Becoming a Care Partner Hospital: Prepare

A strategic initiative of the Eastern US Quality Improvement Collaborative

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Transforming into a Care Partner Hospital

Today's faculty

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Agenda

- Introduction
- Becoming a Care Partner Hospital
  - Step 4: Prepare
  - Action steps
- Questions and wrap up

Strategies to reduce readmissions

- Discharge planning begins at admission
- Assess care partner's educational needs
- Integrate patients and care partners in care transitions

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Implementation steps

Care Partner Framework

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STEP 1: Commit

- Dedicate a program leader
- Establish a care partner program
- Broadly promote the care partner role
- Continuously evaluate and improve the program

STEP 2: Identify

- Support patient to designate a care partner
- Introduce care partner to the medical team
- Identify a proxy care partner in special circumstances
- Display name and contact information of care partner in highly visible areas
- Provide a visual identifier for care partner to wear in the hospital

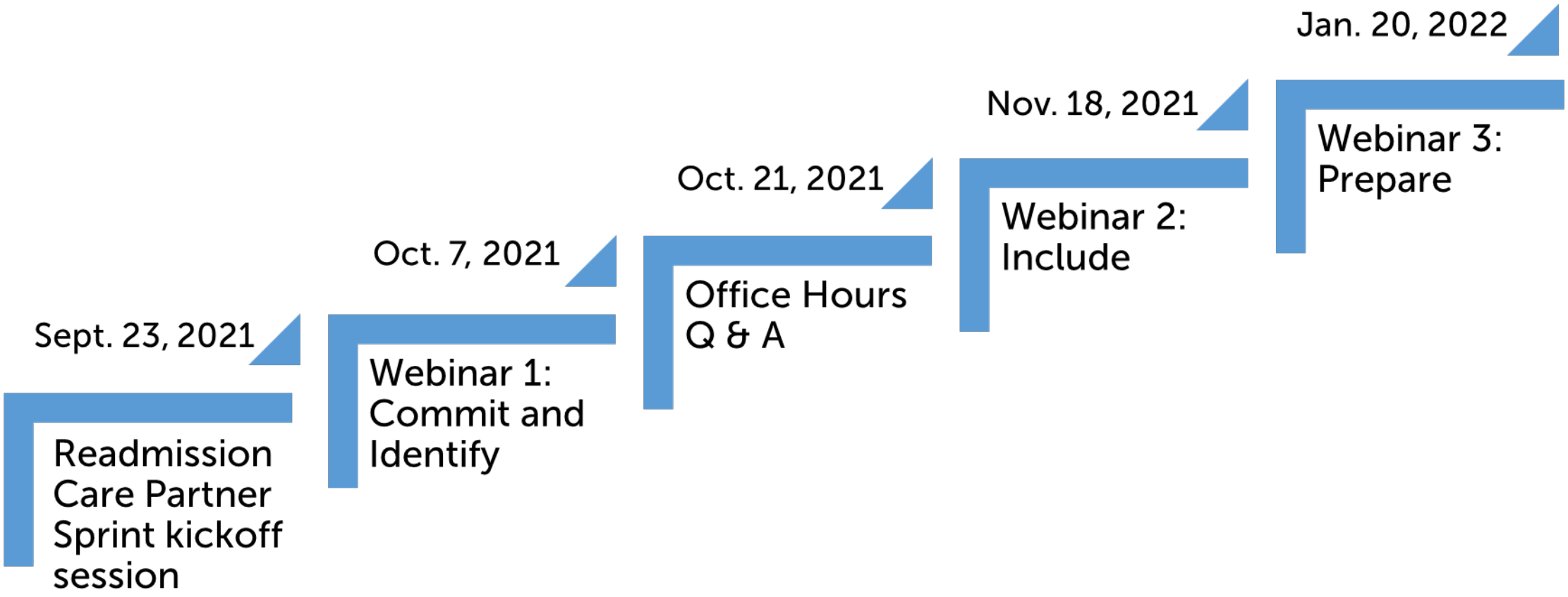
STEP 3: Include

- Orient the care partner to the unit environment and routine
- Invite care partner to daily patient rounds and bedside huddles
- Involve care partner in discussions about the patient's care plan
- Empower care partner to perform simple patient care activities

