Comagine Health

Department of Health Care Finance & Comagine Health
Nursing Facility Quality Improvement Collaborative

End of Life Care Collaborative

Prework Packet

November 2019 – February 2020

Version 1

This document was developed by Comagine Health through funding provided by the Department of Health Care Finance, District of Columbia. The contents have been reviewed and approved by The District of Columbia Department of Health Care Finance.

Acknowledgments

Welcome to the Department of Health Care Finance and Comagine Health Nursing Facility Quality Improvement Collaborative. We are delighted that you will be joining us for our first Learning Session for Collaborative Year Two scheduled for February 2020. The overall aim of the Year Two Collaborative is to achieve and sustain person-centered End of Life care at the systems level to improve quality and safety in resident care.

To prepare you for the February 2020 Learning Session, we have compiled this **Prework Packet**. Many organizations and individuals contributed to the development of this Collaborative Prework Packet. We would like to recognize the following organizations and individuals for providing direction, funding, and expertise.

Department of Health Care Finance (DHCF) District of Columbia

Comagine Health
Comagine Health is contracted by DHCF to lead the Nursing Facility Quality Improvement Collaborative.

The Institute for Healthcare Improvement (IHI)
IHI-developed the Breakthrough Series Collaborative learning methodology including the Model for Improvement with colleagues from Associates in Process Improvement.

If you have questions, please contact:

Gazelle Zeya, Comagine Health QI Consultant and Improvement Advisor Lead
gzeya@comagine.org | 800-949-7536 ext. 2992

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About This Prework Packet

This Prework Packet contains essential information about the *Department of Health Care Finance (DHCF) Nursing Facility Quality Improvement Collaborative* for participating nursing facilities in the District of Columbia. Its purpose is to provide participants with background and reference information on the Collaborative and to help teams prepare for a successful start to this exciting quality improvement process.

The **Introduction** sets the stage by giving some background information on Collaboratives as well as a schedule of major events and time periods.

The **Framework** contains the Collaborative charter, which provides some background on improving resident care, satisfaction and costs of care, defines the overall mission, goals, and methods of the Collaborative, and outlines expectations for Collaborative participants.

The Nursing Facility Quality Improvement Collaborative is structured to focus on one-year topic cycles, over a five-year period. **Topics for Collaborative** include but are not limited to: bowel or bladder incontinence, End of Life Care, pressure ulcers, MDS Assessment, documentation and workflow training, nursing facility system level topics (for example; leadership, team building, the role of the medical director, consistent assignment, and staff stability), clinical topics related to nursing facility quality measures (for example: mobility, antipsychotics, falls), care transitions, reduction of preventable ER and hospital admissions and readmissions, and interventions relevant to the findings/gaps from Consumer Assessment of Healthcare Providers and System (CAPHPS®) surveys. Topic related Change Packages containing a variety of strategies, change concepts, and specific actionable items for changing processes of care will be available to Collaborative members to improve residents' quality of life and care.

The **Measurement Strategy** section provides you with data definitions for the required measures and provides teams with optional measures, and it describes the data that your team will collect to monitor your progress during the Collaborative.

The section on **Prework** activities will walk your team step-by-step through preparing for the first Learning Session.

A **Glossary** of terms and concepts and a list of **Collaborative Leadership** will serve as a reference throughout the Collaborative.

A Collaborative is a systematic approach to quality improvement.

Introduction

This section contains background information on Collaboratives, the Nursing Facility Quality Improvement Collaborative sponsored by the Department of Health Care Finance (DHCF), an overview of the Collaborative, a schedule of activities, and a Prework activities checklist.

Overview

A Collaborative is a systematic approach to healthcare quality improvement in which organizations and providers test and measure practice innovations, then share their experiences to accelerate learning and widespread implementation of best practices. Teams are expected to use the Collaborative resources – faculty, other teams, materials, and methods to make significant and sustainable improvements in their organizations.

In 1995, the Institute for Healthcare Improvement held the first Breakthrough Series Collaborative. Since then, IHI has successfully trained more than 2000 teams from over 1000 healthcare organizations, including many skilled nursing facilities, in the fundamentals of improving quality.

The Nursing Facility Quality Improvement Collaborative Background

The Nursing Facility Quality Improvement (NFQI) Collaborative involves 17 long-term care nursing facilities in the District of Columbia, working together to individually test system changes aimed at improving quality and building tools for successful participation in pay-for-performance programs. A primary focus of the Collaborative is to collectively share learnings. The four main components of the Collaborative are prework activities, Learning Sessions, action periods, and the outcomes congress.

The Nursing Facility Quality Improvement Collaborative is structured to focus on one-year topic cycles, over a five-year period. The Collaborative structure is designed to focus on a limited number of improvement goals over a relatively short time frame to develop skills in rapid process improvement. New priorities will be assessed each year to determine new topics, evidence-based practices and support to bridge care gaps and ensure the success of nursing facilities in the pay for performance environment.

Collaborative Year One (November 2018 – October 2019) focused on the topic of bowel and bladder incontinence. Providers also had the option to select their own topic(s) of interest (e.g., falls, pressure ulcers, MDS training, staffing, etc.) based on assessments and baseline data collected by DHCF to improve Nursing Facility Quality Improvement (NFQIP) Program. **End of Life Care** has been selected as the primary topic for Collaborative Year Two (November 2019 – October 2020) with the overall aim of achieving and sustaining quality, person-centered End of Life Care at the systems level that is consistent with residents' wishes. **An End of Life Care Change Package and** measurement strategies that support learning quality improvement methodology and rapid cycle improvement and resources topic will be included in a separate handbook and made **available to Collaborative members at the February 2020 Learning Session.** The Collaborative will address other topics related to improvement and payment incentive opportunities as well. The Collaborative Change Package and measurement strategies will be updated for future topics.

