Partnering with High Need Patients

Kelly Kruse Nelles MS RN APRN-BC
Lead Faculty

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- Population Health
- Population Health Management
- Public Health
- High Need Patients
- Vulnerable Populations
- Health Disparity
- Chronic Disease
- Patient Engagement
- Care Management
- Health Equity
- Racism and Race
- Implicit Bias
- Social Justice
- Cultural Humility
- Equity Minded Nurse

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Population Health & Chronic Illness

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People Centered Care

… care that is focused and organized around the health needs and expectations of people and communities rather than on diseases. People-centered care extends the concept of patient-centered care to individuals, families, communities and society. Whereas patient-centered care is commonly understood as focusing on the individual seeking care — the patient — people-centered care encompasses these clinical encounters and also includes attention to the health of people in their communities and their crucial role in shaping health policy and health services.

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Population Health

The "scientific study of the distribution and determinants of health and disease states in the population.

Population Health Management

Uses data to identify and monitor the health of populations of patients. Focus is on prevention as well as the management of chronic conditions.

Public Health

The science and art of preventing disease, prolonging life and promoting health and efficiency through organized community effort"… and "develops and implements the policies and programs that promote health.

Population Health Goals are a Match with Public Health

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High Need Persons

"People who have three or more chronic diseases and a functional limitation in their ability to care for themselves or perform routine daily tasks" (NAM, 2022)

In the U.S. about 12 million people meet this high need definition

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Vulnerable Populations

Refers to

> "those who have poor access to health care, receive poor-quality care, and experience poor outcomes – often resulting from societal injustices related to race, ethnicity, poverty, gender, sexual orientation, age, first language or physical or mental condition."
>
> The Commonwealth Fund

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Health Disparities

The differences in incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific populations.

Health Care Disparities

The difference in the preventive, diagnostic or treatment services offered to people with similar health conditions

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5%

of patients account for NEARLY HALF of the nation's spending on health care

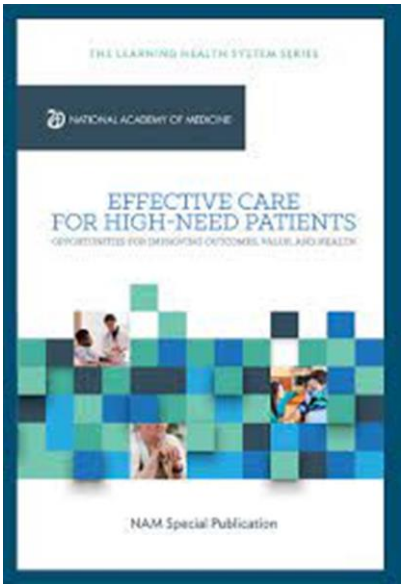
55%

of high–need patients are AGE 65+

52%

of high–need patients' annual income is BELOW 200% of the federal poverty level

https://nam.edu/HighNeeds/highNeedPatients.html



Chronic Disease & the Health of U.S. Populations

1. Percent of population with **fair or poor health**:
   - All ages — **10.4 percent**
   - 65 years and older — **24.7 percent**
2. Percent of population with **heart disease**:
   - 18 years and over — **11.6 percent**
   - 65 years and over — **30.5 percent**
3. Percent of population with **cancer**:
   - 18 years and over — **6.3 percent**
   - 65 years and over — **18.5 percent**
4. Percent of population with **hypertension**:
   - 20 years and over — **31.9 percent**
5. Percent of population with **high cholesterol**:
   - 20 years and over — **13.6 percent**
6. Percent of population categorized as **obese**:
   - 20 years and over — **35.9 percent**
7. Percent of population who **smoke cigarettes**:
   - 18 years and over —**19 percent**

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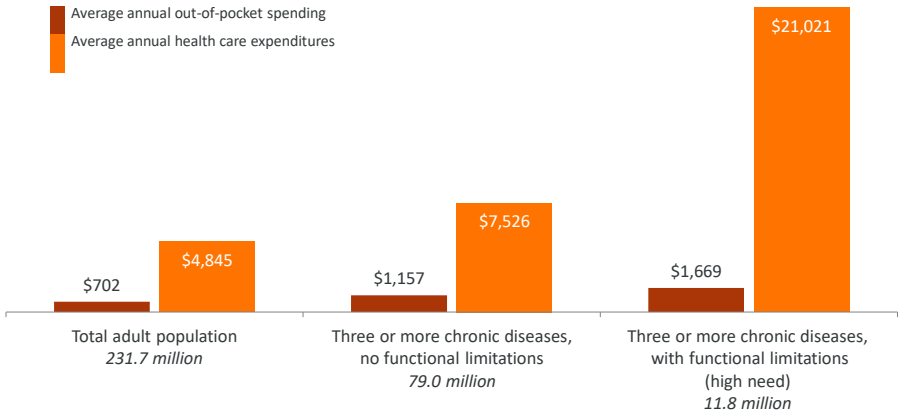
Exhibit 1

Adults with High Needs Have Higher Health Care Spending and Out-of-Pocket Costs



Note: Noninstitutionalized civilian population age 18 and older.
Data: 2009–2011 Medical Expenditure Panel Survey (MEPS). Analysis by C. A. Salzberg, Johns Hopkins University.

