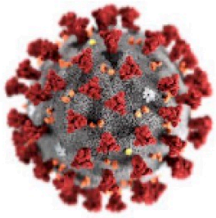
CALTCM
California Association of Long Term Care Medicine



Stay Calm
Stay Prepared
Stay Informed
CALTCM.org

COVID-19 Webinar Series

January 23, 2023

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Webinar Planning Committee

Heather D'Adamo, MD, CMD
Janice Hoffman-Simen, Pharm.D., EdD, APh, BCGP, FASCP
Ashkan Javaheri, MD
Albert Lam, MD
Jay Luxenberg, MD
Noah Marco, MD
Karl Steinberg, MD, CMD, HMDC
Michael Wasserman, MD, CMD

CALTCM

January 23, 2023

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CALTCM is a non-profit association.

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Visit: caltcm.org

Non-Profit Status
The California Association of Long Term Care Medicine (CALTCM) is currently exempt under section 501(c)(3) of the Internal Revenue Code. Contributions or charitable donations made to our non-profit organization are tax-deductible under section 170 of the Code.

To request a copy of our 501(c)(3) status letter or current Form W-9, please contact the CALTCM Executive Office at (888) 332-3299 or e-mail: info@caltcm.org

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CALTCM Membership

- **Physicians**: $150.00
- **Clinical Affiliates**: $125.00
- **Retired Physicians**: $100
- **Retired Clinical Affiliates**: $75
- **Students** (all disciplines): Eligible for Complimentary Membership - Standard rate is $100

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Infection Preventionist Orientation Program
All the foundational information and processes an IP needs to start a successful Infection Prevention & Control Program.
CALTCM
Dolly Greene, RN, BSN, CIC

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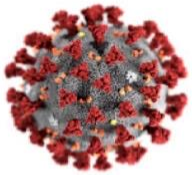
Upcoming Webinars

March 27

May 22



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January 23, 2023

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Webinar Faculty

Alice Bonner, PhD, RN, FAAN

Nurse Practitioner

Senior Advisor for Aging at the Institute for Healthcare Improvement (IHI)

Chair of Moving Forward: Nursing Home Quality Coalition

Adjunct Faculty at the Johns Hopkins University School of Nursing

January 23, 2023

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Webinar Moderator

Ashkan Javaheri, MD, CMD

Geriatrician

Mercy Medical Group–Dignity Health Medical Foundation

Head of the Geriatric Division, Associate Clinical Professor, UC Davis School of Medicine

Sacramento, CA

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Webinar Moderator

Jay Luxenberg, MD

Retired Geriatrician

CALTCM, Wave Editor-in-Chief

San Francisco, CA

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Webinar Faculty

Elizabeth Sobczyk

Director

CDC Cooperative Agreement to Improve Immunization Rates in PALTC

AMDA – The Society for Post-Acute and Long-Term Care Medicine

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Webinar Faculty

Stella Veraflor-Rundell

Training Specialist

California Department of Aging

Office of the Long-Term Care Patient Representative

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Webinar Faculty

Amy Walsh, M.Sc.
Project Manager
Institute for Healthcare Improvement

January 23, 2023

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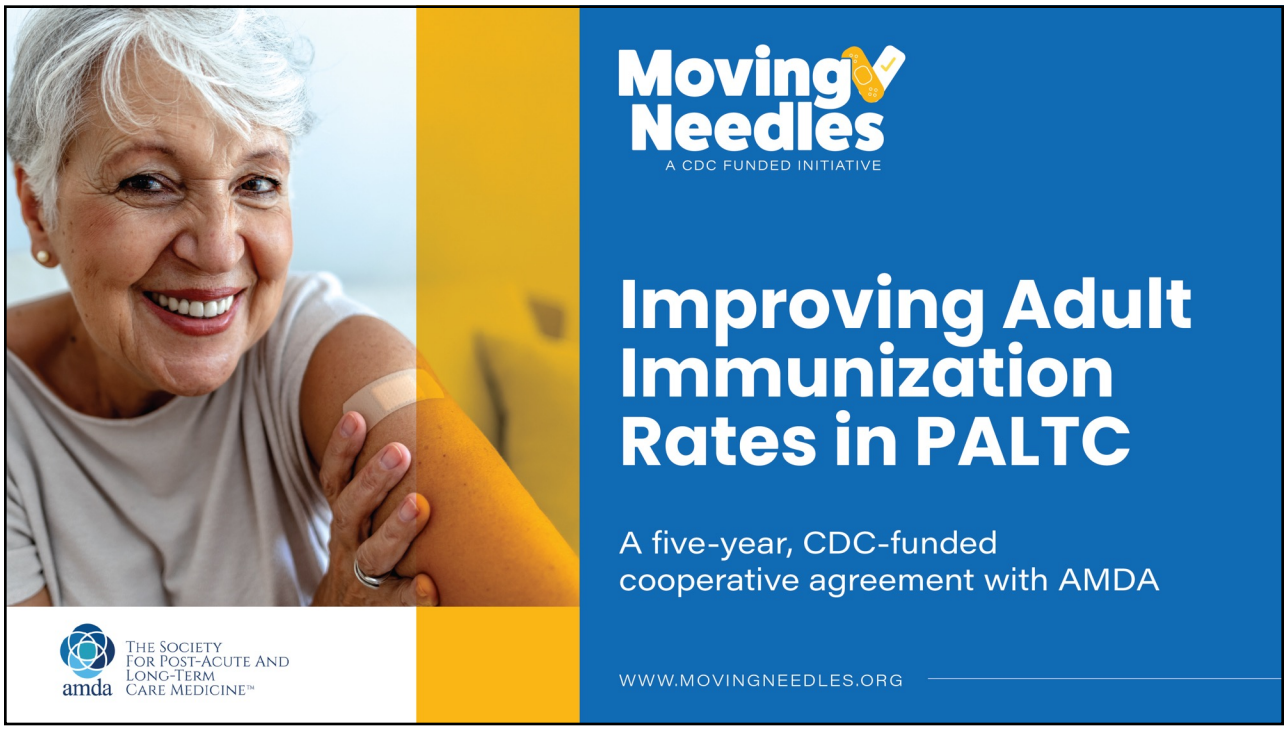