Prework is the period between receipt of this handbook and Learning Session 1 (February 2020). During this time, the nursing facility has several important tasks to accomplish in order to prepare for the first Learning Session. The prework section of this packet details these tasks, provides a checklist for prework activities (including creating a Storyboard), and provides a worksheet for documentation (see Appendix A and B).

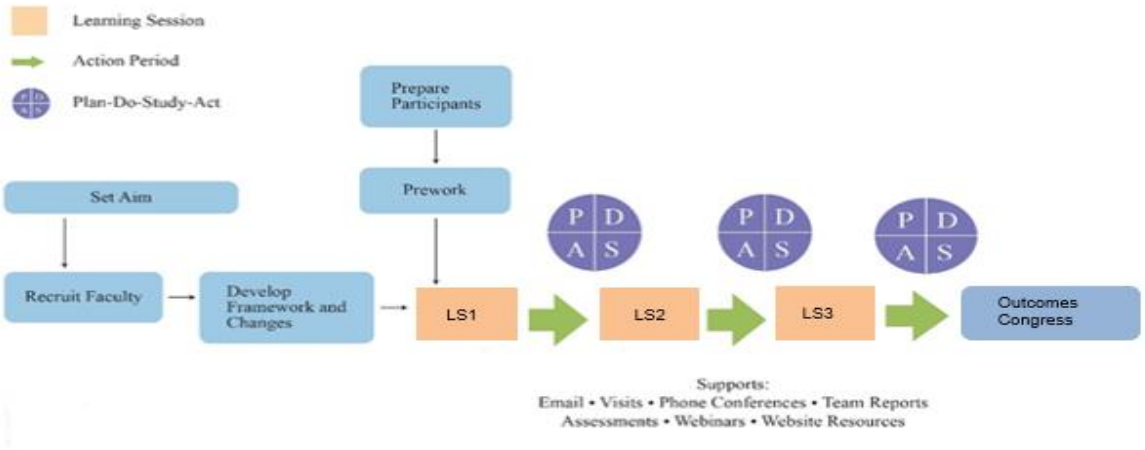
Learning Sessions are the major interactive events of the Collaborative. Through plenary sessions, small group discussions, and team meetings, attendees can:

- learn from expert faculty (see Collaborative Leadership section) and colleagues,
- receive individual coaching and technical assistance,
- gather knowledge on the subject matter and on process improvement,
- share experiences, learn from peers and collaborate on improvement plans, and
- problem solve barriers to improving care and decide on next steps.

Action Periods are the times between Learning Sessions. During action periods, nursing facility teams work within their organizations to test and implement small gradual changes using the Plan, Do, Study, Act (PDSA) model of continuous cycles of improvement, aimed at improving specific clinical and organizational quality indicators. Teams share the results of their improvement efforts in monthly senior leader reports and participate in shared learning through an email distribution list, conference calls, and webinars. Participation in action periods is not limited to those who attend the Learning Sessions; we encourage and expect the participation of other team members and supporters in the nursing facility.

Outcomes Congress. The Collaborative will share its findings and achievements at an annual outcomes congress that will highlight the accomplishments of the teams and present effective models of improving care for nursing home residents.

Department of Health Care Finance & Comagine Health NFQI Collaborative Model



Collaborative Schedule

The sequence of events for the Collaborative is as follows: A specific schedule will be provided.

Prework	November 2019 – February 2020 • Site Visits to be scheduled with each facility
Learning Session 1	February 27, 2020 (8:30am - 12:30pm)
Action Period 1 • TA Visits • Webinar #1	February – April 2020 • To be scheduled with each facility • April 13, 2020 (1:00 – 2:00pm)
Learning Session 2	May 14, 2020 (8:30am - 12:30pm)
Action Period 2 • TA Visits • Webinar #2	May – July 2020 • To be scheduled with each facility • July 16, 2020 (1:00 – 2:00pm)
Learning Session 3	August 20, 2020 (8:30am – 12:30pm)
Action Period 3 • TA Visits • Webinar #3	August – October 2020 • To be scheduled with each facility • September 17, 2020 (1:00 – 2:00pm)
Outcomes Congress	October 29, 2020 (8:30am - 12:00pm)

Prework Getting Started Checklist

Prework is the period between receipt of this handbook and the initial Learning Session, targeted for February 2020. During this time, the nursing facility will have several important tasks to complete in order to prepare for the February Learning Session. This section includes a checklist of prework activities and specific tasks that need to be completed during the prework period (see Appendix A and B).

A required site visit will be made to each individual Nursing Facility by the Quality Improvement Consultant – Collaborative Lead prior to Learning Session 1 to assist in preparing for the prework activities.

Checklist for Completing Prework Activities

To prepare for Learning Session 1, participating nursing facility teams should complete the tasks listed below:

- ❑ 1. If not previously arranged, schedule a prework site visit with the Comagine Health QI Consultant
- ❑ 2. Read the Collaborative Prework Packet
- ❑ 3 Form a team or review current Collaborative team
- ❑ 4. Complete the Prework Activities Worksheet
- ❑ 5. Develop an Aim Statement
- ❑ 6. Define a Population of Focus/Pilot Unit
- ❑ 7. Define Measures
- ❑ 8. Prepare a Storyboard for Learning Session 1
- ❑ 9. Register and Plan for Learning Sessions
- ❑ 10. Communications with Facilities
- ❑ 11. Senior Leader Reports

The following pages provide more detail about each task.

