Consider these staggering numbers:

- In 2005, 37 million Americans were 65 or older. By 2050, that number is expected to exceed 81 million.
- Currently, about 35 percent of those 65 or older require skilled care, a figure estimated to reach 12 million by 2020.

Add the number of people who will need assisted living, rehabilitation or other transitional care, and it’s easy to see that our current system does not meet current demand, let alone the bolus of baby boomers to come.

What can we do? Promising new resources include having home care provided by a variety of caregivers, assisted by technology. Wearable mobile devices are currently available, which could provide meaningful data to assist both caregivers and patients; yet so far they are rarely leveraged to support care for this huge demographic.

Eric Dishman is a researcher for Intel. He believes that part of the answer is to take health care off the mainframe — literally and figuratively. He says, “As our aging population booms, it’s imperative to create personal, networked, home-based care for all.” He argues that many elderly patients are afraid of computers. Instead, he suggests, we can use familiar technology, such as the telephone, to provide medication reminder calls and to study behavioral markers.

But until our health care system implements these technologies and strategies, caregivers will deal with current realities as best they can. They will have to cope with these questions: How will we do more with less, and how will we respond to transitions in care and the growing demands of patients and their families?

We want you to know we are committed to helping you deal with these challenges. As a start, this issue of Brink is devoted to providing ideas, tools and resources for clinicians at long-term care facilities. Your efforts are critical in providing the quality of life our seniors deserve, and we are here to support you with patient safety and risk management resources, new ideas and talented, dedicated professionals. For assistance in meeting these challenges, contact your patient safety and risk management consultant or any of us at Constellation (Arkansas Mutual, MMIC and UMIA). We stand ready to help.

I’d personally like to thank you for your dedication, courage and perseverance in providing the best care possible.

Sincerely,
Bill McDonough, President and CEO, Constellation
FEATURE SECTION:
LONG-TERM CARE

8
CHURN, CHURN, CHURN
Staff turnover in long-term care — and how you can reduce it.

11
HANDS ON, HEADS UP
How direct care workers can improve patient safety and the quality of care in your facility.

13
SOCIAL SKILLS
Minimizing the risks and maximizing the benefits of social media in your facility.

14
A SMARTER FACILITY
Technology in the long-term care environment.

18
THE DOCTOR IS IN
How Bluestone Physician Services brings care to where their patients live.

20
NOW TRENDING
Facilities are changing the way they interact with residents and external communities.

23
ETC.
Health care stats and facts.

24
TOUGH CONVERSATIONS
Talking to your patients and their families about advance directives.
While technology has afforded new convenience and efficiency for health care delivery, it has also introduced new vulnerabilities that threaten the safety of confidential patient data. So, it’s extremely important to keep up with system patches and updates to minimize the risk and compliance issues associated with electronically protected health information.

Microsoft recently disclosed a vulnerability of their highest threat level that could allow hackers full control of affected computers so they could view, change or delete confidential patient data. This invites HIPAA compliance issues and a potential audit from the Office of Civil Rights. The vulnerability affects all versions of Microsoft Windows operating systems.

Over the past year, Microsoft also announced the end of support for Windows Server 2003 and XP. Computers still running these defunct operating systems are open to a slew of vulnerabilities that won’t be corrected with Microsoft patches. This makes them easy targets for hackers who want your data.

Due to these risks, we urge you to patch your computers. Work with your network administrator to ensure timely patching and constant updates of your antivirus software that scans for viruses and malware. We also strongly urge you to run Windows updates and antivirus software on any personal computer that you own to protect those systems, too.

Our team of technology experts can help you safeguard your technology systems. We’ll monitor your IT infrastructure 24/7, install vital patches, maintain network assets and mirror important data in the cloud. We’ll help make your IT systems safe and viable so that you can focus on what you do best: delivering patient care.

LEARN MORE ABOUT HOW OUR HEALTH IT SERVICES CAN MINIMIZE VULNERABILITIES AND THE RISK OF CYBER CRIME. CONTACT US AT 877.838.6869 OR INFO@MMICHEALTHIT.COM.
ARKANSAS MUTUAL
JOINS CONSTELLATION

Constellation mutual holding company completed the acquisition of Arkansas Mutual Insurance Company on Aug. 3. Located in Little Rock, Arkansas Mutual is a provider of medical professional liability insurance for physicians and is now the third Constellation member company, joining MMIC and UMIA.

Combined, MMIC, Arkansas Mutual and UMIA insure more than 21,000 physicians in 16 states. All three provide medical professional liability insurance, patient safety solutions and health information technology solutions to the entire health care spectrum: physicians, clinics, large hospitals and health systems, outpatient and long-term care facilities. Visit ArkansasMutual.com for more information.

OLDER DRIVERS

In February 2014 the Insurance Institute for Highway Safety’s Highway Loss Data Institute released a report showing that older drivers are now less likely to be involved in a crash and less likely to be injured or killed. The institute attributes the improvement to safer vehicles and better senior health. The report, which tracked data from 1995 to 2012, found that drivers age 70 and over had bigger declines in fatal crash rates per licensed drivers and per vehicle miles traveled than middle-aged drivers aged 36–54.

Source: bendbulletin.com

EDS BEGIN CATERING TO ELDERLY

Older adults account for as many as 25 percent of all emergency room visits nationwide, and the number continues to climb due to increased longevity and the aging baby boomer bolus. Compared with younger people, seniors use emergency services more often and are more likely to be admitted (and readmitted) to the hospital or have repeat emergency department visits. They also have a higher risk of health problems after being discharged and are more prone to falls, cognitive impairment and infection.

So, just as pediatric services were created to serve the unique needs of children, some hospitals are creating emergency departments and inpatient units to serve the unique needs of seniors. The goal is to reduce preventable hospitalizations and decrease length of stays and readmission rates. And it’s also about providing better overall care in places that seniors often find chaotic and confusing.

New geriatric facilities offer:

- Staff in tune with the special needs of the geriatric population
- Clocks with big numbers, thicker mattresses
- Exams and labs performed only during the daytime, so patients can get uninterrupted sleep at night
- Special beds to prevent bedsores
- Beds that sound an alarm when patients try to get up, so a team member may assist and prevent falls


CUSHIONING THE BLOW

The cost of hospitalization and recovery for hip fractures in those over 65 amounts to more than $20 billion annually. Most of these fractures are caused by falls. Health care startup ActiveProtective Technologies thinks it has created a viable solution — instead of focusing on preventing falls, ActiveProtective has created something to cushion them. Enter the wearable airbag.

Robert Buckman, MD, a trauma surgeon in Pennsylvania, came up with the idea of the wearable airbag after noticing the frequency of hip fractures due to falling. His micro airbag is worn around the waist and deploys to cushion the user’s fall. Unlike air bags in cars, the micro airbag uses cold gas that rushes out quickly and quietly, then alerts an emergency contact that the person has fallen. See a demonstration at activeprotect.co.

The neoprene airbag, which consumers will wear in a belt and keep near them at night, is now being piloted.


COMPILED BY JANE RODRIGUEZ, MA
Communication Director, Constellation
Jane.Rodriguez@ConstellationMutual.com
UPCOMING WEBINARS ON WEDNESDAYS

OCTOBER 14
PERINEAL LACERATION: RISKS AND OPPORTUNITIES FOR PREVENTION
Presenter: Phillip N. Rauk, MD

This webinar will help you understand the factors that lead to perineal laceration and enable you to implement a quality and safety program that reduces perineal laceration occurrences and meets national benchmarking standards.

OCTOBER 28
OPTIMIZING OBSTETRIC PATIENT SAFETY
Presenter: Stephen K. Hunter, MD, PhD

Whether the practice setting is a rural hospital or a large metropolitan medical center, there is expectation for a natural pregnancy and birth experience resulting in a "perfect" baby and healthy mom. The vast majority will achieve their expected results. However, things can sometimes go wrong, and not because of a single act or omission. This presentation will review and offer best practice recommendations for top threats to maternal-fetal patient safety and outcomes. And for those hospitals not providing inpatient maternity services: a discussion of planning for and managing an OB patient in the emergency department.

