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Final Narrative Report:
Replicating Exceptional Care Planning in New York State Nursing Homes
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Background

The original goal of "Replicating Exceptional Care Planning in New York State Nursing Homes" was to improve care and reduce costs in 100 NYS nursing homes by replicating an alternative care planning process ("Exceptional Care Planning") proven effective in an earlier NYSHF-funded study conducted from 2008-2010 in nine diverse nursing homes. This goal has been refined to focus more specifically on improving quality of care through positive impacts on both residents and staff that result from engagement in the ECP process as outlined below:

- Person-centered: incorporates resident's care preferences and goals; builds on strengths and interests
- Efficient use interdisciplinary care team: holistic plan of care that integrates disciplines to address care needs and goals, clinically linking approaches from different disciplines when appropriate
- Based on current standards of practice: care activities described are in accordance with best practice recommendations from the research that is most currently available
- Accessible to residents, their families and staff: streamlined, concise plans of care that clearly and easily show the standard approaches being used as well as the care strategies, needs and goals that are specific to a particular resident

The project's primary objectives largely remain the same (the exception is in bolded text):

(1) Teach this process to the staff of 100 NYS nursing homes via a day-long training

(2) Support the implementation of the process via multiple user group teleconferences and

(3) Evaluate the extent to which the project is replicated on selected units of the **33** participating nursing homes.

The expected outcomes remain consistent: successful implementation of new resident-centered care plans that utilize an interdisciplinary approach, resulting in care that is holistic, grounded in the current evidence-based Standards of Care and accessible to staff, families and residents.

Activities

During this reporting period, FLTC applied for and received a no cost extension from NYSHF to complete the project by the end of June 2013 so that we could train more sites in the regions we hadn't reached previously and provide further individualized support to existing and new sites in developing research-based, interdisciplinary Standards of Care (SOC).

Conference calls and individualized consultation

Conference calls began in June and continued at regular intervals throughout the project period for a total of twelve call offerings for the ECP user group (Please see **Appendix A: List of ECP Participant Sites and Implementation Activities**). In addition, several sites received refresher and SOC development trainings specifically for their staff including CVPH in Plattsburgh (ECP Lead Trainer, Barbara Bates, provided a three-hour on-site consultation on October 11, 2012), Somers Manor in Westchester County (two-hour online trainings, May 8 and May 31, 2013) and Cayuga Ridge (1.5 hour online training, June 20, 2013).

New regional trainings

As planned, three new ECP fundamentals trainings were held in the North country at Adirondack Tri-County Nursing Home (11.27.12), the Syracuse region at Van Duyn Home and Hospital (11.29.12) and Suffolk County at the Long Island State Veterans Home/LISVH (12.6.12). A total of 112 professionals (Adirondack-16, Van Duyn-42, LISVH-54) representing 23 nursing homes (Adriondack-3, Van Duyn-10, LISVH-10) completed the six-hour training led by ECP Lead Trainer, Barbara Bates, with assistance from Nurse Educator, Ann Marie Bradley, and Project Manager, Karen Choens.

Dissemination and outreach

The interactive webinar for the Department of Health surveyors was delayed several times due to scheduling conflicts; however, the online presentation led by Barbara Bates with assistance from Karen Choens was given on October 15, 2012 with surveyors in Albany and Syracuse participating. The recorded presentation and slides were added to the ECP webpages.

ECP was further promoted at the LeadingAge NY statewide Directors of Nursing and Directors of Social Work Conference held on November 15, 2012 in Bolton Landing. ECP information was made available at a booth with ECP Lead Trainer, Barbara Bates, and Project Manager, Karen Choens, explaining the approach to visitors and promoting the upcoming trainings scheduled for late November and early December. In fact, the training held in December at the Long Island State Veterans Home led to an offer for Ms. Bates and Ms. Choens to present on ECP at the National Association for State Veterans Home Conference in February 2013. This presentation, ***Pearls of Wisdom on Care Planning: Ideas to help residents and staff get exceptional results***, is available in **Appendix D.**

Outcomes, Analysis, and Interpretation

Refinement of Project Goals

The focus of the *Replicating Exceptional Care Planning in NYS Nursing Homes* project continued to be on improving quality of care. While reducing costs through streamlining the care planning process was shown to be successful in the original demonstration and may result for homes in the replication project as well, the goal this time was to improve quality of care and use findings from homes engaged in the ECP implementation process to create tools and guidance documents that would support future dissemination. To accomplish this aim, FLTC analyzed the relationship between the fundamentals of ECP approach and anticipated impacts on both staff and residents. The table below outlines the specific tenants of the ECP approach and their associated expected impacts on residents and staff.

