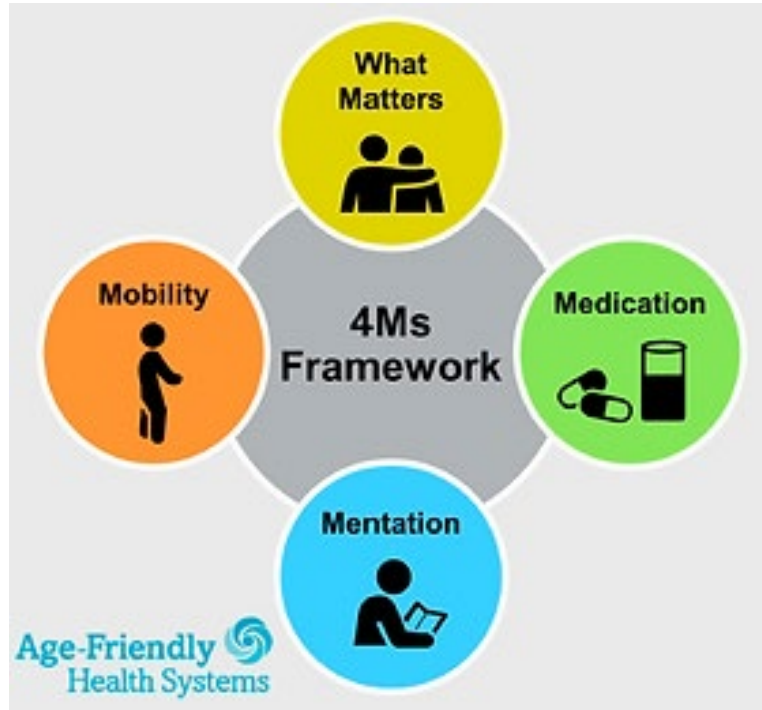


# 4M NH Quality Moving Forward Guide

QAPI



# Age-Friendly- 4Ms Quality Improvement Measures



## CMS Quality Improvement Measures

- Mobility
  - Falls
  - Falls with Major Injury
- Medications
  - Anti-Psychotics
  - Anti-Anxiety/Hypnotic
- Mentation
  - Depressive Symptoms
- Mentation & What Matters Most
  - Behaviors Affecting Others

**MDS Reports**

**Surveys**

**Staff**

**Resident Councils**

**Families**

---

*CMS has identified five strategic elements that are basic building blocks to effective QAPI. These provide a framework for QAPI development.*