NOVEMBER 4
FALL REDUCTION IN LONG-TERM CARE
Presenter: Christine Osterberg, RN, BSN

Methods and recommendations to reduce falls in long-term care facilities are a part of most long-established and newly published safety initiatives. These efforts are strongly supported and researched by the CDC, Veterans Affairs, INTERACT and the Affordable Care Act. This comprehensive webinar will familiarize you with the latest assessment and intervention strategies and give you practical tools to meet the requirements of F323, as well as develop a reputation in your community for safety and fall prevention.

NOVEMBER 18
ERRORS IN DIAGNOSIS: ANALYSIS AND PREVENTION STRATEGIES
Presenter: Laurie Drill-Mellum, MD, MPH

Diagnostic errors in ambulatory health care settings are twice as frequent as errors caused by medical and surgical treatment, but because they are harder to define, detect and measure, they have escaped the scrutiny trained on more visible errors. In addition, many physicians are unaware of cognitive biases that can adversely affect their day-to-day clinical decision-making. This presentation addresses these biases as well as many other factors contributing to diagnostic failure, and presents strategies to minimize their impact.

DECEMBER 2
WHEN THINGS GO WRONG: APOLOGY AND COMMUNICATION
Presenters: Emily Clegg, JD, MBA, CPHRM and Shelly Davis, BSN, JD

To err is human, and members of the health care team are human, too. When errors happen, your team may feel hesitant to engage in meaningful and open communication with patients and families. This program will discuss the moral and ethical importance of open and timely communication about unanticipated outcomes and adverse events. Participants will hear about strategies, tools and best practices for communicating effectively, preserving relationships and enabling patients and families to begin the healing process.
Cautious, but driven. The updated "Federal Health Information Technology (IT) Strategic Plan 2015-2020," recently released by the Office of the National Coordinator for Health Information Technology (ONC), signals the federal government’s continued commitment toward the widespread adoption of health IT, but not without more careful consideration.

The plan shows a commitment to remain flexible to “the evolving definitions of health and health care.” After all, the more than 400,000 providers and hospitals who have participated in the Centers for Medicare & Medicaid Services’ Electronic Health Record (CMS’ EHR) Incentive Programs haven’t yet recovered from the previous five years of health IT implementations or perfected their aim at the moving regulatory targets defining the programs’ requirements. And by admission, the plan acknowledges that the health IT ecosystem changed and that innovative technologies were introduced even within the duration of the previous five-year strategic plan.

A positive impact
In a study published in February 2015, a systematic review of literature shows significant affirmation that the quality and safety of health care have been positively impacted and improved by health IT. It further identifies areas for improvement, such as interoperability, usability and safety, which the new plan further supports in its goals and objectives.

Collect. Share. Use.
In the new plan, the strategy for the next five years summarizes the five goals under the headings collect, share and use.

- **COLLECT.**
  Expand Adoption of Health IT (Goal 1).

- **SHARE.**
  Advance Secure and Interoperable Health Information (Goal 2).

- **USE.**
  Strengthen Health Care Delivery (Goal 3). Advance the Health and Well-Being of Individuals and Communities (Goal 4). Advance Research, Scientific Knowledge and Innovation (Goal 5).

The first goal includes the objective to “increase user and market confidence in the safety and safe use of health IT products, systems and services.” It is also under the first goal that the plan addresses health IT adoption across the care continuum, including long-term and post-acute care (LTPAC).

New funding opportunities
A lot is at stake in the plan for LTPAC providers. Recognizing that LTPAC was ineligible for the CMS’ EHR Incentive Programs, the ONC announced new funding opportunities this year to support interoperability within communities, including support for health information exchange, telehealth and mobile health. From the introductory paragraph, the plan reveals a renewed emphasis on the importance of integrating health IT for long-term care services to strengthen health care delivery.

An excerpt from the plan: “Providers” is meant to be a broadly inclusive term for health care workers and service providers in all settings...

Successful implementation of the Plan will also mean that health IT is culturally and linguistically sensitive, safe, accessible for everyone (including those with limited English proficiency or with disabilities), intuitive, functional and provides a rewarding user experience.

References

Resources
ONC: Health IT Strategic Planning healthit.gov/policy-researchers-implementers/health-it-strategic-planning
ONC: New Funding Announcements www.healthit.gov/newsroom/grants-funding

TRISH LUGTU, BS, CPHIMS, CHP
Associate Director, Research, Development & Education, MMIC
Trish.Lugtu@MMICgroup.com

Long-term care facilities can now apply for federal grants to improve their health IT.
GOOD READS ON AGING

**Being Mortal: Medicine and What Matters in the End**
by Atul Gawande, MD
Review by Laurie Drill-Mellum, MD, MPH

In *Being Mortal*, Dr. Gawande makes a strong argument for expanding the goal of health care beyond prolonging life. Through deep analysis of how care for the aged and terminally ill is often delivered in the U.S., he invites us to expand the choices for care and living arrangements and to consider how we might provide what's most important to people at the end of their lives. He takes us on both a professional and personal journey, exposing his vulnerability and heart at every turn. *Being Mortal* is a courageous, academic, heart-centered, thought-provoking read.

**Creating Moments of Joy**
by Jolene Brackey
Review by LeAnn Hanson

This isn't a book to borrow — it's one to own and highlight. I highly recommend this book to anyone, but particularly to those who are close to someone with dementia or Alzheimer's. This book provides a good understanding of an affected person's experiences during different stages of his or her disease and offers suggestions for working with the person at that stage. It also provides basic tips. For example: Are the person's actions hurting anyone or just annoying you? It helps a reader to recognize when to let things go. The guidance it provides will help both patient and caregiver cope with the disease and can even help to create those much needed moments of joy.

**Still Alice by Lisa Genova**
Review by LeAnn Hanson

If you think it is frustrating to keep repeating yourself to someone with Alzheimer's, just think about how they feel. How frustrated are you when you misplace your keys? Now think about misplacing 10 or 20 things a day. This novel will take you on an emotional journey with a woman who has been diagnosed with early onset Alzheimer's disease. You will experience her frustrations and fears, admire her resourcefulness and coping skills, and feel the sadness and loneliness she and her family experience. This insightful and moving story about the progression of her disease takes readers into the heart of her experience. On The New York Times Best Seller list for more than 50 weeks, the book was made into a movie starring Julianne Moore, whose performance earned the 2015 Oscar for Best Actress.

**Bettyville: A Memoir**
by George Hodgman
Review by Devon Thomas Treadwell

When the author, a cultured gay man in New York City, loses his job, he returns to his tiny hometown of Paris, Mo., to stay with his 90-year-old mother, Betty. Cranky, stubborn, proud and increasingly confused by the onset of dementia, Betty resists moving into a facility. "Don't leave me," she says if he goes to bed before she does. "See me," he wishes he could say to her, as they have never been able to discuss his sexual orientation. Warm, witty, achingly honest and — above all — kind, *Bettyville* tells the story of a courageous senior aging in place and the self-described “care inflictor” devoted to sharing her journey.
The ground is shifting underfoot. Already troubled by high staff turnover, economic constraints and pressures to provide more complex care, long-term care (LTC) facilities now face the daunting prospect of millions of additional patients as baby boomers age to the point of needing care. As the LTC industry adjusts to this changing landscape, how will caregivers reduce risk and keep their patients safe? In this issue of *Brink*, we explore what’s harmful, helpful and hopeful in today’s LTC environment.
The shirt goes on before the pants.

Andy knew that.

There should be a glass of water next to the bed every night.

Andy knew that, too.

