Clinical Decision Support Tools and Advance Planning: Engaging the Patient and Care Partner

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Amy Daly, LNHA, MA

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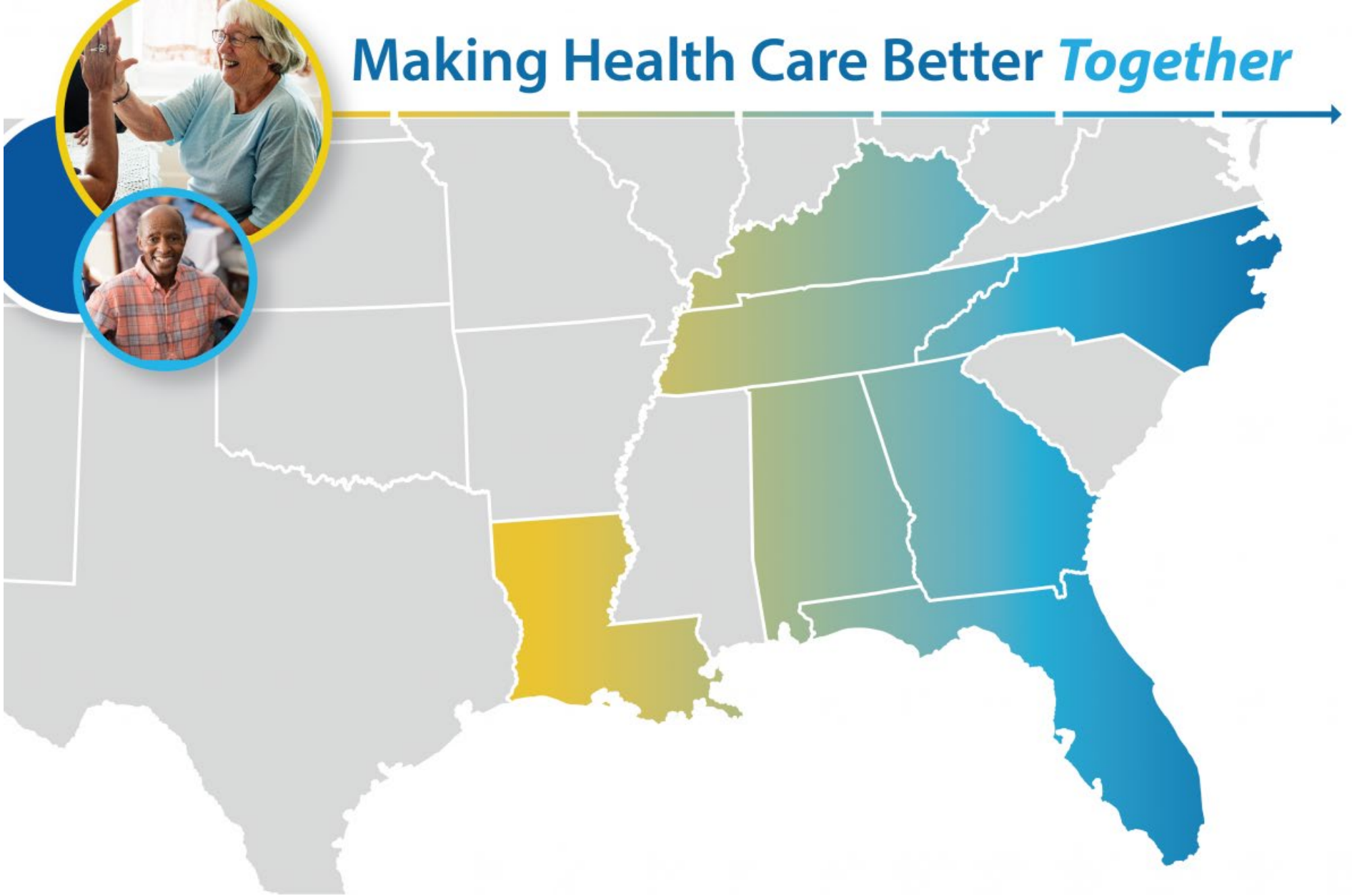

About Alliant Health Solutions

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Danyce Seney, RN, BSN, IP, RAC-CTA

QUALITY IMPROVEMENT SPECIALIST

Danyce Seney is a quality improvement specialist and a registered nurse with Lean, Infection Control Preventionist and Educator for Adult Learner certifications.

Danyce supports skilled nursing facilities in utilizing a quality improvement framework to implement evidence-based interventions and strategies to improve patient safety, improve immunization rates and reduce avoidable readmissions.

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Amy Daly, MA, NHA

SENIOR QUALITY IMPROVEMENT SPECIALIST

Amy Daly is a licensed nursing home administrator with over 20 years of leadership and long-term care management experience. In addition to her prior work as a VP of long-term care and facility administrator, Amy has served on the boards of the Genesee Health Facilities Association (as treasurer and education committee member) and the Genesee Health Facilities Foundation. Amy serves as an NYS Department of Health Informal Dispute Resolution (IDR) panel member and has been an adjunct clinical instructor of dental hygiene at Monroe Community College. Amy has a master's degree in health promotion and a bachelor's degree in health sciences.

Email: adaly@ipro.org

Scan the QR codes or Click the Links to Complete the Assessments!