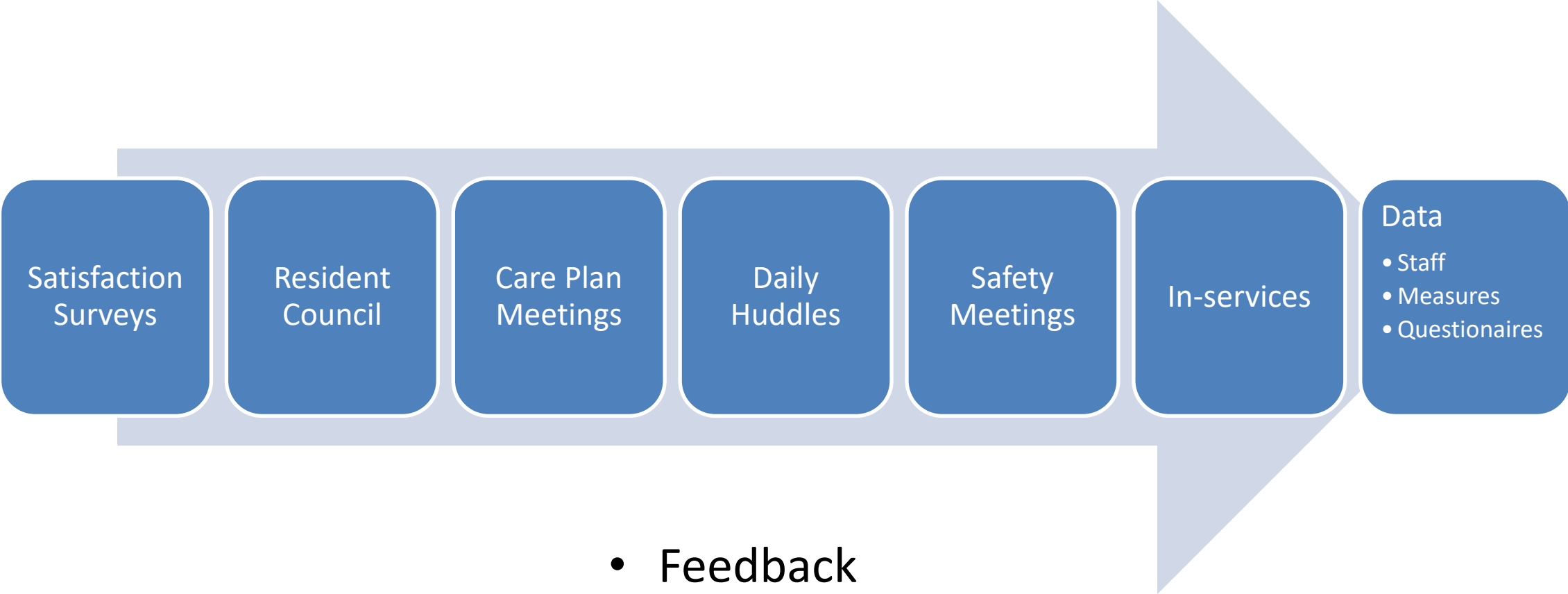


## QAPI

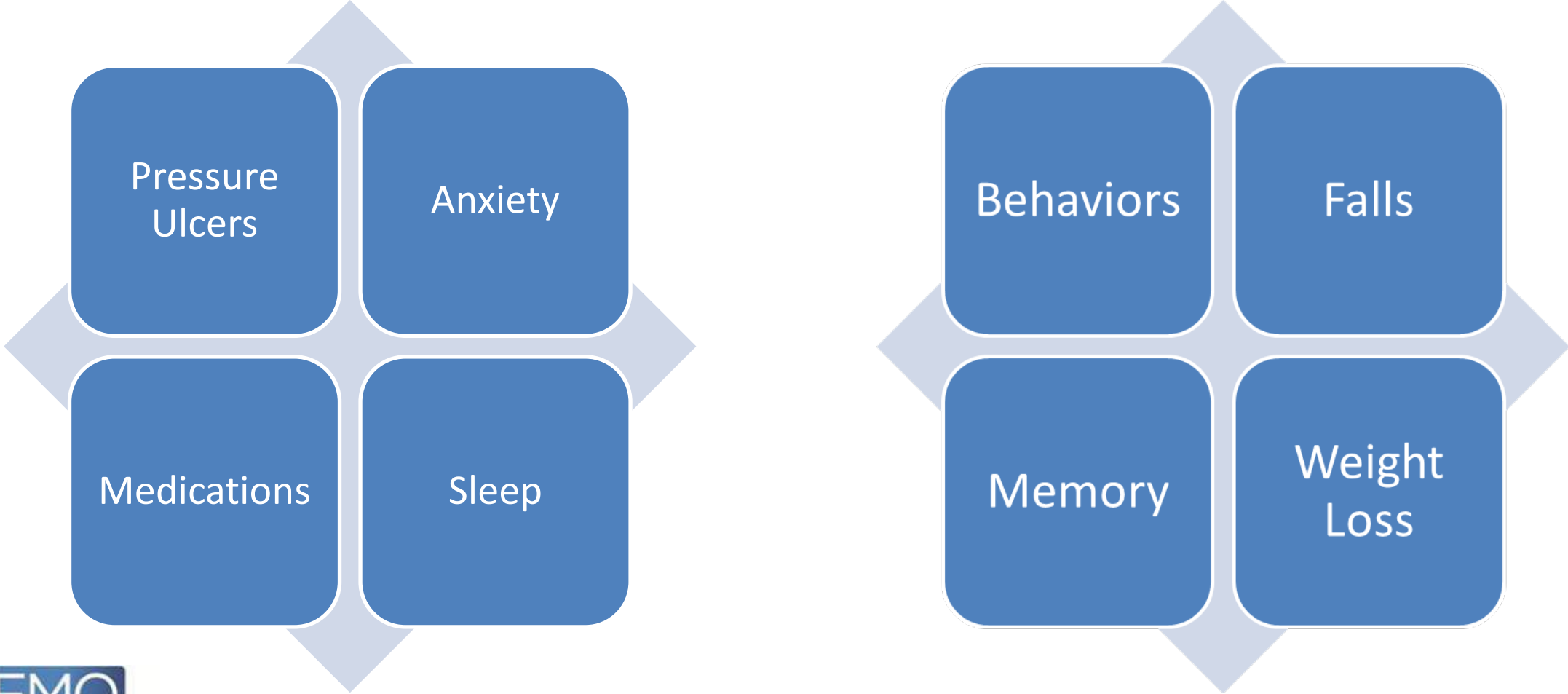
Implemented in 3 phases 2016, 2017 & 2019

F-tags- F865, F867, and F868

# Quality Assurance Performance Improvement



# Quality measures



## Performance Improvement Projects (PIPs)

- Each NH MUST conduct specific PIPs with scope, complexity and available resources in mind
- EVERY NH MUST conduct AT the VERY LEAST 1 improvement project every YEAR.
- These PIPs MUST focus on high-risk or problem-prone areas, identified by the facility through data collection and analysis.

