EQIC Care Partner Program

Transitions of Care

March 17, 2022

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HQIC | Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

Transforming into a Care Partner Hospital

Today's faculty

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HANYS

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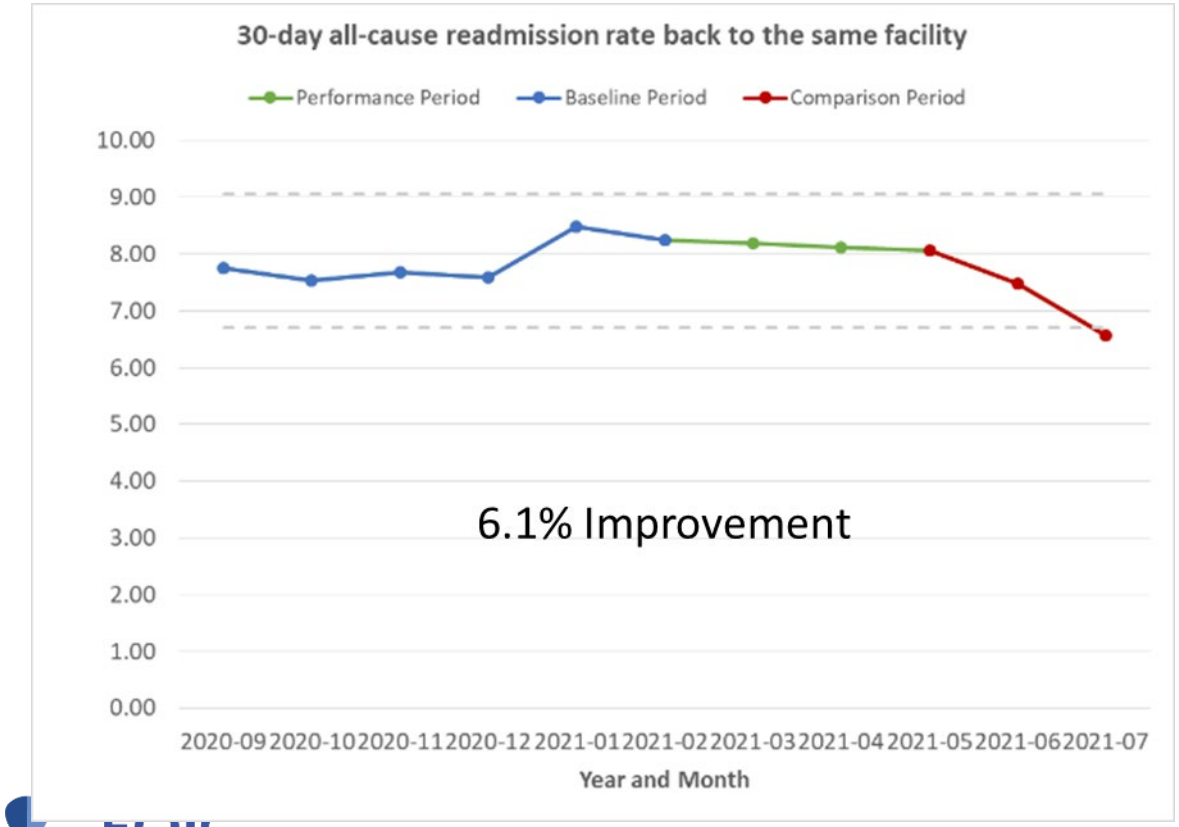
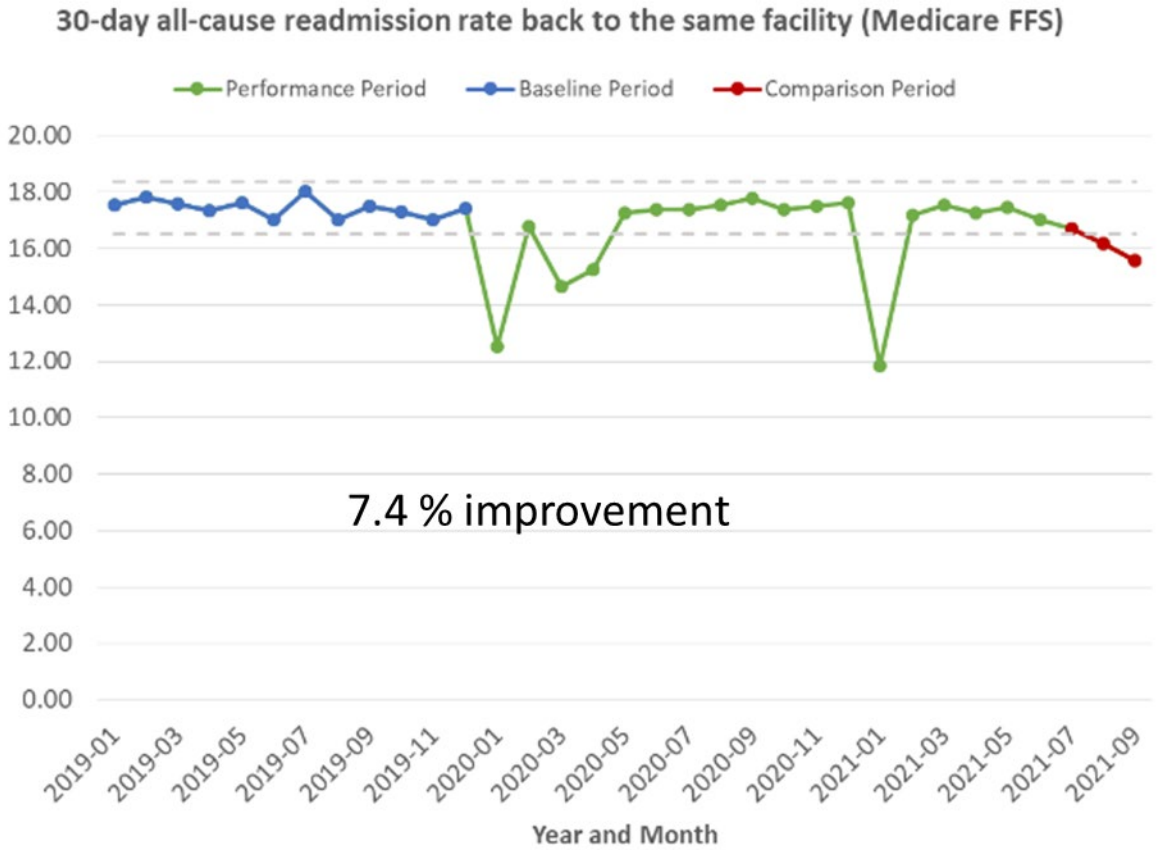
Polling and chat: Who's in the room?