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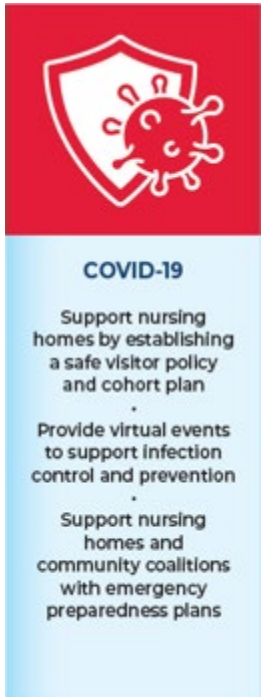

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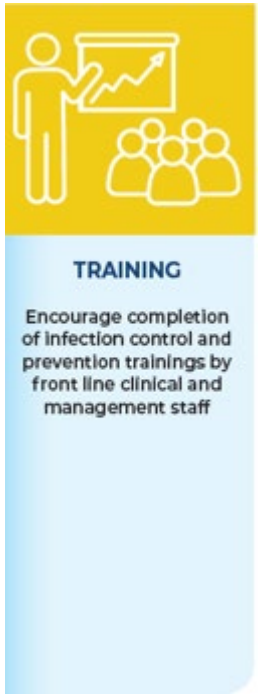
https://bit.ly/AHS_NHEPPAssessment



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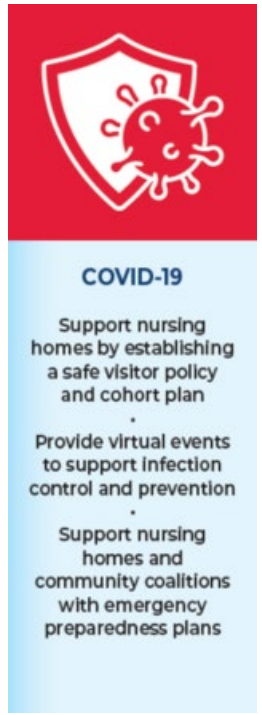

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Continuing Education Information - LIVE

Learning Outcome:
Following this activity, we expect learners to share their plans to do differently when back at work in the post-activity poll.

Nursing Professional Development: ANCC Contact Hours & Accreditation Statement
This nursing continuing professional development activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91) This activity (each event) awards 0.5 contact hours and 0 hours of pharmacology.

National Association of Long-Term Care Administrator Boards
This program has been approved for Continuing Education for 1.5 total participant hours by NAB/NCERS—Approval #20230815-1.50-A86674-DL.

Disclosure of Financial Relationships
No one with the ability to control the content of this activity has a relevant financial relationship with an ineligible company.

Instructions for obtaining credit
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1. Identify tools and resources for decision support, advance care planning and engaging patients and care partners

2. Learn the impact of utilizing decision support, ACP and patient and family engagement tools on readmissions.

Use Tomorrow:

- ✓ Review your most recent six months of readmissions (high-level for trends, adjust months based on facility census)
- ✓ Review your current resident population and flag residents with similar conditions/risk
- ✓ Identify which decision support tool(s) align with your highest readmission cause/condition
- ✓ Identify your team members

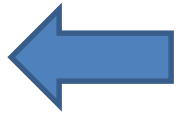
    - ❑ Think about all shifts and line staff that have an interest in the condition and/or advancing to a leadership role
    - ❑ Frontline staff, medical staff, patients and families

Reducing Avoidable ED Visits and Readmissions

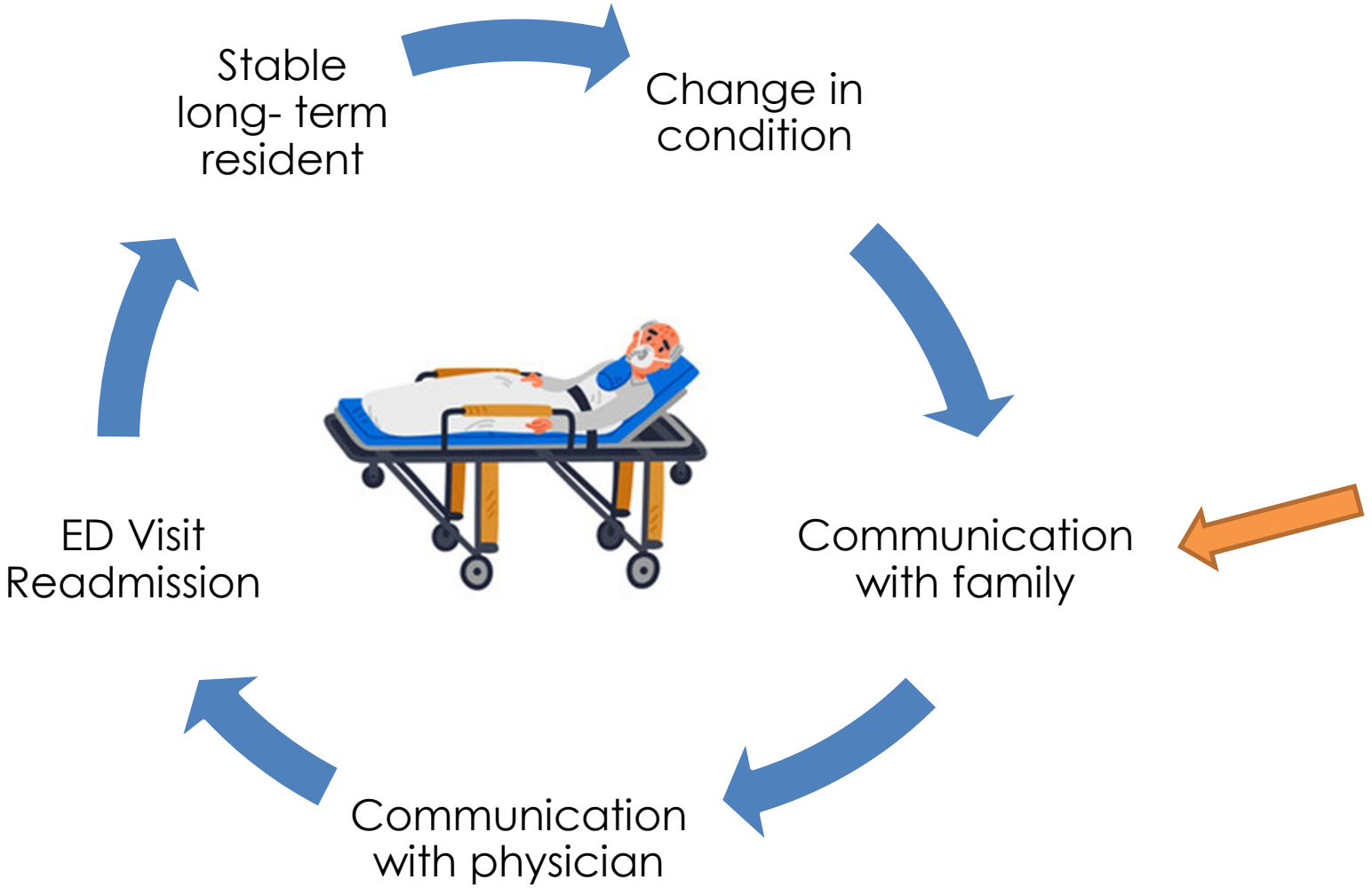
Session 1:
- Overview of Interact® as a Quality Improvement Initiative
- Quality Measures Related to Re-Admissions and Emergency Department Visits
- Facility Capabilities and Impact on Admissions, Re-Admissions, ED Visits

