



# **Nursing Home Quality Improvement through Culture Change: Quality of Life and Good Clinical Care Need to Go Hand in Hand**

November 16, 2022

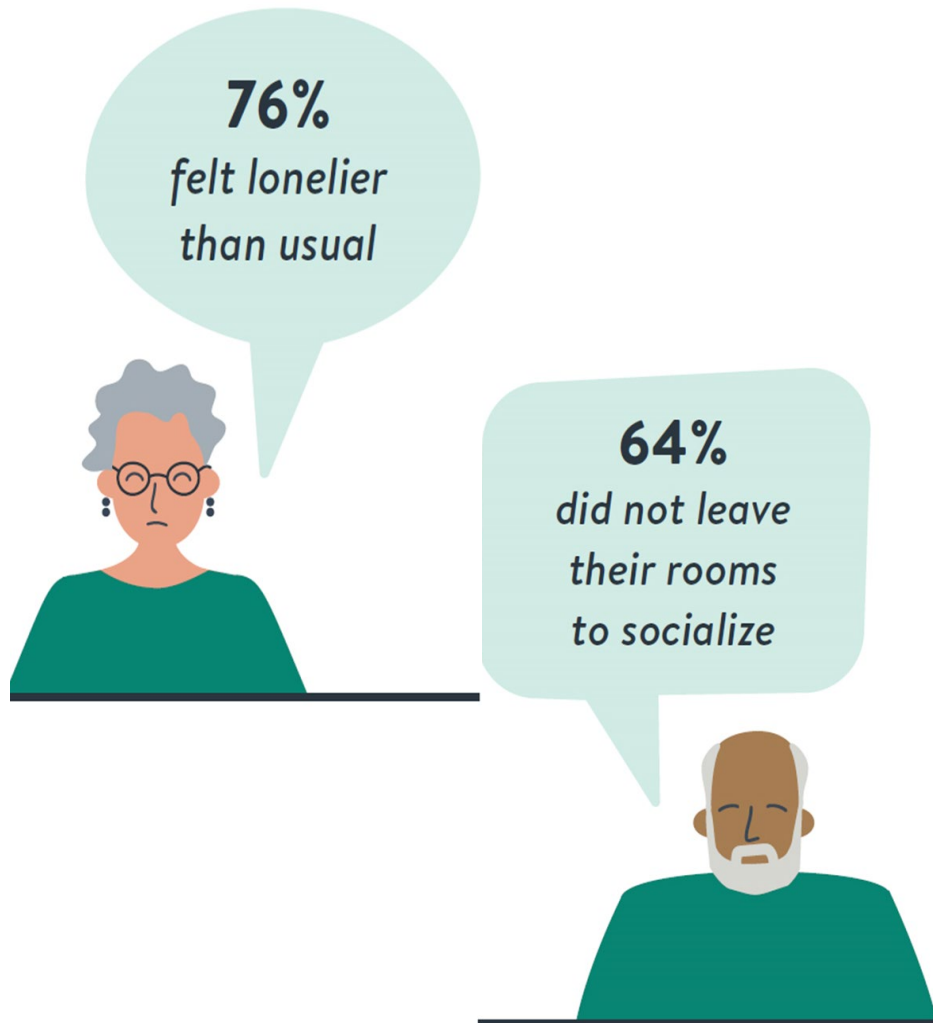
Sarah Slocum, Program Director, Delivery System Transformation

ALTARUM



# Agenda

- ▲ What is culture change and why is it important?
- ▲ Overview of our culture change work
- ▲ What clinical measures are we tracking and how?
- ▲ Overview of the Systems Change Tracking Tool (SCTT)
- ▲ Case Study: Michigan nursing home using the SCTT to create a formal QI project
- ▲ Findings & next steps



## The U.S. Nursing Home Sector was Deeply Impacted by COVID-19



- ▲ Low census, financial uncertainty, & poor staffing are increasingly common. This exemplifies the need to rethink and/or substantially upgrade the NH care model.
- ▲ In the summer of 2020, Altarum developed and fielded an online convenience survey examining quality of life of residents in U.S. nursing homes.
- ▲ *Along with infection prevention, a strong focus is now needed to restore and improve resident well-being - focusing on resident experience, choice & quality of life, as well as improvements in the status of direct care workers. This is the work of culture change.*

# Our Work on Culture Change is Multifaceted, Ongoing

## Challenge

For transformative QOL work prioritizing culture change/resident-centered care to continue during an era deeply impacted by COVID-19, **a stronger focus on measuring resident experience & choice is central.**

Culture change necessitates

- Training/coaching/mentoring & ongoing analysis of staff-led practices
- Emphasis on team-based care
- Monitoring of clinical quality metrics & financial impact.



