# Creating a Culture of Quality

**The role of business acumen for Community Based Organizations (CBOs) that serve people with disabilities. A vehicle for improving financial performance and leadership development**

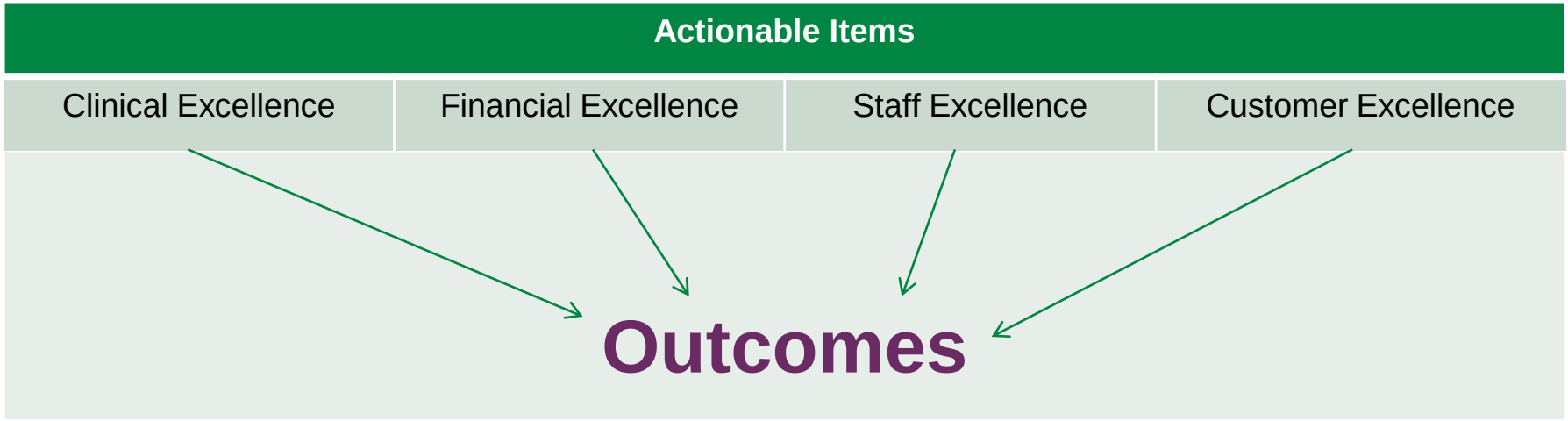
Debra Scheidt, HCBS Executive Director
Judy Naylor, Chief Operations Officer

# HCBS Culture Change

**“Merging Social & Medical Models in HCBS to fully embrace Person Centered Care through Quality Measures”**

uds FOUNDATION

# A Strength Based Approach



# Vision – Mission- Purpose

There is general agreement that Long-Term Services and Supports programs must address a range of social and pragmatic needs, like transportation, housing, nutrition, isolation, **emotional well-being**, and **medical problems**.


HQC Health Care Quality Congress

# We are Social Workers after all…

- We already do person centered care
- We are not medical
- We have always used a social model
- We do not want to change – it's working this way
- Will this mean more forms?

---

Translation…

- Will I be good at it?

Again, We are Social Workers after all…So let's start with emotional wellness.

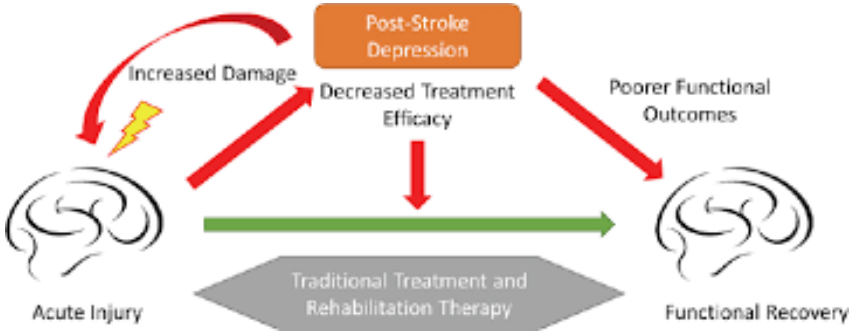
# Association between physical disability and depression

The disabled are at dramatically elevated risk for depressive symptoms for both men and women of all ages. Longitudinal analyses show eventful stress and chronic strain to be significant determinants of depression. The positive effects of mastery and social support are clearly observable within all age groups.