Session 2:
- Detecting and Communicating Changes in Condition
- Impact Communication Can Have on Reducing Admissions and Emergency Department Visits
- Use of Tools like Stop & Watch, SBAR, Communication Checklists and Clinical Management

Session 3:
- Clinical Decision Support Tools and Advanced Care Planning
- Involving the Resident/Patient Voice in Care Decisions



The Readmission/ED Visit Cycle



Interact® 4.5 Decision Support Tools

Decision Support Tools: Change in Condition File Cards and Care Paths

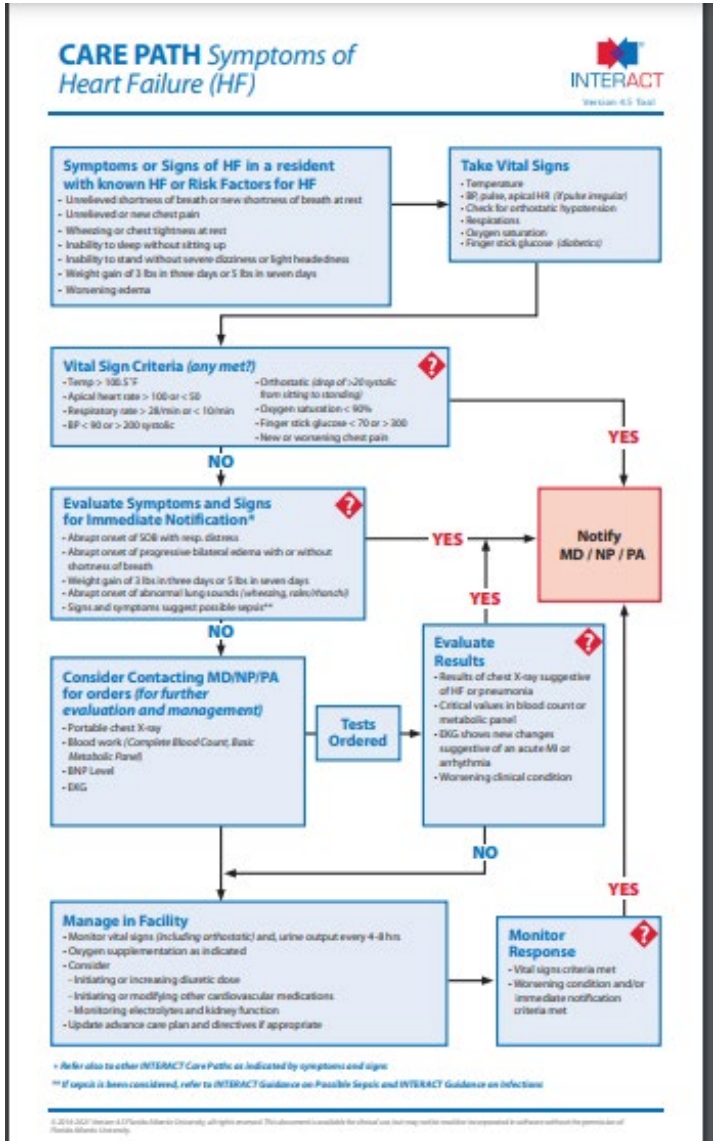
Acute Change in Condition File Cards

- Acute Change in Condition File Cards

Care Paths

- Acute Mental Status Change
- Change in Behavior: New or Worsening Behavioral Symptoms
- Dehydration
- Fever
- GI Symptoms – nausea, vomiting, diarrhea
- Shortness of Breath
- Symptoms of CHF
- Symptoms of Lower Respiratory Illness
- Symptoms of UTI
- Fall

Interact Decision Support Tools



How to Operationalize

- Readmission Root Cause identifies the high rate of CHF readmissions
- Review the Care Path with the facility medical director
- Develop high-level order sets or order bundles that can be individualized for person-centered care
- Build into the electronic medical record
- Education: staff, medical staff, patients and families
  - Include the role of the patient and family in the pathway
- Ongoing monitoring

Zone Tools

Incorporating Zone Tools

- Provide at admission.
- Educate on the zones during the stay to reduce ED visits and hospitalizations at discharge.
- Engage the therapy team with the use of zone tools.
- Hang in visible areas for all care team members to reinforce incorporation into routines.
- Use to guide communication and care.

https://quality.allianthealth.org/?s=zone

ZONE TOOL | COVID-19 Self-Management Zone Tool

This tool is used by healthcare providers across the continuum of care to educate and prepare patients for safe self-management of COVID-19 illness.