ECP Tenants	Impact on Resident	Impact on Staff
Person-centered	Incorporate care preferences and goals, building on strengths	Bring staff back to roots – helping people
Interdisciplinary	Holistic, integrated care; takes into account all conditions and strengths and how they are related	More efficient use of staff time, reduces unnecessary redundancies in care provision; provides more comprehensive picture of resident and how disciplines can work together to maximize care quality
Based on current standards of practice	Care received is based on procedures and strategies evaluated to be the best in the field	Confidence and pride in providing care that corresponds with evidence-based care practices
Accessible	Easier to understand and evaluate if goals align with preferences, less intimidating to discuss options	Immediate picture of person and his/her specific preferences, goals and care approaches; more time and information to provide individualized direct care

Realistic Objectives
The objective of teaching 100 nursing homes the ECP fundamentals in a day-long training was achieved; In fact, a total of 104 nursing homes attended the seven trainings held in the spring and winter of 2012. However, the target for the number of communities that actually went on to engage in the process of implementing ECP had to be revised to a more realistic number of 33 homes. FLTC revised this number in consultation with the NYSHF after the spring 2012 trainings based on feedback we received from sites and discussions that had emerged during the first follow-up conference calls.

The response to the fundamentals trainings was overall very positive; however, many sites expressed concern that implementing ECP would involve a big commitment that would be difficult to fulfill given competing demands for time and resources stemming from three system levels:

- **Federal:** new Centers for Medicare and Medicaid Services (CMS) Quality Measures related to use of antipsychotics; DOH surveys based on Minimum Data Set (MDS) 3.0 and Quality Indicator Survey (QIS)
- **State:** Medicaid redesign and the upcoming mandated transition of permanently-placed Medicaid-only nursing home residents throughout the state to Medicaid managed care plans
- **Facility:** meeting daily needs of residents with complex medical conditions; implementing new Electronic Medical Record (EMR) systems

While the quality improvements ECP promotes align with many of these initiatives, facilities were clearly at different stages of readiness for implementing a standards-based, fully integrated and person-centered approach to care planning. This became evident when reviewing comments on the training evaluations. Responding to what attendees viewed as the most valuable part of the training, numerous people indicated that the approach of "listening to members of all disciplines and respecting their points of view" (The Osborn training evaluation, Rye, 5/16/12) along with involving families and "having the resident actively participate" (Parker Jewish training evaluation, New Hyde Park, 5/15/12) in the care planning process was the most useful take away skill. At the same time, the integration of all disciplines needed to develop evidence-based Standards of Care (SOC) and the transition to holistic, resident-centered care plans would require a fundamental shift in the way many care teams were operating. When asked what steps their nursing homes needed to make next in order to be successful in implementing ECP, responses included: "do a lot of work"; "get better buy-in from all disciplines" (LISVH training evaluations, Stony Brook, 12/6/12) and "look at how our current system and ECP could mesh, or do we need to start at ground one" (Van Duyn evaluation, Syracuse, 11/28/12).

Everyone at Own Pace, Each Step is an Improvement
To encourage nursing homes in their efforts to transition to a new care planning approach, the FLTC ECP project team stressed that every facility go at its own pace and understand that each step in implementing ECP represents an improvement in care. For example, reviewing and updating, as necessary, existing care protocols and policies to ensure they reflect current standards of best practice is a significant quality improvement activity. Throughout the project period, we had several sites begin the ECP implementation process, form an interdisciplinary

committee for developing SOC and then need to take a break from the implementation process due to another need or project taking priority, such as a Department of Health survey or implementation of a new Electronic Medical Record (EMR). We wanted sites to feel welcomed to return to ECP and resume their activities; thus, during conference calls we focused on the process and acknowledging each care improvement along the way.

