EQIC Care Partner Program

Capstone

April 21, 2022

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

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

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Transforming into a Care Partner Hospital

Today's faculty

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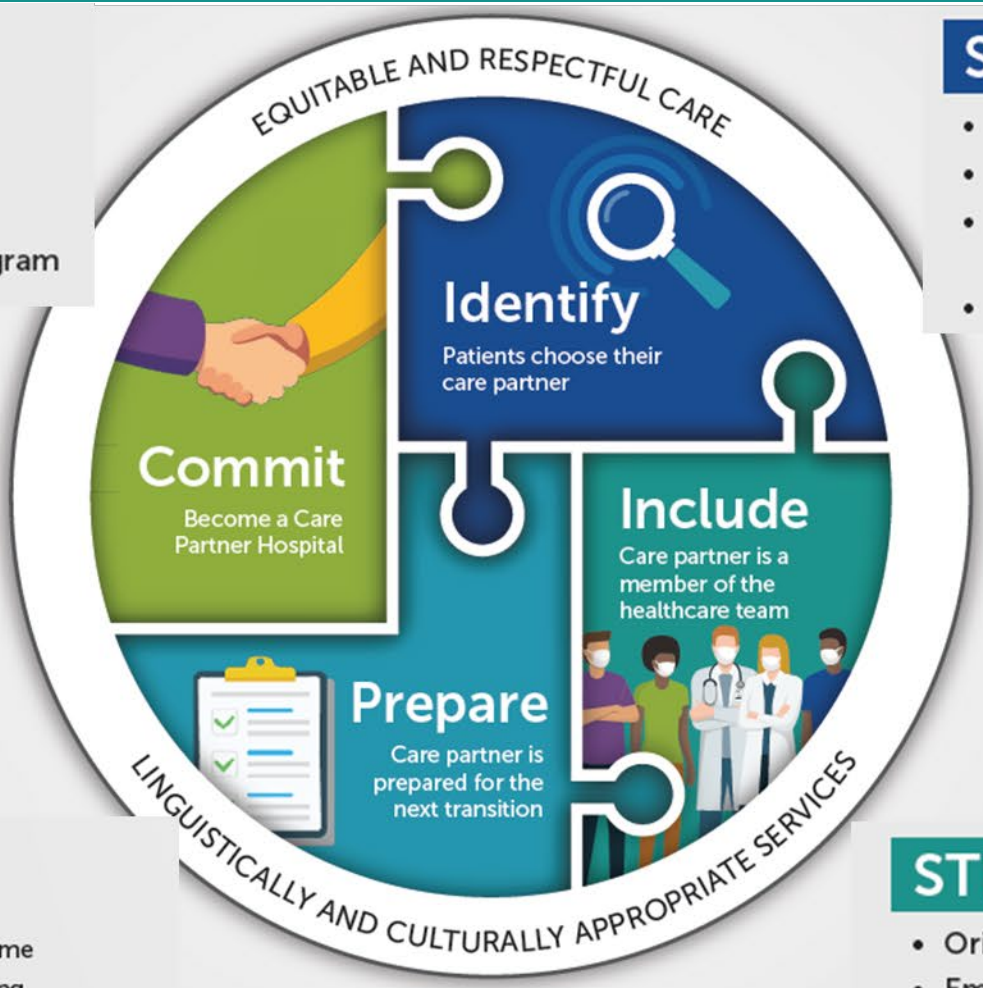
EQIC Care Partner Framework

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 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

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

Care Partner implementation

- **Capstone presentations from EQIC Hospitals:**
  - Elizabethtown Community Hospital
  - Claxton-Hepburn Medical Center
  - Carteret Health Center
  - Ellenville Regional Hospital
  - Canton-Potsdam Hospital

Elizabethtown Community Hospital

Care Partner Program

THE University of Vermont HEALTH NETWORK

Elizabethtown Community Hospital

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Hospital demographics

- *Elizabethtown, NY*
- *Bed size - 25*
- *Hospital type: Critical access hospital*

Commit

Our care partner team:

- Team lead - Vicki L. Smith, RN, ACM
- Also on the team (multidisciplinary team):
  - Nursing, Case Manager, Care Partner & Patient

