

**Department of Health Care Finance  
Nursing Facility Quality Improvement Collaborative**

# Handbook

February 2019



Version 1.0

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## **Department of Health Care Finance (DHCF) District of Columbia**

### **Qualis Health**

Qualis Health is contracted by DHCF to lead the Nursing Facility Quality Improvement Collaborative.

### **The Institute for Healthcare Improvement (IHI)**

IHI-developed the Breakthrough Series Collaborative learning methodology including the Model for Improvement with colleagues from Associates in Process Improvement.

### **Incontinence Management Training Module**

Vanderbilt University Medical Center

Center for Quality Aging

[www.vanderbiltcqa.org](http://www.vanderbiltcqa.org)

# Contents

About This Handbook.....	1
Introduction.....	2
Overview.....	2
About the Nursing Facility Quality Improvement Collaborative.....	2
Schedule.....	4
Pre-work Activities.....	5
Pre-work Checklist.....	5
Reading the Collaborative Framework.....	6
Forming a Team.....	6
Registering and Arranging for Learning Sessions.....	8
Scheduling a Pre-work Visit.....	8
Communications with Facilities.....	9
Completing the Worksheet.....	9
Developing an Aim Statement.....	9
Defining a Population of Focus.....	10
Defining Measures.....	10
Senior Leader Reports.....	11
Preparing a Storyboard.....	12
Pre-work Activities Worksheet.....	13
Collaborative Framework.....	15
Charter.....	15
Problem Statement.....	15
Mission.....	16
Goals.....	17
Methods.....	17
Expectations.....	18
Change Package.....	20
Measurement Strategy.....	22
References.....	27
Collaborative Leadership and Faculty.....	28
Collaborative Glossary.....	29
Appendix A: Pre-work Activities Checklist.....	35
Appendix B: Pre-work Activities Worksheet.....	36

# About This Handbook

This handbook contains essential information about the *DHCF Nursing Facility Quality Improvement Collaborative* for participating nursing facilities in the District of Columbia. Its purpose is to provide participants with background and reference information on the Collaborative and to help teams prepare for a successful start to this exciting quality improvement process.

The **Introduction** sets the stage by giving some background information on Collaboratives as well as a schedule of major events and periods.

The **Framework** contains the Collaborative charter, which provides some background on improving resident care, satisfaction and costs of care, defines the overall mission, goals, and methods of the Collaborative, and outlines expectations for Collaborative participants.

**Topics for the Collaborative** include but are not limited to: Prompted Voiding Program, End of Life, pressure ulcers, MDS Assessment, documentation and workflow training, nursing facility system level topics (for example; leadership, team building, the role of the medical director, consistent assignment, and staff stability), clinical topics related to nursing facility quality measures (for example: mobility, antipsychotics, falls), care transitions, reduction of preventable ER and hospital admissions and readmissions, and interventions relevant to the findings/gaps from Consumer Assessment of Healthcare Providers and System (CAHPS®) surveys. Topic related Change Packages containing a variety of strategies, change concepts, and specific actionable items for changing processes of care will be available to Collaborative members to improve residents' quality of life and care.

The **Measurement Strategy** section provides you with data definitions for the required measures and provides teams with optional measures, and it describes the data that your team will collect to monitor your progress during the Collaborative.

The section on **Pre-work** activities will walk your team step-by-step through preparing for the first learning session.

A **Glossary** of terms and concepts and a list of **Collaborative Leadership** will serve as a reference throughout the Collaborative.

## A Collaborative is a systematic approach to quality improvement.

# Introduction

This section contains background information on Collaboratives, the Nursing Facility Quality Improvement Collaborative sponsored by the Department of Health Care Finance (DHCF), and a schedule of activities.

## Overview

A Collaborative is a systematic approach to healthcare quality improvement in which organizations and providers test and measure practice innovations, then share their experiences in an effort to accelerate learning and widespread implementation of best practices. In 1995, the Institute for Healthcare Improvement held the first Breakthrough Series Collaborative. Since then, more than 2000 teams from over 1000 international healthcare organizations, including many skilled nursing facilities, have participated in Collaboratives.

## The Nursing Facility Quality Improvement Collaborative

The Nursing Facility Quality Improvement Collaborative involves all the long term care nursing facilities in the District of Columbia, working together to individually test system changes aimed at improving quality and building tools for successful participation in pay-for-performance programs. A primary focus of the Collaborative is to collectively share learnings. The four main components of the Collaborative are pre-work activities, learning sessions, action periods, and the outcomes congress.

The Nursing Facility Quality Improvement Collaborative is structured to focus on one year topic cycles, over a five year period of time. The Collaborative structure is designed to focus on a limited number of improvement goals over a relatively short time frame to develop skills in rapid process improvement. New priorities will be assessed each year to determine new topics, evidence based practices and support to bridge care gaps and ensure the success of nursing facilities in the pay for performance environment.

**The Department of Health Care Finance (DHCF) has begun a Collaborative that is foundational to the planned activities outlined in the Handbook which describes the IHI Collaborative structure. Several learning sessions and activities have occurred over the past few months as part of DHCF's Collaborative work with the nursing facilities. The numbering of Learning Sessions and Webinars in this handbook are reflective of the IHI structure.**

Assessments and baseline data collected by DHCF indicates an opportunity to improve Nursing Facility Quality Improvement (NFQIP) Program Measure #7 (bowels and bladder). Incontinence reduction has been selected as the first topic for Year One as the change package and measurement strategies readily support learning quality improvement methodology and rapid cycle improvement. Resources for this topic are included in this handbook. The Collaborative will address other topics related to improvement and payment incentive opportunities as well. The Collaborative change package and measurement strategies will be updated for future topics.

**Pre-work** is the period between receipt of this handbook and Learning Session 1.

During this time, the nursing facility has several important tasks to accomplish in order to prepare for the

first learning session. The pre-work section of this handbook details these tasks, provides a checklist for pre-work activities, and provides a worksheet for documentation (see Appendix A and B).

**Learning Sessions** are the major interactive events of the Collaborative. Through plenary sessions, small group discussions, and team meetings, attendees have the opportunity to:

- learn from faculty (see Collaborative Leadership section) and colleagues,
- receive individual coaching and technical assistance,
- gather knowledge on the subject matter and on process improvement,
- share experiences and collaborate on improvement plans, and
- problem solve barriers to improving care.

**Action Periods** are the times between learning sessions. During action periods, nursing facility teams work within their organizations to test and implement changes aimed at improving specific clinical quality indicators. Teams share the results of their improvement efforts in monthly senior leader reports and also participate in shared learning through an email distribution list, conference calls, and webinars. Participation in action periods is not limited to those who attend the learning sessions; we encourage and expect the participation of other team members and supporters in the nursing facility.