As ***Appendix A*** shows, the ECP Replication Project engaged 32 nursing home sites, including two corporate implementations in Western New York, thus nearly meeting our goal of 33 communities. ***Appendix A*** (page 2) also reveals that ECP requires considerable planning prior to full implementation and participation in conference calls at nearly 91% was rated as the top activity engaged in by ECP sites in a final online survey. In addition, these preparation activities do promote quality of care improvements because they **(*Appendix A*, page 2, *Planning Activities Chart*):**

- Facilitate nursing homes in looking at their traditional approach to care planning and evaluating its effectiveness (*Reviewed current care plans and our team's care planning process.*)
- Begin the process of starting interdisciplinary discussions with leadership staff (*Held a meeting with Directors of Nursing Services, Staff Educators, Head Nurses and other key staff members to discuss the ECP approach.*)
- Highlight the importance of communicating with direct care staff, such as Certified Nursing Assistants or CNAs, about why management has decided to adopt ECP and how it affects their work with residents (*Planned how to market or introduce ECP to direct care staff.*)
- Necessitate review of methods for educating staff and ensuring they are providing care that aligns with current best practices (*Discussed how to educate staff on Standards of Care that are developed.*)

Outcomes Tied to Replication of ECP Approach

Based on Current Standards of Practice

Appendix B: Replication of the ECP Approach shows that many of the planning activities carried over into actual quality improvement work, particularly in regards to reviewing, updating and developing care protocols to align with Department of Health regulations (Chart 1, RA=3.0/ Considerable action taken) and current research findings (Chart 1, RA=2.82). The need to align care with regulations and best practices is clearly evidenced by recent survey findings. According to LeadingAge New York's online data analysis, *Top Deficiencies by Region*, Quality Indicator Surveys (QIS) and traditional MDS surveys (non-QIS) both found the following within the top eight deficiencies reported for all seven DOH regions: Develop Comprehensive Care Plans, Development/Prepare/Review of Comprehensive Care Plan, Clinical Records Meet Professional Standards, Services Provided Meet Professional Standards and Services By Qualified Persons in Accordance with Care Plan.

The care protocols updated according to research conducted and the SOC ECP sites drafted or developed (Charts 2 and 3) align with the Quality Measures established by Centers for Medicare and Medicaid Services (CMS) for Long Stay and Short Stay Residents: Falls, Pain, Prevention of Skin Breakdown and Urinary Incontinence are within the top four on both charts. In addition, 50% or more ECP Sites worked on care standards concerning Behavior Related to Dementia, Depression and Use of Psychotropic medication. As medication, particularly in regards to use of antipsychotics with residents without certain mental health conditions, and use of non-pharmaceutical interventions are now a CMS focus area for quality improvement, ECP enabled these nursing homes to review and develop care protocols to support these efforts. The findings of the final on-line survey and discussions in conference calls suggest that ECP's tenant of basing care on current standards of practice was being realized in the replication project.

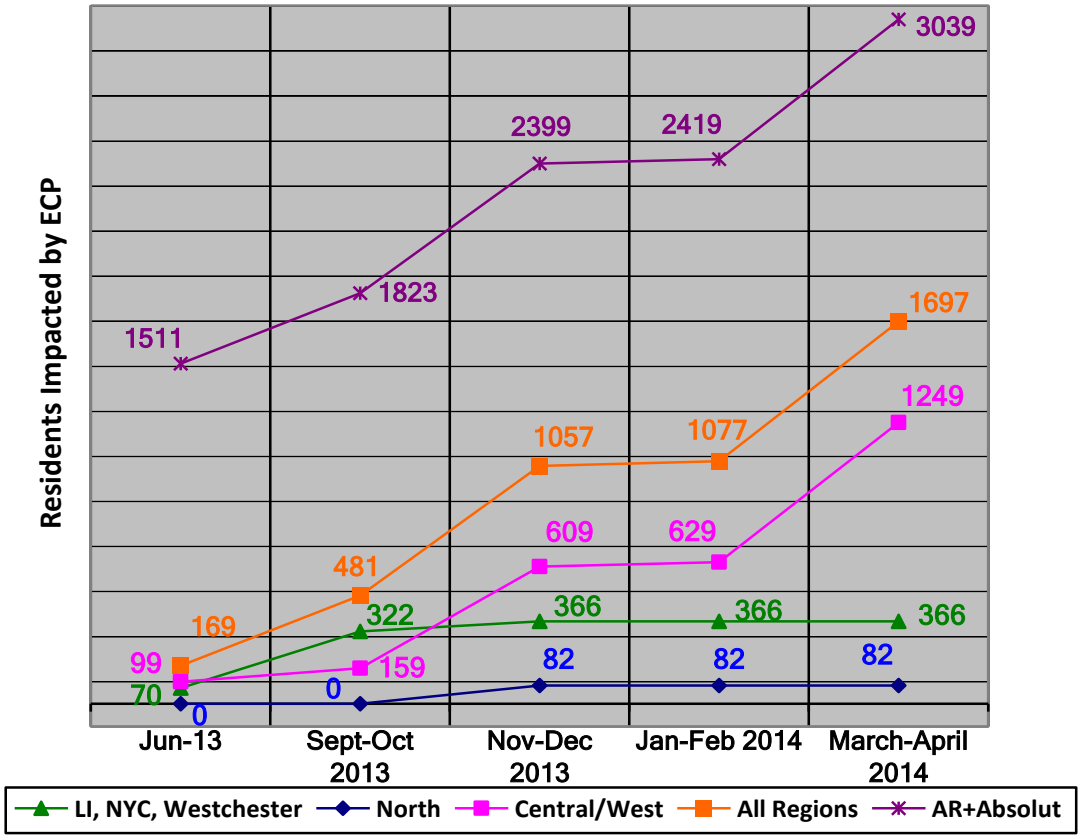
Interdisciplinary, Person-Centered and Accessible

