about common afflictions of aging by funding research and demonstration projects to understand whether many of the conditions facing the elderly could be prevented or successfully treated, including depression, falls, and poor nutrition.

"If we learned one thing in our early years," says Dr. Feinstein, "it's that real change requires a shared agenda among multiple stakeholders, including community, government, healthcare providers, insurers, the private sector, academic institutions, and other funders."

Pennsylvania has the fifth largest percentage in the U.S. of residents who are 65 years or older<sup>1</sup>, and by 2020, more than one in four will be at least 60 years of age.

According to the 2013 Institute of Politics report *The Future of Medicaid Long Term Care Services in Pennsylvania*<sup>2</sup>:

- 70 percent of Pennsylvanians reaching age 65 will need long term services and supports (LTSS) for an average of three years;
- Over 65 percent of the State's Medicaid budget covers payments for skilled nursing care; and
- About 40 percent of the Commonwealth's Medicaid LTSS expenditures are spent on home- and community-based services costs compared to a national percentage of 50 percent.



**Working Hearts**<sup>SM</sup> spokesperson Sally Wiggin and committee chair Pat Siger, with Karen Feinstein (top photo) at Women's Heart Day, held February 2004 at the David L. Lawrence Convention Center.

Thousands of women were offered free heart health screenings, consultations with health professionals, fitness tips, and information from dozens of exhibitors.

Through **Working Hearts**<sup>SM</sup>, which ran from 2003 through 2007, JHF inspired women to improve their heart health through incremental, lifelong changes in everyday behavior. The average age of women who have heart attacks is late 60s to early 70s, but almost 20 percent of heart attacks occur in women under age 65.

The Foundation helped support a study, *Caring for Those Who Cared for Us*, to identify Jewish community needs in aging. As a result, JHF was instrumental in the creation of the Jewish Association on Aging (JAA), committing more than \$33.5 million to rebuilding the long-term-care facility, building an assisted living residence, and creating a new network of services, all of which serve both the Jewish and the general communities. Over the years, JHF committed an additional \$10 million to the JAA and other Jewish communal agencies serving the Jewish and general communities—including the Jewish Community Center, Jewish Family & Children's Service, and Riverview Towers—for older adult programs and services.

In 1995, JHF partnered with the United Way of Allegheny County and the Southwestern Pennsylvania Partnership for Aging in a nine-month study of the area's 65-and-older population, then the nation's second largest concentration of seniors. The goal of the *Aging Environmental Scan* was to present the community with a vision and an action plan, including a new paradigm of aging focused on wellness, security, independence, and community involvement.

## AGING ENVIRONMENTAL SCAN PROPOSES

### A NEW PARADIGM OF AGING



More than 25 thought leaders from the older adult service community, academia, government, and philanthropy worked to define the vision and specific recommendations that would drive our region's aging agenda for the next decade. Several initiatives resulted from the *Aging Environmental Scan*, including: the Community-University Partnership for Successful Aging, a collaboration of four regional aging service providers and a local community college that provided caregiver training, home-safety audits, an awareness campaign around wound healing, a community-based Elderhostel program that provided local educational opportunities to keep active seniors engaged in learning and exploration, the call for successful elder protection legislation, and Elderlink (now AgeWell Pittsburgh)—a resource in the east end of Pittsburgh that links older adults, family members, and caregivers with resources.

JHF also embarked on a multi-year initiative to promote public and private solutions for long-term-care financing and partnered with the Allegheny County Health Department to restore Social Security and Medicare benefits to low-income seniors.



### **FOCUS EXPANDS TO IMPROVING INSTITUTIONAL CARE**

In the late '90s, having established the Pittsburgh Regional Health Initiative (PRHI), the Foundation began working directly with healthcare professionals to provide high-quality care for patients, including training for frontline healthcare professionals in Perfecting Patient Care<sup>SM</sup> (PPC), a quality improvement methodology built on Lean principles and designed by PRHI to meet the unique needs of health care.

Over the next several years, we worked to make hospitals safer. Eventually we moved outside of hospitals to primary care and skilled nursing facilities to avoid preventable hospitalizations. We implemented a series of one to two year Champions programs—including Physician Champions, Nurse Navigators, EMS Champions, Pharmacy Agents for Change, and MA/LPN Champions—to instill quality improvement and leadership skills in our regional healthcare workforce.

Extending our reach beyond acute care settings into skilled nursing facilities (SNFs) was a natural addition. We began working with individual SNFs and created the Long Term Care Champions program, an 18-month program designed to “put the skills back into skilled nursing facilities” for its six participating SNFs.

### **STRENGTHENING PRIMARY CARE DELIVERY TO KEEP SENIORS OUT OF NURSING HOMES AND HOSPITALS**

Institutionalization is not only expensive, but it can itself be detrimental. Care received in a hospital saves lives and helps restore health for millions of seniors annually, but studies confirm that, for many older people, care transitions and hospitalizations result in irreversible functional decline.

“A hospital stay, in even the best hospitals,” notes Dr. Feinstein, “can leave seniors vulnerable to sleeplessness, medication problems, urinary tract and other infections, bedsores, falls, and hospitalization delirium. So while we help hospitals achieve better outcomes for the elderly, we also improve the care seniors receive in the community to keep them out of institutions. Complex patients—particularly the frail elderly—present a significant opportunity for primary care practices to keep patients healthier and thus reduce emergency room visits, hospitalizations, and

**“Our goal was to create an integrated delivery system that helped seniors preserve their physical, mental, and social well-being, that coordinated assistance when they became vulnerable, and that provided comprehensive services for all seniors — from the most independent to the most frail.”**

— Karen Wolk Feinstein, PhD, President and CEO  
Jewish Healthcare Foundation

institutionalization. These are important factors because of the high per capita cost of care for seniors, detrimental effects of hospitalization, and the challenges of caring for a larger volume of frail elderly as baby boomers age.”

Through PRHI, the Foundation works with federally qualified health centers and primary care practices to strengthen primary care delivery for elderly and other patients through integration of electronic health records, transformation to the patient-centered medical home (PCMH) model of care, and the integration of behavioral health into primary care (depression is common among the elderly and presents barriers to the management of chronic disease).

A 2013 policy brief by the University of Pittsburgh Institute of Politics (IOP)<sup>3</sup>, co-sponsored by JHF, *The Future of Medicaid Long Term Services in Pennsylvania: A Wake-Up Call*, dove into the issues of community-based care for seniors. The report highlighted readmissions reduction; the use of advance directives, palliative care, and hospice; reduction of hospital-acquired infections; medication reconciliation; and the integration of behavioral and physical health as effective strategies for improving care for seniors and controlling/reducing costs. All of these are part of the JHF aging agenda.

The IOP report’s first direction, keeping seniors in their homes, is the basis of JHF’s newest effort to improve the health and quality of life for seniors by integrating community health workers (CHWs) into the primary care team to perform the outreach activities vital to frail seniors living in the community.

“The most important service needed is coordination,” says Nancy Zionts, JHF COO and chief program officer who oversees the Foundation’s long-term-care and end-of-life work. “Many residents have comorbid health conditions, and they are



overwhelmed by the number of prescribed medications, providers, interventions, and office visits. Our goal is to create strong networks of care for seniors in the community.

“Meeting the demand will require an expansion of the roles of some members of the healthcare team. We began to address this with our Medical Assistance/LPN Champions program and will continue with the Community Health Workers Champions program we will be kicking off shortly.”

### **BRINGING END-OF-LIFE AND PALLIATIVE CARE DISCUSSIONS INTO THE MAINSTREAM**

JHF is committed to end-of-life care and bringing real shared decision-making into healthcare facilities, communities, and families. The Foundation supported the Pennsylvania Orders for Life-Sustaining Treatment (POLST), created the Coalition for Quality at End of Life (CQEL), and developed *Closure*—an education, planning, and outreach effort to cultivate patient and family-centered experiences at the end of life.

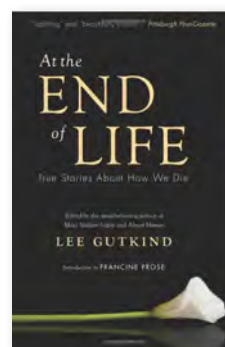
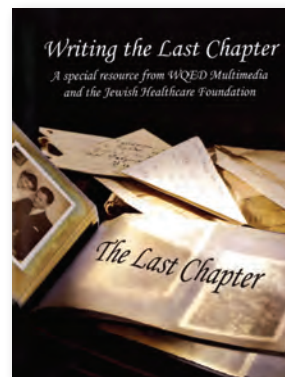
Through television (*The Last Chapter*, a WQED Public Television documentary) and literature (Creative Nonfiction’s *At the End of Life: True Stories About How We Die*), JHF supported media innovations that brought the end-of-life conversation to the public. In addition, the 2013 Fine Awards for Teamwork Excellence in Health Care, a partnership of JHF and The Fine Foundation, focused on end-of-life and exemplary teamwork to ease the physical, emotional, and financial burdens of patients and loved ones coping with a life-limiting illness.

In January 2015, JHF launched a new fellowship for graduate students on death and dying that explores end of life issues, providing participants with experiential learning not found in a typical graduate curriculum. This is the newest of the Foundation’s four fellowships (the others include Patient Safety, Jonas Salk, and QI<sup>2</sup>T Health Innovators) that foster the development of young professionals committed to careers in health care or healthcare information technology.

This *ROOTS* presents the work of the Foundation over the last several years in three areas:

- Home- and community-based services;
- Skilled nursing; and
- End of life.

“Growing old could possibly lead to some of the best years of life,” notes Dr. Feinstein. “For the past 25 years, we’ve aimed for ‘gratifying aging,’ consistent with a person’s capacity and preferences for care, and we’ll continue to do so for at least the next 25.”



Through television (*The Last Chapter*, a WQED Public Television documentary) and literature (Creative Nonfiction’s *At the End of Life: True Stories About How We Die*), JHF supported media innovations that brought the end of life conversation to the public.



Jewish Family & Children's Service geriatric care manager, Sandy Budd, LCSW, meets with client Sonya Sydney. JF&CS's certified care managers assess needs, develop care plans, and give older adults immediate access to whatever help they need to attain maximum functional potential. JF&CS is a partner in AgeWell Pittsburgh, both supported by JHF through an annual block grant to the Jewish Federation of Greater Pittsburgh.

## AGING AT HOME

JHF has implemented and supported initiatives that help people to age in place since our inception; some aimed at keeping active seniors engaged and active, others aimed at helping frailer seniors to maintain their independence and remain in the community for as long as they can safely do so. A number of these initiatives were mentioned in the Introduction.

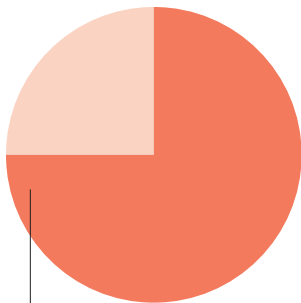
“A complex interplay of medical, social, and personal factors determines whether seniors can safely age in their home, or can successfully recover from hospitalizations without experiencing deterioration that leads to readmission,” notes JHF President and CEO Karen Wolk Feinstein. “Our current aging agenda is focused on ensuring that older people are provided with care that is streamlined and coordinated.

“We are developing and institutionalizing a new model of community-based care that integrates community health workers (CHWs) into the care team to improve communication, care transitions, and a patient’s ability to manage their health at home, and we are encouraging innovation in health IT products that help seniors to manage their health conditions and maintain their independence.”

Across the nation, considerable attention is now focused on keeping the elderly and their substantial healthcare needs from overwhelming hospitals, nursing homes, and the elderly’s own middle-aged children or other family caregivers.



Sponsored by JHF and prepared by the Alliance for Aging Research, “Moderating the Effects of Aging” was a resource guide for caregivers, providing the most recent information on issues related to aging, as well as referrals for more information.



By some estimates, more than three-quarters of seniors who live in the community and require regular care rely upon family and friends exclusively.

“When one looks at the cost, quality, and preferences of seniors and families,” says Dr. Feinstein, “it’s clear that there is a need to improve the system of home- and community-based care if we are to reduce seniors’ unnecessary ER visits, hospitalizations, and nursing home placements.”

### JHF’S COMMITMENT TO SENIORS EXTENDS TO CAREGIVERS

As individuals age, family is increasingly called upon to serve as informal caregivers. These spouses, offspring, siblings, and friends—approximately 29 percent<sup>4</sup> of the U.S. population—provide critical assistance to seniors and may help them avoid preventable hospital stays and institutionalizations. By some estimates, more than three-quarters of seniors who live in the community and require regular care rely upon family and friends exclusively.

But caregiving can take a physical, emotional, and economic toll. Almost one in seven informal caregivers feel as if their health has worsened due to their caregiving role, according to a 2014 analysis of the 2011 National Study of Caregiving.<sup>5</sup> Slightly more than one in four<sup>6</sup> consider caregiving to be emotionally stressful. And with caregivers spending an average of 20 hours per week attending to their loved one (nearly 40 hours for those living in the same space), caregiving can be an overwhelming responsibility.

JHF’s commitment to seniors has always extended to those who care for them. The Foundation has worked to strengthen the region’s caregiving network, and to help informal caregivers manage their own health, reduce stress, and access relevant information and resources.

In the early 1990s, JHF created and housed Interfaith Volunteer Caregivers of Southwestern Pennsylvania. Participating worship centers trained volunteers to connect with isolated seniors and offer them living assistance to maximize independence.

In 1995, the Foundation developed a caregiver’s manual distilling advice on geriatric assessments, medication management, nutrition, falls prevention, chronic wound treatment, and senior citizen benefits. The manual was created based on research from a JHF-sponsored study by the Alliance for Aging Research. In 1995, JHF also provided support to the Caregivers Training Institute, a model program to strengthen caregiving skills across the continuum.