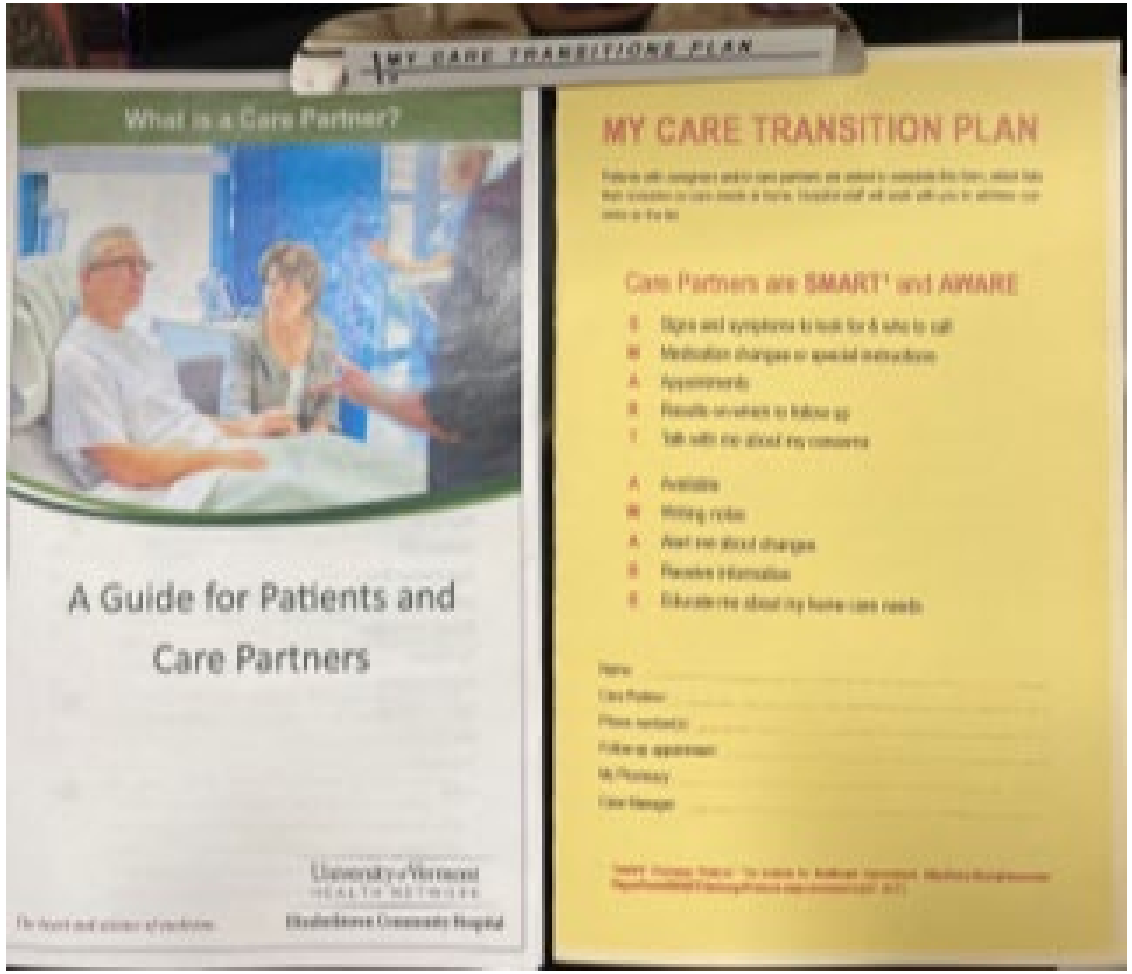
Commit

How you gathered staff and patient/care partner feedback:

- PFAC: flyers in rooms, phone calls to each care partner
- STAFF: Educated on the need for care partner, added phone numbers to white board with the care partner name

How you evaluated EQIC tools for adoption:

- We used the information from NYS partnership for patients
- Smart and Aware tool: My care transition plan



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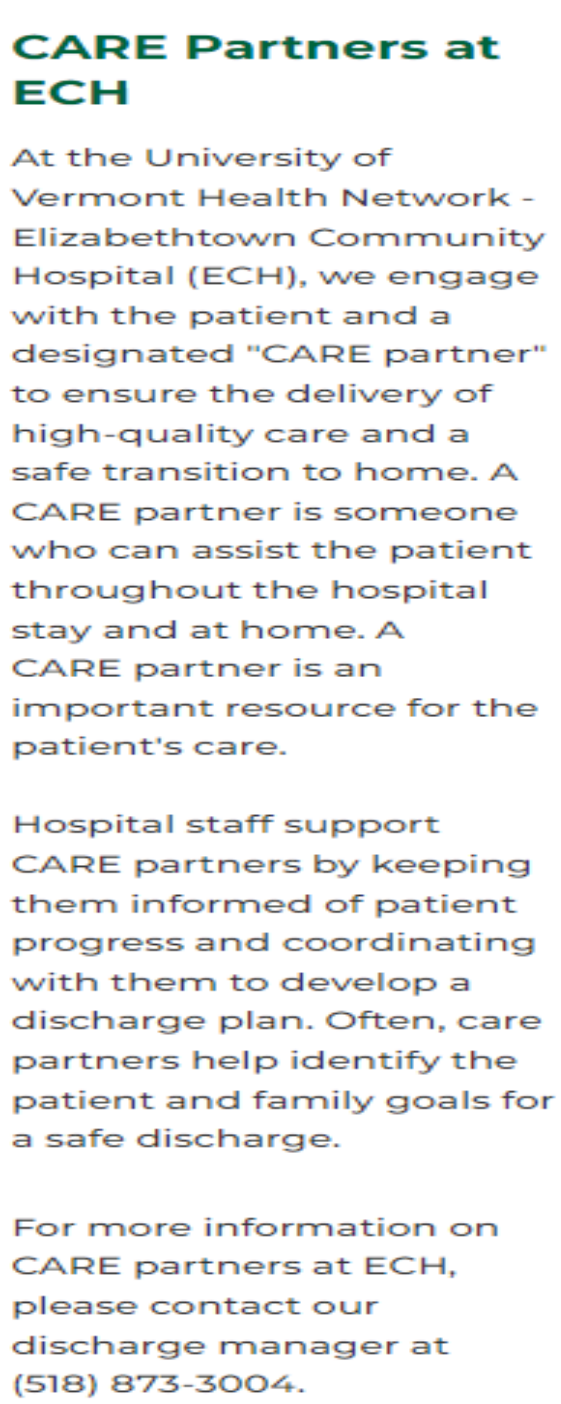
Commit

- Describe staff education and how your facility broadly promoted the Care Partner Program:
  - We utilized our communications person to place information on our website.