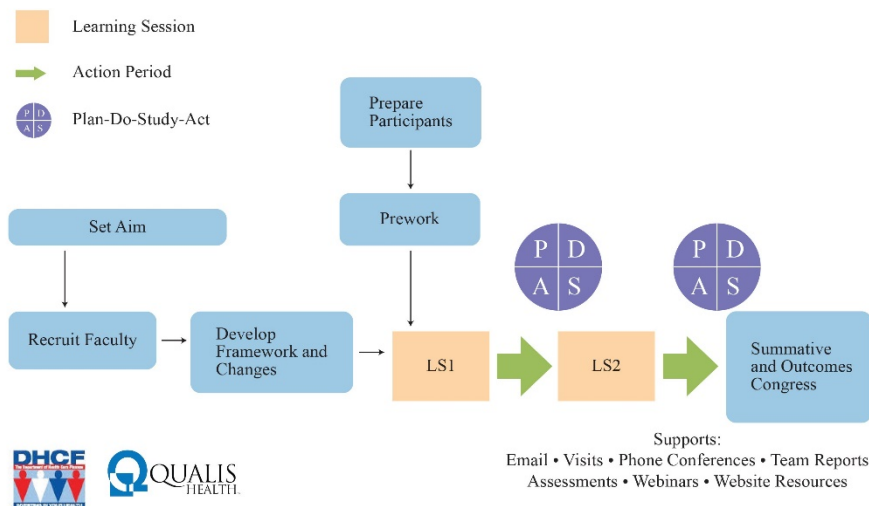
**Outcomes Congress.** The Collaborative will share its findings and achievements at an annual outcomes congress that will highlight the accomplishments of the teams and present effective models of improving care for Medicaid residents.

## Schedule

The sequence of events for the Collaborative is as follows: A specific schedule will be provided.

Pre-work	February 2019
Learning Session 1	March 2019 (8:00am - 12:30pm)
Action Period 1	March – May 2019
<ul style="list-style-type: none"> <li>TA visits</li> </ul>	<ul style="list-style-type: none"> <li>To be scheduled with each facility</li> </ul>
<ul style="list-style-type: none"> <li>Webinar #1</li> </ul>	<ul style="list-style-type: none"> <li>April 2019</li> </ul>
<ul style="list-style-type: none"> <li>TA visits</li> </ul>	<ul style="list-style-type: none"> <li>To be scheduled with each facility</li> </ul>
<ul style="list-style-type: none"> <li>Webinar #2</li> </ul>	<ul style="list-style-type: none"> <li>May 2019</li> </ul>
Learning Session 2	June 2019 (8:00am - 12:30pm)
Action Period 2 (with TA and Webinars to be scheduled)	June – August 2019
Outcomes Congress	Sept or Oct , 2019 (8:00am - 12:30pm)

## Department of Health Care Finance Nursing Facility Quality Improvement Collaborative



# Pre-work Activities

Pre-work is the period between receipt of this handbook and the initial learning session, targeted for March 2019. During this time, the nursing facility will have several important tasks to complete in order to prepare for the initial learning session. This section includes a checklist of pre-work activities and specific tasks that need to be completed during the pre-work period (see Appendix A and B).

A site visit will be made to each individual Nursing Facility by the Quality Improvement Consultant – Collaborative Lead to assist in preparing for the Pre-work activities.

## Checklist for Completing Pre-work Activities

To prepare for Learning Session 1, participating nursing facility teams should complete the tasks listed below:

- 1. Read the Collaborative framework
- 2. Form a team or review current Collaborative team
- 3. Register for Learning Session 1
- 4. If not previously arranged, each nursing facility team must schedule a pre-work visit
- 5. Coordinate email and internet access for accessing the Collaborative e-mail list and materials
- 6. Complete the pre-work activities worksheet
- 7. Develop an aim statement
- 8. Define (or identify) a population of focus (unit, floor, etc.)
- 9. Define optional measures
- 10. Plan for preparing senior leader reports
- 11. Prepare a storyboard for Learning Session 1



The following pages provide more detail about each task.

## 1. Reading the Collaborative Framework

Please read the Collaborative framework, which is the next section of this handbook. The framework defines the Collaborative mission, summarizes the evidence that will direct your work, outlines methods that your team will use to achieve the mission, and lists what teams can expect from the Collaborative.

## 2. Forming a Team

Each nursing facility needs to form a Collaborative team to test and implement system changes related to improving care. It is recommended that each team have at least four team members. These four, along with other members, comprise the facility team.

### Selecting Team Leaders

When forming your facility team, you will need to fill four leadership roles (one individual may fill multiple roles): senior leader, system leader, clinical champion, and day-to-day leader. Individuals in these roles represent the team at the learning sessions and the outcomes congress, and they share their learning with other members of the team. Team members will report progress to the senior leader, who is encouraged to attend all learning sessions and the outcomes congress but need only attend, at a minimum, the first learning session and the outcomes congress. Ideal team members are described below.

#### Senior Leader (either at the building or corporation level)

The ideal senior leader:

- has ultimate authority to allocate the time and resources to achieve the team's aim;
- has ultimate authority over all areas affected by the change; and
- will champion the spread of successful changes throughout the organization.

Examples of senior leaders include a *nursing facility administrator or director of nursing*. The senior leader is encouraged to attend all learning sessions and the outcomes congress and is required, at a minimum, to attend Learning Session 1 and the Outcomes Congress. Nursing facilities operated by corporations are encouraged to identify BOTH a building AND a corporate senior leader, and at a minimum, keep the corporate leader apprised of progress throughout the Collaborative, where necessary.

#### System Leader (in charge of line staff operations)

The ideal system leader:

- has direct authority to allocate the time and resources to achieve the team's aim;
- has direct authority over the particular systems affected by the change; and
- will champion the spread of successful changes throughout the facility.

An example of a system leader would be the *director of nursing or a charge nurse*. Please note: this individual may serve both roles (e.g. Senior Leader and System Leader). The system leader attends all learning sessions and the outcomes congress.

## Clinical Champion

The ideal clinical champion:

- is a respected clinical staff person with interest and expertise in improving clinical care;
- understands current processes of care;
- has a good working relationship with colleagues and the day-to-day leader; and
- wants to drive improvements in the system.

An example of a clinical champion would be a *physician, geriatric nurse practitioner, or medical director*. It is essential to have a clinical champion on the team. The clinical champion is encouraged but not required to attend Collaborative activities.

## Day-to-day Leader

The ideal day-to-day leader:

- drives the project, ensuring that cycles of change are tested, implemented, and documented;
- coordinates communication between the team and the Collaborative;
- oversees data collection; and
- works effectively with the clinical champion.

The day-to-day leader should understand how changes will affect systems and have the time to keep the project moving forward. The day-to-day leader should have the skills necessary to write summary reports of quality improvement progress. A *quality improvement leader, charge, resident care manager or highly motivated staff nurse* might serve as day-to-day leader. The day-to-day leader attends all learning sessions and the outcomes congress.

## Other Team Members

In addition to the facility team leaders, the Collaborative team should also include members from nursing facility departments potentially affected by system changes related to the clinical quality improvement aim. These other members should be included, but will not need to travel to Learning Sessions. These members should include people from departments and work areas that will be affected by the changes, to ensure that the team understands the system it is trying to redesign and to promote buy-in for the changes.

