Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Health Quality Innovation Network

Simple Strategies: Recognize and Respond

September 12, 2023

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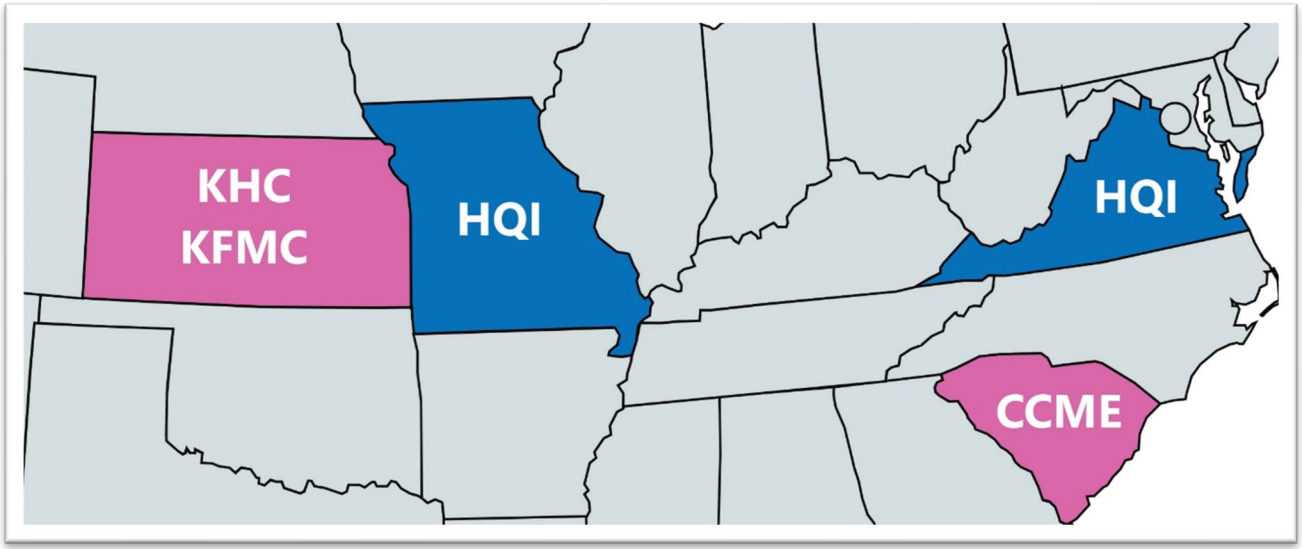

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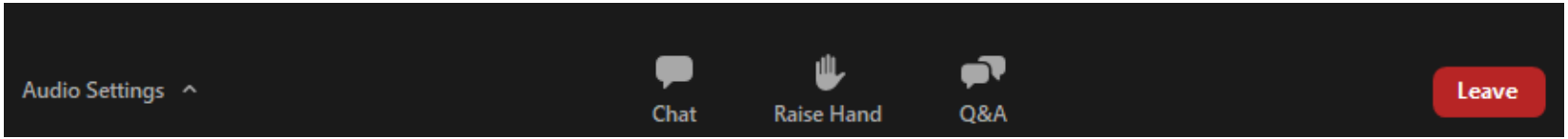
Logistics – Zoom Webinar



To ask a question, click on the **Q&A** icon.

Raise your hand if you want to verbally ask a question.

Resources from today's session will be posted in **Chat**.

You may adjust your audio by clicking **Audio Settings**.

You have been automatically muted with video turned off.