CARE Partners at ECH

At the University of Vermont Health Network - Elizabethtown Community Hospital (ECH), we engage with the patient and a designated "CARE partner" to ensure the delivery of high-quality care and a safe transition to home. A CARE partner is someone who can assist the patient throughout the hospital stay and at home. A CARE partner is an important resource for the patient's care.

Hospital staff support CARE partners by keeping them informed of patient progress and coordinating with them to develop a discharge plan. Often, care partners help identify the patient and family goals for a safe discharge.

For more information on CARE partners at ECH, please contact our discharge manager at (518) 873-3004.

https://www.ech.org/About-Us/

Commit

Describe your facility's data measures chosen for evaluation and ongoing monitoring of the Care Partner Program:

- This is difficult as the pandemic hit: I, myself, was keeping track of the family and care partner with writing them down. Once the pandemic hit, it has gone to the wayside **BUT,**
- One good thing that came out of the pandemic: the care partners were more engaged because they had to talk on the phone about the loved ones care.
- No visitors were allowed.

Questions?

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Thank you.

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Elizabethtown Community Hospital

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Claxton-Hepburn Medical Center

Care Partner Program

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Hospital demographics

Claxton-Hepburn Medical Center is a private, not-for-profit, 127-bed community hospital and regional referral center. Claxton-Hepburn includes 67 acute-care beds, a 10-bed intensive care unit, a 10-bed birthing center, a 28-bed adult mental health center, and a 12-bed children's mental health unit. The medical center provides primary care to nearly 40,000 residents of Ogdensburg and surrounding communities and regional services to the 108,000 people of St. Lawrence County.

Regional and countywide services include radiation and medical oncology provided by the Richard E. Winter Cancer Center, dialysis treatment provided by the Dr. Ravinder N. Agarwal Renal Center, the Rev. Thomas T. Patterson Wound Healing Center, and a state-of-the-art diagnostic imaging department.

Commit

Care Partner Team:

- Executive Sponsor - David Ferris, CNO-VP of Pt. Care Services
- Team Lead - Michael Beldock, Dir. of Case Management
- Multidisciplinary Team:
  - Maggie McKernan, Patient Relations
  - Roberta Taylor, Med/Surg Nurse Manager
  - MaryEllen Judware, Dir. of Patient Registration

Commit

Gathered staff and patient/care partner feedback from:

- Patient-Family Advisory Council
- Foundation Board of Directors
- Hospital Staff:
  - Nursing
  - Case Management
  - Patient Registration

Evaluated EQIC tools:

- Reviewed at Program meetings with team

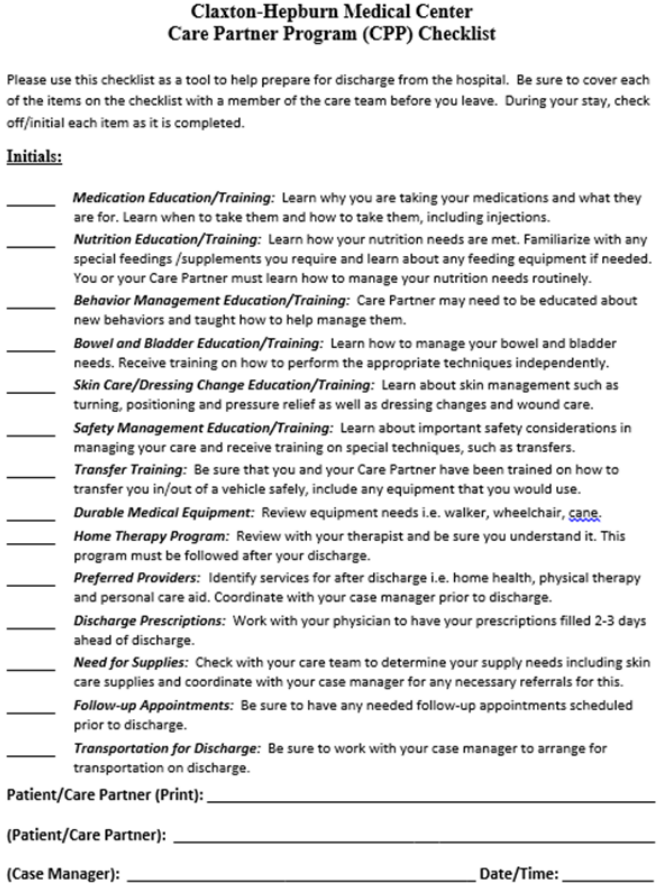
Commit

Staff Education

- EMR modifications to capture Care Partner
- Staff training/scripting
- Care Partner Access Code

Program Promotion

- Pamphlet created for patients
- EQIC posters and videos
- presented to Senior Management
- Staff feedback
- Discharge checklist



Claxton-Hepburn Medical Center
Care Partner Program (CPP) Checklist

Please use this checklist as a tool to help prepare for discharge from the hospital. Be sure to cover each of the items on the checklist with a member of the care team before you leave. During your stay, check off/initial each item as it is completed.

Initials:

_____ ***Medication Education/Training:*** Learn why you are taking your medications and what they are for. Learn when to take them and how to take them, including injections.

_____ ***Nutrition Education/Training:*** Learn how your nutrition needs are met. Familiarize with any special feedings /supplements you require and learn about any feeding equipment if needed. You or your Care Partner must learn how to manage your nutrition needs routinely.

_____ ***Behavior Management Education/Training:*** Care Partner may need to be educated about new behaviors and taught how to help manage them.

_____ ***Bowel and Bladder Education/Training:*** Learn how to manage your bowel and bladder needs. Receive training on how to perform the appropriate techniques independently.

