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LONG TERM CARE INSTITUTE REVIEW is a theory development journal for scholars of long term care and related disciplines. Long Term Care Institute Review publishes articles that make theoretical contributions in papers devoted to theory development, foundations of long term care, theory building methods, and integrative reviews of the literature.

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Editorial

This volume is a series of papers that focuses on the challenges long term care providers face and the best practices for meeting those challenges.

The overarching goal of long term care organizations is to provide quality care for residents. Innovative advances in our clinical practices are undoubtedly necessary to improve care. Here in lies the first challenge addressed in this volume. Most long term care providers lack a clear, standardized process for medical staff credentialing, orientation, and monitoring. The first paper proposes new process improvement strategies to effectively address this medical staff misalignment. As this paper shows, better processes have an immediate impact on clinical and financial outcomes.

The success of a long term care facility lies in the quality of its frontline staff. Unfortunately, with all of the other demands, the education of staff is often neglected. This presents the second challenge addressed in this volume. While its universally accepted that education creates better employees, it can be expensive and difficult to coordinate. This paper presents an implementation plan that can be utilized by any organization and shows the benefits of transforming the culture into a learning organization.

While it’s expected that clinical needs are addressed, often missing from the long term care environment is attention to the spiritual needs of residents, families, and employees. To tackle this challenge, an in-house Chaplain can help promote best outcomes, prevention and holistic wellness. This paper discusses the need for a Chaplain program and provides benefits that go well beyond “feeling good.”

Since the beginning of time, music has played a significant role in the healing of people, yet many long term providers do not have an established music therapy program. Research has shown that music
can be used to decrease agitation, anxiety, wandering, and reduce the likelihood that future behavioral outbursts occur in residents diagnosed with Dementia and Alzheimer’s disease. This paper discusses how music can be used as a nonpharmacological alternative to interventions related to behavioral outbursts and concerns.

Thank you for choosing this publication. In our attempt to revolutionize the long term care industry, it is essential that we maintain a medium where practitioners and scholars can share information, develop workable theories, and educate one another. This journal provides that avenue; however, only with your involvement can we move the industry to where it needs to be – to better serve our residents, their families, and the people who have dedicated their life to working in this field.

David Kahn, Ph.D.
Editor- in-Chief
Institute for Long Term Care Advancement, Inc.
MEDICAL STAFF MISALIGNMENT: THREE PROCESS IMPROVEMENT STRATEGIES FOR THE PRESCRIBING PEN

Christine J. Gerace Johnson, MPA, NHA, PA-C

INTRODUCTION

Skilled Nursing Facilities (SNFs) and their residents are often negatively impacted by the medical providers who attend to their residents. This occurs because many medical practitioners:

- Provide on-site medical visits only periodically
- Document inadequately and/or inappropriately in the medical record
- Order unnecessary and/or inappropriate medications and diagnostic studies.

Each of these often overlooked problems result in poor outcomes for both the resident and the skilled nursing facility.

Medical providers servicing SNFs are largely unaware of the negative consequences caused by the low frequency of on-site visits, their medical documentation (or lack thereof) and their order-writing habits. In fact, the formal education of most medical providers includes no orientation in SNF-medicine. Most medical providers are unaware of the ramifications of their decisions for both their patients and the facility. In addition, they do not know how or where to gain this niche expertise.
Every SNF in the United States is required to have state-licensed physicians attend to their residents. These physicians may be either a medical doctor (MD) or a doctor of osteopathy (DO). Physicians who attend to SNF residents often utilize non-physician practitioners (NPPs).

A non-physician practitioner can be either a physician assistant (PA) or an advanced practice nurse (APN). Each of these four types of medical provider attends to SNF residents, records medical documentation, and initiates orders which impact both the resident and the SNF.

The dominant medical model in the United States is one in which medical care is provided through out-patient offices and hospital visits. Care for SNF residents, however, is provided from their office base. They manage residents via telephone and faxed messages from the SNF nurses. Physicians are required by federal statute to visit SNF residents upon admission and at least monthly during the first ninety days of admission, then every sixty days thereafter. These federally required visits may be alternated with a PA or APN.

Unfortunately some physicians erroneously believe that this minimum requirement represents a visit threshold over which they will be audited by Medicare. In 2001, the American Medical Director’s Association (AMDA) published a white paper on medically necessary visits in nursing facilities to address this problem.

This research describes the many types of medically necessary visits which occur in SNFs every day. It endorses the concept that residents receiving skilled nursing and/or rehab may, by reason of medical necessity, require being visited by their medical provider on a weekly basis. It supports long term care residents being visited at least monthly.

Since the publication of this paper and due to the increased acuity and complexity of SNF residents, many medical providers visit at more frequent intervals than the minimum federal government requirement.
A SNF resident’s primary payer source for medical care is Medicare Part B. Unfortunately, Medicare Part B’s site of service with the lowest reimbursement per visit is a nursing facility. In fact, the Medicare Part B program pays medical providers more per visit type when they provide out-patient services in their offices and when they attend daily to hospitalized patients than when they attend on-site to SNF residents.

These economic realities result in some physicians having SNFs bring residents to their out-patient offices for their required visits or the resident is sent to the emergency room (ER) to be managed. There are at least three negative consequences resulting from the Medicare Part B Program’s misaligned incentives:

1. Inconvenience and risk for the resident
2. Additional transportation expense and risk to the facility
3. De facto rationing of medical services for SNF residents

A major limitation in dealing with these problems is that medical providers are commonly not employees of the SNF and thus directly report to no one at the facility. Most medical practitioners provide SNF services as independent contractors who bill the resident’s health insurance (primarily Medicare Part B) for their visits.

Residents are negatively affected by the consequences of poly-pharmacy and unnecessary trips to the emergency room/hospital, while the SNF is exposed to increased regulatory scrutiny; risk of litigation; and the burden of directly paying for inappropriate, unnecessary, expensive medications due to current Medicare Part A and Medicare Part D program requirements.

The objective of this paper is to endorse three orientation and management process improvement strategies to effectively address the problem of medical staff misalignment. It will describe how SNFs and their residents will benefit when the SNF:
• Creates and manages a Drug Formulary
• Implements and manages a Medicare Part D Management Model
• Creates problem-specific “Change in Condition” documentation tools for nursing to communicate with medical providers

PROBLEM STATEMENT

The main problem which results in medical staff misalignment is a lack of SNF processes to adequately credential, orient, monitor and manage their medical providers. Since most SNFs have no medical staff credentialing process, any physician who wants to attend may attend. Any PA or APN working under the supervision of or in collaboration with an attending physician may also care for residents.

Even though many providers are inadequately oriented and trained in alignment with current evidence-based medical care recommendations regarding SNF patients, they continue to attend to residents and rely on their out-patient and hospital experiences to guide their SNF documentation and orders. The lack of awareness towards issues unique to SNFs and their residents and the lack of continuing education opportunities result in:

• Residents being seen on-site only periodically
• Inadequate and inappropriate medical documentation
• Unnecessary and inappropriate medical orders
• Poor outcomes for both the resident and the SNF

Just look at the medical notes in almost any SNF chart. For some physicians, can they even be read?
The solution to the problem is the development of strategies to accomplish aligned and effective medical staff orientation, continuing SNF-medicine education and better daily communication from nursing.

Since nursing home or SNF-medicine is not a significant part of any primary medical education program, nursing home medical care is commonly first encountered by a medical provider who is already in practice and is either asked to or seeks to attend to SNF residents. Few providers are aware of the regulatory, risk and economic concerns of the nursing facility where they provide services. Additionally, few SNF administrators know what to do about this problem.

Some administrators and nursing directors have attempted to educate their medical staff by first educating the facility’s medical director. They have reimbursed their medical directors when they have joined AMDA or have taken it a step further by reimbursing their medical director’s expenses to become an AMDA certified medical director (CMD).

A common challenge has been the reluctance of some well informed SNF medical directors to work effectively with other attending physicians due in part to concerns about local “medical politics”. Administrators have too often been told by their medical directors that they will not challenge another attending physician’s decisions too emphatically because they “still have to live and work in this community”.

Another challenge is that it remains the right of residents and their families to not change medical providers even when presented with medical care concerns. Often a resident won’t change providers because they have utilized that physician for many years while residing in the community.

