This session will present a comprehensive approach to nursing home improvement based on key clinical and management principles, focusing on clinical reasoning. The presenters are jointly responsible for overseeing approximately 60 facilities across multiple states as regional medical directors. In collaboration with those of other key disciplines, they have conceived, developed, and implemented a program that cuts across all measures and topics. The “Thinking Right and Acting Right” program, based on clinical reasoning and across-the-board accountability, has been deployed successfully across multiple facilities and in multiple states. This session will show in detail how this common approach has led to multiple desirable outcomes including sustained improvement in care, improvement in diverse quality measures, better regulatory survey outcomes, more effective medical practitioner roles, and a general strengthening of facility processes and systems. The session will show in detail how medical directors can provide leadership for comprehensive, facility-wide improvement of care and performance in nursing homes. Actual cases and data will be presented to show how this common approach is sustainable and reproducible across settings, and can be understood and applied by those of all disciplines, not just medical practitioners.

Learning Objectives
Identify key clinical and management principles for meaningful and sustained improvement in a nursing home's care and performance.
Discuss the critical role of medical directors in leading a nursing home to analyze and improve its entire approach to care.
Identify and address in meaningful ways challenges to improvement including the major impact of cognitive biases on care quality.
Implement meaningful, sustained improvement in a nursing facility using efficient and effective clinical and management strategies.

Presenter(s): Steven Levenson, MD, CMD; Jean Storm, DO

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
Thinking Right and Acting Right: How Medical Directors Can Lead the Way in Nursing Home Improvement

Steven Levenson, MD, CMD
Jean Storm, DO, CMD
Genesis Healthcare

Speaker Disclosures
Dr. Storm has no financial relationship(s)
Dr. Levenson has no financial relationship(s)

Learning Objectives
By the end of the session, participants will be able to:
• Identify key clinical and management principles for meaningful and sustained improvement in a nursing home’s care and performance
• Discuss the critical role of medical directors in leading a nursing home to analyze and improve its entire approach to care
• Identify and address in meaningful ways challenges to improvement including the major impact of cognitive biases on care quality
• Implement meaningful, sustained improvement in a nursing facility, using efficient and effective clinical and management strategies

“This is the City... My Name’s Friday”
• The story you are about to hear is true
• Only the names have been changed to protect the innocent... and the not so innocent

This is Our Region

Our Facilities
Our Facilities

• Bardwell KY (691)
• Bowling Green KY (65,234)
• Brownsville KY (832)
• Elizabethtown KY (29,906)
• Florence KY (32,460)
• Frankfort KY (27,885)
• Lewisport KY (1,720)
• Lexington KY (318,449)
• Louisville KY (765,232)
• Madisonville KY (19,399)
• Owensboro KY (59,273)
• Paducah KY (25,145)
• Shelbyville KY (15,514)
• Williamstown KY (3,925)
• Woodburn KY (382)
• La Follette TN (6,971)
• Maynardville TN (2,357)

Foundation of Our Approach

• Framework
  - Physician leadership as clinicians and as medical directors
  - Clinical (primarily, geriatrics and basic clinical principles and practices)
  - Basic and advanced management (including crucial conversations and accountability)
• Components
  - A clinical strategic plan template, adapted to every setting
  - Routine, ongoing application of medical and management foundation
  - Education and training at all levels
  - Routine, ongoing problem solving (primarily, inductive and deductive)
  - In-depth case reviews as the indispensable focus
  - Accountability for conduct, performance and practice at all levels
• Not an extra project or program
• Essentially, entirely free

The Secret is... No Secret

• Back-to-basics
• Standard, readily available knowledge and methods
• Strategic plan and consistent use
• Truly integrated and coordinated approach
• Physician clinical and management leadership
• True problem solving, as QAPI was meant to be

Recipe For Success

• 1 - CED to lead the charge
• 1 - CNE to promote the process at all times
• 1 - willing and reasonably capable physician
• 1 - dash of case reviews
• Directions: Follow the recipe (strategic plan) at all times. Make sure all ingredients (plan components) are present in the right proportions. Oversee the cooking (implementation) frequently. Apply the heat to everyone at a steady pace. Do not let enthusiasm cool too quickly.

Diverse Results From a Single Comprehensive Approach

• Relieve suffering, save lives, improve patient outcomes
• Falls, psychiatric behavior, pain, rehospitalization, medications
• Improve multiple quality measures (above and others)
• Save money, reduce wasted time and resources
• Reduce unnecessary lab tests
• Radically reduce medications and facility in-house medication costs
• Prevent avoidable hospitalization
• Improve staff engagement and reduce staff workload
• Improve patient and family satisfaction
• Improve survey results
• Including decertified facilities and those on (or close to) special focus or worse
Quality Measures

Lower Costs, Improved Measures

Orthodoxies and Truths

Our Theme For Today

What We Need vs. What We Get

Plentiful Platitudes
Jumping Off the Bandwagon

Geriatrics

- "Much of geriatric care is, in effect, remedial. It addresses problems produced by the care of others, errors of both commission and omission. Were other medical practitioners to become more sensitized to the needs of their frail older patients, the need for geriatric care as a separate activity would decline."
  - How Effective is Geriatrics? - 1994

Our Crucial Conversations

Real Reasons For Care Problems

- Insufficient crucial conversations
- Inadequate crucial accountability
- Most efforts to fix nursing homes are inadequate and unnecessarily complicated, and chase symptoms, not root causes
  - QAPI is often far too statistical and chases symptoms rather than root causes
  - Inadequate understanding of root causes and too many generic "solutions" from those with limited hands-on experience in organization or patient management

A Few Openings, Unlimited Exploration

How to Save Lives
"The measure of achievement is not winning awards. It's doing something that you appreciate, something you believe is worthwhile."

~ Julia Child

**Cooking is a lot Like Medicine**

- Cooking is about getting just the right balance of spices and flavors (just like medications).
- No matter how many times you’ve made a recipe, you still have to test and taste it like it’s the first time you’ve made it (just like treating a medical condition).
- Good chefs don’t settle for mediocre results (just like good doctors).
- Things might go wrong and you might not have any idea why.

**My adventures in LTC**

- Hired by Genesis Physician Services 1/2013 as attending physician in 1 facility (approximately 75 residents)
- Became Medical Director of facility later that same year and became attending physician at an additional facility
- Became Medical Director of 2nd facility 1/2014.
- Primary attending and Medical Director of 2 facilities (approximately 200 residents in a skilled and LTC mix)
- Regional Medical Director of WV 1/2016 (overseeing 38 facilities in the state)

**Changes and Challenges**

- The residents under my direct care continue to become more acute
- Increasing pressure to reduce rehospitalizations in the centers where I am Medical Director
- The centers across the state have the same challenges and I am often asked to provide advice and support remotely
- The numbers of physicians who are interested in taking care of residents in our centers is dwindling
- It is often difficult to communicate with other Medical Directors in the state to get them on board with clinical initiatives to improve outcomes
Challenges From All Sides

• As medical directors we face unique challenges from many different areas
• The following note illustrates typical thinking in LTC and is more common than many would believe
• Is the note an example of “Thinking Wrong?”

Are We All “Thinking Wrong?”