1. Schedule and Participate in a Prework Facility Site Visit

Each team must schedule a prework site visit before the first Learning Session. Visits are used to review the prework and plans for Learning Session 1 and assess each teams' readiness to participate in the End of Life Care Collaborative, understand facility issues and goals, and to assist teams in preparing for Learning Session 1. If you still need to schedule a facility visit, please contact: Gazelle Zeya at: gzeya@comagine.org. These prework site visits are scheduled December 2019 – January 2020. The system leader, the clinical champion, and the day-to-day leader, at a minimum, should attend all site visits.

2. Read the Collaborative Prework Packet

Please read this Prework Packet. Nursing facility will have several important tasks to complete in order to prepare for the February 2020 Learning Session.

3. Form a Team

Each nursing facility needs to form a Collaborative Team to test and implement system changes related to improving care. It is recommended that each team have at least four team members. These four, along with other members, comprise the Facility Team.

A nursing facility project team that will guide the work and execute the tests of change throughout the Collaborative. Include members representing various areas of work being undertaken in the Collaborative. Consider frontline representation from the key areas of work (e.g., pharmacy for pain management, nurses, social worker, physicians for resident/family communication with the care team, CNAs, spiritual services, etc.)

Your team should include individuals who:

- have a working knowledge of the area selected;
- can work together as a functioning team that works at an accelerated pace;
- have time allocated by senior leadership to work on this project, and are motivated and excited about change and creating new designs; and
- can make the work of the team visible to the departments/services that will be involved in the spread by sharing results and inviting other staff members to attend team meetings.

It is important to plan for flexibility in staff schedules and coverage to attend Learning Sessions.

Select Team Leaders

When forming your facility team, you will need to fill four leadership roles (one individual may fill multiple roles): senior leader, system leader, day-to-day leader, and clinical champion. Individuals in these roles represent the team at the Learning Sessions and the Outcomes Congress, and they share their learning with other members of the team. Team members will report progress to the senior leader. Ideal team members are described below.

Senior Leader (either at the facility or corporate level)

The ideal senior leader:

- Encourages the improvement team to set its goals at an appropriate level to meet organizational goals and reaching agreement on the team charter;
- Provides the team with the resources needed, including staff time and operating funds;
- Makes it clear to the team that they have the time, resources and authority needed to change organizational systems to accomplish their goal;
- Ensures that improvement capability and other technical resources are available to the team;
- Regularly reviews the work of the team, and
- Develops a plan to spread successful changes from the improvement team to the rest of the organization, including:
    - Communicates what is learned from the improvement work in ways that motivate and mobilize the entire organization.
    - Designates someone who will be responsible for leading the activities needed to support spread.

Examples of senior leaders include a *nursing facility administrator or director of nursing*. The senior leader is encouraged to attend all Learning Sessions and the outcomes congress and is required, at a minimum, to attend Learning Session 1 and the Outcomes Congress. Nursing facilities operated by corporations are encouraged to identify BOTH a building AND a corporate senior leader, and at a minimum, keep the corporate leader apprised of progress throughout the Collaborative, where necessary.

System Leader (in charge of line staff operations)

The ideal system leader:

- has direct authority to allocate the time and resources to achieve the team's aim;
- has direct authority over the systems affected by the change; and
- will champion the spread of successful changes throughout the facility.

An example of a system leader would be the *director of nursing or a charge nurse*. Please note: this individual may serve both roles (e.g. Senior Leader and System Leader). The system leader attends all Learning Sessions and the outcomes congress.

Day-to-day Leader

The day-to-day leader is the critical component of the project, ensuring that changes are tested and implemented and overseeing data collection. It is important that this person understands not only the details of the system, but also the various effects of making change(s) in the system. This person also needs to be able to work effectively with the champion(s), other technical experts, and leaders.

The day-to-day leader should:

- Have a working knowledge of the area selected (in this case, experience with prior improvement efforts related to End of Life Care);
- Be able to carry the work of the improvement team beyond the pilot unit to spread units throughout the nursing facility;

- Be able to organize and coordinate a functioning team that works at an accelerated pace and have time allocated by senior leadership to work on this project;
- Be motivated and excited about change and creating new designs.

A *quality improvement leader, charge, resident care manager or highly motivated staff nurse* might serve as day-to-day leader. The day-to-day leader attends all Learning Sessions and the Outcomes Congress.

Clinical Champion

The ideal clinical champion:

- is a respected clinical staff person with interest and expertise in improving clinical care;
- understands current processes of care;
- has a good working relationship with colleagues and the day-to-day leader; and
- wants to drive improvements in the system.

An example of a clinical champion would be a *physician, geriatric nurse practitioner, or medical director*. It is essential to have a clinical champion on the team. The clinical champion is encouraged but not required to attend Collaborative activities.

Other Team Members

In addition to the facility team leaders, the Collaborative team should also include members from nursing facility departments potentially affected by system changes related to the clinical quality improvement aim. These other members should be included but will not need to travel to Learning Sessions. These members should include people from departments and work areas that will be affected by the changes, to ensure that the team understands the system it is trying to redesign and to promote buy-in for the changes.

These members learn about the Collaborative from the leadership team and participate in implementation at the nursing facility. Potential team members include:

- residents and family members;
- spiritual staff members;
- paraprofessional nursing (nursing assistants) and rehab staff (therapy aide);
- staff development personnel;
- dieticians and dietary staff;
- professional rehabilitation staff (Occupational Therapists, Speech Therapists, and Physical Therapists);
- health information managers;
- activities and social services staff;
- central supply staff; and
- maintenance and environmental services.

