PEAK 2.0 Times

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What is PEAK 2.0?

Improving the quality of life for those who live and work in long-term care settings across the state of Kansas is the primary goal for the PEAK (Providing Excellent Alternatives for Kansas Nursing Homes) program administered by the Kansas Department of Aging and Disability Services. Originally created about 10 years ago the PEAK program has been overhauled and the updated version was unveiled in 2012. In addition to recognition for homes that have achieved a minimum level of achievement in person-centered care, PEAK 2.0 also incorporates a tiered financial incentive package to encourage homes to begin and/or continue to pursue this model of care. For more details on the program, visit http://www.kdads.ks.gov/LongTermCare/PEAK/peak.html.

Design on a Dime

Person-Centered Care: Let's Talk Dollars and Cents

Note from the Program Coordinator:

Overwhelmed? Have you felt this way about PEAK? It sure can evoke these feelings. The K-State Center on Aging is here to help you take the big concepts outlined by the PEAK 2.0 program and break them down into manageable pieces to tackle in your organization. One big concept that comes up frequently is costs associated with implementing person-centered care practices. This issue of the newsletter focuses on this topic. Let's start our discussion by focusing the conversation. We must first recognize that care delivery, whatever the model, has costs associated with it. PEAK is asking you to replace one care delivery model and replace it with a person-centered care approach. PEAK is not asking you to maintain two care delivery models. The key question, then, is does person-centered care cost more than what we do now? And does a person-centered approach make our organization more valuable to consumers? This issue explores these questions further.

-- Laci Cornelison, PEAK 2.0 Program Coordinator

http://shareinspirequotes.blogspot.com/2013/02/

The Business Case for Culture Change

Culture change is understood by a growing number of executives to be a foundational element of successful long-term care business performance. From an economic perspective, in interviews with 15 executives at both for-profit and not-for-profit long-term care communities, culture change was consistently depicted as “good business”.

Leadership

Leaders of national long-term care organizations were asked about the value of investing in resident directed care and each reported many beneficial organizational outcomes from culture change activities, including decreased staff turnover, increased customer satisfaction, and a positive reputation in the community.

Occupancy

Homes with a sustained level of culture change from 2004-2009 maintained, on average, occupancy rates that were seven points higher than the national mean. In research of nursing homes with ulture change underway, 60% of homes with a high number of initiatives reported that culture change had a positive impact on occupancy.

Revenue

Major findings of a recent study indicate that adopter homes achieved an additional $11.43 per bed per day revenue over a comparison group of homes from 2004-2008. Thus, on average and with other factors accounted for, implementing culture change resulted in an additional $1600 per day for a 140-bed nursing home over the comparison group from a pre-to post-time frame.

Quality

One study of Green House homes found more direct care time per resident day and increased engagement for residents, less job-related stress experienced by direct care staff, and fewer acquired pressure ulcers. Correlations between clinical quality improvement and culture change efforts highlight only a narrow slice of the value proposition.

Information from: Planetree and The Picker Institute. (2010). Long-term Care Improvement Guide. Retrieved at http://planetree.org/wp-content/uploads/2011/12/LTC-Improvement-Guide-For-Download.pdf

Home Environment: Overcoming the Money Issue

Let's "Get Small"

A common struggle noted by participants is implementing elements of the home environment domain on a budget. There are several solutions to this that do not result in capital expenditures or increased operational costs. One key element of the home environment is privacy. While private rooms would be a preferred situation, that is not an achievable goal for all homes; however, intentional efforts to enhance privacy are possible in any environment.

Ask yourself some critical questions:
-Do staff members knock and WAIT for permission before entering a resident's room?
-Does your home have spaces that are conducive for residents to have private conversations or to seek solitude?
-Are resident spaces truly controlled by residents or are they largely dominated by staff?

Evergreen Retirement Community

Another critical issue to enhancing the home environment is "getting small". While some homes have interpreted this through structural changes such as neighborhoods, households, or Greenhouses, it is possible to "get small" in traditionally designed buildings, too. One way to get small is to create designated work teams that are consistently assigned to a smaller number of residents. For instance, a home in the PEAK program in a 60 bed building has created three work teams. Each of these teams work consistently with 20 residents. Each team also has a dedicated housekeeping, dietary, nursing, activity coordinator and social service representative.

Lonetree of Meade

A shift to smaller work teams can facilitate consistent staffing and relationships. These meaningful relationships and smaller work teams help the environment feel small even if it is still large in scale. It can also facilitate faster response time to residents' requests because staff members are more aware of resident needs and daily "habits" of behavior-meaning they know people at a deeper level. How can this work? Check out the next page to learn more.

Blending Roles and Departments

Let's look at a model that has been used at Evergreen Retirement Community, one of the PEAK 2.0 mentor homes. Evergreen serves 112 residents with an 85% Medicaid rate. Their census generally runs at 100%. They do not do any formal marketing and rely mostly on word of mouth referral. This organization moved to smaller work groups. Here's what the changes look like:

Old Staffing	→	Culture Change Staffing	=	$avings
2 1/2 Social Workers 4 Activity Staff	→	1 Quality of Life Director 4 QoL Coaches Per 28 Residents	=	$500 weekly plus increased hourly wages
8 Dietary Aides + 4 Housekeeping Aides per day	→	8 Homemakers Per Day 2 per 28 Residents 6am- 9pm coverage	=	48 Hours Per Week $444
1 MDS Coordinator + 1 ADON	→	2 Clinical Managers 1 Per 56 Residents	=	Budget Neutral
Per Day 28 Residents: 6 CNA's @ 8 Hrs = 48 Hrs 1/2 RA @ 4 Hrs = 4 Hrs 1/2 Bath Aide @ 4 = 4 Hrs 2 1/2 Nurses @ 8 Hrs = 20 Hrs Total= 76 Hours Per Day	→	Per Day 28 Residents: 5 or 6 CNA's = Avg 60 Hrs 1 CMA = Avg 10.85 Hrs 3 Nurses= Avg 26.14 Hrs Total= 96 Hours Per Day (Note: Hours above based on a change to 10 or 12 hours shifts)	=	$20,000 per month on Agency $117,000 annually in turnover

Old Staffing - 82 Avg Residents	**Culture Change Staffing - 106 Avg Residents**
2004 - Census was below 85%	2010 - Census Increased to 100%
Average Medicare A=4	Average Medicare A=10
Medicaid Rate at $133.41	Medicaid Rate + at $176.18
Annual Revenue Loss ($253,054)	2009 Ending + $232,013

$ Annual Revenue Gain = Ability to Increase Services

Information Provided By: Evergreen Retirement Community

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