## Solution

- 1- Expert **training, coaching & mentoring** over several years;
- 2- **Targeted TA & QI** to implement, sustain & continue culture change;
- 3- **Multidimensional impact assessment** that examines broad trends & changes in key metrics.

# Altarum's Assessment of Culture Change Impact Examines:



## ▲ Changes in Each Home's Practices & Protocols: **Systems Change Tracking Tool** (*grounded in the HATCh Model framework*)<sup>2</sup>

- Piloting: The Resident Systems Change Tracking Tool

## ▲ Financial Measures:

- Implementation costs - facilities, staff, supplies
- Potential benefits - turnover, occupancy

## ▲ Clinical Quality Measures:

- Depression symptoms
- Antipsychotic Use
- Activities of Daily Living
- Hospitalizations

**Quality of Life:** Focus Groups & Interviews

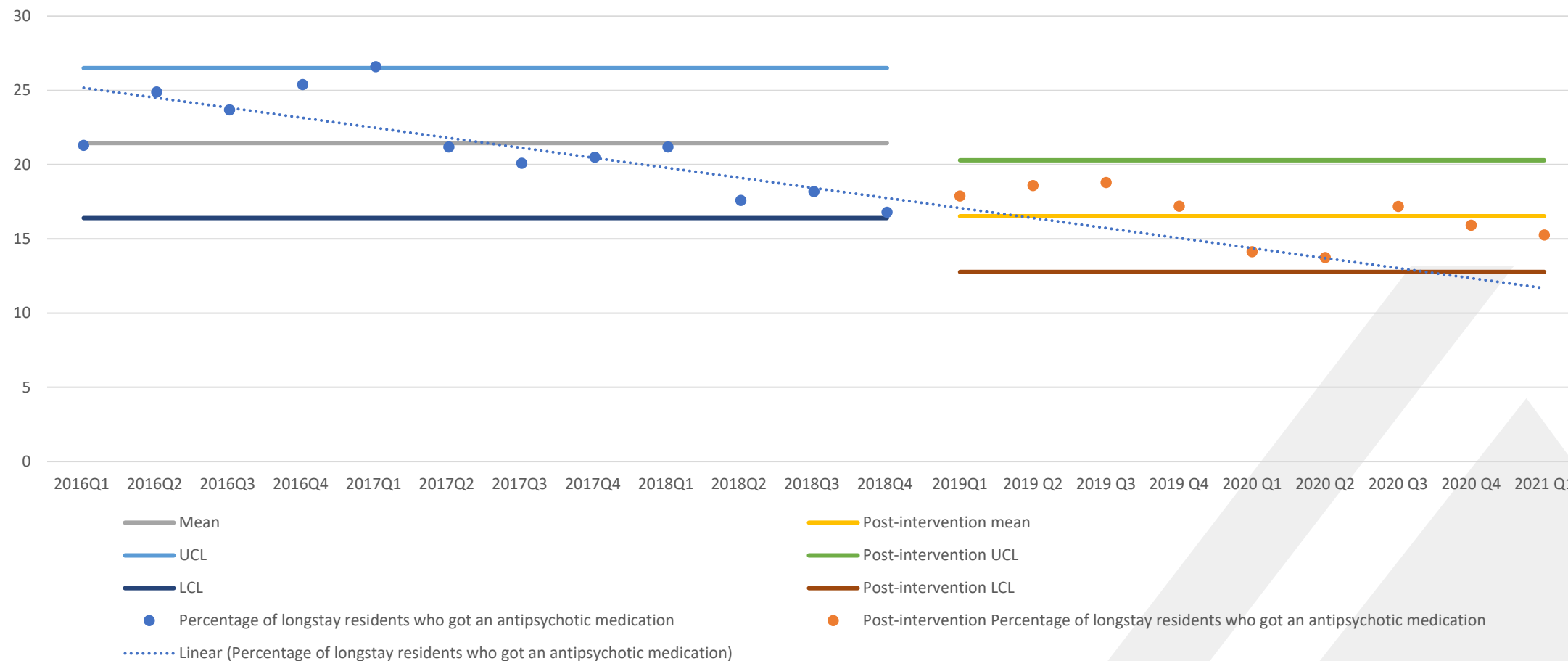




# Clinical Quality Measures: Helping nursing homes use their own data to track performance

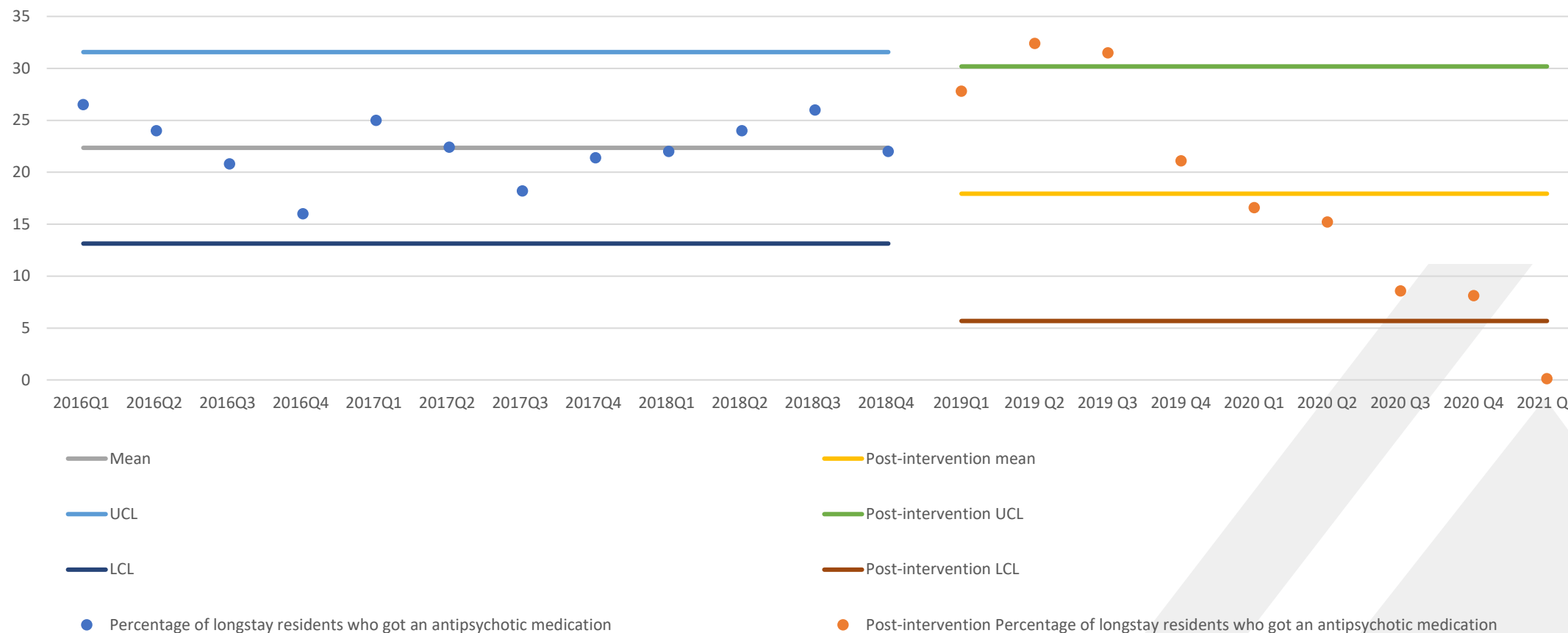


# Large size home: Percent of Longstay Residents who got an Antipsychotic Medication





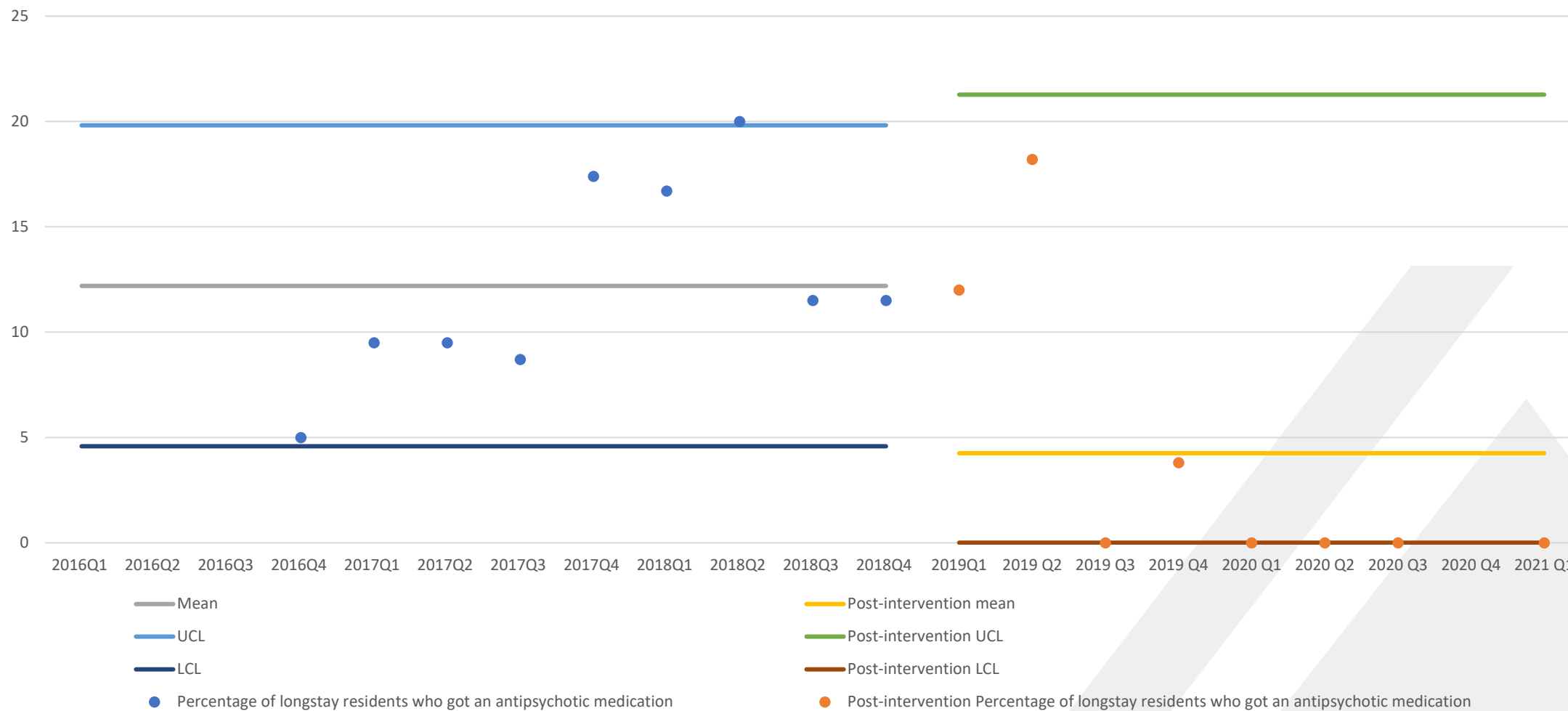
# Medium size home: Percent of Longstay Residents who got an Antipsychotic Medication







# Small home: Percent of Longstay Residents who got an Antipsychotic Medication





## CQM Findings

- ▲ No home has reported significant impacts of culture change on QOC (positive or negative)
- ▲ Where there might be a point or two outside the control limits, it is often explained by something else (e.g., increased symptoms of depression and COVID-19-related isolation; reduction in antipsychotics due to preexisting QI program)



# System Change Tracking Tool



Capturing Changes  
in Homes' Practices  
& Protocols:

The Systems  
Change Tracking  
Tool



# The SCTT provides both a baseline and a longitudinal record of key changes in QI practices and protocols.

- ▲ The SCTT assesses changes occurring in each home over time, as culture change training proceeds. Additional commentary for each change is collected. Not all of the changes in the SCTT happen quickly, and some may not happen at all.
- ▲ There is room for input of additional items from homes.