• Physicians are spending less and less time with patients and often rely on other sources of information (nurses, CNAs, PTs, etc)
• Suggestions such as these listed in the previous note are not unique
• In my experience I have seen Medical Directors respond in 1 of 3 ways:
  A. Give the OK to everything that is suggested (no matter what)
  B. Say no to everything that is suggested (no matter what)
  C. Assess each suggestion and investigate further

Time

• Physicians have complained for years that outside pressures have not allowed the time needed to fully assess patients and make a diagnosis
• When physicians rush through patient visits they don’t have the benefit of seeing the “big picture” along with the subtleties which leads to mistakes
• Recently, there has been a movement to “bring back the bedside” or for “slow medicine” so physicians have the time to fully assess patients
• Our patient population needs this extra time more than any other due to their advanced age, complex medical conditions, and rapidly changing health status

A Better Way

• The “Thinking Right” approach is a simple, effective way to unify center staff and practitioners into a holistic, resident-focused way of thinking
  • It allows everyone caring for residents to “get on the same page”
  • It encourages everyone in the facility who plays a part in resident care to openly discuss every factor affecting the health of the resident (medications, environment, diet, etc).
  • It eliminates “knee jerk” responses and “old thinking”
  • The approach can be easily taught and utilized in all LTC facilities
A Tale of 2 Cases of Chest Pain

“A HEROINE IS NO BRAVER THAN AN ORDINARY (W)OMAN, BUT (S)HE IS BRAVER FIVE MINUTES LONGER.”

~ RALPH WALDO EMERSON

Why does everyone get nervous when someone has chest pain?

- Chest pain is a symptom of several life-threatening conditions and the risks of missing these diagnoses are high
- Clinicians, however, often overestimate the probability of these conditions
- Chest pain is the 2nd most common cause of visits to the ER
- 5.5% of these visits lead to a diagnosis of a serious illness (JAMA Internal Medicine 2016)

2 Residents. 2 days. Same Complaint

- Typically a complaint of “chest pain” buys a resident an ER visit
- These 2 cases illustrate how different presentations of chest pain should be treated differently
- Unfortunately, the same complaint is often treated in the same way

Case #1

- While finishing up rounds in the SNF where you are medical director you are called to evaluate a resident who is sitting in the hall.
- The resident is an 80 year old female who is typically ambulatory with front wheeled walker. She has just returned from breakfast and told her nurse that she was dizzy. On further questioning she admitted to dull chest pain and nausea since waking.
- Med Hx: hypertension, dementia, hypothyroidism
- Meds: aspirin, levothyroxine, furosemide
- Vitals: BP 120/78 HR 82 Temp R 16 98.2 O2 sat 96%

Case #1 continued

- The resident is alert, awake and at her cognitive baseline
- She is pale and appears nervous
- Her physical exam is essentially unremarkable except for an irregular HR
- 911 is called and the resident is found to be in atrial fibrillation on telemetry
- She is taken to the cath lab on arrival to the ER and diagnosed with NSTEMI, cardiology recommends medical management
- She returns to the center after a few days
Case #2

- You are called to evaluate a resident while you are attending the facility’s weekly IDT meeting
- The resident is a 62 y/o female who is currently laying in bed, but typically self-propels her wheelchair around the facility. She states that she is having sharp pain in the middle of her chest which started this morning.
- Med Hx: COPD, CAD, hypertension, depression, anxiety
- Meds: levothyroxine, duloxetine, rivaroxaban, ticagrelor, etc. etc.
- Vitals: BP 122/82 HR 78 Temp 98 R 18 O2 sat 94% on 2L

Case #2 continued

- The resident is alert, awake, and at her cognitive baseline
- She is laying in bed and appears comfortable
- When asked where her pain is, she points to her sternum. When you palpate the spot that she points to she yells, "owwww!"
- You decide that her chest pain does not warrant transfer to ER and advise the resident of your decision
- The resident later calls 911 herself and is admitted to the hospital
- She returns to the center in a few days after work-up which does not reveal cardiac cause

Musings on the 2 Cases

- The cases are unusual due to the fact that the medical director was present to evaluate each resident during the acute presentation
- If either presentation occurred at night or on the weekend, they might have had different outcomes
- Nursing often reacts very differently when a physician is at the bedside
- Residents often react very differently when a physician is at the bedside
- Medical Directors can have the greatest impact when we lead through our example

How have I used “Thinking Right” to Improve Resident Care?

My goal is to improve care in all buildings across the state, so I saw solutions in 4 areas:
1. Improve the care of my own residents directly
2. Educate all APPs in the state
3. Educate center executive staff in all facilities in the state
4. Encourage all Medical Directors to adopt the approach

Advanced Practice Providers

- I am lucky to have a strong, motivated team of APPs working in our facilities across WV
- Webinars have been provided remotely several times a year on many topics:
  1. Opioid and benzodiazepine reduction
  2. AMDA’s “Choosing Wisely” guidelines
  3. Diabetic management
  4. INR “decision tree”
  5. Medication debridement and the Beers list

Quick Beers List Guide

[Link to a comprehensive list]
Drama, Drama, Everywhere

- Many difficulties and "issues" in LTC facilities are caused by interpersonal conflicts
- The SNF is an emotionally charged environment which often causes individuals to not communicate effectively
- It is important that all individuals feel safe to express their opinions and viewpoints
- The Medical Director can (and should) lead the way in communicating effectively through example
- The following guidelines were used to stress to facilities across the region the importance of peaceful and effective communication

- If another individual escalates conflict, do not engage. Remove yourself and contact the appropriate manager (CEO, CNO)
- Avoid using broad assumptions. Clearly state the conflict in simple, direct terms and avoid exaggeration
- Avoid using residents as "pawns" in any conflict. This tactic is very harmful to quality care and clouds judgement in making clinical decisions
- Do not resort to personal attacks or name calling
- Do not mass email when reporting a conflict which cannot be resolved. Report the concern directly to the appropriate manager
- Treat everyone you interact with in the Center the way you would like to be treated

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“The best doctor gives the least medicines.”

Benjamin Franklin

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Basic Rules of Human Engagement in the LTC Setting

We have all chosen a rewarding field in which to work, but it is also an emotionally demanding field and it is sometimes difficult to interact professionally with our work colleagues when we are stressed. Communicating effectively and peacefully is essential to provide the best care of our residents, which should be our main focus. A few simple techniques can improve any interaction which translates into better care for our residents.

- We are all on the same team caring for our residents. When approaching a provider you don’t agree with keep in mind that the provider is concerned with the best care for the resident as well. Express your opinion in a constructive, professional manner.
- Practice direct, direct communication when relaying resident information or receiving orders, to reduce mistakes
- Facility administrators are responsible for maintaining a peaceful center for staff and residents.
- Do not escalate conflict. Do not throw out words like “misrepresentation” or “abuse” unless the situation is clearly in that category. If unsure, call your HR manager to discuss the issue
Words Don’t Teach
Experience Teaches

“There is only one way to learn,” the alchemist answered, “it’s through action.”
— Paulo Coelho

- Each center leadership team in WV attended strategic plan presentation
- Each team was encouraged to see each resident as a whole individual instead of a sum of problems
- Each team was encouraged to contact RMD with “difficult” cases to discuss

“Difficult” Cases

- Most of the case reviews share some similar features
  - Frequent falls
  - Behaviors that have become problematic, prompting ER visits or psychiatric referrals
  - Weight loss
  - Escalating addition of medications (antipsychotics, benzodiazepines) to control behaviors
  - Diet texture or liquid consistency changes without clear reason

Resident #1

- 89 y/o male who presented to facility for skilled stay after acute hospitalization for gangrenous appendicitis
- Med Hx: HTN, CAD, CHF, DM
- No opioid, benzodiazepine, or antipsychotic medications (just antihypertensives, antibiotics, and supplements)
- On initial exam resident is grabbing at the air, cannot answer questions or follow commands

WHAT TO DO NEXT?