Source: S. L. Hayes, C. A. Salzberg, D. McCarthy, D. C. Radley, M. K. Abrams, T. Shah, and G. F. Anderson, *High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care?* The Commonwealth Fund, August 2016.

The COMMONWEALTH FUND

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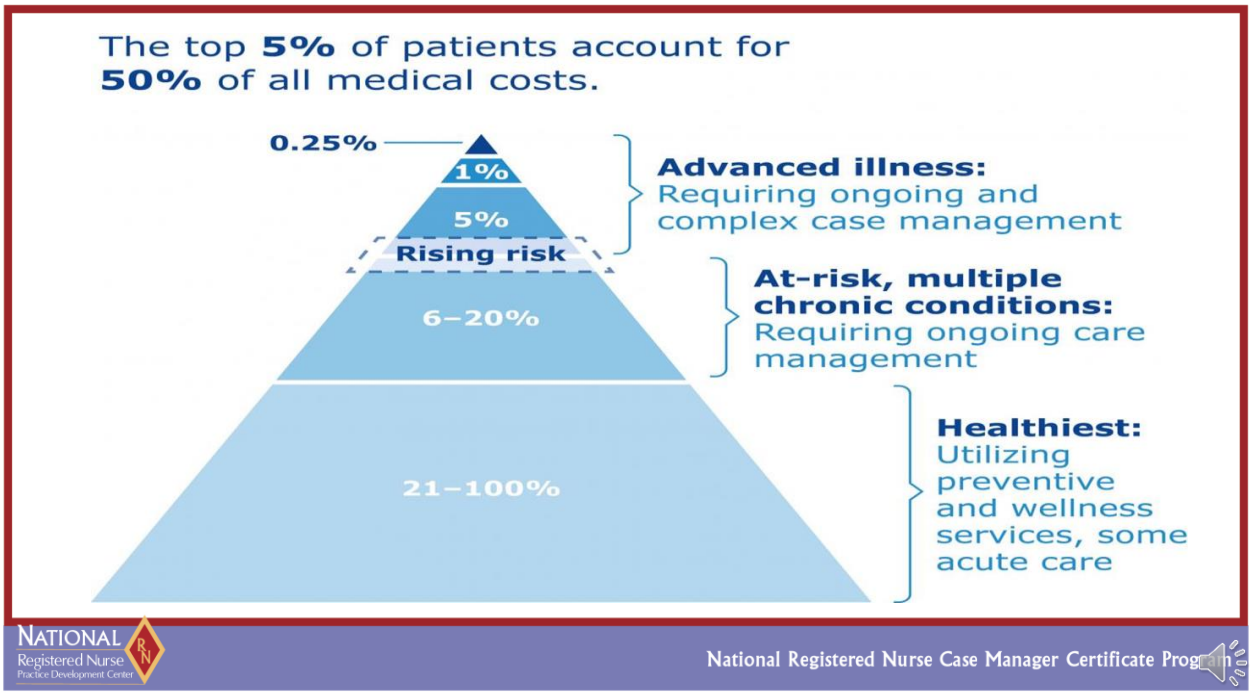

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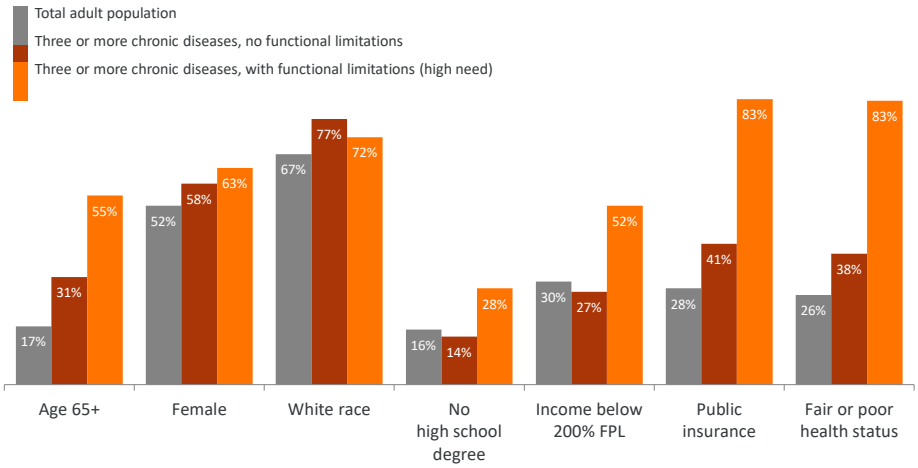
Exhibit 3

Adults with High Needs Have Unique Demographic Characteristics



Notes: Noninstitutionalized civilian population age 18 and older. Public insurance includes Medicare, Medicaid, or combination of both programs (dual eligible). Data: 2009–2011 Medical Expenditure Panel Survey (MEPS). Analysis by C. A. Salzberg, Johns Hopkins University.

