Broad River Rehab Reflections: Promoting Patient Healthcare Literacy

JULY 16TH2020

BRR | BROAD RIVER REHAB

"A *Knowledgeable* and *Compassionate* partner"

Overview

Healthcare literacy, its impact on understanding of disease processes and progression, has been showed to be a significant influencer on one's ability to advance and maintain strides achieved during their rehab course.

This session will:

1. Provide regulatory overview related to Healthcare Literacy

2. Highlight BRR's clinical programming which aims to increase understanding of each individual's diagnoses and best practices for achieving and maintaining function

3. Present guidance on training healthcare literacy to a level of "return demonstration" among patients and caregivers to prevent further declines or risk for rehospitalization.

Healthcare Literacy Defined

The U.S. Department of Health and Human Services (HHS) defines health literacy as **'the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions**

Health literacy challenges may impact older adults more than other age groups. On average, adults age 65 and older have lower health literacy than adults under the age of 65. Low health literacy among older adults is associated with increased reports of poor physical functioning, pain, limitations of daily activities, poor mental health status

Methods to Improve Literacy

Improvements in health practice that address low health literacy are needed to reduce disparities in health status.

As limited health literacy is common and may be difficult to recognize, “experts recommend that practices assume all patients and caregivers may have difficulty comprehending health information and should communicate in ways that anyone can understand.”

Examples include:

Simplifying communication; confirming comprehension for all patients to minimize risk of miscommunication; making the health care system easier to navigate; and supporting patient’s efforts to improve their health.

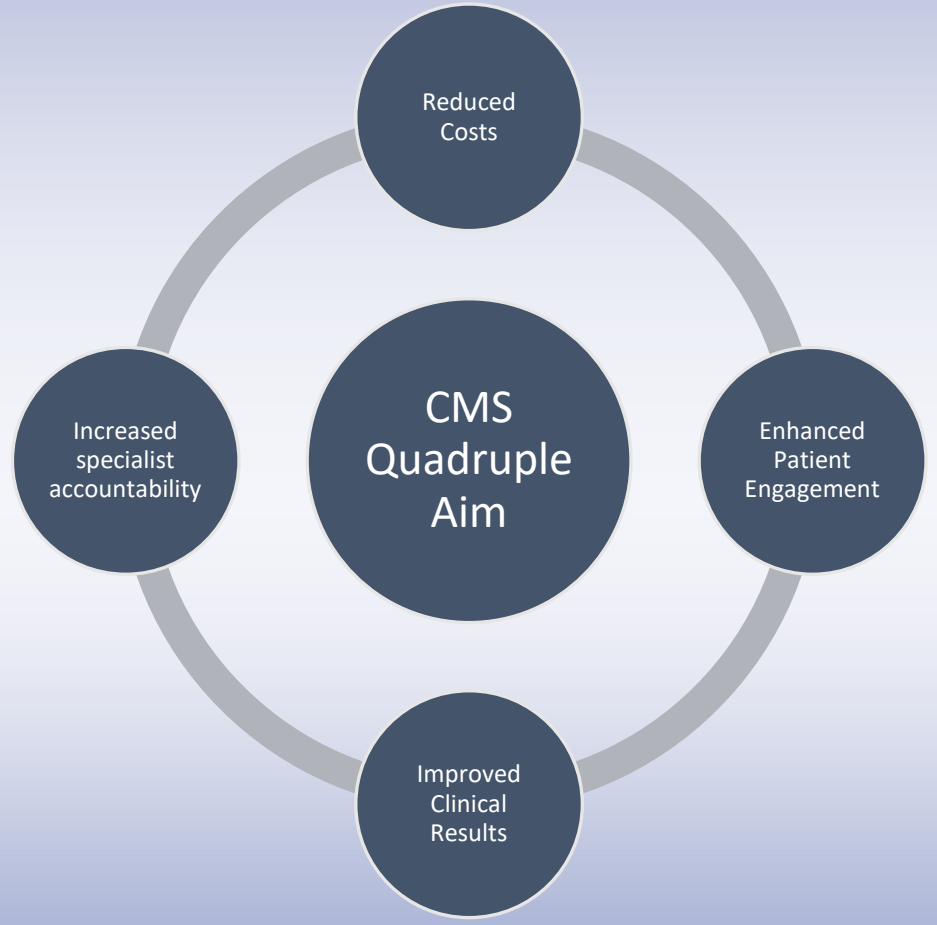
CMS Quality Strategy

Better Care: Improve the overall quality of care by making health care more person-centered, reliable, accessible, and safe.