- Hospital
- Nursing home
- Primary care
- Home health
- Behavioral health
- Community-based organization/Other

EQIC goal

Reduce hospital readmission by 5%





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Objectives

- Identify what a care partner program is and why implementing one will benefit your facility.
- Identify principles and methodology to develop a care partner program.
- Determine what to do when patients are unable to identify a care partner.
- Collaborate with transitional care community providers.

43 million people annually serve as a caregiver

Caregivers spend:

- 13 days/month shopping, food prepping, housekeeping, laundry, transportation, giving meds
- 6 days/PO feeding, dressing, grooming, walking, bathing
- 13 hours researching information, services, coordinating visits, managing finances

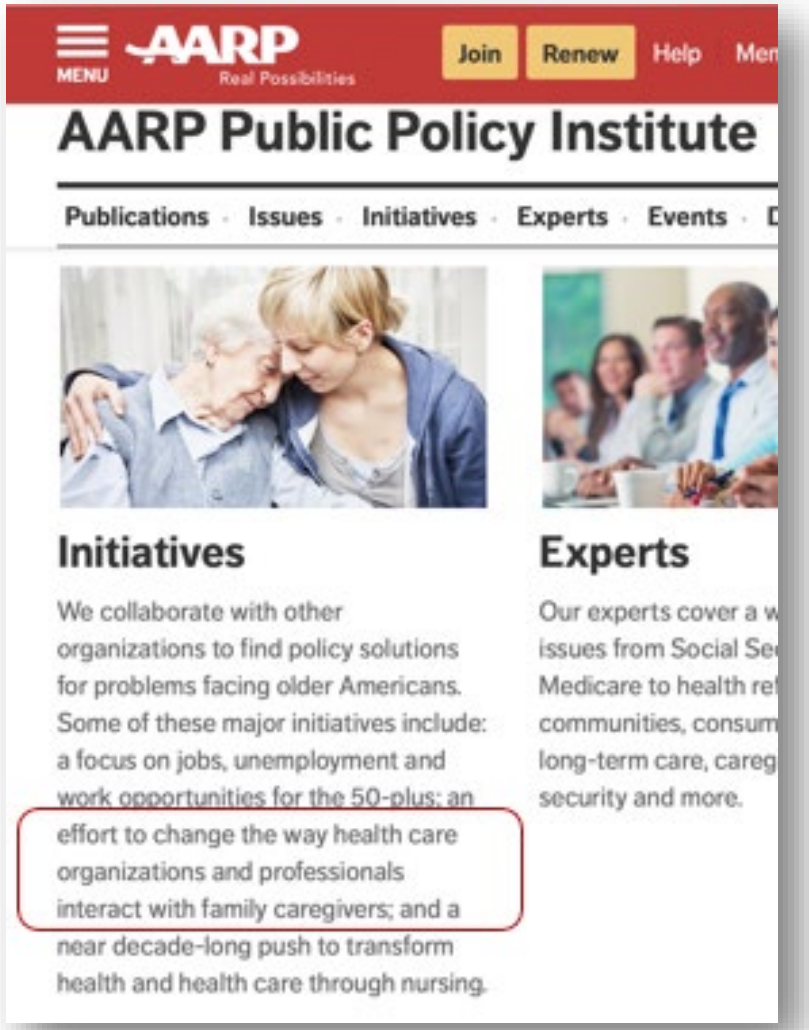
Caregivers of people with chronic issues:

- 46% perform medical and nursing tasks
- 96% help with ADLs and IADLs

Caregivers report holding significant decision-making authority to:

- monitor the care recipient's condition and adjust care (66%)
- communicate with healthcare professionals on behalf of the care recipient (63%)
- act as an advocate for the care recipient with care providers, community services or government agencies (50%)

Source: www.caregiver.org



Gallup-Healthways. (2011). Gallup-Healthways Well-Being Index.

AARP and United Health Hospital Fund. (2012). Home Alone: Family Caregivers Providing Complex Chronic Care

National Alliance for Caregiving and AARP. (2015). Caregiving in the U.S.

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Journey

In performance improvement, one can never do enough to increase awareness and a sense of urgency

The CARE (Caregiver Advise, Record, and Enable) Act 2015

- Designates a caregiver and provides permission for full review of records and participation.
- Helps patient and caregiver prepare for discharge, including teaching, patient care techniques and post-hospital services if needed.
- United Hospital Fund published "*Implementing NYS's Care Act – A Toolkit for Hospital Staff*" https://www.nextstepincare.org/Provider_home/NYS_CARE_Act_Hospital_Toolkit
  - Crosswalk with federal and state discharge planning regulations
  - Medical record documentation requirements
- Intent of the law is very good . . .
  - Unintended consequences: Task, check-the-box regulations

Goal: *Beyond compliance to high value care*

Care partner program purpose

This is a journey to transform the care delivery systems in patient-centered care and its impact on the readmission reduction initiative while demonstrating value in other key domains across a continuum of patient safety outcomes.

- Taking the opportunity to align with and optimize parts of the CARE Act.
- Providing other ways that the process impacts all staff and patient communication throughout the hospitalization.
- Turning patient-centered care concepts into concrete steps for real change.

