**2012 Exceptional Care Planning (ECP) Replication Project**
**Summary of First Follow-up Conference Calls:**
**Greater NYC Metro Area, Queens & Westchester**

A total of 16 people representing 6 Nursing Homes participated in the July 18 and 19, 2012 conference calls for the greater NYC Metro Area, Queens and Westchester regions. The call was facilitated by Nurse Educator, Ann Marie Bradley. ECP Trainer, Barbara Bates, and Project Manager, Karen Revitt, were available to provide additional feedback.

## Different Stages of SOC Development

Nurse Educator, Ann Marie Bradley reviewed the Steps to Successful Implementation and SOC template provided at the workshop trainings. Many of the eldercare providers had staff participating in the calls that had not attended the in-person spring workshops and one facility specifically requested a brief overview of ECP as a way to further orient staff new to the process.

Eldercare providers reported as being at different stages in forming an interdisciplinary task force and beginning to review Standards of Care (SOC). Three of the six facilities participating had submitted a signed letter of agreement to implement ECP and two of these had formed interdisciplinary task forces and were starting to develop their process for SOC development/refinement. One home in the Queens area reported that their task force intended to review the SOC developed by a sister facility in their health care network and use these standards as the basis for theirs. Another Westchester site with an interdisciplinary task force shared they intend to develop their Falls SOC first. The remaining site with a signed letter of agreement said they had not formed an interdisciplinary task force yet and were considering the call a kick off to beginning the process.

The three sites that had not yet officially joined the project were at different levels of implementation and SOC development as well. One assisted living facility reported that it had already been using ECP principles and SOC in care planning for its residents and is seeking to refine and tighten existing SOC; since the spring trainings, the other two skilled nursing facilities had shared the workshop materials with their administrators and nursing management staff. They are in the process of deciding whether they will implement ECP at this time and wanted to learn more about developments thus far at implementing sites.

## Resources and Ideas for the Process of SOC Development

The facilities that had begun to review/refine SOC asked the call facilitators about resources and ideas for the development process. Specifically, they wanted more information about homes in the demonstration project, in terms of what department initiated and then reviewed a particular

SOC. Barbara Bates described how the pilot project homes used sub-groups of their interdisciplinary task force to begin the shell of the SOC and then brought the drafted standard back to full committee for further review and refinement. She suggested that sites develop approximately 20 SOC before beginning to phase in ECP on chosen unit(s). The demonstration project homes developed ECP-based care plans with new admissions, at annual reviews, when changes in the resident's medical condition warranted re-visiting the care plan or, when necessary, choosing a sub-population of their residents. The development of a resident's ECP care plan was based on the results of the MDS screening and the teams used the same staff member(s) to start the shell of the care plan as it had with traditional care planning.

Ms. Bates also shared how facilities can use the results of the MDS to identify potential problems and begin linking clinical conditions. For example, if the MDS and CAA (Care Area Assessment) triggered a risk for pressure ulcers, the facility could then consider how skin breakdown could affect nutrition and pain. The shell of the care plan could begin with some preliminary work by the applicable disciplines and then be brought to the care planning meeting to fully integrate and refine into an ECP care plan that is holistic and incorporates the resident's/family perspective. The assisted living provider that had already been using an interdisciplinary approach confirmed that this is the process they use when doing care planning by exception.

Ms. Bradley said that all the sites participating in the calls would receive a review she prepared based on the final report of the ECP demonstration project that includes tips/suggestions as well as time savings reported after implementing ECP. This review along with the call summaries will also be posted to **FLTC's ECP Replication Project web page**.

**ECP versus Simple Preferences**

In addition, there was discussion about the differences between an ECP care plan and simply listing the resident's preferences. Ms. Bates indicated that ECP was very similar in the sense that it makes a resident's preferences and strengths an integral part of the care plan. In fact, the CAAs direct nursing homes to get the input of residents and their families. She suggested sharing the shell of the care plan and ideas for incorporating positive aspects of the resident into his/her care with the resident and family at the care planning meeting. The assisted living provider that had already been using a resident-focused approach confirmed they use this same process when doing care planning by exception. ECP care plans provide more detail than a simple list of resident preferences because they view a resident's preferences and strengths through the lens of applicable SOC and, when appropriate, must clinically justify aspects of the care plan that differ from the standards. Standards must be based on current research of best practices while incorporating a facility's specific population and methods for addressing care needs.

**2012 Exceptional Care Planning (ECP) Replication Project**
**Summary of First Follow-up Conference Calls: Greater Rochester and Capital Regions**

A total of 18 people representing 14 Nursing Homes participated in the June 28 and 29, 2012 conference calls for the greater Rochester and Capital regions. The call was facilitated by Nurse Educator, Ann Marie Bradley. ECP Trainer, Barbara Bates, and Project Manager, Karen Revitt, were available to provide additional feedback.