Attributes of Highly Effective Team Members

Highly effective teams don't just happen! Time, cultivation, and attention are needed to create an environment for high-functioning teams. Here is a list of attributes of highly effective teams:

- The purpose and objectives of the team are clear;
- The roles of team members are clear;
- A climate exists that seeks and supports participation of all team members;
- A climate exists that supports problem solving and learning;
- Decision making processes are clear;
- Leaders model a clear conflict resolution process;
- The team practices good housekeeping; clear agendas, start and stop times, role assignments (facilitator, note taker, timekeeper);
- Leadership is distributed, and shared among team members;
- Team members' strengths are utilized to the fullest;
- The team encourages risk taking and creativity;
- The team has method to assess itself as a team.

Checklist for Selecting Effective Team Members

- ❑ Is the person respected for his/her judgement by a range of staff?
- ❑ Does he/she enjoy a reputation as a team player?
- ❑ What is the persons' area of skill or proficiency?
- ❑ Is he/she an excellent listener?
- ❑ Is this person a good verbal communicator within and in front of groups?
- ❑ Is this person a problem-solver?
- ❑ Is he/she disappointed with the current system and processes and wants to improve things?
- ❑ Is this person creative, innovative, and enthusiastic?
- ❑ Is he/she excited about change?

4. Complete the Prework Activities Worksheet

The prework activities worksheet at the end of this section will help you document progress as your team:

- forms;
- develops an aim statement;
- defines (or identifies) a population of focus (for example a wing or unit);
- and begins to select measures.

5. Develop an Aim Statement

The Collaborative is modeled after the Institute for Healthcare Improvement (IHI) Breakthrough Series Collaboratives, which use the Model for Improvement, a "trial-and-learn" approach to quality improvement. The Model for Improvement couples three fundamental questions with plan-do-study-act (PDSA) cycles:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in an improvement?

The first question is answered in an aim statement. An aim statement is a concise written statement describing what the team expects to accomplish in the Collaborative; it provides guidance for the team's specific improvement efforts. The aim statement ensures that team activities align with the strategic goals of the team's organization. Involving senior leadership in developing an aim statement can help teams ensure support for their work.

An example of an aim statement consistent with the goals of this Collaborative is as follows:

Provide End of Life Care that is person-centered and resident directed to meet 100% compliance with DC Medicaid End of Life Program requirements by October 31, 2020.

In setting your aim, be sure to

Involve senior leaders. Senior leaders must align the aim with strategic goals of the organization. They must also provide for support personnel and resources from information systems, finance and reimbursement, medical affairs, etc.

Base your aim on data or organizational needs. Examine data within your organization. Refer to the Collaborative charter and focus on issues that matter at your nursing facility.

State the aim clearly and use numerical goals. Teams make better progress when they have an unambiguous, specific aim. Setting numerical targets clarifies the aim, helps create tension for change, and directs measurement. For example, an aim to "ensure that 100% of CNA's will be trained in the "End of Life Care program within one month of orientation" will be more effective than an aim to "improve staff communication."

There will be time to refine your aim statement at the Learning Session and time during the year to further refine goals and tests of change related to the aim statement.

6. Define a Population of Focus/Pilot Unit

For participating nursing facilities, *the population of focus may be Medicaid residents*. The pilot unit is the first location in your nursing facility where testing will occur. It works better to begin testing in a focused location to keep the tests on a small enough scale and to allow for revision of the tests before implementation and spread occur. Ideally, nursing facilities would select a unit that has had stable staffing, has a good working environment among frontline staff, has individuals who are excited about creating a change, and have a high tolerance for rapid change early on.

7. Define Measures

Measuring performance during the Collaborative will enable the team to evaluate the impact of changes it makes to improve the delivery of care. Performance measurement is not an end. Measurement should be designed to accelerate improvement, not slow it down.

Each team will monitor progress on selected measures that can be tracked and may choose additional process measures based on changes implemented.

Suggested Draft Measures

Here are some suggested draft measures to address *outcomes* and *processes* of care. These measures will be further developed/refined in the End of Life Change Package.

Outcome measures:

- Percent of residents who self-report moderate to severe pain (Long-Stay)
- Percent of residents with decrease in all-cause readmissions and emergency department visits for our enrolled population (Palliative Care + Residents) compared to the target population

Process Measures:

- Percent of residents with pain assessment completed and documented within 24 hours of admission, within 24 hours of change of diagnosis/prognosis indicating a significant decline in overall health
- Percent of residents with documented Advance Care Planning discussion with resident (and family per resident choice) within 14 days of admission, and within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.
- Percent of residents with identified proxy decision-maker and document in the medical record within 14 days of admission, with 14 days of change or diagnosis/prognosis indicating a significant decline in overall health
- Percent of residents with documented MOST discussion within 14 days of admission, and within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.
- Percent of residents with documented discussion of resident goals around care and treatment within 14 days of admission, and within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.
- Percent of residents with documented assessment of resident's need for spiritual care and support is completed within 14 days of admission, within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.
- For those residents who expressed a desire or need for spiritual care, percent of residents that care is documented and provided within 3 days of having identified this need.

- Percent of staff trained in holistic, person-centered and resident directed EOL care concepts and interventions within 30 days of hire and annually.

Balancing Measures:

- Resident satisfaction with overall End of Life Care program
- Family satisfaction with overall End of Life Care program
- Staff satisfaction with overall End of Life Care program

Additional Measures

Other optional measures may be defined and collected by the participant nursing facility based on process improvement activity specifics.