JHF in 2010 established Caregiver Champions, a program that helped family and informal caregivers balance their life commitments. The program, which was hosted by an experienced informal caregiver, offered six free sessions on topics that included communicating with care recipients and healthcare providers, creating a safe home environment for seniors, and avoiding burnout. Caregiver Champions was supported by JHF, the Harry and Jeanette Weinberg Foundation, the Pennsylvania Department of Community and Economic Development, and the Pennsylvania Department of Human Services.

Currently, JHF is working in partnership with the United Way of Allegheny County on their strategy and action plan for family caregivers. The Foundation is sharing all of its caregiving-related materials, resources, and curriculum with the United Way.

# Q&A

## MILDRED MORRISON, MPM



The Area Agency on Aging (AAA) serves as a resource hub and advocate for Allegheny County seniors, connecting residents who are 60 years of age or older with crucial health and social services. AAA Administrator Mildred Morrison, MPM, a Long Term Care Champions program advisor, gave a presentation to the Champions in May of 2013 on how long-term-care facilities can work with the AAA to provide seamless care.

**Q: What were the main take-aways from your presentation to the Long Term Care Champions?**

**A:** I gave participants a concrete understanding of the range and depth of services available to Allegheny County residents when they are discharged from skilled nursing facilities. I explained some of the programs — which are basically nursing home diversions (federal grant dollars that enable states to develop programs that help families care for their loved ones at home instead of having to place them in skilled nursing facilities) — that are under the public dollar. There are programs for people at different stages of their abilities, and we can link them with home modifications and personal, hands-on care that can be delivered in the home.

**Q: Why is it important for long-term-care workers to understand the public resources that are available to residents?**

**A:** Nursing homes increasingly have sicker, higher-need patients, but those patients do come in and out of nursing homes. Part of being a good champion of services within the nursing home is to understand what's available outside of the nursing home so patients can move between settings as easily as possible. It's important for the champions to know that the financial burden for in-home services is not entirely on families. Moves between care settings only work well only when all parties know how all of the parts work. That's where you get a public-private partnership.

**Q: How does the AAA work with long-term-care facilities?**

**A:** We at the AAA have multiple relationships with long-term-care. If the consumer is seeking that an extended stay (for many months, years, or the remainder of their life) be paid by Medicaid, the Pennsylvania Department of Human Services contracts with the AAA to make the clinical determination of the consumer's need for that level of care, while they make the financial determination.

We also serve as an ombudsman, an advocate for the rights of the resident. That can range from two people sharing a room, one of whom doesn't like the radio being played loudly, to a facility wishing to have a patient removed. Our job is to make sure the patient's rights are being honored. Are they being given a full, clear explanation?

The AAA also has a unit called Nursing Home Transitions, for those residents who wish to return to their homes after a nursing home stay. We come in and sit with the resident, exploring the barriers to the person going home and what services and support are available to him or her. It's collaborative, and centered around the resident's goals.

We find that when there's uncertainty about whether someone can return home, it's often possible if there's an informed discussion. But it's not automatic that the person goes home. Sometimes the answer is no, and we are willing to say, "That's not going to be possible." But we tend to say it in English, not "medicalese" language. We say high blood pressure, not hypertension. That way, the consumer can understand that because they are unable to stand for five minutes, and their home has too many steps, those two things combined make it difficult to go home. That's a different conversation than one filled with clinical terms.

The Pennsylvania Health Funders Collaborative, a network of 40 foundations from across the Commonwealth co-chaired by Dr. Feinstein and Russell Johnson, MSW, president and CEO of North Penn Community Health Foundation, is working to make home- and community-based services a more viable option for our region's seniors.



JHF's COO and CPO Nancy Zionts (L) and Karen Feinstein (center) with members of the Pennsylvania Health Funders Collaborative, including Ann Torregrossa, executive director (third from right)

## PA HEALTH FUNDERS WORKING TO STRENGTHEN LONG-TERM-CARE SERVICES AND SUPPORTS ACROSS THE COMMONWEALTH

The Pennsylvania Health Funders Collaborative (PHFC), a network of 40 foundations from across the Commonwealth co-chaired by Dr. Feinstein and Russell Johnson, MSW, president and CEO of North Penn Community Health Foundation, is working to make home- and community-based services a more viable option for our region's seniors.

“Nursing homes serve an incredibly valuable purpose for those who need them, but there should also be robust options for people who want to stay safely at home and receive services in the neighborhoods in which they're rooted,” says JHF COO and Chief Program Officer Nancy Zionts. “We see opportunities to match what people want, and what's in the best interest of the Commonwealth, by strengthening our network of home and community-based services.”

To accomplish that goal, the PHFC has established a working committee to advocate for policy changes that would deem more seniors eligible for home- and community-based services, create a strong workforce and monitoring procedures, and study successful national models for delivering long-term care outside of institutional settings. The PHFC also partnered with the University of Pittsburgh's Institute of Politics to develop the report on Pennsylvania's long-term-care services and supports noted in the introduction to this chapter, and helped craft a demonstration model for home- and community-based services for seniors on Medicare Managed Care.

“Those of us on the PHFC working committee are meeting monthly to look at how we can re-balance long-term-care delivery, and make the case to the new administration in Harrisburg,” Zionts says. “This is both a quality-of-life and a cost imperative for Pennsylvania and Pennsylvanians.”

## MEETING THE NEEDS OF COMMUNITY-DWELLING SENIORS WITH COMMUNITY HEALTH WORKERS

The use of community health workers (CHWs) as a vital component of the U.S. healthcare system has been documented for decades. CHWs can improve population health; lower healthcare costs by reducing emergency room visits, hospitalizations, and institutionalizations; and improve patient experience, primarily among high utilizers, of which the elderly are a large percentage. However, despite CHWs' potential to deliver many solutions to the current healthcare system's shortcomings, their work is largely underutilized.

JHF sees the integration of CHWs into the medical care team as a cost-effective means to honor the wishes of seniors to age in place and also meet the demand that the aging population is expected to place on the health and social service systems in the coming years.

“We see tremendous opportunity to use CHWs to help slow the rate of age-related decline in vulnerable seniors by ensuring that they have the resources they need as they age in place—including connections to community resources and help with navigating the healthcare system when necessary,” says Dr. Feinstein.

# Recognizing that much of health happens *between* physician visits, JHF efforts extend from home to community to institution, focusing not only on what happens within each of these “spaces,” but also on the transitions between them.

Recognizing that much of health happens *between* physician visits, JHF efforts as presented in this *ROOTS* extend from home to community to institution, focusing not only on what happens within each of these “spaces,” but also on the transitions between them. CHWs can play a significant role in this model.

In 2014, the Foundation began its work to build the CHW workforce in our region by collaborating with NEHI (Network for Excellence in Health Innovation) to host a national CHW Summit. The learnings from this Summit informed a statewide Summit on CHWs that JHF held in April 2015 in Harrisburg, Pa.

The participants at the Harrisburg CHW Summit helped JHF to outline the elements of a standardized CHW training curriculum, certification, and reimbursement mechanism to promote the use of CHWs in the Commonwealth’s healthcare and social service systems; and JHF is now working to develop the Foundation’s newest Champions program: Community Health Workers Champions, which will focus on enhancing the skills of area CHWs to improve the care and outcomes for community-dwelling seniors.

JHF has created an advisory group of experts in senior services—those involved in home- and community-based care as well as those from the clinical healthcare sector—who will work with the Foundation to identify the factors that predict hospital and nursing home admissions for seniors, and to develop a competency-based CHW training curriculum and service delivery model focused on preventing hospitalizations and avoidable institutionalization for community-dwelling seniors.

The training curriculum and service delivery model will then be pilot-tested as a two-year demonstration with select local agencies (CHW Champions).

“Once the model and curriculum are refined based on that pilot phase,” noted Dr. Feinstein, “JHF will submit this CHW model for statewide adoption.”

The use of community health workers as a vital component of the U.S. healthcare system has been documented for decades. These workers can:

- improve population health;
- lower healthcare costs by reducing emergency room visits, hospitalizations, and institutionalizations; and
- improve patient experience, primarily among high utilizers, of which the elderly are a large percentage.





In Pennsylvania, more than 80,000 people reside in the state's more than 700 nursing homes.

## PUTTING THE SKILL IN SKILLED NURSING FACILITIES

Skilled nursing facilities (SNFs) play a vitally important role in the care of our nation's frail and medically complex individuals. They provide safe long-term care for individuals with complex medical conditions or disabilities who often cannot be safely or efficiently cared for in private homes or assisted living facilities. And they provide transitional care for fragile individuals who must leave a hospital setting because they no longer need the acute care that hospitals provide, but who still require the services of a nurse, rehabilitation specialist, or other healthcare professional to further improve functioning before they can safely return home or to an assisted living facility.

According to Eric Rodriguez, MD, MPH, associate professor of medicine in the Division of Geriatric Medicine at the University of Pittsburgh, the pressures on SNFs have increased significantly. "Skilled nursing facilities are seeing an influx of more post-acute care patients as hospitals are releasing patients to skilled nursing 'sicker and quicker' as they strive to cut length of stay," he says.

"SNFs must now also (along with the care of the traditional long-stay resident) manage the care needs of sicker patients who require aggressive short-term

In the U.S., about 40 percent of people over 65 years of age will spend time in a nursing home at some point. Numerous studies, however, paint a troubling picture on a national basis:

- 22 percent of Medicare SNF patients experience events that cause lasting harm, and another 11 percent experience temporary harm events.<sup>7</sup>
- About 20 percent of Medicare patients who are discharged from the hospital are admitted to a skilled nursing facility to complete their recovery,<sup>8</sup> and almost one in four of these Medicare patients are readmitted to the hospital within 30 days of discharge.<sup>9</sup>

In Pennsylvania, a Department of Public Welfare's review of hospital admissions for people using long term services and supports (LTSS)<sup>10</sup> found that 30 percent of the hospitalizations were unnecessary.

Furthermore, the aforementioned University of Pittsburgh Institute of Politics report cites a review of medical records that shows that 40 percent of hospitalizations among nursing facility residents could have been prevented with well-targeted interventions.

rehabilitation or short-term complex medical care. They have been asked to take on much more than they were ever designed to do. They are being asked to step up and provide patient care as if they are a hospital, yet most lack trained staff and resources to do so.”

In Pennsylvania, more than 80,000 people reside in the state's more than 700 nursing homes.

“In addition,” says Rodriguez, “many hospitals are looking at where their readmissions from SNFs come from, facility by facility. If they see that a particular facility has an extraordinarily high 30-day readmission rate, the hospital may want to avoid sending patients to that facility.”

### **ACA Provisions Present Tremendous Opportunities for SNFs**

A number of provisions in the 2010 Patient Protection and Affordable Care Act (ACA) have the power to transform the way skilled nursing facilities provide care and also their relationships with hospitals:

- As part of the ACA, hospitals with higher than expected readmission rates for select conditions are penalized in the form of decreased Medicare payments. And while hospitals are taking significant measures to reduce readmissions, some of the factors that lead to preventable admissions are beyond their control. As noted by Dr. Rodriguez, hospitals are looking to the next caregiver “down the line” to be just as diligent in their efforts to reduce preventable readmissions. This is resulting in increased attention being paid to SNFs and will likely result in hospitals diverting their discharges to higher-performing SNFs.
- In October 2018, using 2015–2016 as the base year, the Centers for Medicare & Medicaid Services (CMS) will reduce Skilled Nursing Facilities' (SNF) Medicare payments by 2 percent and redirect a percentage of these funds as a “reward” to SNFs with the lowest preventable readmissions rates.
- The ACA also calls for the creation of a national voluntary program for accountable care organizations (ACOs) in which hospitals, SNFs, and other care settings work closely together to care for their Medicare patients; and payment is bundled and tied to achieving healthcare quality goals and outcomes that result in overall cost savings.

Additionally, in this era of readily accessible health and quality data, people are increasingly seeking quality and outcome information. CMS's Five-Star Quality Rating System for SNFs on the *Nursing Home Compare* website, for example, includes quality measures such as rates of pressure ulcers, falls, urinary tract infections, and the use of antipsychotic medications.

# “Skilled nursing facilities are seeing an influx of more post-acute care patients as hospitals are releasing patients to skilled nursing ‘sicker and quicker’ as they strive to cut length of stay.”

—Eric Rodriguez, MD, MPH, associate professor of medicine in the Division of Geriatric Medicine at the University of Pittsburgh

This transparency, coupled with the numerous payment models and penalties implemented as a result of the ACA, provide significant incentive and opportunity to SNFs to improve care, control costs, and develop effective partnerships with hospitals to improve care transitions.

“Preventable hospital admissions drive up costs, but, just as important, they diminish health outcomes, especially for the frail elderly,” adds Rodriguez. “The stress of the transfer and hospitalization can lead to medical and emotional setbacks that can significantly impact recovery of the condition for which they were admitted, as well as functional decline and complications unrelated to the problem that caused admission.”

## Preparing SNFs for the New LTC Environment

Nicholas G. Castle, MHA, PhD, a professor and researcher at the Graduate School of Public Health at the University of Pittsburgh, also reminds us that all staff within SNFs need to be prepared, from the front line to the C-suite.

“If we get to pay-for-performance in SNFs,” he says, “there will be a whole slew of quality metrics thrown into the reimbursement pot. Facilities that improve quality in as many areas as possible are going to be ahead of the game.

“SNFs will need not only better trained frontline staff, but also better trained top managers who understand the issues and who are informed about resident care in terms of quality measures, relationships with hospitals to lower admission rates, and best practices.”

“The current landscape,” says Dr. Feinstein, “presents unprecedented opportunity for skilled nursing facilities—originally designed for long term patients who did not need intensive care—to learn the skills and build the relationships necessary to successfully adapt to the new reality. In our region, they have the support of the Jewish Healthcare Foundation.”



A resident works with one of the physical therapists at Marian Manor’s short-term rehabilitation center.