These members learn about the Collaborative from the leadership team and participate in implementation at the nursing facility. Potential team members include:

- residents and family members;
- paraprofessional nursing (nursing assistants) and rehab staff (therapy aide);
- staff development personnel;
- dietitians and dietary staff;

- professional rehabilitation staff (Occupational Therapists, Speech Therapists, and Physical Therapists);
- health information managers;
- activities and social services staff;
- central supply staff; and
- maintenance and environmental services.

## Checklist for Selecting Team Members

An effective team has members who work well together and who have a combination of skills, styles, and competencies. Effective team members have the following qualities:

- Leaders
- Team players
- Have specific skills and technical proficiencies relevant to the clinical quality improvement topic
- Possess excellent listening skills
- Communicate well verbally
- Problem-solvers
- Motivated to improve current systems and processes
- Believe it is possible to improve care related to incontinence and other topics
- Creative, innovative, and enthusiastic

## 3. Registering and Arranging for Learning Sessions

Team leaders represent the team at the learning sessions and the outcomes congress, and they share their learning with other members of the nursing facility team. The senior leader, at a minimum, should attend the first learning session and the outcomes congress. The system leader, the clinical champion, and the day-to-day leader should attend all learning sessions and the outcomes congress.

**It is important to allow flexibility in staff schedules and coverage to attend Learning Sessions.**

### Registering

Nursing facility teams must register for Learning Sessions so that Collaborative leadership can provide adequate supplies and materials. You will receive information on how to register at the pre-work site visit.

## 4. Scheduling a Pre-work Facility Visit

Each team must schedule a pre-work site visit before the first learning session. Visits are used to assess the teams' readiness to participate in the Collaborative, understand facility issues and goals, and to assist teams in preparing for Learning Session I. If you still need to schedule a facility visit, please contact {Gazelle Zeya at [gazelleZ@qualishealth.org](mailto:gazelleZ@qualishealth.org).}

## 5. Communications with Facilities

The Collaborative leadership and nursing facility team members will use the email system to distribute information and tools, ask questions and receive replies, and conduct ongoing discussions of changes tested, barriers encountered, and lessons learned. At least one member from each team and a back-up contact will take responsibility for distributing information to the rest of the team.

## 6. Completing the Worksheet

The pre-work activities worksheet at the end of this section will help you document progress as your team:

- forms;
- develops an aim statement;
- defines (or identifies) a population of focus (for example a wing or unit); and
- begins to select measures.

## 7. Developing an Aim Statement

The Collaborative is modeled after the Institute for Healthcare Improvement (IHI) Breakthrough Series Collaboratives, which use the Model for Improvement, a “trial-and-learn” approach to quality improvement. The Model for Improvement couples three fundamental questions with plan-do-study-act (PDSA) cycles:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in an improvement?

**The first question is answered in an aim statement.** An aim statement is a concise written statement describing what the team expects to accomplish in the Collaborative; it provides guidance for the team’s specific improvement efforts. The aim statement ensures that team activities align with the strategic goals of the team’s organization. Involving senior leadership in developing an aim statement can help teams ensure support for their work.

An example of an aim statement consistent with the goals of this Collaborative is as follows:

*To decrease the rate of incontinence for Medicaid residents at General Nursing Facility, by implementing a targeted prompted voiding program, resulting in the rate of incontinence being reduced by XX% by XX.*

In setting your aim, be sure to

**Involve senior leaders.** Senior leaders must align the aim with strategic goals of the organization. They must also provide for support personnel and resources from information systems, finance and reimbursement, medical affairs, etc.

**Base your aim on data or organizational needs.** Examine data within your organization. Refer to the Collaborative charter and focus on issues that matter at your nursing facility.

**State the aim clearly and use numerical goals.** Teams make better progress when they have an unambiguous, specific aim. Setting numerical targets clarifies the aim, helps create tension for

change, and directs measurement. For example, an aim to “ensure that 100% of CNA’s will be trained in the “Prompted Voiding Program within one month of orientation” will be more effective than an aim to “improve staff communication.”

There will be time to refine your aim statement at the learning session and time during the year to further refine goals and tests of change related to the aim statement.

## 8. Defining a Population of Focus

For participating nursing facilities, *the population of focus will be Medicaid residents*. It is recommended that teams select units, wings or resident areas that will be most impacted by the changes being made. Enthusiastic individual staff members for implementing tests of change or other considerations may also be factors in selecting a population of focus. The ultimate goal is to spread tested processes to all applicable areas and populations.

## 9. Defining Measures

Measuring performance during the Collaborative will enable the team to evaluate the impact of changes it makes in an effort to improve the delivery of care. Performance measurement is not an end in itself. Measurement should be designed to accelerate improvement, not slow it down.

Each team will monitor progress on selected measures that can be tracked and may choose additional process measures based on changes implemented.

### Suggested Measures

The suggested measures address *outcomes* and *processes* of care.

#### Outcome measures:

- Percent of low-risk residents who start an individualized Prompted Voiding (PV) Program (beyond the initial trial period)
- Percent of low-risk residents started on individualized PV Program who achieve level of continence = to code of 0 or 1 in section H0300 of MDS 3.0
- Relative improvement in low-risk incontinence Quality Measure(QM) from baseline (baseline QM remeasurement QM / baseline QM)

#### Process Measures:

- Percent of residents who qualify as low-risk for incontinence by MDS 3.0 who:
  - Have had an initial Pre-Trial Toileting Preference and Motivation Interview documented or
  - Who have had a recall assessment (section C0900 of MDS 3.0) conducted which indicates the resident would not be a reliable respondent to the Toileting Preference and Motivation Interview.
- Percent of residents who qualify as low-risk for incontinence by MDS 3.0 who have had a completed PV trial documented.
- Percent of residents who have had a PV trial documented who have had a Post-trial Toileting Preference and Motivation Interview documented.

## Balancing Measures:

- Staff satisfaction with overall incontinence program
- Staff satisfaction with PV program
- Resident satisfaction with overall incontinence program
- Resident satisfaction with PV program
- Family satisfaction with overall incontinence program
- Family satisfaction with PV program

## Additional Measures

Other optional measures may be defined and collected by the participant nursing facility based on process improvement activity specifics.

