Transforming chronic disease management practice in a skilled nursing facility:

Ohio program redefines the care team

Change AGEnts Initiative

The John A. Hartford Foundation's Change AGEnts Initiative was a three-year effort dedicated to improving the health of older Americans, their families, and their communities through practice change. Managed by The Gerontological Society of America, the initiative harnessed the collective strengths, resources, and expertise of the foundation's interprofessional community of scholars, clinicians, and health system leaders.

The 34 projects funded through the Action Awards grants program showcased the improvements that interprofessional teams can bring to light by implementing evidence-based programs into targeted care settings in local environments.

Costly hospital readmissions – most common among elderly patients – are often the result of tiny oversights. Eliminating these little oversights, however, is no small task. Non-clinical health care staff might be a valuable, yet wholly untapped, resource in this effort.

Jennings Center for Older Adults, recipient of a 2015 John A. Hartford Foundation Change AGEnts Action Award, is making non-clinical staff the eyes and ears of the care team at its skilled nursing facility. Led by Evelyn Duffy, DNP, of Case Western Reserve University, the innovative inter-professional team-based initiative aims to reduce hospital readmissions by transforming management of chronic disease.

Managed by The Gerontological Society of America, the John A. Hartford Foundation Change AGEnts Initiative accelerated sustained practice change to improve the health of older Americans, their families, and communities. It did so by harnessing the collective strengths, resources, and expertise of the John A. Hartford Foundation's interprofessional community of scholars, clinicians, and health system leaders to learn from and support one another while they adopted, evaluated, and sustained changes in practice and service delivery. The Change AGEnts Action Awards grants program was designed to support Change AGEnts in implementing promising ideas in practice change.

The Situation

Hospitals have become more selective when choosing the rehabilitation and skilled nursing facilities to which they discharge their patients. Now that hospitals are penalized for readmissions, they won't trust just any facility with patients' post-discharge care.

"Hospitals are looking for those facilities that have the best records, so how well a skilled nursing facility is able to keep patients out of the hospital is important," Duffy said.

Skilled nursing facilities, as a result, are looking to reduce their readmission rates, which are particularly high among older adults. Seniors over age 65 are 54 percent more likely to be readmitted than their younger counterparts, says Journal of the American Geriatrics Society. This demographic is also disproportionately burdened by chronic disease. Sixty-five percent of Medicare beneficiaries have at least two chronic conditions; 43 percent have three or more. An initiative to reduce readmissions among older adults with chronic disease would significantly reduce readmissions overall.

The Solution

Duffy drew from personal experience when she set out to devise a plan for slashing hospital readmission rates. "My mother was a patient in long-term care. Housekeeping and nursing assistants are in and out of the room all the time. They get patients out of bed, dress them, turn them, clean their rooms," Duffy said.

These staff members may be privy to more information about the patients, too. Patients may share a symptom or concern with housekeeping staff that they wouldn't share with the professional staff because they fear it could prolong their stay. Yet these staff members are not considered members of the care team. They don't receive any training about the most common conditions that ail the people they serve.

"Housekeeping may have no idea why someone with chronic heart failure shouldn't drink as much fluid as they want. If the patient asks for a glass of water, there'd be no reason for housekeeping not to give it to him," said Duffy.

It was this thinking that led Duffy and her colleagues to propose training in basic chronic disease management for non-clinical staff at Jennings. Working with Jennings education department, Duffy and her colleagues created a basic curriculum that covered COPD, chronic heart failure, chronic kidney disease and diabetes. They piloted the program on one floor of the skilled nursing facility.

The center also devised a discreet coded system to alert non-clinical staff about the needs and restrictions of patients without violating patients' rights and privacy. Symbols on a white board placed in each patient's bathroom denote the patient's needs. "A cactus for fluid restriction, a watering can if you are to push fluids, a honeybee for thickened liquids, and so on," Duffy said. "It's a very clever system."

When non-clinical staff enter the room, they check the board in the bathroom and then act accordingly. While in the room, staff also make observations that they can pass along to nursing staff. "If they see that a patient with diabetes has just gotten a Coca-Cola and a supersize McDonald's meal from their family, they don't have to act on it, but they can tell the nursing staff about it," Duffy said. These new teammates report these concerns at daily five-minute team huddles.

At first it was a challenge to get non-clinical staff to attend huddles. Then Jennings' director of nursing Susan LoDolce and head nurse on the skilled nursing floor Renee Gall attended the 2015

John A. Hartford Foundation Change AGEnts Communications Institute in Chicago. There they received valuable advice on boosting attendance at huddles. “Someone told them, ‘If you have doughnuts, they’ll come.’” It worked. Staff began to attend the huddles, and soon they saw the value of them. “Then we didn’t need the doughnuts anymore,” Duffy said.

In the beginning, Duffy wasn’t sure she’d be able to pull off integrating non-clinical staff into the health care team, pushing them to get additional training and attend daily huddles. “But the members of these ancillary services were thrilled to get this additional knowledge, become more of a partner, and have their viewpoint recognized.” A survey at the end of the pilot program found that most staff felt they had contributed to improving patient outcomes and that they were an important part of the care team.

How the Change AGEnts Action Award improved outcomes

Besides covering a few dozen doughnuts, the Change AGEnts Action Award freed up the time of Jennings Chief Planning Officer Colleen Lavelle, who partnered with Duffy in the creation of the program. “Initially, I met every week with Colleen, Susan [LoDolce] and Renee [Gall] to iron out the kinks.” The grant also allowed Duffy to take one day a week away from her responsibilities at Case to focus on the project.

The grant sent LoDolce and Gall to the Chicago conference where they learned about the movement to develop inter-professional health care teams and got practical advice on how to build and run their own team. “It gave them more buy-in,” Duffy said. “They saw that this is something really important that we need to be involved in.” LoDolce is now so convinced of the program’s value that she has extended it to other floors of the facility.

In addition to crucial funding, the Change AGEnts Initiative gave Duffy and her colleagues advice and support. “The Action Award was much more than the money we got. It was also the support we got from the John A. Hartford Foundation. Without that support, I don’t think we would have been able to pull this off.”