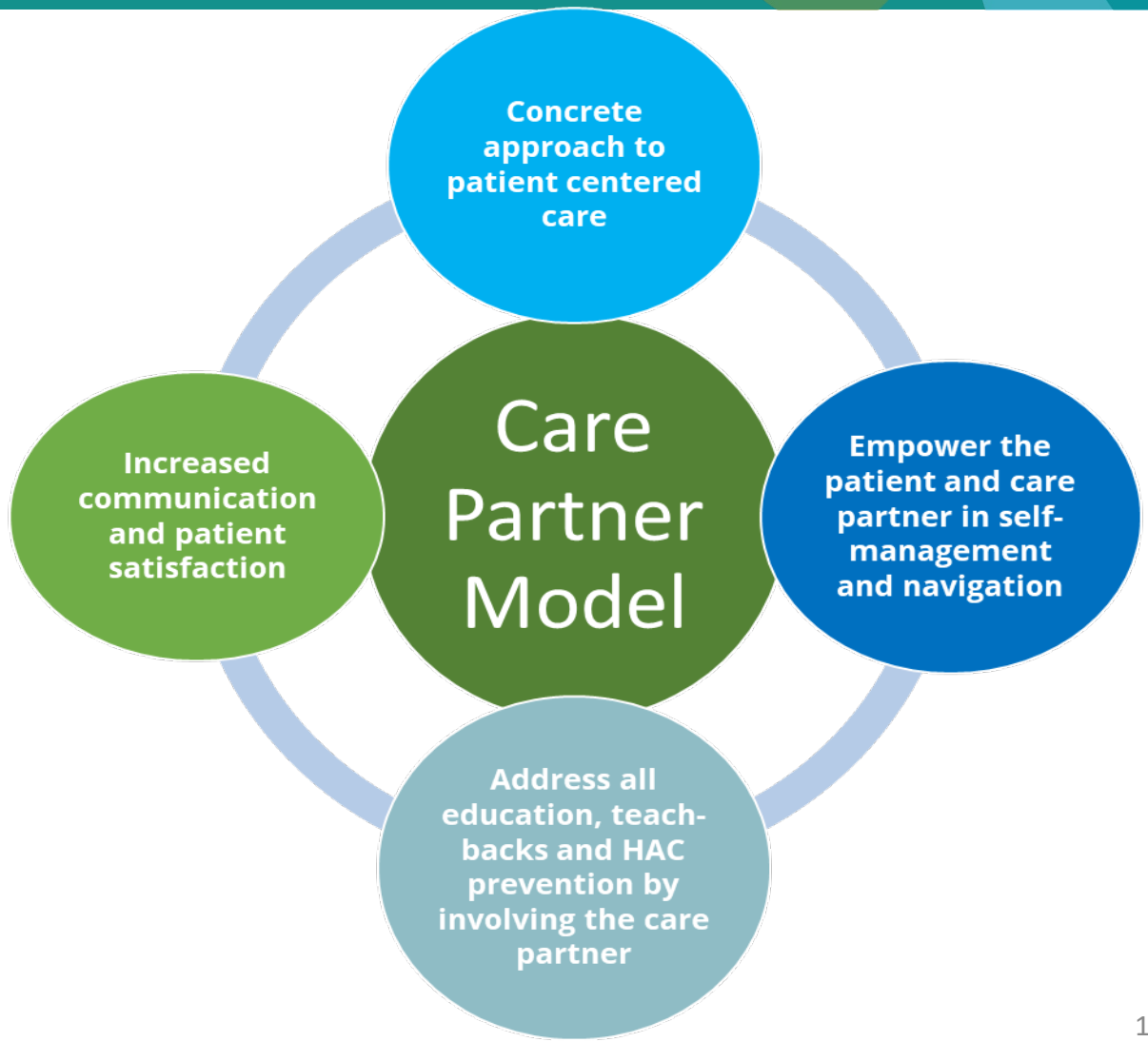
The importance of a care partner

Play video

The Importance of a Care Partner Program

Patient outcomes

Incredibly impactful Intervention



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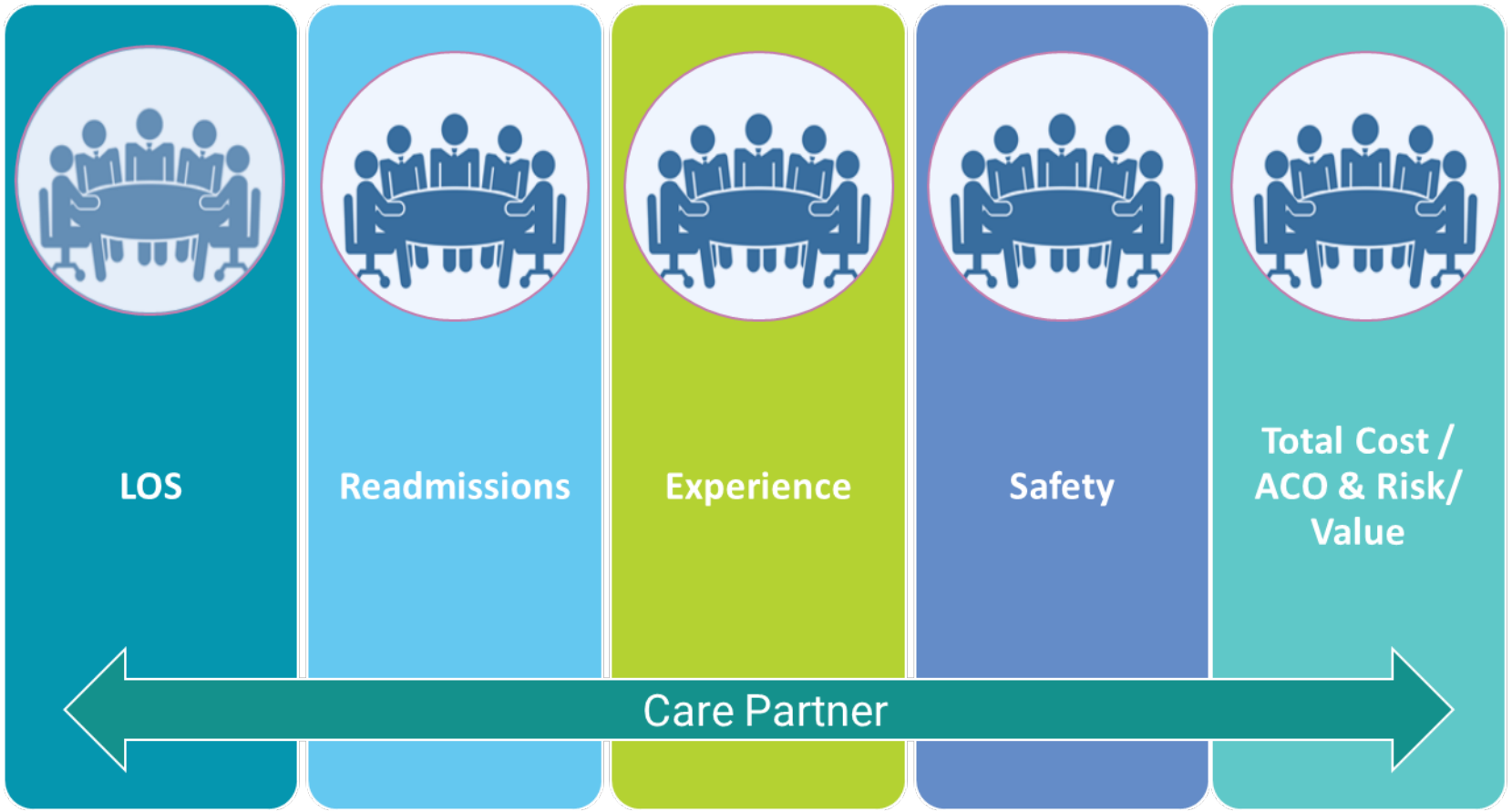
Hospital or system outcomes