STEP 4: Prepare

- Assess care partner's education needs
- Educate care partner on essential care activities at home
- Allow care partner to demonstrate understanding using teach-back
- Integrate care partner into discharge planning
- Discuss and plan for post-discharge medical care with care partner

Readmission Care Partner sprint



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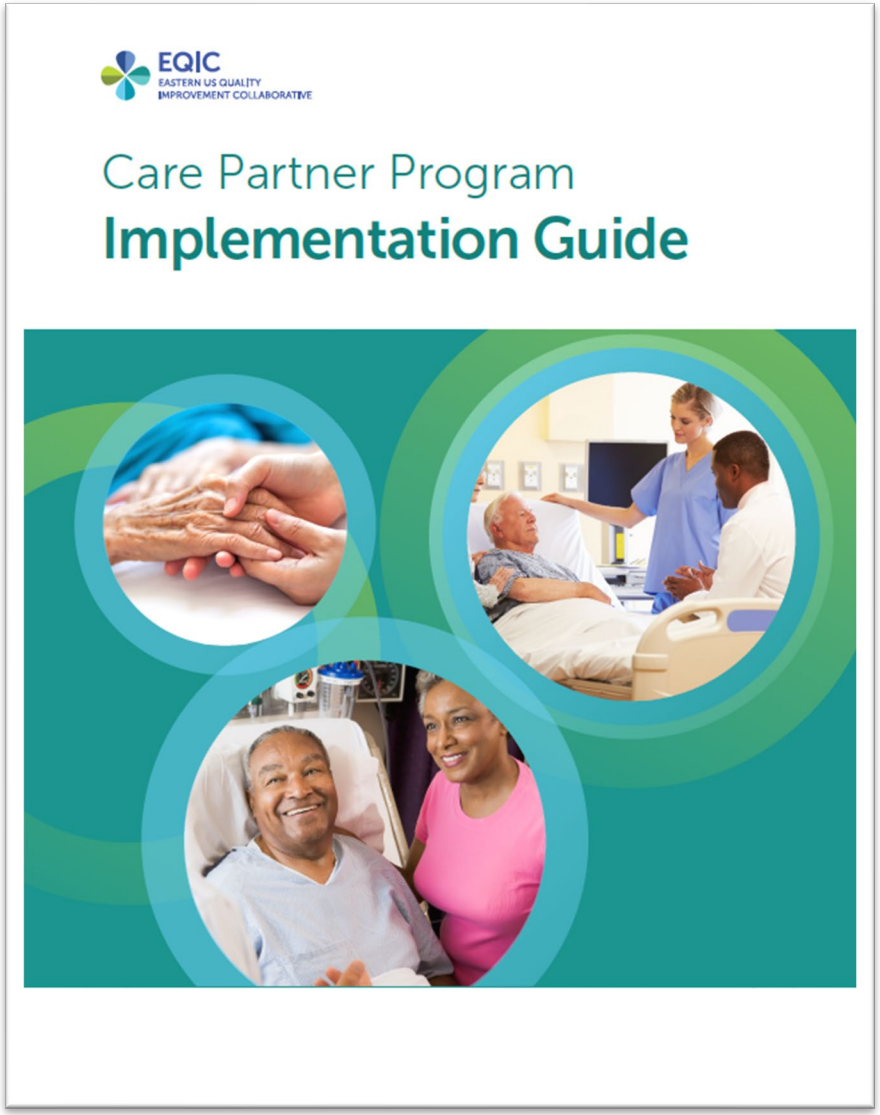
Implementation Guide