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Today's Objectives

- Provide an overview of the Moving Needles Project
- Share details about the quality improvement pilot
- Encourage PALTC staff to visit the website and sign up for the newsletter

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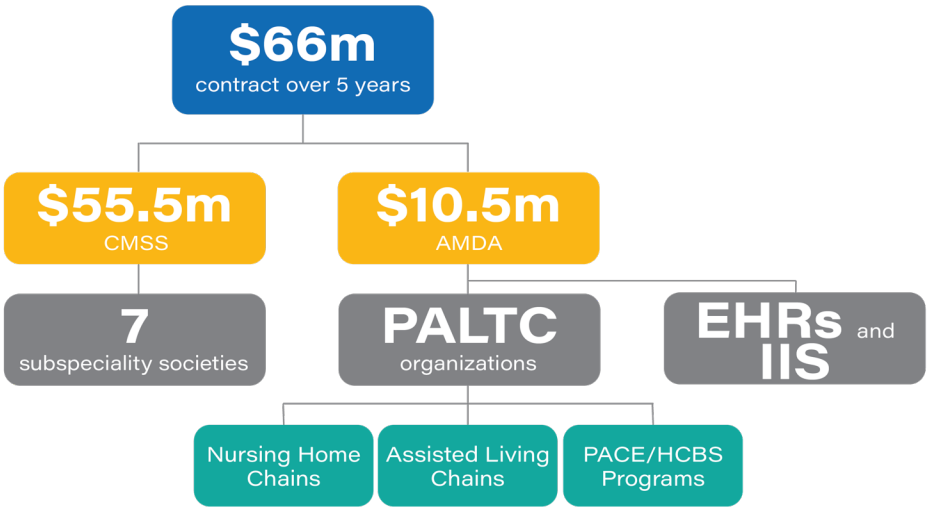
The Big Picture



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Overview

Goal

Make routine adult immunizations a standard of care for PALTC residents and an expectation for employees.

Main Components

- Align existing immunization policies and procedures in PALTC
- Develop pilot programs to test standardized routine adult immunizations across all PALTC settings, for both residents and staff
- Establish baseline data and measure improvement
- Integrate routine immunization and reporting to state IISs into workflows and EHR systems for both staff and residents
- Demonstrate both clinical benefits and operational/cost benefits to implementation
- Establish a permanent resource on PALTC immunization

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Timeline

- Funding Awarded September 2021
- Pilot Chains, Sites, and Team Identified January-April 2022
- Quality Improvement Pilot Round 1 July 2022 – June 2023
- Interventions and Supports Reviewed May 2023
- Quality Improvement Pilot Round 2 July 2023 – June 2024
- Change Package and Training Curriculum Produced July 2024 – June 2025
- Economic and Workflow Analyses Completed September 2025
- Quality Improvement Expansion to AMDA Members and Partners October 2025 – September 2026
- Project Completion September 2026

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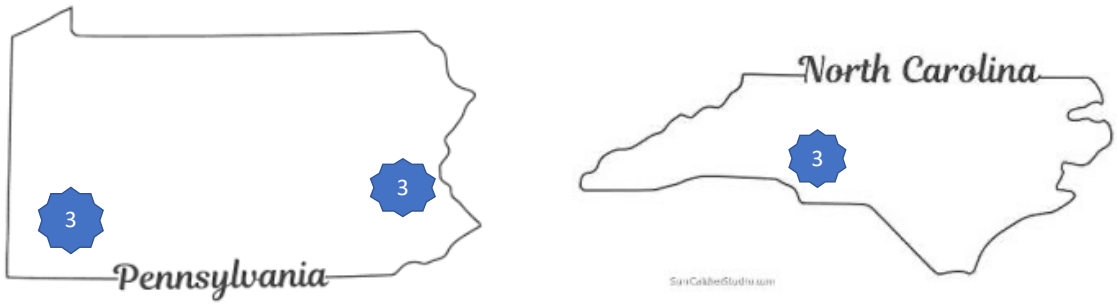
Round 1 Pilot Sites



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Structure of the Pilot

Teams in each site: medical director (where applicable), CNA or other front-line staff, director of nursing, etc.