Source: S. L. Hayes, C. A. Salzberg, D. McCarthy, D. C. Radley, M. K. Abrams, T. Shah, and G. F. Anderson, *High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care?* The Commonwealth Fund, August 2016.

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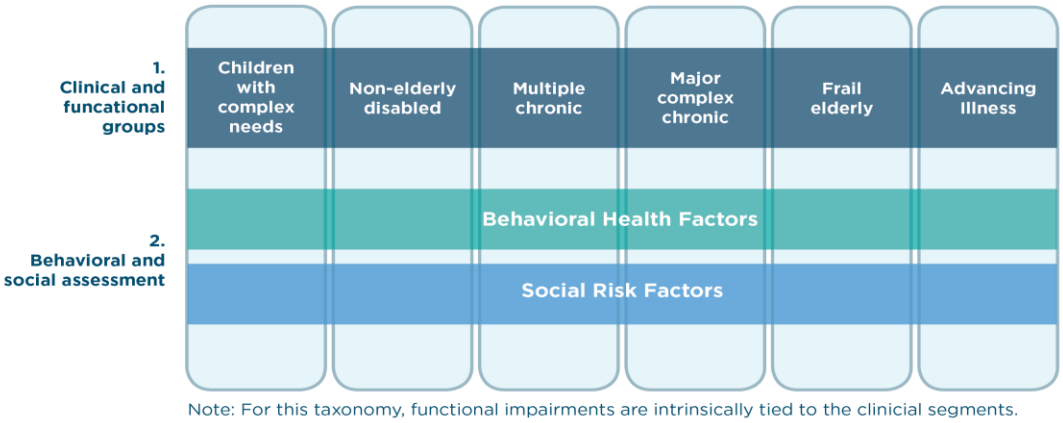
Conceptual Model of a Starter Taxonomy for High-Need Patients



Note: For this taxonomy, functional impairments are intrinsically tied to the clinicial segments.

Source: Effective Care for High Need Patients (NAM Special Report, https://nam.edu/HighNeeds/)

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Population Health Management

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How Are Organizations Doing This?

Strategies for Improving Health Outcomes for Populations

- Define the Population
- Identify Care Gaps
- Stratify Risks
- Engage Patient & Providers
- Manage Care
- Measure Outcomes

Requires leveraging Meaningful Data Stored in the EHR

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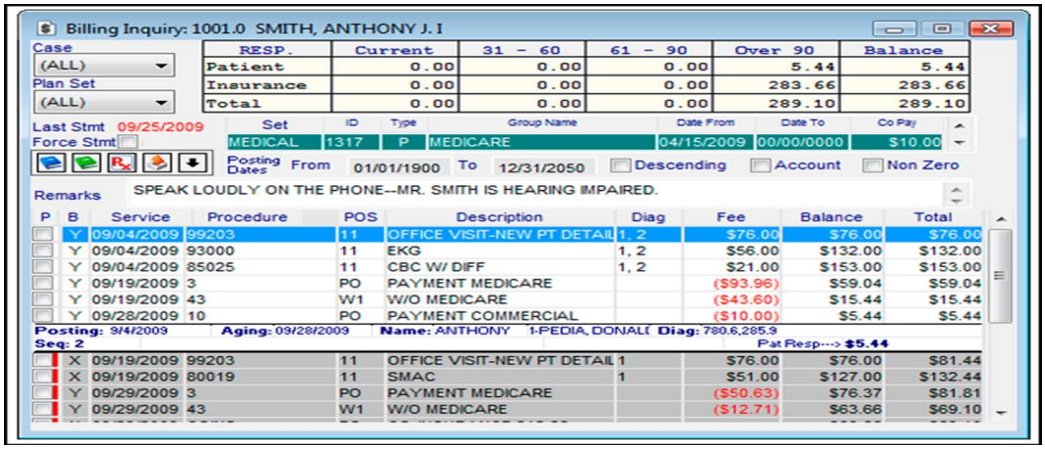
1 - Defining the Population

- Must be able to understand the health of the population served
  - Who is and is not being served
  - Risk stratification
  - Focus resources, interventions and services – target care
  - Trends, patterns and outliers that require further study

- Starts with pulling billing data to identify patients with chronic conditions to create **Patient Registries**



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Patient Registries

- Are patient data bases
  - Frequently seen or have certain diagnoses
    - Ex: ED visits or Heart Failure, COPD
  - Critical test results that need attention
    - Ex: Diabetic patients with elevated A1c levels
  - Patients who are candidates for preventive services
    - Ex: Older adults who are candidates for flu vaccine
- Track key outcome measures related to evidence-based treatment guidelines and standardized clinical pathways

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Think About This….