# Using the Systems Change Tracking Tool

- ▲ The SCTT is a quality improvement tool.
- ▲ Care team members document their culture change accomplishments and challenges once each quarter.
- ▲ The purpose is to operationalize person-centered care.
- ▲ The SCTT questions are grouped by the Holistic Approach to Transformational Change (HATCh) theoretical model domains.





## Sample SCTT Items

- Residents are engaged in determining menu selections for communal meals.
- The community offers clinical and non-clinical staff enough information to understand each resident's unique background, history and interests.
- Adequate space is available for family and friends to interact and spend time with residents, including private space.

Scale for Items			
1 = Have not developed a plan for implementation	2 = Have a plan for implementation	3 = Partly implemented	4 = Fully implemented



## **Your Turn: Look at HANDOUT#1: Select Items from the Systems Change Tracking Tool**

- **Which item pops out to you & why?**
- **Write down two things a nursing home/assisted living facility could do to make that item a reality.**



# Select Systems Change Tracking Tool Items (handout)



▲ *1 = Have not developed a plan for implementation*

▲ *2 = Have a plan for implementation*

▲ *3 = Partly implemented*

▲ *4 = Fully implemented*

▲

▲ ***Care Practices:***

▲ Residents choose when to go to bed for the night and when to wake up in the morning.

▲ Residents choose when to bathe.

▲ Residents have options to dine at flexible times and in multiple locations.

▲ Residents have easy access to snacks and beverages of their choice all day long.

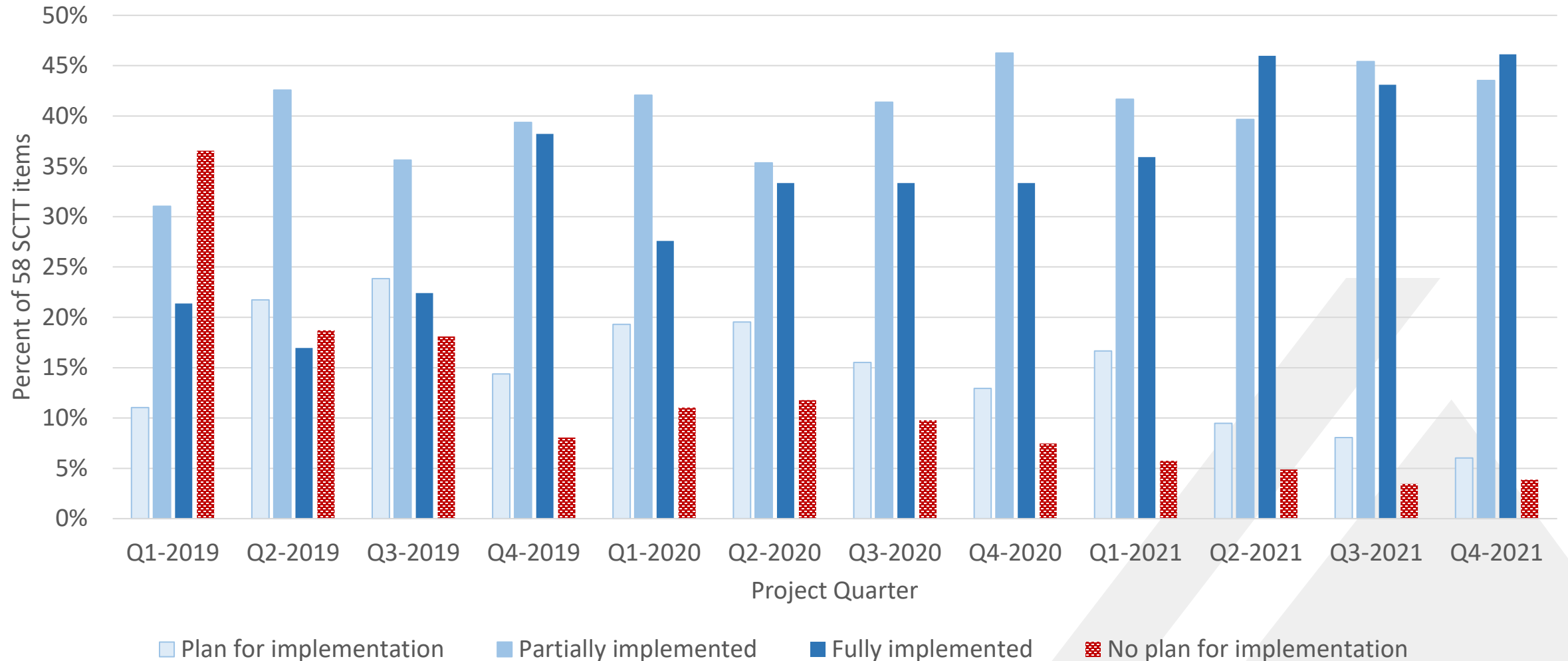
▲ Residents are able to keep snacks in their rooms as long as they are stored safely.