Cross-cutting initiative, benefitting multiple current priorities



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Care partner model evidence

Two of the most respected national patient engagement organizations' models

- **Planetree**:
  - A family member or friend appointed by the patient who is included as a member of the care team
- **Institute for Patient- and Family-Centered Care**:
  - Entitled their "Better Together Program" for understanding and practicing patient-centered care culturally that enhances participation and collaboration

Experimental – Medical centers

- **University of Pittsburgh, Pennsylvania:**
  - Discharge planning interventions with care partner integration were associated with 25% fewer readmissions at 90 days

  https://pubmed.ncbi.nlm.nih.gov/28369687/
- **Intermountain Healthcare Partners In Healing®**
  - 65% reduction in 30-day all-cause readmission

  https://journal.chestnet.org/article/S0012-3692(17)32890-8/fulltext

Reduce health disparities

Patient and Family Engaged Care: An Essential Element of Health Equity

"improved population health, which is becoming the new fundamental premise of health care delivery today, cannot be achieved without progress toward a culture of patient and family engaged care (PFEC) that ensures all populations (and members within populations) have equitable opportunities to achieve and maintain health"

"The time for changing organizations from the inside moving forward with patients and their ***caregivers as full partners***, for creating the inclusive environments that break down the usual siloed and biased care, and for driving a shift toward health equity that lifts health for all is now."

https://nam.edu/patient-and-family-engaged-care-an-essential-element-of-health-equity/

Leveraging Meaningful Use to Reduce Health Disparities

"Ensuring that EHRs can capture and record factors pertinent to individuals' health, such as sexual orientation, gender identity, occupation, disability status, environmental factors, ***caregiver presence***, and race, ethnicity and language, ensures that providers see the whole picture surrounding their patients and are more adequately equipped to identify and address factors associated with health disparities."

https://www.nationalpartnership.org/our-work/resources/health-care/digital-health/leveraging-meaningful-use-to.pdf

What is a care partner?

A care partner is someone the patient chooses to help the patient during and after the hospital stay. The care partner also will help the healthcare team to better understand the patient's needs and preferences and may also participate in the patient's medical care and treatments.

https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/NYSPFP_CarePartner_Brochure.pdf

FOR THE PATIENT

Why do I need a care partner?

Taking care of yourself alone can be difficult, especially when you are sick and in the hospital. Having someone who knows you well and is willing to be another set of eyes and ears can help you get the care you want and need in the hospital and have a smooth transition to successful recovery at home.

What is a care partner?

A care partner is someone you choose to help you during and after your hospital stay. Your care partner also will help the healthcare team better understand your needs and preferences and may participate in your medical care. Your care partner should be prepared to be involved in your care for the entire hospital stay and help with your needs at home.

Your care partner will be informed of your health progress. They should be ready to participate in rounds and discussions with the medical team and other staff.

Both the person you select and the hospital staff should know that they are your care partner. Once the hospital staff know who you have selected, they will ensure that your care partner is aware of any changes in the treatment plan and include your care partner in conversations with you regarding your care.

Having a care partner does not mean that you no longer get to choose what you want! The care partner helps support you and your choices and expresses them to the medical team.

Who can be a care partner?

Care partners can be family members, friends, neighbors or paid assistants. Whoever you choose, you should be comfortable discussing your healthcare with that person and working with them to ensure you receive care that you want.

The care partner should be available to support you both during and after the hospital stay.

FOR THE CARE PARTNER

What can I do as a care partner?

During the hospital stay

You can help staff understand the patient's care preferences and goals. This information is critical to helping staff understand what is important to the patient in their everyday life. To do this, you may want to participate in shift reports or daily rounds to share their care preferences and goals, shape the plan of care and inform the team of any issues they should take into consideration.

During the rounds, please feel free to:

- take notes;
- ask questions; and
- let the team know of anything that is concerning or confusing to you or the patient.

If you are not able to attend the rounds, please tell the staff how to reach you to tell you the care plan and give you an opportunity to ask questions, e.g., the team could connect with you via phone or text, on the patient's whiteboard or you could set up a time to speak to them in person.

During the hospital stay and after

As the care partner, you can help the patient by reinforcing instructions that were provided regarding the patient's care, looking for specific signs and symptoms related to the patient's disease/diagnosis that should be reported to the medical team, preparing the patient for discharge and, most importantly, preparing for a smooth transition to managing the patient's care at home. The medical team will tell you what to look for and who to talk to if you have concerns, including after the patient goes home.

After discharge

The hospital team may ask you to assist with certain care or coordination tasks for the patient. If any help is needed, the hospital staff will teach you and the patient how to do the task and ensure that you're both fully comfortable with everything before leaving the hospital.

