CASE STUDY

The Importance of Collaboration between Social Work and Medical Staff to Promote MOLST Completion

Nursing Facility: Buena Vida Continuing Care and Rehabilitation Center
Location: Brooklyn, NY
Number of Beds: 240
Number of NY–RAH Payment Eligible Residents: 85
CMS Nursing Home Compare Star Rating: 5 (highest rating)
NY–RAH Group: B

ORGANIZATION DESCRIPTION

Buena Vida Continuing Care and Rehabilitation Center is a skilled nursing facility (SNF) located in Brooklyn, New York, that provides both long-term care services and short-term rehabilitation. Buena Vida prides itself on active resident and family council meetings that help to ensure that the facility continues to serve the needs of the community. This case study reviews the New York–Reducing Avoidable Hospitalizations (NY–RAH) palliative care intervention and discusses how Buena Vida worked with the NY–RAH project to further improve its palliative care capability.

BACKGROUND ON NY–RAH PALLIATIVE CARE INTERVENTION

Since 2012, NY–RAH has promoted palliative care interventions at SNFs in an effort to reduce the number of avoidable hospital transfers by documenting family and resident wishes on advance directives, including the Medical Orders for Life-Sustaining Treatment (MOLST) form. Advance care planning discussions require specific communication skills; NY–RAH has trained facility staff to facilitate these discussions with residents and families.

Palliative Care Promotion and Resources

NY–RAH evaluated the palliative care capabilities of each participating facility and found that the highest functioning facilities had designated a palliative care leader; had a formal process for initiating palliative care; and gave staff, including certified nursing assistants, education on palliative care. While some facilities provided education and training, NY–RAH found that social work and nursing staff—often the first to introduce advance directives—sometimes believed they were inadequately prepared to engage in conversations about a resident's wishes for care in serious and terminal illness. This task is crucial to understand and document residents' wishes and avoid unnecessary care and/or transfers. NY–RAH provided training for facilities through The Conversation Project and the promotion of National Healthcare Decisions Day (NHDD).

The Conversation Project

In collaboration with the Institute for Healthcare Improvement (IHI), The Conversation Project provides training in advance care planning and discussion of desired care in serious and terminal illness. NY–RAH hosted trainings in 2015 and 2018, and participants used the Starter Kit to reflect on their own wishes in the event of serious or terminal illness. The Starter Kit, which has been translated into 14 languages, is an effective tool to ensure staff have the skills needed to engage in these conversations with their own loved ones before residents and families.

National Healthcare Decisions Day

NHDD is held annually on April 16, the day after tax day, as a reflection of the adage, "the only things in life that are certain are death and taxes." This national initiative promotes completing advance directives and advance care planning. NHDD also provides an opportunity for facilities, residents, and families to set aside time to speak about wishes for care in serious and terminal illness and to complete advance directive and MOLST forms.

Quarterly Palliative Care Reports

NY–RAH gives facilities a quarterly Palliative Care Report that contains information on a facility's eligible resident population's advance directive designations: the percentage with a MOLST form, a partially completed MOLST form, no advance directive, a Health Care Proxy—as well as other medical intervention designations such as do not resuscitate, do not intubate, and do not hospitalize. NY–RAH has promoted completing the MOLST form in its entirety and has specifically discouraged facilities from only completing the resuscitation instructions on the first page. A clinical discussion and a fully completed form will allow the resident and/or family to know their treatment options and ensure that there are no contradictions.

ACTIONS TAKEN BY BUENA VIDA

Use Data to Drive Change

Review of the Q3 2017 Palliative Care Report by the Registered Nurse Care Coordinator (RNCC) at Buena Vida showed that while 92% of NY–RAH eligible residents had a MOLST form (Appendix A), 85% of them were only partially completed, causing confusion and uncertainty about the resident's wishes for care and unnecessary hospital transfers.

Using this data, the RNCC participated in a Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) with the Director of Social Work (DSW). The project consisted of four Plan-Do-Study-Act (PDSA) cycles starting in the third quarter of 2017.

Identify Gaps in Workflow and Challenges with Practitioner Participation

To understand why MOLST forms were only partially completed, the RNCC and DSW spoke with each social worker at Buena Vida. They discovered that while MOLST was offered to each resident at admission or shortly thereafter, it was not always completed. A social worker would initiate MOLST, but medical practitioners, needing to confirm choices and ensure understanding, were not always present or available. Follow-up conversations were necessary in certain instances. If these follow-up conversations did not occur, it led to permanently incomplete forms. Also, social workers were not always comfortable initiating conversations when medical practitioners were not present. A medical practitioner's presence was essential to getting the required signature, properly explaining choices for care, and providing peace of mind to residents and family members.

The RNCC and DSW met with the medical staff to discuss these difficulties, and learned that the best approach was to schedule an acceptable time when all parties could be present to review next steps. When residents and families did not want to engage in these conversations at admission, the medical practitioners and DSW revisited the topic with them within 24 hours, and then again monthly, providing continued education on the benefits. The DSW coordinated with medical staff to ensure practitioner attendance.