**“Incredible mental fitness both intellectually and emotionally;” words that described scientist Stephen Hawking**

*R. Jay Turner and Samuel Noh, Journal of Health and Social Behavior Vol. 29, No. 1 (Mar., 1998), pp. 23-37*


# Major depression in stroke patients

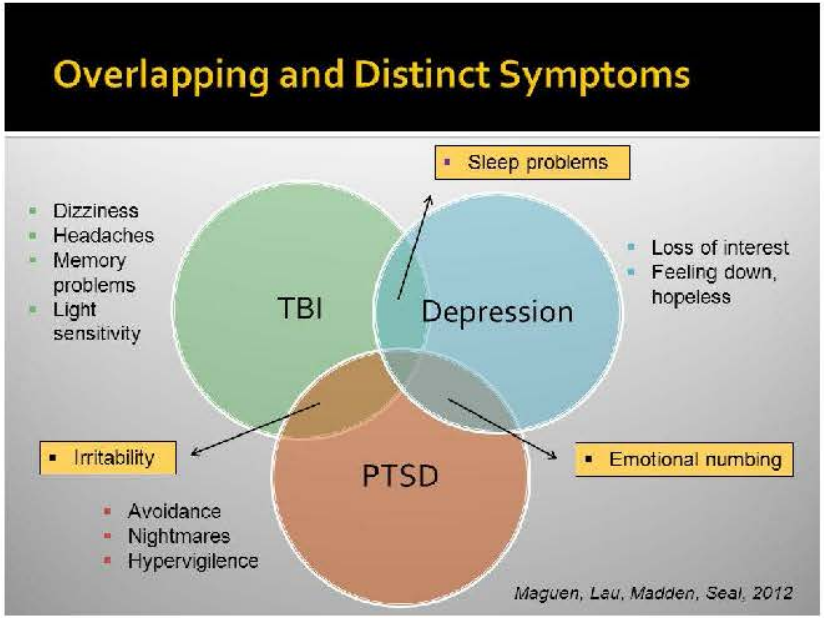



Monica Åström, MD; Rolf Adolfsson, MD; Kjell Asplund, MD

https://doi.org/10.1161/01.STR.24.7.976 Stroke. 1993;24:976-982

# The prevalence of Depression after TBI

The risk of depression after a TBI increases whether the injury is mild, moderate, or severe.




*Carla & Hicks, Amelia & Sherer, Mark & L. Ponsford, Jennie. (2018). Psychological Resilience Is Associated With Participation Outcomes Following Mild to Severe Traumatic Brain Injury. Frontiers in Neurology. 9. 10.3389/fneur.2018.00563.*

http://dx.doi.org/10.1080/02699050116884

# Fatigue in MS: Reciprocal relationships with physical disabilities and depression


*Journal of Psychosomatic Research: September 2012 Volume 53, Issue 3, Pages 775–781*

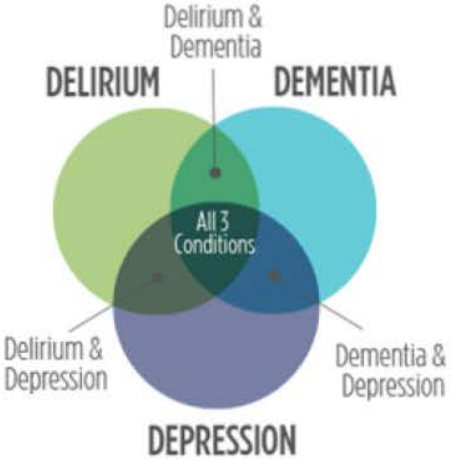
# Depression in Older Adults

## Causes of Depression in Older Adults and the Elderly

As you grow older, you face significant life changes that can put you at risk for depression. Causes and risk factors that contribute to depression in older adults and the elderly include:

- **Health problems** – Illness and disability; chronic or severe pain; cognitive decline; damage to body image due to surgery or disease.
- **Chronic diseases** – Parkinson's disease, Alzheimer's disease, stroke, heart disease, cancer, diabetes, lupus, multiple sclerosis, thyroid disorders, vitamin B12 deficiency and dementia and side effects from their treatment medications.
- **Loneliness and isolation** – Living alone; a dwindling social circle due to deaths or relocation; decreased mobility due to illness or loss of driving privileges; isolation due to hearing and vision deficits.
- **Reduced sense of purpose** – Feelings of purposelessness or loss of identity due to retirement or physical limitations on activities.
- **Fears** – Fear of death or dying; anxiety over financial problems or health issues.
- **Recent bereavements** – The death of friends, family members, and pets; the loss of a spouse or partner.

