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American Health Care Association

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National Center for Assisted Living

ROLE OF HEALTHCARE LEADERSHIP AND REGULATIONS TO ACHIEVING HIGH QUALITY OUTCOMES

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FOCUS

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Five Key Strategies to Achieving Excellence

- Implement policies that work vs for compliance reasons
  - Chair alarms scenario
- Focus on the system not individuals
  - Wrong sided surgery
- Collect & analyze near misses (e.g. good catches)
  - Pressure ulcer scenario
  - Retained Foreign Object scenarios
- Changing attitudes and beliefs
  - Rehospitalization scenario
  - Antipsychotic scenario
- Balance Technical vs Adaptive Change
  - Rehospitalizations scenario (SBAR & n of 1 trials)

Chair Alarms

- 89 year old woman with dementia, CHF, hypertension, osteoporosis, and arthritis. Has a history of falls in facility (admitted 6 months ago after hip fracture). She is found on the floor out of her chair. She has bruises on her left side and c/o left wrist pain. X-ray shows a fracture. She has an order for a chair alarm but it was not on that day. The CNA forgot to put it on and the RN did not check.
- Should this facility be cited?
- Should the CNA and RN be disciplined?

Compliance Improvement

- Easy to defend practice(s) that have an evidence base or that help improve resident outcomes
- Easy to cite provider for deficiency when they do not follow their own policy & procedures
- Demoralizing to staff to follow practices that are unlikely to be effective or done for compliance reasons only
- Compliance improvement: "Red Flag" statements
  - "we can't do <fill in the blank> because CMS/regulations will not allow us to do that"
  - "We have to do that because the state says we have to"
  - "Another nursing home was cited for not doing <fill in the blank>; so we need to do that so we do not get cited."

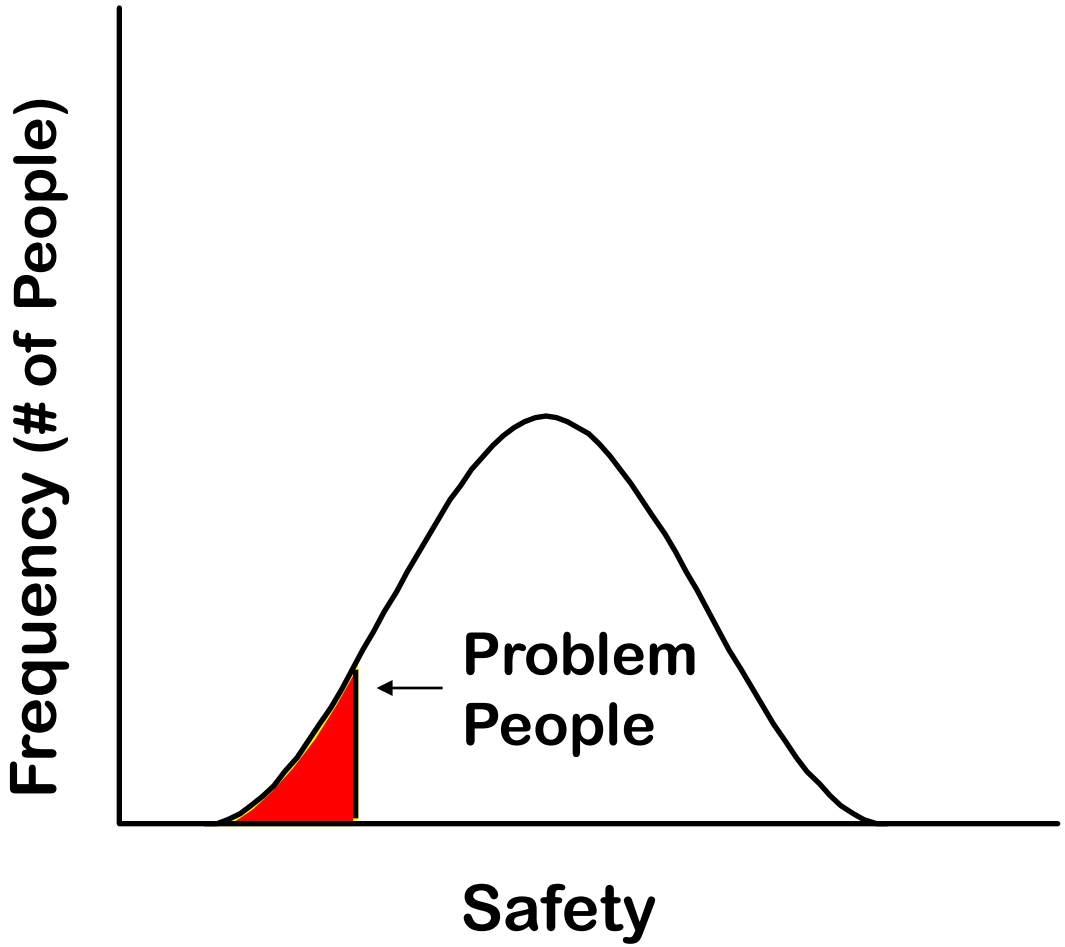
Implications for Providers & Regulators

- Providers
  - Adopt policies that have evidence base
  - Avoid policies or practices that are impossible to follow or create conflicts (multiple documentation locations)
  - Ask to see the regulations when you hear "the regulations will not allow that"
- Regulators
  - Make clear citation was for failure to adopt evidence based practices rather than to follow a policy that was not evidence based
    - Do not accept POC that proposes more intense practices that are unlikely to help
  - If a provider is following a evidence based practice but an adverse event occurs, have good justification for citing deficiency
  - Don't cite for failing to follow a poor policy; cite for having a poor policy

Wrong sided surgery

- Patient who needs arthroscopic knee surgery has surgery on the wrong knee when they discovered a normal knee joint during the surgery. The patient had the wrong knee draped. The "time-out" checklist was recorded as complete.
  - Is this the fault of the surgeon?
  - Is this the fault of the circulating nurses?
  - Is this the fault of the scrub tech who draped the wrong knee?
  - Is this the fault of anesthesiologist?
  - Is this at fault? Who do we blame?

The Prevailing Theory: Traditional Model of "Bad Apples"