Your Team

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Session 2
Plan For Success: Resident and Family Engagement

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Resident and Family Engagement

- Is an important component of person-centered care
- Creates an environment in which every team member, including the resident and their family, can work as partners to improve health care quality and safety
- Recognizes residents and family as valuable members of the health care team

Benefits of Resident and Family Engagement

Residents and Families

- Ensures residents are in an environment that promotes trust and respect
- Fosters collaboration with staff who are attuned to their goals, preferences and needs and who will respond appropriately and per their preference
- Provides the opportunity to achieve the best quality of life possible

Staff

- Understands resident preferences and goals, which better equips them to provide holistic, quality care
- Feels valued in person-centered care organizations

Common Gaps in Patient and Family Engagement (PFE)

- Failure to actively engage the resident/family in identifying needs, resources and planning for the discharge and end of life
- Unrealistic optimism of resident and family
- Multiple medications are exceeding their ability to manage them all
- Resident/family failure to ask clarifying questions on instructions and plan of care and teach-back was not utilized
- Resident lack of adherence to self-care because of poor understanding or confusion
- Lack needed care, transportation, how to schedule appointments or how to obtain or pay for medications

How Can PFE Improve Readmissions and Unnecessary Transfers?

By implementing processes that focus on engagement, assessment of resident knowledge, and teaching residents and their care partners about their current health status, we can:

- ✓ Improve clinical outcomes
- ✓ Improve resident quality of life
- ✓ Improve quality metrics

Advance Care Planning

The process of advance care planning can be daunting for a resident and/or his/her family.

Facility staff must use their knowledge as well as communication skills to assist the resident/resident representative in understanding his/her rights and options.

§483.10(g)(12) Advance Directives

- This includes a written description of the facility's policies to implement advance directives and applicable State law.
- Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
- If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
- The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

Documenting Resident Wishes

An **advance directive** is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated.

Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive.

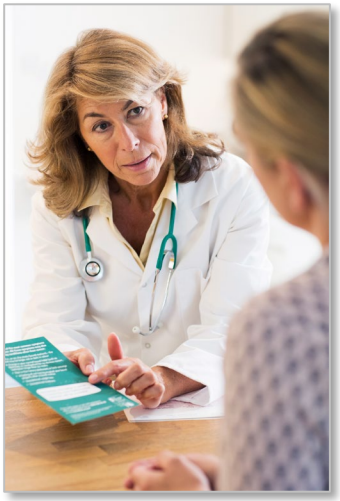
Let's CHAT

- Are resident choices reviewed and clarified as part of the overall care planning process?
- Are resident choices communicated to the staff responsible for the resident's care to ensure the resident's wishes are carried out?
- Do you have a process to identify when to initiate conversations about hospice and end of life?
- Do you have a process to ensure the resident and family understands their disease process before establishing ADs?

Health Literacy

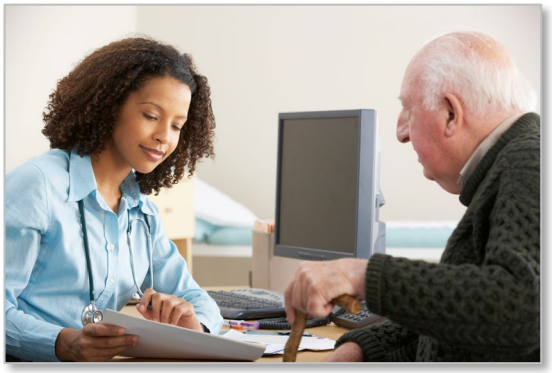
The CDC has two definitions of the term, based on the Healthy People 2030 initiative:

- **Personal health literacy** is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
- **Organizational health literacy** is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.



Low Health Literacy Indicators

Be alert to residents who:



- Fill out forms incompletely or inaccurately
- Say that they will read written material later
- Ask staff to read written information
- Are unable to name their medications, explain their indication or properly describe how to take them
- Fail to comply with medication regimens
- Fail to experience a change in physiologic parameters even though they say they are taking the medications prescribed
- Fail to complete recommended tests or referrals

Practical Tips to Ensure Understanding

Health literacy happens when providers and those receiving care truly understand one another. The essence of health literacy has to do with mutual understanding and sometimes a shared decision making.

- **Communicate clearly**
- **Clarify and question**
- **Confirm understanding**
- **Be creative**

Let's CHAT

What are some actionable ways that we can incorporate health literacy into our processes?

