

# UNMC College of Public Health ECHO

July 14, 2021

**AHRQ ECHO National Nursing  
Home COVID-19 Action Network**



# Welcome and Announcements

Kristi Sanger

**AHRQ ECHO National Nursing  
Home COVID-19 Action Network**



# Announcements

- Please type your ***name, email, and facility name*** in the chat box for us and ECHO Institute to capture your attendance – **this is for training center accountability**
- Please type your questions in the chat box, and they will be addressed during the situation discussion and/or the Q&A
- The materials from the sessions are available for you to download from our website
- The recording of the sessions, which are required by AHRQ and ECHO Institute, are available only for special circumstances and a request must be made to Krista Brown
- Throughout the week, if you have questions, concerns, or issues to raise, please send Krista an email at [Krista.Brown@unmc.edu](mailto:Krista.Brown@unmc.edu)
- **Today we are starting the next module of “*Addressing and Supporting Needs of Residents, Families, and Care Partners*”**

# Week 12 Agenda

Time	Subject	Speaker/Facilitator
1200 - 1205	Welcome and Announcements	Kristi Sanger
1205 - 1215	COVID-19 Update	Kristi Sanger
1220 - 1300	Addressing & Supporting Needs of Residents, Families, and Care Partners	Peg Bradke
1300 - 1330	Optional Q&A, Discussion, and Coaching	Public Health Core Team

# Core Domains

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# Content – Core Domains

“What do Nursing Homes need to implement systems that help prevent, manage, and improve COVID-19 outcomes?”

1. Post-vaccination practices – visitation policies, PPE practices ✓
2. Ongoing COVID-19 identification and treatment – plan for recognizing patients with COVID, post-COVID syndromes, testing, treatment, and cohorting
3. Emotional and organizational support for staff ✓
4. Vaccinations – vaccine confidence, testing, logistics, ongoing compliance and complications
5. **Addressing and supporting the needs of resident and families or care partners – isolation, family communications** ✓
6. Stopping the spread (infection control) – building sustainable infection control practices
7. Leadership communication for COVID-19 – huddles, rounding, etc. ✓
8. Leadership practices and behaviors to support teams during COVID-19 – teamwork, roles, and psychological safety ✓