As with all JHF Champions programs, only those organizations that demonstrate criteria JHF has found to be critical for successful Champions were recruited:

- From the top down, organizations had to be motivated to improve quality and assure patient safety;
- Leadership recognized that the engagement of frontline staff in training, problem identification, and workflow redesign is crucial; and
- Organizations were capable of quantifying clinical and financial outcomes of the work accomplished during the program, and were willing to make these outcomes known to others in the field.

## LONG TERM CARE CHAMPIONS PROGRAM

JHF has a long history in aging and a track record in developing successful Champions programs (see *Appendix*) that bring process engineering principles, systems thinking, and other quality improvement tools into the hands of our region's healthcare professionals to dramatically improve safety, efficiency, reliability, quality, and cost of patient care. The Foundation combined our passions and expertise to develop the Long Term Care Champions program, which was funded through grants from JHF and The Pittsburgh Foundation.

Over an 18-month period, from October 2012 through March 2014, JHF staff worked with six SNFs in the Pittsburgh region to build the competence, confidence, and culture needed to improve the quality of life, care, and services delivered to residents in order to prepare them for the changes we knew were coming as a result of the ACA.

The six SNFs included:

- Asbury Heights, Pittsburgh
- Charles M. Morris Nursing and Rehabilitation Center of the Jewish Association on Aging, Pittsburgh
- Kane McKeesport Regional Care Center, McKeesport
- Kane Ross Regional Care Center, Pittsburgh
- Marian Manor of the Vincentian Collaborative System, Pittsburgh
- Southmont of Presbyterian Senior Care, Washington

Under the guidance of JHF COO and Chief Program Officer Nancy Zionts and LTC Champions program director Maureen Saxon-Gioia, RN, a core team of quality improvement specialists with expertise and experience in long-term care provided training and coaching, helping the LTC Champion sites to transform their culture, processes, and outcomes using simple, but powerful, quality improvement tools such as JHF's Perfecting Patient Care<sup>SM</sup> (PPC) quality improvement methodology, INTERACT II, and Advancing Excellence.

Health economist Christine Bishop, PhD, of the Heller School for Social Policy and Management at Brandeis University, keynoted the April 2014 Long Term Care Champions finale, in which LTC Champions presented their quality improvement projects, many of which are illustrated in the chapters of this publication.

Bishop's work focuses on the economics of long-term-care services and supports and the economics of aging, including the ability of human resources management systems to access the knowledge and commitment of frontline nursing home staff for better performance. According to Bishop, "investing in high performance work practices has not been a high priority for nursing homes, because resources have not necessarily followed their efforts to improve clinical quality or customize person-centered care.

## LONG TERM CARE CHAMPION ADVISORS

Eight experts in long-term care and aging served as resources to the LTC Champions team. They helped to develop programming, served as a sounding board for ideas, guided staff to additional resources, attended LTC Champions events, and served as speakers for LTC Champions' learning sessions. Advisors included:

- **Bob Arnold, MD**, professor of medicine; chief, Section of Palliative Care and Medical Ethics; director, Institute for Doctor-Patient Communications; Leo H. Crip chair in Patient Care; medical director, UPMC Palliative and Supportive Institute
- **Nicholas G. Castle, MHA, PhD**, professor, Graduate School of Public Health, University of Pittsburgh
- **Tanya Fabian, PharmD**, director of pharmacy at University of Pittsburgh Medical Center
- **Pearl Moore, RN, MN**, retired CEO of Oncology Nursing Society; JHF and Health Careers Futures\* Board Member
- **Mildred Morrison, MPM**, administrator of the Allegheny County Department of Human Services Area Agency on Aging (AAA); JHF Board of Trustees; Health Careers Futures\* Board Member
- **Eric Rodriguez, MD, MPH**, Division of Geriatric Medicine, University of Pittsburgh; JHF Board of Trustees
- **Daniel Rosen, MSW, PhD**, associate professor, University of Pittsburgh School of Social Work; JHF Board of Trustees
- **Neil Resnick, MD**, Thomas Detre Professor of Medicine; chief, Division of Geriatric Medicine; associate director, Aging Institute of UPMC Senior Services and University of Pittsburgh; director, Hartford Center of Excellence in Geriatrics; JHF Board of Trustees

\*Health Careers Futures is an operating arm of JHF

“But,” says Bishop, “in the emerging world of accountable care organizations, bundled payment, pay-for-performance, and Medicare Advantage, nursing home success and even survival may hinge on the ability to meet new benchmarks. The LTC Champions program helped participating nursing homes implement several classic high-performance workplace practices, including team building, frontline worker empowerment for problem solving, and training to enhance quality. It would be great to see these organizational change strategies rolled out across the country.”

Each SNF participating in the LTC Champions program identified a team of clinical and management personnel who were trained through a customized Perfecting Patient Care<sup>SM</sup> University; armed with their new skills, the LTC Champions set to work.

Each facility identified areas for quality improvement; depending on the problems each facility chose to address, teams received additional training in:

- INTERACT II and Advancing Excellence tools;
- Strategies for increasing the quality of life for patients with dementia;
- POLST (Pennsylvania Orders for Life Sustaining Treatment) and advance directives; and
- *Closure* Community Conversation, a program designed by JHF to help redefine quality end-of-life care by giving people access to tools and resources to make educated end-of-life decisions consistent with their clinical conditions, legal options, and values and beliefs.

JHF quality improvement specialists supported the LTC Champions in problem identification; increasing clinical, leadership, and teamwork skills; and developing skills to execute quality improvement projects. A number of their stories are included in this *ROOTS*.

## ACHIEVING SUSTAINABLE IMPROVEMENTS

# CELEBRATING 'CHAMPIONS FOR CHANGE'

Creating a quality-oriented culture that empowers frontline staff requires more than enhanced clinical and communication skills — it also requires buy-in from senior management. Asbury Heights set the stage early on. Their organizational leadership recognized that problems are often solved on nursing units, not behind administrators' desks; and their commitment to quality and patient safety created an environment in which sustainable improvement can be achieved.

You can count Betty Zawatski, RN, among a “champion for change.” The LTC Champions at Asbury Heights identified resident falls as an area of concern. Each week, they carve out time to meet with caregivers and medication technicians to gather information on falls and to brainstorm ways to prevent them in the future.

Getting protected time for such initiatives only happens when there's a senior-level commitment to quality improvement, Zawatski notes.

“It's crucial to have the C-suite behind you,” Zawatski says. “If they don't support your ideas, why should anyone else? It speaks volumes when you see administrators on the floor, interacting with staff. It means they're listening.”

The Kane Regional Centers have a conduit for listening to the problems identified by staff and their proposed solutions: they created a quality improvement council at each Kane regional center. The councils, which are open to all staff, meet monthly. Each quarter, the Kane councils gather to discuss their shared concerns and ways to streamline care and communication.

“The important thing that I learned is that everyone in the building matters,” says Kane Regional Center – McKeesport Administrator Charlene Flaherty, RN. “Our team meetings bring nurses, dietary staff, housekeeping, and others together to solve problems. It's not just one discipline that has the answers.”

“When you go to the meetings, you can sense that the Kanes aren't tied to doing things ‘the old way,’” says Quality Improvement Specialist Stacie Bonenberger, MOT. “They're inquisitive, and when they hear that something is working somewhere else, they can't wait to implement it at their own facility.”



For JAA President and CEO Deborah Winn-Horvitz, the Long Term Care Champions program reinforced her belief that those who care for residents directly drive facility-wide improvement.

“The more that we get the staff involved, the more buy-in we

get,” Winn-Horvitz says. “We've put together a shared governance group that's mainly frontline staff so they can bring their challenges to us. As administrators, we can eliminate barriers to improvement and provide the resources necessary to make their jobs easier and achieve better outcomes for residents.”

While frontline workers are crucial to identifying areas for improvement, management must foster an environment in which staff feels comfortable expressing their concerns, Winn-Horvitz notes.

“There can't be any blaming or finger-pointing,” Winn-Horvitz says. “You have to get past that and realize that people don't want to make a mistake. There's a problem with the process. If an employee makes a mistake and comes to you, congratulate them for recognizing the problem and help them fix it. Our staff feels safe. That, in turn, makes our residents safe.”



## RAVEN PROGRAM

Shortly after kicking off the LTC Champions program, JHF pursued another opportunity to help SNFs improve the quality of their care.

In October 2012, CMS announced seven four-year cooperative agreement awards to implement an initiative to Reduce AVOIDable hospitalizations using Evidence-based interventions for Nursing facilities in Western Pennsylvania (RAVEN).

The four main objectives of RAVEN are to reduce avoidable hospitalizations for long-stay (100+ days) SNF residents, improve SNF resident health outcomes, improve the bi-directional process of transitional care between hospitals and SNFs, and reduce overall healthcare spending without compromising access or quality.

UPMC Community Provider Services was one of seven awardees, and UPMC partnered with JHF, Excelsa Health, Heritage Valley Health System, and Robert Morris University in the RAVEN initiative. JHF serves as the lead education provider at the 19 participating western Pennsylvania sites, which include LTC Champions sites Kane Regional Center–McKeesport and Kane Regional Center–Ross.

JHF offers the facilities participating in the RAVEN project many of the resources and trainings utilized during the LTC Champions program, including PPC, the INTERACT (Interventions to Reduce Acute Care Transfers) quality improvement program to enhance clinical skills, and support for advance care planning discussions and palliative care treatment.

“UPMC has relied upon JHF for its robust palliative education curriculum, and we’ve also learned from JHF in terms of deploying adult learning theories and creating culture change,” says Katy Lanz, DNP, then-co-project director for RAVEN and director of Education and Geriatric Services for UPMC Palliative and Supportive Institute. “We’re empowering the front line to use their nursing skills to their full scope, to consider family values within discussions, and to communicate confidently with physicians.”

Robert Morris’ Joe Angelelli (RAVEN partner) and LTC Champions finale keynote speaker Dr. Christine Bishop chat with Karen Feinstein (left) at a reception following Bishop’s remarks and presentations by the Long Term Care Champions.

According to the Centers for Medicare and Medicaid Services (CMS):

- Most SNF residents are enrolled in Medicare
- Almost two-thirds are also enrolled in Medicaid
- 45 percent of hospitalizations among Medicare–Medicaid enrollees, which cost CMS \$7–\$8 billion in 2011, could have been prevented



JAA Care Navigator  
Nadine Kruman, MSW, LSW,  
chatting with a resident  
of Weinberg Village.

Through the Long Term Care Champions program, JHF gained an understanding of the common challenges in long-term-care settings and fine-tuned ways to reach a large group of facilities, which they were able to apply to RAVEN.

“Long-term-care facilities share many of the same issues, such as staff turnover, ‘siloe’d’ disciplines, and the old ‘we’ve always done it this way’ resistance to change,” says Zionts. “We have learned that you need leadership participation to empower the frontline staff. If they’re not behind you and part of the process, changes won’t stick.”

The LTC Champions program also provided JHF with experience in preparing RAVEN facilities to meet Quality Assurance Performance Improvement (QAPI) standards, a series of best practices to continuously improve care and services in nursing homes. The Affordable Care Act requires that nursing homes have a QAPI plan within one year of the regulations being finalized.

“QAPI requires long-term-care facilities to work at a different pace,” Zionts says. “They’re going to have to focus on quality assurance improvement, working system-wide and working together as teams. We started to see that quickened pace at the LTC Champions sites, and we’ve taken that momentum over to RAVEN.”

Now in its third year, the RAVEN initiative is achieving positive results. Facilities participating in RAVEN are reducing avoidable hospitalizations and reducing staff turnover at a higher rate than benchmark nursing homes where residents receive usual care, Lanz notes. The initiative is also increasing confidence among nursing staff to design new policies and programs that will help keep residents in place.

“Many people in this region are deeply committed to improving the lives of high-risk individuals in nursing homes,” Lanz says. “That commitment has broken institutional walls and created new partnerships. If you start with passionate people, then you can really motivate what the process looks like.”



“

**Many people in this region are deeply committed to improving the lives of high-risk individuals in nursing homes. That commitment has broken institutional walls and created new partnerships. If you start with passionate people, then you can really motivate what the process looks like.**

— Katy Lanz, DNP, former director of education and geriatric services for UPMC Palliative and Supportive Institute

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## CASE STUDIES

The following pages provide short case studies of a number of the interventions undertaken by Long Term Care Champions sites to address problem areas, including:

- Dementia care;
- Resident falls;
- Workspace organization;
- Acute changes in resident condition; and
- Pressure ulcers.

The tools described in these case studies, and elaborated on further in the next section, are also part of the training JHF is providing to the SNFs participating in the RAVEN project.

# WHEN IS MOTHER COMING TO VISIT?

The Marian Manor resident, a 90-year-old woman, sought out staff most mornings to ask this painful question. Suffering from dementia, the woman sat and waited for her mother to arrive. She missed her terribly.

“We weren’t really sure how to approach her,” says Marian Manor Director of Nursing Pat Gallagher, RN. “Some of our staff were afraid to engage a resident with dementia, wondering, ‘Do I go along with what they’re saying? Do I tell them the truth? Lie? Run away?’ ”

Such encounters are becoming more common, with elderly residents living longer thanks to medical advances but often with cognitive decline for which there’s no cure. Approximately one in ten Americans over the age of 65 suffers from Alzheimer’s disease or a related form of dementia, according to the Geriatric Mental Health Foundation. Half over the age of 85 are thought to have a disease that ravages parts of the brain related to thought, memory, and language skills.

“Taking care of a resident with dementia is stressful,” says PRHI Senior Quality Improvement Specialist Terri Devereaux, MPM, FNP-BC. “We have a tendency to want to orient people, and become frustrated when it doesn’t work. We want to know, ‘Why don’t they get this?’ It’s because their brain is dying.”

Devereaux conducted focus groups with LTC Champions, in which nurses expressed a desire to communicate more effectively with residents who have dementia and their families. She also learned that Teepa Snow, MS, a trained occupational therapist and dementia expert, had previously provided dementia education at Asbury Heights.