FOLLOW the steps

- Step 1: Take a history
  - Son at bedside says resident was “sharp as a tack” before hospitalization and drove himself to the hospital
  - Confusion started a few days after surgery
  - Resident did not eat or drink well following surgery

STEP 2

- Develop a hypothesis regarding the resident’s confusion
  1. Dementia (worsened with recent hospitalization)
  2. Infection (UTI, wound, etc)
  3. New onset mental illness
  4. Electrolyte abnormalities
  5. Elevated ammonia level
  6. Medications
  7. Delirium
  8. Elevated CO2
Further Steps

• Step 3: Perform a physical exam
  • Essentially unremarkable except the resident is barely A0x1
• Step 4: Make a problem list
  • In this case, we cannot explain why the resident is confused
• Step 5: Generate differential diagnosis
  • Look at hypothesis and remove those that can be excluded with the physical exam

Getting Closer

• Step 6: Test the Hypotheses
  • Pick lab tests or imaging studies to test the diagnoses (look at tests already ordered in the hospital)
• Step 7: Modify Differential Diagnosis
  • Use test results to evaluate hypotheses
  • In this case, the resident had a normal ammonia level in the hospital, he had a normal head CT, and his CO2 level was normal in hospital
• Step 8: Repeat process until diagnosis made
• Step 9: Make (tentative) diagnosis: Delirium in this case

Murky Waters

• Challenges in this case:
  • Son asked for antipsychotics to “cure” the resident’s confusion
  • Resident was mildly hypernatremic
  • Staff (and physician) felt resident might be “end of life”
  • Urge to “do something”
  • Family felt symptoms were due to “antibiotic sensitivity”

Were We right?

• We watched closely and waited, based on delirium diagnosis
  • Resident was “alert and oriented x 3” several days after admission
  • Resident attended meeting with social worker, physician, and multiple family members a week after admission and asked “what am I required to do to be discharged?”
  • Resident’s Na did remain mildly elevated, but no intervention was done (i.e. IVF) because resident was IMPROVING CLINICALLY
  • Diagnosis of delirium was correct

Resident #2

• 73 y/o male, LTR of facility with hx CVA, dementia, malnutrition
• Key medications: olanzapine 5mg po bid, alprazolam .5mg tid, trazodone 25mg bid
• Pureed diet, nectar thickened liquids due to “drowsiness”
• Problems: frequent falls, weight loss

WHAT TO DO NEXT?

What is going on?

• After following the clinical reasoning process a few questions came to mind:
  1. Why is the resident on trazodone? Depression? What is the PHQ-9?
  2. What is the BIMS?
  3. Why is the resident on a pureed diet? Thickened liquids? MBS?
  4. Why is the resident receiving an antipsychotic?
  5. Why is the resident receiving alprazolam?
Recommendations

- GDR alprazolam and olanzapine
- Perform a PHQ-9 and treat depression accordingly
- Advance diet and thin liquids

Resident #3

- 76 y/o male initially brought to the ER due to frequent falls, diagnosed with UTI and transferred to our facility
- Med Hx: dementia, HTN, hypothyroidism, seizure disorder
- Meds: colace-senna, amiodipine, phenytoin, dofetilide, levothyroxine, calcium +D
- Many, many falls after his admission to facility (one results in femur fx)
- He insists on ambulating and becomes combative if he is encouraged to sit in wheelchair
- Interventions tried: lorazepam, olanzapine, hydrocodone. All were ineffective and all were stopped

Resident #4

- 80 y/o male LTR of facility
- Med Hx: dementia, HTN, atrial fibrillation
- Meds: Donepezil, ASA, Lisinopril
- Problem: new onset aggressive behavior requiring IM lorazepam to stop aggression toward staff and roommate, eventually sent to ER for psych evaluation
- Pertinent findings from history: Diet had been changed to pureed after dentures broke

ALWays ask why

- The resident was on dofetilide which is a medication for atrial fibrillation (to convert to sinus rhythm)
- EKG was obtained to determine the resident’s heart rhythm
- EKG demonstrated normal sinus rhythm, but QTc was >440msec which indicates the dose of dofetilide should be reduced or the medication discontinued
- Dofetilide was weaned slowly and eventually stopped
- The resident had no more falls once the medication was weaned off

Easy Fix

- Dentures were fixed and the resident’s diet was advanced to regular/liberalized
- No further lorazepam was needed as combative behaviors stopped
Resident #5

- 84 y/o female LTR of facility
- Med Hx: Dementia, DM, hypothyroidism, HTN
- Acute issue: Nurse calls physician concerned because resident threatened to kill herself if she “had the means” and requests to send resident to the ER. Physician advises nurse to monitor resident and call if resident condition worsens. CNE calls physician and requests to transfer resident to ER. Physician advises to monitor resident closely for now and keep in facility. CED finally calls physician and advises that it is “policy” to transfer a resident to the ER once the resident voices desire to harm herself.

**WHAT WOULD YOU DO?**

Resident #5 (cont)

We Can’t Win Them All (or can we?)

Result: Physician finally agrees to given order to transfer resident to ER. Resident is transferred to ER where she is evaluated by ER physician (who has never evaluated the resident). Resident is sent back to facility 4 hours later with diagnosis of dementia.

Learning Points from Case #5

- Do not assume that the information regarding “policy” is correct until you see it with your own eyes
- Trust your own experience and information about the residents under your care
- Know that you are ultimately responsible for the medical care of the residents under your care
- Assume positive intent, but understand that perspectives differ

Resident #6

- 89 y/o male presented to the ER after suffering MVA due to syncopeal event while driving. SDH, SAH, sternal fxs, rib fxs, C2 fx
- PMHx: a-fib, HTN, anxiety
- Meds: amiodarone, chlordiazepoxide, metoprolol, asa, omeprazole
- SNF course: Arrives with BMI 19.2, not eating well. BMI drops to 18.4 in a month and the resident falls out of bed which results in intertrochanteric hip fx. He is sent to hospital for surgical repair.

**WHAT SHOULD WE DO WHEN HE RETURNS?**

RESIDENT #6 (CONT)

- On arrival back to SNF the IDT looked at all of his meds and current condition
- EKG obtained which revealed paced rhythm
- TSH obtained was 16.9
- The resident’s amiodarone was weaned off and synthroid 25mcg po qd started
- The resident’s BMI increased from 18.4 to 19.7 in 3 weeks after interventions put into place
Take home points for case study reviews

- Always, always, always look at the entire resident (not just the major issues or difficulties)
- Medications have different effects on different individuals
- Do not underestimate the adverse effects of a pureed diet or thickened liquids
- Do not underestimate the adverse effects of not allowing a resident to ambulate
- Keep in mind that human beings are dynamic
- Most of our residents crave routine and become agitated when the routine is disrupted

Good Intentions

- "The chief cause of problems is solutions."
  - Eric Sevareid (CBS News Reporter and Commentator from 1939-1977)

Orthodoxies

- IDT
  - Assessment
  - Everything is based on the MDS and the RAI / care planning
  - Person-centered care
  - Medical model vs. social model
  - Hospice
  - Behavioral health / dementia care / anti-antipsychotic medication
  - Staffing
  - Survey / enforcement
  - Quality measures / best practices
  - Research / 24 million

People Can Improve—With Proper Guidance

World's Most Plentiful Paving Material

- Hell
- Near Exit
- Good Intentions
- More, Less of Well-Intended People
- Think They Can Fix Nursing Homes
- But That's Why They Say the Road to Hell Never Lacks for Paving Materials

You can observe a lot by watching
— Yogi Berra
The Haves and Have-Not

Islands of True Evidence-Based Care in a Sea of Whatever

- Excellent clinical care that clearly reflects good practice derived from authoritative sources: 30 percent
- Care that is not really understood or is not fully rational, but that guesses right or is partially flawed: 30 percent
- Inadequate and inappropriate care that is based on guessing, myth, misunderstanding, conventional wisdom, bandwagon, relationships, authority: 40 percent