8. Prepare a Storyboard for Learning Session 1

To maximize the group learning at the February 2020 Learning Session, each facility is required to bring a Storyboard describing your current End of Life Care program. Prior to the Learning Session, nursing facility teams will be provided a display board so that teams can present what they have accomplished and learned so far. Storyboards help create an environment conducive to sharing and learning from the experiences of others.

The storyboard should be as clear and concise as possible. The audience for storyboards consists of other nursing facility teams, Collaborative leadership, and faculty, and observers attending a Learning Session. Suggested content for a team storyboard is:

- Brief description of your nursing facility
- Team name, with team members and their titles
- Draft aim statement
    - What aspect of End of Life care are you trying to improve?
    - Why is it important to tackle this issue now? How is it important to residents, your facility, and the potential teams?
    - Expected start and end date
- Draft description of your resident population
- Draft list of selected measures with placeholder for data display (run chart, etc.)
- Description of progress so far

You may wish to personalize your storyboard with pictures or other decorations that show your team spirit! Don't stress over this, however – start small and add on to the Storyboard as the Collaborative progresses. **The Storyboards will be displayed at the February Learning Session, and you will have opportunities to share your Storyboard with your peers.**

9. Register and Plan for Learning Sessions

Team leaders represent the team at the Learning Sessions and the outcomes congress, and they share their learning with other members of the nursing facility team. The senior leader, at a minimum, should attend the first Learning Session and the Outcomes Congress. The system leader, the clinical champion, and the day-to-day leader should attend all Learning Sessions and the outcomes congress.

Registering

Nursing facility teams must register for Learning Sessions so that Collaborative leadership can provide adequate supplies and materials. Nursing facilities will receive email invitations to register for each Learning Session.

10. Communications with Facilities

The Collaborative leadership and nursing facility team members will use the email system to distribute information and tools, ask questions and receive replies, and conduct ongoing discussions of changes tested, barriers encountered, and lessons learned. At least one member from each team and a back-up contact will take responsibility for distributing information to the rest of the team.

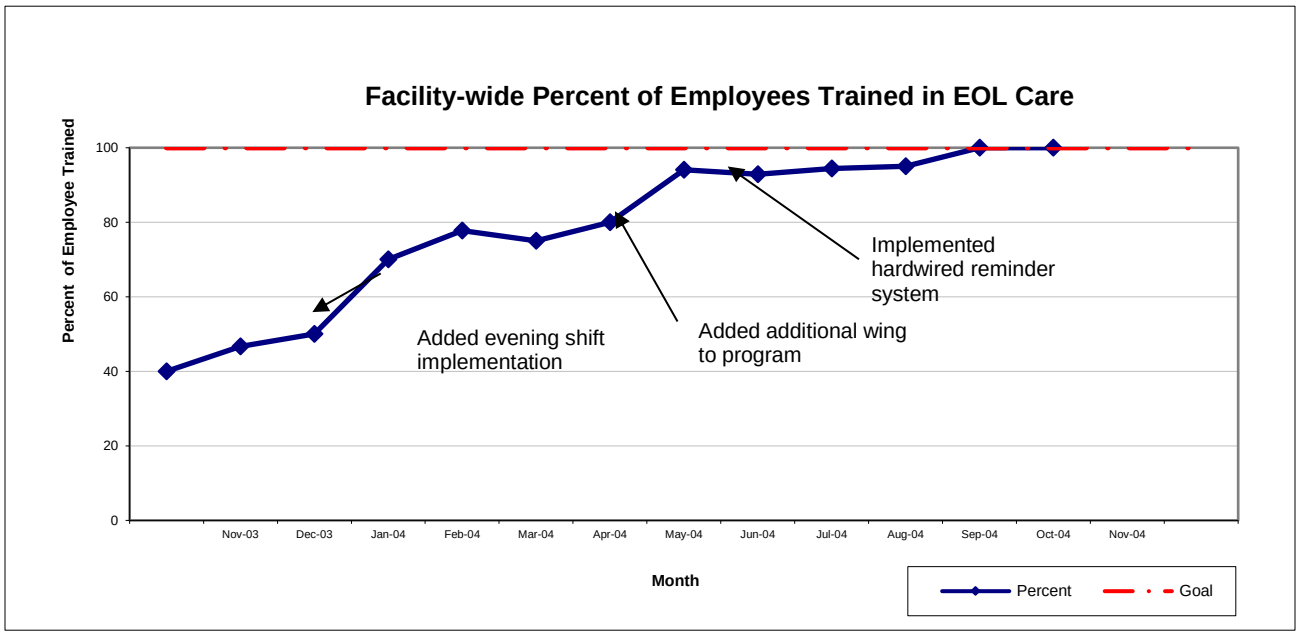
11. Senior Leader Report

Each nursing facility will be expected to prepare and maintain monthly reports tracking the team's progress on the selected measures and documenting the system changes tested during that month. The audience for the report is the senior leadership at the nursing facility. Each nursing facility will also share the report with other Collaborative participants and faculty. More information about the senior leader report (templates, tools, etc.) will be distributed at the first Learning Session.

Annotated Run Chart

A run chart is a line graph of data plotted over time. By collecting and charting data over time, you can find trends or patterns in the process and assess whether the changes you are making are leading to improvement. The minimum standard for monitoring the progress of your team throughout the Collaborative is an annotated run chart of the process measures selected. Data points should be plotted monthly on a run chart and submitted with senior leader reports. Run charts can be constructed via a run chart template provided to Collaborative members. The following run chart is one example of appropriate presentation of a prompted voiding process measure for the Collaborative:

Annotations on the run chart should include changes that are being evaluated or implemented as well as other circumstances that could impact Collaborative measures.