**Quality over Quantity**
As anticipated, discussion revealed that participating nursing homes are at varying stages of ECP implementation, with several just beginning the process of reviewing the training materials with their team, some reviewing current policies/procedures and others having established an implementation timeline and task force to spearhead the development/refinement of Standards of Care (SOC). Ann Marie Bradley emphasized that every facility must go at its own pace, with each step in the process creating a tangible improvement in care planning and delivery. The goal is quality over quantity.

**Decision to Implement ECP**
Most homes on the calls had submitted a signed Letter of Agreement (LOA) to the FLTC; however, three facilities were reviewing materials with their administrative team to evaluate whether the timing was right for them to implement ECP. Considerations include commitment to other projects and mergers, the degree of change required to move from traditional to person-centered/interdisciplinary care planning and the integration of ECP with current software.

**Integration with Computers & Software**
Greater Rochester and Capital Region facilities participating in the calls had varying levels of electronic care planning capacity. One home said they had electronic task lists that were updated weekly; however, they were not cross walked directly to the paper care plans. While another site in the greater Capital Region indicated that its electronic task lists are connected directly to care plans, nurses use hand-held tablets to document completion of tasks and the software enables them to monitor staff review of care plans as well as automatically update the aide care cards. One facility felt it had underutilized its electronic care planning software and was currently reviewing how ECP might be integrated. Barbara Bates said that most software has the ability to add to and customize the "point and click" care libraries and Standards of Care (SOC) can be put into the computer enabling staff to easily access the information.

**Development of SOC**
Two corporate entities in the greater Rochester region shared their plans to implement ECP across their eldercare facilities using an interdisciplinary task force with representatives from all campuses to establish the corporate-wide SOC and coordinate the implementation process over a 6 month period. One of these facilities indicated its taskforce meets weekly and is working to **first** finalize their SOC based on the ten sample SOC that Barbara Bates gave out for the staff trainings: Activities of Daily Living (ADL), Behavior Related to Dementia, Delirium,

Depression, Falls, and Nutrition/Hydration in the Elderly, Oral/Dental, Pain, Prevention of Skin Breakdown and Urinary Incontinence. Next, they plan to add 4 or 5 more SOC that are used frequently for their population and then will begin implementation at their smallest long term care community (that does not have any special care units) before rolling ECP out to the other sites.

Ms. Bates said establishing about 15-20 SOC before implementing was a good idea so that homes have a solid foundation for building ECP care plans that will address a majority of their resident needs. One home shared that they have formed a small task force and have begun gathering more information about SOC development because they don't want to "reinvent the wheel" when drafting their SOC but would rather use a template that has been successful for other sites. The FLTC team offered to provide recommendations/suggestions from the final report of 2008-2010 demonstration project as well as ask previous implementers if they would be willing to share the SOC they had developed.

Several homes asked about care planning as it relates to the two new antipsychotic Quality Measures (QMs). Ms. Bradley stated that the Centers for Medicare and Medicaid (CMS) is still clarifying them through the National Quality forum; however, presently the same psychiatric diagnoses such as Schizophrenia, Tourette's, and Huntington's, are excluded so facilities should focus on accurately coding these on the MDS and on having a psychiatric assessment and good documentation to back up the reasons for use of antipsychotics especially in dementia residents who are not diagnosed with a psychotic condition. Focusing on medication alternatives for behavioral issues in care planning is encouraged.

**Interdisciplinary Task Force and Ongoing Education**

The groups also discussed whether a taskforce should include CNAs/Aides, and if yes, should they attend all meetings and should there be representation from each campus when implementing across several facilities. Ms. Bradley and Ms. Bates both recommended that aides definitely be included in the process of developing SOC and a more viable option might be to rotate which CNAs/Aides attend meetings as well as varying how often they go depending on scheduling and topics to be discussed at the meeting; the importance of at least having the CNAs/Aides review the drafted SOC was stressed to help ensure that standards are written in clear, easy-to-understand language. As illustrated in Ms. Bates' sample SOCs, "Special Considerations for CNAs" can be built right into the standard. Also, Nurse Aides can serve as "the motivators" and sites from the pilot project that involved them right from the beginning in the development of SOC and gave them designated roles in the process had a smoother implementation.

Ms. Bates suggested that sub-groups of the task force representing certain disciplines could start the shell of a particular SOC and then bring back the draft to the larger committee. She also stressed that ongoing education is critical and inclusion of a staff educator or in-service coordinator in the task force greatly assists sites in planning the initial introduction of ECP to staff as well as providing updated education on SOC that respond to changes in regulations and clinical practice based on new research on best practices and protocols.