# 10. Senior Leader reports

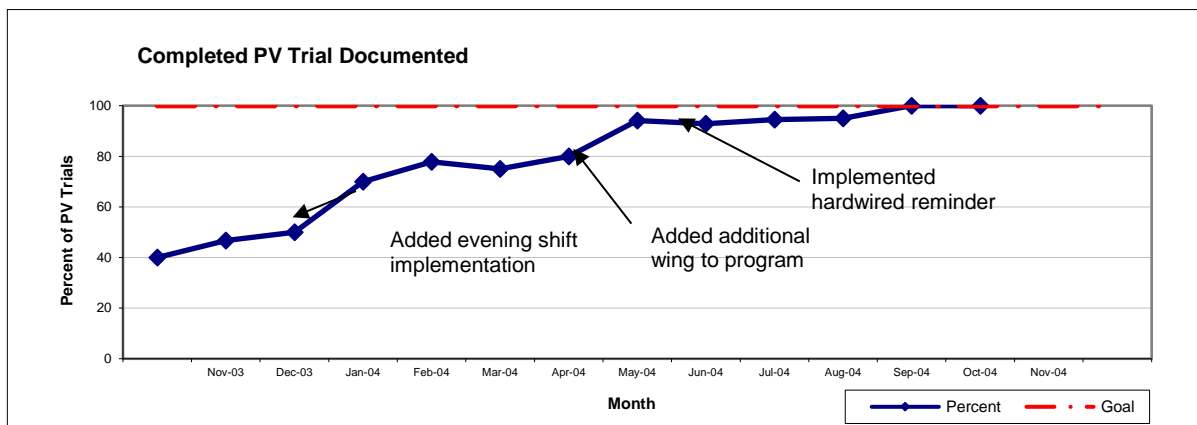
## Senior Leader Report

Each nursing facility will be expected to prepare a monthly report tracking the team's progress on the selected measures and documenting the system changes tested during that month. The audience for the report is the senior leadership at the nursing facility. Each nursing facility will also share the report with other Collaborative participants and faculty. More information about the senior leader report (templates, tools, etc.) will be distributed at the first Learning Session.

## Annotated Run Chart

A run chart is a line graph of data plotted over time. By collecting and charting data over time, you can find trends or patterns in the process and assess whether the changes you are making are leading to improvement. The minimum standard for monitoring the progress of your team throughout the Collaborative is an annotated run chart of the process measures selected. Data points should be plotted monthly on a run chart and submitted with senior leader reports. Run charts can be constructed via a run chart template provided to Collaborative members. The following run chart is one example of appropriate presentation of a prompted voiding process measure for the Collaborative:

Annotations on the run chart should include changes that are being evaluated or implemented as well as other circumstances that could impact Collaborative measures.



## 11. Preparing a Storyboard for Learning Session 1

At each learning session, nursing facility teams will be provided a display board, push pins, tape, an easel, and other supplies, so that teams can present what they have accomplished and learned so far. Storyboards help create an environment conducive to sharing and learning from the experiences of others.

At the first learning session, your storyboard will be a way to help introduce your team to the other Collaborative participants. The storyboard is an opportunity to have some fun and show the unique character of your nursing facility and your team. This is also the first opportunity of many to introduce the concept of “all teach, all learn” in that the participating nursing facilities will become the true experts over the course of the Collaborative. This first step – sharing the initial storyboard, which will be added to and reviewed at each learning session, allows each team to convey its goals and any work they've already done on this topic to the other teams.

The storyboard should be as clear and concise as possible. The audience for storyboards consists of other nursing facility teams, Collaborative leadership, and faculty, and observers attending a learning session. Suggested content for a team storyboard is:

- Brief description of your nursing facility
- Team name, with team members and their titles
- Draft aim statement
- Draft description of your resident population
- Draft list of selected measures
- Description of progress so far

You may wish to personalize your storyboard with pictures or other decorations that show your team spirit! Don't stress over this, however – start small and add on to the Story Board as the Collaborative progresses.

# Pre-work Activities Worksheet

- | <b>1. Team Members</b> | (Name) | (Title) |
|------------------------|--------|---------|
| a. Senior Leader       | _____  | _____   |
| b. System Leader       | _____  | _____   |
| c. Clinical Champion   | _____  | _____   |
| d. Day-to-Day Leader   | _____  | _____   |
| e. Other Team Members  | _____  | _____   |

## 2. Working Draft of Aim Statement

*Example: Implement Prompted Voiding Program to achieve a relative improvement for Medicaid residents by 30% by January 2019.*

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## 3. Definition of Population of Focus

*Identify the nursing units or areas from which your population of focus is drawn (this could be all or a subset of units in the facility with Medicaid residents).*

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## 4. Working List of Measures Selected

### Sample suggested measures:

- Percent of low-risk residents who start an individualized Prompted Voiding Program (beyond the initial trial period)
- Percent of low-risk residents started on individualized Prompted Voiding Program who achieve level of continence = to code of 0 or 1 in section H0300 of MDS 3.0
- Relative improvement in low-risk incontinence Quality Measure from baseline (baseline QM-remeasurement QM / baseline QM)

### Potential issues in collecting data for the required measures:

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### Other optional measures selected:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### Potential issues in collecting data for the optional measures selected:

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# Collaborative Framework

The Collaborative framework includes the charter—problem statement, mission, goal, methods, and expectations—the change package, and measurement strategy, all of which were developed by Qualis Health, DHCF Nursing Facility Quality Improvement Program, and the Incontinence Management Training Module using the Institute for Healthcare Improvement (IHI) techniques. References and recommended reading follow the measurement strategy.

## Charter

The purpose of the Collaborative (Year One) is to decrease incontinence by improving the effectiveness and efficiency of nursing facility treatment. This will be accomplished through the application of evidence-based practices to the processes of assessment, treatment, and monitoring of nursing facility residents. The immediate goal of this Collaborative is to assure that 100 percent of the eligible resident population receives appropriate assessment, preventive care, and treatment 100 percent of the time. The ultimate goal of this Collaborative is to deepen the organizational commitment to improved systems of care for frail and chronically ill Medicaid patients between and among all providers in the local community.

## Problem Statement\*

The prevalence and incidence of incontinence in nursing facilities is a topic of national interest in improving care for nursing facility residents. Incontinent nursing facility residents are among the frailest of the frail. Most have physical impairments that restrict their mobility and many suffer from dementia. Given the profound functional and cognitive losses they've experienced, you might think these residents would be poor candidates for prompted voiding programs that improve continence. However, a significant proportion of these severely impaired residents are motivated to stay dry. More than 50% of nursing facility residents suffer from urinary incontinence, and most of them have both physical and cognitive problems that prevent them from independently using the toilet. National research indicates that residents are changed an average of 1.34 times per 12 hours and are provided toileting assistance an average of .5 times, and very rarely more than twice a day. Lack of staff time partly explains the latter findings, but lack of staff knowledge is another, often un-credited culprit. Many nursing facility staff are unaware of key findings from more than 10 years of research on prompted voiding programs, the most extensively evaluated toileting assistance intervention for nursing facility residents. Prompted voiding programs are designed to create awareness among residents of their continence status (i.e., whether they are wet or dry) and to encourage them to ask for toileting assistance. When implemented properly, the programs work. Findings show:

- Prompted voiding results in a 40% to 50% overall reduction in the frequency of daytime urinary incontinence (4, 8)
- Between 25% and 40% of incontinent residents will respond to prompted voiding, with a reduction in their incontinence frequency from three to four episodes per day to one per day

- Residents who are most responsive to prompted voiding can be easily identified in a three-day trial of the intervention
- Even residents with severe cognitive and physical impairments have proven responsive to prompted voiding

One obvious key to program success is assessment of resident responsiveness to the intervention. In the absence of these initial assessments, it is impossible to objectively determine who should receive toileting assistance and who should be managed on a check-and-change program.

Without the benefit of a resident assessment, nursing facility staff members often attempt to toilet all incontinent residents, but then fall short of recommended care standards due to excessive workloads.