- Currently in the U.S. Healthcare System
  - Providers wait for patients who are chronically ill to show up at their practice with an acute problem
    - They then address any chronic disease issues at that time

      or
    - reschedule the patient for another visit dedicated to the chronic illness

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Problem

- This "reactive" approach
  - Delays care
  - Neglects patients who rarely visit the practice
  - Does not encourage the healthcare team to consider a "population perspective" and design proactive strategies for earlier intervention and management

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Population Health Management

- Requires a departure from traditional care delivery in which care is focused on a single patient's needs at a particular point in time
- Instead, now must think of the entire patient population as well as the individual patient

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Patient Registries

- Provide a "**proactive**" way to identify high risk patients so the practice or healthcare organization can shift to anticipating and responding to their care needs
- Multiple interventions occur at different levels
- Allows for stratification:
  - **Patients with chronic illnesses** may be partnered with a Nurse Care Manager who can provide anticipatory guidance, implement standardized treatment protocols, provide self-management support, facilitate care coordination
  - **High Need patients** are partnered with an RNCM who regularly reviews the patient record, assesses risk factors, coordinates care, support self-management and follows up
  - **Healthy populations** may be offered health promotion strategies to support wellness
  - **All populations** should receive tailored prevention interventions

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- **Defining the Population** is a proactive way to:
  - Ensure patients are getting the "right care at the right time" consistent with their health care needs
  - Improve health outcomes
  - Reduce healthcare costs that moves beyond limiting to restricting services or care

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2 - Identify Care Gaps

- **Meaningful Use Criteria** is applied to the population to identify gaps in care and improve healthcare delivery

Stage 1: Meaningful use criteria focus on:	Stage 2: Meaningful use criteria focus on:	Stage 3: Meaningful use criteria focus on:
Electronically capturing health information in a standardized format	More rigorous health information exchange (HIE)	Improving quality, safety, and efficiency, leading to improved health outcomes
Using that information to track key clinical conditions	Increased requirements for e-prescribing and incorporating lab results	Decision support for national high-priority conditions
Communicating that information for care coordination processes	Electronic transmission of patient care summaries across multiple settings	Patient access to self-management tools
Initiating the reporting of clinical quality measures and public health information	More patient-controlled data	Access to comprehensive patient data through patient-centered HIE
Using information to engage patients and their families in their care		Improving population health

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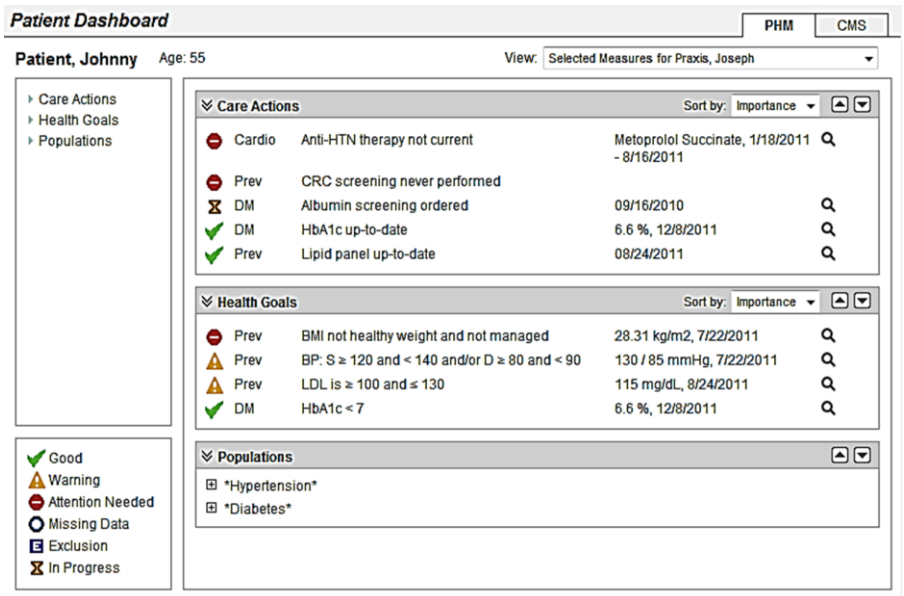

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3 - Stratifying Risk

Focuses On:

- Identifying Population Risk and Targeting Services
- Managing High Risk Visits

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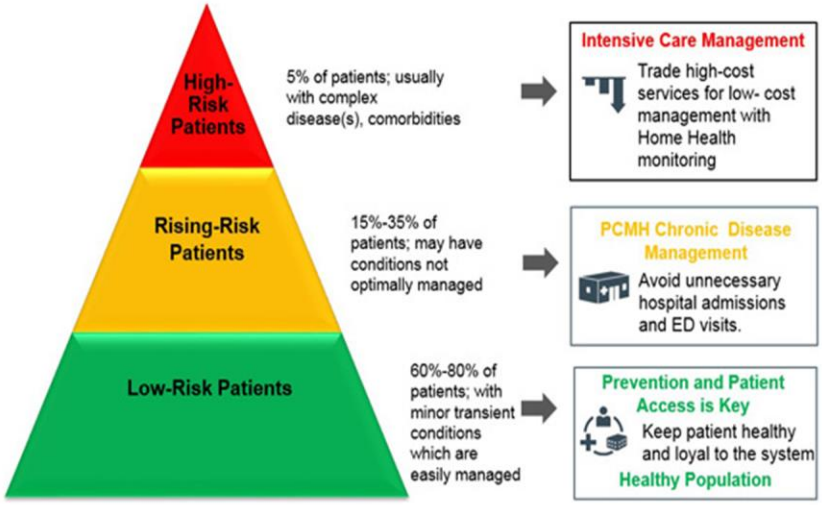

Adapted From: Health Care Advisory Board interviews and analysis.