COVID-19 Self-Management Plan

Name _____ Date _____

Do not smoke and avoid secondhand smoke.

GREEN Zone: In Control

- I can breath easily without shortness of breath.
- I am not experiencing chest tightness.
- My energy level is nearly normal.
- I can think clearly.

GREEN Zone Means I Should:

- Use oxygen if prescribed by my doctor/healthcare provider.
- Check my oxygen level (pulse oximetry) if ordered by my doctor/healthcare provider.
- Keep a diary of symptoms including temperature, heart rate, and oxygen levels if ordered by my doctor/ healthcare provider.

YELLOW Zone: Caution

- My breathing is fast.
- I have a new or worsening cough.
- I am having trouble catching my breath.
- My heartbeat feels much faster than usual.
- I have a fever.
- I feel cold and am shivering -- I can't get warm.
- My thinking is slow -- my head feels "fuzzy".

YELLOW Zone Means I Should:

- Be evaluated by my doctor/healthcare provider.
- Call or message my doctor or healthcare provider. (Do not go to the doctor's office unless instructed to do so.)
- Share my symptoms and follow their directions.

If receiving home healthcare services:

Agency: _____ Phone: _____

My doctor/healthcare provider:

Agency: _____ Phone: _____

RED Zone: Medical Alert!*

- My breathing is very fast.
- I can't catch my breath and can't speak an entire sentence.
- My fingernails or my lips are pale and blue.
- I am having chest pain.
- I can't eat or drink.
- I am confused.
- I can't stay awake.

*This list does not include all possible symptoms. Please discuss with your medical provider any other symptoms that are severe or concerning to you.

RED Zone Means I Must:

- **Take action!**
- **Call 9-1-1 or call ahead to your local emergency facility:** Notify the operator that you are seeking care for someone who has or may have COVID-19.

Sources: Centers for Disease Control and Prevention (CDC). Coronavirus Disease 2019 (COVID-19): Symptoms of Coronavirus. Available at: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html. CDC: COVID-19: How to Protect Yourself and Others. Available at: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html. Accessed: March 3, 2021.

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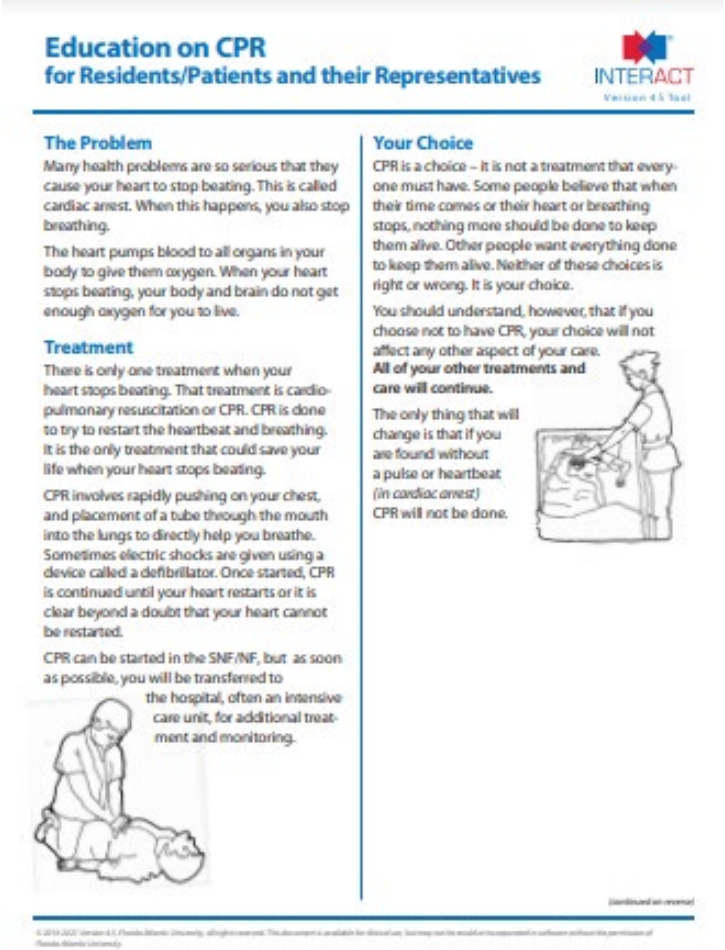
Interact® 4.5 Advance Care Planning Tools

Advance Care Planning 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 Possible Sepsis
- Guidance on Possible Infection

Consider:
- Clinician comfort in having the CPR discussion
- Scope of practice



Education on CPR
for Residents/Patients and their Representatives

INTERACT

The Problem

Many health problems are so serious that they cause your heart to stop beating. This is called cardiac arrest. When this happens, you also stop breathing.

The heart pumps blood to all organs in your body to give them oxygen. When your heart stops beating, your body and brain do not get enough oxygen for you to live.

Treatment

There is only one treatment when your heart stops beating. That treatment is cardio-pulmonary resuscitation or CPR. CPR is done to try to restart the heartbeat and breathing. It is the only treatment that could save your life when your heart stops beating.

CPR involves rapidly pushing on your chest, and placement of a tube through the mouth into the lungs to directly help you breathe. Sometimes electric shocks are given using a device called a defibrillator. Once started, CPR is continued until your heart restarts or it is clear beyond a doubt that your heart cannot be restarted.

CPR can be started in the SNF/NF, but as soon as possible, you will be transferred to the hospital, often an intensive care unit, for additional treatment and monitoring.