The First Law of Improvement

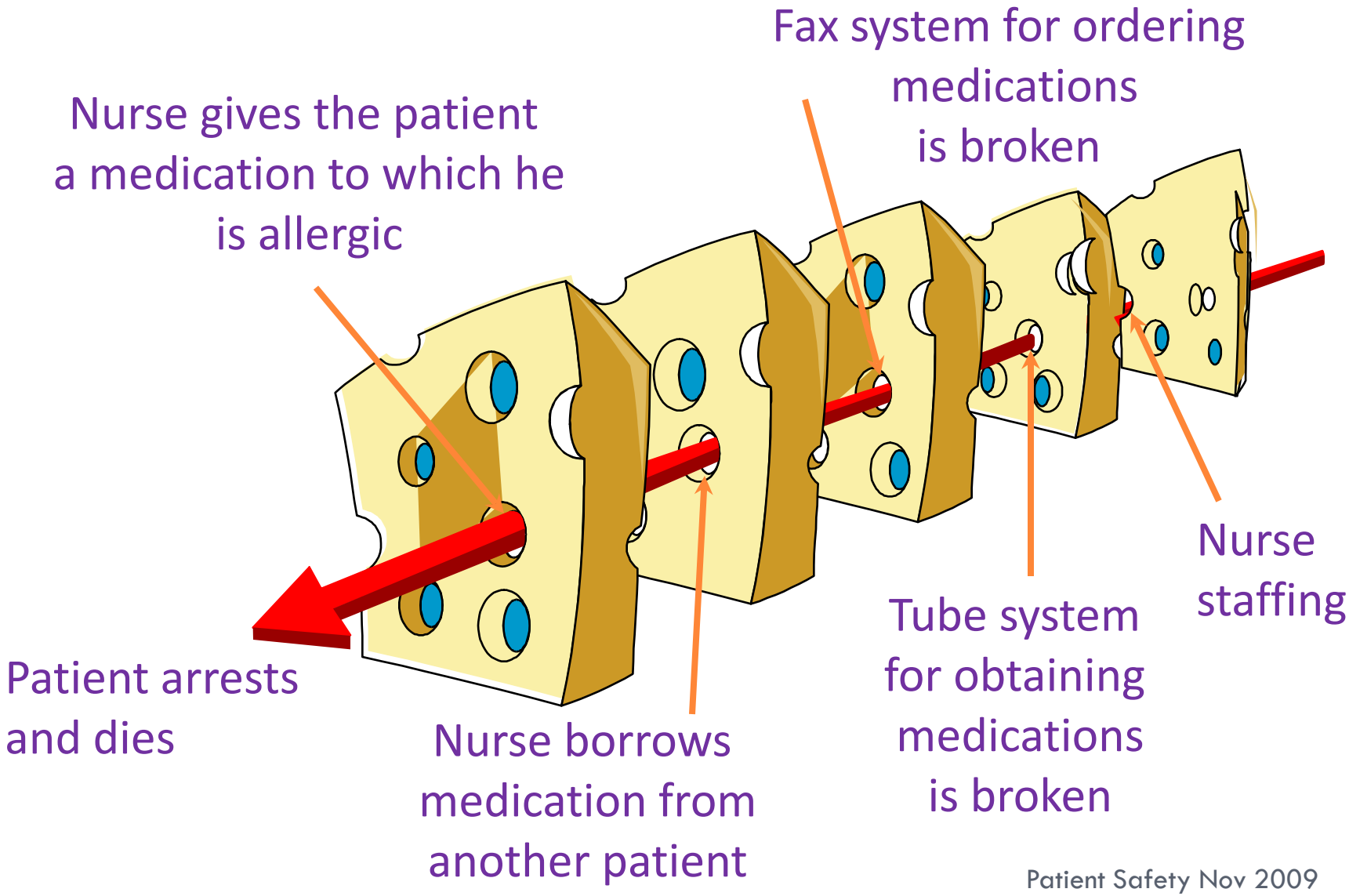
Every system is perfectly designed to achieve exactly the results it gets

-Paul Batalden, MD, Dartmouth

Wrong Side Surgery System failures

- Critical information (Name, type of procedure, & location) often conflicted
  - Initial form on type and site from MD office generated 44 different forms
  - Transferred critical info from paper to computer 7 different times
- The policy allowed the surgeon to proceed If staff agreed when paper work was inconsistent on the site of the surgery.
- New surgical prep was alcohol based and washed off the site markings
- Some MDs marked with an X and others marked X on the side not to operate
- Staff frequently filled out the time-out checklist after the surgery began
- Confirming the X-rays prior to surgery in OR was not part of check list because X-rays were not always available in the OR
- In emergent cases, the policy allowed the time-out checklist to not be used

Swiss Cheese Hypothesis for Errors



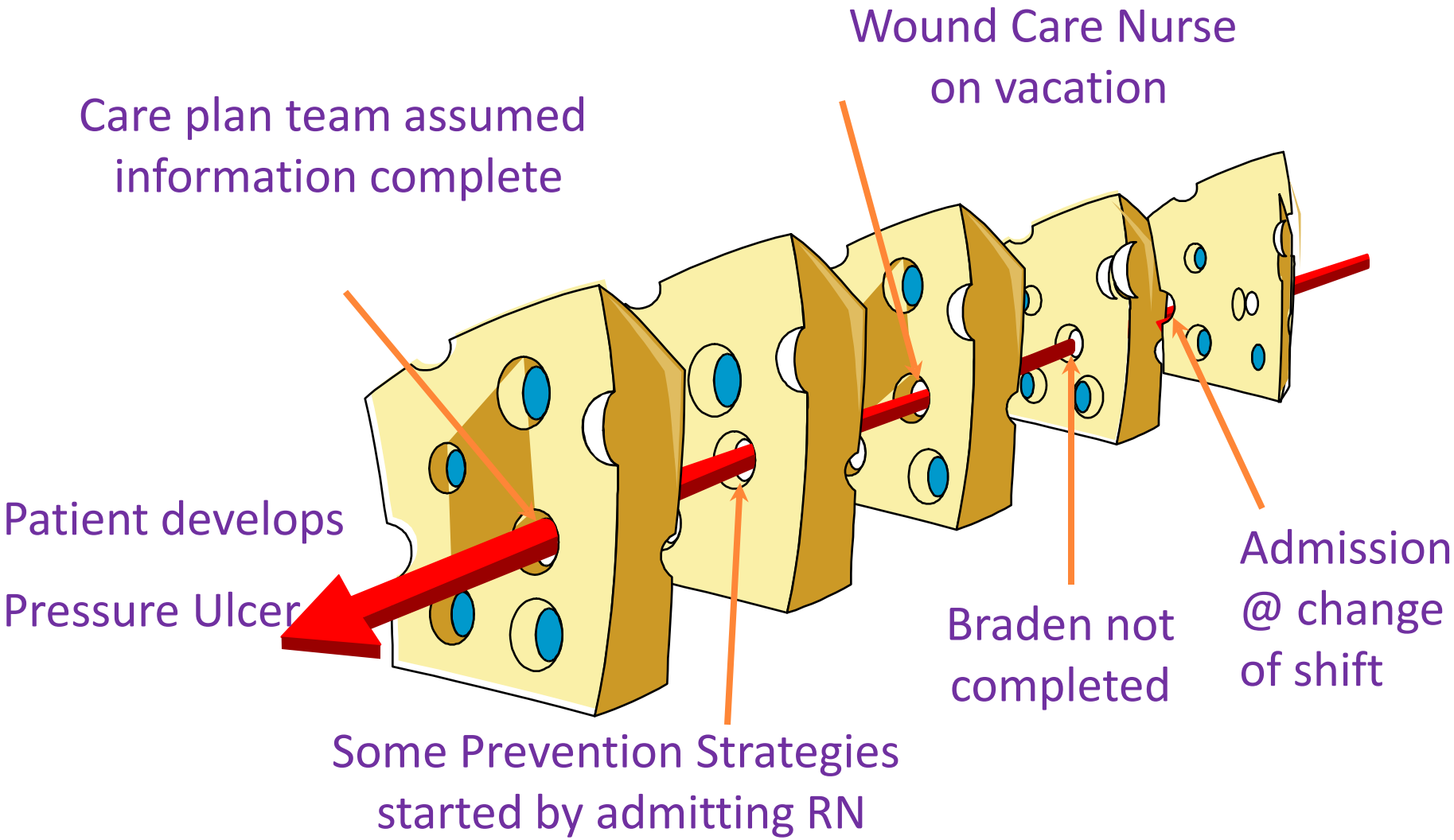
Pressure Ulcers

- Facility receives a deficiency for patient who developed a pressure ulcer 1 week after admission and did not have a risk assessment performed on admission even though the facility has a policy to complete Braden scale at admission. Therefore, the care plan did not address all the pressure ulcer prevention strategies.
  - Is this the fault of the admission nurse?
  - Is this the fault of the MDS coordinator?
  - Is this the fault of the Unit Manager?
  - Who do you blame?