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FIGURE 1. Conceptual Model of the Domains and Drivers of Poor Outcomes and Avoidable Spending for High-Need, High-Cost Medicaid Patients

MEDICAL COMPLEXITY AND HEALTH TRAJECTORY	CARE COORDINATION AND ENGAGEMENT	SELF-MANAGEMENT AND BEHAVIORAL HEALTH	ENVIRONMENTAL AND SOCIAL SUPPORTS
• Medication management • Utilization • Priority conditions • End of life	• Access to care • Provider communication and relationships • Getting needed services • Getting needed equipment and supplies	• Coping and activation • Behavioral health • Substance use	• Housing • Benefits and employment • Food and nutrition • Family, personal, and peer support • Legal

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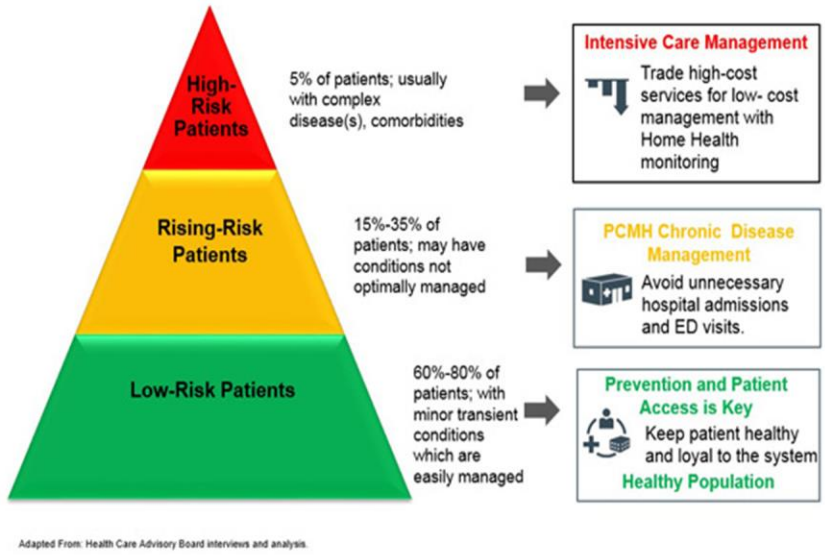

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High Risk Visits Can Also Trigger Action & Focused Intervention

- ED Visits
- Hospital admissions
- Hospital Discharge

- **High Risk Visits Trigger RNCM Action** (Partnership):
  - **Acute Care**
    - RNCMs manage safe, effective care transitions including discharge, medications, recommended follow up, etc. is coordinated and communicated to primary care
  - **Primary Care/Community**
    - RNCMs reconnect patients back into primary care providing reassessment of chronic conditions, medication management and adjustment of self-care. On-going follow up is put in place, care plan updated, and patient status communicated to the team.
  - **LTSS**
    - RNCMs receive care transitions and stabilize patient health status implementing the plan of care including ensuring primary care has been reestablished and patient condition is communicated

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4 - Engage Patients and Providers

PATIENT ENGAGEMENT

"Actions individuals must take to obtain the greatest benefit from the health care services available to them."

(Center for Advancing Health, 2010, p. 2).

Patient Engagement is directly linked to the quadruple aim

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Technology is Key

Evidence shows that patient access to their health records, health care team and health tools supports a high degree of patient engagement and improves the health of populations

- Secured Patient Portal gives Patients and their Caregivers the ability to:
  - Schedule and cancel Appointments
  - Refill Prescription
  - Review Medical records
  - Communicate Directly with their health care team
  - Coordinate multiple appointments
  - Schedule lab work and review test results
  - Receive notifications and reminders