Case #1

- 120-bed facility
- MAR review and scan
- 50 residents on Megace, Remeron for “appetite stimulation”
- 42 pages worth (almost 600) of psychopharmacological medications and opioids
- Diagnosis review: Very large number of patients had some mental illness or psychotic / delusional diagnoses
- Diagnosis review: mostly incorrect and conflicting
- Psychiatric services and medication recommendations done by a psychologist
- Everything driven by the Director of Nursing and select staff
- Attending physician / medical director and NP uninhibited and largely passive
- Quality measures on antipsychotic medications near perfect over a year
- QIO impressed and requested statewide presentation

Orthodoxy: QAPI is About Data and Measures

- Data and measures are useful, but most of it is about reasoning and problem solving
- Given lip service
- Countless facilities doing it the CMS way have actually had serious care issues
- A prime example is antipsychotic medications

Lessons From Case #1

- Data must be explored
  - BIMS
  - Diagnoses
  - Drug lists
  - Lab tests
  - Quality measures
- Staff and practitioners cause enormous damage by doing things they don’t understand

Care Process Failure = Not Cool
Case Reviews

- “Retrospective medical record review is often considered the most definitive method for detecting adverse events, because it can provide detail about both the adverse event and the circumstances, such as the patient's or resident's condition prior to and following the event.”

Systems and Process Clues Related to Patient Safety

- What characteristics of facilities promote or undermine patient safety?
- What clues can help identify adverse events, problematic facilities, and high-risk situations?
- What are root causes of safety-challenged facilities?
- How can medical directors and practitioners improve safety by improving systems, processes, and practices?

Medications Galore

- Patients using at least one PIM (excluding NSAIDs) had a 13% greater risk of being hospitalized than patients using no PIMs
- Patients using at least two PIMs had 21% greater risk
- Similar associations were found between PIMs and re-hospitalization risk among patients referred to home health from a hospital
Patient #1
- Ativan Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 24 hours as needed for anxiety and worry over health status, crying, and crying金额
- Baclofen Tablet Give 10 mg by mouth two times a day for muscle spasm金额
- Metoprolol Tartrate Tablet Give 150 mg by mouth one time a day for HTN金额
- Percocet Tablet 5-325 MG (Oxycodone- Acetaminophen) Give 500 mg by mouth every 4 hours as needed for pain金额
- Promethazine HCl Tablet Give 25 mg by mouth every 4 hours as needed for nausea金额
- Wellbutrin Tablet (Bupropion HCl) Give 300 mg by mouth one time a day for depression

Patient #2
- Cymbalta Capsule Delayed Release Particles (Duloxetine HCl) Give 60 mg by mouth one time a day for depression
- Flexeril Tablet (Cyclobenzaprine HCl) Give 10 mg by mouth three times a day for muscle spasm金额
- Lyrica Capsule 150 MG (Pregabalin) Give 1 capsule by mouth two times a day for neuropathy金额
- Percocet Tablet 3-325 MG (Oxycodone- Acetaminophen) Give 5 mg by mouth every 4 hours as needed for pain金额
- SEROquel Tablet (Quetiapine Fumarate) Give 25 mg by mouth at bedtime for depression金额
- Tramadol HCl ER Tablet Extended Release 24 Hour 100 MG Give 100 mg by mouth two times a day for pain

Patient #3
- Cymbalta Capsule Delayed Release Particles (Duloxetine HCl) Give 60 mg by mouth one time a day for depression
- Flexeril Tablet (Cyclobenzaprine HCl) Give 10 mg by mouth three times a day for muscle spasm金额
- Imitrex Tablet (Sumatriptan Succinate) Give 100 mg by mouth every 4 hours as needed for H/A max 2 tabs in 24 hours的
- OxyCODONE HCl Tablet 15 MG Give 15 mg by mouth every 6 hours as needed for pain金额
- Promethazine HCl Tablet Give 12.5 mg by mouth every 4 hours as needed for N/V金额
- Vistaril Capsule (HydroXYzine Pamoate) Give 50 mg by mouth every 6 hours as needed for anxiety

Patient #4
- Flexeril Tablet (Cyclobenzaprine HCl) Give 5 mg by mouth one time a day for muscle spasm金额
- Lyrica Capsule 150 MG (Pregabalin) Give 150 mg by mouth two times a day for neuropathy金额
- Norco Tablet 7.5-325 MG (Hydrocodone- Acetaminophen) Give 7.5 mg by mouth every 6 hours as needed for pain金额
- Sertraline HCl Tablet Give 50 mg by mouth at bedtime for depression金额
- TIZANidine HCl Tablet Give 4 mg by mouth three times a day for muscle spasm金额

Patient #5
- Clozaril/HCl Tablet 6.5 MG Give 1 tablet by mouth three times a day for anxiety金额
- DilataZan HCl Tablet Give 120 mg by mouth one time a day for A-Rhs金额
- Furosemide Tablet Give 20 mg by mouth one time a day for HTN金额
- Klucopin Tablet 0.5 MG (Clozapine) Give 0.5 mg by mouth three times a day for yelling and crying金额
- Norco Tablet 3-325 MG (Hydrocodone- Acetaminophen) Give 5 mg by mouth every 6 hours as needed for pain金额
- Reversal Tablet (Mirtazapine) Give 30 mg by mouth at bedtime for depression金额

Thinking Right / Acting Right
- Clinical
  - A scientifically valid, patient-centered, well-established, universally applicable approach to all conditions, symptoms, problems in all settings金额
- Management
  - A sound, universally applicable approach to attaining desirable outcomes by optimizing practice, performance, processes, and systems金额
  - A way to restructure organizations and facilities for optimal resource use and results金额
Same Approach For All Topics

- Acute change of condition
- Anticoagulation
- Atrial Fibrillation
- GI Disorders (upper and lower)
- COPD
- Delirium
- Dementia
- Depression
- Diabetes
- Dysphagia/Swallowing Difficulty
- Falls and Fall Risk
- Fever/Septicemia
- Functional Impairment
- Gastrointestinal Bleeding
- Heart Failure
- Hydration/Fluid Maintenance
- Hypertension
- Infections
- Lab and Diagnostic Test Results
- Lower Respiratory Infections
- Medication Prescribing and Deprescribing
- Nutrition / Unplanned Weight Loss
- Osteoporosis
- Pain
- Palliative/End-of-Life Care
- Pressure Ulcers/Skin Breakdown
- Prevention  and Screening
- Psychiatric and Behavior Issues
- Seizures and Epilepsy
- Sensory Impairments
- Sleep Disorders
- Stroke/TIA
- Surgery-Related  (Pre- and Postoperative) Issues
- Urinary Incontinence
- Urinary Tract Infections/Bacteriuria

A Few Openings, Unlimited Exploration

- Any and all data
- Data is just an entry point to exploration, never an endpoint in itself
- Medications
- Facility-wide MAR
- Facility-wide categories of psychopharmacological medications
- Especially, opioids, psychopharmacological medications, and all Beers list medications
- Unplanned transfers / rehospitalization reports
- Incidents and accidents
- Survey results / quality measures / OSCAR data
- Altercations, disputes, complaints about behavior and performance

Entry Points

- Any and all data
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- Survey results / quality measures / OSCAR data
- Altercations, disputes, complaints about behavior and performance

There is Digging. . .and DIGGING

Case #2

- 80 y.o. man admitted 2/17/15 after hip surgery
- Mild cognitive impairment, BIMS=11
- No evidence of mood disorder
- ADLs supervision only for eating, otherwise range from limited to extensive assistance
- Not having much pain and stating desire for minimal medication
- Identified as a fall risk
- Anticoagulation was ordered
- Patient had periodic, usually vague pain symptoms that appeared mostly unrelated to hip replacement