Baseline data collected by DHCF indicates that there is opportunity to improve the percent of low-risk long-stay residents who lose control of their bowels or bladder for District of Columbia nursing facilities. In the 2018 baseline period, over half of the facilities had rates higher than the 25th percentile threshold, for at least one quarter.

## **THE BENEFITS OF PROMPTED VOIDING PROGRAMS**

Providing proper toileting assistance to residents makes sense clinically and economically. Urinary incontinence is estimated to cost nursing facilities close to \$5 billion annually, including costs for laundry, staff time, and supplies. Urinary incontinence also is associated with a high rate of infection, requiring costly medical treatment both in the hospital and within the nursing facility. Prevention programs such as prompted voiding address both problems, enhancing clinical outcomes for residents while possibly improving the facility's bottom line. Prompted voiding programs also offer public relations value. Surveys have shown greater resident and family satisfaction related to improved continence.

Additionally, prompted voiding programs can contribute to better scores on publicly reported quality measures for nursing facilities, including measures related to catheter use, urinary tract infections and control of bowels or bladder.

Finally, improved incontinence care can improve staff morale with the reduction of family complaints and nurse aides recognition of the restorative nature of their role.

(\*Problem statement background material is from the Incontinence Training Module, Vanderbilt University Medical Center, Center for Quality Aging at [www.vanderbiltcqa.org](http://www.vanderbiltcqa.org).)

## **Mission**

The mission of this Collaborative is to achieve, in 12 month cycles, breakthrough improvement in the assessment and treatment of Medicaid nursing facility residents through consistent use of evidence-based clinical practices in the nursing facilities participating in the Collaborative.

Consistent use of these evidence-based practices is best achieved in nursing facilities that use a resident-centered care philosophy and that have created a culture of safety.

Systems designed to promote resident-centered care provide each resident with meaningful choices in treatment and lifestyles, and honor those choices whenever possible. A culture of resident-centered care places the resident's quality of life at the center of clinical decisions.

A safety culture can be defined as “the product of individual and group values, attitudes, competencies, and patterns of behavior that determine the commitment to, and style and proficiency of, an organization's health and safety programs.” Nursing facilities with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of assessment, treatment, and preventive measures. Early assessment and treatment of nursing facility residents is a perfect example of improved resident safety, ensuring that residents receive needed care as quickly as possible and that they avoid unnecessary and/or unwanted care. This Collaborative supports, as central to its mission, a nursing facility culture that embraces both resident safety and resident-centered care.

The Collaborative faculty will help each of the nursing facilities achieve this mission and their facility-specific aim. The faculty will support the teams in meeting the Collaborative goals by sharing the best available scientific knowledge on creating resident-centered care in a safe environment through improved clinical practices and by teaching and applying methods for organizational change.

## Goals

The primary goals of the Year One Collaborative are:

- to engage in a collaborative learning process with the nursing facilities in the District of Columbia to implement best practices to reduce incontinence for Medicaid residents in order to achieve a 30% relative improvement or the 10<sup>th</sup> percentile (25%) by January 2019. (Based on research regarding the effectiveness of Prompted Voiding in nursing facilities, a 30% RIR in the QM is reasonable goal. There is a national percentile ranking for the QMs. A stretch goal would be for all facilities to reach the 10<sup>th</sup> percentile for the QM. As of quarter 2, 2018, the 10<sup>th</sup> percentile for incontinence QM was 25%);
- to address other individual facility quality improvement priorities to be addressed via individual technical assistance, coaching and training;
- to capture learnings for sustainability and spread to local and national Medicaid nursing facility populations.

## Methods

Each nursing facility is expected to develop an aim statement (a statement on what the team expects to accomplish during the Collaborative) that includes for example, specific goals relating to reducing incontinence via prompted voiding best practices. Nursing facilities may begin by working initially within a specific population (population of focus) within their facility. The ultimate goal is to spread the improvements to other populations either within or beyond the facility. Nursing facilities should select a population of focus based on the need for improvement in incontinence prevention and reduction.

Both process and outcome measurement strategies will be used to assess organizational progress toward achieving Collaborative goals. Nursing facilities will learn an improvement strategy that includes breakthrough goals and a method to develop, test, and implement changes in their processes of care and infrastructure. Nursing facilities will be expected to collect well-defined data that relate to their aim at least monthly and to plot these data over time for the duration of the Collaborative. An annotated time series or run chart (see Glossary) will be used to assess the impact of changes.

The Collaborative will use the “all teach, all learn” methodology – at first, faculty (mainly Qualis Health and its expert consultants) will provide most of the teaching – but as the Collaborative progresses, the participant nursing facilities will assume larger roles in sharing successes and providing mentorship. The all teach, all learn methodology is apparent during all learning sessions, beginning with the first learning session, in the form of storyboard displays and reviews.

The Collaborative faculty will aid nursing facilities in capitalizing on the learning and improvement from the focused project by simultaneously coaching senior leaders in nursing facilities to develop a system for spreading improvement to other facility areas or to other clinical topics.

## Expectations

### The Collaborative faculty will:

- provide expertise on clinical content and process improvement, both during and between learning sessions;
- offer coaching to teams;
- provide an electronic mailing list (email list) and other communication venues for shared learning;
- assess team progress and provide feedback to teams monthly;
- plan and implement the face-to-face meetings (learning sessions and an outcomes congress);
- provide resources to participants to accelerate spread among nursing facilities in the District of Columbia; and
- maintain and safeguard the confidentiality of privileged data or information in compliance with HIPAA regulations—whether written, photographed, or electronically recorded and whether generated or acquired by the team—which can be used to identify an individual patient, practitioner, nursing facility, health plan, or patient population), per Department of Health Care Finance contract section H.7 HIPAA Business Associate Compliance requirements applicable to Qualis Health.

