Trauma-Informed Health Literacy:

A COVID-19 Perspective

Joel VanEaton, BSN, RN, RAC-CTA, MT
EVP, Compliance and Regulatory Affairs, Broad River Rehab

Renee Kinder, MS, CCC-SLP, RAC-CT
EVP, Clinical Services, Broad River Rehab

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Objectives

- Define Health Literacy and Trauma-Informed Care
- Explain the importance of how COVID-19 informs both aspects of PAC care
- Identify current PAC Health Literacy gaps
- Understand MDS Revisions/The path forward

Live poll

What’s your current role at your organization?

Health Literacy Defined

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 aged 65+ have lower health literacy than adults under 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

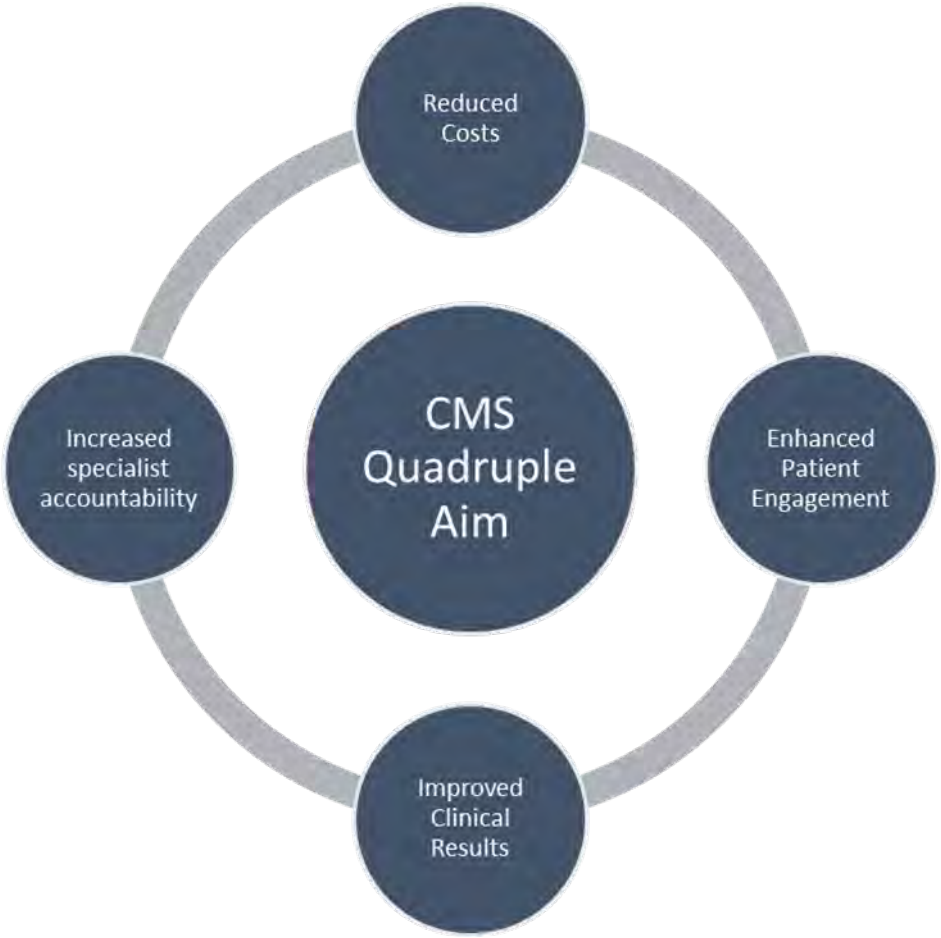
Prevalence of Limited Health Literacy Among American Adults

POPULATION SUBGROUP	PREVALENCE
Race/ethnicity	
White	28%
Asian/Pacific Islander	31%
American Indian/Alaska Native	48%
African-American	58%
Hispanic	66%
Age (years)	
19–24	31%
25–39	28%
40–49	32%
50–64	34%
65+	59%

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



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
- 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)?

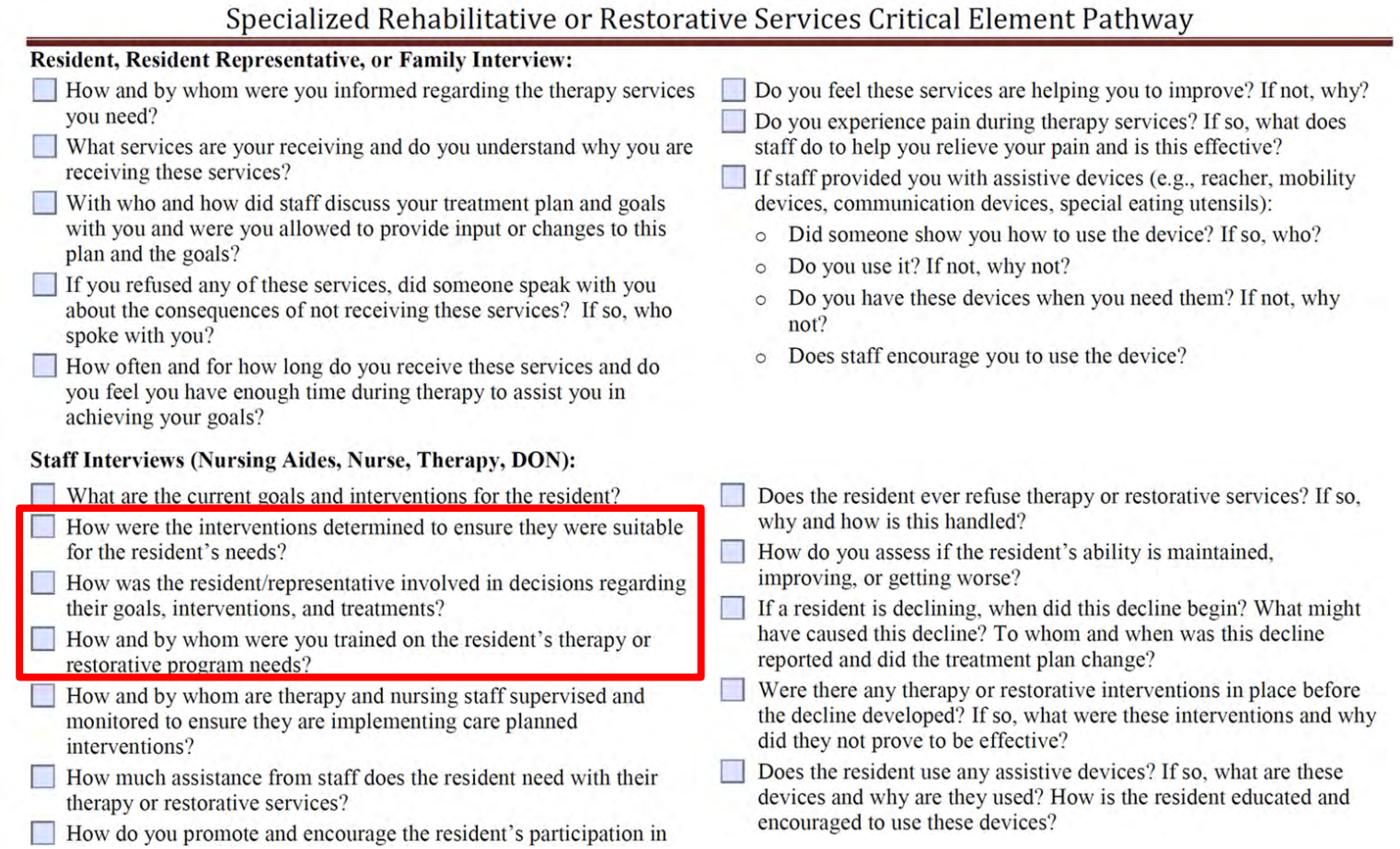
PT, OT, SLP, or Restorative Manager Interview:

- ☐ 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

CMS Survey Critical Element Pathway Activities of Daily Living (cont.)



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?

Trauma-Informed Care Defined

Regulatory

Phase 3 COP Implementation

- **F659**
- §483.21(b)(3) Comprehensive Care Plans
- The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
- (iii) Be culturally-competent and trauma–informed.

Regulatory

Phase 3 COP Implementation

- **F699**
- §483.25(m) Trauma-informed care
- The facility must ensure that residents who are trauma survivors receive culturally competent, **trauma-informed** care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

Regulatory

Phase 3 COP Implementation

- **F741**
- §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:
- §483.40(a)(1) Caring for residents with mental and psychosocial disorders, **as well as residents with a history of trauma and/or post-traumatic stress disorder**, that have been identified in the facility assessment conducted pursuant to §483.70(e), and

Regulatory

Phase 3 COP Implementation

- **F940**
- §483.95 Training Requirements
- A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to—
- §483.95(i) Behavioral health.
- A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e).

Survey

Behavioral and Emotional Status Critical Element Pathway

- Use this pathway to determine if the facility is providing necessary behavioral, mental, and/or emotional health care and services to each resident. Similarly, the facility staff members must implement person-centered, non-pharmacological approaches to care to meet the individual needs of each resident. While there may be isolated situations where pharmacological intervention is required first, these situations do not negate the obligation of the facility to develop and implement non-pharmacological approaches. Refer to the Dementia Care pathway to determine if the facility is providing the necessary care and services necessary.

Survey

Behavioral and Emotional Status Critical Element Pathway

Observations Across Various Shifts:

- ☐ If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how does staff address these indications?
- ☐ Are staff implementing care planned interventions to ensure the resident's behavioral health care and service needs are being met? If not, describe.
- ☐ Focus on staff interactions with residents who have a mental or psychosocial disorder to determine whether staff consistently apply accepted quality care principles.
- ☐ Is there sufficient, competent staff to ensure resident safety and meet the resident's behavioral health care needs?
- ☐ What non-pharmacological interventions (e.g., meaningful activities, music or art therapy, massage, aromatherapy, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment) does staff use and do these approaches to care reflect resident choices and preferences?
- ☐ How does staff monitor the effectiveness of the resident's care plan interventions?
- ☐ How does staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Does staff demonstrate competent interactions when addressing the resident's behavioral health care needs?
- ☐ Is the resident's distress caused by facility practices which do not accommodate resident preferences (e.g., ADL care, daily routines, activities, etc.)?

Survey

Behavioral and Emotional Status Critical Element Pathway

Staff Interviews (Interdisciplinary team (IDT) members) across Various Shifts:

- ☐ What are the underlying causes of the resident's behavioral expressions or indications of distress, specifically included in the care plan?
- ☐ What specific approaches to care, both non-pharmacological and pharmacological, have been developed and implemented to support the behavioral health needs of the resident, including facility-specific guidelines/protocols? What is the rational for each intervention?
- ☐ How are the interventions monitored?
- ☐ How do you ensure care is provided that is consistent with the care plan?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ What types of behavioral health training have you completed?
- ☐ Ask about any other related concerns the surveyor has identified.
- ☐ How do you monitor for the implementation of the care plan and changes in the resident's condition?
- ☐ How are changes in both the care plan and condition communicated to the staff?
- ☐ How often does the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?

Note: If care plan concerns are noted, interview staff responsible for care plan development to determine the rationale for the current care plan.

Survey

Behavioral and Emotional Status Critical Element Pathway

Record Review:

- ☐ Review therapy notes and other progress notes that may have information regarding the assessment of expressions or indications of distress, mental or psychosocial needs, and resident responsiveness to care approaches.
- ☐ Determine whether the assessment information accurately and comprehensively reflects the condition of the resident.
- ☐ What is the time, duration, and severity of the resident's expressions or indications of distress?
- ☐ What are the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress, such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?
- ☐ What non-pharmacological approaches to care are used to support the resident and lessen their distress?
- ☐ What PASARR Level II services or psychosocial services are provided, as applicable?
- ☐ Does the facility ensure residents with substance use disorders have access to counseling programs (e.g., 12 step groups)?
- ☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, expressions or indications of distress and includes measurable goals and timetables? How did the resident respond to care-planned interventions? If interventions were ineffective, was the care plan revised and were these actions documented in the resident's medical record?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ Was behavioral health training provided to staff?