Prework Activities Worksheet

1. Team Members (Name) (Title)

a. Senior Leader _____

b. System Leader _____

c. Clinical Champion _____

d. Day-to-Day Leader _____

e. Other Team Members _____

2. Working Draft of Aim Statement

Example: Implement a comprehensive, holistic, person-centered, End of Life Program to include 100% of the DHCF EOL program audit criteria, by October 2020.

_____

_____

_____

_____

3. Definition of Population of Focus

Identify the nursing units or areas from which your population of focus is drawn (this could be all or a subset of units in the facility with Medicaid residents).

4. Working List of Measures Selected

Suggested draft measures:

Here are some suggested draft measures to address *outcomes* and *processes* of care. These measures will be further developed/refined in the End of Life Change Package.

Outcome measures:

- Percent of residents who self-report moderate to severe pain (Long-Stay)
- Percent of residents with decrease in all-cause readmissions and emergency department visits for our enrolled population (Palliative Care + Residents) compared to the target population

Process Measures:

- Percent of residents with pain assessment completed and documented within 24 hours of admission, within 24 hours of change of diagnosis/prognosis indicating a significant decline in overall health
- Percent of residents with documented Advance Care Planning discussion with resident (and family per resident choice) within 14 days of admission, and within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.
- Percent of residents with identified proxy decision-maker and document in the medical record within 14 days of admission, with 14 days of change or diagnosis/prognosis indicating a significant decline in overall health
- Percent of residents with documented MOST discussion within 14 days of admission, and within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.

- Percent of residents with documented discussion of resident goals around care and treatment within 14 days of admission, and within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.

- Percent of residents with documented assessment of resident's need for spiritual care and support is completed within 14 days of admission, within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.

- For those residents who expressed a desire or need for spiritual care, percent of residents that care is documented and provided within 3 days of having identified this need.

- Percent of staff trained in holistic, person-centered and resident directed EOL care concepts and interventions within 30 days of hire and annually.

Balancing Measures:

- Resident satisfaction with overall End of Life Care program
- Family satisfaction with overall End of Life Care program
- Staff satisfaction with overall End of Life Care program

Measures selected:

1. _____

2. _____

3._____

4._____

Potential issues in collecting data for the required measures:

_____

_____

_____

_____

Other optional measures selected:

1. _____
2. _____
3. _____
4. _____

Potential issues in collecting data for the optional measures selected:

_____

_____

_____

_____

References

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Collaborative Leadership and Faculty

Comagine Health Improvement Advisor Lead:
Gazelle Zeya
Email: GZeya@comagine.org | Phone: 800-949-7536, ext. 2992

DHCF Improvement Advisor Lead:
Derdire “De” Coleman
Email: Derdire.coleman@dc.gov | Phone: 202-724-8831

Comagine Health System Leader:
Selena Bolotin
Email: SBolotin@comagine.org

Comagine Health Faculty Chair
Dan Lessler, MD, MHA, Senior Vice-President, Clinical Leadership
Email: DLessler@comagine.org

DHCF Staff:

Cavella Bishop
Contract Administrator – Comagine Health
Email: Cavella.bishop@dc.gov | Phone: 202-724-8936

Ieisha Gray
Director, Long Term Care Administration
Email: Ieisha.gray@dc.gov | Phone: 202-442-5818

Collaborative Glossary

Action Period

The time between Learning Sessions when teams work on improvement in their own facilities. Teams are supported by the Collaborative staff and faculty, and they are connected to other Collaborative team members.

Aim, or Aim Statement

A written, measurable, and time-sensitive statement of the accomplishments a team expects to make from its improvement effort. The aim statement contains a general description of the work, the population of focus, the numerical goals, and a statement on spreading the changes to another population.

Annotated Run Chart, or Annotated Time Series

A line graph showing results of improvement efforts plotted over time. The changes or annotations made are also noted on the chart at the time they occur, allowing the viewer to connect changes made with specific results.

Assessment Scale

A numerical scale used to assess the progress of participating teams toward reaching their aim. 1 = forming team, and 5 = outstanding, sustainable improvement. In each Collaborative, Collaborative faculty assesses teams and may also ask them to evaluate their own progress using this scale. The expected level of attainment by the end of the Collaborative is a 4 (significant progress).

Breakthrough Series (BTS) Collaborative (see Collaborative)

Change Concept

A general idea for changing a process. Change concepts are usually at a high level of abstraction but evoke multiple specific ideas for how to change processes. “Simplify,” “reduce handoffs,” “consider all parties as part of the same system,” are all examples of change concepts.

Change Package

A list of essential process changes that will help to lead a breakthrough improvement, usually created by the Collaborative faculty based on literature and their experiences.

Clinical Champion

An individual in the organization who believes strongly in the improvements and is willing to try them and work with others to learn them. Teams need at least one nurse champion on their team. Champions in other disciplines who work on the process are important as well.

Collaborative

A time-limited effort (usually 6–18 months) of multiple organizations that come together with faculty to learn about and to create improved processes in a specific topic area. The expectation is that the teams share expertise and data with each other; thus, “All teach, all learn.”

Collaborative Chair

The leader of the Collaborative, usually an expert in the topic.

Collaborative Coordinator

The noted authority in Collaborative topic. Creates a shared vision and provides intellectual leadership on the topic, helps form and guide faculty, assists the Improvement Advisor to develop the change package and measurement system, chairs and teaches at Learning Sessions, coaches and mentors organizations to achieve goals, and reviews Collaborative progress.

