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Original Study

Implementation of a Person-Centered Medical Care Model in a Skilled Nursing Facility: A Pilot Evaluation

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A B S T R A C T

Keywords:

Person-centered skilled nursing facility (SNF) implementation

Objectives: The objective of this study was to evaluate the feasibility and impact of implementing a person-centered medical care model for post-acute care residents within a skilled nursing facility (SNF).
Design: A mixed-method (qualitative and quantitative) pilot evaluation.

Setting: An 89-bed SNF located within a large midwestern city.

Participants: Forty SNF post-acute patients admitted to the facility during a 6-month period were enrolled in the pilot evaluation. The patients were 75% women, 57% African American, and had an average age of 73. To meet inclusion criteria, patients must have been admitted to the facility for rehabilitation with a plan for community discharge, and be cognitively able to consent as indicated by a cognitive screening tool or assent to participation with family member consent.

Intervention: The person-centered medical care model included (1) biweekly interdisciplinary care plan meetings, scheduled at a time of patients' preference and held in the patient's room; (2) patient selection of health-related goals that guide team discussions; (3) use of lay-language that facilitated patient understanding; (4) team accountability to the patient for patient care preferences; and (5) monthly care-team meetings to exchange feedback regarding the team's performance and the model.

Measurement: Evaluation data included admission and discharge Patient Activation Measure surveys; admission and discharge Care of Chronic Conditions surveys; admission and biweekly modified Castle Satisfaction Surveys; admission and discharge Patient and Caregiver Engagement surveys; and semi-structured interviews with a sample of staff, family members, and patients.

Results: A significant ($P < .01$) improvement was noted between admission and discharge on both the Care for Chronic Conditions and the Patient Activation Measure surveys. Patient satisfaction surveys trended toward higher ratings over time on most questions, with significant improvement in 2 questions addressing satisfaction with their medical provider. Interviews revealed a perception that the model encouraged an environment of respect and honesty in patient communications, and an overall positive experience. The challenges of scheduling and time were noted by respondents.

Conclusions: Implementation of person-centered medical care within an SNF was feasible, yet required changing care processes to better address individual goals and facilitate communication among patients, providers, and SNF staff. Overall pilot results indicated that patients and staff members viewed the person-centered care experience positively. Further research is needed to examine long-term effects of the model on resident outcomes.

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Approximately 20% of hospitalized Medicare beneficiaries are discharged to a skilled nursing facility (SNF) for ongoing care and rehabilitation.¹ These post-acute patients commonly enter the SNF

with unresolved acute health issues and multiple functional and psychosocial needs. The increased clinical demands that result from increased numbers of post-acute admissions have not been paralleled by changes in SNF care delivery models. For example, SNF regulations require a minimum of 1 physician visit a month, which may be insufficient to provide high-quality, evidence-based care. An Office of the Inspector General report² noted that more than 30% of patients risk harm from poor care within 30 days of their admission to an SNF. Multicomponent, interdisciplinary interventions have improved care in hospital settings, but are yet to

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be widely implemented to improve the quality of SNF care.^{3–5}

The current study was a pilot examination of the Patient-Oriented Interdisciplinary Sub-acute Care (POISE-Care) model. The POISE-Care model introduced an interdisciplinary team care method into the traditional SNF care processes with the intention of changing the way in which subacute SNF care was delivered. The interdisciplinary team consisted of a physician and/or advanced nurse practitioner, physical and/or occupational therapists, social workers, nurses, nursing assistants, and activities and food service personnel. Patients directed the care decision process by selecting the day and time for the meeting in their room and providing the care team with their top 3 goals to be achieved during the SNF stay. The interdisciplinary team used lay terminology to facilitate patient and caregiver understanding, spoke directly to the patient while addressing the patient in the first person, and viewed the patient as team leader, or “CEO” of his or her own care.