An additional challenge is in rural SNFs where medical providers willing to attend at SNFs are scarce and effectively training or replacing them is not an easily accomplished option.
Ultimately, medical staff misalignment manifests itself in three measurable ways:

**Measurement 1: The SNF’s Medicare Part A Medication Cost**
Since most nursing facilities do not have a drug formulary, medical providers feel comfortable prescribing any medication they want in the SNF setting. They may receive some recommendations (which they may or may not consider) from the facility’s consulting pharmacist, but there is often little guidance regarding current, evidence-based medical care and appropriate therapeutic interchanges which would be both efficacious and a more cost-effective option for the SNF.

**Measurement 2: The SNF’s Medicare Part D Cost**
These costs are incurred when prior authorization is not effectively managed for the long term care residents. When a medical provider does not complete the prior authorization form in a complete and timely manner, the pharmacy is permitted to bill the facility for the medications dispensed to their long term care residents. Since the prescribing clinician is not adversely impacted by their lack of timely attention and they are largely unaware that the facility bears this expense, there exists no incentive for them to be compliant.

**Measurement 3: The Quality of Nursing-Medical Communication**
Since this communication mostly occurs by phone or fax, it is often the reason certain inappropriate and unnecessary tests and treatments are prescribed or residents are inappropriately sent to the emergency room (ER). When a Medicare Part A resident is unnecessarily re-hospitalized, the facility loses their daily payment rate times the number of days the resident is in the hospital. This is an expensive problem for SNFs. If a SNF’s daily Medicare Part A rate is $500 per day and a resident is out of the facility unnecessarily for several days, the losses add up for the facility.
SOLUTION

Three process improvement strategies are a starting point to effectively address the problem of medical staff misalignment.

**Strategy 1**
The SNF needs to create and manage a written Drug Formulary. Creating a formulary begins with the process of clarifying the reasons to create it; then gaining the support of the facility’s medical director and all attending medical staff. The reasons for implementing a formulary fall into several categories including clinical, regulatory, risk management and financial. Having the medical director engaged and aligned in the drug selection criteria is essential to establishing an effective formulary.

As the leader of medical care in the facility, the medical director sets the example for all other providers attending to SNF residents. It is also essential that the medical director be involved in the orientation of the medical staff and in assuring ongoing education and compliance.

If the medical director does not communicate the standards and expectations, it is unlikely that other attending providers will embrace them and be in compliance. Once this is accomplished, the nursing staff must be involved during each shift each day to effectively implement the formulary.

To develop and manage the formulary most effectively, a strong team needs to be selected. In addition to the Medical Director, this would include:

- Experienced SNF PA or APN who would bring real world medical practice considerations to the team.
- Director of Nursing who would represent clinical logistical concerns.
- Consultant Pharmacist who would be the drug expert especially related to appropriate therapeutic interchanges.
- Administrator or Business Office Manager who represents the business of medicine perspective for the SNF.

This Formulary Team needs to review and consider such documents as:

- The SNFs current LTC pharmacy agreement
- Monthly pharmacy invoices
- The Beers Criteria
- F-329
- Current evidence-based medical articles regarding acute and chronic disease management in elderly SNF residents

The formulary should include the brand and generic names of the drug and a brief description regarding why the drug is included or excluded. The document may be set up alphabetically by drug or drug class. Once complete, it should be copied to all nursing and medical staff at the time of their initial training. It is advisable that it be laminated and posted in each nursing station.

TABLE 1. Drug Formulary Example: Statin Drugs to be Avoided

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pravachol</td>
<td>Pravastatin</td>
<td>Simvastatin is available generically.</td>
</tr>
<tr>
<td>Lescol</td>
<td>Fluvastatin</td>
<td>Crestor - Best $ value; ↑’s HDL; ↓’s LDL &amp; Trigs</td>
</tr>
<tr>
<td>Mevacor</td>
<td>Lovastatin</td>
<td>Consider D/Cing any statin if Prognosis &lt; 2 years</td>
</tr>
</tbody>
</table>
Strategy 2
The SNF needs to implement a Medicare Part D Management Model. Once again, select the best possible team. This would also include:

- Medical Director
- Experienced SNF PA or APN
- Director of Nursing
- Consultant Pharmacist
- Long Term Care Pharmacy Liaison/Manager
- Administrator or Business Office Manager

The Medicare Part D Management Team needs to review and consider such documents as:

- Current pharmacy agreement
- Monthly pharmacy invoices
- Prescription Drug Plans (PDPs) of long term care residents

The team should create a process to assure that any drugs requiring prior authorization are immediately identified and that the appropriate forms are completed by the prescriber in a timely manner.

Strategy 3
Create problem-specific “Change in Condition” documentation tools for nursing. Like the previous two strategies, this begins with the selection of a team that includes:

- Medical Director
- Experienced SNF PA or APN
- Director of Nursing
- MDS Coordinator
- Consultant Pharmacist
This Change in Condition Team needs to review and consider at least the following documents:

- Current change in condition policies and procedures
- Any change in condition forms in use to communicate with medical providers via fax
- List of most common changes in condition that occur

This team needs to identify the most common changes in condition and the most important data to be communicated by nursing to the medical provider. For example, the data to best care for a resident who has shortness of breathe differs from the data considered to be important to best manage a patient with knee pain. There is, however, a certain minimum data set which should be gathered regardless of the symptoms of change. This includes current vital signs, active co-morbidities, current medications, recent laboratory results and allergies.

One example of a current practice used to measure the effectiveness of medical staff realignment efforts is Signature HealthCARE, LLC’s (SHC’s) use of monthly “Data Points”.

Data Points are measurable items related to both care and cost. For example, the percentage of residents in a SNF on 9+ medications each month is a measurable data point. The SNF’s Medicare Part A pharmacy cost per patient per day is a data point. SHC has identified over twenty-five medical and clinical data points. These items are captured each month and provided to the SNF’s medical director and house staff NP/PA (if applicable).

The medical providers utilize their monthly data points to assess morbidity and work together to become better aligned with the SHC formulary and current, evidence-based medical care.
BENEFITS

With MDS 3.0 rapidly approaching, there has never been a more serious need on the part of the SNF to take immediate action to better align its medical staff in achieving the best clinical and economic outcomes. There are three main benefits of creating and managing a Drug Formulary.

Benefit 1: Clinical
A good formulary will exclude inappropriate and unnecessary drugs still commonly prescribed to the elderly population. It will draw attention to medications that were not intended to be used indefinitely and encourage stop dates to better manage these issues. This will result in more improved, evidence-based medical care, improved regulatory compliance and decreased risk of litigation related to medication errors and adverse drug effects.

Benefit 2: Economical
Currently SNFs pay for countless inappropriate and unnecessary medications prescribed for their skilled Medicare Part A residents.

An improved Medicare Part D management Model results in a huge cost savings to the facility. When a medical provider does not complete the prior authorization forms in an appropriate and timely manner, the pharmacy is permitted to bill the facility for the medications dispensed to their long term care residents. Creating, implementing and managing a Medicare Part D Prior Authorization Model will save the facility hundreds if not thousands of dollars each month in unnecessary charges from their long term care pharmacy.

Benefit 3: Communication
When nursing documentation tools are improved through the creation of such tools as a problem-specific “Change in Condition” forms, the quality of nursing documentation and communication via fax or e-mail
exchange between nursing and the medical provider is greatly improved.

In addition, a common customer service complaint by medical providers is the quality of information they receive from nursing when a patient’s condition changes. This contributes to frustration in dealing with the SNF. To make the best decision, the medical provider often needs trended information with dates regarding vital signs and laboratory studies. Knowing their current co-morbidities and medications is also essential. Having problem-specific nursing documentation tools which are completed before the medical provider is contacted results in more appropriate medical orders and outcomes.

**IMPLEMENTATION**

To develop and implement a Drug Formulary, Medicare Part D Management Process, and Change in Condition Nursing Documentation Tool, Signature HealthCARE, LLC, involved their Chief Medical Officer (CMO) and Chief Nursing Officer, their Pharmacy Representative, and the COO from Integritas Professional Development Services who is a Physician Assistant. An exhaustive review of current evidenced-based medicine articles regarding the care of SNF residents was begun by Signature’s CMO and Integritas’ COO.