Source: http://www.helpguide.org/articles/depression/depression-in-older-adults-and-the-elderly.htm




*Frank, Christopher. "Pharmacologic Treatment of Depression in the Elderly." Canadian Family Physician 60.2 (2014): 121–126.*

# Performance Improvement Analysis (PIA)

PERFORMANCE IMPROVEMENT ANALYSIS

**Goals:** **Baseline: =**

1st Quarter: _ _____ 2nd Quarter:_____ 3rd Quarter:_____ 4th Quarter: _____

| ACTIVITY/INDICATOR (Discovery) | FINDINGS (Analysis) | CONCLUSIONS (Design) Update material | ACTIONS/RECOMMENDATIONS (Implementation) | Evaluation (Outcome) |
|---|---|---|---|---|
| Why are we looking into this indicator:<br>• New Directive<br>• Suspect need<br>• Best Practice | What we find once we look at the indicator. | What is needed to improve the process, generate a better outcome, etc. | Process steps<br>• What will we do and why<br>• Who will do what<br>• How will we communicate the process<br>• How we track and trend | Will be reviewed monthly and written updates to this plan quarterly. Results shared with all team members (stakeholders) |

**If asked they might tell. Then what?**

# How to overcome Don’t Ask/ Don’t Tell

- Understand the basics
- Ask the basics
- Use an emotional wellness survey
- Understand how you can help
- Know resources
- Communicate with those able to help and provide follow up services

“Emotions” are your feelings

&

“Wellness” is a way of being

So:

# All Achievable Outcomes start with a good plan

- Select the tools – We used PHQ2 and PHQ9
- Train a pilot group – **We used QPR (Question, Persuade, Refer) Certification**
- Review progress/trends for at least 6 months
- Make corrections along the way
- Allow the Pilot Group to roll out the program
- Allow for a lot of testimonials
- Highlight successes – We like to know we make a difference
- Be flexible in the beginning. Encourage questions and challenges from staff
- Provide staff with tracking and trending data –We like Graphs
- Make sure managers understand the hypothesis and can speak to it.

## Inform Participant:

Part of routine screening for your health includes reviewing mood and emotional concerns.