Depending on the patient's needs, tasks may include:

- making and getting to appointments for follow-up care;
- remembering how and when to take medication;
- performing simple wound care and dressing changes;
- understanding dietary considerations to stay well post discharge;
- troubleshooting events, problems or setbacks; or
- coordinating needed services like a visiting nurse, medical equipment or other help.

The above are examples only. You may be asked to assist with none or all of the above. Please say something to staff if you have any questions!

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COVID-19 pandemic forced changes

- Limited or no visitation
- Staffing shortages
  - Revised staffing models, new team members
- Need to limit staff “in-person” potential exposure
  - Outside the room
  - Adoption of technology solutions
    - Medical equipment
    - Communication technology

We make sure we stay connected!

a. Schedule daily updates with care partner/family

b. Deploy technology for patient care

c. Deploy technology for patient/care partner visitation

d. Staff aware of the fear; prioritize keeping care partners and family involved and informed

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From the patient and care partner's perspective

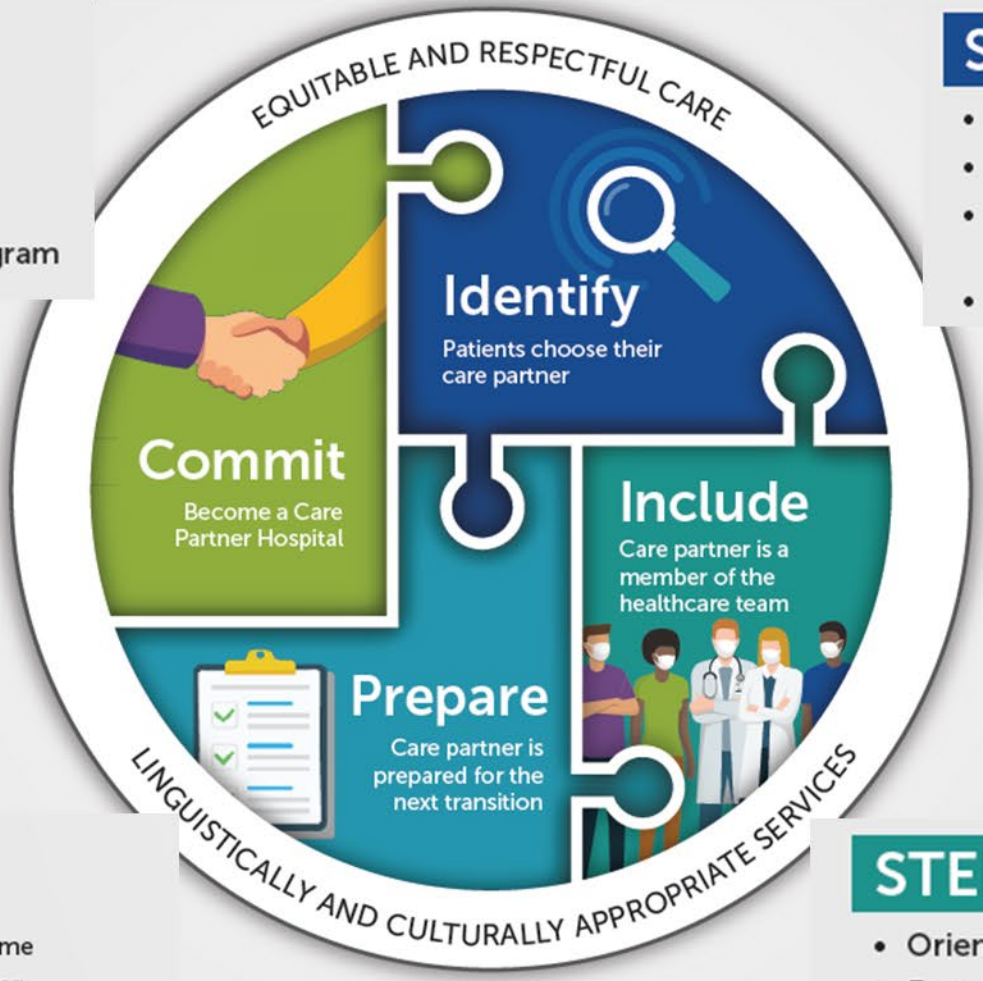
Play video:

The Power of the Care Partner: The Maria and Don Story

EQIC Care Partner Framework

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 qualified care partner
- Introduce care partner to the medical team
- 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 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

STEP 3: Include

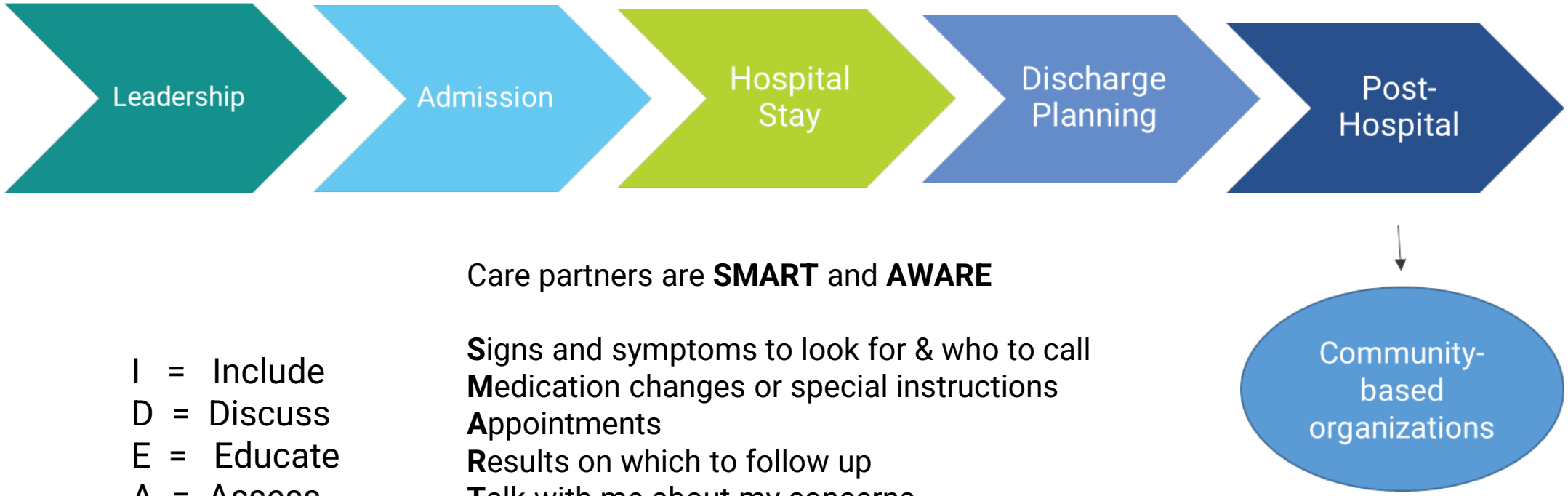
- Orient the care partner to the unit environment and routine
- Empower care partner to perform simple patient care activities
- Invite care partner to daily patient rounds and bedside huddles
- Involve care partner in discussions about the patient's care plan