Bar Chart 1: Overview of Replication Activities Undertaken by ECP sites also reveals some of the more challenging aspects of ECP implementation – making care plans more person-centered (RA=2.73) and approaching (2.73) as well as developing (2.64) care plans with an interdisciplinary mindset. Evaluations from initial fundamentals trainings and conference calls support this finding. Several ECP sites, including one corporate entity, shared that when they began to actually move towards integrating their SOC into the care planning process, they realized the traditional way of care planning by discipline was actively being practiced and would need to be addressed in order to have care plans that are holistic and person-centered. In addition, they indicated that while sometimes all the care plans are stored within the home's Electronic Medical Record (EMR), they are not integrated and interdisciplinary standards are not used to pull together approaches from all disciplines to address a common health condition or challenge (March 2013 Conference Call Summary). The first bar chart in ***Appendix C: Challenges to Implementation*** may seem to contradict this assertion in that the Average Rating for developing truly interdisciplinary SOC is 1.6, falling between "Not Difficult" and "Somewhat Difficult". However, it should be noted that this response relates specifically to drafting care protocols using an interdisciplinary committee; discussions in the ECP User Group conference calls as well as follow-up consultation trainings focused on the challenge of actualizing a facility's SOC into the care plan and integrating approaches from different disciplines in the clinical record as well as out on the floor.

The fourteen communities (11 Absolut sites, Crown, Long Island State Veterans Home and Steuban) that did implement ECP during the project period reported success in making care plans more person-centered, concise and thereby accessible. In the March 27, 2013 conference call, Steuban shared that it had cut care plans by 1/3 of their former size, from an average of 36 pages to an average of 10 (Final Online Survey response), making them much easier to navigate and implement person-centered aspects of care. Long Island State Veterans Home indicated a 50% reduction from an average of 20-page to 10-page care plans (Final Online Survey response). Absolut said that ECP allows them to "get right to the point" and address the resident's main problems, challenges and goals in the care planning meeting because the ECP format of referencing standards and including individualized details in the care plan is "much more concise" (February 14, 2013 conference call).

Certainly, these sites were successful in finalizing interdisciplinary standards that when utilized in care plans enabled them to easily hone in on individualized details of person's care needs, preferences and strengths; however, the integration of all disciplines into care planning processes and delivery is more complex and further analysis is needed to evaluate if homes sustain and improve upon their earlier efforts at interdisciplinary work. Another limitation to the findings presented here is that FLTC was not able to maintain consistent contact and feedback from sites due to competing priorities for time and resources. As discussed previously, nursing homes were regularly invited to "return" to the project after another more pressing need had subsided. Thus, the experience of all participant sites could not be represented equally and impacts could be over or under reported.