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Tools and materials


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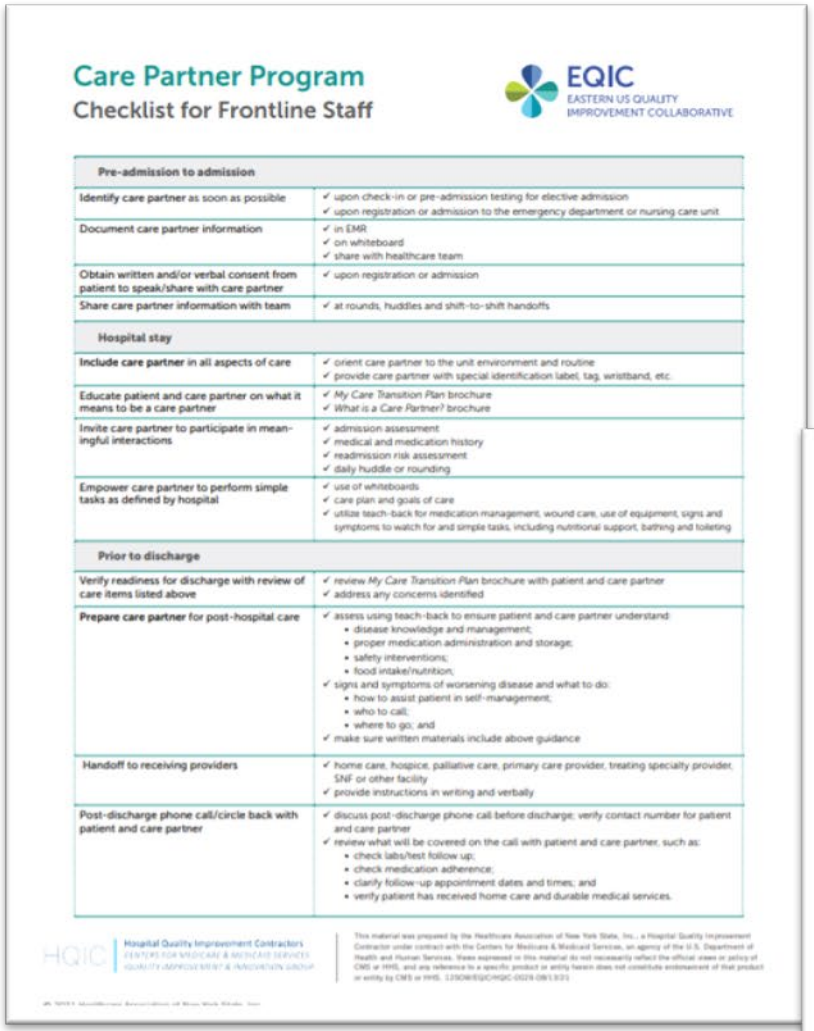
THANK YOU FOR BEING A
CARE PARTNER

A care partner* is someone chosen by the patient to help them during and after their hospital stay. The care partner also helps the healthcare team better understand the patient's needs and preferences and assists with the transition home or to post-hospital care.

*The term "care partner" is used to reflect the level of participation and support provided to the patient throughout their illness and treatment period. This program is promoted by Planetree and the Institute for Patient- and Family-Centered Care®.


Care Partner Program
Checklist for Frontline Staff

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Pre-admission to admission	
Identify care partner as soon as possible	✓ upon check-in or pre-admission testing for elective admission ✓ upon registration or admission to the emergency department or nursing care unit
Document care partner information	✓ in EMR ✓ on whiteboard ✓ share with healthcare team
Obtain written and/or verbal consent from patient to speak/share with care partner	✓ upon registration or admission
Share care partner information with team	✓ at rounds, huddles and shift-to-shift handoffs
Hospital stay	
Include care partner in all aspects of care	✓ orient care partner to the unit environment and routine ✓ provide care partner with special identification label, tag, wristband, etc.
Educate patient and care partner on what it means to be a care partner	✓ *My Care Transition Plan* brochure ✓ *What is a Care Partner?* brochure
Invite care partner to participate in meaningful interactions	✓ admission assessment ✓ medical and medication history ✓ readmission risk assessment ✓ daily huddle or rounding
Empower care partner to perform simple tasks as defined by hospital	✓ use of whiteboards ✓ care plan and goals of care ✓ utilize teach-back for medication management, wound care, use of equipment, signs and symptoms to watch for and simple tasks, including nutritional support, bathing and toileting
Prior to discharge	
Verify readiness for discharge with review of care items listed above	✓ review *My Care Transition Plan* brochure with patient and care partner ✓ address any concerns identified
Prepare care partner for post-hospital care	✓ assess using teach-back to ensure patient and care partner understand: • disease knowledge and management; • proper medication administration and storage; • safety interventions; • food intake/nutrition; ✓ signs and symptoms of worsening disease and what to do: • how to assist patient in self-management; • who to call; • where to go; and ✓ make sure written materials include above guidance
Handoff to receiving providers	✓ home care, hospice, palliative care, primary care provider, treating specialty provider, SNF or other facility ✓ provide instructions in writing and verbally
Post-discharge phone call/circle back with patient and care partner	✓ discuss post-discharge phone call before discharge; verify contact number for patient and care partner ✓ review what will be covered on the call with patient and care partner, such as: • check labs/test follow up; • check medication adherence; • clarify follow-up appointment dates and times; and • verify patient has received home care and durable medical services.