Designation of a Care Partner Proxy

A patient who does not have a care partner should trigger an automatic referral to discharge planning/case management to identify a proxy care partner in the community.

- Navigators
- Home care agencies
- Health homes
- Primary care
- Community support networks

How to engage the patient and care partner



I = Include
D = Discuss
E = Educate
A = Assess
L = Listen

Care partners are **SMART** and **AWARE**

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

Available
Writing notes
Alert me about changes
Receive information
Educate me about by home care needs

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Lewis County General Hospital

Care Transitions

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Lewis County Health System
Your Health Partner

What have our hospitals been doing?

Gale Grunert, RN
Director of Quality and Case Management
Lewis County General Hospital
Lowville, New York

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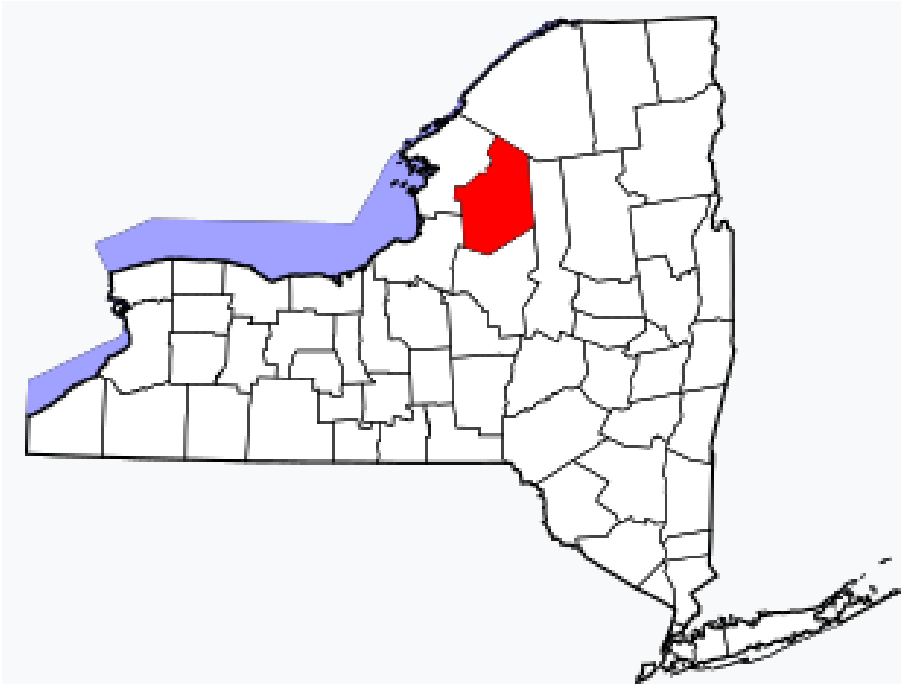
About Lewis County Health System

- Rural
- Critical Access Hospital
- 160 bed nursing home
- Home Health, Hospice
- Primary Care clinics
- Community



Lewis County Health System
Your Health Partner

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Objectives

- Describe community collaborative
- Care Transition program
- Integration of the Care partner into the collaborative and transitions of care
- Outcome of collaborative to date

Community Collaborative

- Development of **Care Coordination Team**
- Chair and co-chairs
- Team - Mental Health, EMS, Social Services, Skilled Nursing Facility, Adult Day Care, Health Home, Public Health, Case Management, Social workers, Prevention and Addiction Services, Home Health and Hospice, Loving Lewis County, Disability Rights and Resource Center
- Meetings held monthly
- Goals – Reduce readmissions and inappropriate use of the ED and hospital, improve communication and services
- Education – services offered by each agency, new services in surrounding counties
- Interventions – Community service Directory, EMS referral program. HealthEConnections, increased referrals with a feedback loop, care partner program, universal referral
- Data – Hospital and IPRO readmission

Care transitions

- Case Management structure
  - Director - Chair of Community Coalition, Community Service Board
  - Emergency Room – Gatekeeper, bedside referrals, post discharge follow up, appropriate use of the ED, LWBS follow up, Community Service Board member
  - Hospital – early referrals, CBO visitations, “owner” of readmissions, PCP
  - Clinic – high utilizer, chronic CM, transition of care calls
  - Skilled Nursing Facility - readmissions
  - Utilization Review – insurance
- Social Work - Social Determinants of Health, referrals
- Interdisciplinary Team meetings

Adding the Care Partner Program

- Policy and consents developed
- Education (hospital, CBOs)
- Registration service offers program and obtains Consent/Revocation
- Involve patient and care partner in care and decisions
- Education, hands-on training, discharge planning, referrals, discharge instructions
- Referrals - include patient as well as care partner information (ex. Home health)
- Transition of care with CBOs (in-person hospital visit, d/c date and plan)
- Post-discharge phone call (patient and/or care partner)
- Hand off communication to Chronic Case Management (RN, Health Home, Insurance Company, other)

Policy: Care Partner Identification Authorization

Lewis County Health System

NURSING

Subject: CARE PARTNER IDENTIFICATION AUTHORIZATION

Effective Date: October 25, 2017 Approval: Chief Nursing Officer

POLICY:

Patients ≥ 18 years (or emancipated minors) - Lewis County Health System patients or their legal representatives can identify individual care partners who will be involved in the patient's post-hospital care. This will include discharge planning and instruction in after-care for during the hospitalization and after discharge. A care partner may be a spouse, partner, family member, friend, neighbor, or community member who is available to assist with the needs of the patient after discharge. They do not need to be the Health Care Proxy or Power of Attorney.