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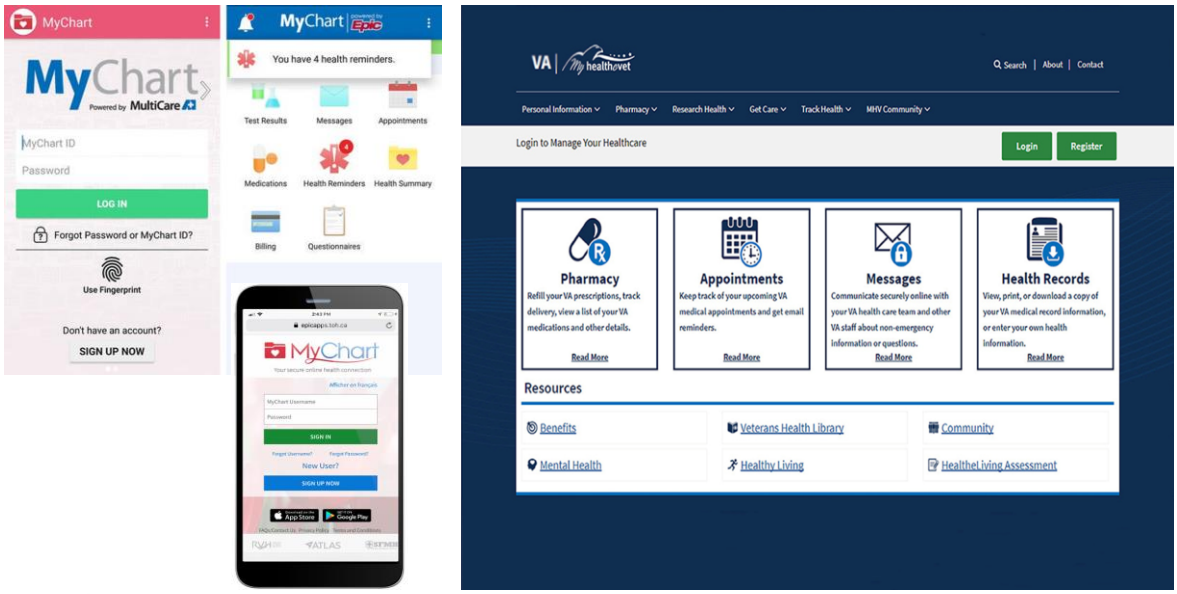

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MyMedicare.gov
The official U.S. Government Site for Medicare

type search term here | Search

Home | Plans & Coverage | My Health | My Account

Home

Blue Button Download My Data

Welcome to MyMedicare.gov

Check this page often for a snap shot of your Medicare account activites.

Search Claims

Select a Service Date Range:

36 Months

Submit

Advanced Search

View Recent Claims

You currently do not have any recent claims.

Preventive Services

Favorite Providers

My Account Information

Go to My Messages
Go to My Account
Part A Effective Date: 02/01/2001
Part B Effective Date:
Health & Drug Plan: Original Medicare
Does not cover Prescription Drugs

Additional Information

Forms
Medicare Publications and Podcasts

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The Current Blue Button Usage

Federally Inspired
Blue Button Community
- VA
- DoD (TRICARE)
- CMS

1.6M
CMS users

Beneficiaries can download up to 3 years of claims data
- Hospital
- Physician
- Prescription drugs

20–30k
Downloads/Month

Your Report:JOHN A DOE
Demographic
Source: MyMedicare.gov
Name: JOHN DOE
Date of Birth: 1/1/1910
Address Line 1: 123 ANY ROAD
Address Line 2:
City: ANYTOWN
State: IN
Zip: 46250
Phone Number
Email:
Part A Effec
Part B Effec

2x text downloads

Private sector applications already ingest, optimize, and visualize data from Blue Button text files

BlueButton Download my data

Medicare.gov
Log in or create account
Log in

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5 - Care Management

Care management is a set of activities designed to assist patients and their support systems in managing medical conditions more effectively

Goals:

- Improve patients' functional health status
- Enhance coordination of care
- Eliminate duplication of services
- Reduce the need for expensive medical services
- Increase patient engagement in self care

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Managing Care for Chronically Ill and High Need Populations

- Enhanced Primary Care Management
  - Chronic Care Management
- Transitional Care Management
  - Acute Transitional Care
- Integrated Care Management
  - Complex Case Management

All require robust RN Care Management

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Care Attributes of Successful Care Management Models

- **Assessment.** Multidimensional (medical, functional, and social) patient assessment
- **Targeting.** Targeting those most likely to benefit
- **Planning.** Evidence-based care planning
- **Alignment.** Care match with patient goals and functional needs
- **Training.** Patient and care partner engagement, education, and coaching
- **Communication.** Coordination of care and communication among and between patient and care team
- **Monitoring.** Patient monitoring
- **Linking.** Facilitation of transitions

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Delivery Features of Successful Care Management Models

- **Teamwork.** Multidisciplinary care teams with a singe trained care coordinator as the communication hub and leader
- **Coordination.** Extensive outreach and interaction among patient care coordinators and care team with an emphasis on face-to-face encounters among all parties and collocation of teams
- **Responsiveness.** Speed provider responsiveness to patients and 24/7 availability
- **Feedback.** Timely clinician feedback and data for remote patient monitoring
- **Medication Management.** Careful medication management and reconciliation, particularly in the home setting
- **Outreach.** The expansion of care to the community and home
- **Integration.** Linkage to social services
- **Follow Up.** Prompt outpatient follow up after hospital stays and the implementation of standard discharge protocols

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Organizational Culture of Successful Care Management Models

- **Leadership** across all levels
- **Training** appropriate to circumstances
- **Customization** to context
- **Continuous Assessment** with effective metrics
- **Strong Relationships**
- **Use of Multiple Sources** of Data

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6 - Measuring Outcomes

- Outcome:
  - Change in the health of an individual, group of people or population that is attributable to an intervention or series of interventions
- Match the Outcome Measure to your population
  - Remember there are hundreds
- Outcome Process
  - Design how you will achieve and capture
  - Consistent standards of recommended care
-