Definition

Trauma

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (SAMHSA)

Definition

According to the National Council for Community Behavioral Health Care, **"Trauma occurs when a person is overwhelmed by events or circumstances and responds with intense fear, horror, and helplessness."**

Extreme stress overwhelms the person's capacity to cope.

There is a direct correlation between trauma and conditions such as diabetes, COPD, heart disease, cancer, and high blood pressure.

Trauma may be experienced and expressed in numerous ways and dimensions." Often trauma, like grief, is misunderstood or misdiagnosed and not attributed to the effects of trauma. People deal with trauma differently.

- **Biological symptoms** include brain function, headaches, stomach aches, sleep changes
- **Psychological symptoms** include fear, anxiety, outbursts, flashbacks, nightmares
- **Social symptoms** include apathy, isolation, difficulty trusting, detachment
- **Spiritual symptoms** include struggle to find meaning, anger with God

Definition

Trauma-Informed

A program, organization or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths to recovery; recognizes the signs and symptoms of trauma in clients, families, staff and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures and practices to actively resist re-traumatization. (SAMHSA)

Trauma Statistics

- Somewhere between 55% and 90% of persons have experienced at least one traumatic event.
- An estimated 6% of men and 10% of women experience Post Traumatic Stress Disorder (PTSD) within their lifetime.
- Potentially traumatic experiences include: experiencing or witnessing childhood adverse events (e.g. experiencing or witnessing emotional, physical or sexual abuse or neglect, living with a parent with mental illness or substance misuse disorder, death or absence of a parent because of imprisonment) - domestic and sexual violence; natural disasters; - car, train and airplane crashes; - combat; - becoming a refugee; - homelessness; - **medical trauma**; - violent crime; - bias discrimination, hate crimes and hate speech; -

Trauma Statistics

- Medical events and procedures associated with life threat, even when they are successful, are associated with relatively high rates of PTSD development. For example, myocardial infarct / acute coronary syndrome is associated with up to 15% rate of PTSD, Major thoracic surgeries such as cardiac artery bypass graft (CABG) and open abdominal aortic aneurysm (AAA) repair, even when scheduled and expected, are also associated with ~20% rates of de novo PTSD.
- Particularly relevant to the COVID-19 pandemic, prolonged treatment in intensive care units (ICUs) such as for sepsis, and in particular, intubation, are associated with some of the highest rates of medical PTSD, with 35% of ICU survivors having clinically significant PTSD symptoms 2 years subsequent to the ICU care. Thus, in addition to "post-intubation syndrome" in survivors, once a patient is medically stabilized, it is important to assess and provide care for psychiatric responses like PTSD that are expected to be common.

Trauma-Informed Approach

Trauma-Informed Care understands…

- **The 3-E's**
  - **Events** – what happened
  - **Experience** – The resident's unique experience
  - **Effect** – How did the experience effect the resident
- **The 4-R's**
  - **Realizes** the widespread impact of trauma and understands potential paths for recovery.
  - **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system
  - Seeks to actively resist **re-traumatization**
  - **Responds** by full integrating knowledge about trauma into policies, procedures, and practices

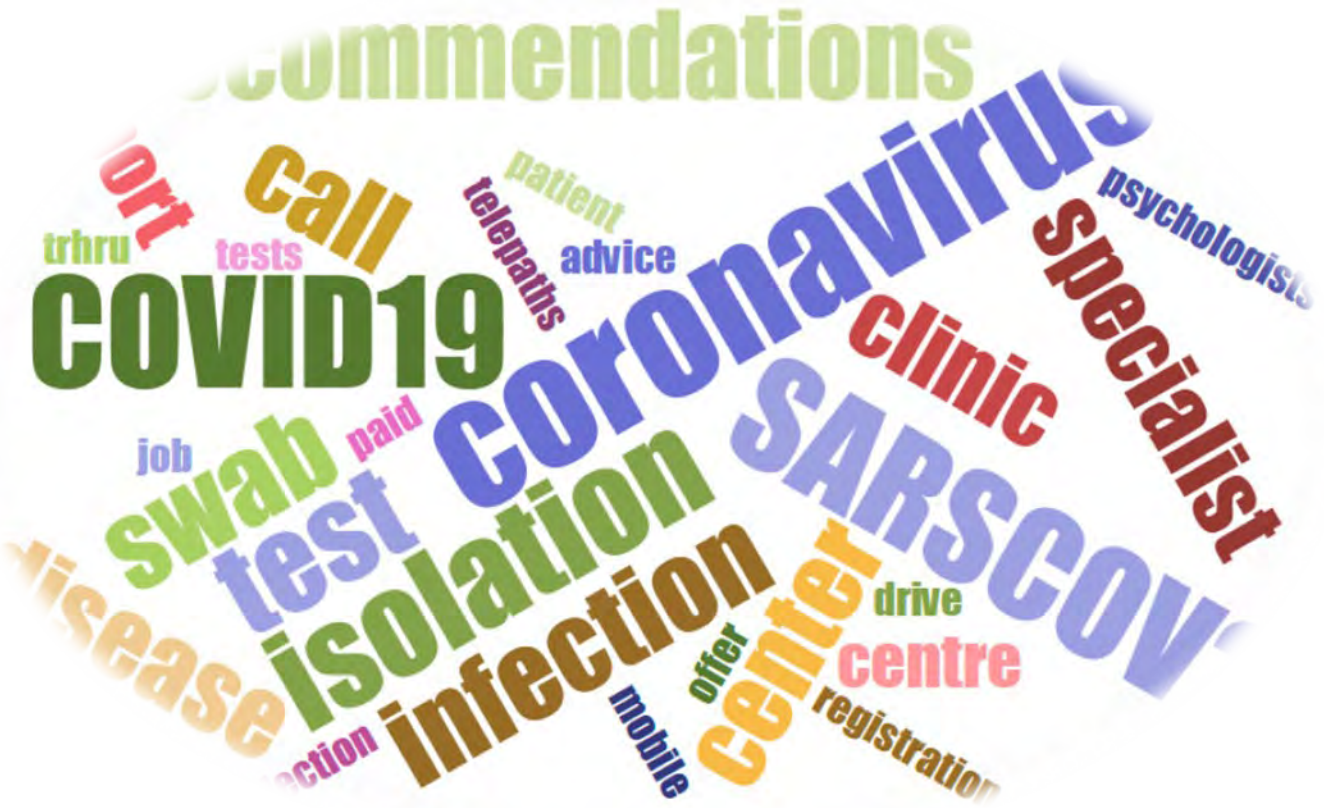
Trauma-Informed Care is a process, not a destination