The criteria developed by the late Dr. Mark H. Beers was utilized to define the potentially unnecessary and inappropriate medications Signature desired to exclude from their formulary. Dr. Beers was a scientist and geriatrician who, among other roles, was past editor-in-chief of The Merck Manuals. The team reviewed the guidance information provided to state surveyors in particular the thirty plus page table of drugs listed for F Tag 329.

In the end, this information was distilled into an 8.5 x 11 sized, double-sided, laminated “Formulary” document which is now updated
annually. The formulary is provided to all prescribing practitioners and is available on each nursing unit’s medication carts.

A Formulary Facilitation Nurse (FFN) was identified in each SNF. The FFNs are registered nurses working in clinical administration at the facility. Their role is to monitor and manage the new Formulary and the Medicare Part D prior authorization process to assure compliance.

Signature initially developed and implemented Change in Condition documentation tools for the following common changes: Fall, Fever, Depression, Delirium, Diabetes, Edema, Pain, Pressure Ulcers, Respiratory, Urinary and Weight Loss. These common problems were chosen based on the facility’s quality indicators.

It is not difficult for SNFs to create and implement a Drug Formulary, Medicare Part D Model, and a Change in Condition Process. It takes resources, research skills and monitoring as well as education and re-education to make it effective and keep it relevant. To achieve the desired outcomes, a continuous quality improvement approach is essential.

**SUMMARY**

Skilled nursing facilities and their residents are often negatively impacted by their medical provider’s decisions, documentation and orders. This medical staff misalignment results in poor outcomes for both the resident and the skilled nursing facility.

Those who are viewed as “residents” by SNF operators are seen as “patients” by their medical providers. Two patient-related considerations affect decisions made by SNF medical providers:

1. Medical Care
2. Economic Considerations
All medical providers will tell you that their number one consideration is patient care, yet many choose to not seek out and implement better practices from current evidence-based articles and information regarding SNF care. Most medical providers are owners/employees of a medical business established to provide a service for an acceptable fee.

The Medicare Part B Program is the primary source of payment for SNF medical visits. The Program, however, creates a financial incentive for medical providers to see patients either in their out-patient offices or in a hospital because the SNF site of service currently provides the lowest reimbursement rates for visits done on-site by medical providers. As if that were not challenging enough, a further 21% reduction in Part B reimbursement is expected in 2010.

Most SNF operators do not have an effective plan to align their medical providers with their facilities, nor do they realize that medical providers are more likely to “do it with data” if the data is provided to them. The creation and implementation of an aligned drug formulary which notes medical rationale regarding why certain drugs are being excluded, the implementation and management of a Medicare Part D Prior Authorization Model, and the creation of problem-specific change in condition documentation tools for nursing will go a long way to bridge this alignment gap.

Skilled nursing facilities can positively impact their medical provider’s decisions, documentation and orders if they are willing to invest the time and talent to create more effective medical staff education and management processes. Better medical staff orientation, education, monitoring and realignment results in improved outcomes for both the residents and the skilled nursing facility.
INTRODUCTION

A nursing home is in trouble, financially not performing as it should, so the decision is made to “change out” the administrator. The human resource department recruits, interviews, and subsequently hires a new administrator. This new administrator is on top of her game, not only knowing how to perform but excelling at it. She is on the floor driving resident care, monitoring critical processes, just getting it done.

The once faltering facility soon becomes a top performer. The company recognizes the superior skills of this administrator and promotes her to a regional position, moving her out of what is now a dynamic facility. Six months later, the once flourishing facility is in trouble again. The systems and processes that made it successful are no longer working. Staff morale is low and resident care is suffering.

This is a pattern all too often repeated in the nursing home industry. In these situations, it has been shown that replacing a strong administrator, which can be critically important, may be a short term fix to a more deep rooted problem.

An enduring solution to this rollercoaster ride rests in the organization’s ability to educate all front line employees, including staff in all departments and all levels, not just upper management teams. While this solution may seem simple, the process of educating so
many people can be costly, hard to organize, and difficult to successfully implement.

As a case study, a facility located in Maryland, Signature HealthCare’s Mallard Bay, made the decision to embrace a more educationally-gear ed culture and prove that learning is the key to long term success. During this journey, the facility noted that the benefits of taking the time to educate all of its employees led to:

- Decreased turnover,
- Increased staff engagement,
- Reduced worker’s compensation claims,
- Improvements in the overall culture of the facility,
- Fewer complaint surveys, and
- Significantly improved bottom line performance.

This educational journey demonstrates that the education of line staff is not only necessary but crucial for long term success to become a reality. All long term care entities can benefit from organizing its efforts to include meaningful, measureable initiatives related to educating one hundred percent of their staff.

PROBLEM STATEMENT

The need for educating line staff is not a new concept, as most healthcare organizations already have some form of formal education in place. The vast majority of these involve mandated in-services, which most would agree are inadequate and border on useless. The only beneficial aspect of this type of training is that they fulfill most state requirements for instructing staff on a variety of mandatory subjects. However, for the most part, they prove to be an ineffective training method and simply amount to a signature on a sign-in sheet.
showing that one attended the meeting. The downside of mandatory in-services as a primary method of training is too numerous to list. A few of the shortcomings include:

Most are held during payday which requires night shift employees to come in on off hours thereby affecting morale and performance.

Employees working second and third shift often have to bring their children to the meetings. They can arrange babysitting needs for their scheduled shifts but since many are single moms without any family support, they are forced to bring their children to the in-service. Children being children tend to be somewhat disruptive and distracting.

Without proper training space, meetings are typically held in the dining room where frequent distractions (noise, wandering residents and visitors) promote a difficult learning environment.

A portion of the staff must remain on the floor providing resident care, with these individuals often lost in the mix and some never receiving the training.

Nobody really wants to be there anyway, making the meeting almost useless from the start. Combined with ineffective teaching styles, usually lectures with no hands on participation, the meeting almost always receive a failing grade.

From this limited list, it is abundantly clear that this form of education is not effective with the cost-to-value ratio completely off the chart.

An article written as far back as 2005¹ states that “the national turnover rate for Certified Nursing Assistants in long term care is 71%.” These staggering numbers seem to be a direct result of the nursing home industries lack of ability to fulfill the educational requirements of Certified Nursing Assistants.

Another article\textsuperscript{2} cited a “lack of mentorship and inadequate education” as a reason for such high turnover. A lack of career advancement opportunities for Certified Nursing Assistants was also mentioned as a problem in retaining qualified employees.

With the national turnover rate averaging 70% for CNAs and with lack of education being cited as a primary concern, some type of educational program should have been established via Federal, State, and private funding. A national educational initiative would require Federal and State funding in order to be viable. That funding never happened and in 2008 the American Health Care Association presented a stinging report on CNA turnover and nursing vacancies in the long term care industry. This study concluded that:

- Approximately 109,900 full time nursing staff is needed to fill vacancies across the United States.
- The majority of these vacancies, nearly 60,300 are Certified Nursing Assistants.
- There are 19,400 staff RN positions vacant with 24,200 Licensed Practical Nursing positions vacant.
- Most notable is the 66% national turnover rate among Certified Nursing Assistants.

All of these statistics point toward the need to expend more resources to educate our most valuable asset, the front line employee, who provides most of the care in any facility.

**SOLUTION**

Mallard Bay, a Signature HealthCare facility located in Cambridge, MD, provides an example of leading the way toward innovative change via the utilization of education. Consider the following statistics:

\textsuperscript{2} Rose, J. McKnight’s Long Term Care News, 12/31/2008.
As the above graphs indicate, there was a vibrant improvement of overall performance from the Mallard Bay facility. After the implementation of an aggressive line staff educational effort, turnover, employee retention, average daily census, customer satisfaction, operating potential and annual income all demonstrated significant improvements.
According to Peter Senge\(^3\), “learning organizations are a place where people continually expand their capacity to create the results they truly desire, where new and extensive patterns of thinking are nurtured, where collective aspiration is set free and where people are continually learning how to learn together.”

In short, companies must change the way they educate their line staff if they desire a greater level of engagement from their employees. The employees of Mallard Bay had their minds stimulated by a new process, which required them to elevate their thought processes to a new level, working outside of the established norm.