Team development was a central feature of the model. A “real team,” as opposed to a quasi-team, is one that has a clear task, and in which members have clear roles, specific authority to manage their own work processes, and high membership stability.⁶ The current environment in a typical SNF suffers from poor organizational support, absence of clear leadership, lack of understanding of staff roles and tasks, misaligned aims and priorities, and vertical management structures.⁷ As a result, only 16% of SNF staff members organize in a manner consistent with the concept of real teams⁷; this despite evidence that team-driven care promotes positive health and safety outcomes, enhanced continuity of care and patient trust, group problem solving, and staff satisfaction.⁸ Additionally, existing research indicates that having a prescribing provider (physician or advanced practice nurse [APN]) as part of the team increases the probability of improved health outcomes.⁹ Currently, a prescribing clinician’s availability in interdisciplinary care planning is rare, with fewer than 5% of care plans having any physician or APN involvement.¹⁰ The POISE-Care Model was developed on this evidence, with the goal of integrating more effective team work into the patient-centered model. Further detail about this model is available in the article by Nazir et al.¹¹

The objective of this study was to evaluate the feasibility and impact of the POISE-Care model. It was predicted that the evaluation would provide positive evidence of model success to support a larger translation of the POISE-Care model into practice.

Methods

Study Design

Evaluation participants were selected from patients admitted to the intervention facility, a for-profit SNF that is located within a large midwestern city and has an average daily census of more than 20 short-stay residents. The facility had a Centers for Medicare and Medicaid Services quality rating of 4 of 5 stars at the time of POISE-Care model implementation. Participant inclusion criteria included the following: (1) admitted to the facility for skilled rehabilitation with a plan for community discharge, and (2) able to consent to participation as indicated by a cognitive screening tool or able to positively assent to participation with the consent of a guardian or power of attorney. Participants were excluded from the evaluation if they were (1) unable to communicate in English; (2) diagnosed with a terminal illness, defined as less than 6 months to live with comfort care only; or (3) cognitively impaired without an available surrogate. All short-stay patients at the intervention facility received person-centered medical care through the POISE-Care model; a patient did not need to consent to provide data for this study to

receive care using the innovative model. Study participants received the POISE-Care model of medical care, described previously, as part of their routine care. All patients were informed of their right to refuse any aspect of the model and/or to participate in data collection.

Data

Complimentary data were collected concurrently from multiple sources to address the complexities surrounding implementation of a new model of medical care within an SNF, and equal weight was given to each form of data. Demographic, health, and functional information was extracted from the patient Minimum Data Set data. Additional data were collected from participating patients by using the Assessment for Care of Chronic Conditions scale at admission and discharge, the Insignia Patient Activation Measure at admission and discharge, and a modified Castle Satisfaction survey at admission, every 2 weeks, and again at discharge. Family caregivers were given the Preparedness for Caregiving Scale on admission and at discharge. The modified Castle Satisfaction survey data were collected from patients by facility staff as part of the POISE model process and used to encourage discussion at POISE-Care meetings. All other surveys were completed by a study research associate. Survey data were analyzed using SPSS version 23 (IBM SPSS Statistics, IBM Corporation, Chicago, IL) to determine descriptive statistics and comparison of means between survey administration time periods. Semistructured interviews addressing perceptions of model implementation, feasibility, and impact were conducted by a study research associate with staff members, patients, and patient family members until such a point in which data saturation was reached. Institutional review board approval was received before the beginning of data collection.

Results

Study Sample

Of the 64 eligible patients admitted during the study period, 13 refused participation, 12 did not remain in the facility to meet the minimum 2-week participation window, and data were collected from 39 enrolled participants. The mean age of enrolled participants was 73.4 years (range 42–100 years); 75% were women; and 95% had Medicare coverage, 44% were Medicaid eligible, and 5% were privately paying for their stay. Twenty (50%) of the participants identified a primary caregiver. Consistent with the patient population of the intervention nursing home, more than half of the participants (57%) self-identified as African American, 41% self-identified as white, and 2.5% as Hispanic/Latino. The 3 most common medical diagnoses were diabetes (50%), kidney disease (38%), and heart failure (33%). The average number of prescribed medications on admission per study participant was 10.7 scheduled, 2.5 as needed.

Among the 39 study participants, 85% had reported pain in the previous 5 days, 63% had fallen within the 2 months before the nursing home admission, and 2 residents fell within the first 5 days of their nursing home admission. With regard to physical function, 15% could walk without assistance or with only supervision, 90% required some assistance with dressing and grooming, and 92% required some physical assistance with toileting. Seventy-six percent of enrolled patients were cognitively intact on the Brief Interview for Mental Status cognition scale, and 87% demonstrated no sign of depression using the Patient Health Questionnaire-9 scale. Sample characteristics are displayed in [Table 1](#).

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