Trauma-Informed Approach

Trauma-informed Care understands…

- **The 6 Key Principles**
  - **SAFETY** — all people associated with the organization feel safe. This includes the safety of the physical setting and the nature of interpersonal interactions.
  - **TRUSTWORTHINESS AND TRANSPARENCY** — your organization is run with the goal of building trust with all those involved.
  - **PEER SUPPORT** — support from other trauma survivors is a key to establishing safety and hope. Peer support may be from others in the community.
  - **COLLABORATION AND MUTUALITY** — recognition that everyone at every level can play a therapeutic role through healing and safe relationships. Your organization emphasizes the leveling of power differences and taking a partnership approach with staff.
  - **EMPOWERMENT, VOICE, AND CHOICE** — your organization recognizes and builds on the strengths of people — staff members and residents. You recognize the ways in which nursing home residents and staff members may have been diminished in voice and choice and have at times been subject to coercive treatment. You support and cultivate skills in self-advocacy, and seek to empower residents and staff members to function or work as well as possible with adequate organizational support.
  - **CULTURAL, HISTORICAL, AND GENDER ISSUES** — your organization actively moves past cultural biases and stereotypes (gender, region, sexual orientation, race, age, religion), leverages the healing value of cultural traditions, incorporates processes and policies that are culturally aware, and recognizes and addresses historical trauma.

COVID-19 Trauma-Informed Health Literacy



Trauma-Informed Care and IDT Considerations

- Consider how we will holistically address the following key elements:
  - Comprehensive Care Planning
  - Trauma-Informed Care
  - Clinical Competencies

Trauma-Informed Care and IDT Considerations (cont.)

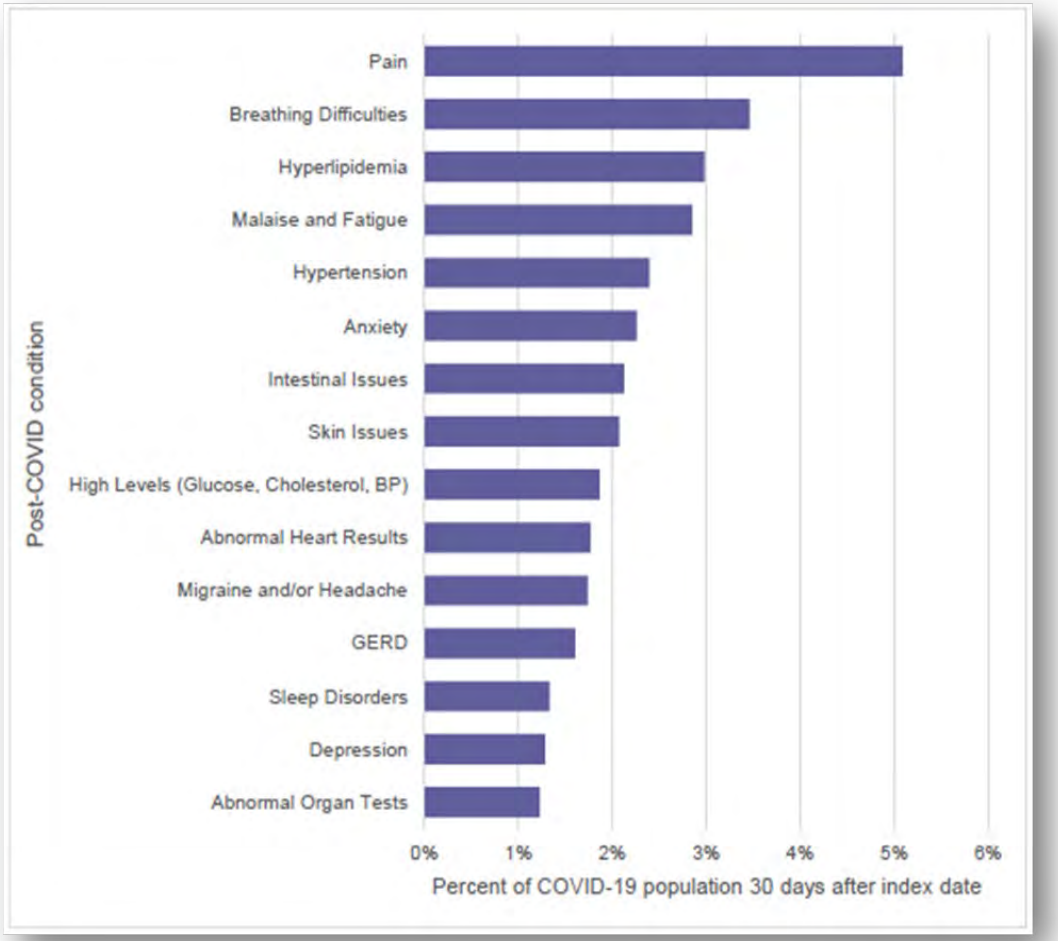
Many patients recover from COVID-19 within a few weeks, but some exhibit persistent or new symptoms more than four weeks after first being diagnosed. Patients with such post-COVID conditions are variously referred to as having long-haul COVID, long COVID or post-acute sequelae of COVID-19 (PASC).