▲ Residents are engaged in determining menu selections for communal meals.

- ▲ Residents are offered alternative non-pharmacological therapies, treatments and modalities (e.g., music therapy, stress reduction techniques), and staff are trained in how to offer these to residents and to carry them out.
- ▲ Personal expressions (typically referred to as behaviors) by people living with dementia are seen as unmet needs by clinical team members.
- ▲ ***Family/Community/Activities:***
- ▲ Residents are engaged in determining the types of daily choices to engage in a range of activities that are meaningful for them.
- ▲ Residents have opportunities for spontaneous and meaningful enjoyment of simple daily pleasures.
- ▲ Residents have opportunities to lead activities and events as they wish.
- ▲ Residents have opportunities to engage in activities promoting relationship building that include different ages and abilities.
- ▲ Families are invited to bring their passion and interests into the community.
- ▲ Residents have choice about what type of activities and events come in from the community.
- ▲ The community learns about residents' interests, memberships, and relationships and fosters continuation of those external activities.

- ▲ The community learns about residents' interests, memberships, and relationships and fosters continuation of those external activities.
- ▲ The community learns about residents' tastes and desire to dine out and enables the wishes of those residents who occasionally want to dine in local restaurants to do so.
- ▲ The community has an engaged Resident Council and residents are involved in community decision making. The residents are running the Resident Council.
- ▲ The community has an active and engaged Family Council.
- ▲ Residents, employees and family members have meaningful opportunities to grieve and process the loss of a resident, staff or family member.
- ▲ Residents are supported in identifying and implementing opportunities for purpose and ways that they can give back to staff and other residents.
- ▲ Residents are supported in identifying and implementing opportunities for purpose and ways that they can give back to their families and others who live in the wider community.