Once a month:

- Hour long virtual meeting – part information/education, part group discussion and measures review
- Individual site 15-minute check in
- Data submission

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Pilot Interventions

Residents:

- Adopt standard operating procedures
  - Standing orders, prompts or reminders, offer onsite with regular calendar
- Address concerns of residents and families
- Create immunization champions/advocates

Staff:

- Offer vaccines on site at no cost
- Address concerns of staff
- Build trust between administration and front line staff
- Consider the impact of mandates

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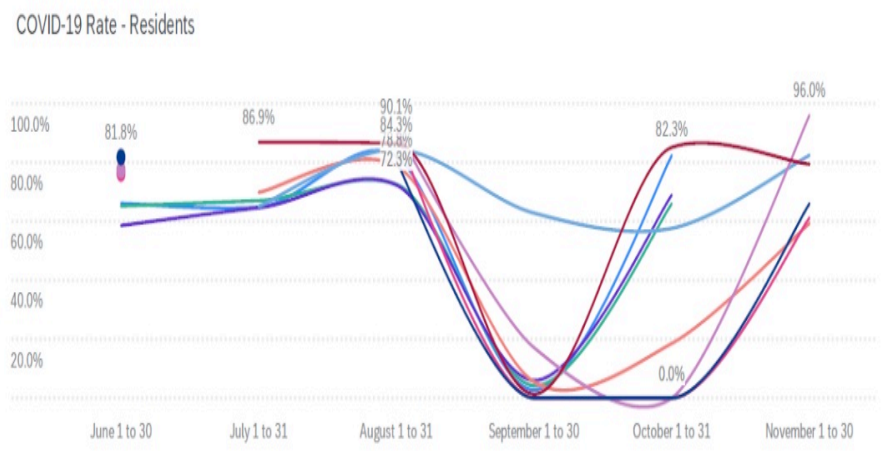
Residents: COVID-19 Vaccination Rates



Notes

- Facilities agreed to add the bivalent booster into their COVID-19 measures, so facilities went back to zero in September.
- Most have vaccinated residents back to or exceeding their pre-bivalent booster numbers in 1-2 months.

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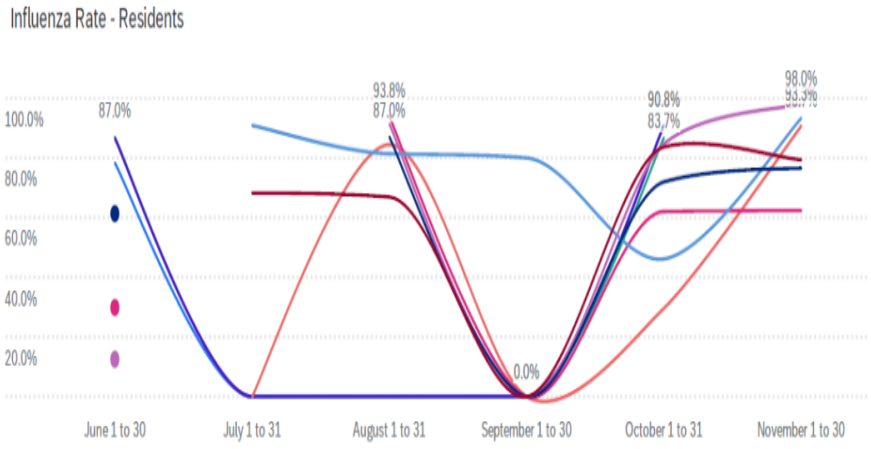
Residents: Influenza Vaccination Rates



Notes

- We used June/July as a benchmark for last year's rates.
- Almost all facilities have met or exceeded last year's baseline in 1-2 months of vaccinating for influenza.

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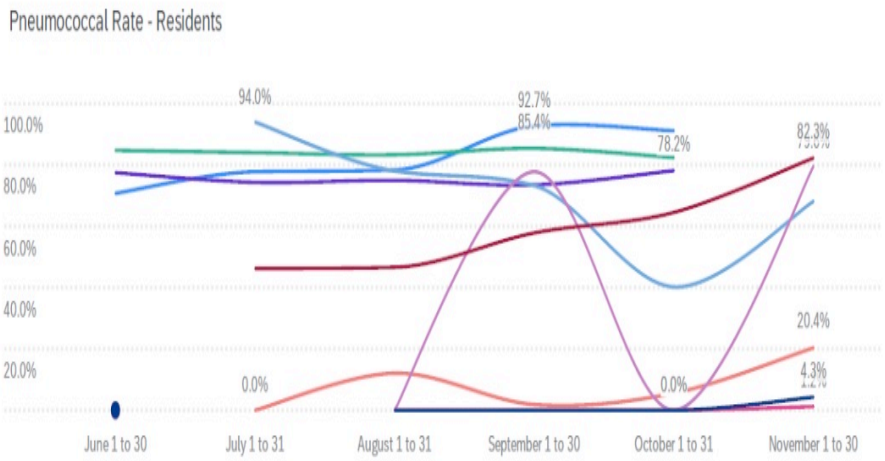
Residents: Pneumococcal Vaccination Rates



Notes

- Facilities have been highly focused on COVID-19 and influenza vaccination for most of the project due to the season and changing recommendations.
- Despite this, several facilities took the opportunity to incorporate pneumococcal vaccination into their processes and have seen jumps between 15 and 20% in their rates.

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Residents: The Takeaways

- In many facilities, COVID-19 vaccination rates are the same or higher than when we first started.
- In almost every facility, influenza vaccination rates are higher than when we first started.
- In many facilities, pneumococcal vaccination rates are significantly higher than when we first started.

- Facilities have been implementing structured processes and procedures because of the pilot. They are working to routinize offerings and are expanding what vaccines they provide.
- Billing for Tdap and shingles remains a big challenge for skilled nursing – we need guidance that explicitly allows billing for Part D vaccines when a resident is using their Part A benefit.