Smarter Spending: Reduce the cost of quality health care for individuals, families, employers, government, and communities.

Healthier People, Healthier Communities: Improve the health of Americans by supporting proven interventions to address behavioral, social, and environmental determinants of health, and deliver higher-quality care.

CMS Quadruple Aim



BRR | BROAD RIVER REHAB

"A *Knowledgeable* and *Compassionate* partner"

National Quality Strategy Priorities

To advance its three aims, the National Quality Strategy identified six priorities:

1. Making care safer by reducing harm caused in the delivery of care;

2. **Ensuring that each person and family is engaged as partners in their care**;

3. Promoting effective communication and coordination of care;

4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;

5. Working with communities to promote wide use of best practices to enable healthy living; and

6. Making quality care more affordable for individuals, families, employers, governments, and communities by developing and spreading new health care delivery models.

Person Centered Engagement

- A person-centered approach considers the individual as multifaceted, not merely as a “receiver” of services.
- This approach demands that providers and individuals share power and responsibility in goal setting, decision-making, and care management.
- It also requires giving people access to understandable information and decision support tools to equip them and their families with the information to manage their health and wellness, navigate the full span of the health care delivery system, and make their own informed choices about care.

Medicare Population & Chronic Conditions

- Medicare covers a large population of patients with multiple chronic conditions.
- In 2010, approximately 21.4 million Medicare beneficiaries had at least 2 chronic conditions and accounted for the bulk of healthcare services provided under Medicare.[3]
- There are multiple chronic conditions that require not only management by specialty and primary care physicians, but also data exchange and a common understanding between patients and physicians of treatment goals and monitoring

Impact of Multiple Chronic Conditions

MCCs are associated with approximately 66 percent of the total health care spending in the United States.

- As many as three out of four Americans aged 65 or older have MCC and approximately two out of three Medicare beneficiaries have MCC.
- Approximately one in four Americans in any age group has MCC, including one in 15 children.
- People with MCCs are also at increased risk for mortality and poorer day-to-day functioning

CMS Survey Critical Element Pathway Activities of Daily Living

Resident, Resident Representative, or Family Interview:

- ☐ How did the facility involve you in developing the care plan? Did you talk about your preferences and choices regarding care (e.g., when care should be provided such as bathing)?
- ☐ If you are aware that the resident has specific ADL concerns, ask: What did staff discuss with you regarding how they would maintain or improve your ability to [ask about specific ADL]?
- ☐ Are you able to actively participate in ADLs? If so, what is your involvement? How and who instructed you in the interventions? Does staff provide encouragement and revision to the interventions as necessary?
- ☐ What type of interventions are done? Have assistive devices been provided (e.g., reachers, mobility devices, or communication devices)? If so, were you instructed on how to use them? If not, why not?
- ☐ How much help do you need from staff with [ask about specific ADL]? If help is needed or the resident is unable to perform ADLs, ask the following:
  - Does staff tell you what they are going to do before they do it?
  - How does staff encourage you to do as much as you can?
  - Does staff allow ample time for you to do as much as you can on your own?
  - Does staff provide timely assistance (e.g., toileting needs)?

PT, OT, SLP, or Restorative Manager Interview:

- ☐ When did therapy/restorative start working with the resident?
- ☐ How did you identify that the interventions were suitable for this resident?
- ☐ What are the current goals?
- ☐ How do you involve the resident or resident representative in decisions regarding treatments?
- ☐ How often do you meet with the resident?
- ☐ How often does therapy screen residents? Where are screening results documented?
- ☐ How much assistance does the resident need with [ADLs]?
- ☐ How do you promote the resident's participation in [ADLs]?

If the resident is not on a therapy or restorative program: How did you decide that the resident would not benefit from a program?