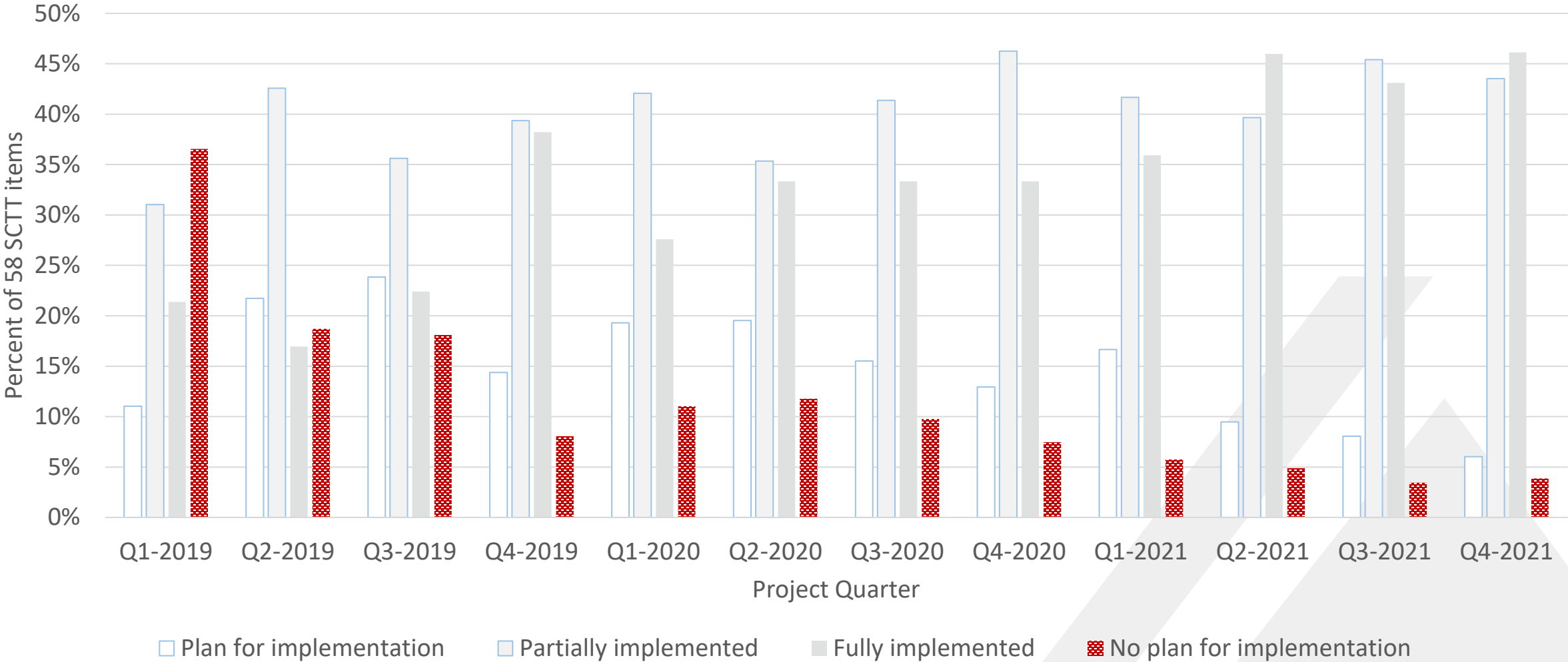
# SCTT Trends Across 6 MI Nursing Homes 2019-2021



# SCTT Trends Highlight: Fully Implemented



# SCTT Trends Highlight: No plan for implementation





## Resident experience and choice can be improved by:

- Using data in a meaningful way.
- Using formal quality improvement projects to focus and accelerate change.



*But How?*

# Designing a Formal Quality Improvement Project using Quality of Life Data





# HANDOUT #2 Prioritization Matrix

# Prioritization Matrix for Identifying Quality Improvement Focus (handout)



Domain	Potential QI Area #1	Potential QI Area #2	Potential QI Area #3	Potential QI Area #4	Potential QI Area #5
<i>Scoring Guidance included below each category</i>					
<b># impacted</b>					
<i>Nearly all residents will be impacted – 4, 50-90% of residents - 3, 25-50% of residents -2, fewer than 25% - 1</i>					
<b>Safety</b>					
<i>Will directly decrease the likelihood of events that have caused resident harm -4, will directly decrease the likelihood of events that could theoretically cause harm – 3, will indirectly help decrease the likelihood of resident harm – 2, minimal impact on reducing resident harm – 1</i>					
<b>Dignity</b>					
<i>Very likely to directly increase resident dignity – 4, moderately likely to improve resident dignity, modest impact on resident dignity -2, little impact on resident dignity -1</i>					
<b>Survey risk if not changed</b>					
<i>If this is not addressed, the facility will be at risk for a citation at high scope and severity -4, At risk for citation with low scope and severity – 3, failure to address is unlikely to result in citation but could be damaging to the reputation of the facility-2, This issue poses little to no likelihood of citation or reputational damage -1</i>					
<b>Ease of change</b>					
<i>Employees are enthusiastic and a champion is identified-4, Employees are willing and have capacity -3, Employees are willing, but there is not capacity -2, Significant employee resistance to this would need to be overcome -1</i>					
<b>Cost of change</b>					
<i>Cost is minimal and could be absorbed in current budget -4, Cost is low and donations could support -3, Cost is moderate and there may be funding available – 2, Cost is relatively high and would require fundraising -1</i>					
<b>Total Score:</b> Higher score indicates that this project is likely to have a higher impact and be more sustainable.					