Post-COVID Condition Identification: • Abnormal Heart Results; • Abnormal Organ Tests; • Adjustment Disorders; • Anemia; • Anxiety; • Blood Clot; • Breathing Difficulties; • Cardiac Inflammation; • Cognitive Impairment/Brain Fog; • Depression; • Diabetes; • Eye Issues; • General Signs and Symptoms; • Gastroesophageal Reflux Disease (GERD); • Hearing Loss; • Heart Disease; • High Levels (Glucose, Cholesterol, Blood Pressure [BP]); • Hyperlipidemia; • Hypertension; • Intestinal Issues; • Kidney Failure; • Liver Disease; • Loss of Taste or Smell; • Malaise and Fatigue; • Migraine and/or Headache; • Overweight; • Pain; • Respiratory Disorder; • Respiratory Distress; • Skin Issues; • Sleep Disorders; • Stroke; • Swallowing Difficulties; • Thyroid Issues; • Tic Disorders; • Tinnitus; • Vertigo; and • White Blood Cell Disorders.

The five most common post-COVID conditions across all ages, in order from most to least common, were pain, breathing difficulties, hyperlipidemia, malaise and fatigue, and hypertension

The body of evidence continues to grow relative to other body systems affected by COVID

Top 15 post-COVID conditions by percent of COVID-19 population 30 days or more after index date, all ages (Mar 2020-Feb 2021)



Pain

- **Pain** was the top post-COVID condition, affecting 5.1 percent of COVID-19 patients 30 days or more after their initial diagnosis. Pain includes ICD-10-CM diagnoses such as M79.2, neuralgia and neuritis, unspecified, and M79.1, myalgia. Pain is frequently cited by other researchers as a common post-COVID condition, though in some other studies fatigue is the most commonly reported symptom.
- Patients who had been hospitalized had the highest odds of reporting post-COVID pain (odds ratio [OR]=2.941, 95 percent confidence interval [CI], 2.874-3.010, P<0.0001), and symptomatic individuals also had high odds of reporting the condition (OR=1.428, 95 percent CI, 1.409-1.447, P<0.0001). Patients who were asymptomatic were the reference group in both cases. Male patients were less likely than female patients to report this condition (OR=0.748, 95 percent CI, 0.738-0.758, P<0.0001).

Breathing Difficulties

- **Breathing difficulties** were the second most common post-COVID condition, affecting 3.5 percent of the total population after COVID-19. This includes diagnoses such as R06.00, dyspnea, unspecified, and R06.02, shortness of breath. Difficulty breathing, like pain, is often cited by other researchers as a common post-COVID condition.
- As with pain, patients who were hospitalized had the highest odds of reporting post-COVID breathing difficulties (OR=5.775, 95 percent CI, 5.637-5.917, P<0.0001). Those with symptoms also had higher odds for breathing difficulties than asymptomatic patients (OR=2.062, 95 percent CI, 2.027-2.097, P<0.0001).

Hyperlipidemia and Hypertension

- Of particular interest were **hyperlipidemia and hypertension**, which appeared as, respectively, the third and fifth most common post-COVID diagnoses—even though, as noted above, these diagnoses had never been reported before in these patients' history. Hyperlipidemia occurred in 3 percent of COVID-19 patients, hypertension in 2.4 percent. Other researchers have observed these as post-COVID conditions,29,30 though it is possible that patients may have had the conditions before and not had them detected by providers.

Malaise and Fatigue

- **Malaise and fatigue**, which are commonly reported in the literature,31,32 were the fourth most common condition, affecting 2.9 percent of COVID-19 patients 30 days or more after their index date. As with pain and breathing difficulties, patients who had been hospitalized had higher odds of reporting this condition (OR=4.201, 95 percent CI, 4.088-4.318, P<0.0001), and symptomatic patients also had higher odds (OR=1.736, 95 percent CI, 1.705-1.768, P<0.0001).

Other Body Systems: **Pulmonary**

- The lung damage of COVID-19 leads to an impairment of gas exchange, with potential for impaired pulmonary function.
- As a result, many patients report prolonged dyspnea and chest tightness, although the dyspnea may not be commensurate with the degree of hypoxia.
- Pulmonary fibrosis is another factor that may affect long-term lung function

Other Body Systems: **Cardiac**

- Complications can include hypotension, arrhythmia, reduced ejection fraction, and myocarditis.
- Left ventricular dysfunction in the acute phase may be attributed to markedly increased cytokine levels.
- Activation or enhanced release of inflammatory cytokines can lead to necrosis of myocardial cells and exacerbations of coronary atherosclerotic plaques, making them prone to rupture.
- An intense inflammatory response superimposed on preexisting cardiovascular disease may precipitate cardiac injury.
- Myocardial damage might result in long-term dysfunction and must be taken into consideration for patients entering rehabilitation.
- Although most patients develop persistent tachycardia, it has been found to be relatively benign and self-limiting.

Other Body Systems: **Neurologic**

- Acutely, 36% of patients with COVID-19 develop neurologic symptoms, including headaches, altered consciousness, seizures, absence of smell and taste, paresthesias, and stroke.
- Posterior reversible encephalopathy syndrome, which causes headache, confusion, seizures, and visual loss can be a complication.
- COVID-19 has been associated viral encephalitis has also been rarely reported.
- Patients are found to have very high D-dimer levels and hypercoagulability, in turn potentially increasing the risk of acute cerebrovascular events.
- As with many viral syndromes, Guillain-Barre´ syndrome, acute demyelinating encephalopathy, acute necrotizing hemorrhagic encephalopathy, and acute transverse myelitis have also been rarely reported.
- Myopathy with severe muscular symptoms is commonly observed among moderate and severe cases.