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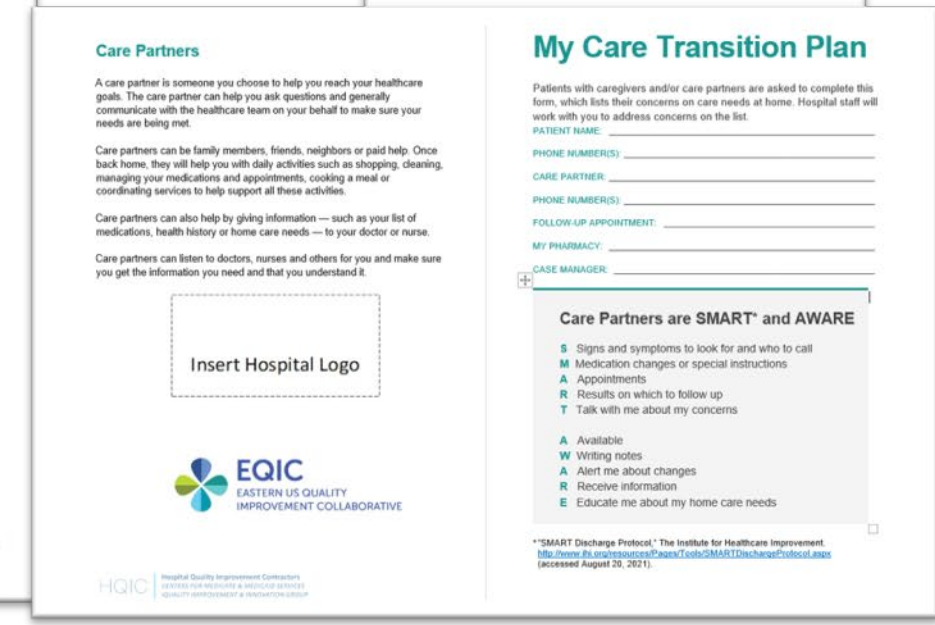
WHAT IS A
CARE PARTNER?


Care Partners

A care partner is someone you choose to help you reach your healthcare goals. The care partner can help you ask questions and generally communicate with the healthcare team on your behalf to make sure your needs are being met.

Care partners can be family members, friends, neighbors or paid help. Once back home, they will help you with daily activities such as shopping, cleaning, managing your medications and appointments, cooking a meal or coordinating services to help support all these activities.

Care partners can also help by giving information — such as your list of medications, health history or home care needs — to your doctor or nurse.

Care partners can listen to doctors, nurses and others for you and make sure you get the information you need and that you understand it.

Insert Hospital Logo

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My Care Transition Plan

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

PATIENT NAME: _____
PHONE NUMBER(S): _____
CARE PARTNER: _____
PHONE NUMBER(S): _____
FOLLOW-UP APPOINTMENT: _____
MY PHARMACY: _____
CASE MANAGER: _____

Care Partners are SMART* and AWARE

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

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

*"SMART Discharge Protocol," The Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/Tools/SMARTDischargeProtocol.aspx (accessed August 20, 2021).

https://qualityimprovementcollaborative.org/focus_areas/readmissions/tools_resources