System failures

- Admitting RN was responsible for completing the Braden scale
  - Most admissions occur during afternoon change of shift leaving little time to complete
  - Information needed to complete Braden was not always available before end of shift
- Developing the Formal Care Plan assumed all admissions assessments were completed if info was missing
- Wound care nurse who developed the care plan was on vacation and Braden scale results were left in the wound care nurses “inbox”.
- Some prevention strategies were implemented by nurses at admission so everyone assumed a risk assessment was done

Swiss Cheese Hypothesis



Implications for Providers & Regulators

- Focus on identifying the system failure rather than finding a staff person to be held responsible
  - Consistency or inconsistency across multiple patients is sign of good or poor system, respectively
- Plans of correction that propose more in-services assume the problem is related to an individual's knowledge deficit
- Do not propose (or accept) adding "more" to an already complex system that guarantees failure
- Utilize Failure Effects Mode Analysis (FEMA)
- Ask "what is the problem that does not allow staff to follow our policy?"
- Ask "Is this due to a knowledge deficit?"

Retained Foreign Object

- Patient had a colectomy. First day post op, the patient c/o atypical abdominal pain. A CT scan revealed a surgical forceps in the abdomen. The surgical counts showed all instruments accounted for. Whose fault is it?
  - Is this the fault of the surgeon?
  - Is this the fault of the circulating nurses?
  - Is this the fault of the scrub nurse?
  - Who do we blame?

Near Misses related to RFO

- The number of pieces of surgical equipment did not match the count on the package so most surgical counts were inaccurate at end of surgery
  - When instrument was dropped additional packages had to be opened quickly during the operation so a count check was not possible.
- The number of surgical sponges often did not match the count on the package so
  - When additional sponges were needed unexpectedly during the operation, additional packages had to be opened quickly so a count check was not always possible or rushed.
- Surgical Counts were routinely off at end of surgery but no RFO was found so policy to x-ray in OR was not followed because it also delayed the next case which the hospital was trying to speed up.

“Near Miss” Psychology

- Close calls are near disasters not lucky breaks
- Near misses create a sense of overconfidence
  - NASA scientist asked to rank two missions, both with the same result, even though one nearly self-destructed but was saved by a lucky break (e.g. foam damaging a heat shield)
  - 50-100 significant near misses occur prior to serious accident
    - 10,000 minor errors occur prior to a serious accident
- Employees who are told/reminded that their work is “highly visible” and “safety first” identify and report more near misses

Paynter B. “Close Calls are near disasters, not lucky breaks .WIRED magazine Aug 14, 2012

Implications for Providers & Regulators

- Providers
  - Collect near misses
    - Remind employees "safety first"
    - Reward near miss reporting
    - Need a method to review and prioritize near misses and Performance Improvement Projects (PIPs) to address near misses
- Regulators
  - Encourage near miss collection (Consider citing if they do not have effective near miss reporting in place)
  - But only use near misses to site deficiencies when provider does not have process to review and address in a priority manner. Do NOT cite their priority ranking if its rational and they have not yet gotten to responding to a near miss ranked lower but associated with a bad event.

But system problems with potential for harm trigger an Immediate Jeopardy

- Identifying and labeling near misses or bad events due to system problems would trigger a rash of IJs
- Nursing Facility <u>requirements</u> of participation require immediate compliance of IJs but
  - fixing systems takes time
- QAPI recommends using data to prioritize performance improvement projects but
  - to be in compliance with requirements, do all near misses need to be fixed immediately?

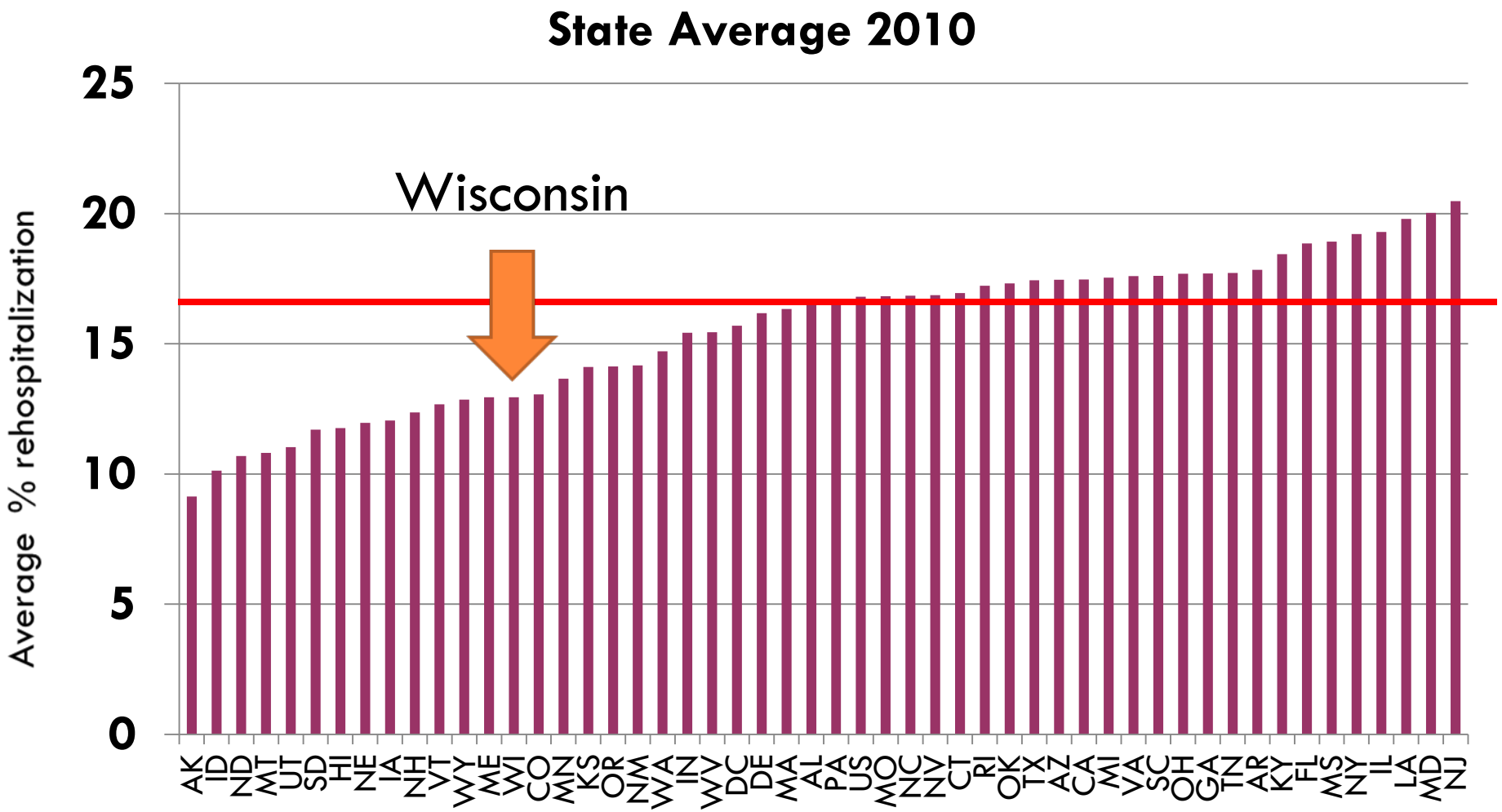
Rehospitalization Scenario

- Hospital calls the administrator because they are concerned with the facilities high 30 day readmission rate. The administrator asks the QA committee to review their rehospitalizations. They review the medical record of each rehospitalization in past 3 months and can find only one case that could have been prevented. Most readmissions were due to
  - severe medical problems (i.e., CHF, pneumonia, urosepsis, falls with fractures, or CVA)
  - lack of equipment/medication/test results available after admission from the hospital
  - Family request