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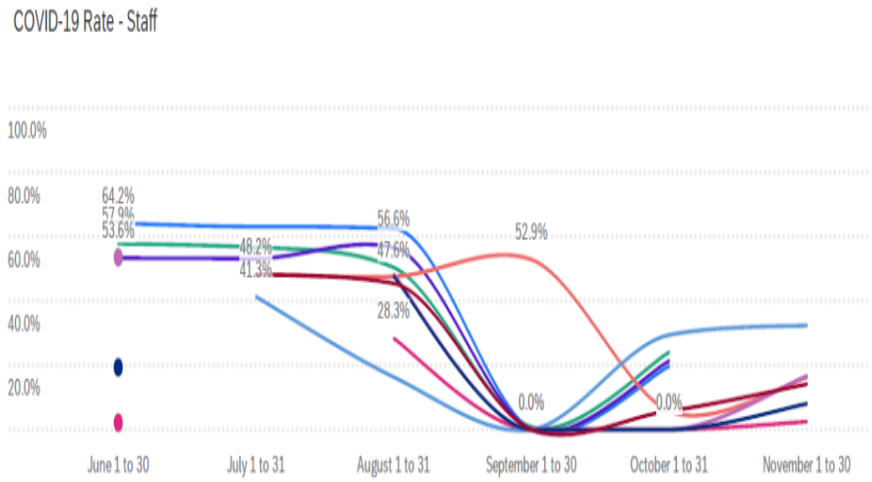
Staff: COVID-19 Vaccination Rates



Notes

- Facilities are universally struggling with staff acceptance of the bivalent booster.
- Facilities have been able to tailor the approach to what works best for them – for example, some have to use staff incentives to get any movement. Some have found that a peer champion offering three or more times gets movement, while others are recognizing vaccine fatigue and more resistance with continued offering.

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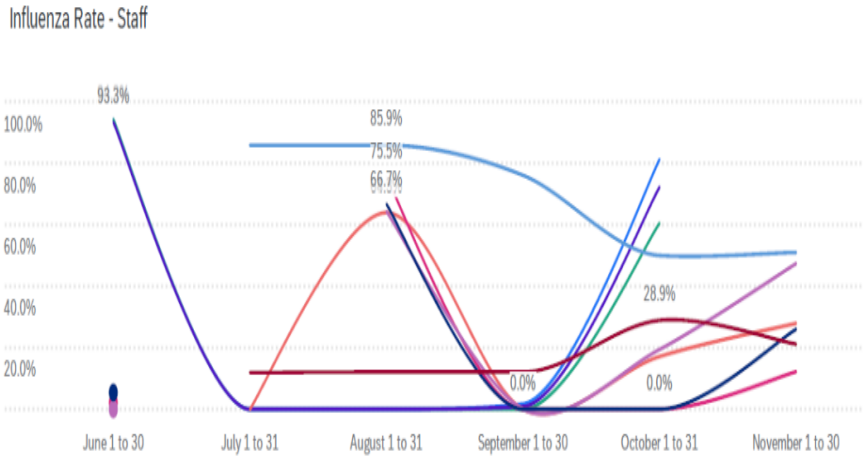
Staff: Influenza Vaccination Rates



Notes

- Facilities are seeing success with increasing accessibility of vaccine, such as rounding on units instead of only offering vaccines during designated clinic times.
- COVID-19 fatigue has spilled into some facilities with influenza vaccine, too.
- Even chains that have mandated the vaccine face difficult decisions due to extreme staffing shortages.

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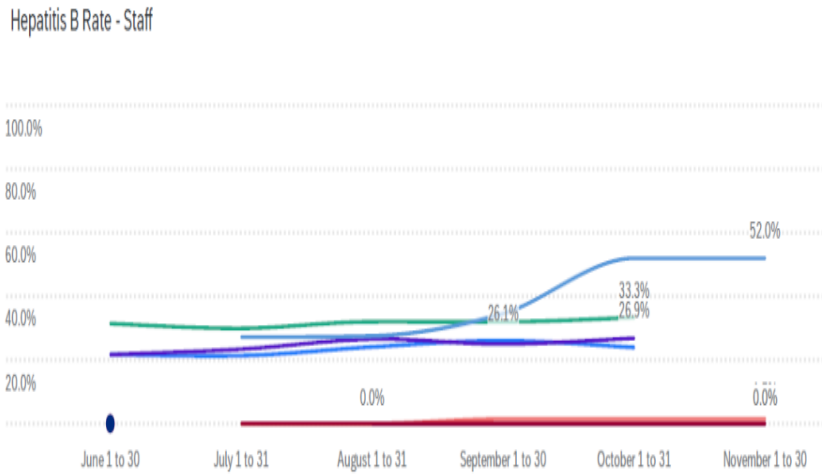
Staff: Hepatitis B Vaccination Rates



Notes

- Most facilities have been heavily focused on influenza and COVID-19 vaccination for the past few months.
- The zeroes represent lack of access to data, not a reflection of rates.
- One facility has had great success cohorting staff – housekeeping, kitchen staff, etc – providing education and vaccination in small groups.

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Staff: The Takeaways

- All facilities are struggling with COVID-19 bivalent booster rates.
- Vaccine fatigue has spilled over to influenza in some facilities.
- Where we are seeing success, facilities are making vaccine more accessible, addressing staff in cohorts, and persistently offering vaccine. But we also recognize that strategies need to be tailored to individual circumstances.

- Education/awareness and accessibility are no longer the challenges. We will be focused on providing more direct support in the new year to help leaders build peer champions and trust with their staff.
- We are very concerned about the cost of COVID-19 vaccine once it goes commercial. Facilities want to offer it on-site, at no cost to staff, but if the cost is prohibitive, the ease of accessibility will go away.