- Do you have a reliable process for identifying residents' understanding of their disease process?
- Do you regularly provide educational materials to residents and families to help engage them in their health care?
- Do your daily clinical operations allow for clinical staff to coach and train residents and families on health-related tasks?

Health Equity

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

Achieving this requires ongoing societal efforts to:

- Address historical and contemporary injustices
- Overcome economic, social and other obstacles to health and health care
- Eliminate preventable health disparities

To achieve health equity, we must change the systems and policies that have resulted in the generational injustices that give rise to racial and ethnic health disparities.

Polling Question

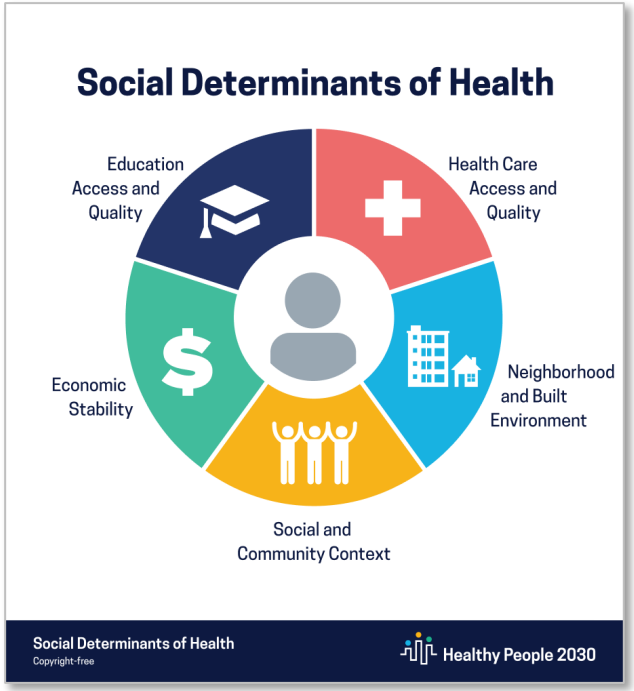
Do you know what the social determinants of health are?

A. Yes

B. No

Social Determinants of Health

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.



[Social Determinants of Health - Healthy People 2030 | health.gov]

SA Disparity Data – Rehospitalizations

Age

- For both SS and LS, our 64 years and younger population makes up the majority of rehospitalizations

Gender

- Men are more likely to experience a rehospitalization than female residents

Race

- African-Americans have the highest incidence of rehospitalizations among LS residents
- Hispanic Americans have the highest incident of rehospitalizations among SS residents

Rural vs. Urban

- Residents in urban areas continue to have more rehospitalizations than those living in rural areas

SA Disparity Data – ED Visits

Age

- Residents aged 64 and under and 65-74 have the highest rate of ED visits

Gender

- SS men are more likely to experience an unnecessary ED visit than SS female residents; incident rate was the same for LS

Race

- African-Americans have the highest incidence of rehospitalizations among SS residents
- Hispanic Americans have the highest incident of rehospitalizations among LS residents

Rural vs. Urban

- Residents in urban areas continue to have more ED visits than those living in rural areas

CLAS Standards

CLAS helps you take into account:

- Cultural health beliefs
- Preferred languages
- Health literacy levels
- Communication needs

CLAS helps make your services:

- Respectful
- Understandable
- Effective
- Equitable

> "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."
>
> — Dr. Martin Luther King, Jr.

What is CLAS? - Think Cultural Health | hhs.gov

Culturally Competent Workforce

- Developing a culturally competent workforce helps us understand, communicate with and effectively serve people across cultures
- It gives us the ability to compare different cultures with our own and better understand the differences
- One's own unique history and personality also play an important role

Let's CHAT

What are some actionable ways that we can incorporate health literacy into our processes?

- Do you consistently inquire on community supports at time of admission? And re-establish upon discharge?
- Do you consistently inquire on the resources they have available at home?
- Do you have a process in place for providing culturally sensitive education to staff to ensure resident needs are being met?