If a care partner is appointed, over the course of hospitalization the hospital interdisciplinary team will engage with the appointed care partner to share and exchange post-hospital care information and instructions. The sharing of the information allows the care partner to be in the best position to assist the patient with the continuing care needs at home.

In addition, if the patient or representative consents to "yes" for the health Information release, the Discharge Summary and Patient Health Summary may be released by the hospital to the care partner identified.

Procedure:

1. Within the first 24 hours of hospitalization, prior to discharge or transfer, upon identifying the need, or by patient request, the patient or their legal representative will be offered the "Care partner identification authorization" form which will be completed by the registration or admissions clerk. If Registration or Admissions are unable to offer it, or if the patient is unable to receive the authorization, then the social worker, case manager or nurse can offer the consent.
2. If no aftercare care partner is chosen, "no" will be checked, and a patient signature and date will be obtained.
3. If an after-care partner is identified, "yes" will be checked.
4. The identified care partner name, relationship, address, and phone number section will be completed.
5. Assign an expiration date for the release of healthcare information.
6. Obtain patient or patient's legal representative signature and date of signature
7. If an interpreter is used complete the interpreter information section.

Lewis County General Hospital

7785 N. State Street, Lowville, NY 13367
315-376-5200

CARE PARTNER IDENTIFICATION AUTHORIZATION

Patient Identifiers (3)

At Lewis County General Hospital, we provide hospital patients or their legal representatives with the opportunity to identify individual caregivers who will be involved in the patient's after-hospital care. A care partner could be a spouse, partner, family member, friend, neighbor, or community member who is available to assist with limitations in daily living as well as with medical tasks at home.

1. Would you like to designate a care partner, who the hospital will include in your discharge planning and instruct in after-care?

☐ Yes ☐ No **(If "No", please proceed to Box 5 and provide your signature and date.)**

IF YES:

2. Over the course of your hospitalization, the hospital treatment team may wish to share information and exchange updates with an identified care partner about your status, course of treatment, and post-discharge care and instructions. This will enable your care partner to effectively assist you with your continuing care needs at home after you are discharged.

In order for the hospital to provide this information and specific after-care instructions to a care partner, you must specifically consent to the release of such information to the identified care partner for this episode of care. Please know that you will also receive a copy of your Patient Health Summary and Discharge Summary and can share the enclosed discharge instructions with whomever you wish for the purpose of your continuing care needs at home.

☐ **YES – I would like the hospital to speak with the individual identified below about my status and course of treatment throughout my hospitalization. I further authorize the hospital to release my Discharge Summary and Patient Health Summary to the individual identified below. I understand that this document may include information related to alcohol and drug abuse, mental health treatment and/or confidential HIV-related information.**

3. If you are identifying a care partner, please provide name and contact information:

Care Partner Name: _____ Phone: _____

Care Partner Address: _____

Care Partner Email: _____ Relationship to the Patient: _____

4. **Given that I am consenting to the release of health information to the care partner as noted above, I understand that:**

I may revoke this authorization at any time by notifying a member of my treatment team; however, such revocation will not apply to information which has already been disclosed based on this authorization.

Signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure.

If the recipient is not a healthcare or medical insurance provider covered by the privacy regulations, the information indicated above could be re-disclosed.

My authorization will expire ☐ 30 days after discharge ☐ Other: _____

5. Signature of patient or legal patient representatives:

_____ Date: _____

☐ Interpretation provided: Language _____ Interpreter Name or ID _____

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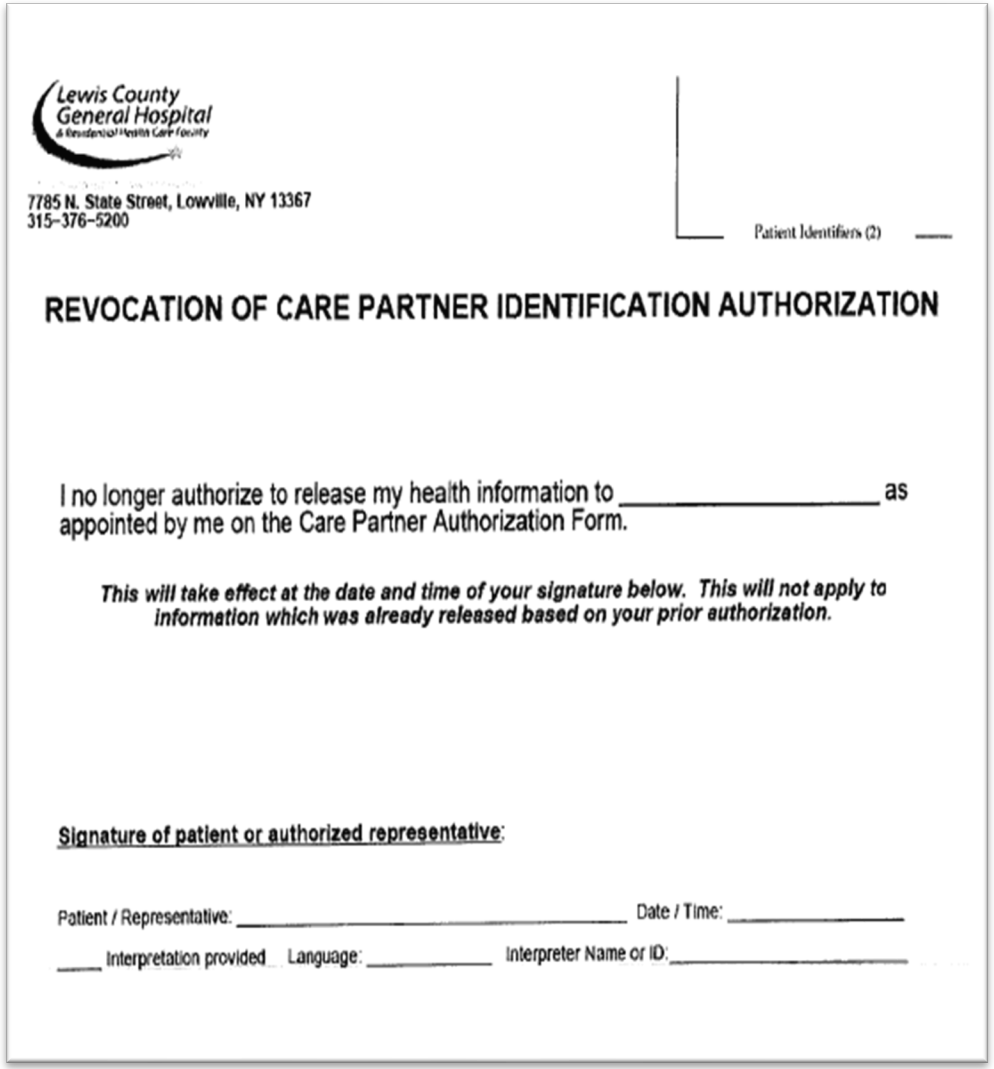
Revocation of Care Partner Identification Authorization