Open the blinds first thing in the morning. Don’t mess with the thermostat! It’s supposed to be this warm. Put the walker closer to the bed — I can’t reach it over there!

Andy knew how things were supposed to be done. Now there’s this new guy. I have to tell him everything. I want Andy back. Why can’t Andy be here?

Like a disturbingly high percentage of other caregivers in long-term care (LTC) facilities, Andy had moved on, leaving behind a patient who had already been feeling anxious and helpless due to his diminishing abilities.

It’s not just certified nursing assistants (CNAs) like Andy who come and go. Churn rates are high for all nursing specialties. According to a recent survey, staff retention is the top concern of LTC administrators.¹ Nationally, annual turnover rates among CNAs, licensed practical nurses (LPNs) and registered nurses (RNs) are estimated at 55.5 percent, 36.4 percent and 50 percent, respectively.²

Why do they leave?
Low pay is one reason. Salary surveys show that RNs in LTC facilities make about $10,000 less annually than in acute care.³ Although many workers find it rewarding to care for the elderly, overall job satisfaction is low due to a host of issues, including:

- Inadequate training
- Few opportunities to advance
- Relationship problems with supervisors
- Physical or emotional challenges
- Lack of respect from residents, residents’ families, supervisors and society at large⁴

Poor retention leads to poor outcomes
Research has shown a connection between turnover and quality of care for nursing home residents. A systematic review of 87 research articles and government documents published between 1975 and 2003 documented a significant relationship between high staff churn and poor quality outcomes for residents.⁵

Further, high turnover rates have been linked to lower-quality care strategies and to patient distress. LTC facilities suffering from
The U.S. population is aging, and scientific advances in geriatrics and medicine are enabling people with chronic diseases to live longer. The result: Demand for direct-care workers will double in the coming decades, requiring up to 5 million direct-care workers, 868,000 RNs and 231,000 LPNs.¹

Demand will double
If the news on employee turnover is bad now, it’s going to be even worse in a few years. The U.S. population is aging, and scientific advances in geriatrics and medicine are enabling people with chronic diseases to live longer. The result: Demand for direct-care workers will double in the coming decades, requiring up to 5 million direct-care workers, 868,000 RNs and 231,000 LPNs.¹

Adding insult to injury, facilities pay a premium to replace direct-care workers. Staff turnover results in reduced productivity, lost revenues or reimbursements, stress and disruption for patients, deteriorating working conditions and worker injuries. When all those costs are added up, it costs an estimated $3,500 to replace a single direct-care worker.²

Job satisfaction is key
While there are social and economic factors affecting staff turnover that are too entrenched for any individual facility to remedy, there are measures you can take to improve retention.

“Satisfaction is a big part of retention,” says Christine Osterberg, RN, senior nursing consultant at Pathway Health Services in Minnesota. That means understanding your employees. “Different generations of nurses look for different things. Baby boomers, for example, often pride themselves on their work ethic and may perceive younger nurses as lazy. Not true; millennials do value a sense of competency but don’t respond well to parental management approaches.”³

She points to the silo approach as problematic. In the typical LTC facility, tasks have been compartmentalized. “Social services may only do social services tasks, for example,” Osterberg says. “It can be very territorial and old-fashioned.” Instead, she suggests increasing employee satisfaction by working more as an interdisciplinary team. Respecting the observations and approaches of caregivers who know residents well can help improve outcomes for all departments.

“Sometimes all the person needs is someone to pick up a remote, close a curtain, give them a glass of water. Why shouldn’t everyone in the facility be answering calls like these?”⁴

Learning from the lights
Osterberg further suggests that a call light audit can help a facility not only improve resident care and satisfaction but also staff morale. The audit would record the room, the resident’s name, how long it took to respond to the call light, the request and — importantly — how long the resident perceived the wait was. “Some residents have patterns and predictable needs.”⁵

Ultimately, the facility can identify a pattern of call light use and learn when to expect a peak. Then all available employees can make rounds just before and during the peak call light period. “Which residents are using their call lights most? Waiting for call lights is not the same as anticipating needs. Making more frequent rounds reassures patients that there’s someone there all the time, decreasing the need to ‘demand’ service.”⁶

When everyone pitches in, everyone’s happier
When even administrators and business managers are responding to call lights and anticipating resident needs, everyone’s safety and satisfaction can increase. In a well-managed facility, “the rallying cry is ‘We’re here for the residents,’” Osterberg says. “The team approach can reduce turnover related to caregiver frustration.”⁷

References
While she gently helped the 90-year-old resident sit up in bed, Naomi felt the woman’s narrow frame shudder as she broke into a prolonged, phlegmy cough. She gave her a tissue, and when the patient handed it back, it was pink with blood. “You doing OK, Eleanor?” Naomi asked.

The caregiver’s question was caring and simple, but her mind filled with doubts. How serious is this coughing? Should I call for a nurse? I’m not sure. She should have stayed longer in the hospital. Will I be able to care for her? I don’t feel up to this.

Now more than ever, long-term care (LTC) facilities are taking in residents like Eleanor who require more complex medical care. The health care landscape is changing. Americans are living longer with chronic illnesses, bringing their medical needs with them as they enter long-term care. Meanwhile, under pressure from insurers to reduce costs, hospitals are releasing more patients before they’re fully recovered, essentially shifting the burden of care to LTC facilities.

In the face of these challenges, many LTC organizations are doing more with less — expecting more capabilities from unskilled and undertrained direct-care workers (DCWs), supervising more caregivers with fewer registered nurses (RNs) and licensed practical nurses (LPNs), and accepting more residents with fewer team members to care for them — all while losing 40 to 50 percent of their staff every year to turnover. (See page 8 for more on staff turnover.)

What many administrators don’t realize, though, is that some relief for these issues can be found just down the corridor. With proper training, your caregivers can help.

**Eyes and ears for the nurse**

As they assist patients with bathing, grooming, bathroom functions and light housework, DCWs such as certified nurse assistants (CNAs) spend the most time with patients. In many ways they have become the nurse’s eyes and ears. They are likely to be the first to observe a resident’s emerging clinical...
issues, such as worsening symptoms or changes in behavior, and to provide an early heads-up for the facility’s time-pressed nurses. But are DCWs prepared for this greater responsibility? Do they know what to look for and how to respond?

Minimal training is not enough
By federal requirement, CNAs receive 75 hours of training before they can be certified. Afterward, they must complete only 12 hours of in-service, continuing education every year. While some states do demand training for CNAs that exceeds federal guidelines, noncertified DCWs like Naomi are not required to meet any minimal training requirements.

More than 1.4 million people live in skilled nursing facilities. With this number expected to rise as the baby boomer generation ages, the long-term care industry must adapt. Facilities must think about what they can do to improve training and care delivered by workers who are increasingly being asked to do more.

Examine your priorities
It’s a matter of priorities, suggests Michelle Kinneer, RN, senior risk and patient safety consultant at MMIC. “One way to show commitment is to make quality of care a part of the budgetary process. I have been involved in strategic planning sessions where patient safety was made a priority. For each capital request that was made, we questioned if the product or service impacted patient safety or the quality of care that was delivered. Capital requests not meeting one of those requirements were not approved. Considering safety and quality of care in the budgetary process shows our organizational commitment.”

Improve care through DCW training
Kinneer recommends that facilities provide robust training for their DCWs. “Formal training programs include LEAP, from the Mather Lifeways Institute on Aging. There’s also WIN A STEP UP from the University of North Carolina Institute on Aging, and the Wellspring model, which focuses on the clinical skills needed to care for the geriatric resident.”

But don’t forget the soft skills, she adds. DCWs need to know how to work as part of a team. Not only should they be able to recognize clinical issues, they need the skills to communicate them to the supervising nurse.