# Current State of the Pandemic

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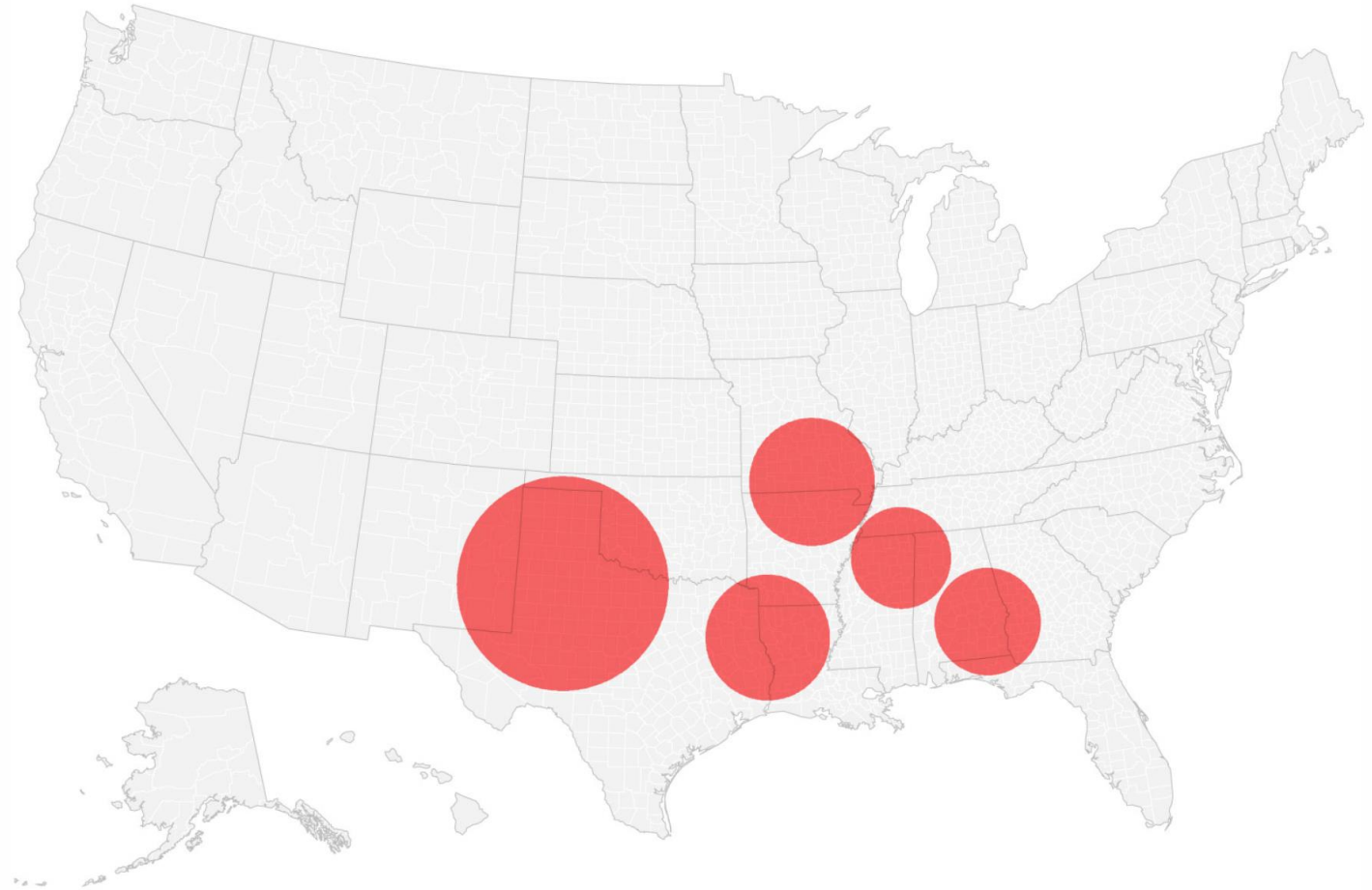
# COVID-19 Update – US

- Pfizer, BioNTech seek authorization for COVID-19 booster shot as Delta variant spreads:
  - Request for approval for 3<sup>rd</sup> shot from FDA
  - Per FDA and CDC, the two-shot regimen is sufficient for now
  - Some erosion of vaccine's efficacy over time has been observed
  - <https://www.reuters.com/business/healthcare-pharmaceuticals/pfizer-ask-fda-authorize-booster-dose-covid-vaccine-delta-variant-spreads-2021-07-08/>



# COVID-19 Update – US

- Clusters of unvaccinated people in the United States
- Georgetown University found 30 clusters of counties that have lower than average vaccination rates, leaving them vulnerable to outbreaks and making them potential breeding grounds for new variants
- <https://www.cnn.com/2021/07/08/health/undervaccinated-clusters-covid-risk/index.html>



Note: Data as of June 28

Source: Covid-19 vaccination analysis by Andrew Tiu, Alexes Merritt, Zack Susswein and Shweta Bansal at Georgetown University

Graphic: Renée Rigdon and Sean O'Key, CNN

# COVID-19 Update – Johnson & Johnson Vaccine

- On July 12, the Food and Drug Administration announced it is adding a warning label to the Johnson & Johnson COVID-19 vaccine, noting increased risk of Guillain-Barré syndrome
- About 100 reports of Guillain-Barré syndrome have been detected in the Vaccine Adverse Event Reporting System, out of 12.8 million administered doses of the Johnson & Johnson vaccine. GBS is a rare condition, and the risk of contracting it due to the J&J vaccine is very low
- The risk of severe adverse events after any COVID-19 vaccination remains very low, and far lower than adverse health outcomes associated with contracting COVID-19
- Data do not show any increased risk of GBS for the Pfizer or Moderna vaccines
- In the U.S., nearly all COVID-19 hospitalizations and deaths are now occurring in unvaccinated people. The CDC recommends that everyone age 12 years and older receive a COVID-19 vaccine

New Messaging Guidance: Johnson & Johnson Vaccine: <https://publichealthcollaborative.org/faq/#Johnson-Johnsonvaccine>

# Follow up ---- Huddles/Rounds

- How are Huddles/Rounds going? Did you change anything or implement anything new from the last Leadership module information?
- Have you tried anything that others could benefit from?