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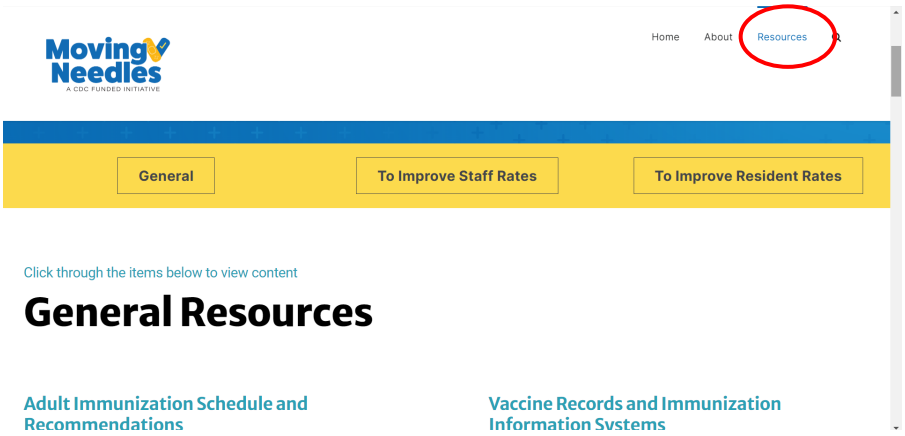
Website and Newsletter

- www.movingneedles.org and movingneedles@paltc.org



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Thank You!

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David Casey dcasey@paltc.org
Heather Roney hroney@paltc.org

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Age-Friendly Health Systems

AFHS@IHI.ORG
IHI.org/AgeFriendly
#AgeFriendlyHealthSystems

Age-Friendly Health Systems: Evidence-Based Care for All Older Adults

January, 2023

Alice Bonner, Senior Advisor for Aging
Amy Walsh, Program Manager

Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

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Age-Friendly Health Systems

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

Build a social movement so ***all care*** with older adults is ***age-friendly care***:

- Guided by an essential set of evidence-based practices (4Ms);
- Causes no harm; and
- Is consistent with What Matters to the older adult and their family.

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www.ihi.org/AgeFriendly

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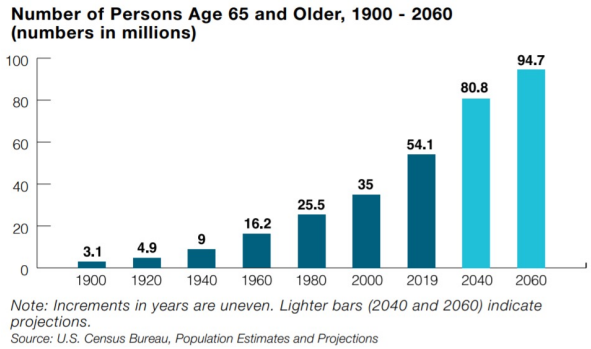
Planning for the Future: We Need Age-Friendly Solutions

- **Demography**: # of older adults is rapidly growing and becoming more diverse
- **Complexity**: multiple chronic conditions, dementia, disability, social isolation, social determinants of health
- **Disproportionate Harm**: higher rates of health care-related harm, discoordination, poor preparation for disasters



Note: Increments in years are uneven. Lighter bars (2040 and 2060) indicate projections.
Source: U.S. Census Bureau, Population Estimates and Projections

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Age-Friendly Health Systems

The 4Ms: What Matters, Medication, Mentation, Mobility

Assess

Know about the 4Ms for each older adult in your care

Act On

Incorporate the 4Ms into the plan of care

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Age-Friendly Health Systems

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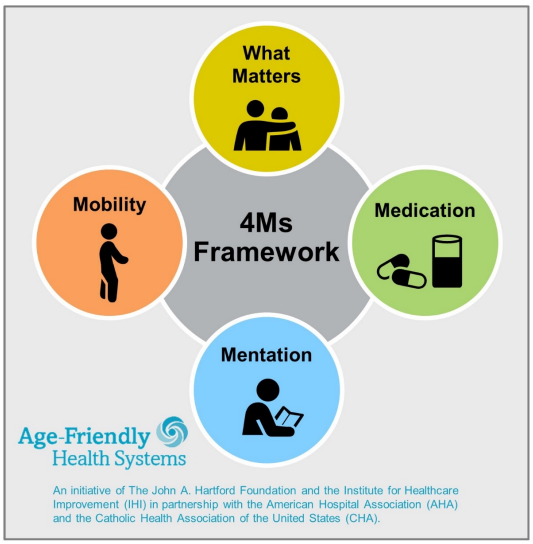
Age-Friendly Care – 4Ms Framework



What Matters
Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication
If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.

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Why the 4Ms?

- 4Ms are a set with a strong evidence-base
- AFHS in nursing homes can lead to improved quality measure scores
- Framework to organize care
- Goal is reliable practice
- Build on what you already do
- Leadership and Communication throughout

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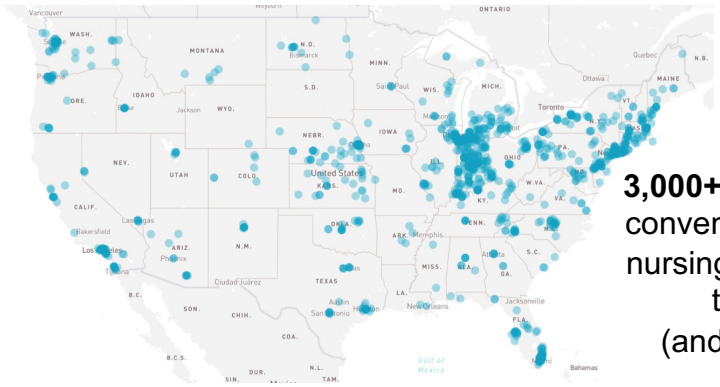
A Goal Met and a Growing Movement!