If your facility is engaged in an organizational quality initiative, be sure to explain the program’s goals and strategies to your hands-on caregivers. DCWs will frequently provide creative solutions for processes that improve quality. “These ideas can offer real improvement strategies for our frontline caregivers,” Kinneer says.

A win for everyone
DCWs deliver 70–80 percent of all paid care. With additional training for an expanded role, they could help patients make safer transitions from one setting to another, contribute to team approaches to chronic disease management and provide support and information to family caregivers.

Kinneer’s perspectives are grounded not only in her work as a clinical instructor but also in her experience as a teenager. “In high school, I worked as a CNA for a skilled nursing facility. Like the other DCWs, I knew the residents as individuals. During semester breaks from college, I would go back to visit.”

These aren’t just facilities, Kinneer stresses. They’re homes, and how care is delivered has a very real impact on residents’ lives. “We have the opportunity to enhance their homes through steps that demonstrate our commitment to quality care and the safety of our residents,” she says. “Our efforts will produce a win for the residents, the DCWs and the organization.”

References
LONG-TERM CARE

SOCIAL SKILLS

Minimizing the risks and maximizing the benefits of social media in your facility.

A nurse’s aide at a New York nursing home pled guilty to sending a photo of an incontinent resident’s genitals to an acquaintance using Snapchat®, a mobile app that allows photos and videos to be viewed briefly before automatically disappearing.7

Another aide was convicted of taking and posting graphic photos of elderly or disabled residents to Facebook®.8

Courtroom cases such as these, involving social media and resident privacy, are popping up around the country. And while these violations of residents’ privacy are extreme, the ubiquitous presence of social media in our social lives and in our workplaces can create new challenges for organizations and caregivers alike.

Social media tweets, comments, shares and likes are used by 70 percent of U.S. health care organizations.3 So it’s important for medical professionals to understand the implications — good and bad — of using social media and the permanent electronic record that it creates, which can be used during litigation.

Social media has many benefits for long-term care (LTC) organizations. It can be a valuable conduit between residents and their loved ones. Studies link social media usage to decreased depressive symptoms in older adults and to increased connection to the outside world. Aided by social media, LTC organizations are able to “keep families informed, educated and involved in the course of resident care, which in turn generates higher overall resident satisfaction.”4

However, as LTC providers attempt to use this technology, they are also entering into a particularly public form of communication, and as such, risk serious legal consequences. Just as easily as a 140-character tweet can garner more goodwill than any paid advertisement, it can also damage reputations and violate the privacy regulations by which LTC facilities must abide.

Social media carries risk in part because medical professionals have access to dozens of social media networks at the same time they have access to the protected health information of their residents. Social media is public, and due to their informal nature, posts may easily be misconstrued, leading to reputation damage for residents, medical professionals or facilities, and to legal and financial consequences. Once content resides in the electronic ether, its author loses control of it. Then it’s at the mercy of Twitter’s® 100 million users and Facebook’s 800 million users — just to name two social media platforms.8

To minimize the risks inherent in social media usage while maximizing its benefits, consider:

- Creating a policy for social media usage
- Gaining employees’ awareness and understanding through training and requiring signed acknowledgment
- Reminding employees that email and Internet usage on company-owned devices may be monitored (this doesn't include monitoring social media usage via private mobile devices)
- Asking employees to refrain from “friending” residents or their family members and to refrain from taking photos or videos of patients on personal devices
- Obtaining permission from residents before posting information about them or images of them
- Prohibiting the inclusion of health information in posts to facility-operated social media sites
- Immediately reporting any privacy breach to the Office of Civil Rights
- Asking employees to clarify when they post on social media that their views and opinions are their own and do not represent those of their employer

References

MIKE MILLER
Communication Specialist, Constellation
A S M A RT E R  F A C I L I T Y

Technology in the long-term care environment.

Room 315... Room 315... Room 315... Room 315...
A slightly mechanical female voice sounded from a nurse’s device as I visited an ill and aging loved one in the memory care unit of a local assisted living facility.

The real-time alert was warning the facility care team that a particular resident — a younger, physically robust woman — had left her room. Her bouts of aggression, which can be common in the later stages of Alzheimer’s, had become more frequent and severe as of late. The motion sensors and door alarms tracking her movements were a safety measure not only for her but also for the care team, other residents and their visiting guests.

The device softly chiming the alerts was resting upon a small work surface atop the nurse’s workstation on wheels (WOW). As the nurse prepared and double-checked medications for my loved one, I glanced around the room reviewing the already familiar motion sensors. Team members tracked her motions as well, but for other reasons. They knew when she was sleeping or awake, when she was summoning for help, and whether she was stirring to rise so they could provide assistance to prevent falls.

Conveniently adjusted to standing height, the WOW screen and keyboard offered the nurse access to the electronic health record (EHR) system and the electronic...
medication administration record (eMAR) system at the point of care. Through the EHR, team members could access care notes and orders for each resident from any location in the facility at any time. Since the eMAR and WOWs were implemented, we experienced first-hand how medication administration had become safer.

Gone were the days when it was possible for a team member to accidentally deliver the wrong pre-prepared pill package to the room and administer someone else’s pills. Thankfully nothing severe ever occurred, but with eMAR available in the room, there was little chance of a repeat mishap with a worse outcome. Instead, they prepared the morning dose of pills from myriad bottles stored in a locked cabinet in the private apartment’s kitchen.

**From remote monitoring to telehealth to mobile X-ray units**

Innovations in health information technology (IT) are improving outcomes, efficiencies and patient satisfaction, and nowhere is this more evident than in the long-term and post-acute care (LTPAC) environment.

These technologies—motion detection systems, emergency response systems and real-time alerting capabilities—empower an already stretched care team to be able to prioritize their attentions.

Of course the applications of remote patient monitoring (RPM)—a type of mobile health—have broadened beyond safety. RPM, which refers to the devices monitoring individuals, is especially effective alongside telehealth, the suite of services by which a provider may provide consultation or supportive services from a different physical location.

RPMs and telehealth serve to monitor daily living activities that can help assess cognitive decline, monitor sleep patterns, reduce hospital admissions and readmissions, support post-acute stabilization of patients and improve management of chronic conditions. Together, these technologies create better health outcomes for individuals, allowing them to live independently longer, while improving quality of life and overall satisfaction.

Mobile X-ray units were also used at the residence I visited. To avoid moving high-risk or injured residents, a provider brought a mobile unit to the facility, while a radiologist remotely read the electronic image and provided his diagnosis.

Because of the published successes of remote patient monitoring, telehealth and mobile health, these innovative technologies have been called out specifically in the Federal Health IT Strategic Plan 2015–2020. (See page 5 for a discussion of the funding opportunities for LTPAC facilities.)

**Considerations**

Of course, along with new technology comes new needs and risks. Each facility or support service must assess their technology infrastructures to support such devices, whether wireless, cellular or Bluetooth® capable. Budget considerations must be assessed in order to determine financial feasibility of mobile health and telehealth services. And employee workload and efficiencies must also be balanced.

A few important points in managing risk when implementing new RPM, mobile health and telehealth services are adapted from a LeadingAge Center for Aging Services Technologies report and summarized below.

1. **ACCOUNTABILITY AND RESPONSIBILITY**

   Create a clear plan of accountability and responsibility, detailing who receives and monitors information received through RPM and telehealth support services, as well as actions that they must take. Consider coverage times, backup for team members, planned clinical interventions and coordination of support partners.

2. **EMPLOYEE COMPETENCIES**

   Create a schedule and expectations for competency-based training for designated employees, including remedial training and periodic training for new functionalities.

3. **DEVICE ACCOUNTABILITY AND SECURITY**

   Coordinate with your IT resources and your privacy and security officers. Protected health information created, maintained and transmitted over RPM and telehealth devices may be protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 or other state privacy or data security laws.

   To learn more about innovative technology in LTPAC, visit the following resources.