# Goal Setting Worksheet

## Goal Setting Worksheet



**Directions:** Goal setting is important for any measurement related to performance improvement. This worksheet is intended to help QAPI teams establish appropriate goals for individual measures and also for performance improvement projects. Goals should be clearly stated and describe what the organization or team intends to accomplish. Use this worksheet to establish a goal by following the SMART formula outlined below. Note that setting a goal does **not** involve describing what steps will be taken to achieve the goal.

**Describe the business problem to be solved:**

------------------

**Use the SMART formula to develop a goal:**

### SPECIFIC

Describe the goal in terms of 3 'W' questions:

What do we want to accomplish?

Who will be involved/affected?

Where will it take place?

### MEASURABLE

Describe how you will know if the goal is reached:

What is the measure you will use?

What is the current data figure (i.e., count, percent, rate) for that measure?

What do you want to increase/decrease that number to?

### ATTAINABLE

Defend the rationale for setting the goal measure above:

Did you base the measure or figure you want to attain on a particular best practice/average score/benchmark?

Is the goal measure set too low that it is not challenging enough?

Does the goal measure require a stretch without being too unreasonable?

### RELEVANT

Briefly describe how the goal will address the business problem stated above.

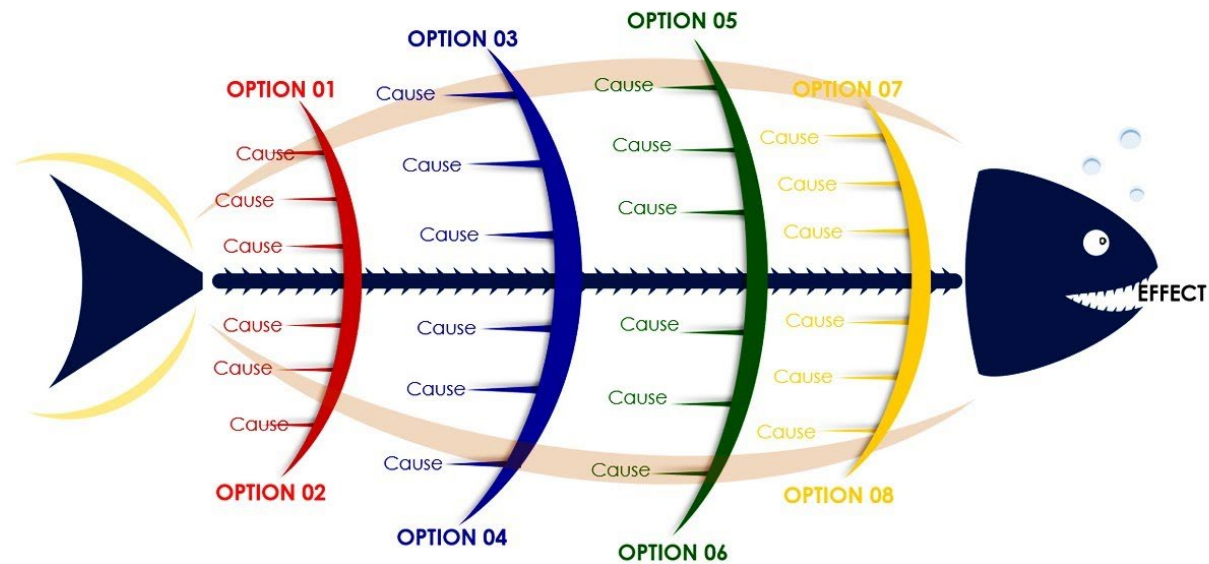
### TIME-BOUND

Define the timeline for achieving the goal:

What is the target date for achieving this goal?

# Track the effects on Quality of Life and Quality Measures

## CAUSE AND EFFECT / FISHBONE DIAGRAM



Why does it matter?