Case Example: Medications

On Admission
- Iron sulfate 325 mg daily
- Flomax 0.4 mg daily
- Oxycodone 5 mg every four hours PRN as needed for pain 1-4
- Vitamin B-12 tablet 2000 milligrams daily
- Acetaminophen 325 mg every four hours
- Acetaminophen 500 mg twice a day
- Vitamin D3 50,000 units weekly for 8 weeks
- Vitamin D3 50,000 units monthly
- Senokot S one tablet b.i.d.
- Viactiv tablet 500 – 500 – 40 (calcium – vitamin D – vitamin K)

Added After Admission
- Saw palmetto 160 mg daily
- Pygeum bark powder daily
- House supplement TID for failure to thrive
- Alarm and fall mat at all times for safety
- OxyContin 10 mg q8h as needed for pain 7-10
- Rivaroxaban 10mg daily

103

104

105

107

108
Case: Blood Pressures

- 02/17/2015 132/86
- 02/18/2015 142/86
- 02/19/2015 138/80
- 02/20/2015 123/78
- 02/21/2015 128/74
- 02/22/2015 120/68
- 02/23/2015 127/56
- 03/05/2015 93/60
- 03/06/2015 107/55
- 03/07/2015 99/52
- 03/08/2015 102/54
- 03/09/2015 100/60
- 03/10/2015 97/56

Summary of This Case

- Shift in pain medication mostly to oxycodone and PRN oxycotin
- Herbal medications added to regimen
- Developed vague swallowing difficulty
- Found to have lost 10 pounds
- Speech recommended GI consult due to esophageal dysmotility
- Developed marked hypotension: mean BP down 20-30 points in 3 weeks
- Developed dizziness

Saw Palmetto

  - "Saw palmetto may increase the risk of bleeding when taken with drugs that increase the risk of bleeding. Some examples include aspirin, anticoagulants such as warfarin or heparin. . ."
  - "Tannins in saw palmetto may prevent iron absorption. . ."
  - "Side effects and warnings the most common complaints involve the stomach and intestines, and include stomach pain, nausea, vomiting, bad breath, constipation, diarrhea, gas, heartburn, and indigestion. . . Use cautiously in people who have stomach disorders. . ."
  - "Saw palmetto may reduce levels of hemoglobin, hematocrit, red blood cells, and platelets."

Quality Issues Identified Via Case Review

- Diagnostic Quality
  - All diagnoses were vague and nonspecific; diagnoses also incomplete
  - No apparent effort to clarify or update diagnoses after admission
- Medications
  - Warnings about medications apparently ignored (including Oxycontin q8h PRN)
- Risk Identification and Intervention
  - Delayed recognition and action related to major decline in mean BP within 3 weeks, despite concern about fall risk
  - Apparent failure of anyone to identify and object to inappropriate oxycontin orders
- Practitioner Roles and Actions
  - PA involved in the care who apparently did not act to address risks, safety issues, medical issues, diagnoses, condition changes, or medication issues
  - Physician apparently had minimal direct contact with patient since admission, and was apparently either unaware of, or did not act on major risk and medical issues
  - Little evidence of a meaningful physical exam of the patient by a practitioner about pain issues and increasing use of opioids
  - No evidence of a differential diagnostic effort by physician or PA regarding 10 pound weight loss or apparent swallowing difficulty
- Quality Issues Identified Via Case Review
  - Excessive doses of Vitamin D without clear rationale
  - Little evidence of a differential diagnostic effort by physician or PA regarding 10 pound weight loss or apparent swallowing difficulty
  - Excessive doses of Vitamin D without clear rationale
  - No evidence of a differential diagnostic effort by physician or PA regarding 10 pound weight loss or apparent swallowing difficulty
Quality Issues Identified Via Case Review

- Knowledge deficits
- Importance of looking things up
- How to look things up
- Inadequate recognition of warnings and risks regarding medications
- IDT
  - Inadequate input by consultant pharmacist regarding medication issues
  - Speculation about causes of symptoms and condition changes despite inadequate knowledge or understanding of the differential diagnosis

Quality Issues Identified Via Case Review

- Assessment and Documentation
  - Patient’s variable pain symptoms were not clarified in enough detail to justify choice of analgesics
  - Frequent use of oxycodone without any meaningful details of pain symptoms
  - No orthostatic BPs done despite BP drop and concern about fall risk
  - No meaningful details regarding the patient’s symptoms, including pain, appetite, difficulty swallowing, dizziness

Crucial Accountability—NOT!

Orthodoxy: The Virtuous IDT

- The interdisciplinary team is virtuous
- Each IDT member plays an important role
- Everyone should respect the contributions of each “team” member
- IDT members know what they are doing, know their limitations, know when to ask for help
- IDTs need “communication”

Never-Ending

Management Nightmares
Challenges to Meaningful Improvement

Overconfidence Bias

• Overconfidence
  • Tendency to think one knows more than one does
  • Especially by placing faith in opinions without gathering the necessary supporting evidence
  • “I learned early in my medical career that the doctor you should worry about isn’t the one who doesn’t know anything. It’s the one who doesn’t know as much as he thinks he does.”

Bad Apples

• “Superstars get a lot of attention from bosses. But bad apples deserve even more.”
• “A growing body of research suggests that having just a few nasty, lazy or incompetent characters around can ruin the performance of a team or an entire organization—no matter how stellar the other employees.”
• “Bad apples distract and drag down everyone, and their destructive behaviors, such as anger, laziness and incompetence, are remarkably contagious.”

Bad Apples

• “Leaders who let a few bad apples in the door—perhaps in exchange for political favors—or look the other way when employees are . . . incompetent are setting the stage for even their most skilled people to fail”
  - How a Few Bad Apples Ruin Everything

You Can’t Do That to a Patient

Our Crucial Conversations
Truth Should Set us Free

The Meaningful Conversation

• The path to high productivity passes not through a static system, but through face-to-face conversations
• Is your organization stuck in its progress toward some important goal?
  • If so, are there conversations that you’re either avoiding or botching?
• Are the people you work with stepping up to or walking away from crucial conversations?
• Could you take a big step forward by improving how you deal with these conversations?
  • Patterson et al. Crucial Conversations, pp. 13-14

The Meaningful Conversation

• Crucial conversations at the heart of almost all chronic problems in organizations, teams, and relationships
• An organization’s performance hangs on how individuals deal with crucial conversations
• The world changes when people have to deal with a very risky issue and either do it poorly or do it well
• Real problem: those who observe deviations or infractions say nothing
  • Example: A doctor is doing something wrong or unsafe, but others either say nothing or their concerns are ignored

Crucial Accountability

• Organizational productivity and performance are not simply about policies, processes, structures, or systems
• Nonhuman changes fail more often than they succeed
• Employee behavior is the real problem
• Key to real change: not a new process, but getting people to hold one another accountable to the process
• In the best companies, everyone holds everyone else accountable—regardless of level or position
• The path to high productivity passes not through a static system, but through face-to-face conversations
  • Patterson et al. Crucial Accountability

Crucial Accountability

• “Six Sources of Influence” as potential root causes of behavior
  • Personal sources
    • 1. Personal motivation
    • 2. Personal ability
  • Social sources
    • 3. Social motivation
    • 4. Social ability
  • Structural sources
    • 5. Structural motivation
    • 6. Structural ability

Crucial Accountability

• 1. Personal motivation
  • Actions based on individual desire or disposition
• 2. Personal ability
  • Skills, knowledge, mental and physical capacity to do what’s required
• 3. Social motivation
  • Desire to be accepted by others
• Healthcare professionals violate standards, scientists turn a blind eye to safety, accountants watch their peers break the law, and nobody says anything
• Presence of others who say nothing causes them to doubt their own beliefs, and their desire to be accepted taints their overall judgment
• Social pressure is the mother of all stupidity
Crucial Accountability

- 4. Social ability
  - Other people are either a help or a hindrance (information, materials, tools, permission, etc.)
- 5. Structural motivation
  - Money, promotions, job assignments, benefits, bonuses, and other organizational rewards
- 6. Structural ability
  - Things can often provide either a bridge or a barrier
  - This includes data

The “Detective” Approach

Rationale For the “Detective” Approach

- “Everyone in the organization—not just technical experts or high-level managers or white-collar researchers, but also hourly employees, front-line staff, people in support departments and in the business offices—everyone becomes, in effect, a scientist able to contribute ideas and knowledge about how work can be done more effectively.”

