PEAK 2.0 Times

This newsletter is brought to you by the Kansas State University Center on Aging through a grant from the Kansas Department of Aging and Disability Services

Volume 1 Issue 4 August 2013

What is PEAK 2.0?

Center on Aging 103 Leasure Hall, Manhattan, KS 66502
785-532-5945 --- ksucoa@gmail.com
Find us on YouTube at www.youtube.com/KSUCOA

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.

How do Deficiencies Effect PEAK 2.0 Incentive Payment?

This is a frequently asked question among PEAK 2.0 participating homes.To clarify this issue, we have turned to Rhonda Boose at KDADS. Rhonda provides the following guidance to us on this issue: KDADS sets NF reimbursement rates on a quarterly basis. A report of survey results for 15 months prior to the rate setting period is run each quarter. If a home receives a survey deficiency of G, H, I, J, or K in the 15 months prior to that quarter, it will have the following effect on incentives.

1) If a home receives a G deficiency and it is corrected within 30 days of the survey, they will be penalized 50% of all incentives for the period until the deficiency no longer appears on the report.
2) If a home receives a G deficiency and it is not corrected within 30 days of the survey, they will be penalized 100% of all incentives for the period until the deficiency no longer appears on the report.
3) If a home receives a H, I, J, or K deficiency, they will be penalized 100% of all incentives for the period until the deficiency no longer appears on the report.

Enrolled homes may continue to participate in the PEAK 2.0 program without payment. Homes that do this and continue to make progress around person-centered care may move up levels when they become eligible for the incentive again. Homes may also wish to discontinue participation and should contact the KSU staff so they can update their records.

The Role of the Nurse in Person Centered Care

Ariticle Written by: Judy Miller, RN &
PEAK 2.0 Project Consultant

"We just can't get them (the nurses) on board with culture change." I have heard this statement numerous times from organizations that are starting on the journey to person centered care. Nurses are often seen as a barrier to person centered care but when they are informed, included and supported they can be powerful change agents. The Director of Nursing, nurse managers, and charge nurses play a critical role in the organization to promote person centered care.

While nurses play a critical role in person centered care they, like everyone else, have concerns and face challenges. Let's take a moment to explore some concerns I think are very common.

PERCEIVED CHALLENGES:

1) Fear of losing control and ability to hold frontline caregivers accountable if they are empowered to make decisions.
2) We are so busy now, if we provide care around resident choices of schedule that includes sleep patterns, eating times, and medication pass times we will never get done.
3) Fear of "getting in trouble" for allowing resident to make choices about their care plan that may put them at risk or that goes against physician orders.

Change is scary for everyone and these concerns are important to understand and address. We can overcome some of the concerns by providing opportunities for open conversation and developing a strategy for change that involves all affected stakeholders. After you have listened well and developed a solid strategy, it is time to set a start date and implement the change(s). You will be pleasantly surprised how many concerns do not become realities!

While many concerns don't become reality there are some real challenges nurses will face in this model of care. Understanding these challenges and being proactive about them is critical.

REAL CHALLENGES:

1) Nurses are very busy meeting the demands of task and the diverse needs/schedule of residents.

The development of self-led work teams and the provision of education that empowers all caregivers to meet residents' needs and preferences actually lightens the load on nurses and leads to better outcomes for residents.
The role of the nurse in person centered care is to become the clinical gerontological expert. To ensure the nurse leaders have the time necessary to fulfill this role, I suggest reviewing the duties of the nurse to evaluate what tasks can be assigned to other team members. For example staff scheduling. This does not require the expertise of a nurse and can take much of their time. When these tasks are redistributed, nurses have more time to shine in their role.

2) Residents make choices that jeopardize resident safety or affect their highest well-being.

It is hard for nurses to grant residents the right to make a choice that will jeopardize his/her safety or put them at risk for negative disease outcome. After all we are trained to keep people safe and do what is necessary to provide good health outcomes. Here's an example of clinical training and culture change creating challenge. A person with diabetes makes a choice to eat foods that cause blood sugars to be out of control. It is hard for nurses to agree with this decision on a medical level. To help with this type of challenge nurses need to be trained and supported to respect resident choice. By developing a care plan that indicates resident choices, documentation that indicates an informed choice was made, and notification of physician as appropriate nurses can feel they are supporting resident choice but still providing good care. Person centered care still requires diligent nursing but flexibility and creativity, too.

3) Lack of knowledge regarding leadership skills that are needed to be a coach/mentor.

This type of care requires nurses to serve as mentors for not only other nurses but everyone on the interdisciplinary team. Nurses have been trained to be nurses not to be mentors. To help nurses succeed in this role they should be educated on leadership skills and styles as well as person centered care. With solid education, nurses feel more confident playing a leading role in change and helping to maintain it.

For this article I was challenged to provide some advice for nurse leaders related to culture change. Here are a few thoughts...

#1: Embrace your role of being a change agent.

#2: Don't allow fears of what might be hold you back.

#3: The hard work to implement person centered care practices is worth every ounce of effort when you measure the outcomes in personal, resident, and staff satisfaction.

#4: The one thing I learned with staff empowerment was this, "By letting go of control the more in control things become."

I am excited to be working on the PEAK 2.0 project and am even more excited to be able to support you on this journey. The PEAK 2.0 team, myself included, would welcome the opportunity to visit with you about the role of nurses in culture change or other challenges you might be facing.

"By Letting Go of Control the More in Control Things Become."

-Judy Miller, RN & PEAK 2.0 Project Consultant

KANSAS STATE UNIVERSITY CENTER ON AGING
103 LEASURE HALL, MANHATTAN, KS 66506-3501
785-532-5945

KANSAS STATE UNIVERSITY

KANSAS STATE UNIVERSITY NOTICE OF NONDISCRIMINATION

Kansas State University is committed to nondiscrimination on the basis of race, color, ethnic or national origin, sex, sexual orientation, gender identity, religion, age, ancestry, disability, military status, veteran status, or other non-merit reasons, in admissions, educational programs or activities and employment, including employment of disabled veterans and veterans of the Vietnam Era, as required by applicable laws and regulations. Responsibility for coordination of compliance efforts and receipt of inquiries concerning Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans With Disabilities Act of 1990, has been delegated to the Director of Affirmative Action, Kansas State University, 214 Anderson Hall, Manhattan, KS 66506-0124, (Phone) 785-532-6220; (TTY) 785-532-4807. Revised April 22, 2008.