System Analysis

=

Post game  
review





# Disrupting the Status Quo of Senior Living: A Mindshift

AARP  
Real Possibilities

DISRUPTING THE  
STATUS QUO OF  
SENIOR LIVING

A MINDSHIFT

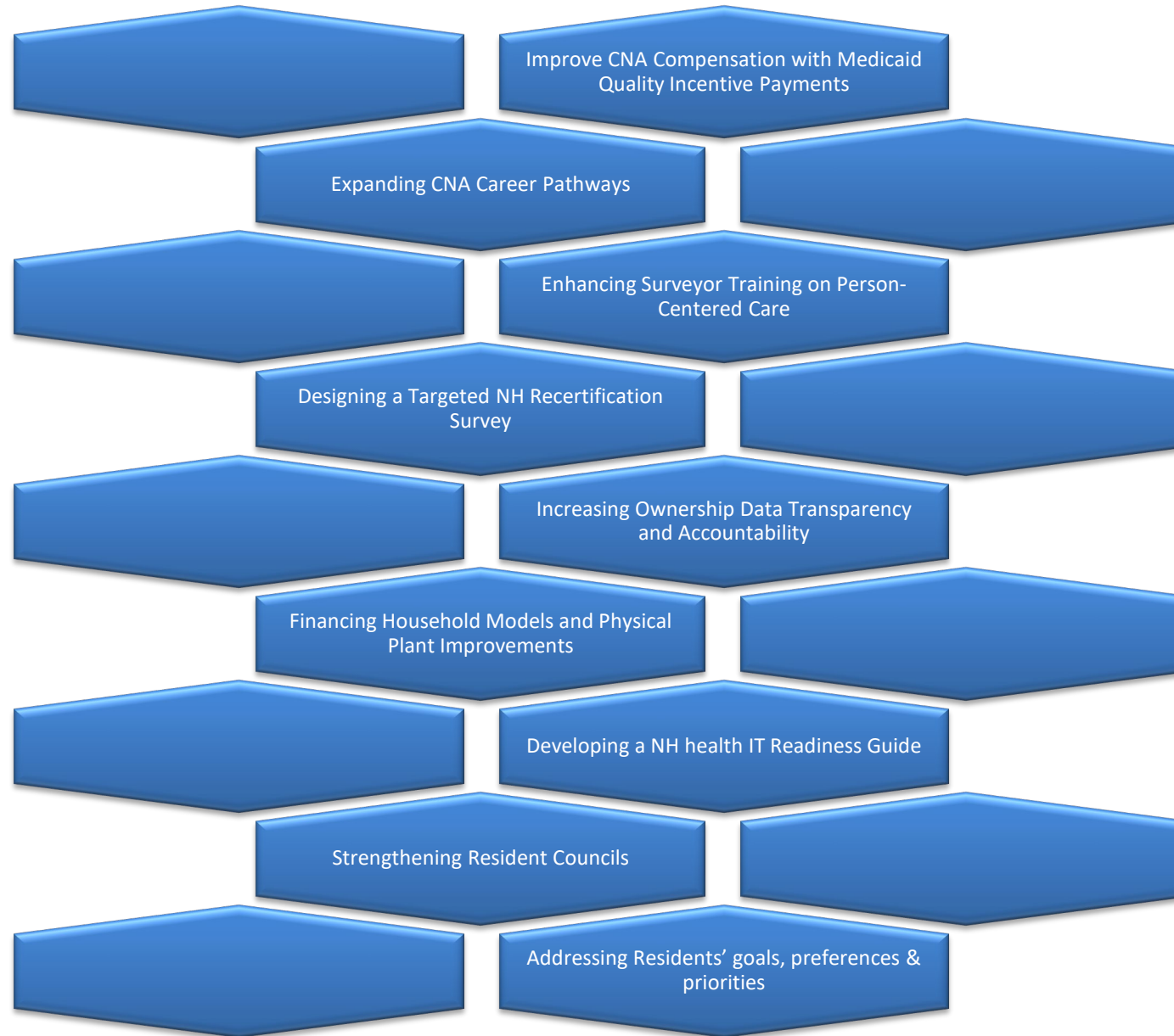


JILL VITALE-AUSSEM

## NASEM Report: 7 Goals

- **Deliver Comprehensive, Person-Centered Care that ensures the health, quality of life, and safety of NH Residents**
  - **Promotes Resident Autonomy and Manages Risk**
- Ensure a well-prepared, empowered, and appropriately compensated workforce
- Increase transparency and accountability of finances, operations, and ownership
- Create a more rational robust financing system
- Design a more effective and responsive system of quality assurance
- **Expand and Enhance Quality Measurement and Continuous Quality Improvement**
- **Adopt Health Information Technology in all NHs**