Age-Friendly Health Systems Participant

Our 1st Goal:
Spread to 1,000 sites by end of 2020
Goal Achieved!
Next Goal:
Spread to 2,600 sites by June 2023
Goal Achieved!



3,000+ hospitals, practices, convenient care clinics and nursing homes have joined the movement!
(and growing globally)

As of January 2023

http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/Background.aspx

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Older Adults Reached with 4Ms

More than 1,996,424 older adults have been reached with 4Ms care

"You guys have given me my mother back." – the daughter of an older adult after seeing the impact of the mobility coaching and "move and grove" program that is part of 4Ms care at the University of Alabama Hospital.

All numbers were self-reported; Counts submitted were averaged; Counts projected through February 2020, if submitted prior to February 2020; Counts projected through March 2021, if submitted after February 2020

Age-Friendly Health Systems

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Members in ACTION

BUILDING AN AGE-FRIENDLY HEALTH SYSTEM AND COMMUNITY ALIGNED WITH STRATEGIC PRIORITIES

MEMBERS IN ACTION CASE STUDY | Rush University Medical Center | Chicago, Illinois

Overview

Since its launch in 2017, the Rush Center for ... in Aging (CEA) has pursued its mission to ... the health and well-being of older adults, ... communities, aligning with the Rush Univer... for Health's (RUSH) strategic priorities. RUS... is to improve the health of individuals and ... communities through the integration of out... patient care, education, research and comm... partnerships.

After learning about the Age-Friendly Health... initiative, the CEA completed the Institute f... Healthcare Improvement's (IHI) self-assess... to find current programs and practices invol... 4Ms across the health system. The Age-Fri... Systems initiative is an evidence-based app... focuses on the 4Ms framework — what ma... medications, mentation and mobility. Altho... discovered pockets of excellence and identi... care teams addressing some or all of the 4... were applied consistently or broadly. There ... opportunities to improve and scale up these... aligning with ongoing health system priorit... quality improvement and cost savings.

Recognizing the synergy of the Age-Friendly ... Systems initiative with RUSH's strategic pla...

RUSH provides services to the Chica... area and is composed of:

- Rush University Medical Center (RUM...
- Rush Oak Park Hospital
- Rush Copley Medical Center
- Numerous outpatient facilities

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Page 1 | www.aha.org

Age-Friendly Health Systems | Case Study

Stanford Health Care

Institute for Healthcare Improvement

Background

Stanford Health Care in California encompasses the new Stanford Hospital, outpatient clinics in Redwood City and Palo Alto, the Stanford South Bay Cancer Center, and primary care offices throughout the Bay Area, as well as virtual services.

In October 2016, Stanford Health Care joined Age-Friendly Health Systems, an initiative of the Institute for Healthcare Improvement (IHI) and The John A. Hartford Foundation, in partnership with the American Hospital Association and the Catholic Health Association of the United States. Becoming an Age-Friendly Health System means providing evidence-based care to older adults that reliably implements the "4Ms": What Matters, Medication, Mentation, and Mobility (see Figure 1).

The Stanford Health Care Inpatient Geriatric Medicine team has long been devoted to providing the best possible care to hospitalized older adults. They recognized that becoming an Age-Friendly Health System created an opportunity to improve reliable use of evidence-based care in their high-risk inpatient population. In addition, they realized that the innovations they piloted, if successful, could then be spread across the whole system.

For the Stanford Health Care team, being part of the national Age-Friendly Health Systems movement enabled them to:

- Access a community of experts in process improvement and other health system teams that were implementing the 4Ms to improve age-friendly care;
- Design and measure key processes based on the 4Ms framework; and
- Build internal support from key stakeholders and resource allocation from hospital teams of various disciplines.

Figure 1. 4Ms Framework of an Age-Friendly Health System

Approach

Leaders selected the geriatric trauma service as the pilot site because older adults on the service tend to have high resource needs, are likely to suffer from frailty, and many have already experienced a fall. For all of these reasons, the cost of caring for the population is relatively high. As a result, this patient population seemed to offer a potentially high payoff for increasing reliable practice of the 4Ms. "It was sort of a natural synergy with our work," said Dr. Ankur Bhanja. "We were working with a high-risk geriatric trauma population already, and it seemed like a natural partnership to improve the care in this population even more through the age-friendly work."

The team started by setting a measurable and time-bound goal: *To improve the consistent delivery of the "4Ms care bundle" from 60 percent to 80 percent in the geriatric trauma population from November 2018 to November 2019.*

Age-Friendly Health Systems

Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

Read More About Outcomes in Case Study Examples at IHI.org/agefriendly

- Anne Arundel Medical Center - Maryland and Washington, DC
- Kent Hospital - Rhode Island
- MaineHealth - Maine Medical Center, Portland, Maine
- MinuteClinic - 1,200 locations inside CVS Pharmacy stores and CVS HealthHUBs
- Rush University Medical Center - Chicago, IL
- Stanford Health Care - California
- University of Alabama Hospital – Alabama
- Nursing home implementation case studies

Case studies developed by AHA, IHI, nursing homes

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Age-Friendly Health System Measures
All Measures to be Stratified by Age and Race and Ethnicity

Access to Care:

- Count of older adults who receive care *(numerator)*
- Count of 65+ population in capture region *(denominator)*

Access to 4Ms in the Health System:

- Count of older adults whose care includes the 4Ms *(numerator)*
- Count of older adults who receive care *(denominator)*