---

**Resources**

- LTPAC Health IT Collaborative
  www.ltpachealthit.org
- Center for Technology and Aging
  www.techandaging.org/
- ONC: New Funding Announcements
  www.healthit.gov/newsroom/grants-funding
- ONC: Long-term and Post-acute Care
  www.healthit.gov/policy-researchers-implemeters/long-term-post-acute-care

**References**


**TRISH LUGTU, BS, CPHIMS, CHP**

Associate Director, Research, Development & Education, MMIC

Trish.Lugtu@MMICgroup.com
Falling Through the Cracks

Poor communication between a hospital and skilled nursing facility contributes to a patient’s fatal fall.

Facts of the case
A 79-year-old woman was brought to the emergency department by her son with complaints of dizziness, weakness and a history of having fallen at home. The hospitalist admitted her for observation with a diagnosis of atrial fibrillation and hypokalemia. The hospital nurse assessed the woman as being at risk for falls and implemented fall precautions. During the night, the woman got out of bed without requesting assistance and was found on the floor of her hospital room unable to get up. The nurse documented that the woman denied complaints and that there were no visible injuries. The nurse did not contact the hospitalist or the patient’s son to report the incident.

The next day when the hospitalist was rounding, her nurse communicated the fall incident. The hospitalist noted left arm weakness and ordered an X-ray, which showed a fractured ulna. No other testing was done. Later that evening, the woman’s son told the nurse that his mother was also complaining of hip pain. The nurse called the hospitalist, who ordered X-rays, which showed a fractured hip. The next morning, an orthopedist performed a closed reduction of the hip fracture and open reduction of the arm fracture. Following surgery, the hospitalist ordered the woman to be transferred to a skilled nursing facility (SNF) for rehab prior to going home. The admitting orders included an anticoagulant medication and orders for lab testing. The transfer information did not include information about her fall history.

Two weeks later, the woman fell in her room at the SNF, striking her head on a table. She was transferred to the local hospital where she died later that day from an intracranial hemorrhage. Her family filed a malpractice claim against the hospital and the SNF.

Disposition of case
The case was settled against the hospital and the SNF.

Patient safety and risk management perspective
The experts who reviewed this case were critical of the hospital nurse for failing to immediately notify the hospitalist when the woman was found on the floor of her hospital room, unable to get up. They were also critical of the discharging nurse for not communicating directly with the SNF’s admitting nurse about the patient’s history of falls, increased risk for injury due to...
her anticoagulant medication and need for close monitoring. The transfer form used by the hospital was incomplete.

The experts were also critical of the SNF nurses for failing to accurately assess the patient’s fall risk and implement appropriate fall precautions, and for failing to clarify treatment orders when there were questions about medications and lab orders. The SNF nurse testified that they did not know who to contact regarding the anticoagulant therapy because the hospitalist who wrote the discharge orders was not available when the patient was admitted.

This case was made difficult to defend due to the family’s anger with the lack of communication between the hospital and the SNF, as well as the lack of communication with the family.

This case illustrates how breakdowns in communication during transitions of care are a frequent cause of serious patient injury and often lead to readmission to the hospital. Many health care organizations are collaborating at a community level to pursue the Institute for Healthcare Improvement’s Triple Aim — improving the health of populations, improving the patient experience of care and reducing the per capita cost of care.1 To that end, some health care systems have begun creating preferred SNF networks and only recommend SNFs with high quality outcomes and low readmission rates in order to minimize lengths of stay and prevent readmissions. Health care systems that have established preferred networks are working closely with their SNFs in deploying physicians, advanced practice providers and care managers to the SNFs to better manage care.2

References

PATIENT SAFETY AND RISK MANAGEMENT TIPS

- Enhance the communication process for provider notification of patient status with communication tools such as SBAR (situation, background, assessment, recommendation)
- Collaboratively plan and directly communicate the details of patient care at transitions of care with the receiving facility team members
- Ensure understanding of care needs and details required to implement care with a read-back communication technique
- Use standardized transfer forms to provide complete and accurate information at transitions of care
- Provide the name and contact information of the discharging physician and nurse so that when questions arise, the receiving facility team members know who to contact for clarification
- Engage the patient and his or her family in developing the plan of post-acute care
- On admission, discuss a communication plan in order to notify family of a change in condition
- Implement specialized anticoagulant therapy teams and monitoring processes in SNFs
- Engage in community collaboration efforts to standardize transitions of care processes and tools
the doctor is in
NINE YEARS AGO, TODD STIVLAND SAT DOWN AT HIS DINING ROOM TABLE AND STARTED A SMALL, QUIET REVOLUTION IN LONG-TERM CARE. THE MINNESOTA-BASED FAMILY-PRACTICE PHYSICIAN HAD SEEN AN INCREASING NUMBER OF FRIL, ELDERY PATIENTS IN HIS OFFICE. "ONE TIME, A TAXI DROPPED OFF A VERY CONFUSED WOMAN AT MY CLINIC," STIVLAND RECOLLS. "THERE WAS A NOTE PINNED TO HER COLLAR, SAYING SHE HAD DEMENTIA AND ASKING US TO CALL THE TAXI TO TAKE HER HOME WHEN HER APPOINTMENT WAS OVER." HE BEGAN TO WONDER IF THERE COULD POSSIBLY BE SOME WAY TO "FIX" A SYSTEM THAT ALLOWED THIS KIND OF SITUATION TO OCCUR.

AT ABOUT THAT SAME TIME, HE HAD GOTTEN TO KNOW A NURSE AT A GROUP HOME FOR PATIENTS WITH TRAUMATIC BRAIN INJURIES. SHE TOLD HIM THAT GETTING A PATIENT READY TO GO TO A DOCTOR'S OFFICE WAS OFTEN A THREE-STAFF-PERSON JOB. "AND THEN SOMETIMES THE PATIENT IS CONFUSED OR AGITATED AND WON'T GET OUT OF THE CAR, SO THE APPOINTMENT HAS TO BE CANCELLED," THE NURSE TOLD HIM.

STIVLAND ASKED HER, "WHAT IF I JUST STOPPED BY ON MY WAY HOME FROM THE CLINIC AND SAW YOUR PATIENTS HERE AT THE GROUP HOME?" THE NURSE WAS ECSTATIC, AND HER FACILITY GLADLY RESERVED A SMALL OFFICE SPACE, FOUND AN OLD EXAM TABLE AND INSTALLED A LOCKED CABINET FOR HIM TO USE. WITH THAT — AND WITH THE NECESSARY PAPERWORK PILING UP ON THE FAMILY DINING ROOM TABLE — STIVLAND BECAME CHIEF EXECUTIVE OFFICER AND EMPLOYEE NUMBER ONE OF BLEUSTONE PHYSICIAN SERVICES (BPS).

"MY WIFE, SARAH, CAME UP WITH OUR NAME," HE SAYS. "WE WANTED TO PUT TOGETHER COMMON WORDS WITH A 'NATURE' THEME. WE FOUND BLEUSTONE, A TYPE OF LIMESTONE SIMILAR TO THAT FOUND IN THE ST. CROIX RIVER VALLEY. ANCIENT EUROPEANS BELIEVED IT HAD HEALING PROPERTIES." STIVLAND EARNED $8,000 IN HIS FIRST YEAR OF BUSINESS. "NEEDLESS TO SAY, THE FAMILY DIDN'T TAKE A SPRING BREAK THAT YEAR," HE LAUGHS.

BPS NOW HAS MORE THAN 145 EMPLOYEES, AND ITS CURRENT ANNUAL REVENUES ARE $20 MILLION. THE ORGANIZATION PROVIDES REGULAR ON-SITE MEDICAL CARE TO PATIENTS IN ASSISTED LIVING, GROUP HOMES AND PRIVATE HOME. THE LARGEST PROVIDER OF RESIDENTIAL-BASED CARE IN THE TWIN CITIES AREA, THEY'VE EXPANDED OPERATIONS TO INCLUDE WISCONSIN AND FLORIDA.