# Collaboration: NASEM Report



## Recommendations or Summary from Goal #1 are:

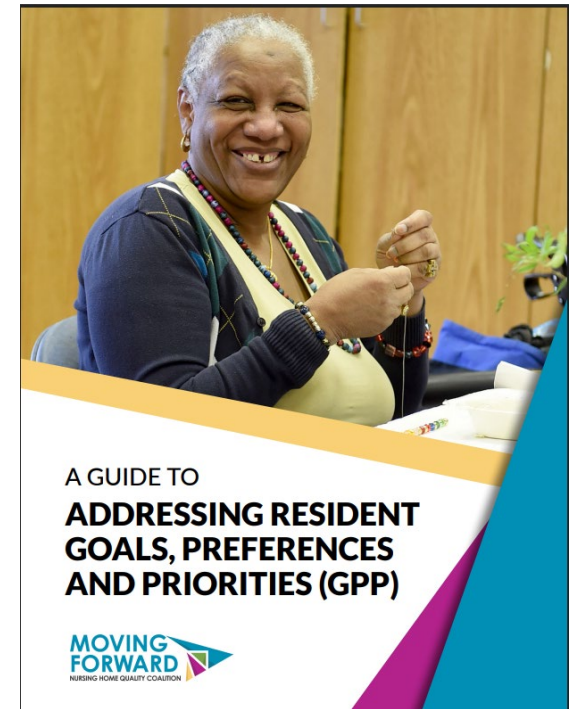
- **Identify** residents' care preferences
- Ensure the resident care preferences are **documented in the care plan**
- Implement and **monitor** the residents' **care plan that reflects their preferences.**

## Resident Goals and Wishes INTO ACTION

Nursing Home Residents should be empowered to direct their care to address What matters Most to them.

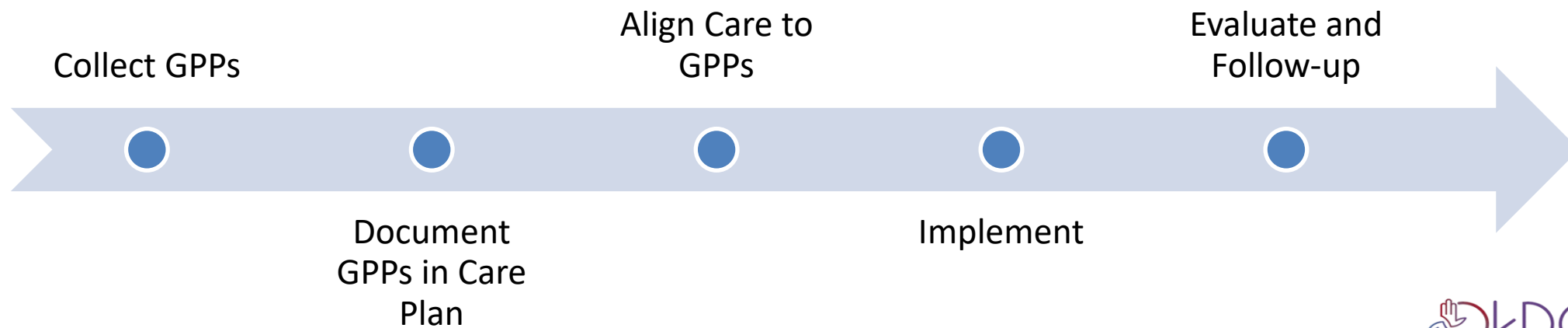
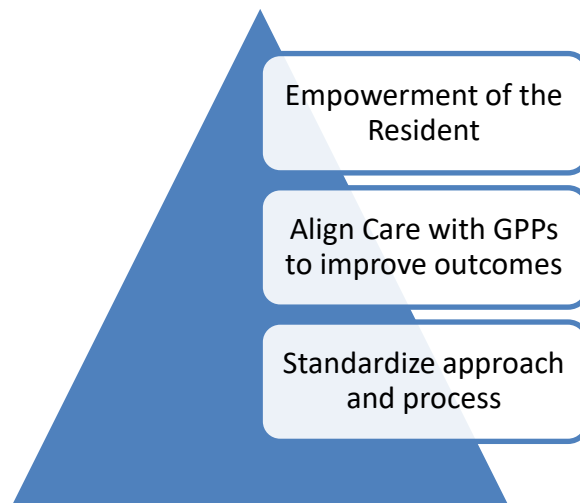
Standardize approaches and processes related to resident goal.

1. A Guide for staff to identify, document & implement resident's goals.
2. An Interview to ask residents, care partners, direct care staff & leaders about care continuity
3. An Outline for a digital tool that residents will be able to complete to share their goals.