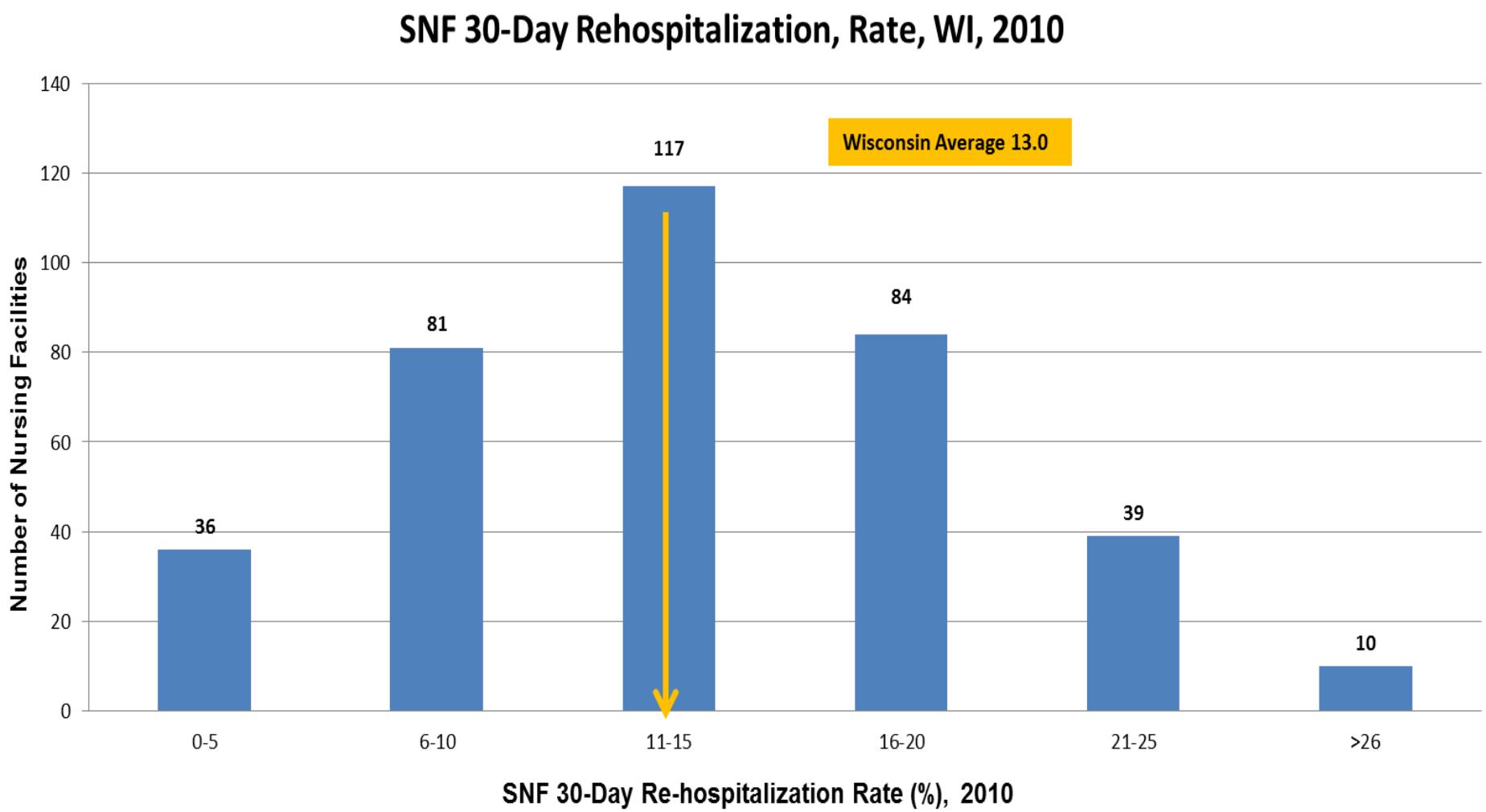
Where Can I Get Data on My Rates?

- AHCA – Long Term Care Trend Tracker
  - Free AHCA member benefit
  - www.ltctrendtracker.com
  - Currently includes claims-based measure
  - Adding MDS-based, risk adjusted measure from PointRight
- Many MDS vendors have similar measures
- Real-time internal data collection & analysis
  - Advancing Excellence free excel tracking tool
  - www.nhqualitycampaign.org/star_index.aspx?controls=HospitalizationsIdentifyBaseline

State Rankings 30d Rehospitalizations



Wisconsin 30-Day Rehospitalization Rate, 2010



Source: Long-Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296), Brown University, 2010.

Challenge is changing attitude

- Many health care professionals and families believe hospitalizations are the best place to go when a person is getting ill
  - When someone is very sick they need to go to the hospital (e.g. pneumonia, CHF, etc), therefore the hospitalization is not preventable

Factors Associated with low rehospitalizations

- 47 Nursing homes in NY (N=26,746 patients)
- Measured Clinical and non-clinical factors associated with rehospitalization rates
- Three strongest predictors

  #1 Training provided to nursing staff on how to communicate effectively with physicians about a resident's condition

  #2 Physicians who practice in this nursing home treat residents within the nursing home whenever possible, saving hospitalization as a last resort

  #3 Provided better information and support to nurses and aides surrounding end-of-life care