Understand Challenges Facing Front Line Staff

The RNCC also met with each social worker to learn about any other factors interfering with MOLST completion, and found that some social workers were uncomfortable talking about serious and terminal illness, especially when the residents and families themselves did not want to discuss the topic. Cultural differences also posed barriers to discussions. The RNCC used The Conversation Project Starter Kit to help social workers overcome some of these difficulties.

RESULTS

During the four quarters of the RNCC's intervention, the percentage of partially completed MOLST forms dropped from 85% in the third quarter of 2017 to just 12% in the third quarter of 2018 (Appendix B). The first quarter alone showed a 19% reduction in partially completed MOLST forms (from 85% to 66%). While the data presented in this case study pertains to NY–RAH eligible residents, the process was adopted facility-wide at Buena Vida.

STRATEGIES FOR SUCCESS

Champion Needed to Lead Change

A key to achieving better results was designating the DSW as a palliative care champion who supported the goals of palliative care and MOLST completion, which prompted a culture change in the facility.

Interdisciplinary Approach Necessary

A champion alone, however, cannot successfully institute palliative care at any institution. An interdisciplinary team approach is vital to successful palliative care. At Buena Vida, social work, nursing, and medical staff collaborated to form a team and implement a successful palliative care program. The RNCC facilitated this process, meeting with all groups to promote communication and coordination, and to review challenges and goals.

Quarterly Review of Advance Directives

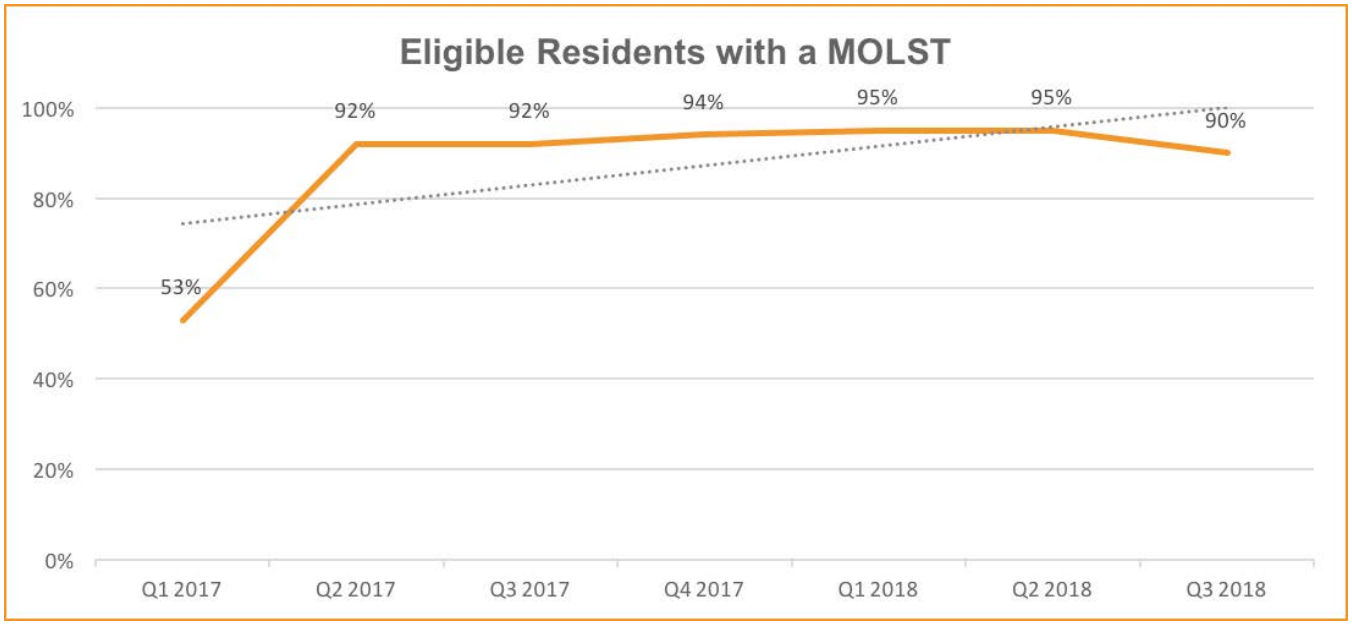
Buena Vida's general practice is to review all advance directives and MOLST forms every 60-90 days to understand any changes to resident/family wishes and provide additional opportunities for discussion.

NEXT STEPS

A continuous emphasis on advance care planning through routine care planning meetings and staff in-servicing will reinforce the importance of palliative care interventions within facilities, ensuring residents' wishes for care are fulfilled and documented.

APPENDIX A:

Percentage of Eligible Residents with a MOLST form (fully or partially complete)



APPENDIX B:

Progression of Percentage of Eligible Residents with a Partially Completed MOLST (lower percentage is better)