[Guide to Addressing Resident Goals Preferences and Priorities.pdf](#)

# Goals, Preferences, & Priorities



## Guidebook

- Is a “How to Manual”
  - Practical
  - Steps and Tips
  - Specific Tools
- How other home used the manual to engage residents
  - One on One Conversations
  - Focus Groups
  - Committees involving residents and data analysis
  - Provider Feedback



# The Process to Implement Change with the Guide

- Identifying, Documenting and Implementing Resident GPPs
  - Resident Checklist
  - GPP Identification and Assessment Tools
  - Care Planning Meetings discussing the process and best practices
  - Care Planning Interventions
    - Tips and best practices for caregiver access
    - Making updates and changes

- Tools
  - Welcome Packet Orientation
  - Direct Care Quick Reference Sheets
    - Integrated into PCC or Matrix Care

Assistive Devices	<ul style="list-style-type: none"><li>• Glasses</li><li>• Walker</li><li>• Walks with stand-by assist; is very slow with transfers so be patient and leave for activities promptly</li><li>• Wears Ted hose on in the AM and off at HS</li></ul>
Cognition	<ul style="list-style-type: none"><li>• Alert and oriented to self</li><li>• Engages in conversation easily</li></ul>
Favorite Foods	<ul style="list-style-type: none"><li>• Enjoys ice cream and candy</li><li>• Eats rice with all lunch and dinner meals</li></ul>
Bathing Preferences	<ul style="list-style-type: none"><li>• Please offer Wan a bath daily</li></ul>
Using the Toilet	<ul style="list-style-type: none"><li>• Continent of bladder and bowel</li><li>• Large pull-ups</li></ul>
Quality of Life Information	<ul style="list-style-type: none"><li>• Enjoys visiting with other residents in the dining room area</li><li>• Do not touch Wan on the top of the head unless bathing or assisting with care where it is required. It is a part of his culture. The head is considered sacred.</li></ul>

# Mini Care Plan Example and how to Integrate GPPs

ROOM#:



## Sally Miller

### Diet:

Smooth pureed and nectar thick liquids with pills only.

### Transfers:

Handheld assist with all transfers.

### Night Checks:

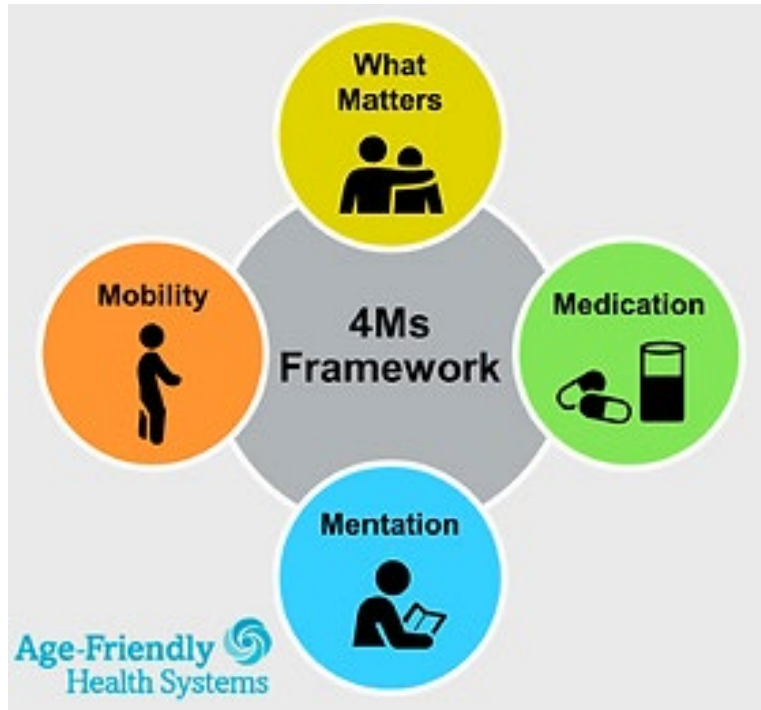
- Motion sensor in place
- Wears pull-ups
- 1 person assist
- Offer help to the toilet and/or check and change if noted to be awake during HS hours.

Assistive Devices	<ul style="list-style-type: none"> <li>• Glasses</li> <li>• Dentures</li> </ul>
Cognition	<ul style="list-style-type: none"> <li>• Alert and oriented to self</li> <li>• Engages in conversation easily</li> </ul>
Favorite Foods	<ul style="list-style-type: none"> <li>• Loves soda</li> <li>• Enjoys ice cream</li> </ul>
Bathing Preferences	<ul style="list-style-type: none"> <li>• Likes a bath in the evening or early morning</li> </ul>
Using the Toilet	<ul style="list-style-type: none"> <li>• Incontinent of bladder, at times</li> <li>• Continent of bowel; occasionally does not always make it to the bathroom in time</li> <li>• Needs assistance with peri-care</li> <li>• Wears large pull-up briefs</li> </ul>
Quality of Life Information	<ul style="list-style-type: none"> <li>• She enjoys visiting with her sister, Mae</li> <li>• Enjoys reading the Bible</li> <li>• Enjoys watching the Price is Right</li> </ul>