- ☐ Does the resident have pain? If so, who do you report it to and how is it being treated?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Is the resident's [ADL] ability getting worse? If so, did you report it (to whom and when) and did the treatment plan change?
- ☐ Has the resident had a decline in his/her ability to [ask about specific ADL]? When did the resident's decline in ADLs occur?
- ☐ What therapy or restorative interventions were in place before the

Specialized Rehabilitative or Restorative Services Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ How and by whom were you informed regarding the therapy services you need?
- ☐ What services are your receiving and do you understand why you are receiving these services?
- ☐ With who and how did staff discuss your treatment plan and goals with you and were you allowed to provide input or changes to this plan and the goals?
- ☐ If you refused any of these services, did someone speak with you about the consequences of not receiving these services? If so, who spoke with you?
- ☐ How often and for how long do you receive these services and do you feel you have enough time during therapy to assist you in achieving your goals?
- ☐ Do you feel these services are helping you to improve? If not, why?
- ☐ Do you experience pain during therapy services? If so, what does staff do to help you relieve your pain and is this effective?
- ☐ If staff provided you with assistive devices (e.g., reacher, mobility devices, communication devices, special eating utensils):
  - Did someone show you how to use the device? If so, who?
  - Do you use it? If not, why not?
  - Do you have these devices when you need them? If not, why not?
  - Does staff encourage you to use the device?

Staff Interviews (Nursing Aides, Nurse, Therapy, DON):

- ☐ What are the current goals and interventions for the resident?
- ☐ How were the interventions determined to ensure they were suitable for the resident's needs?
- ☐ How was the resident/representative involved in decisions regarding their goals, interventions, and treatments?
- ☐ How and by whom were you trained on the resident's therapy or restorative program needs?
- ☐ How and by whom are therapy and nursing staff supervised and monitored to ensure they are implementing care planned interventions?
- ☐ How much assistance from staff does the resident need with their therapy or restorative services?
- ☐ How do you promote and encourage the resident's participation in
- ☐ Does the resident ever refuse therapy or restorative services? If so, why and how is this handled?
- ☐ How do you assess if the resident's ability is maintained, improving, or getting worse?
- ☐ If a resident is declining, when did this decline begin? What might have caused this decline? To whom and when was this decline reported and did the treatment plan change?
- ☐ Were there any therapy or restorative interventions in place before the decline developed? If so, what were these interventions and why did they not prove to be effective?
- ☐ Does the resident use any assistive devices? If so, what are these devices and why are they used? How is the resident educated and encouraged to use these devices?

Care Planning

SOM F655

§483.21(a) Baseline Care Plans

§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must—

(i) Be developed within 48 hours of a resident's admission.

§483.21(a)(3) The facility must ***provide the resident and their representative with a summary of the baseline care plan*** *that includes but is not limited to:*

(i) The initial ***goals of the resident****.*

(ii) A ***summary of the resident's medications and dietary instructions****.*

(iii) Any ***services and treatments to be administered by the facility*** *and personnel acting on behalf of the facility.*

(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

BRR | BROAD RIVER REHAB

"A ***Knowledgeable*** and ***Compassionate*** partner"

Care Planning

Nursing homes are required to develop a baseline care plan within the first 48 hours of admission which provides instructions for the provision of effective and ***person-centered care to each resident****. This means that the baseline care plan should strike a balance between conditions and risks affecting the resident's health and safety,* ***and what is important to him or her,*** *within the limitations of the baseline care plan timeframe.*

Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home.

The baseline care plan must include the minimum ***healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary****. Baseline care plans are required to address, at a minimum, the following:*

• Initial goals based on admission orders. • Physician orders. • Dietary orders. • Therapy services. • Social services. • PASARR recommendation, if applicable.

BRR | BROAD RIVER REHAB

"A *Knowledgeable* and *Compassionate* partner"

Care Planning

SOM F656

§483.21(b) Comprehensive Care Plans

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are

identified in the comprehensive assessment. The comprehensive care plan must describe the following—

(iv)In consultation with the resident and the resident's representative(s)—

(A) The resident's goals for admission and ***desired outcomes****.*

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) ***Discharge plans*** *in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.*

BRR | BROAD RIVER REHAB

"A *Knowledgeable* and *Compassionate* partner"

Discharge Critical Element Pathway

Use this pathway for a resident that has been or is planning to be discharged to determine if facility practices are in place to ensure the resident's discharge plan meets the needs of the resident.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A – Discharge Status (A2100), C – Cognitive Patterns, G – Functional Status, and Q – Participation in Assessment and Goal Setting.
- ☐ Physician's orders (e.g., medications, treatments, labs or other diagnostics, and the discharge order – planned or emergent).
- ☐ Pertinent diagnoses.
- ☐ Care plan (high risk diagnoses, behavioral concerns, history of falls, injuries, medical errors, discharge planning to meet the resident's needs including but not limited to resident education and rehabilitation, and caregiver support and education).