**BENEFITS**

It would be difficult for anyone to argue against the need for significant change in the educational structure of the long term care industry. The benefits of modernizing the educational instruction for line staff include:

*An almost immediate increase in employee engagement.*

When employee’s minds are actively challenged and they are empowered to take a more active role in the organization, their behavior changes for the better. This leads to higher retention levels with decreased time spent training new hires.

*Enhanced customer service.*

When staff was asked if they would recommend Mallard Bay for care, the score increased from 88% in 2008 to 95% in 2009. Elevated customer service means fewer complaints from unhappy customers, an improved reputation within the local community, and more potential referrals from discharge planners.

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As staff are educated and become more engaged, the bottom line tends to perk up.
Engaged employees translate into happy families who spread the word within the local community, increasing referrals, decreasing turnover, and forcing the bottom line upward.

The status quo simply will not cut it in today’s business environment. Diligence in updating obsolete educational programs is paramount. The sooner this initiative begins, the faster results will be realized. The primary question for most organizations is how do they put it all together?

**IMPLEMENTATION**

All new programs come with their specific challenges and shortcomings. Working through these areas of concern can be frustrating and somewhat demoralizing to even a seasoned manager.

To help alleviate the vast majority of what may be termed “start up anxiety”, the administrator of Mallard Bay put together a “where to start” presentation. By following this format, it was much easier to begin the process, measure the organizations progress, and assess the many difficult roadblocks that took up so much valuable time.

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**Where to start??**
- Theme
- Dates/Module Topics
- Get your Team Excited!!
- Schedules
- Collateral
- Resident Concerns

**The 30 Minute Module**
- 5 Star Rating
- Dementia Room Training
- Clinical Standards Roll-out
- Welcome to the Neighborhood
- Engagement/Feed the Strength
- Restorative – is it working?
- Which Hat Are You- Communication is the Key
- Duck Pond U.- Becoming a Learning Organization
- Wii Sports- Stress Relief
- Renew- Pharmacy Pilot
- Beyond Bingo- What is quality of life?
Evaluation Results: 97% Agreed or Strongly Agreed that participation was valuable to them
Other strategies utilized while preparing for the training and measuring the effectiveness of the training included:

Presenters become Adult Learning Certified with no presenter teaching more than 2 modules to increase variety of speakers. Becoming Adult Learning Certified will be critical to how successful the training will be. If a presenter does not know how to teach adults and has never been taught this skill, the effectiveness of the training will be significantly diminished.

Review of facility-specific strategic plan, company vision/mission and industry regulatory requirements to decide which learning modules to present. The training must be aligned with company objectives or it will not be as well received by the employees. Employees want and need to understand how the training will have a positive impact on their daily operations.

Employees were signed-in to the training, provided name tags, their individualized schedule and collateral material to signify that this was not the typical “in-service” type education.

Compact 30-minute modules were utilized per the research on adult learning with employees rotating from one learning exercise to the next via their personalized schedule. This allowed them to move around instead of sitting in one chair all day, keeping them attentive throughout the day.

To improve the effectiveness of the modules, Mallard Bay included interaction with the employees. For example, they rolled out their Fine Dining Program by utilizing the lunch time during the training to show staff what the program should look and feel like. This included employees being seated by a hostess, met by servers at their tables, served on fine china, with soup and salad service, while listening to classical music.
Each module built upon another to create a circle of vision that assisted the employees in understanding the strategic mission, vision and plan for the coming year.

At the conclusion of the training, each participant was required to complete an evaluation of each module presented as well as the training as a whole.

This information was analyzed to improve on speaker performance, topic choices and overall presentation of the training. A follow-up training will be provided to the staff as to not lose the momentum gained by the first congress.

**SUMMARY**

In summary, there can be no argument that the educational structure of the long term care industry is in many ways antiquated and ineffective. As a whole, all evidence indicates that recruitment and retention of line staff will continue to provide a negative hygiene for the nursing home industry. With national turnover rates hovering around the 70% mark for certified nursing assistants, a change in fundamental educational efforts must be a priority.

This process is a journey, not a one stop fix-it shop. It will take dedication and a personal commitment from upper management for this change to be successful.

“The roll in a learning organization must demonstrate that everyone is learning and working together and that they can lead by example. Dowd (1999)\(^4\) identified two requirements of such leadership; the first being to roll up your sleeves and join the learning and improving and the second, you are critically important for inspiration. In this way it is

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not enough merely to establish a creative learning environment; someone is needed to sustain the vision and its implementation.”  

Mallard Bay has provided a beneficial example of a program that can be used to create an educational program with the ability to be tailored to the needs of any organization. The step by step instructions provided includes how to successfully organize, teach, and monitor the effectiveness of training. It also includes a list of strategies meant to enhance any organizations ability to teach/reach the targeted audience. The most important of these strategies is to require all presenters to become Adult Learning Certified. This will significantly increase the quality of any training initiative for the congress as well as any future training/in-services that may be provided.

The time is now; the opportunity is great and the challenges enormous. So, let us roll up our sleeves and begin the journey of transforming the educational structure of the nursing home industry. When patience runs thin, let us remember that this endeavor will have a huge impact on the employee, the customers and the company, so perseverance is a must with failure not being an option.

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SPIRITUALITY AND ITS VALUE-ADDED IMPACT ON CARE DELIVERY AND REVENUE IN THE LONG-TERM CARE SETTING

Dianne Timmering & Eddy Stockton

INTRODUCTION

Through a full-time Chaplain program that provides inter-faith spirituality initiatives in senior care facilities, spirituality has a tremendous impact. It affects such key indicators as revenue, census, Quality Mix, clinical outcomes, family complaints, and stakeholder engagement and helps to optimize care delivery and ROI in the current healthcare environment that faces daily federal and state budgetary cuts.

Spirituality or “spiritual care” is defined as meeting people at the point of their need through spiritual encounters, interdisciplinary clinical partnerships, one-on-one visits, fellowship, worship, and prayer. The intent is to provide encouragement; assurance; and a multitude of interventions to help residents alleviate or release anxiety, depression, and a general feeling of hopelessness.

Incorporating spirituality into long-term care entails a change in mindset about how facilities provide care. It involves a more holistic approach than what the industry currently utilizes. Spirituality in the facility encompasses a behavioral shift away from the thought that it is a separate entity in the healthcare arena. Caregivers have historically considered it as a silo, without direct involvement in interdisciplinary care as a specific intervention addressing the patient’s condition.
Perhaps most importantly, with current economic conditions, growing state and federal budget deficits and a fragile economy and job market, Medicare and Medicaid cuts are inevitable. As a nation, the country is looking at a permanent rebasing of how payments for skilled nursing or senior care services are calculated, delivered, and funded. According to one article\textsuperscript{6}

Medicare’s 48 hour “observation status” regulation where patients admitted to the hospital under observational status which are usually those patients that are too sick to go home would NOT be eligible for Medicare-reimbursed skilled nursing after discharge. This could result in Medicare beneficiaries having to absorb huge costs for skilled nursing care usually paid by Medicare.

Based on the estimated revenue reductions from proposed Medicare Part B Therapy rate cuts\textsuperscript{7}, providers need to consider new revenue streams and creative sources for revenue enhancement. Wellness initiatives like spirituality are key to performance and new payment methodologies.

The need for spirituality-based wellness initiatives is partly related to the increase in litigation. One of the most recent cases included an award of $677 million to the plaintiff due to staff shortage. Chaplains can assist with staff shortage through viable retention and healing programs. In addition, research has shown that spiritual care and prayer help to prevent pressure sores and other causes for medical malpractice cases.

Some providers are working to fill or provide grants for healthcare workforce shortage, particularly nursing, primary care doctors and geriatricians. Offering spirituality services to senior care and employee base has been shown to help recruit employees as well as impact stability and retention of workforce.

\textsuperscript{6} http://www.mcknights.com/providers-patient-advocates-decry-medicares-48-hour-observation-status/article/178118/
\textsuperscript{7} http://www.mcknights.com
In addition to staff retention, with the new ACO test model that reimburses collaborative providers based on performance and clinical outcomes instead of fee for service, resident wellness and clinical efficacy is perhaps the most significant reason to consider spirituality as an integral part of care.