# COVID-19 Supporting the Psychosocial Wellbeing of Residents, Families, and Care Partners

## Supporting Resilience with Strengths Based Person-Centered Care

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# Supporting the Psychosocial Wellbeing of Residents, Families, and Care Partners

## 5 Critical Change Opportunities

- **Emphasize person-centered care as the foundation to discover what is important to residents and families.**
- Integrate trauma screening to identify post-traumatic stress and triggers in order to minimize retraumatizing residents.
- Engage staff in strategies to respond to expressions of distress by identifying feelings and needs with the language of Nonviolent Communication (NVC).
- Support person-centered care by enhancing staff capacity and comfort to be present with grief.
- Support residents' needs for connection, to matter, and to be understood by building resource enhancement grounded in person-centered care into daily interactions.

# Waterfall Question

- *What are three key attributes that you would use to describe person-centeredness?*

# Person Centered Care (F675)

“...focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.”

- Emphasis on self-worth, self-esteem
- Resident as the decision-maker
- Staff supports the resident to make choices
- Staff make effort to understand what the resident is communicating verbally and nonverbally
- Staff help the resident identify what is important regarding daily routines and activities
- Sense of satisfaction with oneself, the environment, care received, accomplishments of desired goals and control over one's life
- Staff has understanding of resident's life before coming to the nursing home

# “The Medical Model and Person-Centered Care: A Blended Approach”

- **CMS quality measures include:** rehospitalizations, antipsychotics, pressure ulcers, falls, functional abilities, catheters, incontinence, weight, depression, antibiotic stewardship and restraints.
- From a regulatory perspective, CMS addresses both quality of care and quality of life, **but only the measurable quality of care metrics contribute to reimbursement.**

By Paige Hector, LMSW and Nina Flanagan, PhD, GNP-BC, APMH-BC  
[https://www.caringfortheages.com/article/S1526-4114\(20\)30142-6/fulltext#%20](https://www.caringfortheages.com/article/S1526-4114(20)30142-6/fulltext#%20)



# Just because we ask these questions...

- What to wear?
- Bath or shower? Morning or night?
- What to eat?
- Favorite music, TV shows, activities, and reading material?
- Who to be involved in discussion about care?
- Desire to go outside in nice weather?
- Use a phone in private?

Doesn't make Person-Centered Care “come alive!”

# A Person-Centered Care Plan

- “...anyone should be able to read it without seeing the resident’s name and recognize whose plan it is...”
- Does NOT define people by their disabilities or “problems”
- Helps identify how people’s abilities can support them in ensuring quality of care and quality of life

Person-Centered Care: Are We Really Doing It? By Joan Devine,  
[https://www.caringfortheages.com/article/S1526-4114\(19\)30186-6/fulltext?rss=yes](https://www.caringfortheages.com/article/S1526-4114(19)30186-6/fulltext?rss=yes)

# How can we honor person-centered care for medical diagnoses or areas of concern?

## Who Is THIS Person?

- Consider your screening and assessment tools or forms - do they included these types of questions?
  - Who is *this* person, not the disease?
  - What is most important?
  - What are their values and beliefs?
  - What helps support their comfort? Brings sadness? Joy?
- Involve Families and Care Partners to complete the story

# Identify Strengths through your questions

- What do you consider your strengths?
- What makes a good day for you?
- What are the things you do each day or each week because you really prefer or choose, not because you must?
- What do you do well? What kinds of things did you previously do well?
- What has made you proud?
- What helps you feel good about yourself and helps you feel good about things?

# More Strengths-Based Questions

- Describe a time when you lived through a period of difficulty/uncertainty? What did you do to get through it?
- Have you had to get creative to make do or make something happen? What did it look like?
- Is there anyone you're appreciating more than you did before the crisis?