Other Body Systems: **Hematologic**

- Patients severely affected by COVID-19 are at high risk for a hypercoagulable state, characterized by very high D-dimer levels, thrombo-embolism, and stroke.
- In one review, thromboembolism was documented in as many as 1 in 5 patients and strokes occurred in 3%.
- Thromboembolic events occur despite prophylactic use of anticoagulants, and both venous and arterial thrombosis occurs.
- In addition, severe COVID-19 infection appears to be associated with bleeding complications, an increased risk for intracranial hemorrhage, and, in some instances, disseminated intravascular coagulation.

Other Body Systems: **Renal**

- Patients severely affected by COVID-19 are more likely to have acute kidney injury.
- Studies have shown that among those with normal creatinine levels on admission, most will recover from an acute kidney injury. However, proteinuria and hematuria can be prolonged.
- It is recommended that patients with acute kidney injury be regularly assessed for 3-6 months after discharge.

Other Body Systems: **Endocrine/Diabetes**

- "The world is currently grappling with a dual pandemic of diabetes and coronavirus disease 2019 (COVID-19)." Current research, "…has raised concerns about a bi-directional relationship between these two health conditions. It is now undoubtedly proven that diabetes is associated with a poor prognosis of COVID-19. On the other hand, COVID-19 patients with diabetes frequently experience uncontrolled hyperglycemia and episodes of acute hyperglycemic crisis, requiring exceptionally high doses of insulin. **More intriguingly, recent reports show that newly diagnosed diabetes is commonly observed in COVID-19 patients**."

Other Body Systems: **Skin**

- COVID-19 has been associated skin lesions include (from most common to least common) maculopapular eruptions, urticarial, acral erythema with vesicles or pustules (pseudo-chilblains), vesicular eruptions, and livedo reticularis.
- Frank necrosis, secondary to vasculopathy, can also occur and may result in limb loss.
- Because of prone positioning, facial wounds may occur among survivors and could be problematic because of secondary infections and necrosis.
- Frequent changes in position and the use of supports to float the bony prominences are required.
- **Interdisciplinary collaboration between the rehabilitation team, nursing, and respiratory therapy is crucial to provide frequent pressure relief. Prone teams that include physical or occupational therapists and are available 24 hours per day 7 days per week may be helpful in reinforcing proper technique to minimize injuries.**

Other Body Systems: **Liver**

- COVID-19 related liver dysfunction with abnormal liver enzymes (mainly elevated serum prominences in those patients who spend significant amounts of time in prone position.
- For noncritically ill inpatients, daily out-of-bed mobility and participation in activities of daily living (ADL) helps to promote functional recovery and improve delirium.
- **Interdisciplinary collaboration between the rehabilitation team, nursing team, and physicians to bundle care and promote mobility activities is recommended to reduce immobility-related harm while ensuring efficient use of resources.**
- Rehabilitation team members play a crucial role in educating nursing and other team members on the safe progression of patient mobility. Education about engaging patients in daily therapeutic exercises, ADLs, and cognitive stimulation tasks is recommended for carry over from therapy sessions to amplify functional recovery.

Chronic Condition and Ventilation

- Survivors of acute respiratory distress syndrome with mechanical ventilation are reported to have complications such as laryngeal injury, tracheal stenosis, heterotopic ossification, contractures, adhesive capsulitis, decubitus ulcers, dysphonia, dysphagia, sensorineural hearing loss, brachial plexus injuries, and peripheral neuropathies (peroneal and ulnar).

Chronic Condition and ICU Weakness

- Weakness and decreased exercise capacity are the most common symptoms after prolonged ICU stay and immobility.
- Critical illness polyneuropathy (CIP), critical illness myopathy (CIM), and muscle atrophy are major causes of functional impairment related to COVID-19. CIP and CIM are characterized by generalized and symmetrical weakness, atrophy, and decreased or absent deep tendon reflexes and can cause difficulty weaning from mechanical ventilation because of associated respiratory muscle weakness.
- CIP and/or CIM co-occur with other symptoms or complications, including pain, reduced range of motion, fatigue, incontinence, and dysphagia.
- Many of these secondary complications are preventable if appropriate rehabilitation is provided early in the disease course

Chronic Condition and Cognition

- COVID-19 can produce prolonged hypoxia that may lead to both acute and long-term neuropsychological dysfunction.
- The further elements of prolonged ventilation, use of sedatives, prone positioning, human isolation, and extended time away from social contacts may contribute to severe delirium.
- All components of cognition can be affected, including attention, visual-spatial abilities, memory, and higher order executive functions.
- Common adverse psychological effects include post-traumatic stress disorder, insomnia, depression, and general anxiety, and they can be exacerbated by fear, stigma, and isolation.

The 6 “M’s” Managing COVID Long-Term

- **Mind** (Cognition),
- **Mobility** (Function),
- **Medications** (Optimizing simplifying Medications),
- **Multicomplexity** (managing the complex medical/social issues of a given patient),
- and **Matters Most** (what patients value most for their care).
- For geriatric rehabilitation and in our COVID-19 survivors, it is also important to consider **Motivation** (factors affecting behavior change and/or health) as being critical factors in our rehabilitative care.

Bridging the Health Literacy Gap

Health Literacy Gap

- "Compared with the general population, people with long-term conditions report more difficulties in understanding health information and engaging with healthcare providers. These two dimensions are critical to the provision of patient-centered healthcare and for optimizing health outcomes. More effort should be made to respond to the health literacy needs among individuals with long-term conditions, multiple comorbidities and low education levels, to improve health outcomes and to reduce social inequality in health."
- The CDC indicates that, "Patients recovering from COVID-19 might experience continued poor health and could benefit from additional support and tailored physical and mental health rehabilitation services. Health care systems and providers should be prepared to recognize and meet the ongoing needs of this patient population. Efforts to increase COVID-19 vaccination could include messaging that states that preventing COVID-19 also prevents post–COVID-19 conditions with potential effects on long-term health."

Care Planning

- **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.

Care Planning

- Nursing homes are required to develop a baseline care plan … 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.