Engagement Strategies: Organizational Practices

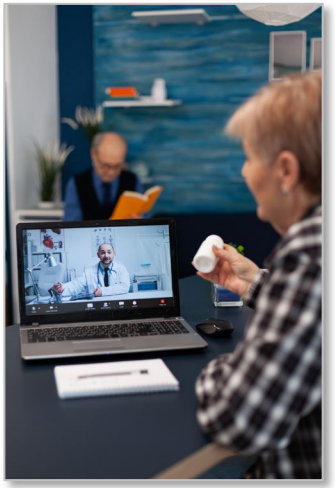
- Host community health fairs
- Provide cultural competency and trauma-informed care training for all staff – *not just clinical*
- Build a health information center with a variety of educational materials that are easily accessible
- Post and distribute signage that outlines the steps of common ADL tasks such as handwashing or blood glucose testing
- Know who your community partners are and establish relationships

Engagement Strategies: Admission and Care Planning

- Assess the resident's knowledge of their personal heath condition at time of admission and implement strategies in the care plan for daily coaching and support to enhance skills
- Ensure health literacy gaps are being addressed in the care plan
- Identify who the caregiver will be at home and include them in coaching and education
- Ensure you have a reliable process for advance care planning that meets the resident's goals and preferences
- Identify if any health equity risk factors are present and what community supports the person was utilizing prior to admit

Engagement Strategies: Discharge

- Ensure the resident and/or primary caregiver understand the discharge plan and strategies to manage their health
- Include resources related to any potential health equity risks the person may have
- Refer to caregiver support or community health groups
- Reconnect them with the community organizations that supported their health prior to admission
- Consider providing follow-up phone check-ins a few weeks after discharge and/or having a phone line that residents and families can call with questions



Resource Spotlight

What is INTERACT®?

Interventions to Reduce Acute Care Transfers (INTERACT®) is a quality improvement program designed to improve the identification, evaluation, and communication about changes in resident status.

The overall goal of the **INTERACT®** program is to reduce the frequency of transfers to the acute hospital.

INTERACT® ACP Tools

- Advance Care Planning Tracking Tool
- Advance Care Planning Communication Guide
- Identifying Residents Who May be Appropriate for Hospice or Palliative/Comfort Care Orders
- Comfort Care Order Set
- Deciding About Going to the Hospital
- Education on CPR
- Education on Tube Feeding
- Guidance on Management of Possible Sepsis
- Guidance on Identification and Management of Infections

INTERACT® Version 4.5 Tools For SNFs/Nursing Homes – Pathway INTERACT®

Improving Health Literacy

Health Literacy Tools

- Health Literacy Guidance & Tools | CDC
- Health Literacy Universal Precautions Toolkit, 2nd Edition | AHRQ