Collaborative Framework

The Collaborative framework consists of the charter, change package, and measurement strategy. The framework provides constant direction to the teams regarding why they are doing this work, what changes they can make, and how they can use measurement to determine if they are making changes that result in improvements.

Collaborative Team

All individuals from the nursing facilities, Comagine Health and DHCF that drive and participate in the improvement process. A core team of three individuals attends the Learning Sessions, but a larger team of six to eight people, often from various disciplines, participates in the improvement process in the organization.

Community of Practice

Groups of people who share a concern, set of problems, mandate or sense of purpose. Communities of practice complement existing structures by promoting collaboration, information exchange, and sharing of best practices across boundaries of time, distance, and organizational hierarchies. A great deal of knowledge creation happens in these less visible but increasingly recognized and supported groups.

Cycle

See PDSA cycle.

Day-to-Day Leader

The person on the nursing facility's team who is responsible for driving the improvement process every day. This person manages the team, arranges meetings, and assures that tests are being completed and that data are collected.

Director

The person who oversees all aspects of the Collaborative. The Director coaches and guides topic experts, facilitates Learning Sessions, teaches and coaches teams about process improvement (with the Improvement Advisor), regularly assesses Collaborative progress and institutes necessary changes to meet Collaborative aim, and supports collaborative learning throughout the Action Periods.

Early Adopter

In the improvement process, the opinion leader within the organization who brings in new ideas from the outside, tries them, and uses positive results to persuade others in the organization to adopt the successful changes.

Early Majority/Late Majority

The individuals in the organization who will adopt a change only after it is tested by an early adopter (early majority) or after the majority of the organization is already using the change (late majority).

Electronic Mailing List, or Email List

A communication system that allows teams to stay connected with the leadership team and each other during the action periods. Sharing information, getting questions answered, and solving problems are all part of email list activity.

Faculty (see Subject Matter Experts)

Handbook

Pages containing a complete description of the Collaborative, along with expectations and activities to complete before the first meeting of the Collaborative.

IHI

Institute for Healthcare Improvement

IHI Breakthrough Series

An improvement method that relies on spread and adaptation of existing knowledge to multiple settings to accomplish a common aim.

Implementation

Taking a change and making it a permanent part of the system. A change may be tested first and then implemented throughout the organization.

Improvement Advisor

The expert in process improvement and measurement who assists the co-chairs and director in guiding the Collaborative's work and teaches and coaches teams on process improvement at Learning Sessions and during Action Periods.

Improvement Cycle

See PDSA cycle.

Key Changes

The list of essential process changes that will help lead to breakthrough improvement, usually developed by the leadership team and chair based on literature and their experiences.

Key Contact

The individual on the organization team who takes responsibility for communication between the team and Comagine Health, including monthly reporting and disseminating information to team members. The key contact is often the day-to-day leader on the team.

Key Messenger

The individual in the organization who can be relied on for spreading ideas to others within the organization.

Knowledge Management

A method for gathering information and making it available to others.

Leadership Team

The small group of experts on the topic who assist the chair and director in teaching and coaching participating teams. Usually the leadership team contains representatives from all the disciplines who are involved in the change process.

Learning Session

A half day meeting during which participating organization teams meet with faculty and collaborate to learn key changes in the topic area, including how to implement changes, an approach for accelerating improvement, and a method for overcoming obstacles to change. Teams leave these meetings with new knowledge, skills, and materials that prepare them to make immediate changes.

Measurement System

The key indicators that teams will use to measure improvement in their own organizations, along with suggested methods for defining variables and collecting data.

Measure

A focused, reportable unit that will help a team monitor its progress toward achieving its aim.

Model for Improvement

An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes.

Organization Team

The group of individuals, usually from multiple disciplines, that participates in and drives the improvement process. Typically, a core team of three individuals attends the Learning Sessions, but a larger team of six to eight people participates in the improvement process in the organization.

Outcome Measure

Measures of change (or lack of change) in the well-being of a defined population. Improvement in an outcome measure reflects the health status of the resident, whereas process measure reflects the care delivery to the resident. Improvement in an outcome measure has a direct effect on mortality and morbidity.

Outcomes Congress

A large public meeting at the end of the Collaborative during which the best practices in the topic area are presented to others interested in making improvements in the area.

PDSA Cycle

A structured trial of a process change. Drawn from the Shewhart cycle, this effort includes the following steps:

Plan—a specific planning phase;

Do—a time to try the change and observe what happens;

Study—sometimes called “check,” an analysis of the results of the trial; and

Act—devising next steps based on the analysis.

This PDSA cycle will naturally lead to the “plan” component of a subsequent cycle. PDSA cycles are also called “rapid cycles” or “improvement cycles.”

Pilot Population

See population of focus.

Pilot Site

The clinic location where changes are tested. After implementation and refinement, the changes will be spread to additional locations.

Population of Focus

A designated set of residents who will be tracked to determine whether changes have resulted in improvements. For this Collaborative, a pilot population might be defined as Medicaid residents on a particular wing or unit.

Prework Packet

A collection of materials (hard copy or electronic) containing a complete description of the Collaborative, along with expectations and activities to complete prior to the first Learning Session of the Collaborative.

Prework Period

The time before the first Learning Session when teams prepare for their work in the Collaborative. Prework activities include selecting team members, registering for the first Learning Session, scheduling initial meetings, preparing an aim statement, defining a pilot population, selecting measures, and initiating data collection.

Process Change

A specific change in a process in an organization. More focused and detailed than a change concept, a process change describes what specific changes should occur. “Institute a pain management protocol for patients with moderate to severe pain” is an example of a process change.