Spirituality is more than simply being a “prayer leader,” it’s an intervention of hope and healing that plays a part in increasing efficiencies, enhancing communication in the wellness structure, and reducing the rising costs of healthcare. Long-term care providers that embrace spirituality as a technique to enhance care will serve as an innovative public-private partner to local governments helping to pave the way for solvency.

With Managed Care expanding at the State level, new ways to consider bundled Managed Care Service payments with Spirituality as a proven, evidence-based product in clinical results will enhance performance, prevention and therefore, possibly reimbursement.

Spirituality programming can provide a competitive advantage if comprehensively developed to meet the needs of resident and employees, and therefore, a driver of market share in a finite market place.

Simple competition is another reason why it matters. Large corporations are widening their mission to consider the ‘well-being’ of its employees and stakeholders because of the many unknowns, the massive overhaul in healthcare legislation and its focus on prevention and wellness.

Spirituality is only recently documented as an effective intervention in various long term care and hospital settings. One study by Dr. Harold Koenig, the Co-Director, Center for Spirituality, Theology and Health\(^8\),

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provided the first joint statement on relationship and significance of spirituality and long-term care.\(^9\)

Based on Dr. Koenig’s research on residents over 50 years of age at the Duke University Medical Center, robust and persistent positive effects were documented for religiousness and/or spirituality in the use of long term care among African Americans and women. These groups had fewer hospitalizations, improved physical health status, and better mental health which resulted in less days in the long term care facility.

The industry trends illustrate that purpose and something greater than self exists. Spirituality offers peace by helping patients cope with fear, anxiety and depression. This impacts overall care and hope for wellness. Spirituality demonstrates that persons are not merely physical bodies that require mechanical care... When facing a crisis, persons often turn to their spirituality as a means of coping.\(^10\) Many believe in its capacity to aid in the recovery from disease\(^11\) and 82% of Americans believe in the healing power of personal prayer\(^12\), using it or other spiritual practices during illness.

Recent study and congressional testimony by the AARP shows that the elderly and disabled would rather stay in their homes as long as possible. Therefore, the issue becomes recreating home-like settings and familiar environments with which to convalesce or live which includes the volume of spiritual services and organized religious activity that were freely once available to an aging population in the communities in which they lived, served and worked.\(^13\)

There is also the concern of “God in the workplace” as it relates to religious proselytizing. This paper proposes a spirituality program that offers the freedom to practice and seek purpose in a specific religion

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\(^9\) An additional interesting study to consider is *Religion, Spirituality and acute care hospitalization and long-term care use by older patients* as documented in the Arch Intern Med. 2004 Jul 26; 164(14):1579-85.


\(^13\) Louisville Courier-Journal
or spiritual preference allowing the patient the freedom to explore without a “right” or “wrong” way of thinking.

Another issue includes understanding the perceived differences among policy and patient expectation, spiritual caregiver’s perception of need, and overall understanding of the word “spirituality.” One study\(^\text{14}\) found that although policy organizations advocate integrating physical, psychosocial and spiritual aspects within palliative care, not all patients understand the term ‘spirituality.’ Having said that, according to the study, 87% of patients consider spirituality important in their lives.”

Clarifying spiritual care and what it means in care settings is a high level issue mitigated or extinguished by a broad base spiritual/Chaplain training strategy, belief in prayer and healing, and specific interventions that connect and build relationships of compassion, the belief in possibility, hope, and “personhood.”

People are spiritual by nature and perhaps the fundamental issue or gap resides between patient and caregiver who lack the confidence or knowledge in discussing spiritual topics. This furthers the argument for full-time spiritual leadership with its proportionate significance to those in senior care settings who have aggravated fears at various levels and stages of illness.

The objective of this paper is to show that a full-time interfaith chaplain corps with well-defined training and purpose has a beneficial place and serves a need in long term care. With qualitative and quantitative evidence, it can strengthen the cultural environment for both residents and staff through care delivery, the utility of team integration, and overall financial outcomes, affecting:

1. key clinical outcomes,
2. stakeholder engagement and retention,
3. market share in the community,

4. customer complaints and the diffusing of aforementioned circumstances, and
5. ancillary influences (Five Star rating, complaint surveys, etc).

PROBLEM STATEMENT

Senior care requires radical changes to its image and future solvency not only financially but as a care resource of choice by an emerging and demanding baby boomer population. Radical changes in care must be made to meet all resident needs. This includes meeting spiritual needs and facilitating the pursuit of questions of ‘life’ purpose.

This study will show that such spiritual and religious services serves a role in improving the long term care industry’s current negative public image. In addition, with the new MDS 3.0 and its focus on clinical outcomes and pay for performance, spirituality interventions enhance the delivery of care and quality of life initiatives, and, as a result, the financial outlook in a very uncertain future.

The implementation of spiritual initiatives in long term care facilities is supported by a wide variety of individuals and groups who are directly or indirectly affected by the quality of care provided, including:

a. Individuals with innate desire for understanding purpose and are interested in such searching questions as: Why do I exist? Why am I sick? Will I die? Do I still have purpose in this phase of life? What will happen to me if I die?

b. Regulatory and accrediting bodies require sensitive attention to spiritual needs. As the Joint Commission on the Accreditation of Healthcare Organizations15 makes clear, “patients have a fundamental right to considerate care that

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15 JCAHO (1998). CAMH Refreshed Core, January, RI1
safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values.”

c. CMS care planning and intervention directives stresses that psycho-social and spiritual needs must be considered in relation with the physical needs.

d. Employees who benefit from spiritual opportunities because of current belief systems and utilize spiritual focus with stress reduction.

e. Religious institutions and spiritual groups who feel a need of call and service to help others

f. Social Services and other psycho-social professionals who experience anxiety and depression and feel the need to incorporate spirituality into care models so as to relieve sadness to moderate behavior for emotional wellness.

g. Family members in need of relief, comfort and hope in healing.

h. Clinicians, physicians, primary caregivers, and therapists are impacted through partnership with a spiritual care focus through interventions of prayer, encouragement, hope, and spiritual alignment and healing. In addition, through the new ACO model, care efficacy, patient care techniques with evidenced based results have a significant impact on their care delivery systems and payment.

i. Palliative Care patients and their family members helping them face the unknown with new understandings, peace, hope and patience.

In the past, spiritual advisors and members of the local clergy would visit the facility weekly or monthly with infrequent continuity due to schedule demands and prior commitments to their place of worship.
Their visits were often quick and little coordination of care or true understanding of patient’s needs, care plan, etc. was established. Spiritual needs were often ignored and/or were viewed as insignificant to care, i.e., not the facilities problem. This paper hopes to change these views.

**SOLUTION**

The “product” of spirituality proposed in this paper is a service of prayer, encouragement, and hope. It is a first responder in a crisis situation filled with love and discernment for the individual, the situation, and its cause. Spirituality as an intervention or, in many cases, the specificity of a religious practice offers the power of comfort and tradition. This is often present through the use of religious music and favorite scriptures which then alleviates depression and inspires the possibility of wellness.

This program is rooted in the meeting individual’s at the point of their spiritual need without judgment and without representing a particular faith or conviction. It offers a significant impact not only in the wellness of the people but in the overall financial output of the business.

The individuals hired as Chaplains are professionally trained in spiritual care core competencies including religious practices, cultural traditions, bereavement, listening, prayer and empathy. Where their interfaith religious skills and knowledge may be limited in a specific faith or religious practice, they would then call on their chaplain advisory board (a community board) or other members of the community to deliver the specific spiritual needs of the resident and/or employee.

Simply, the chaplain is critical to this model of care because they act not only as a delivery of spiritual care but as a facilitator to meet specific needs and desires to help quench anxiety and pain as well as serve as a clinical intervention. They facilitate the discovery of
purpose, faith journeys and the existence of hope. In addition, while the clinical team is predominantly focused on physical needs, the chaplain can serve as a vital interdisciplinary partner focused on the emotional and spiritual.

To validate the results of spiritual initiative implementation, a study was conducted at Signature HealthCARE, LLC facilities that examined key quantitative indicators from the year prior to the hiring of full-time chaplains and compared it with a one-year controlled study after the chaplains were hired.

This study delved into twelve Signature nursing homes in Tennessee, Florida and Kentucky. It compared the financial and clinical outcomes of facilities that had not yet hired full-time chaplains to those with full-time chaplains. Several evidence-based deductions can be made based on the statistical and anecdotal evidence and trends.