Source: National Conversation Project

# Strengths Approach - ability to cope with challenges

- Optimistic outlook
- Verbalizes desire to get stronger
- Eats independently
- Strong support network
- Smiles
- Good hand/eye coordination
- Values creativity
- Has overcome crisis in the past
- Responds to touch
- Has hobbies that provide comfort
- Good vision
- Participates in decision-making
- Makes needs known
- Ambulatory

# Celebrate Resilience with Stories

People are natural storytellers and stories are powerful









Share their stories (for those who wish to do so and with proper consent)

- Post them on facility social media sites and website
- Consider a volunteer coming in, interviewing and writing up the resident's history
- Use it in one of your resident activities
- Invite people to read their stories (1-2 per day)
- Make plays, skits, monologues that they can act out
- Get local theatre groups involved!

What is most important to you today?

What is most important to you at this moment?



Patient Name: Please Call Me: One Thing You Should Know About Me:  The Most Important Thing To Me During My Hospital Stay:	Today's Date: Anticipated Discharge Date: Plan and Goals For The Day: 
Health Care Team:  Nurse: Tech: Doctors:  Therapists:	Test - Treatments - Procedures: 
Diet: 	Pain Management Goal: <small>Our Goal is to ALWAYS help control your pain!</small> 
Activity: 	My Pain Goal: <input type="checkbox"/> My Last Pain Medication: <input type="text"/>
Safety Alerts/ Special Needs: 	Family - Patient Comments: 
	Key Contact Person:

# Whiteboards

## What Matters .....

# Example of a care plan goal focused on strengths

- Resident will maintain control in reporting issues with his computer so he may continue to effectively communicate via internet, email, etc. throughout the quarter.

# Imagine a new CNA, nurse, social worker or temporary agency team member ...

- Is there “just in time signage to alert them to what matters to the resident?”
- Would the care plan be helpful?
- Would staff know what to do?
- Does the care plan instill warmth or negativity?

# There Are ONLY Resident Goals

- NO social work goals, activity goals, nursing goals, dietary goals, therapy goals
- When the goal is accomplished, the resident's quality of LIFE will be improved

Davis E, Greenwald S, Pareti T. *The New Care Plan Answer Book for Activity, Psychosocial and Social Work Programs*. Glenview, IL: SocialWork Consultation Group Publishing; 2011.

# Goals for Person-Centered Trauma-Informed Care

- **Increase comfort** (mental, emotional, spiritual, physical)
- **Minimize suffering**, reduce distress
- Instead of stopping an action or decreasing episodes, *specify what the resident is supposed to do instead*
  - Instead of “Yelling out will decrease to [ x ]”, a person-centered goal would focus on what the resident would be doing instead of yelling out, e.g., speaking calmly, engaging with staff, etc.

# Examples of Goals that reflect the 6 principles of TIC

- Resident will express comfort to talk about trauma symptoms, triggers and feelings
- Resident will participate in decision-making that supports wellbeing
- Resident will identify and minimize triggers by engaging in self-regulation strategies
- Resident will share with staff if/when the environment is experienced as flexible, healing and nurturing...
- Resident will share when he/she has needed information to inform decision making
- Resident will engage in discussion about boundaries that are important to him/her

# Approaches / Interventions

- What *staff will do* to help the resident meet the goal
- Action verbs
  - Engage
  - Ask
  - Suggest
  - Inform
  - Show
  - Indicate
  - Help
  - State

Davis E, Greenwald S, Pareti T. *The New Care Plan Answer Book for Activity, Psychosocial and Social Work Programs*. Glenview, IL: SocialWork Consultation Group Publishing; 2011.

# Interventions for Safety

- Use non-verbal communication to project calm, e.g., relaxed body stance focused on the person in a way that demonstrates connection/interest, slowed speech, lowered volume of voice
- Validate responses with statements such as “I hear you”, “Thank you for sharing this with me”, and “I’m wondering if [ *fill in* ]”
- Avoid arguing, disagreeing, or trying to ‘fix’ things. Instead, ask, “Can you share with me what is happening right now?” or “*Are you feeling...?*” (rather than staff “labeling” their perceptions such as “You seem anxious...”)
- Support and validate resident experience with statements such as “You’re safe” and “I’m here with you.”