_____ ***Skin Care/Dressing Change Education/Training:*** Learn about skin management such as turning, positioning and pressure relief as well as dressing changes and wound care.

_____ ***Safety Management Education/Training:*** Learn about important safety considerations in managing your care and receive training on special techniques, such as transfers.

_____ ***Transfer Training:*** Be sure that you and your Care Partner have been trained on how to transfer you in/out of a vehicle safely, include any equipment that you would use.

_____ ***Durable Medical Equipment:*** Review equipment needs i.e. walker, wheelchair, cane.

_____ ***Home Therapy Program:*** Review with your therapist and be sure you understand it. This program must be followed after your discharge.

_____ ***Preferred Providers:*** Identify services for after discharge i.e. home health, physical therapy and personal care aid. Coordinate with your case manager prior to discharge.

_____ ***Discharge Prescriptions:*** Work with your physician to have your prescriptions filled 2-3 days ahead of discharge.

_____ ***Need for Supplies:*** Check with your care team to determine your supply needs including skin care supplies and coordinate with your case manager for any necessary referrals for this.

_____ ***Follow-up Appointments:*** Be sure to have any needed follow-up appointments scheduled prior to discharge.

_____ ***Transportation for Discharge:*** Be sure to work with your case manager to arrange for transportation on discharge.

Patient/Care Partner (Print): _____

(Patient/Care Partner): _____

(Case Manager): _____ **Date/Time:** _____

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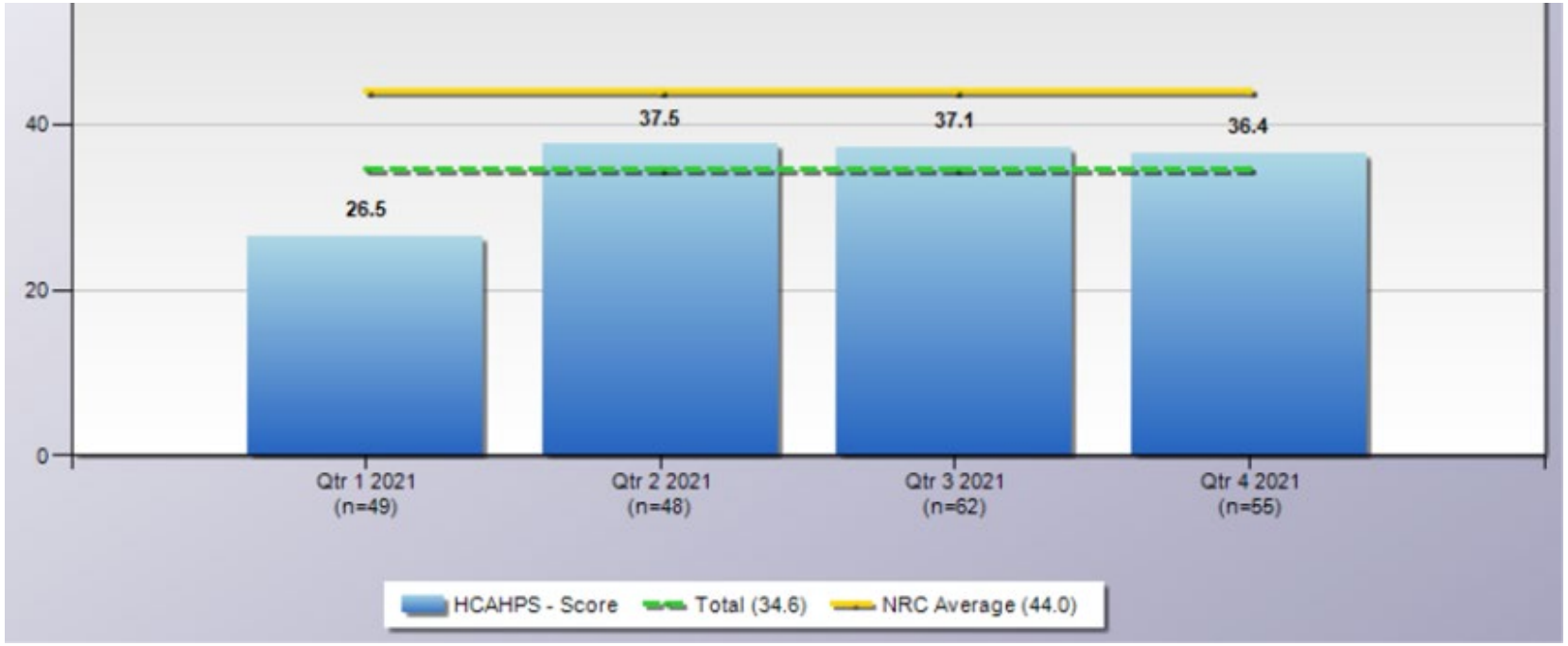
Commit

HCAHPS Care Transitions

"During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left."



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Questions?

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Thank you.

Michael Bedlock, Director of Case Management
Margaret McKernan, Patient Relations Coordinator

mmckernan@chmed.org

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CLAXTON · HEPBURN MEDICAL CENTER

Carteret Health Care

Care Partner Program

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Carteret HEALTH CARE

135 Bed, Not-for-Profit, community acute care facility providing care to the citizens of Carteret County and surrounding counties, as well as tourists from around the world.