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Case Management Outcomes

- CM Programs vary widely throughout health systems
- To date show limited evidence of cost savings or effectiveness
  - May be partly due to the lack of tools to select patients who are most likely to benefit
- University of Wisconsin AI Scoring System shows promise
  - Project: Matching Complex Patients with Case Management Programs
  - High need patients identified by AI scoring system and matched with case management showed significant cost savings
  - University of Wisconsin Health Innovation Program https://hip.wisc.edu/ccm
- Best practices
  - The Better Care Playbook https://www.bettercareplaybook.org/
  - National Complex Care Coalition https://www.nationalcomplex.care/

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Chronic Care Management Outcomes

- Shows significant improvements in outcomes and reduced health care costs
- CMS provides a standardized framework for practices to adapt
- **Improved Outcomes**:
  - Reduced hospitalizations (5%)
  - Reduced ED visits (2.3%)
  - Increased preventative care E&M encounters (8%)
- **Reduced Costs**:
  - Taxpayer savings of $74/pt per month when patients are enrolled for a least 1 year
  - Practice revenue reimbursed through fee for service + shared saving earn $348 per year per beneficiary

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Advancing Health Equity to Improve the Health of Populations

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Institute of Medicine's Six Dimensions of Quality Care

SAFE	Avoid Harm to Patients
EFFECTIVE	Provide services based on sound scientific knowledge to patients who could benefit
PATIENT-CENTERED	Care that is respectful to patient's values, needs, and concerns
TIMELY	Reduce delays in patient care that may be harmful to patient overall well-being
EFFICIENT	Avoid waste of services and resources
EQUITABLE	Provide care to all patients that is of equal quality and does not vary by race, ethnicity, gender or other personal characteristics

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IHI Quintuple Aim

2008 Triple Aim

- Improving health of populations
- Enhancing patient care experience
- Reducing costs

2014 Quadruple Aim

- Healthcare worker job satisfaction

2022 Quintuple Aim

- Advancing health equity

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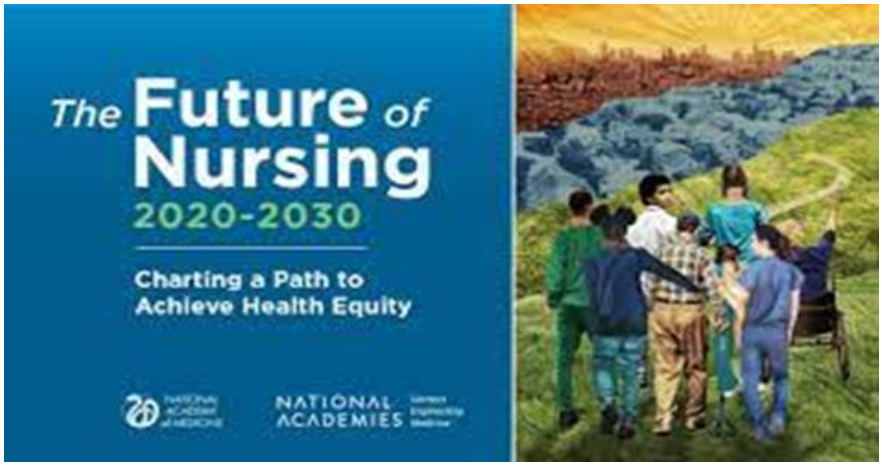

Outlines the goal of achieving health equity in the U.S. built on strengthened nursing capacity and expertise.

https://nam.edu/publications/the-future-of-nursing-2020-2030/

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Health Equity Defined

"The state in which everyone has the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances."

- Requires removing obstacles to health
  - Poverty
  - Discrimination and related consequences including powerlessness
  - Lack of access to good jobs with fair pay
  - Quality education
  - Housing
  - Safe environments
  - Health care

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Health Care Equity

Providing care that does not vary in quality by personal characteristics such as ethnicity, race, gender, geographic location, socioeconomic status and other identity

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One Size Does Not Fit All

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Race and Racism

Racism

> "an organized social system in which the dominant racial group based on an ideology of inferiority, categorizes and ranks people into social groups called "races" and uses its power to devalue, disempower, and differentially allocate valued societal resources and opportunities to groups defined as "inferior".
>
> – Future of Nursing Report 2020-2030, Ch. 2.

- Structural
- Cultural
- Discrimination

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Structural Racism

Racism that is embedded into laws, policies, and institutions and provides advantages to the dominant group while oppressing, disadvantaging or negating other racial groups.

- Residential segregation
- Criminal justice system
- Public education system
- Immigration policy

Structural Racism is the most important way racism impacts health

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Cultural Racism

The instillation of the ideology of inferiority in the values, language, imagery, symbols, and unstated assumptions for the larger society.

- Implicit bias
- Medical mistrust
- Avoidance of the health care system

Implicit Bias contributes to medical mistrust and health care avoidance

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Implicit Biases

"associations outside conscious awareness that lead to a negative evaluation of a person on the basis of irrelevant characteristics such as race or gender"

(FitzGerald and Hurst – Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics* (2017) 18:19 DOI 10.1186/s12910-017-0179-8.)