Rationale For the “Detective” Approach

- “The method of improvement is the key contribution of quality improvement: Instead of management by impulse, or by exhortation, or by preconception, the quality improvement manager is able to manage by facts…”

Rationale For the “Detective” Approach

- “Whether we call the job at the start ‘solving problems’ or ‘improving processes,’ the method is the same: act like a scientist in your daily work. State questions, make a plan, formulate hypotheses, gather data to test those hypotheses, draw conclusions, and test those conclusions.”
  - Using the Scientific Method to Define Problems

Rationale For the “Detective” Approach: Summary

- More widespread use of empirical approach needed to improve healthcare
- Incorporates basic principles of effective problem solving and performance improvement
- Invaluable to problem solving, social progress, performance improvement, financial stability, desirable outcomes
- Behavior is a function of its consequences
Rationale For the “Detective” Approach: Summary

- Identifying and dealing with the truth helps =>
  problem solving => improved processes and practices
  => optimizing outcomes
- Problem solving and accountability in the Centers
  - Major contributor to success and failure in any endeavor
  - “The only thing necessary for the triumph of evil is for good
    men to do nothing”
    - Attributed to Edmund Burke

Rationale For the “Detective” Approach

- “Quality improvement uses the scientific method to understand and improve processes.”
- “Its [the scientific method’s] power lies not so much in its ability to help solve any particular problem as in the extent of its deployment in an organization.”

Cognitive biases and their consequences

Cutting Corners / Skipping Steps

Making Assumptions

Before you “assume” try this crazy method called “asking”.

Jumping To Conclusions
Doing Things Robotically, by Rote

Common Cognitive Biases
- Affective
- Anchoring
- Availability
- Blind obedience
- Confirmation
- Diagnostic momentum
- Framing effect

Acting Without Understanding

Avoiding the “Carnac Syndrome”
- I already have the answer before I even know the question (or get the evidence or clearly understand the problem)
- Evidence becomes an inconvenience
- Key evidence (to the contrary) is overlooked
- “What I know is what I think, and what I think is what I know.”

Avoiding the “Carnac Syndrome”
- Hindsight bias
- Overconfidence
- Premature closure

Perils of “Carnac Syndrome”
- Dangers
  - Ignoring key evidence
  - Missing important causes
  - Implementing ineffective or problematic interventions
  - Causing avoidable complications
  - Failing to manage key correctible conditions or situations
Defective Practice of Medicine

- IDT
  - Highly susceptible to cognitive biases
  - Speculate wildly about causes of symptoms
  - Do not know what they don’t know
  - Hold “psychopharm” meetings and make recommendations
    based on guessing to practitioners who rubberstamp them
  - Request tests and treatments without any effort at cause identification
  - Misread and mistakenly report test and X-Ray results (e.g., “X-Ray
    report says pneumonia;” “urine culture is positive for UTI”)
  - Failure to speak up or act when something is not right

Defective Practice of Medicine

- Administrator
  - Inappropriately directs the diagnosis, testing, and treatment of individual patients
  - Treat an X-Ray finding
  - Get a consult (psychiatric or otherwise)
  - Remove catheters
  - Don’t use antipsychotic medications
  - Do what the patients or families ask for
  - Call the physician/NP/PA and ask for test / treatment / consult / . . .
  - Allows or authorizes untrained, unskilled, unqualified individuals to diagnosis patients
    and practice medicine without a license
  - Inadequate understanding or promotion of appropriate clinical practice
  - Inadequate dialogue with medical director and attending practitioners
  - Excessive attention to survey and quality measures
  - Lets the DON run the whole facility / uninvolved in care
  - Does not ensure that high quality clinical meetings occur with full participation

Defective Practice of Medicine

- Dietitian
  - Speculates about causes of weight loss and anorexia (medical symptom)
  - Recommends “appetite stimulants”
  - Recommends feeding tubes
  - Joins up with the ST to decide who should be NPO and what diet consistency they should have
  - Writes phantom “verbal orders”
  - Talks separately, prematurely, and inappropriately to patients and families about interventions, without involving the IDT or the practitioners

Defective Practice of Medicine

- Therapists
  - Ask for tests and treatments instead of giving detailed, objective information about the patient
  - Talk separately, prematurely, and inappropriately to patients and families about tests, prognosis, discharge readiness, interventions, restrictions, without involving the IDT or the practitioners
  - Speculate about causes of swallowing
  - Recommend NPO and feeding tubes
  - Joins up with the dietitian to decide who should be NPO and what diet consistency they should have
  - Writes phantom “verbal orders”

Defective Practice of Medicine

- Social workers
  - Allowed to direct / control entire psychiatric review, referral, and consultative process
  - Decide on their own who should have a psychiatric consult
  - Erroneously diagnose depression, dementia, and others

Defective Practice of Medicine

- Others
  - Hospices
  - Pain consultants
  - Wound consultants
  - Psychologists
  - Physicians / NPs / PAs
  - Inadequate knowledge and skills
  - Inadequate performance and practice
  - Inadequate communication and collaboration
Making the Right Diagnosis

Antibiotics Cases

• 80 y.o. man who is more tired than usual
• Pseudo-UTI
• SNF patient with cough and RUL infiltrate
• Non-specific infiltrate
• Elderly man with a seizure
• Possible aspiration, but not pneumonia
• Elderly man with increasing bilateral LE edema
• Not cellulitis

Lessons From Cases

• The IDT
  • Does the IDT operate based on cognitive biases and relationships, or on patient-specific evidence and knowledge of clinical practice?
  • Do all disciplines know and acknowledge their limitations or do they cause damage by not knowing, and failing to admit what they don’t know?
  • Are patients managed based on sound clinical principles or based on relationships and other social factors?
  • Is there a truly collaborative problem solving effort as the basis for managing patients, or just uncoordinated simultaneous activity?
  • How strong is the resistance to correction and accountability?
  • Is the care delivery process actually a major inconvenience to power and control?
  • Does the IDT use truly authoritative references or resources, or do they proceed based on myth, habit, opinion, and survey mania?

Lessons From Cases

• Care delivery process
  • Are all staff focused on identifying and providing organized, objective, detailed information about individual patients, or do they focus on diagnosing patients and requesting consults, tests, or treatments?
  • Consultants and outside agencies
  • Are consultants and outside agencies (hospice, pain clinics, psychiatric services, wound clinics, etc.) being used correctly or just rubber stamped?
  • Are consultants victims of the facility’s inadequate care process?
  • Facility culture and methods
  • Is there open dialogue and encouragement of “crucial conversations” and “crucial accountability,” or is there failure to question, challenge, or disagree?