“The LTC Champions knew they couldn’t cure residents’ dementia, but they felt they weren’t being effective in trying to maintain their quality of life and keep them calm,” Devereaux says. “That changed my whole focus.”

With Snow’s input, Devereaux developed a dementia education curriculum to help LTC Champions understand the progression of the disease and equip them with strategies to communicate with residents and families.

Devereaux displayed pictures of a healthy brain juxtaposed with a dementia-afflicted brain during a learning session for all facilities, pointing out the jarring physical differences that affect the learning and memory center of the brain.

“I was able to show them, for example, ‘This is a normal speech center and here’s what happens. This is why they can’t communicate as well,’ ” Devereaux says. “It’s powerful to understand what’s going on in the brain and why residents act in a certain way.”

In the curriculum, dementia residents are considered “gems,” because Snow focuses on what is precious and unique about each senior. There are five different classifications of gems spanning the continuum of dementia. Snow uses each of them to represent a progressive state of the disease. LTC Champions learned about the characteristic behaviors of each gem type, and strategies to reach those residents and their loved ones.

“Terri fulfilled everything the staff was asking for—the ‘what ifs,’ ” Gallagher says. “They’re much more comfortable approaching, and engaging in a conversation.”

LTC Champions also learned how to use Snow’s “Positive Physical Approach,” which emphasizes short, simple, and friendly messages delivered at a resident’s eye level. At Marian Manor, for example, Gallagher and her staff used the Positive Physical Approach to communicate with the woman expecting a visit from her mother.

“After Terri’s education, our response was ‘Your mother loves you very much and thinks about you all of the time,’ ” Gallagher says. “The whole interaction changed, and the resident was less agitated that she didn’t see her mother. She saw the friendly faces of the nurses, and she was totally calm with their response.”

| GEM TYPE        | CHARACTERISTICS  | CARE STRATEGIES   |
|-----------------|--|---|
| <b>Diamond</b>  | <ul style="list-style-type: none"> <li>• Still clear</li> <li>• Can really shine</li> <li>• Hard, rigid, inflexible</li> </ul>   | <ul style="list-style-type: none"> <li>• Keep surroundings familiar</li> <li>• Apologize, don't argue to prove a point</li> <li>• Be a team player: Be friendly, not bossy; share responsibility; "let's try this"</li> <li>• Use as many "old habits" as possible</li> <li>• Go with the flow</li> <li>• When taking away one job, give another</li> <li>• Keep directions simple</li> </ul> |
| <b>Emeralds</b> | <ul style="list-style-type: none"> <li>• Not as clear or sharp</li> <li>• Need to "do"</li> <li>• Flaws are hidden</li> <li>• Time traveling</li> </ul>  | <ul style="list-style-type: none"> <li>• Consider: Is it worth it to argue/reason?</li> <li>• Provide subtle supervision</li> <li>• Don't correct errors</li> <li>• Provide visual prompts</li> <li>• Hide visual cues that trigger unsafe or upsetting behavior</li> <li>• Use humor, friendliness, support</li> </ul>   |
| <b>Ambers</b>   | <ul style="list-style-type: none"> <li>• Caught in a moment</li> <li>• All about sensations</li> <li>• Explorers</li> </ul>  | <ul style="list-style-type: none"> <li>• Provide step-by-step guidance</li> <li>• Give demonstrations</li> <li>• Hand-under-hand guidance</li> <li>• Offer something to handle, manipulate, touch, gather</li> <li>• Limit talking, noise, touch, other activities</li> <li>• Substitute, don't subtract</li> </ul>   |
| <b>Ruby</b>     | <ul style="list-style-type: none"> <li>• Hidden depths</li> <li>• Red light on fine motor skills</li> <li>• Comprehension and speech halt</li> <li>• Coordination falters</li> <li>• Wake/sleep patterns are gone</li> </ul> | <ul style="list-style-type: none"> <li>• Slow down yourself</li> <li>• Hand-under-hand guidance</li> <li>• Move with the person first, then guide</li> <li>• Learn about the resident's patterns</li> <li>• Use music and rhythms</li> <li>• Use touch with care</li> <li>• Use cueing and do it slowly</li> </ul>  |
| <b>Pearls</b>   | <ul style="list-style-type: none"> <li>• Hidden in a shell</li> <li>• Still and quiet</li> <li>• Easily lost</li> <li>• Unable to move</li> </ul>  | <ul style="list-style-type: none"> <li>• Frequent positioning</li> <li>• Check for reflexes</li> <li>• Work slowly</li> <li>• Use calm, rhythmic movements and voice</li> <li>• Stabilize with one hand and work with the other</li> </ul>  |



Dementia expert Teepa Snow compares different states of ability to the characteristics of precious jewels.

## CATCHING ‘FALLING STARS’

On Kane McKeesport’s Unit 2B, everyone knows who’s at a higher risk for a fall — they just have to look for the star on the resident’s door. The star is part of a multidisciplinary falls prevention program, successfully piloted on 2B’s long-stay resident unit as a part of the LTC Champions program that has now been implemented facility-wide.

Unit 2B identified resident falls as an area of concern early on during the LTC Champions program. Injuries from falls are a concern for skilled nursing facilities across the country, as they account for the largest portion (36 percent) of preventable hospital emergency room visits among nursing home residents, according to the Centers for Disease Control and Prevention. In the winter of 2013, Kane McKeesport utilized the structured observation approach taught during PPC training to hone in on the problem of excessive falls on Unit 2B.

“We looked at not just a shift, but a time in a shift and what kind of residents were falling,” says Kathy Jayze, who compiles statistical reports for Kane’s safety committee meetings. “We fine-tuned those stats to find exactly what our problems were.”

They found that about half of resident falls happened during the 3–11 p.m. shift. One-third of the falls during that shift occurred between 3 p.m. to 5 p.m., when fewer staff members were on the unit. Residents were more likely to fall if they had recently been prescribed new medication or changed doses; had health concerns such as poor vision, dizziness, joint pain, and shortness of breath; wore improper footwear; or suffered from memory loss.

In response, Kane McKeesport increased staffing levels on Unit 2B during the 3–11 p.m. shift and placed certified nursing assistants (CNAs) as monitors in dining and recreational areas during high-fall times. They removed unnecessary hazards, including extra tables and chairs, from those areas. Kane McKeesport also created a dedicated falls team — comprised of the medical director, nursing, physical and occupational therapies, and pharmacy — to review all unit falls and develop strategies for prevention.

The team now conducts a resident falls assessment upon admission, and quarterly thereafter unless the resident suffers a fall triggering an immediate review. The facility’s Pharmacy staff review each resident’s medication(s) each month, documenting side effects that could increase the chances of a fall. Occupational and physical therapy staff evaluate residents upon admission and on an as-needed basis. Residents with a history of falls have a star placed outside their rooms, so staff are alerted to be extra vigilant, and those patients may also receive fall mats and a bed alarm for further protection.

The falls prevention program “has really kept the nurses involved and improved communication with the residents,” says Kim Haigy, RN, a resident care coordinator on Unit 2B. “High-risk residents aren’t going to their rooms by themselves or trying to get in and out of bed without help.”

Kane McKeesport’s pilot showed promising early results, with Unit 2B’s number of falls declining from 13 in April of 2013 to seven by September of 2013. The program was rolled out facility-wide, which has helped Kane McKeesport post a lower rate of falls, among long-stay residents, resulting in a lower major injury rate (2.2% as of spring 2015) than the statewide average (3.1%) and national average (3.2%), according to Medicare’s Nursing Home Compare website. Kane McKeesport also shares best practices with UPMC McKeesport, one of the facility’s main referral sites.

“We consider the Kanes our partners,” says Cheryl Como, DNP, RN, NEA-BC, chief nursing officer and vice president, Patient Care Services at UPMC McKeesport. “We understand that a patient’s care doesn’t stop when they exit the hospital. Everything they’ve learned in the LTC Champions program has strengthened our communication — we’re speaking the same language.”



## Perfecting Patient Care<sup>SM</sup> University

### Session 1

#### The Basics of Problem Solving

- Teamwork
- Fundamentals of Lean
- Waste
- Rules in Use
- PDSA
- THC

### Session 2

#### What's Data Got to Do With It?

- Data
- Observation
- Mapping
- Root Cause Analysis

### Session 3

#### Building Bricks of Lean

- 5S
- Visual Management
- Lean Stimulation
- A3 Thinking
- PDSA

# “How do you ensure that 100% of long-term-care residents end up in the hospital?”

(Yes, you did read this correctly).

Nancy Zionts posed this question in October 2012 during the LTC Champions' first session of Perfecting Patient Care<sup>SM</sup> University (PPCU).

The LTC Champions had myriad answers—they lived these problems, after all. They cited poor communication, underdeveloped assessment skills, and inconsistent processes for treating conditions, among other issues. Then, through a customized version of PPC, they were trained in lean quality improvement principles (on which PPC is based) and charged with applying their learnings to solve real-world problems in their own long-term-care facilities.

PPC's traditional four-day university format was reformatted for the program, with PRHI holding three training sessions, spread over two months, at participating facilities. LTC Champions worked through case studies taken straight from nursing home floors.

For instance, participants applied the Lean tool of observation (a structured process by which work is documented exactly as it is performed in order to identify problems) to Unit 2B.

“We tailor PPC training to each client's care setting and needs, and increase learning and retention by providing participants hands-on opportunities to apply what they've learned,” says Terri Devereaux, MPM, FNP-BC, a PRHI senior quality improvement specialist. “That's where the ‘aha moments’ emerge: when participants see the improvement that occurs with their application of Lean. Everything was long-term-care-specific—something they experienced and could take back to their facilities.”

# ORGANIZING CHAOS

Asbury Heights LPN Susan Poland learned to work around the outdated forms, charts, and memos that buckled desks and draped walls at her unit's nursing station, the nexus of information and communication. But even then, she and her colleagues thought there had to be a better way to get what they needed, when they needed it.

"I knew where everything on my unit was," Poland says. "The problem was, no one else did. Our nursing stations were a disaster."

Asbury's nursing stations housed a mix of paper and electronic documentation on residents, clinical and technical procedures, and memos between nursing and other departments. Nursing stations within a unit lacked uniformity, leading staff to hunt for details on residents and procedures — oftentimes buried beneath old paperwork.

The LTC Champions at Asbury Heights recognized that transforming the nursing stations into a place where staff could find accessible, current, and standardized information would streamline care and help prevent hospital readmissions. It was time to clear the clutter.

Asbury used the "5S" (Sort, Set, Shine, Standardize, Sustain) organizational process they learned through PPC University to identify crucial "zones" of information. They categorized information as either resident-related or staff-related, and jettisoned old, unessential documents. Some pieces of information were categorized as consistent (including protocols to treat certain conditions and to obtain needed supplies and equipment), while others were variable (staff schedules and memos, and updates on residents).

The Champions developed a two-pronged strategy (for consistent versus variable information) to help nurses quickly find needed information at the stations. Treatment and supply protocols — the standardized information that shouldn't change — was placed in resource binders that will be uniform across a particular nursing unit.

"The resource binders have those essential pieces of info that nurses need — and are organized so it can be found quickly," says Betty Zawatski, a registered nurse at Asbury Heights. "It provides a framework for labs, supplies, our IV policy, and when to call the doctor. How many ccs do I need to flush out a line? It's down and dirty information they can find without having to rifle through a five-binder, 100-page policy book."

For items that change frequently, Asbury Heights has created a daily management board that includes metrics on a unit's performance, staff schedules, and notes on residents.

"It's the information everyone needs to know," says Zawatski. "Mrs. A lost her dentures. Mr. B wants to go to dinner. Who's on my shift tonight? Now, they'll know where to go."

According to Zawatski, residents at Asbury Heights are arriving "sicker and quicker." Being able to locate key information quickly helps nurses better care for more complex patients.

"Today in long-term care, it's coming at you so fast, from all angles," she says. "You have to be prepared."

"As an organization, Asbury Heights really embraced Lean concepts to improve care," JHF Quality Improvement Specialist Anneliese Perry says. "They launch these team-level improvements, then spread them across the facility. Asbury firmly believes that the point-of-care staff has to drive these improvements."





Asbury Heights used the “5S” (Sort, Set, Shine, Standardize, Sustain) organizational process they learned through PPC University to identify crucial “zones” of information. They categorized information as either resident-related or staff-related, and jettisoned old, unessential documents. Some pieces of information were categorized as consistent, while others were variable.



# A TWO-WAY CONVERSATION

Justina Vance, a nurse practitioner (NP) at Marian Manor, began her shift by making rounds and chatting with residents. She asked one resident the usual questions—How was your day? How’s therapy going? Any new pain I should know about? The resident said that she was fine. But Vance noticed her wincing and shifting uncomfortably in her chair.

“How are you *really* feeling?” she asked. The resident admitted she had been experiencing some stomach and back pain. She was waking up in the middle of the night to go to the bathroom. She didn’t really want to talk about it—it was embarrassing.

“My residents don’t always tell me when there’s a problem, but I can usually tell if something’s off,” Vance says. “She had some of the telltale signs of a urinary tract infection [UTI]. When I called the doctor and told him those symptoms, he said to get urine and send it off to the lab. I had already done that, and she was positive for a UTI. She was treated here and didn’t need to be sent to the hospital.”

Vance says that she was able to recognize the resident’s symptoms and relay pertinent information to the doctor thanks to the Condition-Specific SBAR (Situation, Background, Assessment, Recommendation) forms created by Terri Devereaux.

The SBAR, a tool of the INTERACT quality improvement program, is designed to enhance nurses’ evaluation of and documentation on residents who have an acute change in condition, and to structure and improve communication with primary care clinicians. Devereaux customized the SBAR for specific conditions that are prevalent in long term-care and that drive hospital readmissions, including UTI, congestive heart failure, lower respiratory infection, shortness of breath, acute mental status or behavior change, and dehydration.