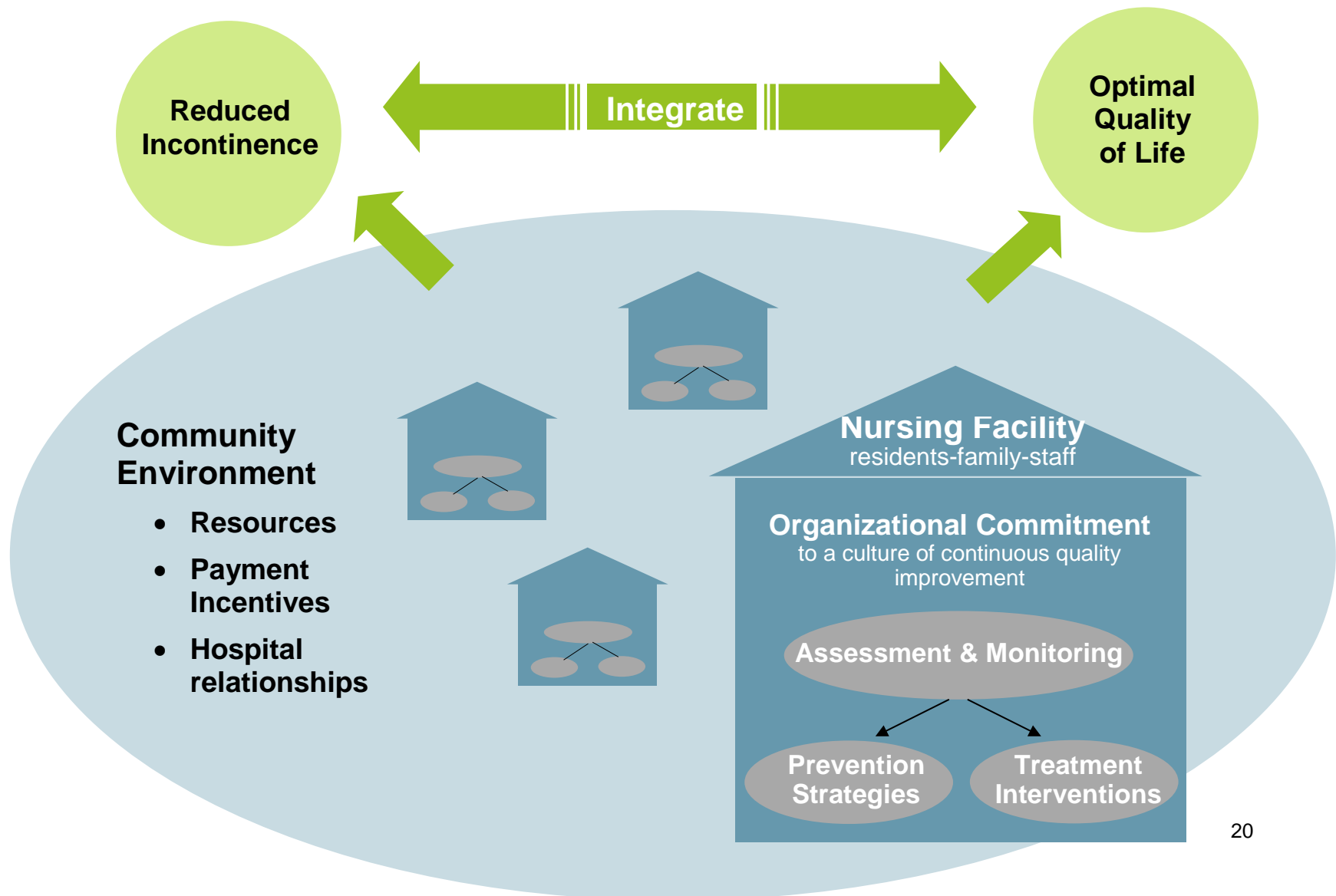
### Nursing facilities are expected to:

- perform pre-work activities as outlined in the **Pre-work Activities** section of the handbook;
- connect the goals of the Collaborative work to a strategic initiative in the nursing facility;
- provide a senior leader to sponsor and actively support the team;
- participate in each learning session (participation by all core team members is highly recommended, and supports the “all teach, all learn” philosophy);

- identify the performance measures that the team will target, including the required performance measures related to decreasing incontinence;
- plan, design and implement plan-do-study-act (PDSA) improvement cycles to meet the targeted performance measures;
- submit monthly reports to the team's senior leader and Collaborative faculty, identifying progress and PDSA cycles implemented;
- create storyboards for presentation at each learning session;
- share information with the Collaborative, including details of changes made and data to support these changes, both during and between learning sessions; and
- maintain and safeguard the confidentiality of privileged data or information in compliance with HIPAA regulations—whether written, photographed, or electronically recorded and whether generated or acquired by the team—which can be used to identify an individual patient, practitioner, nursing facility, health plan, or patient populations per Department of Health Care Finance contract section H.7 HIPAA Business Associate Compliance requirements applicable to Qualis Health.

# Change Package

The change package is a collection of ideas for changing processes of care



Improvement Strategies ("Change Concepts")	Summary of Key Changes
<b>Assess Resident Responsiveness to Prompted Voiding</b>	Rationale for prompted voiding three day trial as best predictor of responsiveness to the intervention (establishing efficient and effective interventions to appropriate residents) <ul style="list-style-type: none"> <li>• Assessing resident preference and motivation for toileting assistance</li> <li>• procedures to implement the prompted voiding trial</li> <li>• treatment options for non-responders</li> </ul>
<b>Implement Time-Saving Strategies to Maintain Prompted Voiding Programs</b>	Strategies to maintain a prompted voiding program and maximize benefits to residents such as; <ul style="list-style-type: none"> <li>• Tips for efficient and effective staffing for residents who most benefit from prompted voiding</li> <li>• Ideas for integrating prompted voiding with other interventions such as mobility</li> <li>• Ways to prioritize shifts, limit hours or narrow prompted voiding criteria to maintain prompted voiding program</li> </ul>
<b>Monitor the Prompted Voiding Program</b>	Provide monitoring checks to; <ul style="list-style-type: none"> <li>• Track performance over time</li> <li>• Share results with staff and elicit help with improvements</li> </ul>
<b>Forms and Tools</b>	Incontinence Management Training Module  --Toileting Motivation and Preference Assessment Survey --Prompted Voiding Trial --Medical Record Review --Wet Check Record --Low-risk incontinence QM exclusions from MDS 3.0  Please note: DHCF will host access to all Collaborative documents on DHCF website

**The Incontinence Management Training Module materials will be provided to Collaborative participants.**



## Measurement Strategy

The following table lists measures that teams can select from and adapt. It is recommended that at a minimum, teams select one outcome measure and one process measure. Teams may also develop new process measures based on the issues that are of most interest and importance to them. All selected measures are reported monthly by the 10<sup>th</sup> of the month.

## Outcome Measures

Measures	Statistic	Data Collection	Appropriate Collaborative Goals	Rationale
Percent of low- risk residents started on individualized Prompted Voiding (PV) Program after initial 3-day trial	Numerator: Number of residents on PV program  Denominator: Number residents with PV trial	PV Roster (record of which residents were trialed and which graduated to long-term PV program)	30% of residents who undergo PV trial will be maintained on PV Program long-term	
Percent of residents started on individualized PV Program who code 0 or 1 on section H0300 of MDS 3.0	Number of residents who code 0 or 1 on section H0300 of MDS  Number of residents who were started on individualized PV Program.	1. Roster of residents started on PV program  2. Current assessment of incontinence in 7 day look-back period based on voiding diary or PV program records		Not all residents in PV programs will achieve total continence, but the greater the proportion who do, the greater the improvement in the incontinence QM is attributable to PV programing

Measures	Statistic	Data Collection	Appropriate Collaborative Goals	Rationale
RIR in low-risk incontinence QM	Numerator: Baseline QM minus remeasurement QM  Denominator: Baseline QM	CASPER / MDS Quality Measures (QM's) to monitor any potential positive or negative impact of interventions	30% RIR or 10 <sup>th</sup> percentile for QM	Indicates if the quality improvement efforts are associated with negative or positive impact on clinical quality measures over a longer period of time