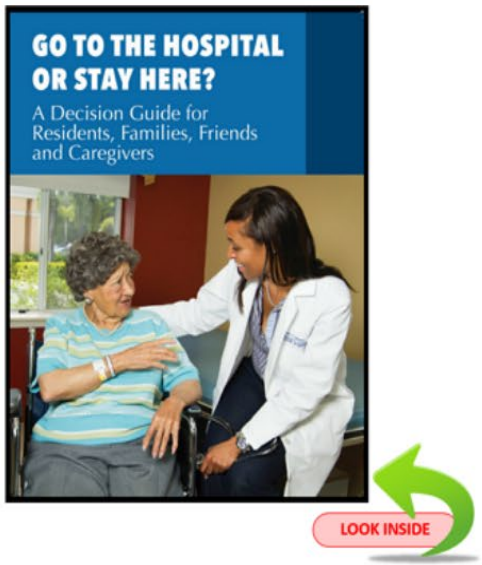
Your Choice

CPR is a choice – it is not a treatment that everyone must have. Some people believe that when their time comes or their heart or breathing stops, nothing more should be done to keep them alive. Other people want everything done to keep them alive. Neither of these choices is right or wrong. It is your choice.

You should understand, however, that if you choose not to have CPR, your choice will not affect any other aspect of your care. **All of your other treatments and care will continue.**

The only thing that will change is that if you are found without a pulse or heartbeat *(in cardiac arrest)* CPR will not be done.

Opportunities to Impact the Cycle or Decision

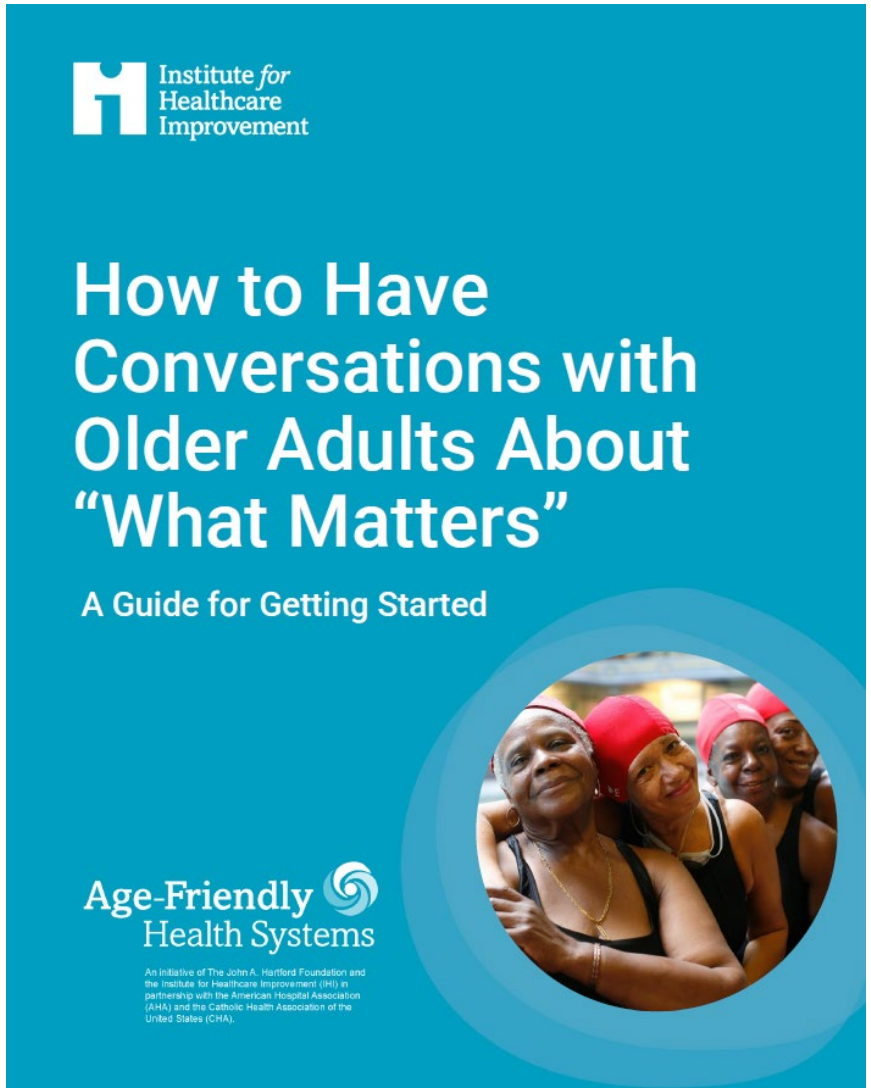


Decision Guide links and resources:

[Alliant Health Solutions Brief Video Overview of the Decision Guide and Resources]

[http://www.decisionguide.org/]

What Matters



- "Asking about—and acting on—What Matters to older adults means knowing and aligning care with each older adult's specific goals and preferences across settings of care. This includes, but is not limited to, care through the end of life."-IHI, Age-Friendly Health systems.

- This can be used by anyone, at any time, with anyone in any setting, because it is important to have that person's voice heard and included.