Lewis County General Hospital
& Residential Health Care Facility

7785 N. State Street, Lowville, NY 13367
315-376-5200

Patient Identifiers (2) ____

REVOCATION OF CARE PARTNER IDENTIFICATION AUTHORIZATION

I no longer authorize to release my health information to _____ as appointed by me on the Care Partner Authorization Form.

This will take effect at the date and time of your signature below. This will not apply to information which was already released based on your prior authorization.

Signature of patient or authorized representative:

Patient / Representative: _____ Date / Time: _____

____ Interpretation provided Language: _____ Interpreter Name or ID: _____

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Agency profile

Lewis County Care Coordination
Agency Profiles

ACR Health- Provides **Health Home Care Management** Services following NYS Medicaid guidelines for adults.

The ARC of Oneida Lewis- Provides **Medicaid Service Coordination** for people with developmental disabilities from birth to death.

Children's Home of Jefferson County- Provides **Health Home Care Management** for adults and children. CHJC also runs a behavioral health clinic in Watertown and has residential foster care and respite services serving Le
Department of Social Services- Provides **case workers** in area of Child Protective Services, Foster Care Services, Children and Adult Preventive Services, PINS Diversion, and Adult Protective Services. All services are available
County residents.

Disabled Person Action Organization-DPAO Provides **Medicaid Service Coordination**, respite and HCBS services to the developmentally disabled population.

Fidelis- Is a health plan that offers **Medicaid Managed Care** and a **Medicaid Managed Long Term Care** Plan (Fidelis Care At Home)

HCR - Provides **Health Home Care Management** Services following NYS Medicaid guidelines for adults

House of the Good Shepard- HGS- **Health Home Care Management** for Children following NYS Medicaid guidelines and has residential and community foster care services serving Lewis County.

Lewis County General Hospital- LCGH Provides an array of medical services including inpatient hospital and all ancillary services. Provides **RN Care Management** to people being discharged from an inpatient stay; ER patie
the nursing home. Also provides the **Certified Home Health Agency and Hospice** with a full complement of services.

Lewis County Public Health – **Early Intervention** provides service coordination for children birth to 2.6 years of age, must be a Lewis County resident and have a suspected developmental delay or diagnosed condition. Provid
directly related to therapy delivery. **Children with Special Health Care Needs**- is a resource and referral program for children birth to 21 years with a suspected developmental delay or condition.

MIT Team- Mobile Integration Team from SLPC. Provides a **Community Health Nurse and Rehabilitation Counselor**. Person must have a mental health diagnosis, can work with any age. Provides education and linkages
transport.

Community Resource Guide

Care Coordination

Multiple Providers Working Together

Prevention

Provides basic health information and guidance. Provides a link to health care providers and insurance. May advocate for the patient and assist with communication to a service provider

Health Homes- Assists in a comprehensive care plan including physical, mental and substance use needs.

Community Services Case Managers-Assists with Social Supports. Aide services, arranges for meal delivery, housing, financial assistance (Both Short and Long Term), Also includes disability case management.

Insurance Case Managers-Authorizes for payment provision of health care services

	Service Provision				Eligibility					
Provider	H/V	Office	Community	Facility	Medicaid	Other Insurance	Diagnosis	Location	Age	Other
NCPPC- Community Health 788-8533	x	x	x		x	x	x		x	
NCFHC- Community Health 782-9450	x	x	x		x					x
NRCIL -Advocate 836-3735	x	x	x	x	x	x	x			
Optum (United Health) 952-687-3248	x		x		x	x	x			
Health Home Care Management Agencies										
ACR Health 785-8222	x	x	x	x	x		x			
Children's Home of Jefferson 777-9731	x	x	x	x	x		x			
HCR 800-270-4904	x	x	x	x	x		x			
HGS (Children Only) 235-7600	x	x	x	x	x		x		x	
St. Joseph's 703-2802	x	x	x	x	x		x		x	
TLSNNY 376-8443	x	x	x	x	x		x			
Community Services										
DSS (CPS, PSA, Preventive) 376-5400	x	x	x	x	x	x				
OFA 376-5313	x	x	x	x		x			x	
ARC 348-8401	x	x	x		x		x			
PH-EI 376-5453	x	x	x		x	x	x		x	
CHHA/Hospice 376-5308	x	x	x	x	x	x	x			
MIT Team 541-2529	x	x	x	x	x	x	x			
DPAO 782-3577	x	x	x	x	x		x			

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Year to date

- Care transition
- Care Coordination team
- Post pandemic re-evaluation

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Thank you.

Gale Grunert, RN

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Community inventory

Connect and partner: Share care partner information, tools and resources

- Identify community-based organizations and resources who can provide timely follow up, monitoring and assistance.
  - ❖Clinical
  - ❖Behavioral
  - ❖Social Services
- Assess community organization capabilities
- Collaborate with community partners

Community Collaborative

- Educate community-based organizations on the Care Partner Model
- Consider developing a Care Transitions Collaborative
  - ❖Monthly meetings
  - ❖Educational sessions
  - ❖Referrals and volume
  - ❖Develop an effective linkage process

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Thank you.

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