“The biggest learning curve for NPs isn’t the clinical side—it’s communicating with physicians,” Devereaux says. “They need to know how to relay information in the way that the doctor has been taught to receive it. But no one ever teaches the nurses how to do this crucial part of their jobs.”

The SBAR for UTI, for example, is structured for nurses to collect information on symptoms (such as painful and frequent urination), onset and duration of symptoms, vital signs, change in daily activities, fluid intake, new or recent medication changes, and lab results. The condition-specific SBARs have played a role in Marian Manor’s impressive reduction in its 30-day hospital readmissions rate from 9.6 percent in November 2013 to 3 percent in January 2015, says Director of Nursing Pat Gallagher.

“We saw there were specific conditions driving hospital admissions—UTI and congestive heart failure were two of our biggest ones,” Gallagher says. “Terri came in and got our input on where some of our nurses might be missing those early warning signs to prevent that return hospital trip. The doctors weren’t confident when the nurses were calling with information, so they would automatically send them to the hospital. Now, the nurses know the warning signs and can speak the doctors’ language. The doctors feel more confident.”

“It’s a two-way conversation now,” Vance adds. “Before, we’d call and if the resident had shortness of breath, the doctor would automatically say, ‘Send them to the hospital.’ Now, it’s, ‘OK, we’ll get a chest X-ray and see what’s going on. We’ll do blood work.’ We work together.”

Vincentian Collaborative System, of which Marian Manor is a skilled nursing facility option, has taken note of nurses’ improved clinical and communication skills through the LTC Champions program, Gallagher says.

“Vincentian bought into Long Term Care Champs right away,” Gallagher says. “They felt the program has made such a difference that they’re going to invest in specific training for each one of our nurses in congestive heart failure, diabetes, and other conditions. They’ve taken a whole different view on how important that investment in education is for nurses.”

The condition-specific SBARs have played a role in Marian Manor's impressive reduction in its 30-day hospital readmissions rate from 9.6 percent in November 2013 to 3 percent in January 2015.

### Mental Status Change SBAR (includes S/S CVA)

**General Information**

Doctor \_\_\_\_\_ Resident Name \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_  
 Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_  A.M. |  P.M. Resident MRN \_\_\_\_\_ Reason for Call \_\_\_\_\_

**Vital Signs**

Temp: \_\_\_\_\_ Apical Pulse: \_\_\_\_\_  Irregular  Normal Respirations \_\_\_\_\_  Labored  Shallow  Dry  Moist  
 BP: \_\_\_\_\_ Pulse Ox: \_\_\_\_\_  Room Air  O2 [If O2, # Liters \_\_\_\_\_ via  NC  FM  Non-Rebreather]  
 Finger stick glucose (diabetics) \_\_\_\_\_ Weight:  5lb gain in the last month  5lb loss in the last month  No change

**Medical History**

Alzheimer's/Dementia  Heart Attack/MI  Congestive Heart Failure  Heart Surgery  Diabetes  Seizure  GERD  
 Chronic Kidney Disease  COPD/Asthma  High Blood Pressure  Stroke/CVA  Smoking  Anemia  TIA  
 Anticoagulant Therapy  Atrial Fibrillation  Recent Head Injury  Recent Falls  DVT  
 Swallowing Difficulties  Other \_\_\_\_\_

**Symptoms**

**Onset:**  Sudden  Gradual **Duration:** \_\_\_\_\_  Worst headache ever  Weakness/numbness/tingling of extremities  
**Cognitive changes:**  Agitated  Combative  Restless  Diff to arouse  Irritable/Grouchy  Reclusive  Slow to Respond  
 Repetitive movement  Resident/family/friends noting change in mental status **Abd Pain:**  N/A  Flank pain  Dysuria

**Physical Exam**

### Miscellaneous Changes SBAR

**General Information**

Doctor \_\_\_\_\_ Resident Name \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_  
 Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_  A.M. |  P.M. Resident MRN \_\_\_\_\_ Reason for Call \_\_\_\_\_

**Vital Signs**

Temp: \_\_\_\_\_ Apical Pulse: \_\_\_\_\_  Irregular  Normal Respirations \_\_\_\_\_  Labored  Shallow  Dry  Moist  
 BP: \_\_\_\_\_ Pulse Ox: \_\_\_\_\_  Room Air  O2 [If O2, # Liters \_\_\_\_\_ via  NC  FM  Non-Rebreather]  
 Finger stick glucose (diabetics) \_\_\_\_\_ Weight:  5lb gain in the last month  5lb loss in the last month  No change

**Medical History**

Congestive Heart Failure  Heart Attack/MI  Heart Surgery  Head Injury  Diabetes  DVT  
 Chronic Kidney Disease  COPD/Asthma  High Blood Pressure  Seizures  Stroke/CVA  GERD  
 Anticoagulant Therapy  Hemodialysis  Recent Fall(s)  Cancer  Anemia  
 Swallowing Difficulties  Atrial Fibrillation  Alzheimer's/Dementia  Other \_\_\_\_\_

**Symptoms**

Resident/family concerns: \_\_\_\_\_  
 Resident complaints: \_\_\_\_\_

**Physical Exam**

**Clinical Appearance:**  No acute distress  Distress [ Mild  Moderate  Severe]  
**Activity:**  Per usual  Other \_\_\_\_\_  
**Cognition:**  Per usual  Other \_\_\_\_\_  
**Appetite:**  Per usual  Other \_\_\_\_\_  
**Cardiac Exam:**  RRR/Per Baseline  Other \_\_\_\_\_  
**Lungs:**  Clear Bilaterally/Per Baseline  Other \_\_\_\_\_  
**Abdomen:**  BS Per Baseline  Other \_\_\_\_\_  
**Skin:**  WNL  Other \_\_\_\_\_  
**Extremities:**  Per Baseline  Other \_\_\_\_\_  
**PO Intake:**  Per Usual  Other \_\_\_\_\_

**Allergies**

**Most Recent Labs and Diagnostic**

BMP \_\_\_\_\_  CMP \_\_\_\_\_  CBC w/diff \_\_\_\_\_  CXR \_\_\_\_\_  U/A \_\_\_\_\_  U/A C&S \_\_\_\_\_  UA to Reflux \_\_\_\_\_  
 DATE DATE DATE DATE DATE DATE DATE

**POLST**

Full Code  DNR  Limited  CMO  Do not transfer

**Comments**

\_\_\_\_\_  
 \_\_\_\_\_

# LOOKING AT THE WHOLE PICTURE

Long-term-care residents, many of whom have limited mobility and multiple chronic health issues, are at an increased risk of developing pressure ulcers. Also called “bed sores,” these open wounds on the skin may lead to infection, pain, and diminished quality of life, and they present expensive problems for skilled nursing home facilities, both in terms of treatment for wound care and lawsuits.

After seeing a spike in their pressure ulcer rate, the staff at Presbyterian SeniorCare Southmont was determined to ensure that every nurse knew the skin pressure-relieving techniques that stave off bed sores and understood how to properly use every item coming into contact with residents, from lotions to linens to beds.

In 2013, PSC Southmont’s pressure ulcer rate was below the national average of 4.2 percent, says Director of Nursing Betsy Openbrier, RN. But it began climbing in January 2014 and reached 8.4 percent by the first week of February.

“We weren’t really sure what happened — we didn’t really change anything that we could see,” Openbrier says. “So we went back to square one and did a Plan-Do-Study-Act cycle.”

Openbrier huddled with the nursing staff to review their stats and discuss how they could prevent wounds. They observed their current process for documenting and treating wounds, discovering that the presence of wounds weren’t always captured when new residents were admitted. Some staff was not comfortable using newly ordered skin products, which keep residents’ skin from sticking to bed sheets and help prevent friction that can lead to the development of bed sores. Others were looking for more guidance on the Braden Scale, an assessment tool that gauges a resident’s risk for developing pressure ulcers.

“Based on their feedback, we did extensive education sessions,” Openbrier says. “We focused on healthy wound care, pressure points, and steps to promote good skin health. We reviewed all of our products to make sure

people knew exactly what they were using, and why they were using it. We even had our bed company come in and hold a demonstration on proper inflation of the mattresses, and best practices for distributing and relieving pressure.”

PSC Southmont also implemented Stop & Watch forms (see page 37) on all units and held an in-service on the Braden Scale so that nurses could better identify residents at risk for pressure ulcers. Residents who often require assistance getting in and out of bed, for instance, may rub against sheets and surfaces that cause friction on the skin. Furthermore, a wound care nurse was assigned to identify any wounds present when a resident is admitted. The wound care nurse makes sure that at-risk residents receive pressure-relieving measures, such as frequently being re-positioned in bed to promote blood flow.

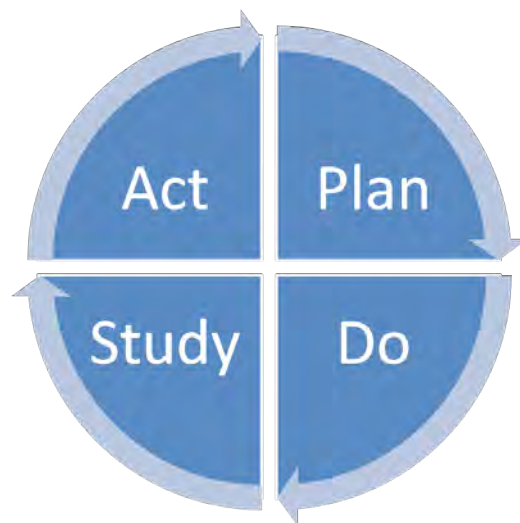
By the spring of 2014, PSC Southmont reduced its in-house pressure ulcer rate to just three percent and has maintained that low rate as of the publication of this document. PSC Southmont accomplished that through a data-driven, evidence-based approach that now permeates the facility, says unit manager Rachael Sholtis, RN.

“The Long Term Care Champions program has given us a lot of tools to take care of residents in a formalized manner,” Sholtis says. “Before, it was pretty much left up to the individual nurse. Now, we look at the whole picture of the resident. Everybody’s doing the same thing, the same way.”

Renowned statistician W. Edwards Deming developed the PDSA model to test and refine a proposed improvement by trialing the change, assessing its impact, and refining the change until satisfied. LTC Champions learned about the PDSA model during Perfecting Patient Care<sup>SM</sup> University training.

**“We weren’t really sure what happened — we didn’t really change anything that we could see, so we went back to square one and did a Plan-Do-Study-Act cycle.”**

— Betsy Openbrier, RN, director of nursing at Presbyterian SeniorCare Southmont



**PLAN-DO-STUDY-ACT (PDSA)**

The four stages of the PDSA cycle are:

**Plan:** Define the change to be tested and create an action plan to implement and monitor it

**Do:** Implement the change and collect data on its impact

**Study:** Evaluate the effect of the change

**Act:** Plan the next change cycle to improve the process, if necessary, or standardize the process and implement the change

“

**The *Stop and Watch* tool provided me with a lot of data so that I could assess the resident more thoroughly, and then get that information to the physician. Then, we could collaborate and develop a plan of care. It helps our facility catch early changes in residents and provide treatment before a resident's condition would worsen enough to require a hospital transfer. We're treating more residents in-house, and physicians are recognizing our assessment skills. It's a morale booster.**

— Kim Haigy, RN and resident care coordinator at Kane Regional Center - McKeesport

”

The *Stop and Watch* Early Warning Tool is a communication tool in the INTERACT quality improvement toolkit. It is used by health-care workers to relay a non-emergent change in a resident's condition; is instrumental in guiding staff in observation, action, and followup; and provides a clear visual on resident concerns for myriad staff involved in resident care.

## Stop and Watch Early Warning Tool



If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

- |  |  |
|--|--|
| S<br>T<br>O<br>P<br><br>a<br>n<br>d<br><br>W<br>A<br>T<br>C<br>H | Seems different than usual                                 |
|  | Talks or communicates less                                 |
|  | Overall needs more help                                    |
|  | Pain – new or worsening; Participated less in activities   |
|  | Ate less   |
|  | No bowel movement in 3 days; or diarrhea                   |
|  | Drank less   |
|  | Weight change  |
|  | Agitated or nervous more than usual                        |
|  | Tired, weak, confused, or drowsy                           |
|  | Change in skin color or condition                          |
|  | Help with walking, transferring, toileting more than usual |

Check here if no change noted while monitoring high risk patient

\_\_\_\_\_  
*Patient / Resident*

\_\_\_\_\_  
*Your Name*

\_\_\_\_\_  
*Reported to*

\_\_\_\_\_  
*Date and Time (am/pm)*

\_\_\_\_\_  
*Nurse Response*

\_\_\_\_\_  
*Date and Time (am/pm)*

\_\_\_\_\_  
*Nurse's Name*

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## HEALTHCARE QUALITY IMPROVEMENT TOOLS

Quality improvement (QI) consists of systematic and continuous actions that lead to measurable improvement in health care and the health status of specific patient groups. To make improvements, an organization needs to understand its own systems and processes and then design and implement strategies that provide improved outcomes.

A number of important tools exist to help organizations vested in healthcare quality improvement. In our work, JHF utilizes PRHI's Perfecting Patient Care and Tomorrow's Healthcare™, electronic health records, INTERACT, and the Advancing Excellence in America's Nursing Homes program.

All LTC Champions and RAVEN participants received PPC quality improvement training and also training in some or all of the other tools, depending on their site-specific needs.

### Perfecting Patient Care<sup>SM</sup> Provides Foundation for Quality Improvement

The Perfecting Patient Care (PPC) methodology was developed by JHF's Pittsburgh Regional Health Initiative. It is based on Lean concepts and Toyota Production System's industrial engineering techniques.

PPC is delivered in a variety of ways—from 1-, 2- and 4-day classroom-based “universities,” to onsite coaching, webinars, videos, and articles. These courses offer participants a thorough introduction to the core concepts and principles of PPC in a variety of learning formats.