Process Measures:

- What Matters:
  - ACP documentation
  - What Matters documentation
- Medications:
  - Presence of any of 7 high-risk medications
- Mentation: Screened & documented for
  - Depression
  - Dementia
  - Delirium
- Mobility: Screened for mobility

Outcome Measures:

- 30-day readmissions
- HCAHPS/CG-CAHPS/NHCAHPS
- Length of stay
- ED utilization
- Delirium

Age-Friendly Health Systems

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Case Study: Examples of Interventions

Anne Arundel Medical Center

- **Organizational Background**
  - Accountable Care Organization serving >1 million people in MD & DC
  - Established Acute Care of the Elderly (ACE) unit in 2013

4Ms Focused Interventions			
What Matters	**Medication**	**Mentation**	**Mobility**
▪ flow sheet in EHR ▪ **whiteboards, visible displays of older adults' values** ▪ wellness visits structured around 4Ms (reimbursed by Medicare)	▪ EHR incorporates updated Beers Criteria ▪ auto-generates a CP2 score for higher med assessment needs ▪ more general awareness and consideration before prescribing	▪ **Brief Confusion Assessment Method (bCAM) delirium screening Qs into EHR** ▪ group/diversion activities ▪ facilitate hydration with easier-to-use water cups ▪ ceased 4AM vitals check to aid sleeping ▪ ACErcize, animal therapy	▪ mobility/quality tech ensures older adults move every day ▪ ACErcize ▪ removing bedpans to encourage getting out of bed ▪ adapted falls committee into safe mobility committee that gives mobility scorecards ▪ mobility contest with prizes

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Anne Arundel Medical Center

Outcomes of Age-Friendly Interventions

- *Reduced 30-day all-cause readmission rates in 3 months*
  - By 7.8% for 65-84 year olds and 22% for 85+ year olds
- *Increased mobility*
  - By 16.7% for 65-84 year olds, 25.5% for 85+ year olds

Lessons Learned

- Starting with What Matters informs other Ms (a theme)
- Older adults are socially as well as clinically complex
  - No intervention is 'one size fits all'
- Engage IT analysis at the start, utilizing community and external resources
  - Appropriate data collection is key to measuring impact
- Positive trends and progress motivate other team members

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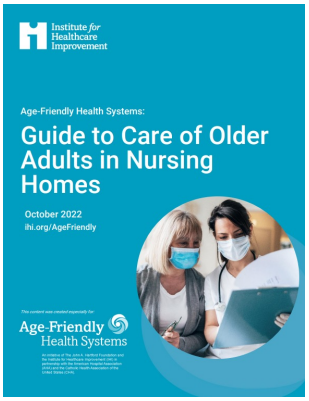
New Age-Friendly Health Systems: Guide to Care of Older Adults in Nursing Homes

Provides recommendations for implementing a series of actions **system-wide (throughout the nursing home or campus)**

Includes recommendations to:

- build the **will for change**
- **communicate about the 4Ms** to all residents, care partners, and staff members
- **engage the entire community** in promoting age-friendly care



https://241684.fs1.hubspotusercontent-na1.net/hubfs/241684/IHI-Age-Friendly-Guide-Nursing-Homes_March28-2022.pdf

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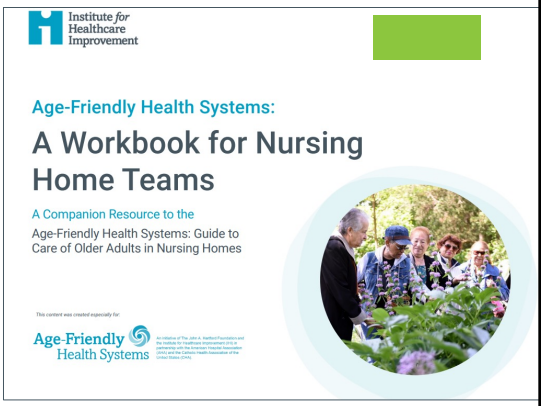
New Age-Friendly Health Systems: Workbook for Nursing Home Teams

Companion to *Guide to Care of Older Adults in Nursing Homes*

- practical and easy to use in **daily practice**
- includes **printable worksheets** that team members (including CNAs) can use to deliver 4Ms care
- **developed through collaboration** - expert faculty; U of Pennsylvania, U of Pittsburgh, & Penn State Schools of Nursing; four pioneering Teaching Nursing Homes; and ten pilot nursing homes



https://241684.fs1.hubspotusercontent-na1.net/hubfs/241684/IHI-Age-Friendly-Workbook-Nursing-Homes_March28-2022%20%28002%29.pdf

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Join IHI's Spring 2023 Action Community!

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- 7-month, virtual community
- Monthly webinars about the 4Ms and resources to support implementation
- Community of testers and learners
- Bright spot examples of organizations sharing how they implement the 4Ms
- Support your health organization's mission, vision, and values

There is no fee to participate

ihi.org/AgeFriendly

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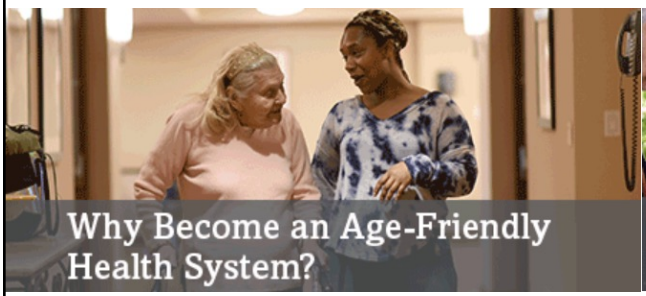
Join the Movement www.ihi.org/AgeFriendly