Teach-Back and Show-Me Methods

- Use the Teach-Back Method: Tool #5 | AHRQ

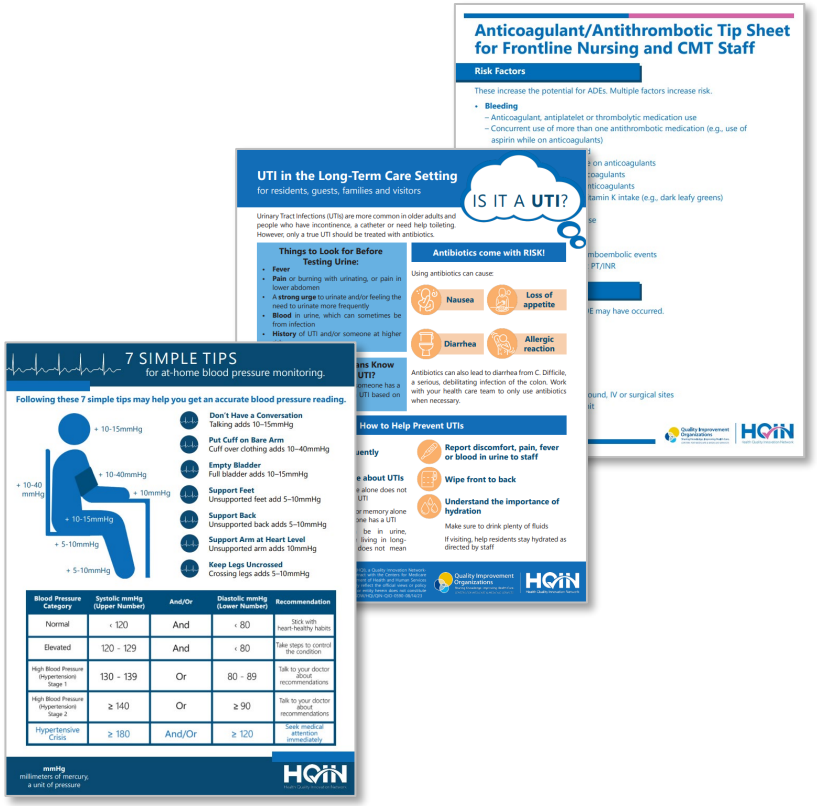
Language Services for Individuals with Limited English Proficiency

- Guide to Developing a Language Access Plan | CMS Office of Minority Health

HQIN Resource Center

The HQIN Resource Center is an online repository of resources, tools and webinar materials to help support your team's efforts.

It includes a variety of tools designed to help educate, coach and support residents and their families as well as facility staff.



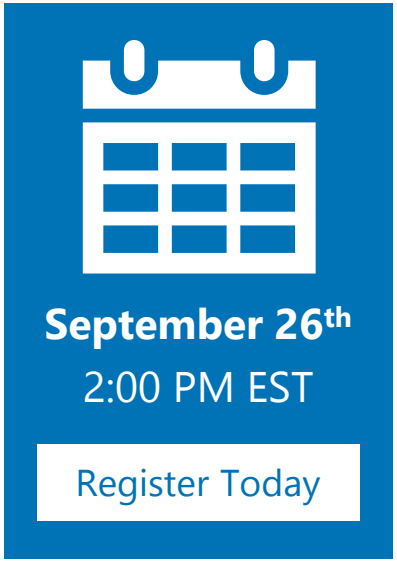
Resources | HQIN

Join Our Next Session

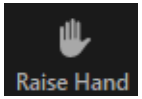
Communication Strategies

Tuesday, September 26, 2023

2:00 p.m. EST | 1:00 p.m. CST



Questions? Comments? Share What is Working or What is Difficult for Your Team!



Raise your hand to verbally ask a question

Type a question by clicking the **Q&A** icon

Don't hesitate to ask a question after the webinar is over.
Email **LTC@hqi.solutions** or your HQIN Quality Improvement Advisor.

Center of Excellence for Behavioral Health In Nursing Facilities

The Center of Excellence focuses on increasing the knowledge, competency and confidence of nursing facility staff to care for residents with behavioral health conditions.

- Provides mental health and substance use trainings, customized technical assistance and resources at no cost
- Services are available to all CMS certified nursing facilities throughout United States
- Established by the Substance Abuse and Mental Health Services Administration (SAMHSA) in collaboration with the Centers for Medicare and Medicaid Services

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

For assistance, submit a request at nursinghomebehavioralhealth.org

Contact us:
National Call Center: **1-844-314-1433**

Email: coeinfo@allianthealth.org

Center of Excellence for Behavioral Health In Nursing Facilities

SCAN ME

Scan QR code to sign up for the COE-NF newsletter.

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

Visit the COE-NF website & Online Resource Hub:
nursinghomebehavioralhealth.org

National Call Center: 1-844-314-1433
For more information or to request assistance.

Subscribe to receive email updates from COE-NF!
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https://engage.allianthealth.org/coenf-newsletter-subscription
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FOR MORE INFORMATION

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