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Care Partner Framework

Becoming a Care Partner Hospital

Step 4: Prepare

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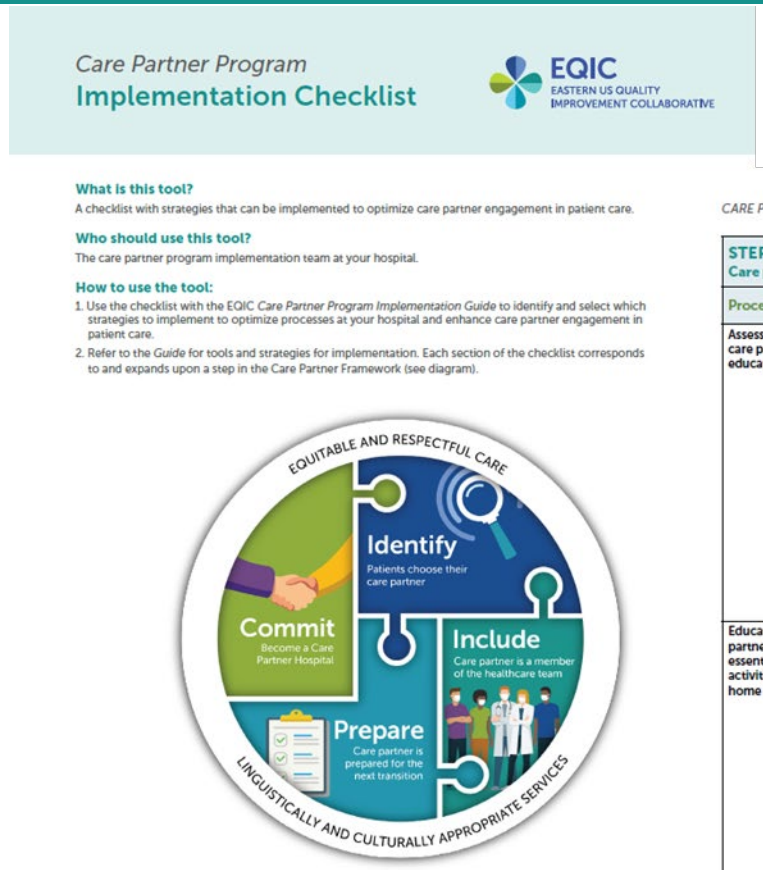
Implementation Checklist



Care Partner Program
Implementation Checklist

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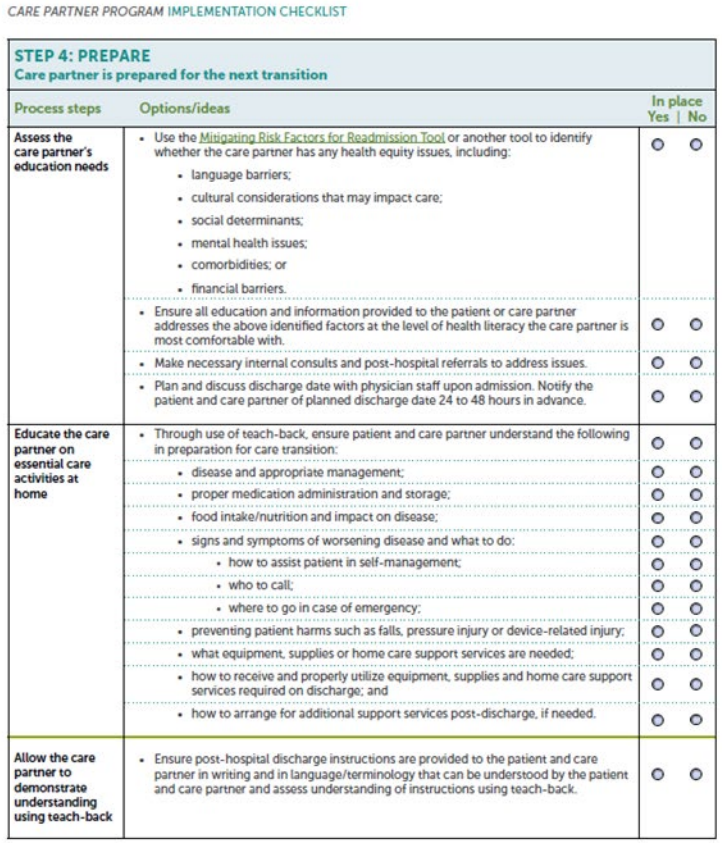
What is this tool?
A checklist with strategies that can be implemented to optimize care partner engagement in patient care.

Who should use this tool?
The care partner program implementation team at your hospital.

How to use the tool:
1. Use the checklist with the EQIC *Care Partner Program Implementation Guide* to identify and select which strategies to implement to optimize processes at your hospital and enhance care partner engagement in patient care.
2. Refer to the *Guide* for tools and strategies for implementation. Each section of the checklist corresponds to and expands upon a step in the Care Partner Framework (see diagram).