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Commit

Carteret Health Care's Care Partner Team:

- **Executive Sponsor**: Patti Hudson, VP Patient Care Services
- **Team Leads**: Tonya Fluellen, Director of Regulatory, Accreditation & Patient Experience; Teresa Schray, Transitional Care Team Leader; Tasia Painter, Patient Advocate
- **Multidisciplinary Team**: Nursing Staff & Leadership, Organizational Development, Decision Support, Patient Access, IT, Physician Champion

Kim Maples, Megan Fischer, Pamela "Faith" Moore, Teresa Schray, Tonya Fluellen, Dawn Farrell-Harkins, Tasia Painter, Nicole Hall
Not Pictured: Kelly Marek, Kristie Richardson, Nina Miller, Cindy Payne, Kelly Cross, Dianne Cape, Dr. Bill Walker

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Commit

- Gathering feedback–Biweekly meetings
  - Brainstormed with bedside and multidisciplinary staff
    - Utilized our Organizational Development team to assist with organizing our direction to make the meetings focused and with clear goals (Monday.com)
  - Unable to work with PFAC due to COVID restrictions
- Adapting EQIC tools
  - Brochure
  - Posters
  - Videos

Commit

How we promoted the Care Partner Program internally

- Multiple Administrative meetings
  - Board Safety & Quality
  - Navigating to Excellence (N2E) Steering Committee
  - Quality Monitoring Committee
- Leadership Meetings
- Provider Meetings
- Updates with Executive Sponsor
- Departmental announcements

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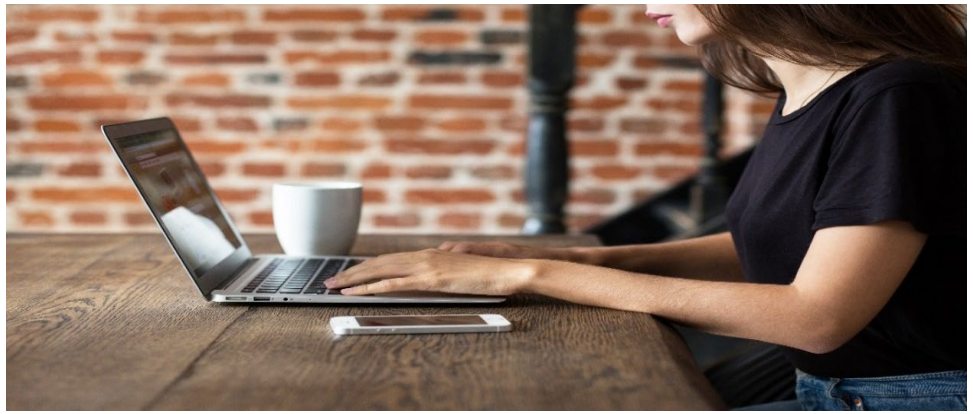
Commit

Educating the Hospital Team

- Presentations during April Department Staff Meetings
- Presentations during April Provider Meetings
- Information included in April Provider Newsletter
- Required computer training module for clinical nursing staff