# Interventions for the All TIC Principles

- Safety
- Trust and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice, and Choice
- Cultural, Historical, and Gender Issues

*Refer to the handout in Higher Logic titled “Person-Centered and Trauma-Informed Care Plan Ideas” for an extensive list of ideas.*

# COVID-19 Supporting the Psychosocial Wellbeing of Residents, Families, and Care Partners

Emphasize person-centered care as the foundation to discover what is important to residents and families.

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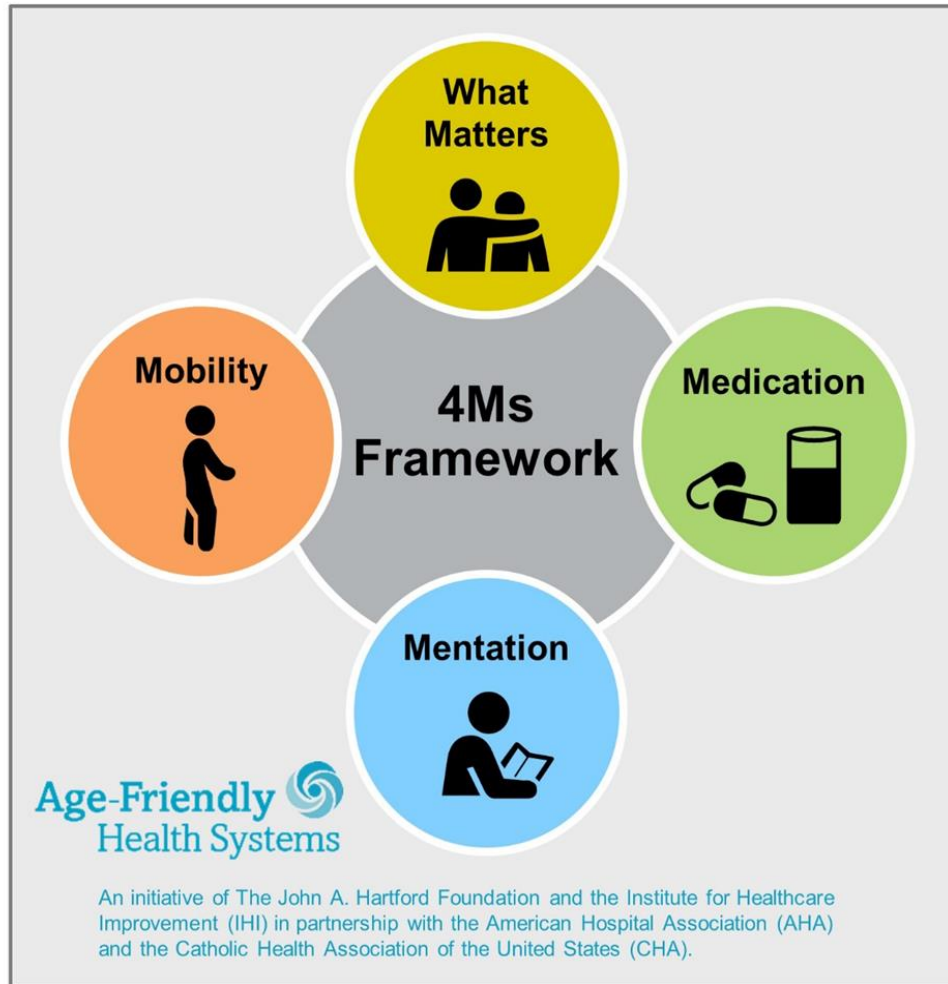
# Why Person-Centered Care Matters

“The bigger question I found myself asking was, **“What really matters to my loved one?”** For my dad, most of the things we think are important for patient satisfaction were meaningless to him.

**What did matter was people listening to my dad’s physical and emotional needs and then doing something about it.** This could be the geriatrics nurse who ordered a personal sound amplifier, so my father could hear people without them yelling...A reassuring grasp of his hand with a pause for acknowledgment meant more than an extra 10 minutes of the physician’s time.

