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## Special Article

# Quality Indicators of Primary Care Provider Engagement in Nursing Home Care



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## A B S T R A C T

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The initiative described here aims to identify quality indicators (QIs) germane to the international practice of primary care providers (PCP) in post-acute and long-term care in order to demonstrate the added value of medical providers in nursing homes (NHs). A 7-member international team identified and adapted existing QIs to the AMDA competencies for medical providers. QI sources included the ACOVE 3 Quality Indicators (2007), NH Quality Indicators (2004), NH Residential Care Quality Indicators (2002), and AGS Choosing Wisely (2014). We recruited a technical expert panel (TEP) consisting of 11 panelists from the US, Canada, and the European Union, selected for their knowledge and leadership in post-acute and long-term care. The TEP, using a RAND Modified Delphi approach, provided pre-meeting ratings, discussed items in-person for clarification, and re-rated items following discussion. When panelists rated more than 1 option for a particular QI as valid and feasible, the most stringent option was selected for inclusion in the final candidate set of QIs. Panelists confidentially rated an initial 103 items on validity and feasibility of implementation. During the meeting, panelists added 18 QIs and modified 18. In post-meeting analysis, we eliminated 7 QIs rated not valid and 9 QIs for which a more stringent QI was rated valid and feasible. This resulted in a final set of 97 QIs rated valid and feasible and 8 rated valid but not feasible. This set of QIs for PCPs in the NH identified practices in which provider engagement adds value through expertise in geriatric syndromes, employing evidence-based practice, advocating for residents, delivering person-centered care, facilitating advance care planning, and communicating effectively to coordinate care. Next steps include pilot testing and evaluating the association between adherence to QIs, PCP staffing models, and better outcomes.

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## Project Rationale and Purpose

Many existing measures of quality for nursing home (NH) care emphasize facility-level processes and characteristics and are not designed to evaluate the role of the primary care provider (PCP, physician, nurse practitioner, or physician assistant depending on the care model employed within a particular jurisdiction) in the NH setting. Reliance on outcome measures derived from existing

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administrative databases provides an incomplete picture of individual provider-level performance. For example, the Centers for Medicare and Medicaid Services quality measure on pressure ulcers—the “Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)” —may reflect many factors unrelated to the care provided by the responsible physician or nurse practitioner. The pressure ulcer rate may reflect the facility staffing ratios that limit or enable attentive hands on care to personal hygiene and frequent repositioning. The rate may reflect a frailer resident population in the facility, or the daily maintenance of quality pressure reducing surfaces for residents. Specifically, the PCP may not be able to change the staffing ratio to improve care or ensure the daily maintenance of pressure reducing surfaces for the resident. As a result, the rate of pressure ulcers may reflect the functioning of the overall system more than the PCP. Therefore, items for which the PCP predominantly influences or controls the process are needed.

The creation of quality indicators (QIs) that reflect the steps of care influenced by the medical provider would allow better measurement and understanding of the added value of medical providers in the NH at 2 levels. First, the QIs can be used to gauge the extent to which the individual provider employs best practices, is engaged with an increased presence in the NH, communicates with the interdisciplinary team, and serves as a resident advocate and check on facility quality. This provider-level quality assessment is increasingly important as NHs monitor and provide feedback to providers practicing in their facilities.<sup>1</sup> For this purpose, process measures are an appealing tool for measuring performance because they specify steps of care that are associated with improved outcomes. Second, at the practice level, the extent to which providers employ these care processes could be compared with the staffing model of the NH to identify the staffing model that delivers higher value care.<sup>2,3</sup>

The goal of this project was to identify QIs that could be used to assess the quality of care of PCPs participating in NH practices. The project intended to identify specific, valid process measures of care quality or QIs that account for the unique population and care environment in NH practices and that operationalize the “Post-Acute and Long-Term Care Medicine Attending Physician Competencies” (Table 1) that had been developed by AMDA. The AMDA competencies describe the types of skills that a NH PCP should possess. However, the competencies had not been linked to specific measures of the actual steps or processes of care that reflect the application of those skills. Our focus, therefore, was on identifying the steps of care that are influenced by a competent PCP and that would lead to better resident outcomes if implemented. As with the AMDA competencies, we focused on provider practices that would be relevant in Canada, the United States, and Europe.