Age-Friendly Health Systems

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California Department of AGING

OFFICE OF THE LONG-TERM CARE PATIENT REPRESENTATIVE PROGRAM (OLTCPR)

Overview of the Long-Term Care Patient Representative Program (LTCPRP) Processes

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The Long-Term Care Patient Representative Program (LTCPRP) – Introduction

California Department of AGING

- A new program within the California Department of Aging (CDA) established by Welfare and Institutions Code (WIC) 9260 that will
  - Provide trained public patient representatives (PPRs) available to participate in interdisciplinary team (IDT) reviews held pursuant to Health and Safety Code (HSC) section 1418.8
  - Serve residents of skilled nursing facilities and intermediate care facilities who
    - ✓ May need medical treatment that require informed consent **but**
    - ✓ Lack the capacity to make health care decisions **and**
    - ✓ Have no legal surrogate decision-maker **and**
    - ✓ Have no family or friend to participate as a patient representative.
- Effective January 27, 2023

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Public Patient Representative (PPR)– Role and Responsibilities

- **Role:** Represent residents on IDTs convened pursuant to HSC 1418.8
- **Responsibilities:**
  - Confirm criteria are met for IDT to convene and for assignment of a PPR
  - Meet and, if possible, interview resident prior to IDT meeting
  - Review resident's medical and clinical records to prepare for IDT review
  - Review facility's policies and procedures related to the IDT process as required by AFL 20-83.2
  - Participate in the IDT review, considering the factors required by HSC 1418.8
  - Articulate resident's preferences, if known, or best approximation of preferences
  - *Additional responsibilities* – mandated reporting and referral to appropriate legal services

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Not the role of the PPR > Whose then?

Serve as decision-maker for resident's: > Fiduciary matters > Admission > Placement	➢ Conservator/guardian ➢ Representative payee ➢ Power of attorney ➢ AHCD agent ➢ Family/Friend
Serve as Case Manager	➢ Conservator/guardian ➢ Representative of other agencies
Provide community resource referral to residents and their families	➢ Facility social worker
Investigate elder or dependent adult abuse and/or neglect; Resolve care issues	➢ Long-Term Care Ombudsman ➢ CDPH ➢ Disability Rights California ➢ Other investigative or enforcement agencies

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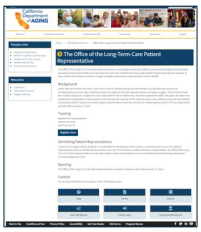
The 4 Required Notices *(1 of 3)*

1. An initial notice providing details about the upcoming IDT review
2. A follow-up notice explaining the IDT review's outcome
3. A notice following an emergency intervention that explains the intervention and states when the IDT review of that intervention will take place
4. A notice of failure to conduct a timely IDT review following an emergency medical intervention.



Effective January 27, 2023

https://www.aging.ca.gov/Providers_and_Partners/Office_of_the_Long_Term_Care_Patient_Representative/

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Requesting for a PPR and what happens next...

- Submit a Request for PPR and resident information related to the IDT review through the California Patient Representative Information System (CAPRIS).
- Assigned PPR will follow-up with the facility.
- If the Office of the Long-Term Care Patient Representative is unable to meet the request for a PPR, your facility shall apply to the superior court
  - For the appointment of a conservator, a health care decision maker, or a public guardian, pursuant to Probate Code Section 2920, or
  - For an order of medical treatment, pursuant to Probate Code Section 3200.

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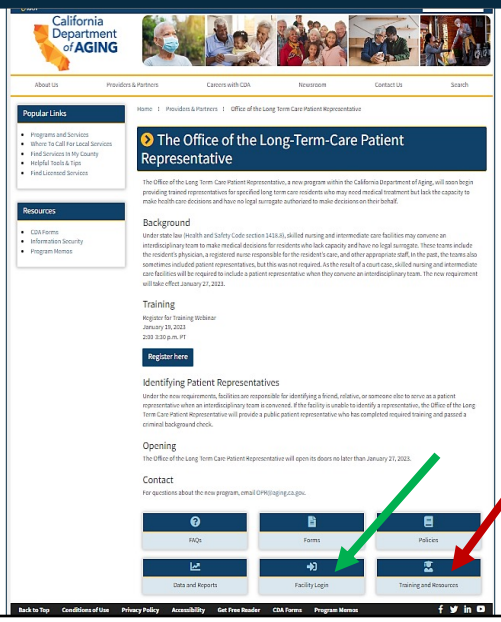
Accessing CAPRIS Information



1. **Review the CAPRIS user guides and recorded trainings** under the Training and Resources tab.
2. **Register to be a CAPRIS user:**
   a) Complete CAPRIS User Action Request Form under the Facility Login tab.
   b) Email completed form to OPR@aging.ca.gov.

https://www.aging.ca.gov/Providers_and_Partners/Office_of_the_Long_Term_Care_Patient_Representative/

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Required Data and Reporting Deadlines

- Facilities are required to report quarterly data **on all IDTs held pursuant to HSC 1418.8** by the following dates:

QUARTER	DEADLINE
Quarter 1: July 1–September 30	October 31
Quarter 2: October 1–December 31	January 31
Quarter 3: January 1–March 31	April 30
Quarter 4: April 1–June 30	July 31

- OLTCPR is developing a process for submitting the required data
- Updates and guidance will be provided

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California Department of AGING

Contact: OPR@aging.ca.gov

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