Rapid Cycle

See PDSA cycle.

Run Chart

See “annotated time series.”

Sampling Plan

A specific description of the data to be collected, the interval of data collection, and the subjects from whom the data will be collected. The sampling plan is included on all senior leader reports. It emphasizes the importance of gathering samples of data to obtain “just enough” information.

Senior Leader

The executive in the organization who supports the team and controls the resources employed in the processes to be changed. This person is usually at the administrator level or higher. The senior leader works to connect the team’s aim to the organization’s mission, provides resources for the team, and promotes the spread of the team’s work to others.

Senior Leader Report

The standard reporting format for monthly progress updates in a Collaborative. This concise, two-page report includes an aim statement, measures to be used, a sampling plan, a listing of the changes made, and the results displayed graphically on run charts. The nursing facility pilot team prepares the report and sends it to the senior leader at the nursing facility, along with submitting the report to the Comagine Health Quality Improvement Advisor Lead. Reports will be reviewed and summarized in Collaborative reports.

Spread

The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements. The theory and application of spread comes from the literature on Diffusion of Innovation (Everett Rogers, 1995)

Staging Plan

A plan of what populations/units will be spread to and in what order.

System Leader

Responsible for all Collaborative Improvement. Charters Collaborative consistent with mission, goals, and resources of their system, provides resources for Collaborative staff and faculty, and provides executive review and guidance. In the present Collaborative, this person may be the administrator or the director of nursing services.

Subject Matter Experts (Faculty)

Viewed as credible experts in the selected team, represent multiple disciplines and multiple organizational structures (primarily practitioners, some researches), specifies goals, high leverage changes, teams for Prework, teaches and coaches at Learning Sessions and during Action Periods, and advises the Chair and Director about teams’ progress.

Technical Expert

The team member in the organization who has a strong understanding of the process to be improved and changes to be made. A technical expert may also provide expertise in process improvement, data collection and analysis, and team function.

Test

A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

Tipping Point

In epidemiology, the concept that small changes will have little or no effect on a system until a critical mass is reached. Then a further small change “tips” the system and a large effect is observed.

Appendix A – Collaborative Tools

Checklist for Completing Prework Activities

To prepare for Learning Session 1, participating nursing facility teams should complete the tasks listed below:

- ❑ 1. If not previously arranged, schedule a prework site visit with the Comagine Health QI Consultant
- ❑ 2. Read the Collaborative Prework Packet
- ❑ 3 Form a team or review current Collaborative team
- ❑ 4. Complete the Prework Activities Worksheet
- ❑ 5. Develop an Aim Statement
- ❑ 6. Define a Population of Focus/Pilot Unit
- ❑ 7. Define Measures
- ❑ 8. Prepare a Storyboard for Learning Session 1
- ❑ 9. Register and Plan for Learning Sessions
- ❑ 10. Communications with Facilities
- ❑ 11. Senior Leader Reports

Appendix B – Collaborative Tools

Prework Activities Worksheet

1. Team Members (Name) (Title)

a. Senior Leader _____

b. System Leader _____

c. Clinical Champion _____

f. Day-to-Day Leader _____

g. Other Team Members _____

2. Working Draft of Aim Statement

Example: Implement a comprehensive, holistic, person-centered, End of Life Program to include 100% of the DHCF EOL program audit criteria, by October 2020.

_____

_____

_____

_____

3. Definition of Population of Focus

Identify the nursing units or areas from which your population of focus is drawn (this could be all or a subset of units in the facility with Medicaid residents).

_____

_____

_____

_____

4. Working List of Measures Selected

Suggested draft measures:

Here are some suggested draft measures to address *outcomes* and *processes* of care. These measures will be further developed/refined in the End of Life Change Package.

Outcome measures:

- Percent of residents who self-report moderate to severe pain (Long-Stay)
- Percent of residents with decrease in all-cause readmissions and emergency department visits for our enrolled population (Palliative Care + Residents) compared to the target population

Process Measures:

- Percent of residents with pain assessment completed and documented within 24 hours of admission, within 24 hours of change of diagnosis/prognosis indicating a significant decline in overall health
- Percent of residents with documented Advance Care Planning discussion with resident (and family per resident choice) within 14 days of admission, and within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.
- Percent of residents with identified proxy decision-maker and document in the medical record within 14 days of admission, with 14 days of change or diagnosis/prognosis indicating a significant decline in overall health
- Percent of residents with documented MOLST discussion within 14 days of admission, and within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.
- Percent of residents with documented discussion of resident goals around care and treatment within 14 days of admission, and within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.
- Percent of residents with documented assessment of resident's need for spiritual care and support is completed within 14 days of admission, within 14 days of change of diagnosis/prognosis indicating a significant decline in overall health.
- For those residents who expressed a desire or need for spiritual care, percent of residents that care is documented and provided within 3 days of having identified this need.
- Percent of staff trained in holistic, person-centered and resident directed EOL care concepts and interventions within 30 days of hire and annually.

Balancing Measures:

- Resident satisfaction with overall End of Life Care program
- Family satisfaction with overall End of Life Care program
- Staff satisfaction with overall End of Life Care program

Measures selected:

1. _____

2. _____

3._____

4._____

Potential issues in collecting data for the required measures:

_____

_____

_____

_____

Other optional measures selected:

1. _____

2. _____

3. _____

4. _____

Potential issues in collecting data for the optional measures selected:

Notes/Planning

December 2019

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

January 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

March 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

April 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

May 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

June 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

July 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

August 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

September 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

October 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31