PRHI's trainers, all of whom have extensive healthcare backgrounds, bring a wealth of experience in Lean and the nuances of the healthcare environment that impact the application of Lean methods to organizational transformation. They bring with them to the classroom their experience with implementing PPC in the field. They have supported healthcare institutions in applying Lean methodology to an array of challenges, including:

- Reducing avoidable hospital readmissions
- Eliminating central line-associated blood stream infections (CLABIs)
- Improving efficiency and reducing errors in pathology
- Improving access and reducing wait times for appointments
- Implementing the Patient-Centered Medical Home (PMCH) model
- Redesigning workflows to integrate behavioral health services into primary care
- Reducing disparities in care for underserved populations

Through multiple learning formats including lecture, videos, and hands-on activities participants are exposed to the philosophy and tools of PPC, including the approach to problem solving, kaizen (continuous improvement), visual management, observation and process and value stream mapping. Participants are given the opportunity to practice skills and apply concepts in the classroom settings, preparing them to take lessons learned back to their places of work and apply them right away to improvement opportunities. Continuing Nursing Education (CNE) and Continuing Medical Education (CME) credits are available for participants who complete the entire four-day program.



(L-R) Quality Improvement Specialists Anneliese Perry and Stacie Bonenberger, MOT, and Senior Quality Improvement Specialist Terri Devereaux, MPM, FNP-BC





### **Tomorrow's HealthCare™ Sparks Virtual Learning, QI opportunities in Long-Term Care**

The LTC Champions continue to learn and share best practices through Tomorrow's HealthCare™, the Foundation's web-based knowledge and communications network. THC features a long-term-care-specific learning library with resources that include education modules, handouts, videos, podcasts, and websites. If an LTC Champion wants to learn more about preventing infections, detecting the signs of heart failure, or starting advance care planning discussions, for example, they can access THC's evidence-based information on demand. The Champions can also discover how colleagues handle challenging situations and share success stories through a Long Term Care Champions community section, which allows them to create discussion threads and upload documents, videos, and photos.

As lead educator in the RAVEN initiative, JHF has also created a virtual learning, quality improvement, and partnership platform on Tomorrow's HealthCare™ for the 19 long-term-care facilities participating in RAVEN.

"We created a community of healthcare problem-solvers during the Long Term Care Champions program, and we want that community to remain vibrant long after the program ends," says JHF Quality Improvement Specialist Stacie Bonenberger, MOT. "Tomorrow's HealthCare™ is the connecting factor that enables quality improvement work begun during the Champions program to continue, and is catalyzing QI in the RAVEN initiative as well."

### **Bringing EHRs to LTC: 'It helps you put the pieces together'**

When a patient is discharged from the hospital to the nursing home, a deluge of paperwork follows. Up to 30 sheets of patient materials, from admitting documents to discharge charts to medication lists, are faxed to the nursing home. Nursing home staff then re-copy information and call the hospital for additional details on X-ray and lab results, among other items.

The process isn't just redundant, says PRHI Chief Learning and Medical Informatics Officer Bruce Block, MD. It's also potentially deadly.

"There are all of these care transition points, and connections between workers at different levels are poor," Block says. "When workers encounter discrepancies, they're expected to get that information to the right person, at the right time, despite all of the



Toya Sanders, RN, enters patient information into the JAA's electronic health record system. The REACH team from JHF's Pittsburgh Regional Health Initiative helped the JAA select, install, optimize, and understand how to use the electronic health record system to manage patient data and coordinate and improve care.

## A3 Thinking

During PPC training, participants are introduced to the A3, a Lean tool that provides a structured problem-solving approach built around PDSA (Plan-Do-Study-Act). The A3 forces workers to systematically look at a problem, determine its root cause, devise a solution, and test that solution to ensure that it solves the problem. It is also a very useful communications tool.

### Identify the problem

- What is a problem?
- Where do we find problems?
- Define problems

### Understand the current condition

- Observations
- Process mapping
- Baseline data collection and analysis
- Root cause analysis

### Create a target condition

- Countermeasures and hypothesis
- Rules of work design and standard work
- Lean tools (visual management, push vs. pull systems, mistake proofing)

### Implement and monitor the target condition

- Action plans
- Data collection and analysis
- Followup

other demands placed upon them. The potential for mistakes is huge. With electronic health records (EHRs), it's much easier to see where the problems are and to flag abnormal results.”

The Foundation always intended to give the LTC Champions a primer on improving communication and delivering safer, streamlined care across settings by trading in piles of paper for EHRs. But during the Champions program, Dr. David Kelley, chief medical officer of the PA Department of Human Services, reached out to JHF with a special opportunity to pilot more expansive EHR assistance to skilled nursing facilities. The yearlong eHealth Pod Pilot Project, sponsored by the Pennsylvania Department of Human Services and managed by JHF COO and Chief Program Officer Nancy Zions, helped nursing homes implement and activate Continuity of Care Documents (CCDs). CCDs offer providers quick access to a patient's most pressing health information, such as chronic health conditions, allergies, and immunization history.

Dr. Kelley contacted JHF because of its track record of improving care in nursing homes and providing technical assistance with health information technology. As a regional contractor for the Office of the National Coordinator for Health Information Technology (ONC-HIT) since 2010, PRHI has provided subsidized EHR implementation

and optimization support to physicians' practices in western Pennsylvania. Originally, ONC-HIT funds could be used only in primary care settings. But not long after the eHealth Pod Pilot Project, another opportunity arose: ONC-HIT expanded its program beyond doctors' offices, allowing PRHI to make its services more broadly available in long-term care—including at Asbury Heights, the Jewish Association on Aging (JAA), and Presbyterian SeniorCare Southmont.

Block and Sheila Kruman, an EHR implementation specialist with PRHI, followed the JAA through its entire electronic journey—identifying workplace needs, studying how other facilities in the region use EHRs, meeting with vendors for product demonstrations, selecting the right product, implementing the EHR, and redesigning workflows to maximize the potential of the system to improve patient care. The process began with JAA gathering staff to evaluate, step by step, how they complete everyday tasks.

“We would hold up a form and ask, ‘How do you use this?’ and there would be six or seven processes for that one form,” says JAA President and CEO Deborah Winn-Horvitz. “It gave us the opportunity to hear from the people who live this work and identify ways to do it more efficiently.”

Without frontline input, EHRs lose their potential to help facilities eliminate duplication and deliver higher-quality care, Block notes. Organizations must be willing to embrace a culture in which what happens at the care level drives C-suite decisions.

“You can’t build a system without staff clarifying what their work is,” Block says. “They are vital to the organization because they’re producing the data and making the connections between their work and the next level. It requires meetings with people who are usually excluded from meetings. The whole idea is that the workers define quality in the system.”

JAA and other LTC Champions sites embraced a frontline-first culture, setting aside protected time for unit and service directors, and providing ongoing EHR training for staff.

“At first, we thought staff would be upset about having to devote time out of their day to get this running,” Winn-Horvitz says. “But the discovery was very important. Now, EHRs standardize our work. This frees up time for staff and streamlines how they do their jobs.”

EHRs improve communication outside of the nursing home walls, too. At Presbyterian SeniorCare Southmont, nursing documentation, vitals, and Medication Administration Records are electronic. The facility has linked its electronic records with Washington Hospital, one of its major referral sources.

“That’s something we utilize,” says Betsy Openbrier, RN, director of nursing at Presbyterian SeniorCare Southmont. “We can quickly look at medical records before a patient comes in. And for our own residents who are in the hospital and have lab work or tests done, we can review those results in our building. The EHRs give you context and keep you up to date on changes, especially to medication. It helps you put the pieces together.”

The year-long **eHealth Pod Pilot Project**, sponsored by the Pennsylvania Department of Human Services and managed by JHF COO and Chief Programming Officer Nancy Zions, helped nursing homes implement and activate Continuity of Care Documents (CCDs). CCDs offer providers quick access to a patient’s most pressing health information, such as chronic health conditions, allergies, and immunization history.

The different INTERACT tools are meant to be used together in the daily work of SNFs. More information about INTERACT can be found on their website: <https://interact.fau.edu/index.aspx>.

### **INTERACT (Interventions to Reduce Acute Care Transfers)**

To help nursing home staff provide the level of care necessary to prevent avoidable hospital readmissions, JHF trained the LTC Champions in INTERACT, a publicly available quality improvement program. INTERACT is designed to improve the care of nursing home residents by identifying, assessing, documenting, and communicating changes in long-term-care residents' health status at the earliest possible stage, and by working together to manage these situations effectively and safely, resulting in fewer potentially avoidable acute care hospital transfers as well as more rapid transfer of residents determined to be in need of hospitalization.

Two of JHF's quality improvement coaches on the LTC Champions project attended training to become certified INTERACT trainers.

Throughout the LTC Champions program, JHF worked with facilities as they put INTERACT tools into everyday use.

#### *Communication Tools*

INTERACT offers a number of communications tools. JHF provided training on two of these tools—the STOP and WATCH early warning tool and SBAR (Situation, Background, Assessment, Recommendation)—which are used to improve communication within facilities.

#### *Decision Support Tools*

*Change in Condition File Cards* help nursing staff determine whether to report specific signs, symptoms, and lab results immediately.

The *Care Paths* are educational decision support tools that offer guidance on recognizing, evaluating, and managing nine conditions that often lead to hospital transfers in long-term care: acute change in mental status; new or worsening behavioral symptoms; dehydration; fever; gastrointestinal symptoms such as nausea, vomiting, and bleeding; shortness of breath; congestive heart failure; lower respiratory illness; and urinary tract infection.

#### *Advance Care Planning Tools*

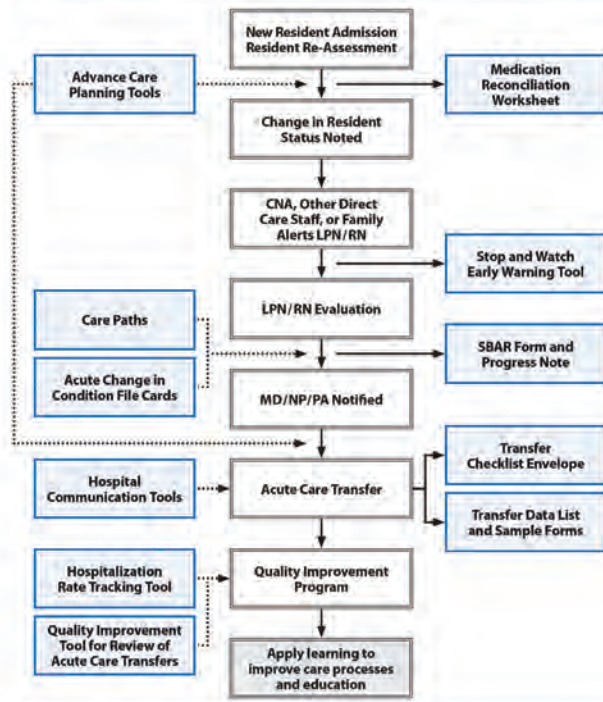
In long-term care, residents may become incapacitated due to physical or mental illness and become unable to express their treatment preferences. Advance care planning works to ensure that patient and family treatment preferences are known and honored. The *INTERACT Advance Care Planning Tools* helped LTC Champions communicate with families and residents on advance care planning, track these discussions, and identify residents who may be appropriate for palliative care or hospice.

The *INTERACT Advance Care Planning Tools* complemented JHF's *Closure* sessions at the Jewish Association on Aging and Asbury Heights, and during clinical skills learning sessions open to all participating sites.

#### *Quality Improvement Tools*

The *Acute Care Transfer Log Worksheet* provides a way to record all acute care transfers during a month.

## Using the INTERACT Tools In Every Day Care



## INTERACT

INTERACT (**I**nterventions to **R**educe **A**cute **C**are **T**ransfers) was initially developed by a team led by Joseph G. Ouslander, MD, and Mary Perloe, MS, GNP, at the Georgia Medical Care Foundation, with support from the Centers for Medicare and Medicaid.

To effectively and sustainably implement the INTERACT tools, Ouslander notes that there must be buy-in from medical directors and primary clinicians in nursing home settings. Ouslander describes five fundamental strategies necessary for implementation:

1. Principles of quality improvement, including implementation by a team facilitated by a designated champion and strong leadership support; measurement, tracking, and benchmarking of clearly defined outcomes with feedback to all staff; and root cause analyses of hospitalizations with continuous learning and improvement based on them.
2. Early identification and evaluation of changes in condition before they become severe enough to require hospital transfer.
3. Management of common changes in condition when safe and feasible without hospital transfer.
4. Improved advance care planning and use of palliative or hospice care when appropriate at the choice of the resident (or their health care proxy) as an alternative to hospitalization.
5. Improved communication and documentation both within the nursing home, between the nursing home staff and families, and between the nursing home and the hospital.

Source: Ouslander, J; Bonner, A; Herndon, L; Shutes, J. "The Interventions to Reduce Acute Care Transfers (INTERACT) Quality Improvement Program: An Overview for Medical Directors and Primary Care Clinicians in Long Term Care." *JAMDA* 15 (2014) 162-170.

The *Hospitalization Rate Tracking Tool* allows staff to enter transfer data directly into a spreadsheet that calculates rates and generates reports. This tool enables nursing homes to track data on hospital transfers, hospitalizations, and hospital readmissions over time. The data can be used to set facility goals, report data to hospital partners, and benchmark the facility's rates against those of other facilities locally, regionally, or nationally.

The *Quality Improvement Tool for Review of Acute Care Transfers* enables facilities to better understand factors that contribute to transfers and identify quality improvement and educational opportunities.

### **Advancing Excellence in Action**

The Affordable Care Act of 2010 requires nursing homes to have acceptable Quality Assurance Performance Improvement (QAPI) plans in place within one year after a final regulation is issued. As of the publication of this *ROOTS*, CMS does not yet have a timeline for publication of the final QAPI regulation. It has, however, developed a program of technical assistance that includes tools and resources for implementing a QAPI program.