Lessons From Cases

• Orthodoxies and bandwagons
  • Orthodoxies lead the multitudes astray
  • It is a struggle to break through orthodoxies and delusions
  • Current approaches to “behavioral health” and psychiatric medications are primitive, misguided, and very dangerous
  • Freed from the tyranny of poor care, patients often flourish—or at least don’t suffer

Case #3

• 110-bed facility in a town (population 48,000)
• 87 y.o. woman on one-on-one for 2 years for recurrent falls and fall risk
• No use of falls protocol or knowledge that medications can cause falling
• Attributed to “dementia,” “noncompliance”
• Medication review: trazodone, risperdone, HCTZ, losartan, buspirone, lorazepam, atenolol, and isosorbide
Case #3

- Physician is also the medical director
- No meaningful dialogue
- No meaningful expectations
- No interest in input or suggestions
- "Psychiatric consultant" is actually a psychologist, who refuses dialogue
- No meaningful administrator activities through the years to address of correct

More Lessons From Cases

- Oversight
  - Is there an interested and engaged administrator who oversees care delivery process adherence, or is the administrator either aloof or actually part of the problem?
  - Does the attending physician have any idea what others are doing to their own patients, and does the attending physician step in and speak up?
  - Is the medical director (or another competent physician) a source of knowledge, a bastion of sanity, and a barrier to doing harm, or is the medical director a major contributor to the problem?

Leadership’s Two Most Important Words

- Yes
- No

Case Example #4

- Unplanned hospital transfer report triggers review
- 96 y.o. woman comes in on montelukast, hydrocodone PRN (given often), gabapentin, amlodipine, metoprolol
- NP adds diazepam 5 mg q12h PRN for “anxiety”
- Nurses keep giving it and the opioid for pain
- Within several weeks after Valium started, sent out 2 times in a week for “behavior” and falls
- No one gets it and practitioners refuse to make changes, even after patient falls off the toilet and smashes her face and upper body
- Finally, forced to stop medications, and improves markedly
- NP adds ertapenem ($3-4000/10 doses) for bacteriuria despite sensitivity to amoxicillin/clavulanic acid ($2/tablet)

Knowing What You Don’t Know

- The most underused statement in health care today (also the most essential)
- "I don’t have any idea what I am doing or talking about, so I am going to stop right now."
Case #5

- 61 y.o. male (identified herein as “Mr. S.”)
- Admitted to a long-term care facility (identified herein as “The Facility”) in June 2015
- Admitting diagnoses

Same Diagnoses After Grouping

- Neurological
  - PARKINSON'S DISEASE
- Psychiatric
  - UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSICAL CONDITION
  - MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED
  - UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
  - ANXIETY DISORDER, UNSPECIFIED
  - BIPOLAR DISORDER, UNSPECIFIED
  - SCHIZOPHRENIA, UNSPECIFIED
- Functional
  - OTHER ABNORMALITIES OF GAIT AND MOBILITY
  - MUSCLE WEAKNESS (GENERALIZED
  - OTHER LACK OF COORDINATION
  - DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED
  - UNSPECIFIED LACK OF COORDINATION
  - UNSPECIFIED ABNORMALITIES OF GAIT AND MOBILITY
- Cardiovascular
  - ESSENTIAL (PRIMARY) HYPERTENSION
- Dermatological
  - UNSP MALIGNANT NEOPLASM OF SKIN OF UNSPECIFIED PART OF FACE

Initial Diagnostic Analysis

- Grouping the diagnoses reveals questions and concerns
  - 6 psychiatric diagnoses, of unclear origin
  - 6 “diagnoses” about function, duplicative and without any evidence of underlying causes
  - 1 major neurological disorder
  - Both the illness and the treatment can cause diverse symptoms and impairments
  - Several miscellaneous conditions

Mr. S.: Admission Medications

- EC ASA 81mg daily
- Azilect 1mg daily
- Sinemet 25mg/100mg tab - 2 tabs q am; 1 tab tid
- Omeprazole 20mg daily
- Seroquel 12.5mg qhs
- Xanax 0.25mg q 8 hours prn anxiety
- Ambien 5mg qhs prn insomnia
- Ibuprofen 400mg q 6 hours prn

Problems and Mistakes in This Case

- Care process failures
  - Communication and coordination of care
  - Quality, accuracy, and completeness of documentation
- Clinical reasoning
  - Excessive and erroneous regulatory preoccupation
  - Detective work
  - Evidence-based care
  - Cognitive biases
  - Cause identification / Diagnostic quality
    - Multiple symptoms and multiple causes
    - Medication-related adverse consequences
    - Patient / family appeasement

The Error “Cascade”

- Cognitive “biases” →
  - cognitive errors
  - diagnostic errors
  - inappropriate and problematic treatment
  - poor outcomes (patient harm + wasted resources)
Problems and Mistakes in This Case

- Clinical practice
- Practitioner failures
  - Attending physician, nurse practitioner, neurologist, psychiatric consultants, consultant pharmacist
- Watching things go wrong and keeping quiet
- Countless individuals exceeding scope of knowledge, skills, and license
- Oversight and accountability
  - Administrator, DON, department heads, medical director roles
  - No meaningful QAPI activity
- Poor risk management / repeated serious errors
  - Example: amitriptyline given to this patient for over a week before the dispensing pharmacy identified the contraindication in someone receiving Azilect and refused to dispense the medication

Uncoordinated Interdisciplinary Care

- A number of disciplines were involved in this patient’s care
- Probably there was some interdisciplinary discussion
  - However, no evidence of an intense group discussion or reconsideration of the goals, assumptions, conclusions, approaches, and decisions related to this patient
- Front line staff mostly deferred entirely to the decision making of facility mid-level practitioners
- No evidence of meaningful attending physician or consultant pharmacist discussions or role in the care

Everyone Doing Their Thing

- It takes very little time, and is free, to use the Internet to look things up
  - For example, mayoclinic.com, drugs.com, rxlist.om, etc.
- Diverse and recurrent or persistent symptoms such as headache, nasal congestion, hypotension, alterations in weight and appetite, and many significant behavior and psychiatric symptoms, could have been readily identified as due to his medications
  - Instead, got many additional medications and many irrelevant tests (such as urinalyses and ammonia levels), instead of dealing with the clinical evidence

The Forest and the Trees
IOM Report: 1986

- Quality of care and quality of life in many nursing homes not satisfactory
- Inadequate assessments
- Scarcity of applying geriatrics
- Psychotropic drugs
  - Overused, and for unclear indications
  - Used for too long and in too high doses
  - Inadequate monitoring of use
  - Many side effects, often not identified

Geriatrics

- "Much of geriatric care is, in effect, remedial. It addresses problems produced by the care of others, errors of both commission and omission. Were other medical practitioners to become more sensitized to the needs of their frail older patients, the need for geriatric care as a separate activity would decline."
  - How Effective is Geriatrics? - 1994

Geriatrics

- Biologically sound
- Humane, highly person-centered thinking
- Requires excellent detective work
- Tailor-made for long-term residents and postacute care patients
- Key principles
  - Focus on the few things that make a significant difference, avoid the "more is better" notion
  - Steer clear of trying to fix the unfixable
  - Don’t make things worse while trying to make them better
  - If you don’t know what you’re doing, don’t do it!

IOM Report and Geriatrics: 1986

- As of mid-1980s, now possible to treat or alleviate many conditions once accepted as inevitable part of aging
- Even in pleasant and humane facilities, proper care could improve function, reduce excess disability, and improve quality of life
- Geriatrics becoming established discipline
  - Physicians and nurses often not aware of advances in geriatrics
What Is “Authoritative”? What Is “Authoritative”? What is the “Practice of Medicine?”