"BRINGING A FRIL OR CONFUSED PERSON INTO A CLINIC JUST ISN'T GOOD MEDICINE," STIVLAND SAYS. "WITH OUR MODEL, A PHYSICIAN IS ASSIGNED TO A LOCATION AND CAN SEE PATIENTS ON A CONSISTENT BASIS, IN THEIR OWN HOME ENVIRONMENT. OUR MODEL HELPS REDUCE STRESS TO COMPLEX, FRIL AND SPECIAL-NEEDS PATIENTS AND THEIR FAMILIES, AND ELIMINATES THE TIME IT TAKES FOR TRAVELING BACK AND FORTH TO A CLINIC."

JESSIE WAKS IS A BPS NURSE PRACTITIONER WHO WORKS IN COON RAPIDS, MINN. "WE INTERACT WITH PATIENTS IN A HOLISTIC WAY, NOT JUST AS A SERIES OF DIAGNOSES AND CHIEF COMPLAINTS," SHE SAYS. WAKS, A FORMER ICU NURSE, WAS SO FRUSTRATED WITH THE CURRENT SYSTEM THAT SHE WENT BACK TO SCHOOL TO BECOME A NURSE PRACTITIONER. "IKE PEWITNESSING OVERLY AGGRESSIVE TREATMENT OF ELDERY PATIENTS, AND I THOUGHT 'I CAN'T STAND BY AND WATCH THIS. I NEED TO ADVOCATE FOR THEM BEFORE THEY GET TO THE ICU.'"

WAKS' PATIENT ASSESSMENT BEGINS THE MINUTE SHE OPENS THE DOOR OF A HOME OR FACILITY. "I ASK MYSELF, 'WHAT IS THE FEELING IN THIS UNIT? ARE PEOPLE AGITATED? IS ONE DISRUPTIVE PATIENT UPSETTING ALL THE OTHERS?' THEN, WHEN I GET TO MY PATIENT'S ROOM, I CAN TELL SO MUCH THROUGH OBSERVATION. DOES SHE USUALLY GREET ME FROM A CHAIR, BUT TODAY I FIND HER IN BED? THAT'S A SIGNAL BEFORE I EVEN BEGIN AN EXAMINATION."

OUTCOMES FOR BPS PATIENTS ARE DRAMATICALLY IMPROVED. VISITS TO THE EMERGENCY DEPARTMENT HAVE BEEN REDUCED BY 73 PERCENT COMPARED TO SIMILAR MEDICARE POPULATIONS, WITH AN ANNUAL HEALTH CARE SPENDING REDUCTION OF $23,000, AS CITED IN A 2013 ANALYSIS CONDUCTED FOR THE FIRM BY CLIFTON LARSON ALLEN. THESE RESULTS ARE ACHIEVED EVEN THOUGH 75 PERCENT OF BLEUSTONE'S BUSINESS COMES FROM ASSISTED LIVING SITES, THEIR PATIENTS' AVERAGE AGE IS 87, AND THEY HAVE AN AVERAGE LIFE EXPECTANCY OF TWO YEARS. MORE THAN 80 PERCENT OF THEIR PATIENTS SUFFER FROM ADVANCED ALZHEIMER'S DISEASE.

RESPONSE TIME IS A KEY PART OF BPS'S SUCCESS, SAYS PRESIDENT SARAH KEENAN. "OUR BLEUSTONE BRIDGE™ COMMUNICATION AND REPORTING PORTAL IS SHARED BY EVERYONE ON THE CARE TEAM, INCLUDING PATIENT FAMILIES," SHE SAYS. "WHEN A NURSE NOTICES SOMETHING AND ASKS A BPS PROVIDER FOR AN ORDER, A RESPONSE COMES BACK WITHIN 15 MINUTES, ON AVERAGE. I COMPARE THAT TO MY DAYS WORKING IN NURSING HOMES, WHEN IT WOULD SOMETIMES TAKE FOUR TO FIVE DAYS TO GET AN ORDER FOR A PATIENT."

WHAT'S THE SECRET OF THEIR SUCCESS? "OUR CULTURE DRIVES OUR INNOVATION, WHICH DRIVES OUR METRICS, AS OPPOSED TO MANY ORGANIZATIONS IN THIS SPACE," KEENAN SAYS. "WE TAKE CARE OF THE BIG ISSUES, BUT WE KEEP OUR EYES ON SIMPLE THINGS, TOO. WE NEVER UNDERESTIMATE THE POWER OF ANSWERING OUR MESSAGES AND PICKING UP OUR PHONES."

JULIE KENDRICK
is a freelance medical and science journalist in Minneapolis, Minn.
Leading the way: 
The Eden Alternative®

Many current trends and innovations in long-term care have their roots in the thinking and work of Bill Thomas, MD, a self-described “nursing home abolitionist” and founder of the nonprofit Eden Alternative. The organization, founded in 1994, works to deinstitutionalize nursing homes and alleviate what it calls the “three plagues” present in many facilities: boredom, helplessness and loneliness. Thomas is also creator of the Green House Project, in which large facilities are replaced with small, homelike environments where people can live a full and interactive life.

Movement matters

As part of her mission to challenge the traditional thought process about the environment of long-term care, Minnesota-based Winona Health CEO Rachelle Schultz is always looking for ways to, as she puts it, “make residents’ time with us more fulfilling and purposeful.” One way she’s achieving her goal is through a partnership with Maria Genné, founder of Kairos Alive! Choreography of Care,™ an intergenerational modern dance company. The group uses dance and storytelling to create a sense of well-being and community. The program began with employee training and is now a regular part of life for everyone at the facility. “The staff might sing songs while working and interacting with residents, or play music that calms people or evokes happy memories,” Schultz says. “If a staff member needs a resident to ambulate down the hall and meets with resistance, moving into storytelling can engage residents in a different, often successful, way.” Evening dance halls, with live music, are open to the community. “They are very popular events,” Schultz says. “People drive from up to 40 miles away to attend.”

The “wow” factor

“We want our residents to live a better life and have better customer experiences with us,” says Chance Becnel, president and Chief Operating Officer of Wichita, Kan.-based Axiom Healthcare Management, LLC (Axiom). Instead of modeling themselves after other long-term care facilities, his leadership team has studied organizations like Disney, The Ritz-Carlton® and online retailer Zappos, rated one of the best places to work in the U.S. As a result, his organization has created a new high standard for customer satisfaction, with an intent to ‘wow’ every resident. “We have facilities that are consistently rated with 80–90 percent of respondents saying they’d ‘highly recommend’ the facility to a friend,” Becnel says. “We want to raise the standards and expectations of what a customer experience in a senior care facility can be.”

A homelike atmosphere is the place where that satisfaction begins. “We’ve developed a house-design format that accommodates 16–20 residents per house,” Becnel says. “There are virtually no straight, long corridors in our facilities, and all rooms are private, with common living areas that include huge fireplaces. Food and activities are customized to individual preferences.”

Community interaction

A spacious town hall is a mainstay of all Axiom facilities, and it’s a space that’s used by the entire community, not just residents. Community meetings and events are a normal part of life at their locations. “We also rent space to an outside beautician, who provides services and treatments not just for our customers, but for a client base from the surrounding community,” Becnel says.
From on-site sports bars to neighborhood dance hall events, facilities are changing the way they interact with residents and external communities.

by Julie Kendrick
“It’s important to get the community through our doors, because most people do not have very positive things to say about long-term care facilities. The more we can encourage them to come in and experience what we’re doing, the better. We often hear comments like, ‘WOW, I never knew a long-term care facility could look like this.’”

In their determination to encourage increased neighborhood interaction, Axiom has even installed a sports bar in one of its newest facilities. “Just because you’re in your later years doesn’t mean you want to give up having an occasional cocktail with friends and family,” Becnel says.