## Ask the participant:

**"During the past two weeks,** have you often been bothered by of the following problems?"

"Feeling down, depressed, irritable or hopeless?" Yes No

"Little interest or pleasure in doing things?" Yes No

**Scoring Instructions:**

**If the response is "yes" to either question, administer the PHQ 9 Questionnaire.**

**If the response to both questions is "no", the screen is negative. Do not administer the PHQ 9**

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

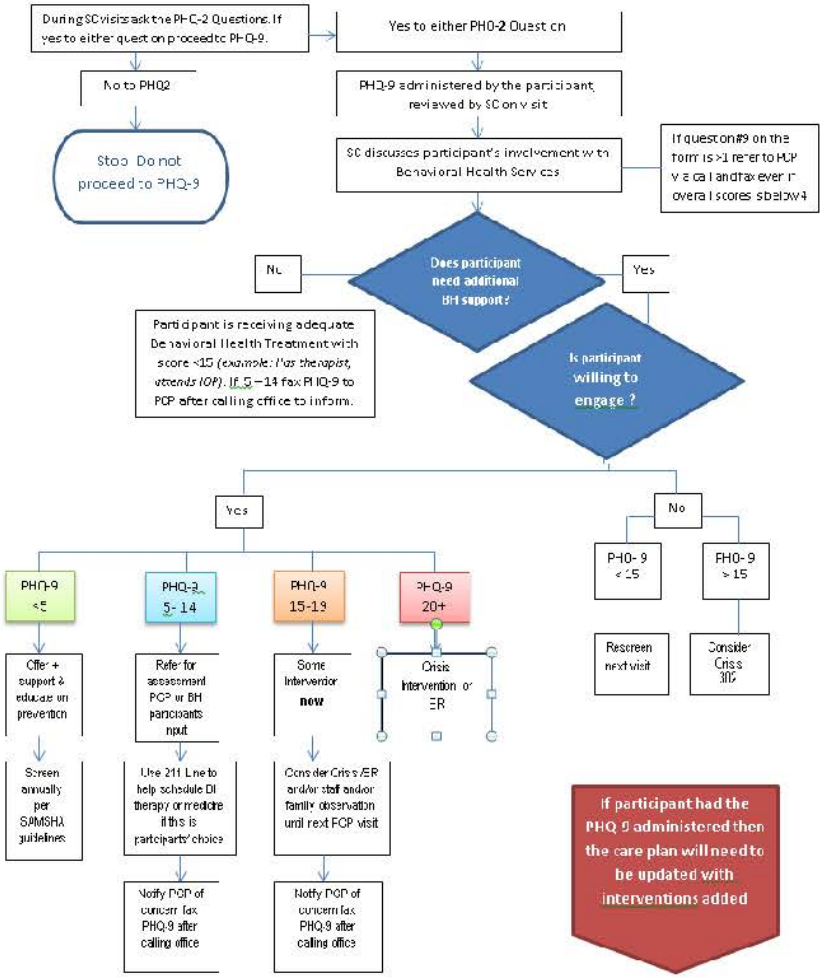
## Scoring

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

uds FOUNDATION

# Sad and Anxious Mood: Start the Conversation
## PHQ-2 and PHQ-9 Screening Tool



Dear Provider:

Your patient _____ Medicaid #_____
is currently a participant working with United Disabilities Services through the Independence Waiver program. As part of her annual visit with her service coordinator, she has completed the Patient Health Questionnaire Screening, used to identify her emotional well being. The screening has noted some symptoms indicating that the patient may require additional support.

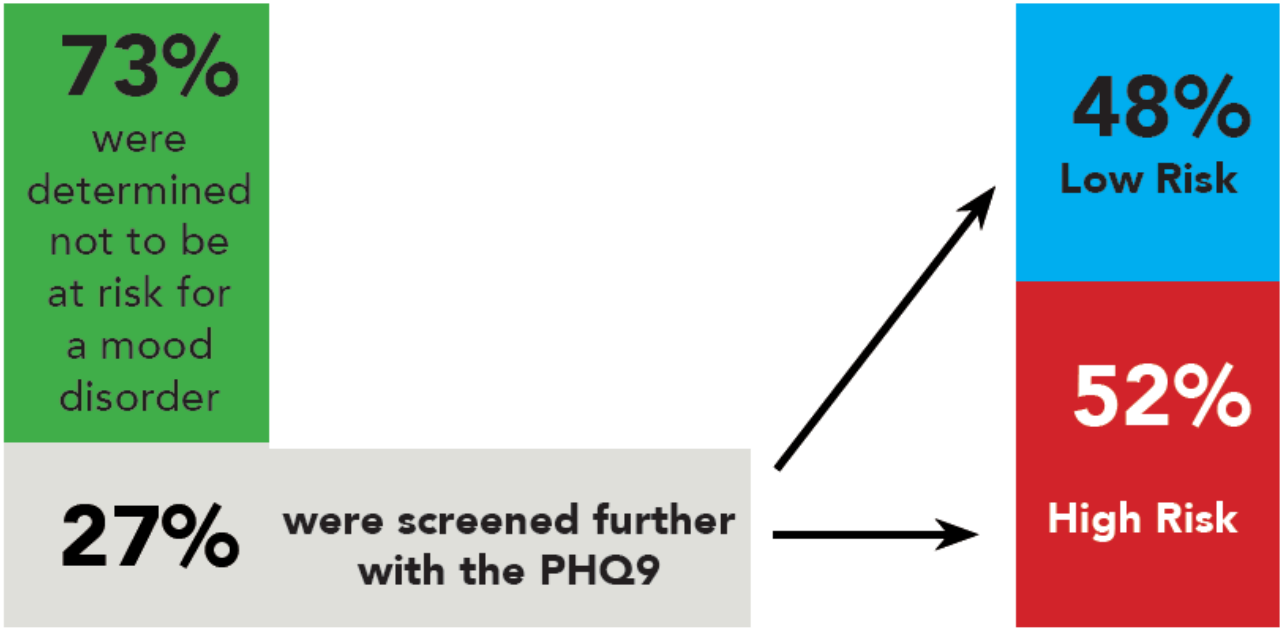
Please see the attached PHQ-2 &PHQ-9 screenings.
We recommend that you review the screening, and consider scheduling a visit with the participant to discuss any needed support or intervention. Crisis information has been provided to the participant in the event that it would be needed.