## Process Measures

Measures	Statistic	Data Collection	Appropriate Collaborative Goals	Rationale
Percent of residents who qualify as low-risk for incontinence by MDS 3.0 who <ul style="list-style-type: none"> <li>have had an initial Pre-Trial Toileting Preference and Motivation Interview documented or</li> <li>have had a recall assessment (section C0900 of MDS3.0) conducted which indicates the resident would not</li> </ul>	Numerator: Number of low-risk long-stay residents who lose control of their bowels or bladder by MDS 3.0 with Interview documented or assessment of not reliable / appropriate for Interview  Denominator: Number of low-risk long-stay residents who lose control of their bowels or bladder by MDS 3.0	Interview documents  MDS recall assessment documented  PV Roster	100% of low-risk incontinent residents	Assessing and documenting pre-trial resident preference and motivation for toileting assistance is key to prioritizing which residents receive PV trial and assessing PV trial results (when compared to post-trial interview)

Measures	Statistic	Data Collection	Appropriate Collaborative Goals	Rationale
<p>be a reliable respondent to the Toileting Preference and Motivation Interview</p>				
<p>Percent of residents who qualify as low-risk for incontinence by MDS 3.0 who have had a completed Prompted Voiding trial documented</p>	<p>Numerator: number of residents who qualify as low-risk for incontinence by MDS 3.0 who have had a completed Prompted Voiding trial documented</p> <p>Denominator: number of residents who qualify as low-risk for incontinence by MDS 3.0</p>	<p>Medical Record</p> <p>Prompted Voiding Program Roster</p>		<p>Measures intervention uptake</p>
<p>Percent of residents who have had a Prompted Voiding trial documented who have had a Post-Trial Toileting Preference and Motivation Interview documented</p>	<p>Numerator: number of residents who have had a Prompted Voiding trial documented who have had a Post-Trial Toileting Preference and Motivation Interview documented</p> <p>Denominator: number of residents who have had a Prompted Voiding trial documented</p>	<p>Interview documents</p>		<p>Assessing and documenting post-trial resident preference and motivation for toileting assistance is key to assessing PV trial results (when compared to pretrial interview)</p>

## Balancing Measures

Measures that together with the selected process and outcome measures describe a great system of care. These measures may be process or outcome measures, and usually measure some aspect of the system that may inadvertently be affected by changes in specific areas of the model.

Measures	Statistic	Notes	Data Collection	Appropriate Collaborative Goals	Rationale
Staff satisfaction with PV program	Average satisfaction score from staff satisfaction survey		<p>Consider a select focus group of staff impacted by process changes to avoid bias from non-respondents (satisfaction level may influence the likelihood that someone completes the survey)</p> <p>Consider using existing survey instruments. May not be appropriate to survey monthly; consider a survey quarterly or at the start and end of the Collaborative.</p>	To be determined by team	Indicates if the quality improvement efforts are associated with negative or positive impact on staff

Measures	Statistic	Notes	Data Collection	Appropriate Collaborative Goals	Rationale
Resident satisfaction with PV program	Resident Preference and Motivation for Using the Toilet Pre/Post Interview data	Survey of resident participating in PV Program		To be determined by team	Indicates if the quality improvement efforts are associated with negative or positive impact on residents/family members
Family satisfaction with PV program	Resident Preference and Motivation for Using the Toilet Pre/Post Interview data (if family member is the interview proxy respondent)	Survey of family member (proxy) of resident participating in PV Program		To be determined by team	Indicates if the quality improvement efforts are associated with negative or positive impact on residents/family members

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# Collaborative Glossary

## **Action Period**

The time between learning sessions when teams work on improvement in their own facilities. They are supported by the Collaborative leadership team and faculty, and they are connected to other Collaborative team members.

## **Aim, or Aim Statement**

A written, measurable, and time-sensitive statement of the accomplishments a team expects to make from its improvement effort. The aim statement contains a general description of the work, the population of focus, the numerical goals, and a statement on spreading the changes to another population.

## **Annotated Run Chart, or Annotated Time Series**

A line graph showing results of improvement efforts plotted over time. The changes or annotations made are also noted on the chart at the time they occur, allowing the viewer to connect changes made with specific results.

## **Assessment Scale**

A numerical scale used to assess the progress of participating teams toward reaching their aim. 1 = forming team, and 5 = outstanding, sustainable improvement. In each Collaborative, Collaborative faculty assesses teams and may also ask them to evaluate their own progress using this scale. The expected level of attainment by the end of the Collaborative is a 4 (significant progress).

## **BTS Collaborative**

Breakthrough Series Collaborative (see Collaborative)

## **Collaborative Chair**

The leader of the Collaborative, usually an expert in the topic.

## **Clinical Champion**

An individual in the organization who believes strongly in the improvements and is willing to try them and work with others to learn them. Teams need at least one nurse champion on their team. Champions in other disciplines who work on the process are important as well.

## **Change Concept**

A general idea for changing a process. Change concepts are usually at a high level of abstraction, but evoke multiple specific ideas for how to change processes. "Simplify," "reduce handoffs," "consider all parties as part of the same system," are all examples of change concepts.

## **Change Package**

A collection of change concepts and key changes.



**Collaborative**

A time-limited effort (usually 6–13 months) made by multiple organizations that come together with faculty to learn about and create improved processes on a specific topic. The expectation is that the teams share expertise and data with each other; thus, “Everyone learns, everyone teaches.”

**Collaborative Framework**

The Collaborative framework consists of the charter, change package, and measurement strategy. The framework provides constant direction to the teams regarding why they are doing this work, what changes they can make, and how they can use measurement to determine if they are making changes that result in improvements.

**Collaborative Team**

All individuals from the nursing facilities, Qualis Health and DHCF that drive and participate in the improvement process. A core team of three individuals attends the learning sessions, but a larger team of six to eight people, often from various disciplines, participates in the improvement process in the organization.

**Community of Practice**

Groups of people who share a concern, set of problems, mandate or sense of purpose. Communities of practice complement existing structures by promoting collaboration, information exchange, and sharing of best practices across boundaries of time, distance, and organizational hierarchies. A great deal of knowledge creation happens in these less visible but increasingly recognized and supported groups.

**Collaborative Coordinator**

Qualis Health staff person responsible for the day-to-day activities of the Collaborative, including meetings, materials, phone calls, website, reports, and information management.

**Cycle**

See PDSA cycle.

**Day-to-Day Leader**

The person on the nursing facility’s team who is responsible for driving the improvement process every day. This person manages the team, arranges meetings, and assures that tests are being completed and that data are collected.

**Director**

The manager of a Collaborative who works with the faculty, teaches and coaches teams, and plans and executes learning session and action period activities.

**Early Adopter**

In the improvement process, the opinion leader within the organization who brings in new ideas from the outside, tries them, and uses positive results to persuade others in the organization to adopt the successful changes.

**Early Majority/Late Majority**

The individuals in the organization who will adopt a change only after it is tested by an early adopter (early majority) or after the majority of the organization is already using the change (late majority).

**Electronic Mailing List, or Email List**

A communication system that allows teams to stay connected with the leadership team and each other during the action periods. Sharing information, getting questions answered, and solving problems are all part of email list activity.