Restaurant-inspired dining

Institution-like dining areas are on the way out, and more restaurant-like facilities are on their way in. One notable example is the $5.2 million dining room renovation at Friendship Village in Bloomington, Minn. The project included the addition of a new second dining venue, a major kitchen expansion and the installation of a hearth pizza oven. With a full bar and an upscale menu, the facility’s offerings include beef tenderloin with a wine demi-glaze, lamb chops with mint jelly and grilled salmon with lime-honey cilantro sauce. In a recent story in Food Service News, Friendship Village’s chef and culinary director Les Johnson said, “Seniors are looking for more diverse foods, not just the blue plate special … They’ve been frequenting restaurants and are looking for that level of dining.”

Animal friends

“People these days view their pets as members of their families, so we’re finding that animals increasingly are being allowed in assisted living and continuing care retirement community settings,” says Elizabeth Newman, senior editor, McKnight’s Long-term Care News, a newsmagazine for those providing long-term care across the continuum of care. “Many facilities are recognizing the good evidence that pets support a number of beneficial outcomes, like lowering blood pressure and contributing to a greater sense of happiness.” Whether they’re pets owned by residents, brought in by team members or visiting as part of a pet therapy program, the presence of pets is a part of a way of life at many facilities. Newman recently wrote about an animal-related success story concerning a man in a nursing home who had been very resistant to participating in physical therapy. “The staff came up with the idea of having the man throw a ball to the facility’s resident dog, and he was very willing to do that, which not only made him feel useful and connected, but met his physical therapy goals. It was a big motivator.”

Beyond bingo and Bible study

Increasing the variety and quality of available activities is a major trend for facilities nationwide. “The stereotype is that bingo and Bible study are the only things to do in a long-term care facility,” Newman says. “But these days, you can find tai chi, scrapbooking, memoir writing groups, pet therapy, group singing and more.” The engagement these activities build can create a significant improvement in individual outcomes. “If you can find activities that reduce agitation, you can potentially decrease the use of anti-psychotics, which is a major goal for all long-term care facilities.”

Aging in place

The desire to remain living at home while staying safe, healthy and comfortable will be a major force as baby boomers continue to exert the influence of their independent ways on the world around them. According to an AARP study titled “A Report to the Nation on Livable Communities: Creating Environments for Successful Aging,” most adults would prefer to remain in their home as long as possible. This mindset creates opportunities for long-term care organizations to include home health and hospice in their continuum of care.

Food flexibility

According to “Emerging Dining Trends in Long-term Care,” a study conducted by Technomic, 90 percent of respondents say foodservice is among the most important factors when choosing a long-term care facility. But interest in sit-down dining room service is decreasing as residents seek greater flexibility about what, when and where they eat. The study cited trends including flexible dining hours, snacking options available throughout the day and more “grab-and-go” items. Trends to look for include more localized dining, carts and kiosks, snack shops, alcohol service, convenience stores and food courts.

References


JULIE KENDRICK

is a freelance medical and science journalist in Minneapolis, Minn.
Alzheimer’s is the only top 10 cause of death in America that cannot yet be prevented, cured or slowed.  

1 in 3 seniors dies of Alzheimer’s or another dementia.  

$43,200

Average annual cost of care at an assisted living facility.  

35-40% of community-dwelling adults aged 65 and older fall each year.  

70% Chance that someone turning age 65 today will need some type of long-term care service and support in his or her remaining years.  

Most people don’t want to think about the end of life, much less talk about it. With advancing medical technologies, however, the end of life can often be a conscious decision as opposed to a predestined moment in time. Not talking about that decision before it arrives can cause unbearable distress — distress we can mitigate by discussing advance directives.

Shawn McGarry, a Utah defense attorney, has been through conversations about advance directives with clients and with his own family. “The fact that people create a will without advance directives is shocking to me,” he says. He observes that people often seem to care more about how their belongings are distributed than alleviating the burden of end-of-life decisions on their loved ones.
LONG-TERM CARE

George Schoephoerster, MD, a family practitioner and geriatrician, engages in end-of-life discussions on a daily basis in nursing homes across central Minnesota. Dr. Schoephoerster describes an advance directive as a conversation about what a patient values and feels was the meaning of his or her life. This leads to decisions about when life is worth living and when to let go.

**Advance directive**

An advance directive or health care directive is a document expressing a patient’s wishes concerning life-sustaining care if he or she becomes unable to make decisions. Any competent adult can and should complete a directive, not just those facing a terminal illness. A directive is where a patient expresses — while still able to think clearly — two important issues: first, what life-saving treatment he or she would choose (also covered by a living will); and second, who can make decisions on his or her behalf (also covered by a power of attorney or proxy). Patients can address either of these separately, but the advance directive usually encompasses both.

A patient can complete an advance directive on his or her own, and with or without help from a provider or an attorney. McGarry agrees that an attorney is usually not necessary. The critical issue is that “there has to be communication between and among family members.” Dr. Schoephoerster, however, feels that as the end of life draws nearer, the provider should be involved so the directive can be more specific to the medical realities.

**Living will**

In a living will, a patient specifies what life-sustaining interventions he or she wants or does not want if certain events become a reality. This may include wishes about care, resuscitation, hospitalization and under what circumstances the patient wants to live or to let go.

McGarry describes how his father’s living will came from jokes about whether he wanted to live if he could only eat tofu. Funny scenarios led to serious scenarios and then to a written document. When his father’s health deteriorated, “it alleviated the burden of having to face those questions,” both for the family and for the providers involved. Knowing his father’s wishes preempted any disagreement between family members and gave them peace.

Without a living will, McGarry believes the burden on his mother to make decisions would have been too much to bear. To illustrate, the living will directed that his father wanted extubation when it was clear he would not recover. When the tube was removed, however, his father seemed to struggle. “If my mom had been saddled with the decision to let him die, then for her to see him struggling to breathe… It would have been horrific for her. But we had a directive in place that said, ‘If these certain things are present, then I don’t want to live.’”

**Power of attorney or proxy**

A power of attorney, also called a proxy or health care agent, designates a loved one to manage a medical crisis, to communicate with providers and to speak on a patient’s behalf should he or she become incompetent.

Dr. Schoephoerster feels that a proxy is the most critical piece of any advance directive. He explains that living wills can be too vague to cover a specific, real-life scenario. A living will requesting “no heroic measures” leaves too much room for interpretation. As scenarios change, a proxy can look at the situation day to day and say, “Now this is what I think the person would want.”

Dr. Schoephoerster explains that a proxy can also take the provider out of the middle of the feeding family members. The patient already selected one representative to speak on his or her behalf, and that person speaks for the whole family.

**Physician order for life-sustaining treatment**

The physician order for life-sustaining treatment (POLST) is a standing and transferrable medical order completed by a physician that directs treatment in specific scenarios. The POLST functions as a do not resuscitate (DNR) order that can transfer between facilities, sometimes even between states.

Unlike other directives, the POLST becomes appropriate at the end of life because it is effective immediately, not when some hypothetical circumstance arrives. It is used for patients with mental capacity, but who face life-threatening illnesses; patients with very specific, perhaps religious, preferences about end-of-life; and patients who want a DNR order outside of a health facility.

Dr. Schoephoerster explains that the POLST form has two advantages over other advance directives. First, it is an order from a physician. The physician is involved with the patient’s care and is involved in the decision-making. Second, it is specific. The POLST is completed when medical realities are present, not hypothetical, and it addresses specifics of chronic disease management, resuscitation, hospitalization and other real scenarios.

The National POLST Paradigm, an organization promoting POLST usage, estimates that 45 out of 50 states have existing or at least developing POLST programs.1 Of Constellation’s 16 states, 13 have POLST programs in place or in the works.