- It's a subconscious human trait that frequently interferes with the best nursing practices
- Recognizing inherent bias means that you understand you might have certain feeling about populations, appearances, or mannerisms that you need to address so you can provide the best possible care

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Discrimination

Occurs when people or institutions treat racial groups differently with or without intent, and this difference results in inequitable access to opportunities and resources.

- Triggers emotional and physiological reactions
- Associated hypervigilance can negatively impact health
- Microaggressions – brief, common place verbal, behavioral, environmental indignities

Discrimination is the most researched form of racism

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Social Justice

… describes one's ability to have what options that others have, to be able to access the "goods of social life" within the context of institutional or community conditions that are needed to develop and exercise individual capacities.

Social Justice in nursing actively analyzes and concerns itself with who is harmed by and who benefits from inequities, discrimination, environmental exploitation, and oppression.

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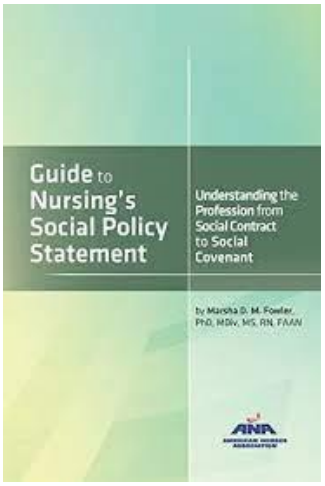
Nursing's Professional Commitment



- A social contract exists between society and the profession.
- This contract reflects the profession's core values and ethical obligations.
- Nursing's response to this contract is to provide care for all who are in need, regardless of their cultural, social or economic standing.
- Nursing is committed to both the welfare of the sick, injured and ***vulnerable*** in society and to social justice.

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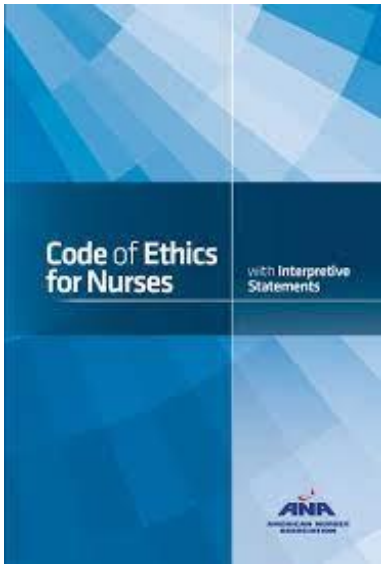

A succinct statement of the ethical values, obligations, duties, and professional ideals of nurses individually and collectively.

It is the profession's non-negotiable ethical standard.

It is an expression of nursing's own understanding of its commitment to society.

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Case Management Society of America (CMSA) Professional Statement Against Social Injustice & Intolerance

- CMSA's Standards of Practice for Professional Case Management embraces unifying and collaborative principles for the profession to include but not limited to:
  - Practice cultural and linguistic sensitivity and maintain current knowledge of diverse populations within their practice demographics
  - Autonomy (to respect individuals' rights to make their own decisions)
  - Beneficence (to do good)
  - Fidelity (to follow-through and to keep promises)
  - Nonmaleficence (to do no harm)
  - Justice (to treat others fairly

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Cultural Humility

…..”defined by flexibility; awareness of bias; a lifelong, learning-orientated approach to working with diversity; and a recognition of the role of power in health care interactions.

(Future of Nursing Report 2020-2030, Ch. 4- The Role of the Nurse in Improving Health Care Access and Quality)

Benefits:

- Effective treatment
- Decision making
- Communication
- Understanding
- Better quality of life
- Improved Care

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Culturally & Linguistically Appropriate Services

Principle CLAS Standard

Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred language, health literacy and other communication needs.

Best Practices for Working with an Interpreter

Trained Health Care Interpreters can reduce liability, help ensure appropriate utilization of services, increase client adherence and satisfaction with services and improve overall health outcomes.

http://refugeehealthta.org/access-to-care/language-access/best-practices-communicating-through-an-interpreter/

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Equity Minded Nurses

"A nation cannot fully thrive until everyone — no matter who they are, where they live, or how much money they make — can live the healthiest possible life. And helping people live their healthiest life is and has always been the essential role of nurses…. Nurses, then, have a critical role to play in achieving the goal of health equity" (Future of Nursing Report 2020-2030: Charting a Path to Advance Health Equity, p 3-4).

"Health Equity is an aspirational vision of what population health can be".
(K. Ackerman-Barger – Advancing Health Equity: The Rise of the Equity Minded Nurse. Campaign for Action, Sept. 26, 2022.)

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Next Steps

- Watch the videos that accompany this lecture
- Review the posted Resources. Download any you would like to keep.
- Complete the Practice Development Activity
- Take the Test Your Knowledge Self-Assessment Quiz.
- When you're ready move onto the next topic

"Start by doing what's necessary; then do what's possible; and suddenly you are doing the impossible."

St.. Francis of Assisi

- Questions? Let me know:
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