Goal	Intervention	Outcome (In resident's own words)
Resident wants to start each day with newspaper and coffee.	<p>Social worker will work with resident's family to ensure she has a subscription to the daily paper.</p> <p>Night shift CNA will get resident a cup of coffee from the kitchen before the end of the shift.</p> <p>OR</p> <p>Night shift CNA will prepare resident a cup of coffee in the unit Keurig before the end of the shift.</p>	I will be satisfied with my daily routine.
Resident wants to be able to transfer in/out of a car to be able to attend her grandson's wedding in October.	<p>PT/OT referral.</p> <p>CNA to assist resident with daily exercises as instructed by PT/OT.</p> <p>SW to work with resident's family to determine what vehicles are available to transport resident.</p> <p>Family will identify who will assist resident on wedding day and that person will work with PT/OT to learn safe transfer techniques.</p>	I will attend my grandson's wedding.



# Age-Friendly- 4Ms Intertwined with the Residents GPPs



## CMS Quality Improvement Measures

- Mobility
  - Falls
  - Falls with Major Injury
- Medications
  - Anti-Psychotics
  - Anti-Anxiety/Hypnotic
- Mmentation
  - Depressive Symptoms
- Mmentation & What Matters Most
  - Behaviors Affecting Others

# Your Choice, Your Voice



Tool Name	Covered Topics (Domains)	Tool Format	Tool Length	Link
<b>This is me</b>	Identity, Physical Environment, Social Engagement, Everyday Living Preferences	Open-ended	24 items/questions	<a href="#">Click here for link</a>
<b>ComPASS-16</b>	Everyday Living Preferences	Open-ended & close-ended	71 items/questions	<a href="#">Click here for link</a>
<b>Well-being Toolkit</b>	Identity, Social Engagement, Autonomy, Safety	Mostly open-ended	15 items/questions	<a href="#">Click here for link</a>
<b>Goal Setting Practice Tool</b>	Other: Treatment/health-related goal setting	Open-ended	2 items/questions	<a href="#">Questions #25 and #26 in the Set of Questions. Organized by the Moving Forward Coalition</a>
<b>PELI (Preferences for Everyday Living Inventory)</b>	Physical Environment, Social Engagement, Everyday Living Preferences, Autonomy, Safety	Open-ended & close-ended	>72 items/questions	<a href="#">Click here for link</a>

<b>Preferences for Activity and Leisure (PAL) Cards</b>	Similar topics as PELI but has a different mode of delivery (not a check box)	Open-ended	No limit on the number of items but has to fit on a card (average of 6)	<a href="#">Click here for link</a>
<b>Set of Questions Organized by the Moving Forward Coalition</b>	This set of questions references the tools in this table and aligns with the 8 GPP domains listed above.	Open-ended & close-ended	52 items/questions	<a href="#">Find the set of questions attached to the Guide</a>

[Assessment Tools.pdf](#)

# Personal Preferences

- Personality
  - Some things about me
  - What makes me happy?
  - What makes me unhappy?
  - What helps me cope?
- Independence
  - Best time of Day
  - I feel strongly about being able to
  - A recent major event that affects
  - I prefer physical activity by
  - Personal Hygiene preferences
  - Healthcare team
- Future Concerns

## What makes me happy?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Being outside / inside     | <input type="checkbox"/> Relaxing              | <input type="checkbox"/> A TV show                    |
| <input type="checkbox"/> Travel or outings          | <input type="checkbox"/> Reading/being read to | <input type="checkbox"/> Certain hobbies / activities |
| <input type="checkbox"/> Certain music or sounds    | <input type="checkbox"/> Being around pets     | <input type="checkbox"/> Certain meals / food         |
| <input type="checkbox"/> Visiting family or friends | <input type="checkbox"/> A special place       | <input type="checkbox"/> Other:                       |

What details should your care providers know?

## What makes me unhappy?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Certain noises           | <input type="checkbox"/> Eating                 | <input type="checkbox"/> Storms / Bad Weather |
| <input type="checkbox"/> Certain smells or tastes | <input type="checkbox"/> Being alone            | <input type="checkbox"/> Crowds               |
| <input type="checkbox"/> Being rushed             | <input type="checkbox"/> Having limited choices | <input type="checkbox"/> Darkness             |
| <input type="checkbox"/> Being moved/startled     | <input type="checkbox"/> Slipping / falling     | <input type="checkbox"/> Death                |
| <input type="checkbox"/> Certain animals          | <input type="checkbox"/> Lack of privacy        | <input type="checkbox"/> Other dislikes:      |

What details should your care providers know?