**Start the conversation**

Providers hold enormous power to break down intimidation and start the conversation. Sharing talking points about options can lead families to face the harder part — talking about values in life, spiritual beliefs and their feelings about their humanity that will lead to decisions about end-of-life care.

**References**


**Resources**

Leaving Well: Utah Guide to End-of-Life Care
www.leaving-well.org

Minnesota Department of Health — Questions and Answers about Health Care Directives
www.health.state.mn.us/divs/lpc/profinfo/advdir.htm

CaringInfo — National Hospice and Palliative Care Organization
www.caringinfo.org

The National POLST Paradigm
www.polst.org

EMILY CLEGG, JD, MBA, CPHRM
Senior Risk & Patient Safety Consultant, UMIA
eclegg@umia.com
Facts of the case
A 72-year-old woman with a complex medical history of coronary artery disease, diabetes, deep vein thrombosis (DVT) and obesity suffered a right distal femur fracture, was admitted to a tertiary hospital and underwent surgery to repair the fracture. The orthopedist ordered her to be placed in a long-leg immobilizer 24 hours a day and transferred her to a local community skilled nursing facility (SNF) for rehab before returning home. To avoid a DVT, he prescribed an anticoagulant and ordered daily INRs until the level was therapeutic. Her local family physician (FP) took over management of her care while in the SNF.

Two weeks later, she was transferred from the SNF to the local hospital emergency department (ED) because the SNF nurse was unable to palpate her right pedal pulse and the woman was complaining of right leg pain. The ED physician ordered an X-ray that showed slow healing of the fracture but ruled out DVT. The ED physician noted that there was no skin breakdown under the immobilizer, but he did not think the skin under the brace was being attended to so he ordered the leg be unwrapped for routine skin assessment and hygiene. The FP recommended transfer back to the tertiary hospital where she had undergone orthopedic surgery due to the slow healing of the fracture, continued complaints of leg pain and complex care needs. The patient and her husband refused transfer because the husband would not be able to travel the distance to visit her in the tertiary facility. She returned to the local SNF.

Three weeks later, the certified nursing assistant (CNA) summoned the SNF nurse to the woman’s room because the immobilizer was wet with urine. The nurse removed the immobilizer and found three pressure ulcers on the back of the right knee. The nurse called the FP who examined the leg and ordered the area to be cleaned and dressings applied and changed every three days.
Over the next week, the SNF team members documented that the pressure ulcers were bleeding moderately at dressing changes but did not communicate this to the FP. They called the FP several days later when the pressure ulcers would not stop bleeding. The FP ordered an INR, which was elevated. The FP examined the patient’s leg and ordered her to be transferred to the tertiary hospital, where she eventually underwent an above-the-knee amputation. Following surgery, she was transferred to a long-term care facility permanently.

The patient sued the FP and the SNF alleging improper post-operative care and failure to prevent pressure ulcers and infection, resulting in an above-the-knee amputation.

Disposition of the case
The case was settled against the SNF.

Patient safety and risk management perspective
The investigation of the claim revealed that the SNF team had not routinely removed the leg immobilizer to provide skin care for weeks despite the ED physician’s orders and only removed it when it became saturated with urine. They also did not follow the orders for routine INRs to determine when a therapeutic anticoagulant level had been achieved, resulting in a supra-therapeutic effect. The experts were critical of the SNF team for failing to communicate with the FP when the pressure ulcers began bleeding. The SNF team testified that they had not been trained to care for this type of high-risk post-op patient with high acuity needs.

Short-stay, subacute and rehab care
Short-stay, subacute and rehab care are services increasingly being offered by many long-term and aging care organizations. These patients, usually recovering from surgery or an illness, need care and rehab following hospitalization before going back to their homes. Many of these patients also have chronic medical conditions requiring close monitoring and are higher in acuity than those routinely cared for in long-term care settings. These factors lead to a higher risk of patient injury if the facility does not have team members with enhanced skills and competency, as well as effective communication processes.

A report released in 2014 by the Department of Health and Human Services’ Office of the Inspector General found that 22 percent of Medicare patients who stayed in a nursing facility for 35 days or less experienced harm as a result of their care. The study also found that 79 percent of the adverse events resulted in one or more of the following: a prolonged stay, a transfer to a different post-acute care facility, or hospitalization.1

References
Our mission at MMIC, UMIA and Arkansas Mutual is to help physicians and all those who devote their lives to health care to attain their dream: to help, to heal, to serve.

We challenge ourselves to interpret our mission as expansively and creatively as possible. And our support takes many forms, from scholarships to sponsorships to research grants.

We are especially keen to align our efforts with the Institute for Healthcare Improvement’s Triple Aim of better health outcomes, enhanced patient experiences and reduced costs. And we support the notion of expanding the Triple Aim to a Quadruple Aim by adding a fourth dimension — health care providers — and setting a goal of improving their health, well-being and work life.

Here’s what we’re doing.

**Physician leadership training**
Some physicians are born leaders. Others get there with training. And some land there on the seat of their scrubs. We need all of you! And we’re here to support physicians who feel their progression to positions of greater responsibility and authority may be hindered by a lack of leadership training.

Compounding the lack of education and preparation that hampers many physicians tapped for leadership roles is a “feedback vacuum.” As a sort of protected class, physicians have largely escaped — but really, missed the opportunity for — thoughtful, regular, authentic feedback. As a result, we have limited experience and comfort either giving or receiving constructive feedback — important skills for leaders.

Because we believe that effective leadership skill development for our policyholders is directly tied to their professional satisfaction and, ultimately, to the safety and experience of their patients, we have long supported physicians who seek training in this area.

We have awarded partial scholarships for programs such as the Physician Leadership College at the University of St. Thomas, the Montana Medical Association’s Physician Leadership Effectiveness Program, and The Action Wheel Leadership Program for multi-disciplinary teams in a variety of health care settings, such as hospitals, clinics and long-term care communities.

**Provider and patient support programs**
We have supported Physicians Serving Physicians, a confidential program that assists Minnesota physicians affected by chemical dependency, since its inception more than 30 years ago. More recently, we have supported a national program, Medically Induced Trauma Support Services (MITSS), that offers support and counseling to providers, patients and families impacted by adverse outcomes.

Just this spring, Constellation co-sponsored the enhancement of an online toolkit on the MITSS website that makes available a wealth of resources for organizations seeking to develop their own programs to support people impacted by unanticipated outcomes.

**Patient safety organizations**
We support a number of patient safety organizations including the Minnesota Alliance for Patient Safety, the Iowa Healthcare Collaborative, the Nebraska Coalition for Patient Safety and the National Patient Safety Foundation.
We believe that by supporting these organizations, we can further the efforts of improving patient care.

**Research initiatives**
Lastly, we are excited to announce our new research granting program, one that will offer support to policyholders interested in conducting research that explores ways to improve patient outcomes, patient and provider experience, and efficiency — in other words, research that supports the Quadruple Aim.

For more information about these grant opportunities and the other organizations mentioned above, please visit MMICgroup.com/grants.

**Resources**
Medically Induced Trauma Support Services (MITSS)
www.mitss.org

**Laurie C. Drill-Mellum, MD, MPH**
Chief Medical Officer
MMIC, UMIA and Arkansas Mutual
Laurie.Drill-Mellum@MMICgroup.com
Successful pre-operative conversations

Emerging data on surgical malpractice claims

How’s your social IQ?

Where the risks are with musculoskeletal and digestive surgeries

When are you too old to practice?
The ground is shifting underfoot. Already troubled by high staff turnover, economic constraints and pressures to provide more complex care, long-term care (LTC) facilities now face the daunting prospect of millions of additional patients as baby boomers age to the point of needing care. As the LTC industry adjusts to this changing landscape, how will caregivers reduce risk and keep their patients safe? In this issue of *Brink*, we explore what's harmful, helpful and hopeful in today's LTC environment.