Additional information on the PHQ-9 can be found at:
http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health.aspx

The PHQ-2, comprising the first 2 items of the PHQ-9, inquires about the degree to which an individual has experienced depressed mood and anhedonia over the past two weeks. Its purpose is not to establish final diagnosis or to monitor depression severity, but rather to screen for depression. Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder. The PHQ-2 has been validated in 3 studies in which it showed wide variability in sensitivity (Gilbody, Richards, Brealey, and Hweitt, 2007).

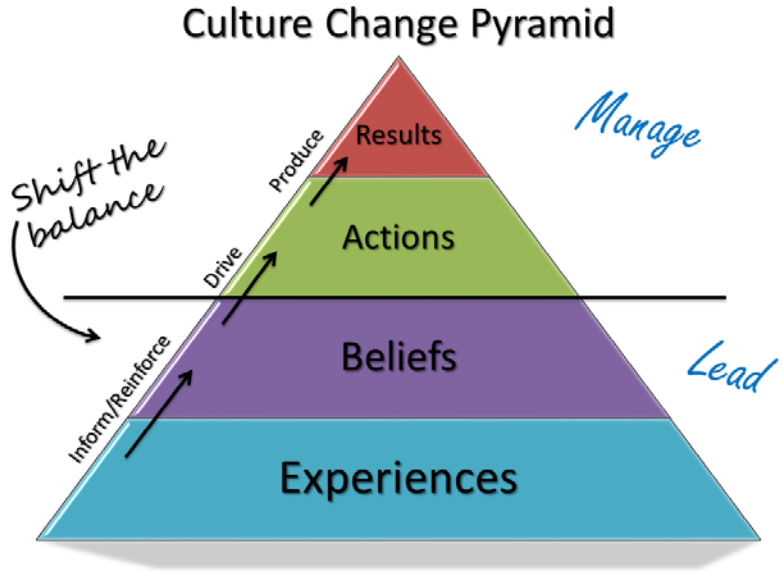
uds FOUNDATION

# Emotional Wellness Findings in our Population



# So How has this changed our culture?

https://youtu.be/anPWbN3cNR4




# Emotional Wellness wasn't our Outcome Goal

But it was our first pilot and a big step towards our goal.  It was an Actionable Item.
We launched other assessments:

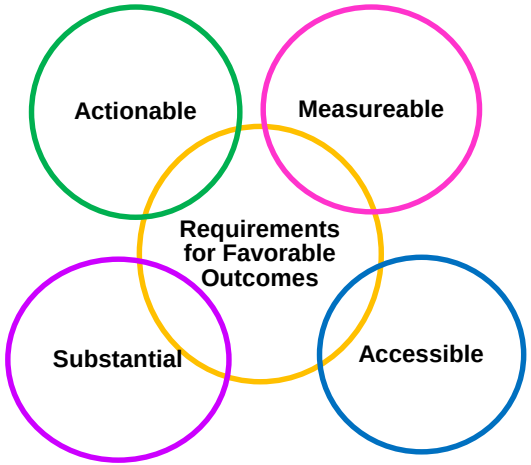
- BRIEF Literacy
- Audit-C
- Falls Assessment
- DSD – Direct Services Assessment (Ability + Preference = Time)
- High Risk Care Plans

**Can you guess what was our outcome goal?**  Hints below:

- We wanted to prevent participants from further decline in health by preventing a certain event
- We wanted to help reduce preventable (MC & MA) costs