QIs were identified for 7 domains: goals of care and palliative care; communication and coordination of care; geriatric syndromes: urinary incontinence; falls, mobility, and pressure ulcers; pain management, and appropriate medication management. The management of geriatric syndromes represents a key knowledge gap among general practitioners with an opportunity for improved care through increased support, direction, and guidance.<sup>4</sup>

## Methods

Valid and feasible QIs were identified in a 2-step process. First the research team identified candidate QIs. In the second phase, a technical expert panel (TEP) reviewed, modified, and rated candidate QIs using a modified Delphi process. The votes ratings were then analyzed by the research team.

### Phase 1: Identification of Candidate QIs

Starting in January 2017, the research team that included NH medical care providers from the United States, Canada, The

**Table 1**  
ADMA Competencies

Domain I: Foundation (Ethics, Professionalism, and Communication)
1.1 Application of Ethical Principles in Clinical Decision-Making
1.2 Clinical Implications of Legal and Regulatory Requirements
1.3 Recognizing and Adapting to Patient Limitations and Impairments
1.4 Optimizing Communication with Patients and Families
1.5 Culturally Sensitive Interactions with Patients, Families and Staff
1.6 Elements of Appropriate and Timely Practitioner Performance
Domain II: Medical Care Delivery Process
2.1 Applying the Care Delivery Process to Patient Care
2.2 Developing a Person-Centered Evidence-Based Medical Care Plan
2.3 Identifying and Incorporating Prognosis into Care Decisions
2.4 Principles of Palliative and End-of-Life Care
2.5 Developing Effective Palliative and End-of-Life Care Plans
Domain III: Systems
3.1 Providing Prudent and Minimally Disruptive Care
3.2 Using Patient Databases in Clinical Practice
3.3 Determining Appropriate Levels of Care
3.4 Optimal Management of Care Transitions
3.5 Working Effectively with the Interdisciplinary Care Team
3.6 Understanding and Explaining the Impact of Finances on Care Decisions
Domain IV: Medical Knowledge
4.1 Identifying and Managing Changes in Condition
4.2 Formulating a Pertinent and Adequate Differential Diagnosis
4.3 Identifying and Developing a Person-centered Medical Plan
4.4 Minimizing Risk and Optimizing Patient Safety
4.5 Managing Pain Safely and Effectively
4.6 Prescribing Medications Prudently and Effectively
Domain V: Personal Professional Development in Post-Acute and Long-Term Care
5.1 Developing a Personal Professional Development Plan
5.2 Utilizing Quality-Related Information to Improve Care
5.3 Using Patient Outcomes to Improve Practice

Netherlands, and EUGMS Special Interest Group for Long-Term Care identified and adapted existing quality measures that map to the AMDA competencies. The team reviewed QIs from ACOVE Quality Indicators for community dwelling elders,<sup>4,5</sup> the ACOVE NH Quality Indicator set published in 2004,<sup>6,7</sup> NH Residential Care Quality Indicators (2002),<sup>8</sup> AGS Choosing Wisely (2014),<sup>9,10</sup> the European Heart Rhythm Association Guidelines (2013),<sup>11</sup> and items in the Consumer Assessment of Healthcare Providers and Systems hospital survey.<sup>12</sup> The team updated and adapted measures to create candidate measures that would be valid and feasible for US, Canadian, and European NHs and that reflect the achievement of AMDA competencies by PCPs. Some QIs were proposed for adoption without change, others were adapted to NH populations and their PCPs. RAND and the UCLA Borun Center drafted tables of candidate measures, obtained prediscussion votes from the international research team and then organized a series of conference calls to discuss each candidate measure in detail.

Most of the QIs were constructed as “IF” and “THEN” statements. An “IF” statement describes the NH residents (NHR) to whom the indicator applies. A “THEN” statement describes the process of care that should or should not be applied under these circumstances.

### Phase 2: Expert Evaluation and Input

In phase 2, we used the RAND modified Delphi expert panel methodology to evaluate the potential QIs. This structured group methodology has proven reliability and predictive validity for identifying appropriate and indicated care processes.<sup>13–15</sup> It is an iterative process in which experts provide an initial rating of each QI, receive confidential feedback comparing their ratings to those of other experts, convene to discuss sources of disagreement, and then re-rate each QI.

The research team identified physicians and advanced practice nurses with expertise in NH care to participate in the TEP. The TEP

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