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Commit: Data Selection

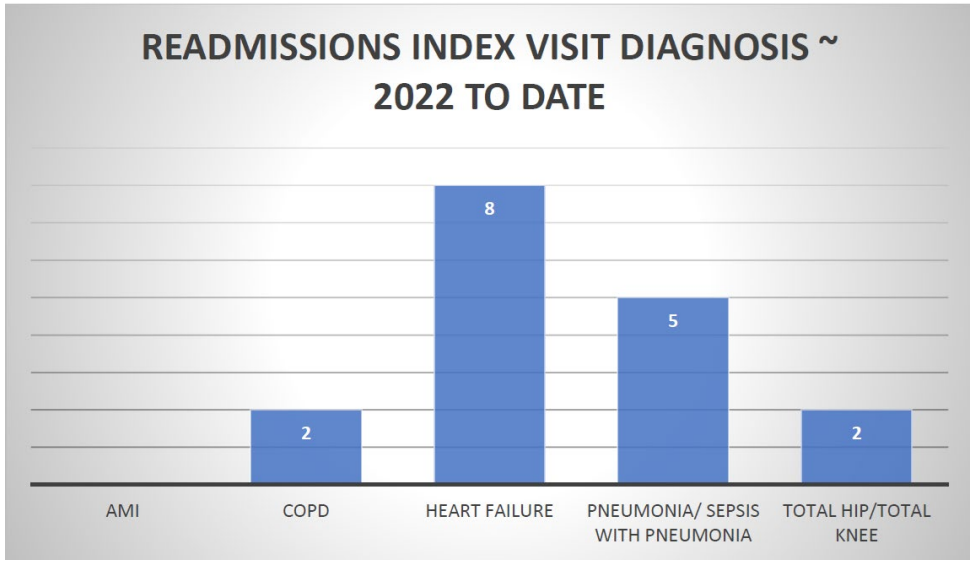
Readmissions Data

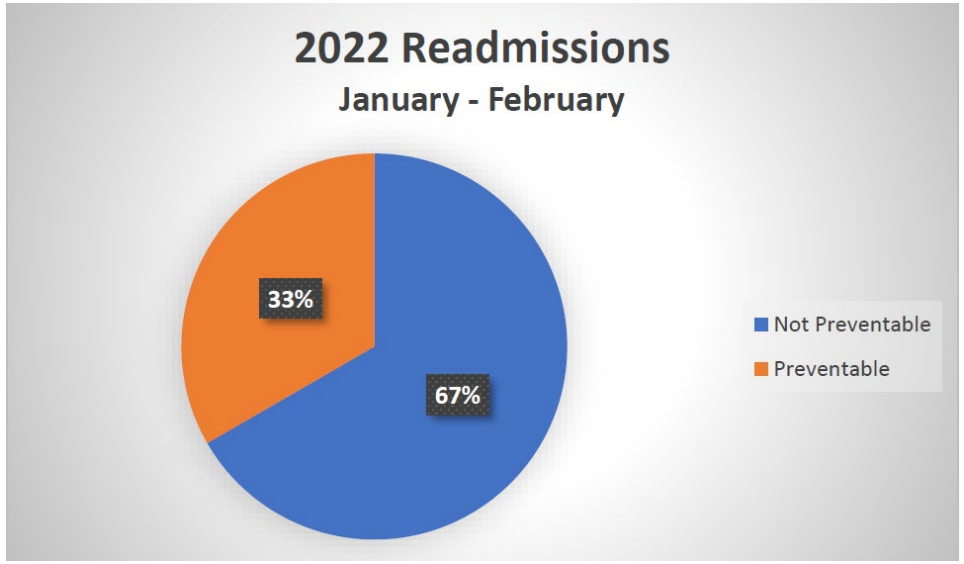
- Hospital-Wide Readmissions (internal, Medicare inpatients)
- EQIC readmissions data
- % of preventable readmissions
- % of readmitted patients with identified care partner

Patient Experience Data

- Communication with Nurses
- Communication with Physicians
- Discharge
- Care Transitions

Commit: Readmissions Data

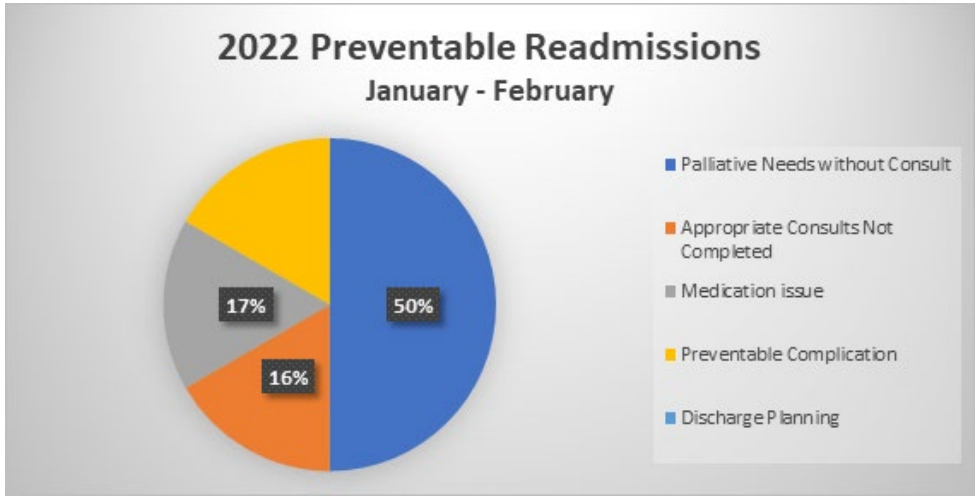




Not Preventable:
- ☐ Refused Services
- ☐ Other

Preventable:
- ☐ Discharge Planning
- ☐ Medication Issue
- ☐ Preventable Complication
- ☐ Palliative Needs without Consult
- ☐ Appropriate Consults Not Completed

- ☐ Patient Had A Care Partner



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Commit: Patient Experience Data

Questions	Top Box	n
*Nurses listen carefully to you	88.52	61
*Nurses expl in way you understand	86.67	60
*Doctors listen carefully to you	93.44	61
*Doctors expl in way you understand	90.00	60
*Staff talk about help when you left	94.74	57
*Info re symptoms/prob to look for	100.00	56
*Good understanding managing health	85.00	60
*Understood purpose of taking meds	96.08	51

*CAHPS

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Identify / Include / Prepare

The following slides from our staff education will cover implementation elements included in Identify, Include and Prepare

Computer-based training for all Clinical nurses

When will this program start and how will the program be formally introduced?

- The starting date for the Care Partner Program will be May 17, 2022.
- The Care Partner Program will be introduced through:
  - EQIC Care Partner posters throughout the hospital
  - CHC Marquee
  - CHC Website
  - Social media (i.e. CHC FACEBOOK page)

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Questions?

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Thank you.

Tonya Fluellen, MSN, RN, NE-BC

Director of Patient Experience, Regulatory and Accreditation

Carteret Health Care

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Work 499-8240 I Fax 808-6613 I tfluellen@CarteretHealth.org

Carteret HEALTH CARE

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Ellenville Regional Hospital

Care Partner Program

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ERH NY
Ellenville Regional Hospital

ERH Demographics

Ellenville Regional Hospital (ERH) is located in the Hudson Valley of upstate New York; in the rural community of Ellenville.

- ***Bed Capacity*** *– 25 Beds*
- ***Hospital Type*** *– Critical Access Hospital*

Commit

Care Partner Team

- **Executive sponsor** –
  Ashima Butler, COO and Maria Gonzalez, CNO

- **Team Lead –**
  Cathy Brooks, Manager, Case Management; Carol Schrowang, Director of Inpatient Services & Emily Swinden – Quality and Clinical Education Manager

- **Who is on the team (multidisciplinary team) –**
  Manager, Case Management; Director of Inpatient Services; Quality Manager; Hospitalist; Medical Director; RN and LPN

Why we do it?