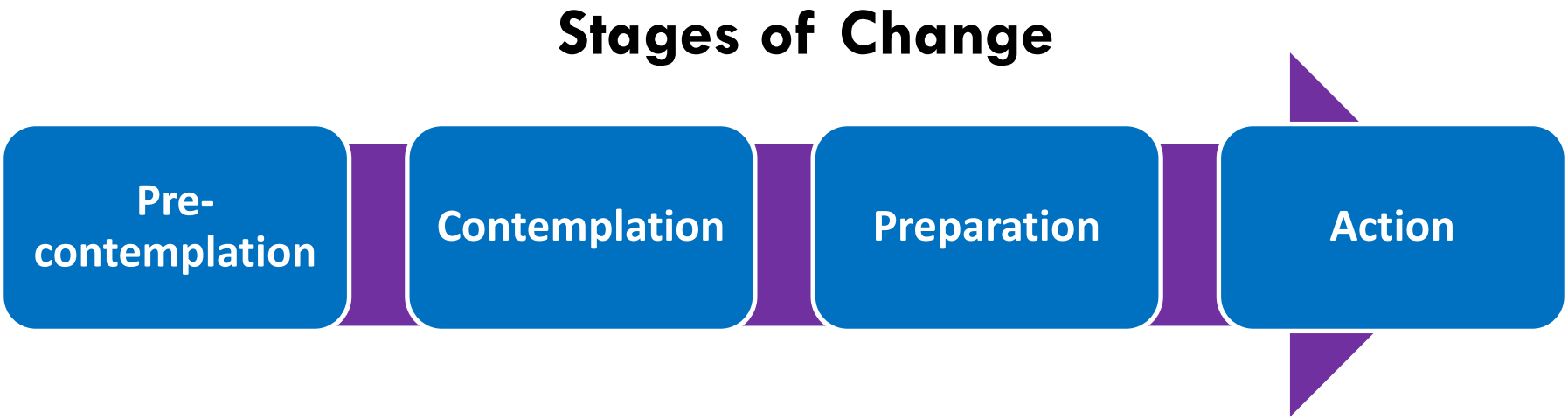
[1]Young Y et al. Clinical and Nonclinical Factors Associated with potentially preventable hospitalizations among nursing home residents in NYS. JAMDA 2011;12:364-371.

Top vs Bottom Performing Hospitals

- Qualitative study of staff interviews comparing top vs bottom performing hospitals based on CMS quality measures over two year period.
- No differences in protocols and processes for AMI care
- Staff at high-performing hospitals shared the common organizational values of providing high-quality care, expressed as “a common vision and purpose,” the “glue” of the organization, and “the driving force behind everything.”
- Staff at high-performing hospitals used root-cause analysis to learn from experiences and improve care.
- At low-performers, problem-solving was less constructive and finger-pointing was more common

Curry LA et al. Ann of Int Medicine 2011; 54(6):384–90

Transtheoretical Model of Behavior Change



Implications for Providers & Regulators

- Providers
  - Leadership sets to the tone on attitude and beliefs
    - Make work visible; recruit respected peers to deliver message
  - Ask "How will <proposed strategy> move staff from pre/contemplators to action phase?"
- Regulators
  - Involve leadership (e.g. CEO, Board Chair, Owner) in discussions about survey findings
  - Don't accept facility wide changes or more in-services to fix the problem since neither knowledge deficit or system changes will work if staff don't believe there is a problem or are defensive
  - Give time to make progress on changing attitudes and beliefs

Antipsychotic use in dementia scenario

- Assisted Living Facility is successfully sued for administering an antipsychotic medication to a resident with dementia who suffers a stroke. The ALF contracts with pharmacy to start a program that recommends GDR to physicians and families. Families, Physicians and Nursing all are very concerned that residents will have a "relapse" of their behavior. The facility documentation for informing families of the risks and why a GDR is not possible increases dramatically but the rate of antipsychotic use remains unchanged.

FDA Black Box Warning

- Issued in 2005
- Warning: Increased Mortality in Elderly Patients with Dementia-Related Psychosis
  - "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death compared to placebo. h… [Name of Antipsychotic] is not approved for the treatment of patients with dementia-related psychosis. "

WARNING

Increased Mortality in Elderly Patients with Dementia-Related Psychosis — Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. [this drug] is not approved for the treatment of patients with dementia-related psychosis.

#1 Challenge: Changing attitudes

- Most families and healthcare providers believe these medications are effective to treat "problem behaviors"
- Behaviors are believed to be a symptom of dementia
  - Most behaviors are either normal for a person with cognitive impairment or are modes of communicating an unmet need
- Use of antipsychotics in dementia are mainly a problem in nursing homes

Antipsychotic Medications

- Conventional
  - Compazine
  - Haldol
  - Loxitane
  - Mellaril
  - Moban
  - Navane
  - Orap
  - Prolixin
  - Stelazine
  - Thorazine
  - Trilafon

- Atypical
  - Aripiprazole (Abilify)
  - Asenapine
  - Clozapine
  - Iloperidon
  - Olanzapine (Zyprexa)
  - Paliperidone
  - Quetiapine (Seroquel)
  - Risperidone (Risperdal)
  - Ziprasidone

Commonly given to individuals with dementia

Antipsychotics are used everywhere

- 13% of individuals with dementia in the community are receiving an antipsychotic
- 17% of admissions from the community to a skilled rehab center are on antipsychotics
- 75% of individuals (in a facility >90 days) who are on an antipsychotic, were receiving the antipsychotic at admission to the facility
- 3% of new admissions to nursing home have an antipsychotic started in the first 100 days

Effectiveness in Dementia is weak Meta-Analysis (JAMA 2011)

- Olanzapine, Risperidone and Aripiprazole, had a small but statistically significant effect (12 – 20% got better) when compared to placebo
- Quetiapine did not have a statistically significant effect
- Antipsychotics led to an average change/difference on the NeuroPsychiatric Inventory (NPI) of
  - 35% from a patient's baseline
  - 3.41 point difference from placebo group

  (note: a 30% change and 4.0 difference is the minimum threshold needed for a clinically meaningful result)

Source: JAMA 306:1359-69 2011; Meta-analysis 38 RCTs in dementia

Dose for Antipsychotics Used in Dementia

Medication	Low Dose	Normal Dose
Aripiprazole (Abilify)	<2 mg/d	2-15 mg/d
Olanzapine (Zyprexa)	<5 mg/d	5-10 mg/d
Quetiapine (Seroquel)	<50 mg/d	50-100 mg/d
Risperidone (Risperdal)	<1 mg/d	1-2 mg/d

Effectiveness with Low Dose Meta-Analysis (Cochrane 2012)