Table 1: Sample of ECP Sites and Impacts on Residents (Appendix C, page 3) provides a window into how many residents are currently and will soon be benefitting from the ECP approach and its foundation on evidence-based, interdisciplinary care standards. The graph below incorporates this information as reported in the on-line survey to show the trajectory of ECP implementation and its anticipated impact on residents for three regions; the total for All Regions (AR) as well as the AR plus residents served by Absolut Facilities Management is also graphed to provide a more comprehensive picture of the ECP Replication Project's impact. Absolut shared that it had implemented ECP in all eleven of its communities in conference calls and its number of residents (1,342) is based on figures from the New York State Nursing Home Profile online tool.



Implications and Sustainment

As discussed previously, finding adequate time to complete the steps necessary for successful ECP implementation was especially challenging for nursing homes. From establishing common times for the interdisciplinary committee to meet and develop SOC (***Appendix C***, RA=3, Very Difficult), to juggling other priorities such as receiving accreditation to managing changes in staff (***Appendix C***, bar chart #2), several sites indicated that they were not pleased with the progress they had made in reaching the goals they had set for themselves for ECP. Competing priorities was a common theme throughout the project period that sometimes proved to be a barrier to implementation. In fact, one corporate group that had attended the fundamentals training and a subsequent Administrators webinar decided to not proceed with implementation at this time due to their commitment to another quality improvement project. While ECP does influence and contribute to other quality improvement work, each initiative or tool (CMS 5-star rating system, Advancing Excellence in America's Nursing Homes campaign, Nursing Home Compare) has its own particular focus and nuanced way of measuring quality. A promising approach is the QAPI (Quality Assurance Performance Initiative) regulation soon to be finalized by CMS because it requires aligning care priorities on a systematic level to establish a continuous quality improvement program. In many ways QAPI mirrors the ECP approach because it necessitates coordination and integration of processes, such as care planning, that play a critical role in health care delivery and resident quality of life.

In fact, several ECP sites shared that they intend to write up ECP as a specific Performance Improvement Project (PiP) required for QAPI and their suggested areas of focus are included in the table below. Additional strategies used by homes to successfully develop care standards, educate staff and integrate ECP with their current care practices are also described and will be added to the ECP webpage.

SOC Development	Educate Staff	Integrate with Current System
Break interdisciplinary committee into smaller groups to work on specific standards – bring back to larger committee to refine/finalize	Have members of corporate group design an in-service education training, bring from one community to the next to introduce ECP	Integrate CNA considerations for each standard into itemized ADLs that are accessible by computerized CNA Touch screens or paper care cards
Cross check SOC with F-tags, MDS 3.0 manual and facility policies	Use actual care plans from residents as samples, show staff how care plans could be turned into person-centered ECP care plans by incorporating facility's SOC	Let DOH Survey Team Leader know about ECP's implementation, how the approach works and give access to the standards (binder or in EMR)
Use Care Area Assessments (CAAs) as basis for SOC	After initial SOC training, ask for staff volunteers to draft new SOC, increasing interdisciplinary buy-in for the process.	Write up ECP as a PiP; options include making plans more individualized, person-centered, updating standards, ongoing education of staff on evidence-based approaches for each care area

SOC Development	Educate Staff	Integrate with Current System
Have CNA on SOC committee (or have review on floor) SOC wording to be sure it is clear/understandable	Assign a "Standard of the Month" for staff to focus on learning/reviewing. Incorporate ECP in-service into orientation for new employees.	Make SOC library accessible through the EMR in care planning section
Review case mix of population and care plans to find health conditions and challenges commonly addressed as likely candidates for developing standards	Hang large posters on all units/break rooms that show a bulleted chart of main points for each standard	Develop a library of common exceptions to SOC for use when building care plans

The other products that resulted from this grant will also be used to assist homes in sustaining ECP and encourage new homes to reach out for additional consultation with existing ECP sites and with ProCare, the professional consulting group affiliated with LeadingAge New York that provided the lead ECP Trainer, Barbara Bates. These presentations, tools and reports will be maintained on the ECP Webpage and include the following:

Appendix D:

- Pearls of Wisdom presentation for the National Association of State Veterans Homes Conference
- Long Island State Veterans Home SOC Poster
- Standard of Care (SOC) explanatory template
- Resources for developing evidence-based SOC
- ECP Auditing Tool
- ECP Consulting Services Menu