CARE PARTNER PROGRAM IMPLEMENTATION CHECKLIST

STEP 4: PREPARE
Care partner is prepared for the next transition

Process steps	Options/ideas	In place Yes	In place No
Assess the care partner's education needs	• Use the Mitigating Risk Factors for Readmission Tool or another tool to identify whether the care partner has any health equity issues, including: ▪ language barriers; ▪ cultural considerations that may impact care; ▪ social determinants; ▪ mental health issues; ▪ comorbidities; or ▪ financial barriers.	○	○
	• Ensure all education and information provided to the patient or care partner addresses the above identified factors at the level of health literacy the care partner is most comfortable with.	○	○
	• Make necessary internal consults and post-hospital referrals to address issues.	○	○
	• Plan and discuss discharge date with physician staff upon admission. Notify the patient and care partner of planned discharge date 24 to 48 hours in advance.	○	○
Educate the care partner on essential care activities at home	• Through use of teach-back, ensure patient and care partner understand the following in preparation for care transition:	○	○
	▪ disease and appropriate management;	○	○
	▪ proper medication administration and storage;	○	○
	▪ food intake/nutrition and impact on disease;	○	○
	▪ signs and symptoms of worsening disease and what to do:	○	○
	▪ how to assist patient in self-management;	○	○
	▪ who to call;	○	○
	▪ where to go in case of emergency;	○	○
	▪ preventing patient harms such as falls, pressure injury or device-related injury;	○	○
	▪ what equipment, supplies or home care support services are needed;	○	○
	▪ how to receive and properly utilize equipment, supplies and home care support services required on discharge; and	○	○
	▪ how to arrange for additional support services post-discharge, if needed.	○	○
Allow the care partner to demonstrate understanding using teach-back	• Ensure post-hospital discharge instructions are provided to the patient and care partner in writing and in language/terminology that can be understood by the patient and care partner and assess understanding of instructions using teach-back.	○	○

Step 4: Prepare

- **Care partner is prepared for transition**
  - Begins at admission, daily updates
  - Identify a proxy if no care partner
- **Assess care partner's educational needs**
  - Literacy and health literacy
  - Language and culture
- **Integrate care partner in discharge planning**
  - Concerns
  - Preferences
  - Readiness for discharge
- **Allow care partner to teach-back**
  - Disease-specific information
  - Medications, diet
  - Follow-up plan
  - What to watch for and who to call
- **Expect and participate in follow up call**

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Prepare: Starts at admission and continues through transition to next setting

Admission

- ✓ Identify the care partner
- ✓ Gather information from care partner
- ✓ Solicit concerns
- ✓ Anticipate LOS for care partner

Hospital stay

- ✓ Include care partner in rounds and teaching
- ✓ Provide daily updates
- ✓ Encourage questions
- ✓ Assess language and health literacy

Discharge planning

- ✓ Prepare for transition with patient and care partner
- ✓ Describe self-care with patient and care partner
- ✓ Use teach-back for self care
- ✓ Identify needs
- ✓ Agree on plan

Post discharge

- ✓ Include care partner in follow-up call
- ✓ Verify patient and care partner know who to call with questions

Consider:

- ✓ Do any of these practices - focused specifically on the care partner - occur as standard care in your hospital?
- ✓ Which ones?
- ✓ How do you know? Are you missing opportunities?
- ✓ Why are they "standard"/ "consistent?" Is it hardwired?
- ✓ How much more successful do you think our patients' transitions would be if we did one best practice from above?
- ✓ How much more satisfied would patients / care partners be with the experience of care?

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Recommendations: Use *Identify* and *Include* as an assessment tool → *Prepare*

Identify: Is the patient able to identify a care partner?

Is care partner information shared with team?

- If no, consider the patient at high risk for readmission.
- Work with patient to identify a care partner/proxy.
- Healthcare team can find care partner on whiteboard, EHR, rounding templates or huddle board.

Include: Do you include the care partner when gathering information?

Do you educate and use teach-back with patient and care partner?

- Readmission Risk Assessment
- Health equity and diversity:
  - Social, health literacy
- Self-care activities and needs

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Prepare the care partner through daily contact

Building on *Include*

- Care partner is involved and asks questions.
- Care partner knows when to expect daily updates.
- Care partner's preferred communication is known (cell, text, email).