**Handbook**

Pages containing a complete description of the Collaborative, along with expectations and activities to complete before the first meeting of the Collaborative.

**IHI**

Institute for Healthcare Improvement

**Implementation**

Taking a change and making it a permanent part of the system. A change may be tested first and then implemented throughout the organization.

**Improvement Advisor**

The expert in process improvement and measurement who assists the co-chairs and director in guiding the Collaborative's work and coaching teams.

**Improvement Cycle**

See PDSA cycle.

**Key Changes**

The list of essential process changes that will help lead to breakthrough improvement, usually developed by the leadership team and chair based on literature and their experiences.

**Key Contact**

The individual on the organization team who takes responsibility for communication between the team and Qualis Health, including monthly reporting and disseminating information to team members. The key contact is often the day-to-day leader on the team.

**Key Messenger**

The individual in the organization who can be relied on for spreading ideas to others within the organization.

**Knowledge Management**

A method for gathering information and making it available to others.

**Leadership Team**

The small group of experts on the topic who assist the chair and director in teaching and coaching participating teams. Usually the leadership team contains representatives from all the disciplines who are involved in the change process.

**Learning Session**

A half day meeting during which team members meet with faculty and collaborate to learn key changes in the topic area, including how to implement changes, accelerate improvement, and overcome obstacles. Teams leave these meetings with new knowledge, skills, and materials that prepare them to make immediate changes.

**Measurement Strategy**

A collection of measures, required and optional, that describe in detail how to calculate statistics and provide direction on appropriate goals.

**Measure**

A focused, reportable unit that will help a team monitor its progress toward achieving its aim.

**Model for Improvement**

An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes.

**Outcome Measure**

Measures of change (or lack of change) in the well-being of a defined population. Improvement in an outcome measure reflects the health status of the resident, whereas process measure reflects the care delivery to the resident. Improvement in an outcome measure has a direct effect on mortality and morbidity.

**Outcomes Congress**

A large public meeting at the end of the Collaborative during which the best practices in the topic area are presented to others interested in making improvements in the area.

**PDSA Cycle**

A structured trial of a process change. Drawn from the Shewhart cycle, this effort includes the following steps:

Plan—a specific planning phase;

Do—a time to try the change and observe what happens;

Study—sometimes called “check,” an analysis of the results of the trial; and

Act—devising next steps based on the analysis.

This PDSA cycle will naturally lead to the “plan” component of a subsequent cycle. PDSA cycles are also called “rapid cycles” or “improvement cycles.”

**Pilot Population**

See population of focus.

**Pilot Site**

The clinic location where changes are tested. After implementation and refinement, the changes will be spread to additional locations.

**Population of Focus**

A designated set of residents who will be tracked to determine whether changes have resulted in improvements. For this Collaborative, a pilot population might be defined as Medicaid residents on a particular wing or unit.

**Pre-work Period**

The time before the first learning session when teams prepare for their work in the Collaborative. Pre-work activities include selecting team members, registering for the first learning session, scheduling initial meetings, preparing an aim statement, defining a pilot population, selecting measures, and initiating data collection.

**Process Change**

A specific change in a process in an organization. More focused and detailed than a change concept, a process change describes what specific changes should occur. "Instituting the INTERACT Stop and Watch tool and protocol for all certified nursing assistants and ancillary staff" is an example of a process change.

**Rapid Cycle**

See PDSA cycle.

**Run Chart**

See "annotated time series."

**Sampling Plan**

A specific description of the data to be collected, the interval of data collection, and the subjects from whom the data will be collected. The sampling plan is included on all senior leader reports. It emphasizes the importance of gathering samples of data to obtain "just enough" information.

**Senior Leader**

The executive in the organization who supports the team and controls the resources employed in the processes to be changed. This person is usually at the administrator level or higher. The senior leader works to connect the team's aim to the organization's mission, provides resources for the team, and promotes the spread of the team's work to others.

**Senior Leader Report**

The standard reporting format for monthly progress updates in a Collaborative. This concise, two-page report includes an aim statement, measures to be used, a sampling plan, a listing of the changes made, and the results displayed graphically on run charts. The nursing facility pilot team prepares the report and sends it to the senior leader at the nursing facility, along with posting it to the electronic mailing list. Qualis Health staff review and summarize monthly reports.

**Spread**

The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements. The theory and application of spread comes from the literature on diffusion of innovation.

**Staging Plan**

A plan of what populations/units will be spread to and in what order.

**System Leader**

The team member who has direct authority to allocate the time and resources to achieve the team's aim, has direct authority over the particular systems affecting the change, and will champion the spread of successful changes to other resident populations. In the present Collaborative, this person may be the administrator or the director of nursing services.

**Technical Expert**

The team member in the organization who has a strong understanding of the process to be improved and changes to be made. A technical expert may also provide expertise in process improvement, data collection and analysis, and team function.

**Test**

A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

**Tipping Point**

In epidemiology, the concept that small changes will have little or no effect on a system until a critical mass is reached. Then a further small change "tips" the system and a large effect is observed.

## Appendix A – Collaborative Tools

### Checklist for Completing Pre-work Activities

To prepare for Learning Session 1, participating nursing facility teams should complete the tasks listed below:

- 1. Read the Collaborative framework
- 2. Form a team or review current Collaborative team
- 3. Register for Learning Session 1
- 4. If not previously arranged, each nursing facility team must schedule a pre-work visit
- 5. Coordinate email and internet access for accessing the Collaborative e-mail list and materials
- 6. Complete the pre-work activities worksheet
- 7. Develop an aim statement
- 8. Define (or identify) a population of focus (unit, floor, etc.)
- 9. Define optional measures
- 10. Plan for preparing senior leader reports
- 11. Prepare a storyboard for Learning Session 1

## Appendix B – Collaborative Tools

### Pre-work Activities Worksheet

- | 1. Team Members       | (Name) | (Title) |
|-----------------------|--------|---------|
| a. Senior Leader      | _____  | _____   |
| b. System Leader      | _____  | _____   |
| c. Clinical Champion  | _____  | _____   |
| f. Day-to-Day Leader  | _____  | _____   |
| g. Other Team Members | _____  | _____   |

### 2. Working Draft of Aim Statement

*Example: Implement Prompted Voiding Program to achieve a relative improvement for Medicaid residents by 30% by January 2019.*

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### 3. Definition of Population of Focus

*Identify the nursing units or areas from which your population of focus is drawn (this could be all or a subset of units in the facility with Medicaid residents).*

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#### 4. Working List of Measures Selected

##### Sample suggested measures:

- Percent of low-risk residents who start an individualized Prompted Voiding Program (beyond the initial trial period)
- Percent of low-risk residents started on individualized Prompted Voiding Program who achieve level of continence = to code of 0 or 1 in section H0300 of MDS 3.0
- Relative improvement in low-risk incontinence Quality Measure from baseline (baseline QM-remeasurement QM / baseline QM)

Potential issues in collecting data for the required measures:

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##### Other optional measures selected:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Potential issues in collecting data for the optional measures selected:

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