Financial Measures

Financial Data

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Rate (approx.)</td>
<td>$336/day</td>
<td>$406/day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A change of 21% or $70/day</td>
</tr>
<tr>
<td>Revenue/day</td>
<td>$197.82</td>
<td>$212.65</td>
</tr>
<tr>
<td>Revenue</td>
<td>$87 million</td>
<td>$91 million</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Up $14.83/per patient day</td>
</tr>
<tr>
<td>Census</td>
<td>439,799</td>
<td>427,944</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Down 33/day</td>
</tr>
</tbody>
</table>
Based on Spiritual interventions it is interesting to note that although census was down from 2008 to 2009, overall length of stay may have been increased based on satisfaction with services. In addition, the facilities with full-time chaplains had more Quality Mix days because of fewer re-admits to the hospital. This impacted strength of care and revenue even with a lower census.

**Quality Measures and Training**

A set of quality measures were developed from Minimum Data Set-based indicators to describe the quality of care provided in nursing homes. These measures address a broad range of functioning and health status in multiple care areas. Quality measures are one of the four ratings that CMS reports.

The utilization of full-time chaplains and the trainings provided focusing on team-building partnerships with the clinical group had a similar positive impact and result. This may be due to the increased frequency of communication in addition to the more specific quality measures/improvement trainings that were provided to link directly to Five Star data.

As a result, after the chaplains were included in the interdisciplinary trainings and were more involved in the communication chain, quality measures improved up to 30% in Five Star ranking. It should be noted that to provide value, these chaplains served as a complementary part of the interdisciplinary team efforts; their attendance alone was not enough. They forged active partnerships with therapy, clinical, and quality of life to meet spiritual needs, physical needs, and emotional support and encouragement.

For instance, the chaplains offer specific prayers of healing and encouragement to those at risk, asking that they use designated ambulation support (like a walker). This prevents a potential fall. The spiritual impact is made not only as an individualized prayer, but as a robust clinical partnership and intervention in the care planning.
process. Chaplains can have similar results when focusing on such resident physical conditions as restraints, pain, falls, pressure ulcers, and weight loss.

Five Star Data and Its Relation to Quality Measures

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. Quality Measure Rating</td>
<td>2.17</td>
<td>2.83</td>
</tr>
<tr>
<td>Increase of 31%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Quality measure training and IDT impact:

<table>
<thead>
<tr>
<th>Long Stay Resident</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>11.6%</td>
<td>4.7%</td>
</tr>
<tr>
<td>ADL Help Increase</td>
<td>15.5%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Movability worsened</td>
<td>15.5%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Restraints</td>
<td>6.8%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>9.1%</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

Note: Falls and weight loss not measured in Five Star

<table>
<thead>
<tr>
<th>Short Stay Residents</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>17.7%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>12.6%</td>
<td>11.6%</td>
</tr>
</tbody>
</table>

**Retention and Turnover**

What makes this chaplain program unusual is that it in addition to serving resident and family needs, it includes the employees in the spiritual purview. Chaplains offer encouragement, hope, and empowerment through one-on-one visits, prayer, and casual
encounters. This has an immediate and long lasting effect on employee retention, stability, and turnover.

To determine the impact on turnover, nursing retention and turnover were evaluated. Nursing retention measures the percentage of nursing employees who have been employed more than one year. Turnover is the annual rate at which an employer gains and loses employees. It is calculated by dividing the actual number of terminated employees for the year with the total number of employees employed by the facility for the year.

As summarized on the chart below, after chaplains were hired, retention improved by approximately 22% and turnover decreased by 32%. There were also 41% less terminations in the second year.

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retention</td>
<td>55%</td>
<td>76.7%</td>
</tr>
<tr>
<td></td>
<td>Increase of 21.7%</td>
<td></td>
</tr>
<tr>
<td>Turnover</td>
<td>77.2%</td>
<td>45.6%</td>
</tr>
<tr>
<td></td>
<td>Decrease of 31.6%</td>
<td></td>
</tr>
<tr>
<td>Annual Terminations</td>
<td>412</td>
<td>244</td>
</tr>
<tr>
<td></td>
<td>40.8% improvement</td>
<td></td>
</tr>
</tbody>
</table>

Moreover, when comparing pre-chaplain with post, facilities with Chaplains were better able to meet the Acuity Based Staffing (ABS) needs due to better retention and turnover numbers. On average, these buildings went from 101% to 106% of achieved ABS.
Annual State Survey

The provided trainings and job focus for the chaplains included understanding the survey process – what to do and not to do, how to aid the clinical team, praying for and maintaining a calm environment, having a general awareness of processes and procedures in each department, knowledge of clinical protocols and five star system, etc.

Six out of seven buildings with chaplains had better survey results. These facilities went from averaging more than 50 health inspection points to 23.4 points.

Health Inspection Measure as It Relates to the Five Star System

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Health Inspection Rating</td>
<td>2.83</td>
<td>3.17</td>
</tr>
<tr>
<td>Increase of</td>
<td></td>
<td>+12%</td>
</tr>
</tbody>
</table>

In addition, the facilities studied had zero complaint survey deficiencies in the post-chaplain year. This is partially due to the use of chaplains in thwarting complaints before they escalated into more serious issues.

BENEFITS

Benefit 1: Residents

Spirituality, a connection or reconnection to ones earliest roots of religious practice, provides comfort and restores faith in what is possible in the healing process. It re-initiates one’s sense of purpose and answers the age old questions, “why are we here” and “what are we to live for.” The active pursuit of these questions creates the desire for wellness and to achieve once again.
With the implementation of a full time chaplain program, one of the most important and fruitful benefits is the power of communication and the increased collaboration amongst disciplines in the facility. Communication increases awareness of angst, depression, hopelessness. The chaplain can serve as a facilitator of prodigious hope to increase understanding of the clinical strategy and overall care needs.

From the clinical aspect, with CMS pursuing the new MDS 3.0, which rebalances the reimbursement rates from therapy to clinical outcomes, the spiritual impact becomes more critical in not just the delivery of quality care but in overall reimbursement opportunities.

Also, when chaplains’ services are care planned as an intervention, this can directly impact resident outcomes such as clinical and psychosocial outcomes. These, in turn, have a financial impact.

For instance, let’s say that a Medicare resident is on Megace, which is a very expensive appetite stimulant taken because of major weight loss. The chaplain can be care planned to visit and encourage the resident during meal times to eat. With personal encouragement and support, the resident has a better chance of gaining the weight necessary for the physician to discharge the Megace medication. In addition to doing the right thing, the facility would have a cost reduction and healthier patient, thereby correlating good performance and the efficiency of care delivery.

**Benefit 2: Employees**

Employee engagement and empowerment of care, not to just complete the systems and rudiments of clinical care, but an increase of hope and purpose for themselves and compassion for others thereby resulting in the delivery of better care. With greater exponential knowledge, experiential growth, and consistency, retention of employee base provides a more cohesive and efficient way to deliver the best quality of care.
Benefit 3: Facilities

The opportunity cost and value of a full time chaplains program pays for itself and appreciates as it becomes more ingrained into the culture of the facility. The return on investment is proven with net operating income impacted based on market share encroachment, improved clinical results, a reduction in nursing turnover, enhanced retention (costs savings and quality improvement), improved efficiencies (eventual cost reduction), communication, and overall goodwill and recognition in the community.

The adherence to standards and regulations is an obvious correlation as, in 2006, CMS directed long term care providers to offer individualized, adaptive, on-going activities of care which include spiritual references if applicable to the patient. In addition, chaplain participation and understanding of the survey process and Five Star system can be an invaluable contributor to the overall climate of care which positively impacts regulatory adherence.

Enhanced branding and market share for the facility and an overall paradigm shift as it relates to how nursing homes are perceived. With a full-time chaplain program, long term care facilities can be seen as a place to get well, begin another journey in life, and/or go home healed and ready to begin again.

The ROI from this holistic approach to overall care, its usability, short and long-term cost savings, and efficiency in care delivery makes it a viable and transferrable model for long-term care providers as well as the healthcare industry as a whole.