Prepare strategies

- Care partner is included in transition and post-hospital care plan development.
- Care partner is included in medication and self-care teaching.
- Care partner understanding is confirmed through teach-back.
- Care partner is encouraged to ask questions, express concerns and preferences.

Prepare the care partner for post-hospital care/activities

Use teach-back

- Do not rely on pre-written handouts
  - Consult with PFAC to review handouts
  - Document teaching and care partner's ability to understand

Identifying needs during daily updates/teach-back

- Follow-up and clarify
- Obtain consult - nurse educator, social worker, pharmacist, physical therapist, home health, palliative care
- Discuss during inter-disciplinary rounds
- Hand off information to next provider of care

Care needs after hospitalization

- Proper medication administration and storage
- Food intake/nutrition
- Signs and symptoms of worsening disease and what to do:
  - who to call and where to go in case of emergency;
- patient safety
- equipment, home care support services
- Verify teach-back

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EQIC tool: My Care Transition Plan

My Care Transition Plan

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

PATIENT NAME: _____

PHONE NUMBER(S): _____

CARE PARTNER: _____

PHONE NUMBER(S): _____

FOLLOW-UP APPOINTMENT: _____

MY PHARMACY: _____

CASE MANAGER: _____

Care Partners are SMART* and AWARE

S Signs and symptoms to look for and who to call
M Medication changes or special instructions
A Appointments
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R Receive information
E Educate me about my home care needs

*"SMART Discharge Protocol," The Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/Tools/SMARTDischargeProtocol.aspx (accessed August 20, 2021).

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

Prepare for discharge:

- Ask questions
- Share concerns
- Follow-up care
  - Medications
  - Appointments
  - Signs/symptoms to watch for
  - Who to call
  - Equipment, supplies
- Transportation
- Personal care (ADL's)

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Taking action

Making change

Commit to action in next 30 days

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How to better prepare the care partner for transitions

Staff role:	What to do:
Day-shift bedside RN	Update care partner daily / make care partner visible
Evening-shift bedside RN	Update care partner after hours, educate them on transitions, meds, etc.
Case manager/Discharge planner	Include care partner in meetings
Attending physician	Encourage questions
Pharmacist/Pharmacy technician	Include care partner in medication teaching
Nurse educator	Include care partner in teaching, teach-back
Nurse manager for the unit	Ensure each RN/CM has identified care partner for all patients
Patient care assistant	Ensure care partner name is on whiteboard
Inter-disciplinary rounds participants	Invite care partner to participate in rounds and decide who will provide daily updates to care partner
Nurse leader/Director of care management	Audit, measure, feedback, coach
Transitional care staff	Prepare patient and care partner to expect post-discharge call
Care management staff	Include care partner in developing post-hospital plan
Patient and Family Advisory Council (PFAC)	Provide feedback on tools, change ideas

Better "prepare" the care partner – Tests of change

Test of Change 1	Test of Change 2
What are we trying to accomplish? • Assess care partner's concerns for discharge. My Care Transitions	What are we trying to accomplish? • Include care partner in follow-up phone call.
How will we know test is an improvement? • Care partner concerns are known and addressed. Be sure to document! • Process measure: Documented review of My Care Transitions brochure with patient and care partner/discharges	How will we know test is an improvement? • Patient and care partner are spoken to on post-discharge call. • Process measure: Care partner and patient spoken to/total number of calls
What change can we make to improve? • Adopt or modify tool for care partner to document questions/concerns. • Work with staff to add review of tool in workflow.	What change can we make to improve? • Develop script to include the care partner in follow-up calls. • Obtain both care partner and patient's contact information.

Examples of tests of change

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What actions will you take?

✓7-day action plan: What can you do “by Tuesday?”

- Engage the care partner in teach-back.
- Ask to talk to the care partner during the post-discharge follow-up call.

✓30-day action plan: What can you do in the next 30 days?

- Have 10 care partners participate in teach-back.
- Include the care partner in 20 post-discharge follow-up calls.

Questions?

Thank you for your commitment to becoming a Care Partner Hospital!

Contact your EQIC Project Manager with any questions.

Next steps

- February 17, 2022 - Office Hours: Preparing for Attestation
- March 17, 2022 – Transitions of Care
- April 21, 2022 – Celebration and Success Stories

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Thank you.

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