- Nearly 20 percent of patients experience an adverse event within 30 days of discharge. Many of these complications can be attributed to:
  - Changes or discrepancies in medications before and after discharge.
  - Inadequate preparation for patient and family relative to medications, potential adverse effects, or lifestyle changes.
  - Disconnect between clinician information given and patient understanding.
  - Discontinuity between inpatient and outpatient providers.
- Engaging the patient and family in discharge planning can improve patient outcomes, reduce readmissions, and increase patient satisfaction!

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ERHNY
Ellenville Regional Hospital

ERH Education

- ERH educates all new staff on the “whys and how,” including a *Guide for Staff* handout.
- Staff are provided with a laminated card for badge attachment. The card defines “Care Partner,” and describes the role of a Care Partner.
- Changed “Admission Packet” to “Discharge Packet,” as discharge planning begins at Admission.
- ERH established a PFAC Committee.
- Case Management attends Nursing staff meetings to speak to the Care Partner Program and our performance.
- Promotion of the Care Partner Program on the local radio station.
- The Care Partner Program posters are displayed throughout the hospital and in patient rooms for viewing by patients and their families.

Letter to patients

Dear Patient:

Thank you for choosing Ellenville Regional Hospital as your hospital/rehab of choice for you and your family's healthcare needs. It is our mission at Ellenville Regional Hospital to provide patients with the highest quality of healthcare.

When you are admitted to Ellenville Regional you will be asked if you would like to designate a **Caregive**r, also known as a **Care Partner**. We recognize that taking care of yourself can be difficult at times, especially when you are sick. A Care Partner can be family, friends, neighbors, or paid help. They can assist you with daily activities such as dressing, shopping, medications, doctor appointments or cooking just to name a few. Care Partners can also help by providing information such as your medication list, health history, or home care needs to your healthcare team. Care Partners can also listen to the healthcare team for you, to ensure that you get the information that you need and understand. Once a Care Partner has been identified, they are an important member of your healthcare team. The Care Partner participates in that role in ways that are comfortable to the patient and the Care Partner.

Enclosed you will receive a "My Care Transition Plan" that both you and your Care Partner are encouraged to complete together that will help bring to light what assist you can anticipate needing when you are discharged to home. It is our hope that this process will help facilitate a seamless discharge to home.

Please accept our best wishes for your good health!

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ERHNY
Ellenville Regional Hospital

Identify

- Implemented a new initial nursing assessment section in the EMR to identify the Care Partner, and address ongoing communication and education. This is asked of all patients who are placed on Med-Surg, regardless of level of care.
- Case Management to follow up if the patient undecided or stated no.
- Identify (with patient's permission) the Care Partner's name and contact number on the patient white board.
- Staff are asked to note the Care Partner on the medical provider's white board.
- A "My Care Transition Plan" worksheet that provides an explanation of the Care Partner and their roles was developed and placed in the discharge packet.
- *Importance of a Care Partner* video placed on the ERH website for staff to play for patients and their Care Partners.

ERH Interventions

- Is the care partner invited to participate in huddles, rounding or shift-to-shift report? ERH experimented and trialed huddles, rounding and shift-to-shift reporting. Semi-successful pre-COVID; patient caregiver feedback that mornings too early and evenings too late.
- Does the care partner receive a daily update? Yes.
- How does that happen if the care partner isn't present at the bedside? By telephone and in-person as much as possible.
- How is the care partner encouraged to share questions and concerns? In person pre-COVID and through COVID, by email and by phone.

ERH Interventions

- Who is tasked with care partner communication on the team? Staff from multiple disciplines – Case Management and Nursing.
- Is the care partner included in goal setting? Yes.
- Does the care partner get included in educational opportunities using teach back, i.e. Meds/PT/OT/RT, nutrition? Yes.

Prepare

Weekly interdisciplinary meetings – Case Management, Nursing, Rehabilitation Services, Hospitalist, Pharmacist, Dietician with Patient and Caregiver

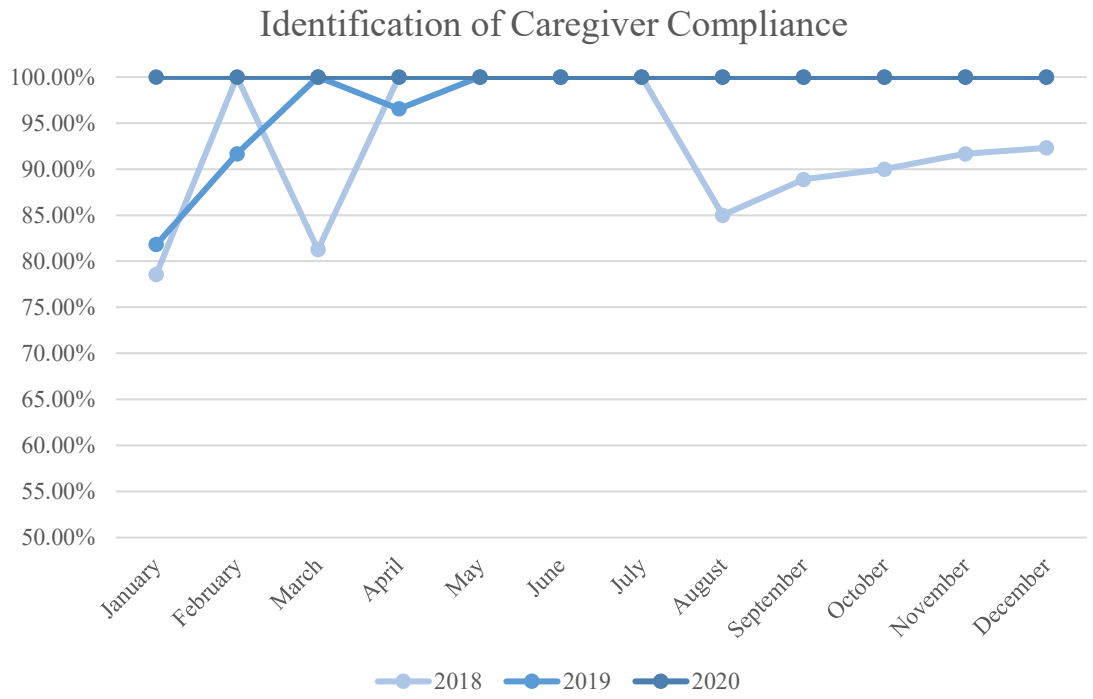
- Does the care partner participate in discharge planning and preparation? Yes.
- Are both the patient and care partner included in teaching using teach-back? Yes.
- Are the care partner and patient given written discharge instructions? Yes.