- Includes prompt to:
  - Plan the conversation—location, what you will say, how to express what you want to say
  - Reflect—what was the impact on the individual following the conversation? Were the results of the conversations shared with the care team?

https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/Resources.aspx

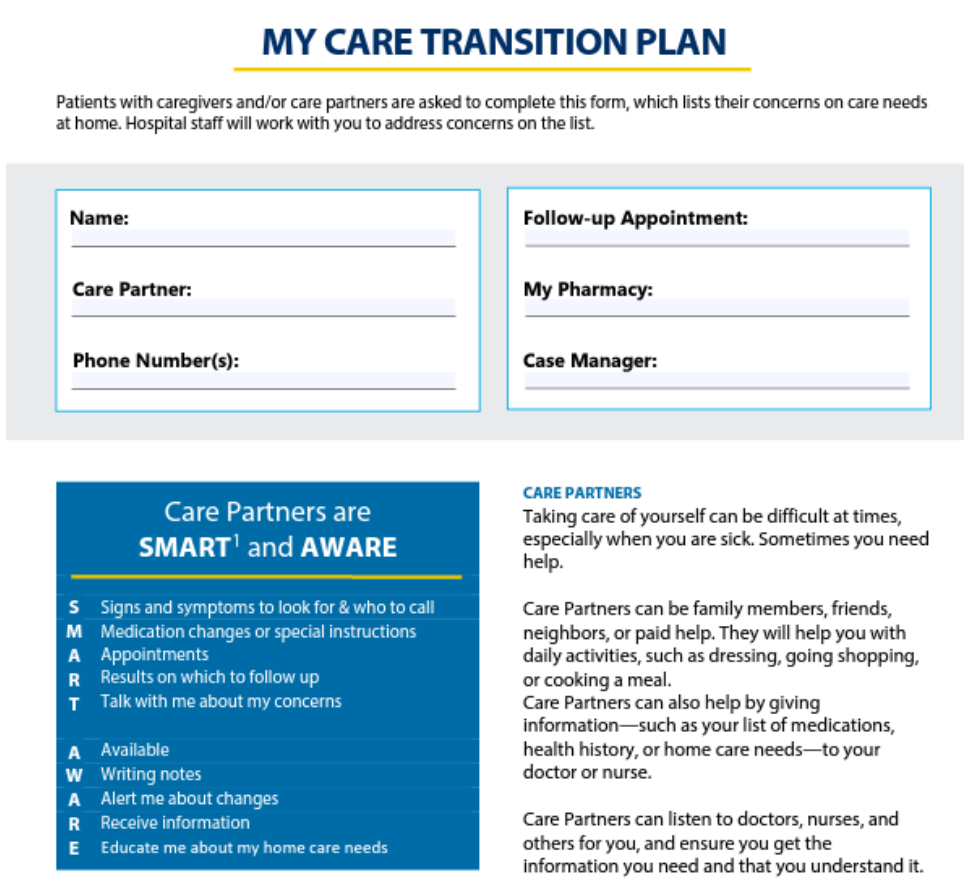
Our Family Our Way (OFOW)

The home…	N/A	Yes	No	Can't agree	Notes
has rooms and hallways clear of clutter.				✓	Mom does not feel "her papers" are a problem
has adequate outdoor lighting.			✓		front porch light is burned out
has an emergency response system (e.g., Lifeline)		✓			
has smoke alarms installed, tested.		✓			
has carbon monoxide detector installed, tested.			✓		
has accessible interior doorways.			✓		Dad's wheelchair does not fit through bathroom door
has lawn care/snow and ice removal when necessary.			✓		

- A communication and care coordination process was developed to help individuals and care partners think and discuss a plan.
- Included are checklists for the care partners and individuals regarding health considerations, environment, and what care/support is needed as well as materials to assist with planning and guiding a meeting with all individuals involved.
- Our Family Our Way can help reduce ED visits and hospitalizations by assisting with planning the details in advance or allowing individuals and their care partners the opportunity to determine that discharge is not the best decision.

https://www.miamioh.edu/cas/academics/centers/scripps/research/ofow/index.html

My Care Transition Plan



MY CARE TRANSITION PLAN

Patients with caregivers and/or care partners are asked to complete this form, which lists their concerns on care needs at home. Hospital staff will work with you to address concerns on the list.

Name:

Care Partner:

Phone Number(s):

Follow-up Appointment:

My Pharmacy:

Case Manager:

Care Partners are SMART[1] and AWARE

- **S** Signs and symptoms to look for & who to call
- **M** Medication changes or special instructions
- **A** Appointments
- **R** Results on which to follow up
- **T** Talk with me about my concerns

- **A** Available
- **W** Writing notes
- **A** Alert me about changes
- **R** Receive information
- **E** Educate me about my home care needs

CARE PARTNERS

Taking care of yourself can be difficult at times, especially when you are sick. Sometimes you need help.

Care Partners can be family members, friends, neighbors, or paid help. They will help you with daily activities, such as dressing, going shopping, or cooking a meal.
Care Partners can also help by giving information—such as your list of medications, health history, or home care needs—to your doctor or nurse.