Benefit 4: Long Term Care Industry

As we look towards the unpredictable future of healthcare with healthcare reform and Accountable Care Organizations (ACOs), spirituality can be a premium partner in the focus on prevention, overall performance, clinical outcomes, and new reimbursement
measures. As demonstrated in this study, spirituality can help build the culture for collaboration. It can aid in developing a self-actualized clinical team with renewed purposes and commitment to help to heal the sick, the dying, and the desperate, thereby increasing efficiencies and possible cost reductions with a positive impact on revenue generation.

Moreover, performance delivery and collaboration are fully subject to the quality and power of teamwork amongst the surgeons, primary care doctors, nursing team, hospitals and nursing homes and other ancillary services. Spirituality can bind together the traditional status quo of siloed teams that has been imbedded in the healthcare delivery system.

IMPLEMENTATION

The program at Signature began with part-time chaplains. However, as the spiritual needs grew amongst the residents, family members, and employees it became evident that full-time chaplains were needed to meet the spiritual and emotional needs of suffering, hurt, pain, hopelessness, grief, purpose unfulfilled, desire for spiritual discovery and multi-faceted programming.

When rolling the program out, the obstacles and skepticism that existed were similar to that of most other new programs. By continually selling the benefits and the corresponding episodic and anecdotal evidence that began percolating throughout the facility, the initial negative views were replaced with excitement for the positive results and the future opportunities for the program. Consistency of program delivery enabled trust to build and the program to grow with spirituality as the center point and discernment at the lead.

Critical partnerships with therapy, clinical, Social Services, and Human Resources as well as legal were evolutionary priorities and necessary for the success of roll out. Crucial to early success was a clear
understanding of the legal aspects of building the program infrastructure and understanding religious and spiritual practices with a respect and acknowledgement to any conflicts with the Human Resources department and the Legal department.

Establishing the spirituality and chaplain program as an interfaith program of unconditional love and respect for all religions, faith journeys, and cultural traditions was the key to the foundational underpinnings of the program and fighting through the cycle of obstacles along the way. This created continual growth, learning inflection points, new understandings, on-going reflection, and additional awareness of possibilities. In addition, it was imperative that to reach the depth of penetration intended in the culture, the program could not be “watering down.” Individuals' free choice to worship or not to worship had to be offered with the freedom to be who they were while respecting those around them.

Education, training, communication of spirituality initiatives and program purpose, peer to peer meetings, and flushing out specifics helped to strengthen content and the necessary processes and systems to deliver spiritual care to thousands of employees and residents.

**SUMMARY**

Chaplains in long term care facilities are more than just a service of words, listening and prayer, although vital services, but an intervention of powerful means when they understand the clinical processes and systems of long-term care including quality measures and survey readiness.

By understanding these measures of care, Chaplains can focus on real ailments offering a specificity of services and tuned in delivery of spiritual care. Faith in one’s well-being heals not just the physical, preventing weight loss, pressure sores and falls, but can also address
the psycho-social issues of depression and anxiety through specific activity or quality of life ideas in partnership with therapy, social services and the quality of life teams.

In the end, spirituality is a unique and hopeful discovery for not only long-term care providers but healthcare as a whole industry promoting best outcomes, prevention and holistic wellness. It serves as a key factor in the clinical food chain to ensure performance efficiencies and communication amongst care providers thus working to heal the people, reduce costs, and save the health care system from eventual insolvency.

Perhaps spiritual essence is the missing piece of transformative leadership, moving employees into a new mindset of teamwork and collaboration for optimum performance at any level of the care continuum.
MUSIC AND DEMENTIA

Jeff Beatty, Ed.d.

EXECUTIVE SUMMARY

Overview

Ruby is 78 years old and has lived with Alzheimer’s disease (AD) since age 65. She does not walk and often babbles continuously as she sits in her room. She goes unnoticed several hours of each day. David, another resident with dementia, often sits in front of the nurses’ station for hours because of his frequent yelling and repetitive vocalizations. When he becomes agitated because he cannot be calmed, he is placed back into his room. Jerry, unable to actively participate in activities or ADL care because of his dementia, is relegated to stare blankly at a television set in the day room at a local nursing facility and often becomes agitated throughout the day.

Is this a quality of life? Are we meeting their needs? Who is advocating for the resident with dementia in our nursing facilities today?

Significant among the characteristics of residents suffering from Alzheimer’s disease is the manifestation of agitated/disruptive behavior among cognitively impaired residents ranging from 42.8 to 86.3%. Such behavior is displayed in a variety of ways, such as kicking, screaming, hitting, biting, scratching, or throwing things (Cohen-Mansfield, 1986).

The increase in the prevalence of such residents, along with the ensuing increase in agitated/disruptive behavior, has necessitated that
a variety of interventions be implemented. Music therapy using brain wave influence is one of those interventions.

This research project seeks to increase our understanding of the effectiveness of interventions for residents with Alzheimer’s disease. Further, we seek to understand the effects of environmental interventions, specifically, different music waves to combat some of the negative behavioral effects of dementia. Music is less invasive, less apt to mask actual resident needs, and can be individualized (Cohen-Mansfield, 2000).

Sixsmith and Gibson (2007) found that many with Alzheimer’s disease, despite aphasia and memory loss, continue to remember and sing old songs, and dance to old tunes. Further, musical abilities appear to be retained amongst those who could play instruments prior to the onset of dementia, indicating that musical abilities may be spared in the progression of the disease (Cuddy & Duffin 2005). Such research has also indicated that musical abilities and memories may not be connected to deterioration in the brain relating to speech and language, raising the possibility of music as a non-verbal form of communication for people with dementia (Hubbard et al. 2002).

Brainwave Frequencies

<table>
<thead>
<tr>
<th>BETA</th>
<th>alertness</th>
<th>concentration</th>
<th>cognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALPHA</td>
<td>relaxation</td>
<td>visualization</td>
<td>creativity</td>
</tr>
<tr>
<td>THETA</td>
<td>meditation</td>
<td>intuition</td>
<td>memory</td>
</tr>
<tr>
<td>DELTA</td>
<td>healing</td>
<td>sleep</td>
<td>detached awareness</td>
</tr>
</tbody>
</table>
According to Blomberg (2009) the four types of brain waves suggest the following:

### Beta

15-30 Hz

This brain wave shows normal alert consciousness. As the fastest waves they represent the most intense alertness state. Beta shows mental activity is taking place right now. When we are up and doing things and are fully awake we are” in Beta”.

### Alpha

9-14 Hz

This brain wave indicates a relaxed mind. It is a meditative mind. The Right and the Left brain are said to be working together in Alpha. Alpha is a good state to be in to learn things fast and for test taking. Psychic/mental states of mind can occur. Here are seen visions, powerful ideas and even the creation of the incredible.

### Theta

4-8 Hz

Deep relaxation and meditation. A high state of mental concentration which is associated with life-like imagination. A magical mind. This brain wave is best for suggestibility, problem solving, and inspiration. Oddly, being in Theta is dominant in children of ages 2 to 5.

### Delta

1-3 Hz

This state puts you in a deep and dreamless sleep. In Delta you are deeply relaxed. Although, there may be some things which can be done in Delta, while you are in this dreamless state.

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**What's the Link Between Brain Waves and Music?**

Music, with a 60 beats per minute beat pattern, activate the left and right brain. The simultaneous left and right brain action maximizes learning and retention of information. The information being studied
activates the left brain while the music activates the right brain. Also, activities which engage both sides of the brain at the same time, such as playing an instrument or singing, causes the brain to be more capable of processing information.

Research has shown that although one brainwave state may predominate at any given time, depending on the activity level of the individual, the remaining three brain states are present in the mix of brainwaves at all times. In other words, while somebody is an aroused state and exhibiting a beta brainwave pattern, there also exists in that person's brain a component of alpha, theta and delta, even though these may be present only at the trace level.

**BUSINESS CHALLENGE**

Behavioral and psychological symptoms of dementia (BPSD) are highly prevalent in Alzheimer's disease (AD) patients. They are a source of distress for the caregivers and one of the main reasons for nursing home placement, which is the major component of the cost of Alzheimer's disease.