# Steps to Pinpoint a Focus Area within the SCTT

- 1. Identify the SCTT domains with the lowest mean score.
- 2. Identify eligible improvement areas within those domains (those marked 1 or 2 in the most recent reporting cycle).

Response Scale			
1 = Have not developed a plan for implementation	2 = Have a plan for implementation	3 = Partly implemented	4 = Fully implemented



## Steps to Pinpoint a Focus Area

3. Use a prioritization matrix to identify the most valuable to focus on.

**Ease of change**

**Safety**

**Dignity**

**Survey risk if not changed**

**Cost of change**

**Number of Residents Impacted**

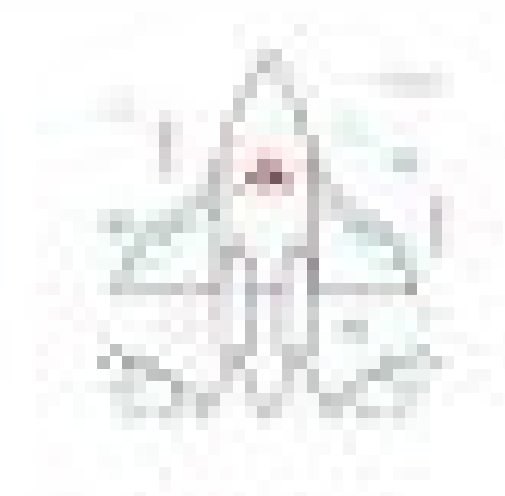
# Leveraging SCTT Data for a QAPI (Quality Assurance & Performance Improvement) Project: *OVERVIEW*



One of our six Michigan nursing homes reviewed 10 possible areas within the Family/Community and Leadership SCTT domains.

Following internal discussions, the home chose to focus on improving an area in the Family/Community domain:

“Residents have opportunities to engage in activities that promote relationship building.”



# Interview with Mission Point of Forest Hills Leaders

Interviewed by Beth Brown, Altarum  
Interview by Dr. Christopher Brown, Altarum





# HANDOUT #3: One-Page QAPI Overview



# What Gets Measured Matters:

Introducing a Culture Change Tracking Tool to Capture Person-Centered Care and Quality of Life Progress for QAPI Initiatives





**Your Turn: Brainstorm how we might involve residents in decision-making or suggestions into your QI project.**

- **How do we find out if it's something that's important to them?**
- **How might we ask them for their input?**
- **What does success look like? How do we find out if residents liked the changes?**

*Pulling It All Together:*



Next Steps



## What Are Possible Pathways Forward? Possible Next Steps



- ▲ Take this information back to county, state, other people connected to quality improvement
- ▲ Share this information with nursing homes, assisted living facilities, CCRCs, and other congregate/residential living
- ▲ Continue to think about how QOL goals and person-centered care can be integrated into care.
  - How do you bring diverse perspectives to the table?
  - How do you ensure residents are involved in decision-making?



# THANK YOU

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# *Supporting Evidence for Moving Culture Change Further Forward Faster is Easy to Find*



- McAllister A, Beaty JA (2016) Aging Well: Promoting Person-Directed Care. J Aging Sci 4: 164. doi:10.4172/2329-8847.1000164
- <http://longtermcare.wi.gov/docview.asp?docid=17285&locid=123>
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- Yang, Y., Li, H., XIAO, L.D. et al. Resident and staff perspectives of person-centered climate in nursing homes: a cross-sectional study. BMC Geriatrics 19, 292 (2019). <https://doi.org/10.1186/s12877-019-1313-x>
- Manley, Kim & Jackson, Carolyn. (2019). Microsystems culture change: a refined theory for developing person-centered, safe and effective workplaces based on strategies that embed a safety culture. International Practice Development Journal. 9. 1-21. 10.19043/ipdj.92.004.