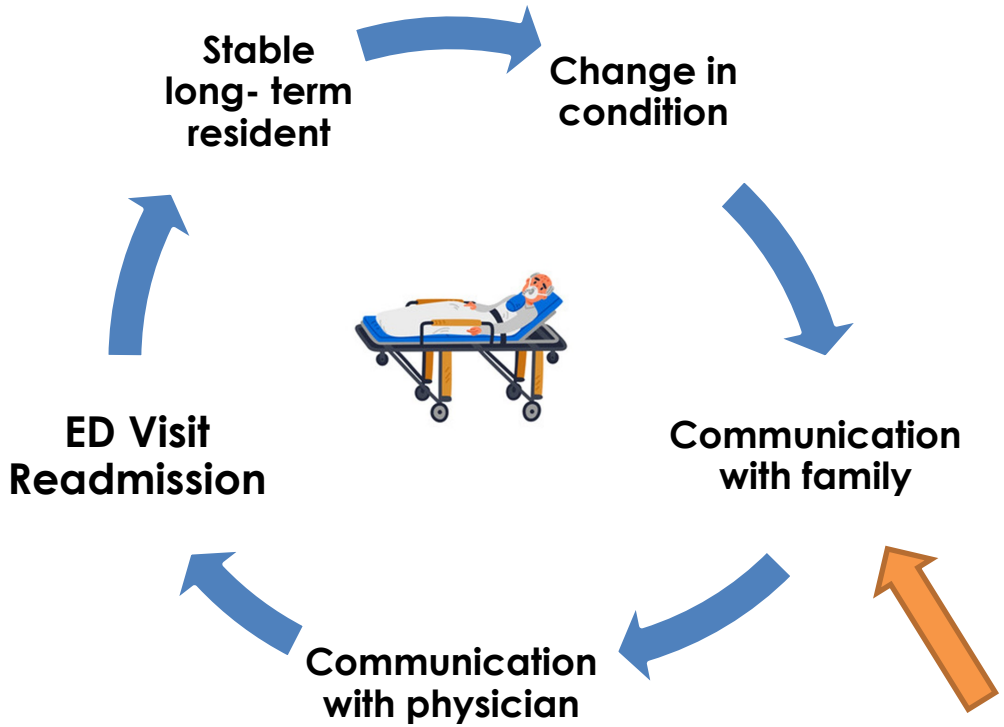
Care Partners can listen to doctors, nurses, and others for you, and ensure you get the information you need and that you understand it.

I AM CONCERNED ABOUT...	YES	NO	COMMENTS
Follow-Up Medical Care			
Having all the information I need when I leave			
Follow-up care after leaving			
Scheduling follow-up appointments and/or tests			
Who to call with questions or concerns			
How I will get to my doctor's follow-up appointment			
Whether I will need home nursing, therapists, nutritionists			
The type of medical equipment I will need (e.g., walker, crutches, insulin pump, oxygen)			
Managing my wound care			
Paying for the care I need			
Medications			
Which medications I should take at home			
When to take my medications			
Taking my medications as prescribed (e.g., swallowing)			
Understanding the side effects of my medications			
Paying for my medications			
Getting my medications from the pharmacy			
Activities of Daily Living			
Getting help with personal care (e.g., bathing, dressing)			
Cooking meals			
Getting help with grocery shopping			
Using medical equipment, changing a bandage, or giving an injection			
Care Partner			
How my family or other caregivers will help me when I am at home			
How my family or other caregivers will manage my illness			
Losing contact with friends and family, and feeling isolated or left behind			
Culture			
Whether I will be able to keep my core beliefs and values despite my illness			

https://quality.allianthealth.org/wp-content/uploads/2020/12/AQ_NYSPF-Portrait_FORM_508-1.pdf

- Helps patients/residents and care partners document their questions and concerns throughout their stay.
- Use of this tool in either brochure or portrait versions can help facility teams proactively implement mitigation strategies.
- Use of this tool helps reduce ED visits and hospitalizations by planning for the unexpected in advance.

The Readmission/ED Visit Cycle



Review of the Cycle

- With this series, we have discussed the areas your facility could potentially focus on to improve and reduce ED visits, readmissions and hospitalizations.
- Resources and tools have been provided to assist you in your efforts.
- Alliant Health Solutions has Quality Advisors who would be happy to work with you to develop an action plan or process regarding ED visits or readmissions.

Learning Objectives

1. Identify tools and resources for decision support, advance care planning and engaging patients and care partners.

2. Learn the impact of utilizing decision support, ACP and patient and family engagement tools on readmissions.

Use Tomorrow:

- ✓ Review your most recent six months of readmissions (high-level for trends, adjust months based on facility census)
- ✓ Review your current resident population and flag residents with similar conditions/risk
- ✓ Identify which decision support tool(s) align with your highest readmission cause/condition
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  - ❑ Think about all shifts and line staff that have an interest in the condition and/or advancing to a leadership role.
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Expiration Date: The credit claiming system for the recording expires 30 days after the last event.

https://bit.ly/NAB_ANCC_ClaimCredit

Q1: Did you attend the live event or watch the recorded version? *

Live

Q2: Which series are you claiming credit for today? *

Affinity Group Series

Q3: Which Affinity Group Sub Series are you claiming credit for today? *

Care Coordination

Q4: Care Coordination Affinity Groups *

Care Coordination-NHs: Decision making and Advanced Care planning held on 10/18...

ALLIANT HEALTH SOLUTIONS

Claim Continuing Education Credit

This evaluation is to claim credit for Alliant Health Solutions events.

Questions?

Nursing Home and Partnership for Community Health:
CMS 12th SOW GOALS

OPIOID UTILIZATION AND MISUSE

Promote opioid best practices

•

Reduce opioid adverse drug events in all settings

PATIENT SAFETY

Reduce hospitalizations due to c. diff

•

Reduce adverse drug events

•

Reduce facility acquired infections

CHRONIC DISEASE SELF-MANAGEMENT

Increase instances of adequately diagnosed and controlled hypertension

•

Increase use of cardiac rehabilitation programs

•

Reduce instances of uncontrolled diabetes

•

Identify patients at high-risk for kidney disease and improve outcomes

CARE COORDINATION

Convene community coalitions

•

Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits

•

Identify and promote optimal care for super utilizers

COVID-19

Support nursing homes by establishing a safe visitor policy and cohort plan

•

Provide virtual events to support infection control and prevention

•

Support nursing homes and community coalitions with emergency preparedness plans

IMMUNIZATION

Increase influenza, pneumococcal, and COVID-19 vaccination rates

TRAINING

Encourage completion of infection control and prevention trainings by front line clinical and management staff

Scan the QR codes or Click the Links to Complete the Assessments!