Between 60 and 90% of residents with dementia will experience BPSD at some time during the course of their illness (Tariot & Blazina, 1994). The reported range of prevalence of individual behaviors in nursing home residents are as follows:

Prevalence of Individual Behavior in Nursing Homes

(Zimmer et al., 1984; Rosewarne et al., 1996)
Simabukuro, Awata, and Matsouka’s (2005) investigation of behavioral and psychological symptoms of dementia (BPSD) found symptoms such as delusions, hallucinations, agitation, dysphoria, anxiety, apathy, and irritability to be equally prevalent in residents with moderate or severe Alzheimer’s disease.

<table>
<thead>
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<th>Top Ten Behaviors not (usually) responsive to medication</th>
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<td>1. Aimless wandering</td>
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<td>2. Inappropriate urination/defecation</td>
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<td>3. Inappropriate dressing/undressing</td>
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<td>4. Annoying perseverative activities</td>
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<td>5. Vocally repetitious behavior</td>
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<td>6. Hiding/hoarding</td>
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<td>7. Pushing wheelchair bound co-patient</td>
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<td>8. Eating in-edibles</td>
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<td>9. Inappropriate isolation</td>
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<td>10. Tugging at / removal of restraints</td>
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Kusano (2004) pointed out that up 90% of the residents in long term care facilities manifest some form of agitated behavior. She identified such behavior as one of the most common reasons for nursing home placement when caregivers and families are unable to deal with the resulting emotional and physical strain.

*Interventions for Alzheimer’s Disease*

Non-pharmacological interventions are first-line in dealing with milder BPSD, while for moderate to severe BPSD, medication is clearly indicated in conjunction with non-pharmacological interventions.
A variety of interventions to address the behavioral and psychological symptoms of dementia have been employed over the years. Cohen (2002) stressed the importance of enhancing the resident’s quality of life by identifying individual skills and creating interventions that would enable them to utilize those abilities.

Treatment options in the management of agitation include pharmacological, behavioral, and environmental approaches (Reuben et al., 2002). For patients whose agitation does not resolve with management of acute underlying medical illnesses and does not respond to nonpharmacological interventions, the next step in clinical management is to consider pharmacotherapy.

Pharmacological approaches (antipsychotics, cholinesterase inhibitors, benzodiazepines mood stabilizers and anti-convulsants) can have instant results but are often accompanied by side effects that may compromise a resident’s functional capability (Cohen-Mansfield, 1989).

Behavioral approaches include increasing the awareness of the caregiver’s own needs as well as identifying the resident’s feelings (Cohen-Mansfield, 1989). Psychosocial and behavioral interventions such as functional performance assistance, music therapy, pet therapy, and reminiscence therapy can significantly enhance the quality of life of both the patient and the caregiver. Environmental approaches involve a variety of interventions that promote safety to the resident. Environmental interventions such as use of white noise or nature sounds, modulated lighting intensity, and way-finding cues such as photographs can also decrease stress and agitation.

**SOLUTION**

*Proof of Concept*

Since the beginning of time, music has played a significant role in the healing of people.
Pythagoras based musical education in the first place on certain melodies and rhythm that exercised a healing, a purifying influence on the human actions and passions, restoring ‘Pristine Harmony’ of the soul’s faculties. He applied the same means to the curing of diseases of both body and mind.

Porphyry (233-309 A.D.) disciple of Pythagoras

Music can minister to minds diseased, pluck from the memory a rooted sorrow, raze out the written troubles of the brain, and with its sweet oblivious antidote, cleanse the full bosom of all perilous stuff that weighs upon the heart.

William Shakespeare (1564-1616 A.D.)

As far back as biblical times, music has been used to calm the troubled soul. For example, 1 Samuel 16:23, “And it came to pass, when the evil spirit from God was upon Saul, that David took a harp, and played with his hand: so Saul was refreshed, and was well, and the evil spirit departed from him.”

Based on prior research, individuals with brain damage from Alzheimer’s disease appear to respond to music that touches uninjured parts of the brain, and music can help them communicate with others and lead a more social life (Cromie, 2002). Music can be used as therapy to decrease agitation, anxiety, and wandering, help them reconnect with memories from the past, and reduce the likelihood that a behavioral outburst occurs.

General Research Framework

The goal for this research study is to investigate the efficacy of using alpha music therapy as a means to help residents with Alzheimer’s disease. An electroencephalography (EEG) will be used to track the brain waves of the residents with Alzheimer’s disease.
Carruth (1997) found general trends that pattern recognition improves after music therapy. However, no statistical tests were conducted and the low sample size limited the ability to analyze the data with any sense of validity. The patterns used were a series of pictures of faces. This study will also examine pattern recognition, but will utilize a larger sample size so that statistical analyses can be performed.

This study will also examine the effectiveness of music therapy by stage of Alzheimer’s’ disease. Previous research by Dunn (2007) called for the need to test whether the impact of music therapy varies based on the severity of the resident’s dementia. Given the vastly different degrees of cognitive deficiency, it is important to ascertain who, if anyone might benefit from music therapy. From a caregiver’s perspective, it is much more practical and useful to be able to identify who specifically benefits from an intervention versus being informed that as a whole it was “helpful”.

As previously mentioned, this study involves the use of music as an intervention. More specifically, alpha music will be used (see brain wave frequencies chart above). We will be creating our own alpha music to be used in this project. This will occur several weeks before the project begins.

**Design**

The dependent variables for this study are: behavioral outbursts, appetite, and sleep. Subsamples will be created for each dependent variable. For the behavioral outbursts subsample, residents will be selected who have had ten or more behavioral outbursts over a six week time frame. The residents will then be randomly assigned to either the treatment group who receives the alpha music treatment or the control group who will not receive alpha music treatment. The treatment group will receive a total of twenty treatment sessions of alpha music over a two week period.
Sessions will be conducted Monday through Friday of each week consisting of one morning treatment and one evening treatment. Caregivers in the Monteagle facility will assist in creating the subsamples for appetite and sleep. This will help identify which residents have a history of sleep or appetite issues. Similar to the behavioral outburst subsample, participants will be randomly assigned to the treatment or control group for the sleep subsample and the appetite subsample. The treatment group for the appetite and for the sleep subsample will also undergo twenty alpha music sessions over a two week period. A series of ANOVAs (Analysis of Variance) will be used to analyze the differences between the treatment and control groups for each of the subsamples.

Technology Concept

1. Production of alpha music.
2. Measure brain wave activity through the use of a portable EEG.
3. Production of a training package for implementation of the music program in a long term care facility or in the home environment.

Design of Experiment
BENEFITS

Music therapy interventions can be designed to:

- promote wellness
- manage stress
- alleviate pain
- express feelings
- enhance memory
- improve communication
- promote physical rehabilitation

SUMMARY

The brain primarily produces brainwaves at 14 to 30 cycles per second (hertz) known as beta waves when in normal consciousness. Brainwaves with frequencies of 8 to 14 cycles per second are alpha waves that are present when one is more relaxed. Around 4 to 8 cycles per second is the theta waves that present a deeper drowsy and meditative state. Finally, when one is asleep, delta waves of fewer than 5 hertz are produced. Normally, alpha brainwaves stimulate a relaxing state, but meditation encourages a more relaxing consciousness state especially if practiced regularly. For those who have no time or inclinations to meditate, music embedded with particular beats works in a similar way. This is the source for brainwave entertainment technology, which alter one’s brainwaves giving a rapid relaxation response. Relaxation music affects the soul. People don’t just merely hear it, they also feel it.

The symptoms of Alzheimer’s disease include a reduction in cognitive and social capacities, and the appearance of negative symptoms
related to agitation. Behavioral problems of mental health users, such as agitation and confusion, are often expressed as an inappropriate verbal, vocal, or motor activity that is generally managed by medication or physical restraint. It is therefore important to identify alternative interventions to help patients and healthcare professionals to control this type of situation. The review of the literature in this particular field suggests that music intervention is one of the most useful tools available to caregivers.

REFERENCES


CONTENTS

Medical Staff Misalignment: Three Process Improvement Strategies for the Prescribing Pen
Christine J. Gerace Johnson, MPA, NHA, PA-C

Built to Last: Creating Learning Organizations in Long Term Care
Ed Hogan

Spirituality and Its Value-Added Impact on Care Delivery and Revenue in the Long-Term Care Setting
Dianne Timmering & Eddy Stockton

Music and Dementia
Jeff Beatty, Ed.d.