Care Planning

- **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.

Critical Element Pathways (cont.)

General Critical Element Pathway

Use this pathway to investigate quality of care concerns that are not otherwise covered in the remaining tags of §483.25, Quality of Care, and for which specific pathways have not been established. For investigating concerns regarding care at the end of life, use the Hospice/End of Life CE Pathway.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for areas pertinent to the concern.
- ☐ Physician's orders.
- ☐ Pertinent diagnoses.
- ☐ Care plan.

Observations Across Various Shifts:

- ☐ Does staff consistently implement the care-planned interventions? If not, describe.
- ☐ Ensure interventions adhere to professional standards of practice.
- ☐ What is the resident's response to interventions? Is the resident's response as intended?
- ☐ Do observations of the resident match the assessment? If not, describe. Are there visual cues of psychosocial distress and harm?

Resident, Resident Representative, or Family Interview:

- ☐ Will you describe your current condition or history of the condition, or diagnosis?
- ☐ How did the facility involve you in the development of the care plan and goals?
- ☐ How effective have the interventions been? If not effective, what alternate approaches have been tried?
- ☐ What are your goals for care? Do you think the facility is meeting them? If not, why do you think that is?
- ☐ For newly admitted residents, did you receive a summary of your (or the resident's) baseline care plan? Did you understand it?

Critical Element Pathways (cont.)

General Critical Element Pathway

Staff Interviews (Nursing Aides, Nurse, DON, Therapist, Attending Practitioner):

- ☐ Will you describe specific interventions for the resident, including facility-specific guidelines/protocols?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How does the interdisciplinary team monitor for the implementation of the care plan and changes in condition?
- ☐ How is information passed across shifts, and between all disciplines?
- ☐ How are revisions to the comprehensive care plan communicated to staff?
- ☐ How was it determined that the chosen interventions were appropriate?
- ☐ Did the resident have a change in condition that may justify additional or different interventions?
- ☐ How does staff validate the effectiveness of current interventions?

Record Review:

- ☐ Review relevant information such as medication and treatment administration records, interdisciplinary progress notes, and any facility-required assessments that may have been completed. Does the information accurately and comprehensively reflect the resident's condition? If not, describe.
- ☐ Are federally required RAI/MDS assessments completed according to required time frames?
- ☐ For newly admitted residents, is there a baseline care plan, and does it describe the instructions necessary to meet the resident's immediate needs? Does it address the resident's clinical and safety risks?
- ☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, preferences, and behaviors? Does it include goals for admission, measureable objectives, timetables, and desired outcomes? How did the resident respond to care planned interventions? Was the care plan revised if interventions weren't effective, the desired outcome was achieved, or if there was a change in condition?
- ☐ Is there evidence of resident or resident representative participation in developing resident-specific, measureable objectives, and interventions? If not, is there an explanation as to why the resident or representative did not participate?
- ☐ Is there evidence that the resident has refused any care or services that would otherwise be required, but are not provided due to the resident's exercise of rights, including the right to refuse treatment? If so, does the care plan reflect this refusal, and how has the facility addressed this refusal?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?

Critical Element Pathways (cont.)

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).

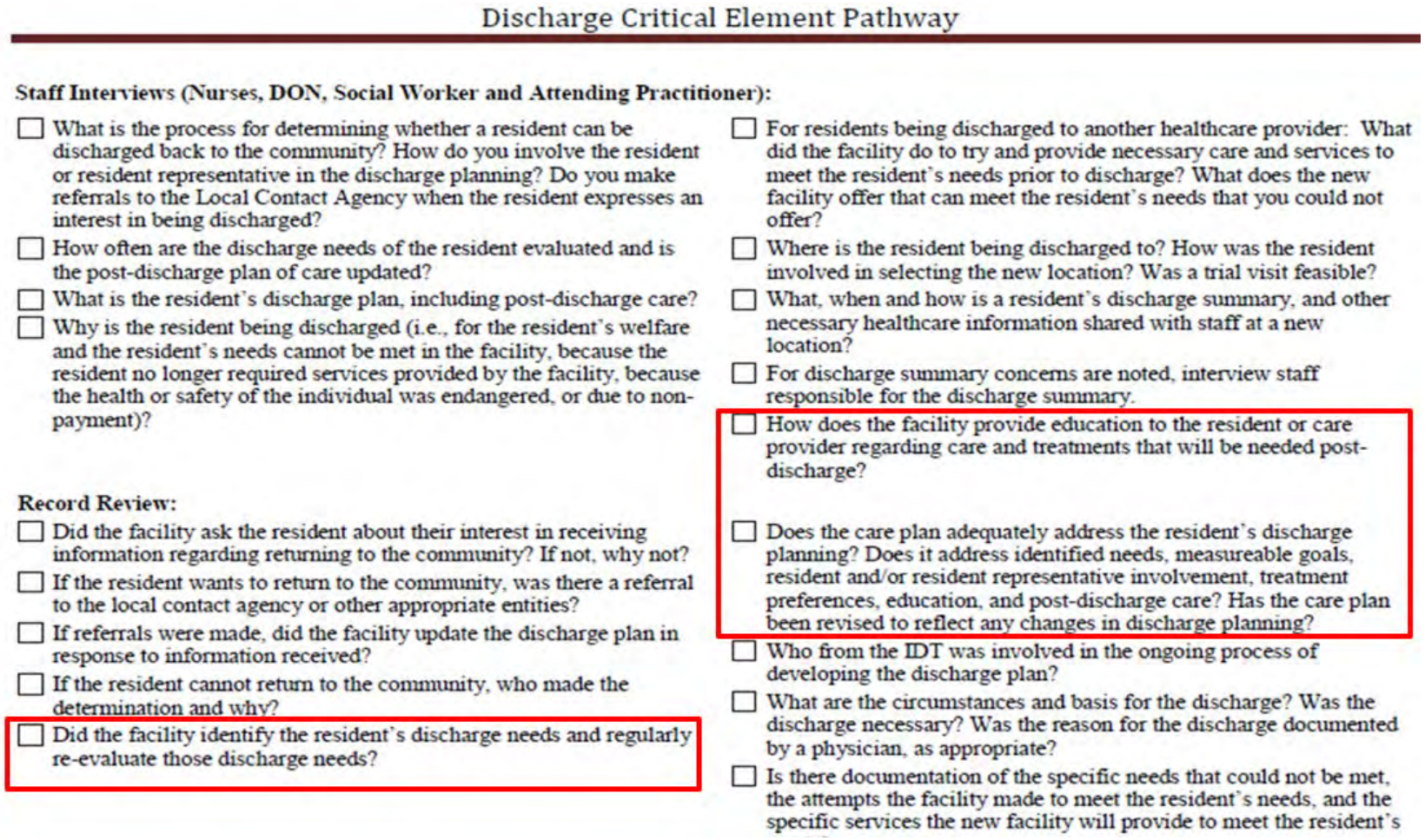
Observations:

- ☐ 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?

Critical Element Pathways (cont.)



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

New QRP Measures

Transfer of Health Information to 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. 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.
- This measure, assesses for and reports on the timely transfer of health information, specifically transfer of a medication list. This measure evaluates for the transfer of information when a patient/resident is discharged from their current setting of PAC to a private home/apartment, board and care home, assisted living, group home, transitional living, or home under the care of an organized home health service organization or hospice.

New MDS Items

A2105. Discharge Status
Complete only if A0310F = 10, 11, or 12

Enter Code	
	01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
	02. **Nursing home** (long-term care facility)
	03. **Skilled Nursing Facility** (SNF, swing bed)
	04. **Short-term General Hospital** (acute hospital, IPPS)
	05. **Long-Term Care Hospital** (LTCH)
	06. **Inpatient rehabilitation facility** (IRF, free standing facility or unit)
	07. **Inpatient psychiatric facility** (psychiatric hospital or unit)
	08. **Intermediate care facility** (ID/DD facility)
	09. **Hospice** (home/non-institutional)
	10. **Hospice** (institutional facility)
	11. **Critical Access Hospital (CAH)**
	12. **Home under care of organized home health service organization**
	13. **Deceased**
	99. **Not Listed**

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.

Route of Transmission	Check all that apply ↓
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

- In the FY 2020 Final Rule, CMS has finalized standardized patient assessment data elements, or SPADEs, to be reported with SNF admissions and discharges for five categories specified in the IMPACT Act.
  - **Cognitive function** (e.g., able to express ideas and to understand normal speech) and mental status (e.g., depression and dementia)
  - **Special services, treatments, and interventions** (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
  - **Medical conditions and co-morbidities** (e.g., diabetes, heart failure, and pressure ulcers)
  - **Impairments** (e.g., incontinence; impaired ability to hear, see, or swallow)
  - **Other categories** as deemed necessary by the Secretary

SNF QRP/SPADES

SPADES

- 3 SPADEs for Cognitive Function.
- 15 SPADEs to Assess for Special Services, Treatments, and Interventions.
- 1 SPADE to Assess for Medical Conditions and Co-Morbidities.
- 2 SPADEs to Assess for Impairments
- 5 SPADEs to assess for a new category: Social Determinants of Health

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

Practical health literacy practice

- It is the IDT's responsibility to ensure that health literacy issues are identified and addressed
- Because limited health literacy is so common, you should assume that all patients need and want easy-to-understand explanations about their medical problems and what they need to do about those problems. Here are five recommendations for communicating with all patients, not just the ones you suspect have limited health literacy:
  - **Explain things without using medical terms.** After you've been working with a patient for a while and listening to the terms they use when discussing their medical problems, you will be able to better match your communication to their level of understanding. But for starters, err on the side of simpler, rather than more complicated, explanations.
  - **Focus on only two or three key messages.** In any individual encounter, people tend to retain only two or three key messages. Pick the things your patients most need to know and emphasize those, rather than telling patients everything there is to know about their problem. If they want to know more they can ask, and patients with chronic problems will learn more over time. Not overloading them with information helps ensure that they will remember most of your messages and know what was most important.

Practical health literacy practice

- **Speak more slowly**. Speaking at a slower pace will make you easier to understand when talking about topics that might be unfamiliar to the listener. If you are worried that your patient encounters will take too long if you speak slowly, consider that limiting your discussion with patients only to the key messages, as discussed above, will reduce visit length.
- **Use teach-back**. Have your patients repeat your instructions back to you in their own words so that you can be sure that you explained it to them in a way that was understandable.
- **Use easy-to-understand written materials**. Just like your spoken instructions, any written information provided to the patient should be easily understandable. Write down the key things your patient needs to do, whether it is preparing for a lab test, scheduling an appointment with a consultant, or taking a new medication, and make sure it is free of medical jargon.

Practical health literacy practice

- **CMS 100-2 Chapter 8:**
  - Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services.
  - The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses to the training. The medical record should also describe the reason for the failure of any educational attempts, if applicable.
  - Example: A newly diagnosed diabetic patient is seen in order to learn to self-administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions. Even though the patient voices understanding of the nutritional principles of his diabetic diet, he expresses dissatisfaction with his food choices and refuses to comply with the education he is receiving. This refusal continues, notwithstanding efforts to counsel the patient on the potentially adverse consequences of the refusal and to suggest alternative dietary choices that could help to avoid or alleviate those consequences. The patient's response to the recommended treatment plan as well as to all educational attempts is documented in the medical record.

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Learn More About Broad River Rehab

BROAD RIVER REHAB

Tricia Wood: Vice President, Business Development (Southern US)
twood@broadriverrehab.com | (919) 844-4800

Randy Wadley: Vice President, Business Development (Northern US)
rwadley@broadriverrehab.com | (330) 495-8854

Jeff Moyers: Vice President, Business Development (Southcentral US)
jmoyers@broadriverrehab.com | (828) 319-9618

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