Advancing Excellence (AE) in America's Nursing Homes is a program developed by a coalition of 28 organizations. Supported by CMS, the Commonwealth Fund, and others, it provides a number of resources to help nursing homes to improve care in clinical and organizational areas. Advancing Excellence is one of the many tools available in the public domain that CMS recommends for helping nursing homes implement QAPI.

Advancing Excellence has selected nine goals and developed new resources to help nursing homes begin quality improvement projects. These goals include person-centered care, staff stability, and managing changes in a resident's condition to avoid preventable hospitalizations. Their "Circle of Success" provides a step-by-step framework to guide staff through quality improvement projects.

Several of the LTC Champions facilities currently use the AE Safely Reduce Hospitalization Tracking Tool. This tool is similar to the INTERACT Hospitalization Rate Tracking Tool, with the addition of process tracking and documentation of the primary contributing reasons for transfers. The AE Hospitalization Worksheet provides a place to collect information used to complete the tool.

SNF residents are often sent to the hospital when they get sick or have a change in condition. Emergency room visits and hospitalizations can cause numerous other complications for SNF residents, so if a resident can be safely and effectively cared for without going to the hospital, this is preferable from both a cost and a quality perspective.

If staff is well-prepared, they may be able to provide the appropriate care without taking a resident to the hospital. The AE Safely Reduce Hospitalization Tracking Tool helps facilities to review situations that commonly result in transfers so they can identify opportunities to improve the identification, evaluation, and handling of changes in resident conditions that resulted in the transfers in order to reduce future preventable transfers.



“

**Before we started using Advancing Excellence (AE), we just hand-tracked hospital transfers — raw numbers, basically. AE got us on track to be data-driven and problem-solvers. We presented our data to the hospital and they were impressed because we had not just the number of people who returned to the hospital, but also why they returned. For instance, we ran the numbers in the first quarter of 2014 and found that eight people were readmitted because of gastrointestinal bleeds within 48 hours of discharge. They were able to use that data to problem-solve on their end. It was a win-win for both of us.**

— Betsy Openbrier, RN, director of nursing at  
Presbyterian SeniorCare Southmont

”





By engaging patients and families, established and emerging medical professionals across the care continuum, and neighborhoods at large, the Foundation has demonstrated a commitment to bringing end-of-life issues out of the shadows.

## CHANGING EXPECTATIONS FOR CARE AT END OF LIFE

End-of-life treatment in the United States too often fails to honor patients' and families' care goals. Seniors and their loved ones may delay uncomfortable conversations about what matters most upon the diagnosis of a life-limiting illness until a crisis arises. Healthcare professionals, rarely trained in palliative care and advance planning, and immersed in a culture where death is sometimes tantamount to a medical failure, aren't always prepared to initiate end-of-life discussions. The silence—from families, clinicians, and the community—serves no one.

In collaboration with many local, regional, and national partners, JHF has issued a clarion call to raise expectations at the end of life. By engaging patients and families, established and emerging medical professionals across the care continuum, and neighborhoods at large, the Foundation has demonstrated a commitment to bringing end-of-life issues out of the shadows.

“We want to normalize end-of-life conversations, and accomplishing that goal requires both systems change and culture change,” says JHF COO and Chief Program Officer Nancy Zionts. “Through education, outreach, and advocacy, we’re focused on providing all stakeholders with the tools to engage in meaningful dialogue about goals of care. Ultimately, it’s about empowering patients and families to make informed decisions about what’s best for them.”



JHF's *Closure* program is a six-module learning, community-organizing, and planning forum to help organizations set up end-of-life care appropriate for their particular community. Its goal is to redefine quality care for people with life-threatening illness by raising expectations and empowering them to seek a healthcare experience that aligns with their values, beliefs, and wishes, as well as their health status.

## BRINGING CLOSURE TO RESIDENTS, LOVED ONES

Nicole Morgan knew the resident and her doting son well. The elderly woman experienced several stays at the Charles M. Morris Nursing and Rehabilitation Center, where Morgan serves as director of social services. The woman's condition was rapidly deteriorating. She had recently suffered multiple severe strokes, leaving her bedridden.

Morgan and the resident's care team at Charles Morris, part of the continuum of health and social services available to residents at the Jewish Association on Aging (JAA), talked about this moment with the woman and her son months before. They discussed her goals of care and documented her treatment preferences on a Pennsylvania Orders for Life-Sustaining Treatment (POLST) form. They asked an uncomfortable—but crucial—question: What would she want her end of life to look like?

"The son always told me, 'Mom wants to be at home. I'll do whatever it takes to make that happen,'" Morgan recalls. "So we made it happen."

Morgan coordinated with JAA's Sivitz Hospice program to set up education sessions for the son, who would be his mother's primary caregiver. He spent a week learning about in-home hospice care, sleeping on a couch overnight at Charles Morris on several occasions.

"We were supervising and educating, but he actually did the care himself," Morgan says. "Once he felt comfortable, he took his mother home. She passed away with her son, like she wanted. It was very peaceful."

It's never easy talking to families and residents about how the resident wants to live out the time he or she has left. Nevertheless, the JHF *Closure* program is designed to help make that conversation easier. Participating in a *Closure* series at the JAA reinforced the importance of honoring residents' and families' end-of-life treatment preferences, Morgan says.

Launched by JHF in 2007, *Closure* is an education, planning, and outreach program that gathers community stakeholders in an effort to raise expectations for end-of-life care. Staff at the JAA participated in the six-part *Closure* Community Conversation series as a part of the LTC Champions program, discussing personal experiences with death and dying, learning about residents' cultural and spiritual values, and developing an action plan to improve end-of-life care.

JHF consultants Jonathan Weinkle, MD, and Tamara Sacks, MD, facilitated the sessions, along with Pearl B. Moore, RN, MN, former chief executive officer of the Oncology Nursing Society, Health Careers Futures board member, and LTC Champions advisor. LTC Champions at Asbury also took part in *Closure* sessions at their facility during the LTC Champions program.

"I had a wonderful experience with *Closure*," Morgan says. "I appreciated the variety of perspectives from the varied participants in the *Closure* sessions. There were community members, doctors, hospice, families, and lawyers. It was eye-opening to hear the range of experiences with dying, from someone passing after enduring

# COALITION FOR QUALITY AT END OF LIFE (CQEL)

JHF helped establish and continues to steer the Coalition for Quality at End of Life, which aligns healthcare systems, hospices, providers, payers, community groups, government, and philanthropic and faith-based organizations behind the shared goal of ensuring that individuals and their families experience end of life as they see fit.

Over the course of its history, CQEL has established working groups to create patient-centered end-of-life demonstration projects; increase the documentation of treatment preferences; engage underserved communities; bolster professional education on end-of-life and palliative care; and carry out public awareness/education campaigns. JHF has collaborated with CQEL on a variety of initiatives to improve end-of-life care, including:

- Championing the implementation and widespread use of Pennsylvania Orders for Life-Sustaining Treatment (POLST)
- Advocating for increased access to palliative care
- Exploring the legal, cultural, and spiritual considerations surrounding end-of-life care in *The Last Chapter*, an hour-long documentary funded by JHF and produced by WQED-TV
- Convening a statewide conference on *Closure* for healthcare professionals, clergy, social service workers, and consumers

Nancy Zionts chairs CQEL, which she founded along with LTC Champions advisory board member Bob Arnold, MD, the Leo H. Crip chair in Patient Care, and medical director, UPMC Palliative and Supportive Institute; and Judith Black, MD, MHA, retired medical director of senior markets for Highmark Inc.

CQEL includes nearly 40 member organizations, including clergy, attorneys, healthcare professionals, aging and policy experts, and consumers. The group meets quarterly to share best practices and advance our region's agenda on palliative care and end-of-life treatment.



Bob Arnold, MD (third from left) and Judith Black, MD (fourth from right) were two of the cofounders of Coalition for Quality at End of Life.



Pearl Moore, RN, MN, FAAN, former CEO, Oncology Nursing Society; Jonathan Weinkle, MD, Squirrel Hill Health Center; Myles Zuckerman, MD, Physician, Family Hospice; and JHF consultant Tamara Sacks, MD, participate in a *Closure* session at the JAA

complicated, aggressive medical treatment to a very peaceful passing. Discussing that whole spectrum showed how we can improve as caregivers and stress quality of care, not quantity of care.”

During *Closure*, JAA staff expressed the difficulty associated with initiating conversations about end-of-life choices with families grieving for a loved one whom they don’t want to let go. One community member, whose husband had recently been under hospice care for an end-stage disease, addressed those concerns in a way that proved cathartic for Morgan and others at JAA.

“She told me it’s OK to tell the truth—that her husband is going to die, and here’s how we can make him comfortable and give him a good quality of life,” Morgan says. “She said that being direct and honest is ultimately what helps her most. Learning to compassionately convey truthful information—that’s what I took away from *Closure*.”

Unfortunately, families and long-term-care professionals don’t always have such candid conversations about care goals. Only 65 percent of nursing home residents have an advance care directive on record, according to a 2011 National Center for Health Statistics Data Brief. Patients without such documented care preferences risk receiving painful, unnecessary, and costly treatments that diminish quality of life without necessarily extending life.

From *Closure*, the JAA recognized the need to focus on pre-planning—talking with residents and families ahead of time to understand what they want and to bring those preferences to fruition.

“We’re educating residents and families,” Morgan says. “Do they want to be resuscitated? Do they want CPR or intubation, knowing how aggressive the treatment can be? We’re connecting the dots from a new admission to get the right code status in place with the physician.”

“A September 2014 report released by the Institute of Medicine (IOM), *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*<sup>9</sup>, validates JHF’s focus on end of life.

“To align end-of-life care with patients’ and families’ wishes, the IOM committee recommends a “life cycle model” in which patients regularly engage in advance care planning conversations

with their doctor. The committee also calls for medical schools, professional societies, and accrediting organizations to increase all clinicians’ knowledge of palliative care, for increased caregiver support, and for payment overhaul that promotes greater care coordination with medical and social services.

“Through our *Closure* initiative, the Foundation has been facilitating meaningful

conversations since 2007—at a community and an individual level—about what matters most at the end of life. The IOM’s recommendations further *Closure*’s goals of making conversations about end-of-life wishes an important and commonplace part of life, and giving patients and families the power to decide what’s best for them.”

*Nancy Zions, JHF COO and Chief Program Officer*

“Long-term care is the best setting for these types of conversations,” Dr. Weinkle says. “Staff knows residents and their loved ones well, and can initiate these talks without the family feeling like they’re being bullied into withdrawing care, which is never the idea. It all centers on the resident’s and his or her family’s goals.”

Although you do not have to be Jewish to use JAA services, many residents are. The *Closure* sessions helped the JAA’s mostly non-Jewish staff understand the spiritual and cultural perspectives that inform residents’ and families’ treatment wishes.

The JAA’s Director of Pastoral Care, Rabbi Eli Seidman, discussed different branches of Judaism and customs. Staff learned, for example, that it’s important to know that when someone Jewish dies, they are not to be left alone, or be touched or washed by anyone other than burial society members.

According to Winn-Horvitz, “*Closure* increased our staff’s comfort in broaching end-of-life subjects—they know where residents and families are coming from.”

Based on feedback during the *Closure* series, the JAA created an action plan to improve communication on end-of-life issues and provide staff with a means of coping with their own feelings of loss when a resident passes.

“Staff is in a particularly sensitive position,” says JAA Care Navigator Nadine Kruman, MSW, LSW. “We have the inside track to what’s medically occurring and what the family is experiencing on two levels: cognitively and emotionally. It’s our obligation and responsibility to help both patients and families so that they are comfortable in their understanding of the resident’s decline and, therefore, are able to deal with their grief, concern, and outcome events.

“There should be no surprises, as it is typically a process involved in someone’s decline and eventual death. Everyone deals with death and grief differently, and it is our professional ability that permits loved ones to handle this life experience in a way that is right for them. Just as important, staff—who typically develop strong relationships with the residents for whom we care—need to be able to express our loss of a resident with whom we have an attachment. We all have learned to respect individual customs for grieving and loss.”

Talking about once-taboo topics means that more families can have the sort of meaningful end-of-life experience that the elderly mother and son enjoyed, Morgan says.

“I think everyone who works with the geriatric population should go through *Closure*,” Morgan says. “It gave me the confidence to initiate these conversations so the resident had the best outcome possible.”



*Death & Dying: The Elephant in the Room.* One session of the fellowship was held at the Good Grief Center, where fellows toured the facility and then engaged in conversation about caregivers’ and family members’ experiences with death, dying, and grief with Tony Turo, Executive Director, Ursuline Support Services; Diana M. Hardy, MSCP NCC, LPC, Director, Clinical Instructor, Adjunct Faculty, Good Grief Center for Bereavement Support; Rabbi Ron Symons, Director of Lifelong Learning and Director of Tikkun Olam, Center for Jewish Social Justice, Temple Sinai; Nina Butler, EdD, Consultant, Jewish Healthcare Foundation; and Robert Ferguson, Program Manager, JHF.

For more information on POLST, please visit the *Closure* website (<http://closure.org/for-the-healthcare-professional/polst>) or contact PA POLST Coordinator Marian Kemp at [papolst@verizon.net](mailto:papolst@verizon.net).

## CQEL TAKES A LEAD IN POLST PARADIGM

Seriously ill patients and their loved ones can ensure that their care preferences are honored during the last few months of life by completing a Pennsylvania Orders for Life-Sustaining Treatment (POLST) form. POLST forms summarize a patient's care preferences in clear, actionable medical orders that transfer across care settings.

A 2011 study of nursing facilities in Oregon, Wisconsin, and West Virginia found that residents who had completed a POLST form received treatment consistent with their stated care preferences 94 percent of the time. Ensuring that those preferences are met requires medical professionals, accustomed to relaying clinical information, to engage in active listening, notes Judith Black, MD, MHA, now-retired medical director for senior markets at Highmark and a member of CQEL's steering committee.