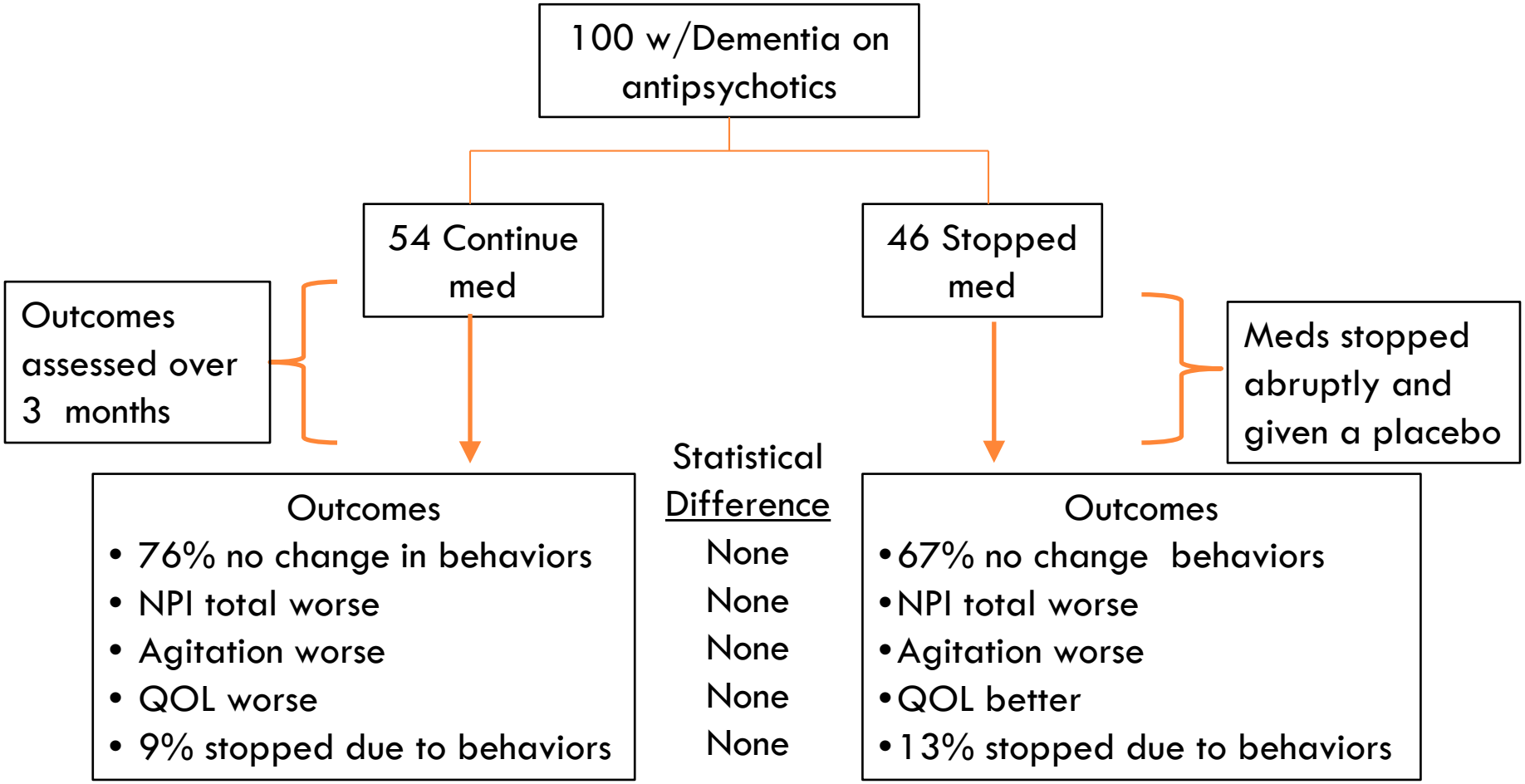
- Low dose Risperidone <1 mg/d) has small positive effective but also has increase risk of adverse events
- Low dose Olanzapine (5 mg/d) has no positive effect but does have increase risk of adverse events
- Low dose Aripiprazole and Quetiapine effectiveness are unknown but Quetiapine at normal dose is ineffective

Source: Cochrane Review 2012; Meta-analysis 16 RCTs in dementia

Evidence based for discontinuing meds at low dose

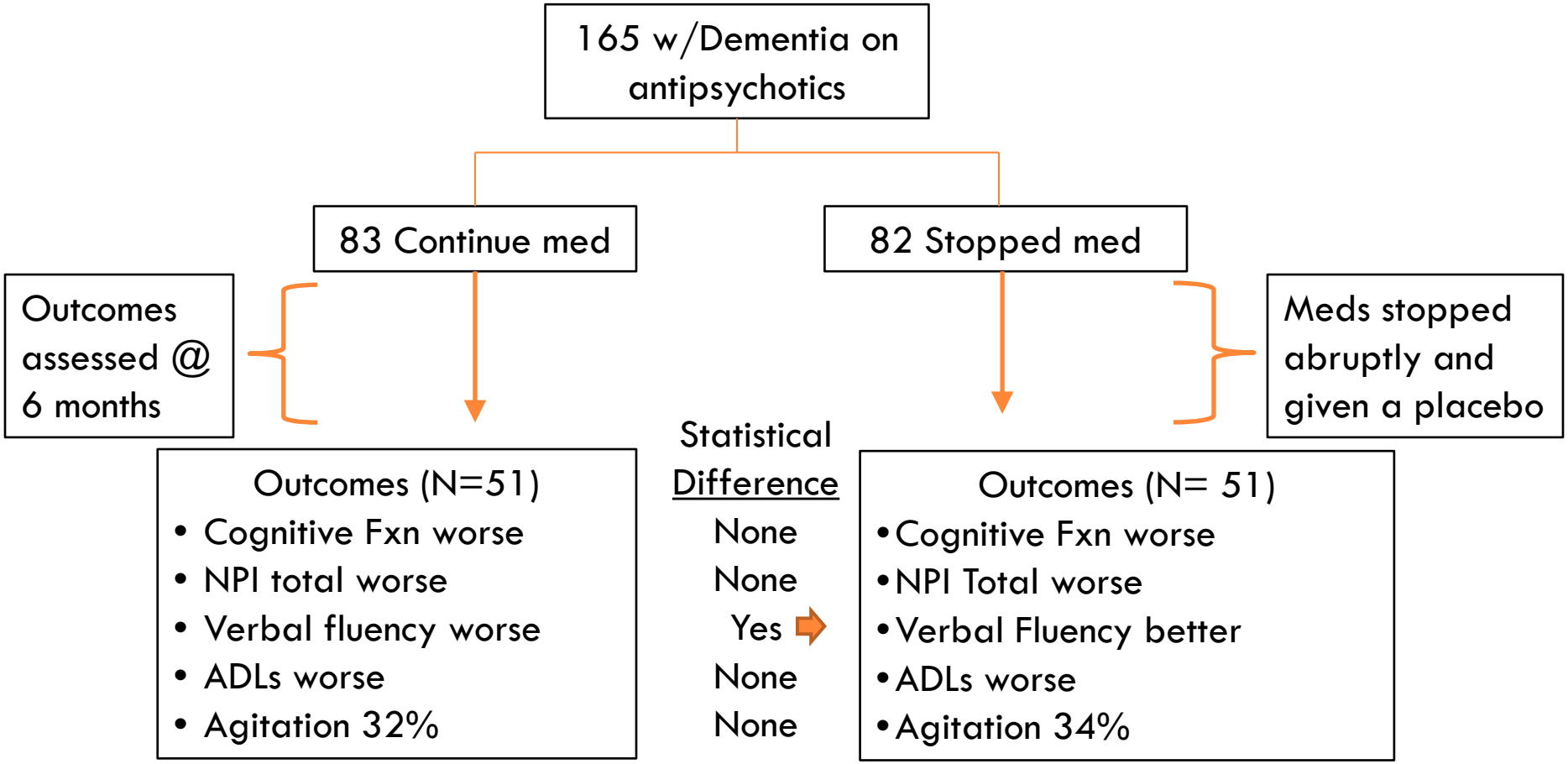
- RCTs comparing withdrawal of medication to continuing antipsychotics show
  - No significant difference in outcomes between placebo group and continued medication group
  - Individuals with psychoses (hallucinations & delusions) are more likely to 'relapse" and need the medication restarted
    - Most individuals with dementia do not have hallucination or delusions as the reason for their antipsychotic prescription

RCT to withdraw antipsychotics[2]