Observations:

- ☐ Does staff provide care for the resident as listed in the discharge plan? If not, what is different?
- ☐ How are staff providing education regarding care and treatments in the care plan?
- ☐ How does the resident perform tasks or demonstrate understanding after staff provides education?

Resident, Resident Representative, or Family Interview:

- ☐ What are your discharge plans?
- ☐ What has the facility discussed with you about returning to the community or transitioning to another care setting?
- ☐ Were you asked about your interest in receiving information regarding returning to the community? If not, are you interested in receiving information?
- ☐ What was your involvement in the development of your discharge plan?
- ☐ What has the facility talked to you about regarding post-discharge care?
- ☐ Ask about any discrepancies between the resident's discharge plan and the facility's discharge plan.
- ☐ If discharge is planned:
  - How did the facility involve you in selecting the new location? Did you have a trial visit, if feasible? How did it go;
  - How were your goals, choices, and treatment preferences taken into consideration;
  - What are your plans for post-discharge care (e.g., self-care, caregiver assistance);
  - What information did the facility give you regarding your discharge (e.g., notice, final discharge plan)? When was it given? Was the information understandable; and
  - What discharge instructions (e.g., medications, rehab, durable medical equipment needs, labs, contact info for home health, wound treatments) has the facility discussed with you? Were you given a copy of the discharge instructions? If applicable, did the facility have you demonstrate how to perform a specific procedure so that you can do it at home?

Discharge Critical Element Pathway

Staff Interviews (Nurses, DON, Social Worker and Attending Practitioner):

- ☐ What is the process for determining whether a resident can be discharged back to the community? How do you involve the resident or resident representative in the discharge planning? Do you make referrals to the Local Contact Agency when the resident expresses an interest in being discharged?
- ☐ How often are the discharge needs of the resident evaluated and is the post-discharge plan of care updated?
- ☐ What is the resident's discharge plan, including post-discharge care?
- ☐ Why is the resident being discharged (i.e., for the resident's welfare and the resident's needs cannot be met in the facility, because the resident no longer required services provided by the facility, because the health or safety of the individual was endangered, or due to non-payment)?

Record Review:

- ☐ Did the facility ask the resident about their interest in receiving information regarding returning to the community? If not, why not?
- ☐ If the resident wants to return to the community, was there a referral to the local contact agency or other appropriate entities?
- ☐ If referrals were made, did the facility update the discharge plan in response to information received?
- ☐ If the resident cannot return to the community, who made the determination and why?
- ☐ Did the facility identify the resident's discharge needs and regularly re-evaluate those discharge needs?
- ☐ For residents being discharged to another healthcare provider: What did the facility do to try and provide necessary care and services to meet the resident's needs prior to discharge? What does the new facility offer that can meet the resident's needs that you could not offer?
- ☐ Where is the resident being discharged to? How was the resident involved in selecting the new location? Was a trial visit feasible?
- ☐ What, when and how is a resident's discharge summary, and other necessary healthcare information shared with staff at a new location?
- ☐ For discharge summary concerns are noted, interview staff responsible for the discharge summary.
- ☐ How does the facility provide education to the resident or care provider regarding care and treatments that will be needed post-discharge?
- ☐ Does the care plan adequately address the resident's discharge planning? Does it address identified needs, measureable goals, resident and/or resident representative involvement, treatment preferences, education, and post-discharge care? Has the care plan been revised to reflect any changes in discharge planning?
- ☐ Who from the IDT was involved in the ongoing process of developing the discharge plan?
- ☐ What are the circumstances and basis for the discharge? Was the discharge necessary? Was the reason for the discharge documented by a physician, as appropriate?
- ☐ Is there documentation of the specific needs that could not be met, the attempts the facility made to meet the resident's needs, and the specific services the new facility will provide to meet the resident's needs?

New QRP Measures

- **Transfer of Health Information to Provider and Patient:**
  - PAC patients often have complicated medication regimens and require efficient and effective communication and coordination of care between settings, including transfer of detailed medication information.9 Individuals in PAC settings may be vulnerable to adverse health outcomes because of insufficient medication information on the part of their health care providers, and their higher likelihood for multiple comorbid chronic conditions, polypharmacy, and complicated transitions between care

SNF

Discharge

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?
Enter Code: □
0. No - Current reconciled medication list not provided to the subsequent provider
1. Yes - Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.
A. Electronic Health Record
B. Health Information Exchange Organization
C. Verbal (e.g., in-person, telephone, video conferencing)
D. Paper-based (e.g., fax, copies, printouts)
E. Other Methods (e.g., texting, email, CDs)

SNF

Discharge

A2123. Provision of Current Reconciled Medication List to Resident at Discharge
At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?
Enter Code: □
0. No - Current reconciled medication list not provided to the resident, family and/or caregiver
1. Yes - Current reconciled medication list provided to the resident, family and/or caregiver?