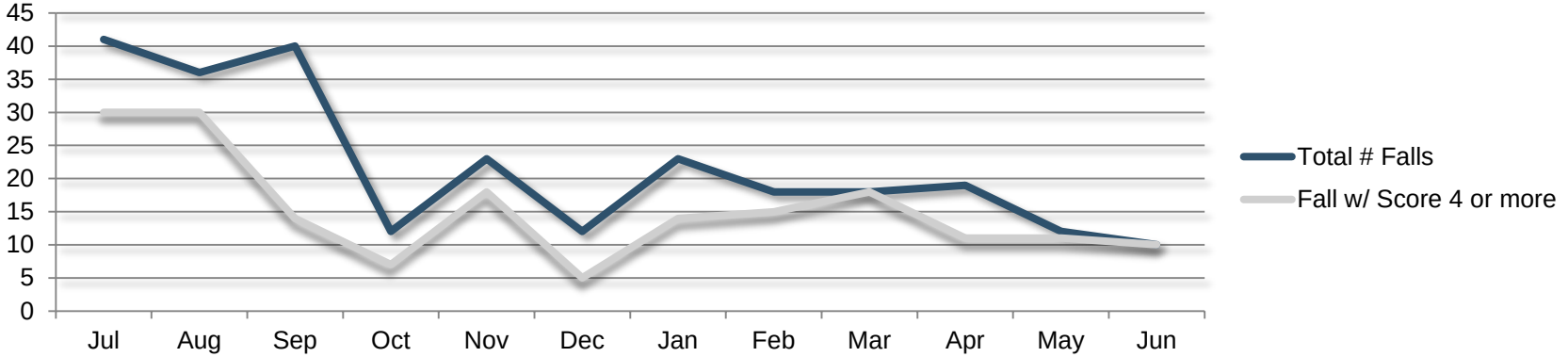
# Our Original Outcome Goal – Prevent Unplanned Hospitalizations