## MY FUTURE CONCERNS

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Pain / medication management     | <input type="checkbox"/> Being a burden      | <input type="checkbox"/> Housing situation   |
| <input type="checkbox"/> Independence (mental / physical) | <input type="checkbox"/> Finances            | <input type="checkbox"/> Health problems     |
| <input type="checkbox"/> Loss of caregivers               | <input type="checkbox"/> Mobility            | <input type="checkbox"/> Unfinished business |
| <input type="checkbox"/> Loss of privacy                  | <input type="checkbox"/> Death / End-of-Life | <input type="checkbox"/> Other:              |

How would you like your current care providers to help you cope with these concerns?

What Matters Most:

# Their Choice, Your Voice

## ASSESSMENT TOOL FOR DIRECT CAREGIVERS: THEIR CHOICE, YOUR VOICE WORKSHEET TEMPLATE

This tool may be used to guide CNAs through conversations with residents about their goals, preferences, and priorities related to the resident's daily life and care. This tool can help CNAs get to know residents well.

### "Their Choice, Your Voice" Care Plan Information Gathering Worksheet

Resident's Name: \_\_\_\_\_

Date of Care Plan: \_\_\_\_\_

CNA Attending the Care Plan: \_\_\_\_\_

	Are you seeing verbal or physical expressions of frustration, fear and anger? Give examples.	What makes me happy? What makes me unhappy?	What is the best time of day to engage me? What are my best and worst times of day?	Is it taking more time for me to participate in ADLs with caregivers? Give examples.	Am I experiencing any challenges participating in things or activities I want to do? If so, what? Why?
CNA 1 (Daytime)					
CNA 2 (Evening)					

Are there things you think I might want to do if I had more help or more time?	What makes my dining experience go well? Not go well? What tips have you picked up on that help?	What changes have you seen with my appetite?	What makes my sleep experience go well? Not go well? What tips have you picked up on that help?	What is my preferred rest period?
--	--	--	---	-----------------------------------

What makes my bathing experience go well? Not go well? What tips have you picked up on that help?	What have you noticed makes me feel comforted or secure? What makes me nervous?	What changes have you seen when I move about the home (ambulation)?	What changes have you seen in the amount or kind of pain I am having?	What changes have you seen with my skin?
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Have you noticed that I seem bored? Lonely? Useless? Provide examples. Are there things that you have noticed help during these times?	Does this individual have a hard time communicating? What have you found to be the best way to communicate with me?	Ask the resident the following two questions and record their responses.	Resident question: If I were caring for you in your home, are there things that you would be doing there that you aren't doing here? What?	Resident question: What is a good day for you? How do you find meaning or purpose in your day?
--	---	--	--	--



## A Case Study

- Mr. Jackson, who is living with dementia (his spouse was his primary caregiver), has recently moved into a nursing home. He is navigating a new living environment resulting in expressions of frustration and social isolation. The unfamiliar surroundings have triggered anxiety and stress, causing Mr. Jackson to react to interactions with staff, routines, or foods and surroundings that are unfamiliar. Additionally, he is constantly trying to go into other resident's rooms or leave the nursing home. Mr. Jackson is overwhelmed and confused by having a new and different caregiver each day let alone every eight hours.



- Prepare residents for care planning conversations. A week or a few days before the care planning meeting, talk with the resident. Questions that could be asked include:
  - ○ What makes you feel valued or worthy?
  - ○ What helps you be willing to share your opinion?
  - ○ What makes you feel better about yourself?
  - ○ What helps you cope with stress or adversity?
  - ○ What helps you want to engage with day-to-day activities or try new things?
  - ○ Would you feel comfortable/or be willing to share [any of the above] in your care plan meeting on [insert date]?

## Begin the change

---

Download and review the Guide as a team

---

Select the GPP Assessment tool to use

---

Obtain and Document GPP Responses for each resident

---

Transfer GPP into a usable format for your home

---

Plan and Implement the GPPs gathered into the care plan

---

Regularly meet to discuss progress and implementation

---

Followup and Update GPPs within the timeframe you chose (monthly, quarterly)



## Implement a Companion Volunteer Campaign

- Interviewed, Screened & Vetted
- Consistency
- 3-4 Volunteers
- Assessments of GPPs
- Validation Therapy
- Wanting to give back to their community

# Transforming to Implement a Residents Goals, Preferences, & Priorities



## References

- Moving Forward NH Quality Coalition
  - <https://www.movingforwardcoalition.org/home>
- Disrupting the Status Quo of Senior Living: A Mindshift by Jill Vitale-Aussem
- CMS QAPI Program
- National Academies of Sciences, Engineering and Medicine (NASEM) report

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