A2124. Route of Current Reconciled Medication List Transmission to Resident
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
A. Electronic Health Record (e.g., electronic access to patient portal)
B. Health Information Exchange Organization
C. Verbal (e.g., in-person, telephone, video conferencing)
D. Paper-based (e.g., fax, copies, printouts)
E. Other Methods (e.g., texting, email, CDs)

SNF QRP/SPADES

- **The IMPACT** Act requires CMS to develop, implement, and maintain standardized patient assessment data elements (SPADEs) for PAC settings. The four PAC settings specified in the IMPACT Act are HHAs, IRFs, LTCHs, and SNFs. The goals of implementing cross-setting SPADEs are to facilitate care coordination and interoperability and to improve Medicare beneficiary outcomes.
- The IMPACT Act further requires that these assessment instruments be modified to include core data elements on health assessment categories and that such data be standardized and interoperable. Implementation of a core set of standardized assessment items across PAC settings has important implications for Medicare beneficiaries, families, providers, and policymakers.

SNF QRP/SPADES

- **Social Determinants of Health**
- CMS has identified data elements for cross-setting standardization of assessment for seven social determinants of health (SDOH). The data elements are as follows:

1. Race
2. Ethnicity
3. Preferred Language
4. Interpreter Services
5. Health Literacy
6. Transportation
7. Social Isolation

SNF QRP/SPADES

- **Data Element for the Assessment of SDOH: Health Literacy**
  - Health literacy is prioritized by Healthy People 2020 as an SDOH.235 NASEM's 2016 report on accounting for social risk factors in Medicare payment considers health literacy an individual risk factor affected by other social risk factors.

B1300. Health Literacy How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	
Enter Code ☐	0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 8. Resident unable to respond

BRR | BROAD RIVER REHAB
"A *Knowledgeable* and *Compassionate* partner"

Making it Work: CMS Million Hearts

- CMS is a lead partner in the Million Hearts® initiative, which seeks to reduce the incidence of heart attacks and strokes by 1 million.
- This will be accomplished by **increasing awareness of the risk factors for cardiovascular disease** and promoting and utilizing proven interventions.
- Decades of research and practice have demonstrated that public health and clinical preventive strategies can greatly reduce the risk of cardiovascular disease.
- The key interventions are referred to as the "ABCs": appropriate aspirin therapy, blood pressure control, cholesterol management, and smoking cessation

Making it Work: BRR Stroke Programming

- Stroke is fundamentally a chronic condition
- The end of formal rehabilitation (commonly by 3–4 months after stroke) should not mean the end of the restorative process.
- Prior approaches have managed stroke medically as a temporary or transient condition instead of a chronic condition that warrants monitoring after the acute event.
- Currently, unmet needs persist in many domains, including social reintegration, health-related quality of life, maintenance of activity, and self-efficacy (i.e, belief in one's capability to carry out a behavior). Apathy is manifested in >50% of survivors at 1 year after stroke; fatigue is a common and debilitating symptom in chronic stroke; daily physical activity of community-living stroke survivors is low; and depressive symptomology is high.
- By 4 years after onset, >30% of stroke survivors report persistent participation restrictions (eg, difficulty with autonomy, engagement, or full filling societal roles)

Making it Work: BRR Stroke Programming

- Contains key elements related to stroke types
- Risk Factors
- Clinical Presentation
- Assessment and treatment methods
- Comprehensive training for patients and caregivers re: prevention and medical management

BRR | BROAD RIVER REHAB

"A *Knowledgeable* and *Compassionate* partner"

References

- Centers for Medicare and Medicaid Services 2016, Quality Strategy, derived from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy-Overview.pdf
- Office of Disease Prevention and Health Promotion 2020, Health Literacy, derived from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/health-literacy

QUESTIONS?

BRR | BROAD RIVER REHAB

"A *Knowledgeable* and *Compassionate* partner"