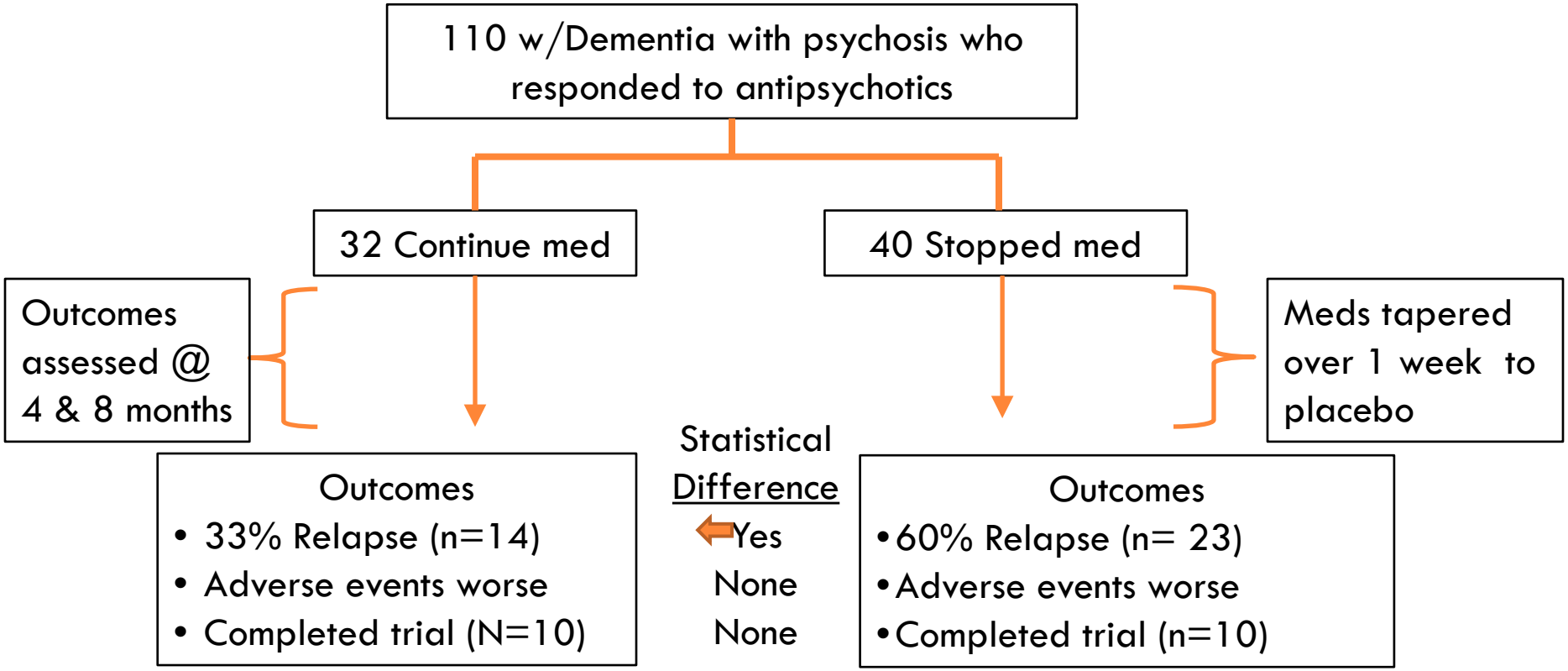
[2]*Ballard C et al J Clin Psychiatry 2004: 65:114-119*

RCT to withdraw antipsychotics[3]



[3]*Ballard C et al Plos Medicine 2008; 5:e76: 587-599*

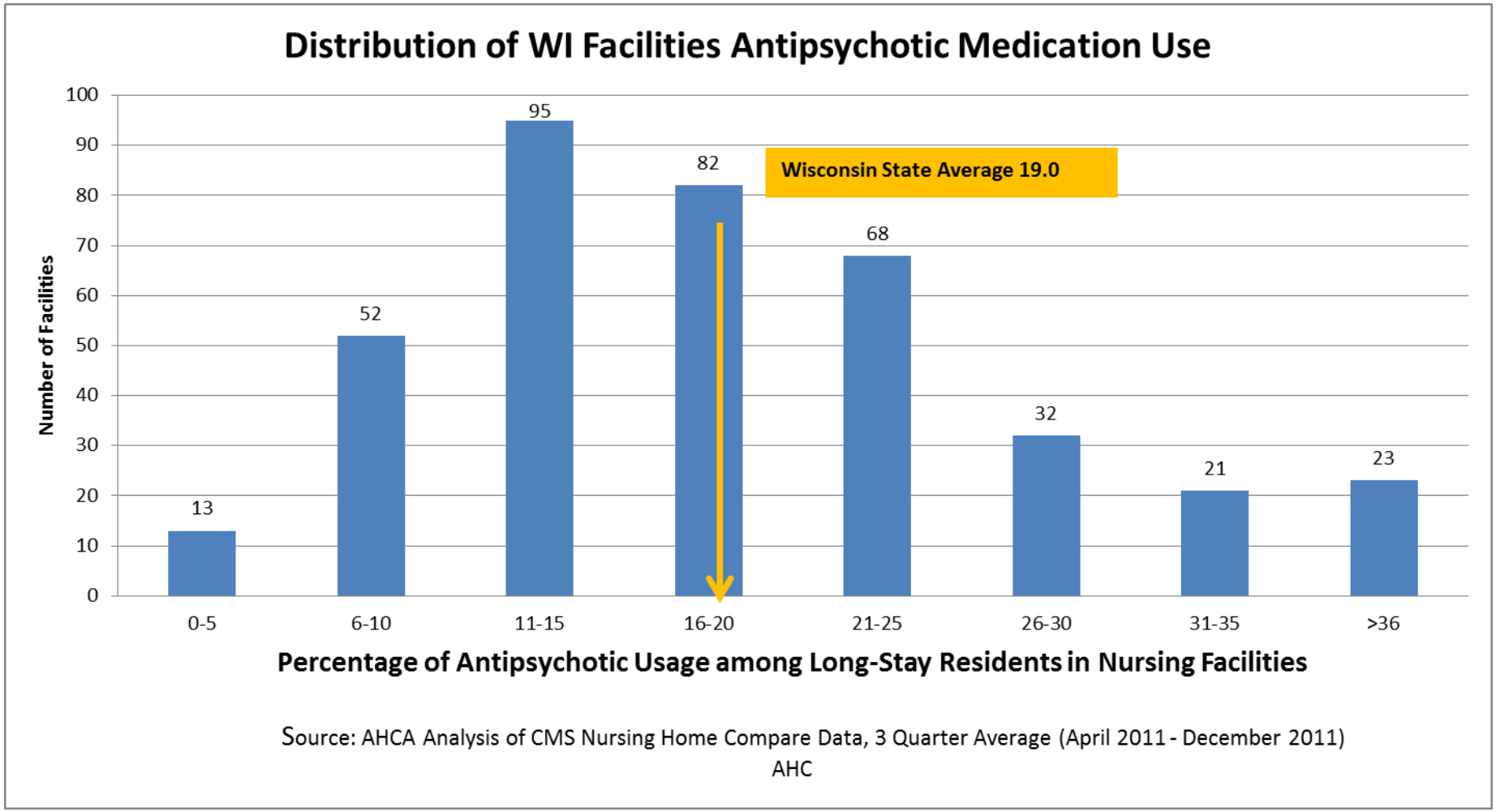
RCT to withdraw antipsychotics[4]



[4]*Devandand DP et al NEJM 2012; 367:1497-1507*

Third group not shown here: continued med for 4 moths then discontinued meds

Wisconsin Antipsychotic Medication



Dementia behaviors are normal

- Group Exercise

Implications for Providers & Regulators

- Providers
  - Need to focus on changing views of families and staff that actions of individuals with dementia are not "abnormal behaviors" caused by dementia but normal predictable actions by individuals with dementia trying to communicate an unmet need
- Regulators
  - Need to also focus on other provider settings to lower antipsychotic use otherwise you pit nursing home provider against the family/hospital

Rehospitalization Scenario

- Hospital calls the administrator because they are concerned with the facility's high 30 day readmission rate and want to know if they are using the INTERACT program? The administrator gets the INTERACT-II program material (www.INTERACT2.net) and has the DON do an in-service. However, their rates do not decline and the hospital starts to refer patients to another facility.