"You want to hear from patients and their loved ones—what matters to them, what makes life worth living," Dr. Black says. "The conversation should be at least 70 percent of the patient and family talking, and the health professional 30 percent. With most medical conversations, it's the opposite."

POLST is recommended for people who have an advanced chronic illness, those who may pass away in the next year, and elderly individuals looking to more clearly define preferences for treatments that include cardiopulmonary resuscitation, intubation, mechanical ventilation, IV fluids, antibiotics, and artificial hydration and nutrition. The form, required to be copied on bright pink paper to stand out in an emergency, is completed by a healthcare professional based on goals-of-care conversations between medical providers and patients.

JHF and the Coalition for Quality at End of Life (CQEL) played a pivotal role in gaining support for POLST, which was accepted for use in Pennsylvania in 2010. JHF also serves as the statewide coordinator for POLST, providing education and resources to help patients, families, and healthcare providers turn care preferences into medical orders.

Central to those efforts is the PA POLST train-the-trainer course, which has engaged more than 450 individuals from across the state in online and in-person education.

The course is offered through Tomorrow's HealthCare™. It provides an overview of POLST; outlines differences between POLST, advance directives, and living wills; and shows providers how to engage in effective goals-of-care conversations. There is also a mandatory in-person training component during which participants take on the perspective of a patient, family member, or provider while working through role-playing exercises. Real-life case studies also allow participants to discuss how they would approach various scenarios, such as updating a POLST form with a patient who has recently experienced a significant change in medical condition.

"Through the train-the-trainer course, we equip people who will engage in goals-of-care conversations with tools and information that they can take back to their organizations and communities," says PA POLST Coordinator Marian Kemp, RN. "They



*Closure* participants represent a natural network of stakeholders who can directly improve end-of-life care. *Closure* participants may include doctors, nurses, caregivers, hospice workers, clergy, lawyers, financial planners, social workers, long-term care professionals, and others engaged in the end-of-life continuum. Through a series of five facilitated sessions (like one pictured here), participants share collective experiences, expertise, and passion to develop a specific, actionable community agenda to advance end-of-life care in neighborhoods, skilled nursing facilities, hospitals, or other healthcare setting.

can become POLST champions within their facilities, assuring that patients and families have the resources and support to make decisions consistent with their values.”

UPMC CRNP Kerri Last became a POLST champion after completing the train-the-trainer course in the summer of 2014. She later performed an in-service on POLST for nursing and administrative staff at Oakwood Heights, which hadn’t previously implemented POLST. Participating in the course allowed Last, a former acute-care provider, to more comfortably explore the meaning of various intervention options with residents and families.

“We had a resident who had been full code since arriving at Oakwood Heights, and he became ill,” Last recalls. “As part of his treatment plan, we contacted the family, sat down, and discussed preferences for end-of-life care. We talked about what it means to have CPR, and the follow-up care that includes intubation and ventilation. It turns out, the resident and family didn’t want that level of intervention. Through POLST, we’re able to facilitate conversations about a resident’s disease state and their desires. Ultimately, that results in a higher quality of care and quality of life for residents.”

In February 2015, Dr. Black and Nancy Zionts presented Pennsylvania’s approach to POLST and JHF’s *Closure* initiative during an annual meeting of the National POLST Paradigm Task Force. Each state with an endorsed POLST program selects two representatives for the conference, which focuses on consumer engagement, best practices in implementing and using POLST, and ways to ensure that even more patients’ and families’ care goals are honored in the future.

“PA POLST is a collaborative community initiative, with JHF, health plans, health systems, nursing homes, hospices, and neighborhood organizations all working together to ensure that Pennsylvanians have choices and are in control of their healthcare decisions,” Dr. Black says.

As a result of the presentation, more than a dozen states requested copies of the JHF *Closure* Community Conversations manuals to facilitate conversations in their communities.



(Top, left to right)  
Representatives from  
the 2013 Fine Award  
Bronze, Silver, and Gold  
organizations, Emily Jaffee  
(Community Life), Bob  
Arnold, MD (UPMC), and  
Judith Black, MD (Highmark).  
(Bottom, left to right)  
Sheila Fine, JHF Board  
President, Alan Guttman,  
Milt Fine, and Karen  
Feinstein, PhD.

### **2013 Fine Awards Recognize Local Healthcare Teams for Honoring What Matters Most to Patients, Families at the End of Life**

Over the last few years, many providers and provider organizations have made great strides in developing systems, tools, and programs that better serve patients and families who are coping with the diagnosis of a life-limiting illness. These advancements help terminally ill patients and their loved ones understand the implications of treatments, define goals of care, and live in accordance with any spiritual values. In recognition of the value of such advancements, the 2013 Fine Awards for Teamwork Excellence, co-sponsored by the Jewish Healthcare Foundation and The Fine Foundation, rewarded local frontline healthcare teams for providing innovative quality, patient-centered, end-of-life care.

Billions of dollars are spent annually on patients in the last year of life—much of that total on patients who may not want or fully understand the potential medical interventions. For example, according to CMS, Medicare paid \$50 billion for doctors and hospital bills during the last two months of patients’ lives in 2009, and an estimated 20 to 30 percent of that amount may have had no meaningful impact. On the contrary, evidence suggests that patients who opt for palliative and /or hospice care often experience a higher quality of life at lower costs in their final days.

The 2013 Fine Awards finalists demonstrated how providers can improve care for those in the final stages of life, such as supporting the all-important—but sometimes forgotten—caregiver; training medical professionals for goals-of-care discussions to enable patients and families to make more-informed decisions; and providing opportunities for patients to remain connected to the communities and social networks that have defined their lives.

“This year’s winners show a deep commitment to putting patients first in end-of-life decisions,” said Milton Fine, chairman of The Fine Foundation. “Through ingenuity and teamwork, they partner with patients and families to ensure patient dignity, and that patient preferences for how they want to live out the end of their lives are honored.”

A distinguished panel of regional and national experts selected the winners based on evidence of data focused on a number of criteria including informed choices, pain management, and advance directives.

“Increasingly, healthcare providers recognize the roadblocks patients face in receiving end-of-life care that they want and need,” said Dr. Feinstein. “We are proud to partner with The Fine Foundation to honor the excellent work being done locally to eliminate gaps in care and align financial incentives with desired treatment options.”



**2013 Fine Awards Finalists**

**GOLD**

Highmark, Inc.

*for Advanced Illness Services: Enhancing Care at End-of-Life*

**SILVER**

UPMC Palliative and Supportive Institute

*for Palliative Care Integration across the Continuum*

**BRONZE**

Community LIFE

*for Honoring Choice*

**FINALISTS**

Children's Hospital of Pittsburgh of UPMC

*for Development of the Supportive Care Program*

Family Hospice and Palliative Care

*for Compassionate Caregiver Training*

Jefferson Regional Medical Center

*for Palliative Care: A Paradigm Shift*

Kane Regional Centers – Scott

*for Effects of Advanced Care Discussion in Patient Care Conferences in a Long term-Care Facility*

Memorial Medical Center of Conemaugh Health System

*for Palliative Care Program*

St. Clair Hospital

*for Designing Electronic Support to Ensure Optimal Advanced Care Planning*

UPMC Shadyside

*for Birth of an End-of-Life Care Team on an Oncology Unit*





## CONCLUSION

The momentum for changes in healthcare service delivery systems has accelerated over the last decade, capped by the passage of the Affordable Care Act. And it will continue over the next several years due, in large part, to the unsustainable cost of medical care (of which the elderly represent a significant proportion) and increasingly activated employers, consumers, and policy makers.

A recent advance was made in Pennsylvania on February 27, 2015, when Pennsylvania Governor Wolf announced a multi-step plan to improve access to home- and community-based services for seniors.

The Foundation's work to provide a continuum of services and a workforce that better address the needs of the elderly continues with JHF's participation in RAVEN, ongoing POLST and *Closure* trainings, a new Death & Dying Fellowship, primary care practice transformation work, training and education for health workers in quality improvement, and a new community health worker initiative.

In addition, JHF is currently partnering with a number of organizations, including Carnegie Mellon University's Quality of Life Technology Center, to continue to explore how we can make life more gratifying for both well and frail seniors.

**“From the beginning,” Dr. Feinstein concludes, “JHF has operated from the premise that aging does not equal inevitable decline. We have been dedicated to helping our region’s seniors maintain the best quality of life and receive the highest quality of health care — that which is the right care, at the right time, and in the right place.”**

“

**Our aspirations go further. We believe that the years post-65 can be truly golden. Worries and challenges of youth and middle age are in the past. There can and should be much joy in the present. We have the largest ever generation of older adults whose potential contributions to our communities' and our nation's vitality are tremendous, but our systems of care must change to better meet their needs.** ”

— Karen Wolk Feinstein, PhD  
President and CEO  
Jewish Healthcare Foundation

# APPENDIX

## JHF CHAMPIONS PROGRAMS AT A GLANCE

### Physicians

The **Physician Champions** program was a two-year program in which physicians identified quality improvement opportunities within their own healthcare institutions, and worked with their clinical teams to address them using the quality engineering skills and work redesign methods of PPC. At the conclusion, participants reported significant reductions in hospital-acquired infections, fewer ambiguities in Pap smears, improved health indicators for diabetic patients, and improved outcomes for open-heart surgery patients, among others. In a number of their projects, the Physician Champions reported that improving efficiency also lowered costs.

### Nurses

The **Nurse Navigators** program was a 12-month program to help support frontline nurses in eliminating errors and using evidence-based knowledge to redesign and improve care delivery. Funded by JHF and the Robert Wood Johnson Foundation, the program hypothesized that guiding nurses to use data and measurement to improve patient outcomes would lead to more nursing autonomy, satisfaction, and employee retention. The use of PPC principles enhanced the frontline nurses' ability to remove obstacles to high-quality care and function as change agents in healthcare quality and safety. Participants tackled projects that reduced patient falls, lowered staff turnover, and reduced hospital-acquired infections, among others, and were able to document financial savings at a number of the host institutions.

### Clinical Pharmacists

Hospitalized patients who suffer from multiple chronic diseases are subject to complications of polypharmacy, an industry term for the use of multiple medications that may be contraindicated, redundant, or, in combination,

dangerous. The **Pharmacy Agents for Change** program was built on a JHF-funded study at the University of Pittsburgh Center for Research on Health Care, which concluded that patients were often able to take fewer medications when pharmacists reviewed their prescription and dosing regimens.

The program showed how expanding the role of clinical pharmacists in medication management and administration can improve safety and quality of care for patients, and potentially reduce costs. Their projects addressed various problems arising from polypharmacy and ranged from reducing patient falls to improving the review of medications at discharge, to ensuring that patients discharged from one mental health facility had their filled prescriptions in hand.

### Librarians

The **Consumer Health Information Champions** program was established to give public librarians the knowledge and skills needed to direct consumers to reliable health information. The program, with its partners, the Carnegie Library of Pittsburgh and the Allegheny County Library Association, trained two cohorts of Champions. Participants had access to healthcare professionals' expertise, and collaborated with health science librarians.

The training included 12 hours of Medical Library Association online continuing education, which allowed each librarian to apply for certification as a Consumer Health Information Specialist. Clinical simulation learning was utilized to provide an opportunity for the librarians to practice skills in researching, reporting, and communicating information to patrons.

The librarians discovered new sources of reliable information about healthcare providers, health conditions, and healthcare quality. This program ultimately helped librarians develop guidelines and electronic resources to better direct patrons to health information.

## EMS

During the **EMS Champions** program, frontline paramedics, EMS chiefs, and executive directors from the southwestern Pennsylvania region designed and executed programs to bolster the safety, quality, and efficiency of pre-hospital care. Through expert mentorship from EMS leaders, collaborations with each other, PPC tools, and, in some cases, traveling abroad to learn best practices in other countries, the EMS Champions demonstrated the value of a focused quality improvement program for EMS professionals.

## Medical Assistants / Licensed Practical Nurses

The passage of the Affordable Care Act and a shift toward patient-centered medical home concepts are redefining the role of medical assistants (MAs) and licensed practical nurses (LPNs) in primary care. In many practices, today's MAs and LPNs handle increasingly complex responsibilities, such as educating patients about their health conditions, monitoring transitions of care, and even conducting certain routine procedures. Yet many MAs and LPNs do not receive the training that would enable them to take on significantly more responsibility for patient care.

To maximize the role of MAs/LPNs and improve practice efficiency by freeing doctors and nurses to focus on tasks best suited to their training, JHF developed an **MA/LPN Champions** program. Twelve local MAs and LPNs participated in a year-long curriculum designed to help them engage patients in their care, collaborate with other care team members, and meaningfully use electronic health records, applying their new skills by developing projects to improve quality, safety, and efficiency within their own primary care offices.

## JHF LONG-TERM-CARE TEAM

The Jewish Healthcare Foundation has a team of professionals dedicated to long-term-care initiatives. They include:

- JHF Chief Operating Officer and Chief Program Officer **Nancy Zionts, MBA**, who serves as the lead on all Foundation long-term care / older adult / end-of-life initiatives
- Quality Improvement Specialist **Stacie Bonenberger, MOT**
- Policy and Program Associate **Neil Dermody, JD, MPA**, who provides program administration for RAVEN
- Senior Quality Improvement Specialist **Terri Devereaux, MPM, FNP-BC**
- Quality Improvement Specialist **Anneliese Perry, MS**, who serves as a trainer and coach
- Medical Advisors **Tamara Sacks, MD**, and **Jonathan Weinkle, MD**
- Administrative Assistant **Catherine Mutunga**

Additionally, two professionals who were an integral part of the LTC Champions program team, but are no longer with the Foundation, include:

- Senior Quality Improvement Specialist **Maureen Saxon-Gioia, RN**, who served as LTC Champions project director and lead coach
- Program Manager **Michelle Anderson, MOT**, who served as a trainer and coach

## ENDNOTES

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