**Emotional Wellness was our first step.  It was followed by other supporting actionable items…**

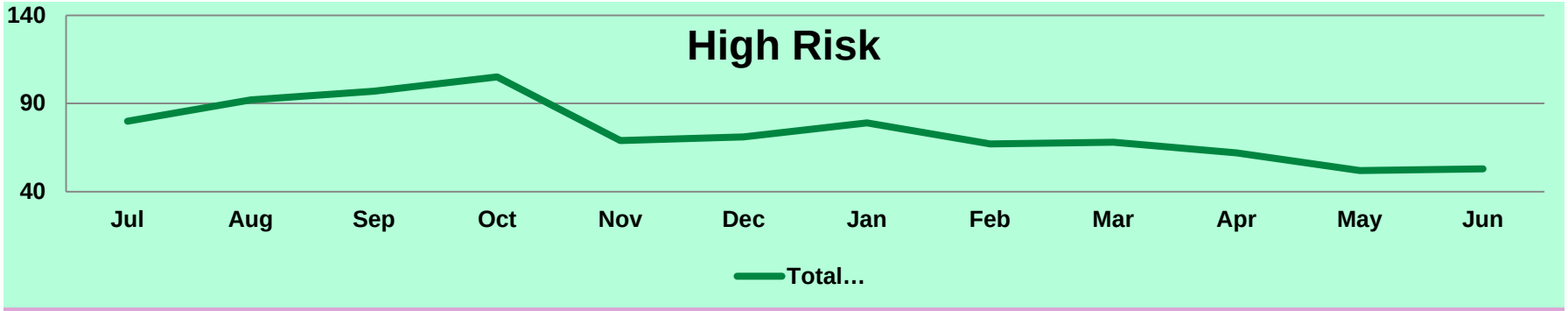


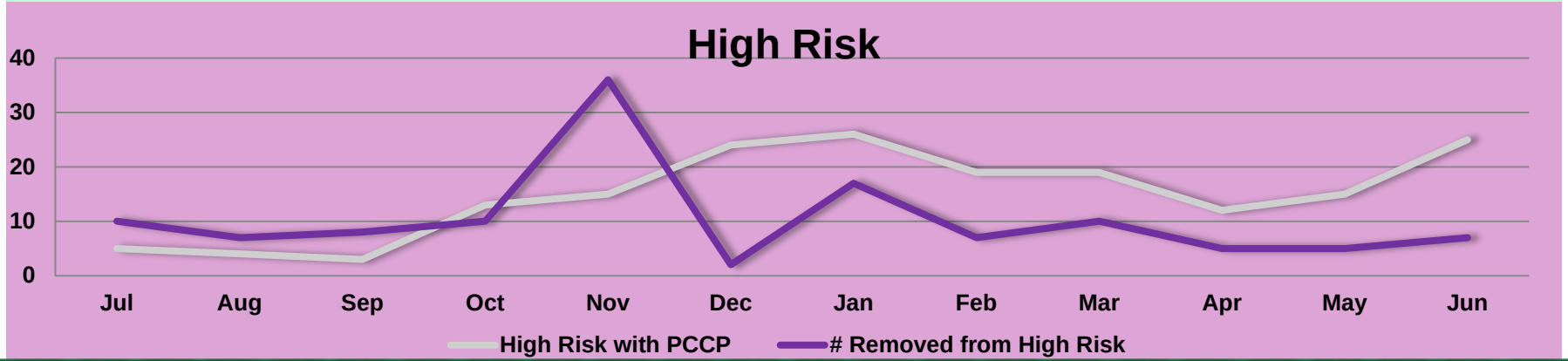

HQC Health Care Quality Congress

# Falls Assessments – Fall Reduction

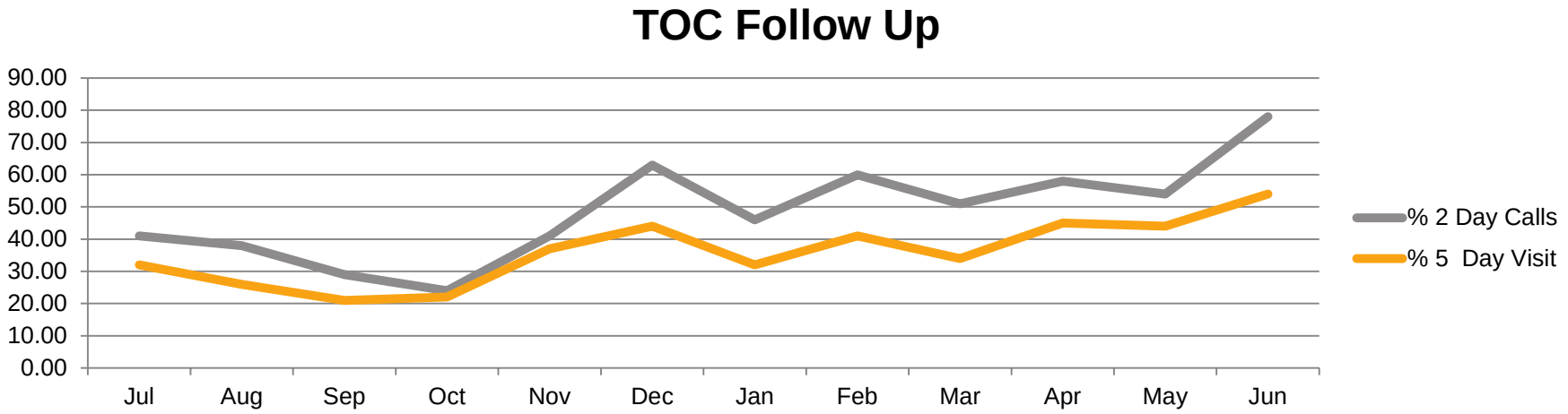



| | |
|---|---|
| **Hypothesis Statement** | The assumption is that mitigation strategies when implemented can reduce the risk of falls. First there is a need to identify those at high risk for falls and to implement fall reduction strategies. Falls contribute to increased Emergency Dept. (ED) visits and hospitalizations. Falls may contribute to a more rapid participant decline and negatively impact a participants ability to remain in the community as well as jeopardize a sense of well-being and safety |