Practice of Medicine: Definition

- Not defined in the OBRA Regulations
- American Federation of State Medical Boards
- Representing in any manner that one is authorized to practice medicine in the jurisdiction
- Offering or undertaking to prescribe, order, give or administer any drug or medicine
- Offering or undertaking to prevent or to diagnose, correct and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect or abnormal physical or mental condition of any person
- Offering or undertaking to perform any surgical operation upon any person
- Rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient
- Rendering treatment to a patient located outside the state as a result of transmission of individual patient data by electronic or other means
- Rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient

A Serious Responsibility

- Medical practice is a serious responsibility
- The quality of such practice has major implications
- Practitioners are expected to do the best possible job, while not causing harm

METHODS and Tools

Report Card - Back to Basics: 5 Key Elements

- Care based on sound principles and evidence
- That accommodates but does not focus primarily on regulations
- Delivered via a proper care process
- By properly qualified individuals who perform their functions and know their roles
- Guided by effective management, following basic management principles

Methods

- Crucial conversations
- Case reviews
- Detailed exploration of situations
- In-depth discussions of decision making and problem solving
- QA meetings
- Medical director rounds and visits
- Conversations with staff, management, and practitioners

Methods

- Crucial accountability
- Strategic plan detailing roles and responsibilities
- Education and training
- Extensive feedback about specific patient cases
- Modifying processes, practices, and performance
- Enlisting support of facility, regional, corporate clinical and operational leadership
- Detailed conversations with staff, management, and practitioners

Thinking Right Strategic Plan

1. Take a consistent, organized approach to improving care in all facilities
2. Use the strategic plan for the region, as the template for each Center
   - Determine roles, responsibilities, specific objectives, time frames
3. Appraise each Center’s clinical systems and processes
   - Use facility “report card” as a springboard for discussion
   - 75-90 minute discussion, involving all the key Center management and leadership, using the “report card” as a foundation
   - Identify areas of strength and those for improvement
   - Discuss their responses to managing patients, including how they have approached implementation of the falls care standard and opioid reduction initiatives
4. Develop a Center-specific strategic plan, based on the master plan
Thinking Right Strategic Plan

4. Review and strengthen facility approach to clinical meetings and patient discussions
   - Use the template for clinical discussions document as a guide

5. Strengthen facility approach to problem solving and quality assurance / performance improvement activities
   - Use the QA meeting discussion template form as a guide
   - Emphasize the meaningful use of data to guide improvement in processes and practices

6. Institute program of region-wide clinical education and training
   - Regular region-wide phone conferences on topics such as managing anticoagulation, diabetes, falls, behavior, pain, etc.
   - For both staff and practitioners

5. Clarify and strengthen roles of Operations in helping insure successful clinical activities

6. Improve facility approaches to coordinating with medical practitioners
   - Address issues of interpersonal relationships and conflict
   - Clarify roles and responsibilities
   - Preventive management approach to dealing with personnel issues

7. Utilize contents of the AHCA “Framework” document for specific approaches that facilities can implement to strengthen their systems and processes

Additional Specific Strategies

- Attain more effective pain management
  - Including restrained, rational opioid use
  - Improve the approach to managing behavior and psychiatric issues, including appropriate medication utilization
  - Improve prevention and management of falls
  - Improve clinical practices to be consistent with reliable evidence
  - Strictly restrict the inappropriate conclusions and recommendations of medical tests and treatments by those of all disciplines

- Improve the performance of attending physicians and other practitioners, regardless of degree or experience
- Improve the performance of medical directors
- Improve collaboration and coordination of care

Common Medication Examples: Categories

- Chasing adverse consequences
- Too much of a good thing
- Many multiple medications for the same thing
- The brake and the accelerator
- Chasing and more chasing
- The Neudexta caper
- The appetite stimulant escapade
- The falls fallacy

Smart case review to reduce polypharmacy and oversee Care
Key Data Sources
- Facility MARs (also, subset of opioids / psychopharmacological medications)
- Resident roster
- Resident diagnoses and orders
- Dashboard (age, admission date, vital signs, CAA triggers, care plan goals, diagnoses)
- Progress notes
- Care plans

Using Key Clinical Information
- How can we identify and use key information to simultaneously
  - Identify clinical and organizational QA and safety issues
  - Monitor care
  - Identify clinical issues
  - Look for complications
  - Assess quality of documentation
  - Identify rationale for interventions

Using Key Clinical Information
- Use key reports to identify clinical, organizational, QA, and safety issues
  - Identify care process problems
  - Assess preventability of outcomes
  - Identify safety issues and adverse events
  - Identify facility process and systems issues

Clinical Uses of Patient Data
- Monitor care
- Identify clinical concerns
- Look for complications / adverse events
- Assess quality and pertinence of rationale for interventions
  - Including pertinence of related documentation

QA/ Safety Uses of Patient Data
- Identify trends and patterns
- Identify care process issues
- Identify issues related to appropriateness of clinical decision making
  - Including those practicing outside of the scope of their capabilities and training

QA/ Safety Uses of Patient Data
- Assess preventability of outcomes
- Identify safety issues and adverse events
- Identify facility process and systems issues
- Identify individual responsibility for appropriate and inappropriate care and care-related decision making
The Great Value of Case Reviews

- How we learn to practice medicine
  - Topic-based approach
    - Deduction: drawing inferences about specific situations from general information or conclusions
  - Case-based approach
    - Induction: drawing general conclusions from multiple specific situations

Lessons for QAPI

- The same methods apply for the medical director’s role
  - Including QAPI and patient safety
- Assumptions made related to quality indicators and survey results must be validated by case reviews
  - Not uncommonly, validation does not occur
  - The results of case reviews are often astounding

Quality Measures

Lower Costs, Improved Measures

<table>
<thead>
<tr>
<th>Metric</th>
<th>Before QAPI</th>
<th>After QAPI</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission Rate</td>
<td>10%</td>
<td>5%</td>
<td>50%</td>
</tr>
<tr>
<td>Fall Rate</td>
<td>12%</td>
<td>6%</td>
<td>50%</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>5%</td>
<td>2%</td>
<td>60%</td>
</tr>
<tr>
<td>Medication Error</td>
<td>3%</td>
<td>1%</td>
<td>75%</td>
</tr>
</tbody>
</table>

QAPI Lessons From Case Reviews

- Whether care is coordinated, integrated, sensible, patient-centered, effective, efficient, timely, and safe
- Whether the staff and practitioners know what they are doing
- Whether overall approach to the resident / patient makes sense
- Whether care plans are relevant
QAPI Lessons From Case Reviews

- Whether nutrition interventions and goals are pertinent
- Whether causes of symptoms and conditions are identified, understood, and being addressed effectively
- Whether diagnoses are correct, pertinent, and validated
- Whether medications are pertinent
- Whether treatments (including medications) are causing complications

QAPI Is a Contact Sport

Real QAPI is Not a Casual Endeavor

Follow-ups to Case Reviews

- Ask lots of questions
- Challenge conclusions
- Expect clinically pertinent rationale, not just "because I said so" or "we used our judgment"
- Talk to staff and practitioners
- Revamp clinical systems, processes, and practices
- Provide valid clinical information

Follow-Ups to Case Reviews

- Facilitate improved accountability
- Focus on clinical meetings and resident / patient discussions and documentation
- Revamp care planning
  - Remove "canned" care plan goals
- Revisit palliative, hospice, and end-of-life decision making, documentation, and order writing

Summary

- Management and clinical approach
- Multiple states, for-profit, non-profit, over many years
- Realization
  - Nursing homes are social institutions where relationships, personal control, and interpersonal issues often overpower clinical competence
  - Delusions are common...and the patients sometimes, too
- Medical direction
  - Medical director as coach, mentor, problem solver, and standard bearer of clinical and operational problem solving
- Medical care
  - Standard bearer for knowing and showing
"Tell Me What You Really Think"

Why We Must Do Better

TWO WRONGS DON'T MAKE A RIGHT, BUT THEY MAKE A GOOD EXCUSE.

Thomas Sorensen
President, Forrester