INTERACT II Program

- Comprehensive approach to reduce hospitalizations
  - Acute care transfer log to track/measure rehospitalizations
  - Standard Transfer Form
  - Communication Tool with Physicians (SBAR)
  - Resident assessment tool & algorithms
    - Stop & Watch and Care Paths
  - QI Improvement review tool
    - Evaluation to assess each hospitalization (Root cause analysis)
  - Advance care planning resources

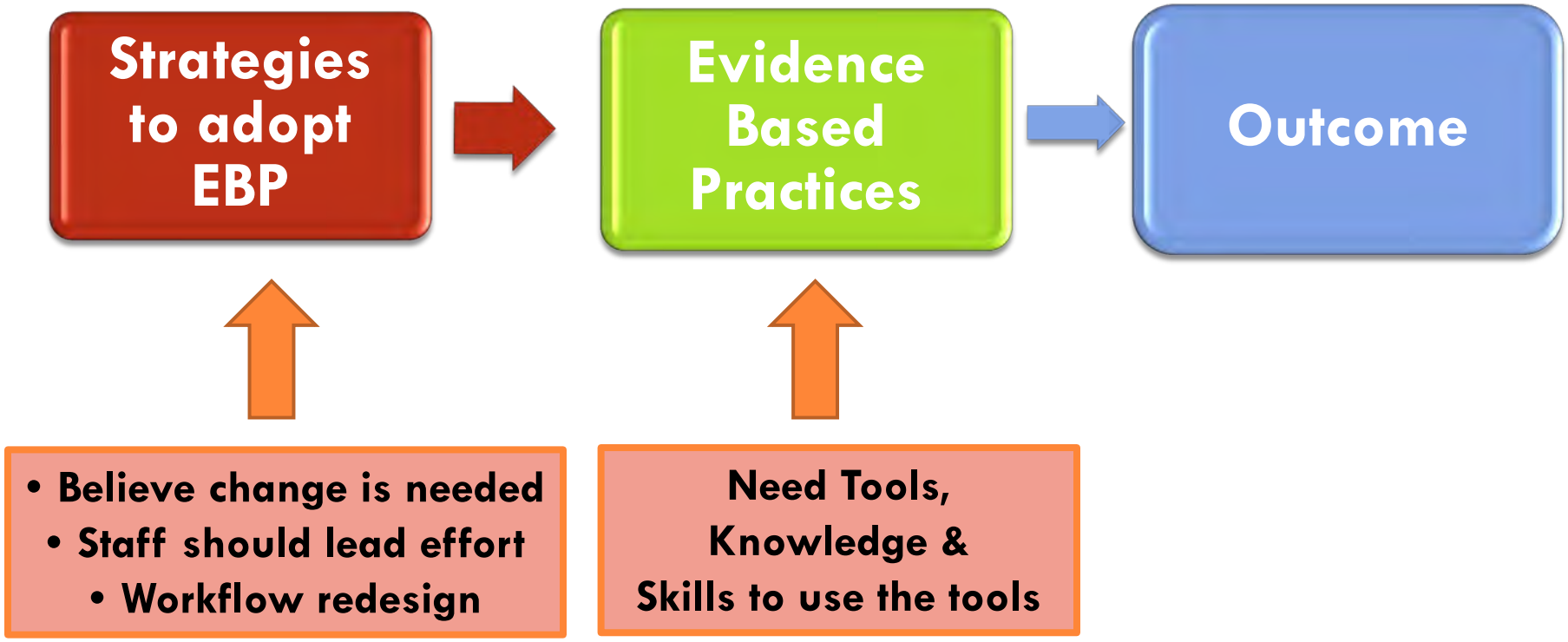
http://www.interact2.net

INTERACT EFFECTIVENESS

Facilities	Mean Hospitalization Rate per 1000 resident days (SD)		Mean Change (SD)	p value	Relative Reduction
	Pre intervention	During Intervention			
All INTERACT facilities (N = 25)	3.99 (2.30)	3.32 (2.04)	- 0.69 (1.47)	0.02	**17%**
Engaged facilities (N = 17)	4.01 (2.56)	3.13 (2.27)	- 0.90 (1.28)	0.01	**24%**
Not engaged facilities (N = 8)	3.96 (1.79)	3.71 (1.53)	- 0.26 (1.83)	0.69	**6%**
Comparison facilities (N = 11)	2.69 (2.23)	2.61 (1.82)	- 0.08 (0.74)	0.72	**3%**

Ouslander et al, J Am Geriatr Soc 59:745–753, 2011

Implementing "Evidence Based Practices"



Technical vs Adaptive Change

- Balance technical vs adaptive changes
  - Technical changes often do not work because the adaptive changes needed to get staff to adopt and utilize the technical change have not been addressed.
  - New form vs workflow redesign to complete the new form

Successful Implementation Strategies

- Rely on staff to design & test implementation strategy
  - Top Down vs Bottom up implementation
- Learn from Peers
  - Learning collaboratives
  - Visit other facilities
- Get at the adaptive change that is needed
  - Ask "what is the problem/issue we are trying to solve?"
  - How will what we/you propose help us solve the problem?
- Pilot Test, Pilot Test, Pilot Test, Pilot Test
  - N of 1 trials (1 unit, 1 staff, 1 resident, 1 day)
  - Rapid cycle PDSA (at bedside or standing in hallway)

N of 1 Trials (rapid cycle PDSA)

- Pilot test on 1 unit, 1 staff, 1 resident, 1 day
  - Find staff here are supportive of new program
    - Optimal if they are respected by peers
  - Let organization know you are pilot testing a new program
  - Promote the 1 unit, "1 staff" who are conducting the pilot
  - Make changes based on staff feedback
  - Once few changes, add additional staff 1 at a time, 1 unit at a time, making changes after each pilot test

Implications for Providers & Regulators

- Providers
  - Leadership sets to the tone on attitude and beliefs
  - Pilot test using N of 1 trials method
- Regulators
  - Don't accept facility wide changes to fix the problem
    - Accept N of 1 trials as a "system wide" approach to fixing the problem

Unintended Consequences of the Regulatory Process

- Makes providers become defensive
  - Justify care was appropriate and optimal
  - Blame individuals rather than focus on changing system
  - Blame regulations as barrier to providing care
- Makes Surveyors avoid focusing on system change
  - Focus on events rather than learning from near misses
  - Accept the providers blaming an individual, so you avoid path termination by labeling adverse event related to system problem

Positive Consequences of the Regulatory Process

- Makes providers focus on issues of importance
  - e.g. CMS dementia initiative
- Move providers from pre/contemplative to action
- Introduce standards of care such as,
  - restraint free environment
  - use of pressure ulcer risk assessment tool
- Has a Hawthorne effect
  - Do better if you know you are being watched

Contact Information

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