Zider A. Start With All the Little Things. *JAMA*. 2021;325(15):1509–1510. doi:10.1001/jama.2021.4885

# One Application of Person-Centered Framework: Age Friendly Health Systems



For related work, this graphic may be used in its entirety without requesting permission.  
Graphic files and guidance at [ihi.org/AgeFriendly](http://ihi.org/AgeFriendly)

## 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

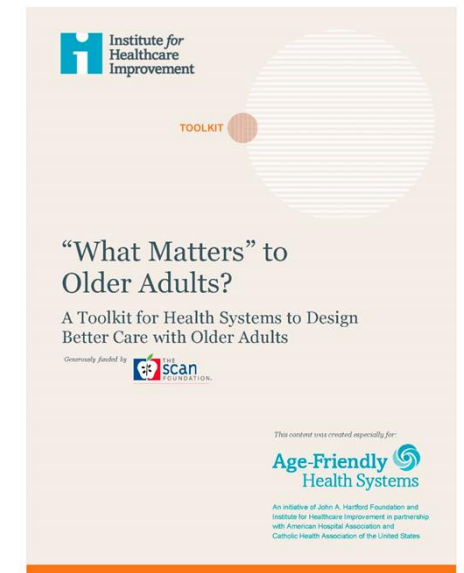
Ensure that older adults move safely every day in order to maintain function and do What Matters.

# Why Ask and Take Action on What Matters?

- For older adults:
  - There is variation in What Matters most (it will include more than just “end of life” issues!)
  - Avoid unwanted care (value-driven) and honor who they are (in *their* words)
  - Acknowledging and acting on care preferences enhances engagement and quality of life by providing value
- For everyone (residents, care partners, clinicians):
  - Everyone is on the same page. It’s an opportunity to walk in each other’s shoes and break down silos
  - Improved relationships and efficiency between residents, staff, and families

# Sample Questions to Get to Know a Person and What's Important (to Them):

- What is important to you today?
- Share with me what makes a good day.
- What brings you joy? What makes life worth living?
- What do you worry about?
- What are goals you hope to achieve in the next six months, one year?
- What do we need to know about you to take better care of you?
- What else would you like us to know about you?



# Tips to Integrate Person-Centered Principles into Existing Improvement Processes

- Who has the primary responsibility for asking these questions? Is it just one person or department or is it a shared responsibility?
  - Specific questions should be specified, not just focusing on end of life
  - How do you include family/caregivers
- What is the frequency of asking the questions?
- Where is it documented and how is it communicated/shared?
  - Describe how you include in care conferences/huddles/EMR.
- Act on aligning Care Plan with “what matters most”

# Tips to Integrate Person-Centered Principles into a PDSA

- Go and “see” (shadow, observe) to objectively experience
  - Can we conduct the 4M’s What Matters intake for one resident?
  - How long does it take?
  - How does it feel for staff conducting the assessment. (What went well; what could be improved)
  - Know if What Matters to residents drives decision making
    - If not, why?
  - What goes well for the resident? Where are the opportunities to improve (through the residents’ eyes)?





# Leave in Action

- Test asking ‘What matters’ question(s) from the list provided on slide 28 (or your own version) on 2-3 residents during the next week.
- What feelings, and needs of residents and families did you discover?

# Wrap up

- What questions would you want me to ask you to learn about what's important in your life? What brings you joy?
- Final comments or questions?
- Any topics you would like the faculty to discuss next week?
- We would like to learn from you! Please share your ideas for tests of change, success stories, challenges and innovations by emailing us.

# Slide Resources

By Paige Hector, LMSW and Nina Flanagan, PhD, GNP-BC, APMH-BC

[https://www.caringfortheages.com/article/S1526-4114\(20\)30142-6/fulltext#%20](https://www.caringfortheages.com/article/S1526-4114(20)30142-6/fulltext#%20)

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# Vaccine Resources

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Five undervaccinated clusters put the entire United States at risk: <https://www.cnn.com/2021/07/08/health/undervaccinated-clusters-covid-risk/index.html>

Q&A: Answers to Tough Questions About Public Health: COVID:19: <https://publichealthcollaborative.org/faq/>

# Thank you!

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