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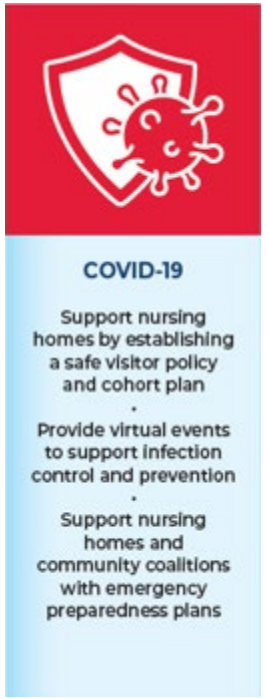

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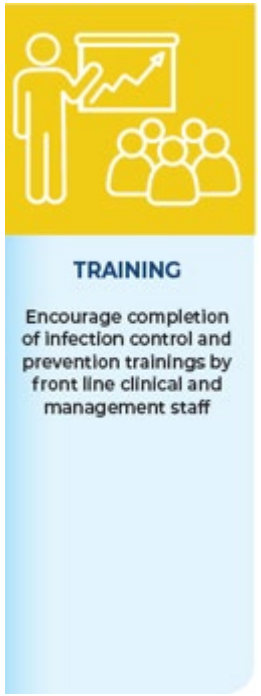

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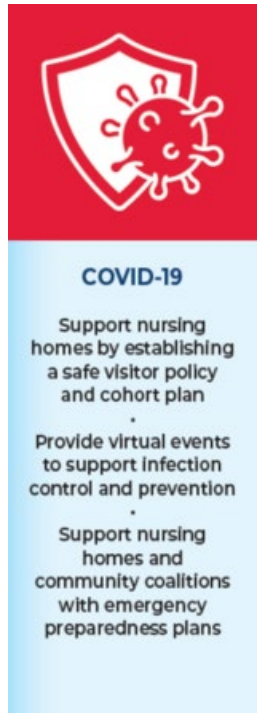

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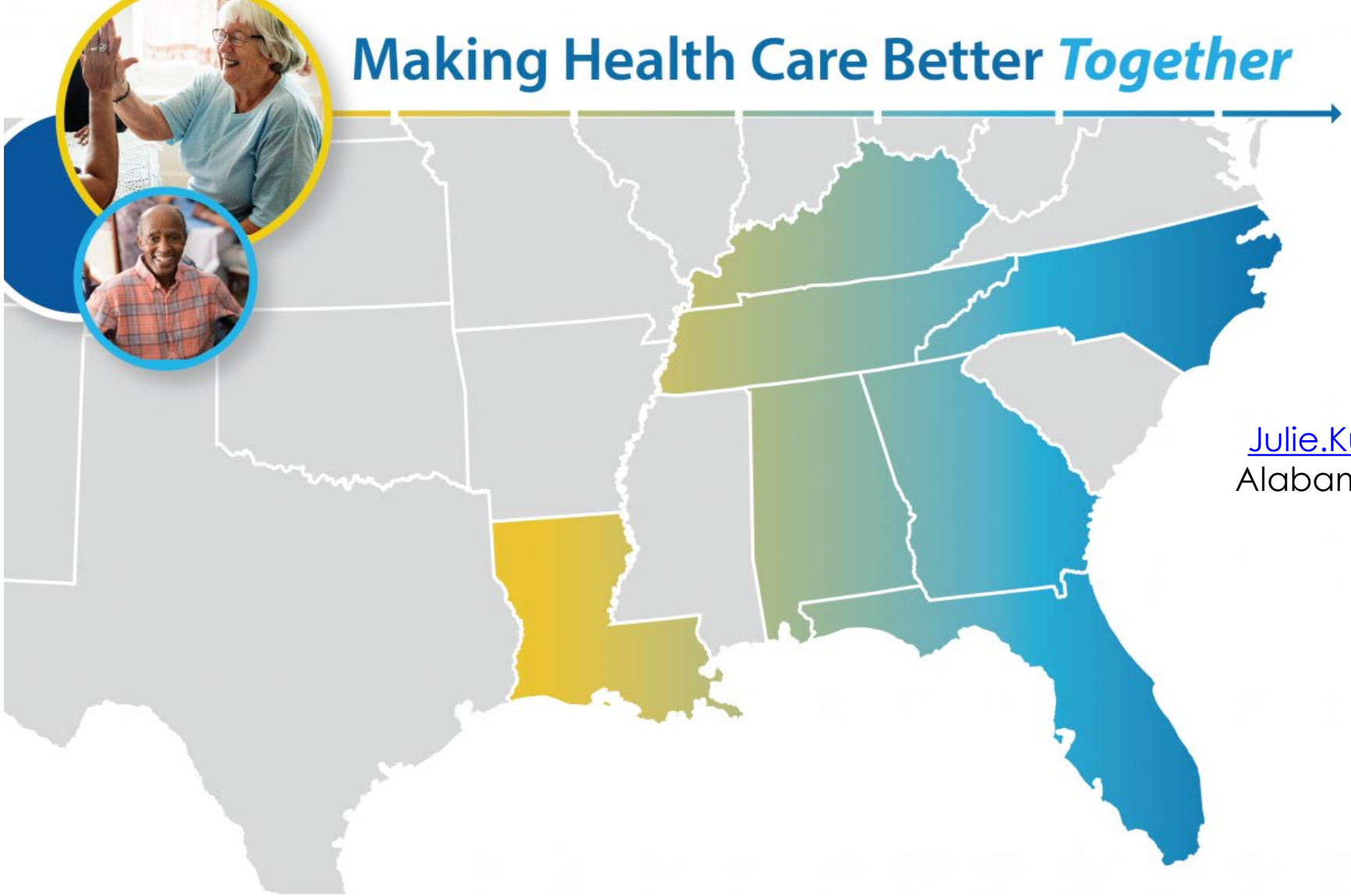

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