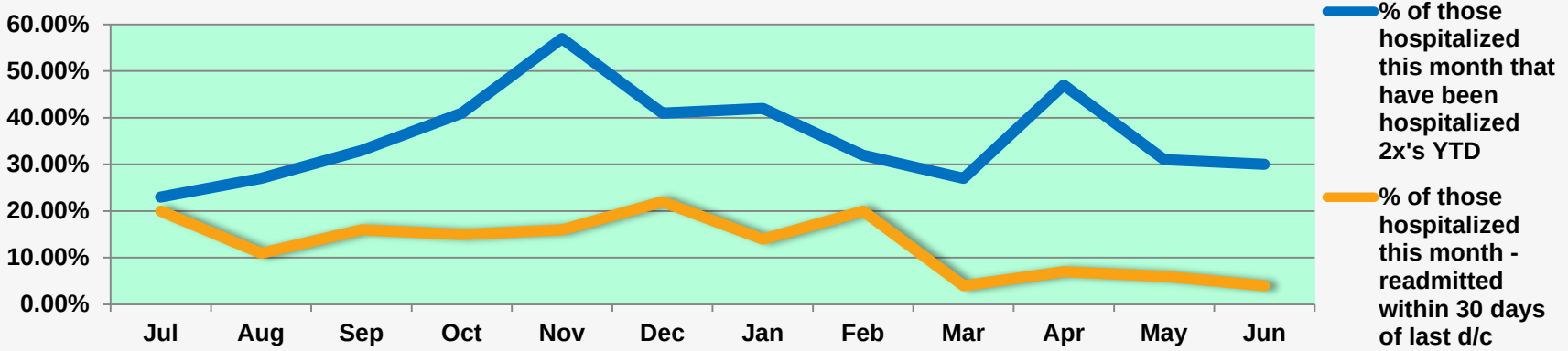

High Risk
140
90
40
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Total...


High Risk
40
30
20
10
0
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
High Risk with PCCP
# Removed from High Risk

# Transition of Care

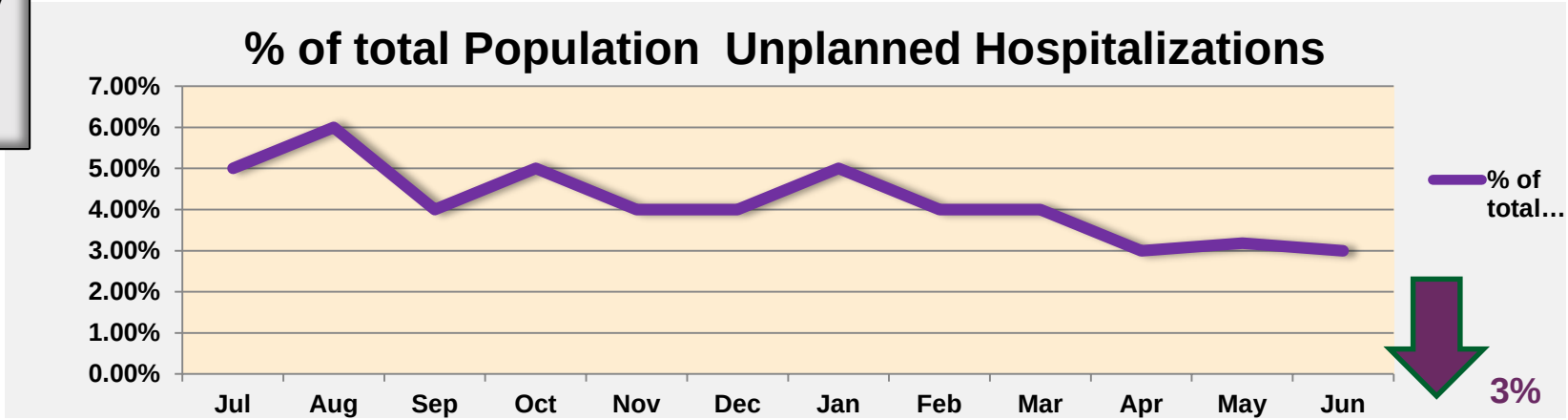


# Unplanned Readmissions



# So did our unplanned hospital admissions decrease?

**Prior Year Baseline**
Annual Average July 2016 – June 2017
**8%**



# And the Steps Were…

1. It’s all about the plan
2. Culture is Critical
3. Focus on Key Measures

**Actionable Measures**

- Emotional Wellness
- Fall Assessment
- High Risk Focus
- Transition of Care

**Outcome Measure**
**Unplanned Hospitalizations**

- Clinical Excellence
- Financial Excellence
- Staff Excellence
- Customer Excellence

4. Analyze, Trend & Repeat (Change as Needed)
5. Make Quality the Culture

uds FOUNDATION

## Questions Now and Later…

Contact information:
Debra Scheidt, Executive Director HCBS
United Disabilities Services
Lancaster, PA
717-397-1841
debrams@udservcies.org