Prepare

- Do you include the care partner in the post-discharge follow-up call? This is in the next iteration as we rejuvenate the program.
- Does the care partner receive instructions on what to watch for, and who to call with questions or concerns? Yes.
- Is the care partner encouraged to share questions or concerns? Is there a tool used? Yes.

EMR has a caregiver note template for multidisciplinary staff to document all interactions with the team and caregiver.

ERH data



Identification of Caregiver Compliance			
	2018	2019	2020
January	78.57%	81.82%	100.00%
February	100.00%	91.67%	100.00%
March	81.25%	100.00%	100.00%
April	100.00%	96.55%	100.00%
May	100.00%	100.00%	100.00%
June	100.00%	100.00%	100.00%
July	100.00%	100.00%	100.00%
August	85.00%	100.00%	100.00%
September	88.89%	100.00%	100.00%
October	90.00%	100.00%	100.00%
November	91.67%	100.00%	100.00%
December	92.31%	100.00%	100.00%

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ERH NY
Ellenville Regional Hospital

Questions?

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ERH NY
Ellenville Regional Hospital

Thank you.

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ERH NY
Ellenville Regional Hospital

Canton-Potsdam Hospital

Care Partner Program

ST LAWRENCE HEALTH

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Hospital demographics

- *94-bed community hospital in the north country of NYS.*
- *Core programs include emergency medicine, acute care, hospitalist medicine, critical care, and a Level III Trauma Center.*
- *45 specialty care areas including orthopedic surgery, sports medicine, and center for cancer care.*

Commit

Canton-Potsdam Hospital CP Team

- *Executive sponsor - Lisa Oldham,CNO*
- *Team lead - Laura Kiely, Director of Nursing Operations*
- *Multidisciplinary CP team includes:*
  - *Case Management*
  - *Social Workers*
  - *Hospitalists*
  - *RN Staff Champion*
  - *Patient Experience*
  - *Nursing Education*
  - *Patient Access*
  - *Quality and Risk Management*
  - *PPM*

Commit

- *Implemented the Care Partner program in 2019 with guidance from the care act regulation, Planetree, and NYSPFP*
- *Included staff and patient advisor feedback*
  - *PFAC monthly meetings - presented the care partner program and asked for input and suggestions*
  - *Staff - communication provided via email, walking rounds, staff meetings*

Identify

- *During the admission assessment process, the patient is asked if they want to identify a care partner.*
- *CP name and contact information is documented in the EMR admission assessment.*
- *CP information is also shared with the healthcare team during shift report and interdisciplinary rounds.*
- *During early adoption, blue-colored CP bracelets were used to identify the CP to our team and also as identification to provide the CP a complimentary fountain drink from our cafeteria – seemed to be a good idea, however, not successful.*

Welcome packet

St. Lawrence Health System
Canton-Potsdam Hospital

The Patient and Care Partner Guide to Your Hospital Stay

Table of Contents

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CP vs. other roles - requires education

Quality, Patient-Centered Care

St. Lawrence Health System (SLHS) is committed to providing the highest quality, patient-centered care through the right combination of medical expertise, leading edge technology, and a commitment to humanity.

At the heart of SLHS is our commitment to our patients. This commitment to patient-centered, family-focused care is at the core of everything we do. Highly-skilled providers, state-of-the-art technology, and a professional staff of caregivers are in place to ensure you and your family receive treatment in a caring, respectful, and nurturing environment.

The difference between a Care Partner, Health Care Proxy, and Power of Attorney.

There are various ways in which loved ones can support a patient; however, the difference in what each role entails can become confusing at times. The following definitions may better help you determine which situation best meets your needs.

- **Health Care Proxy (HCP):** An agent who is designated by the patient to legally make healthcare decisions on behalf of the patient when he/she is incapable of making and executing the healthcare decisions. A Health Care Proxy form must be completed, signed, and provided to medical records.
- **Power of Attorney (POA):** An agent who is granted authority by an individual on Power of Attorney documents to act for him/her in specified or all **legal** or **financial** matters. This does not grant authority for medical decisions.
- **Care Partners:** A Care Partner may be a spouse, family member, or friend who is identified by the patient as a person who helps support his/her care and well-being. A Care Partner can be someone other than the Health Care Proxy agent. It is someone the patient and partner mutually decide will be able to provide support and care during a hospital stay, and throughout the duration of care.

The SLHS Care Partner Program

St. Lawrence Health System
Canton-Potsdam Hospital

50 Leroy Street
Potsdam, NY 13676
(315) 265-3300
StLawrenceHealthSystem.org

Include

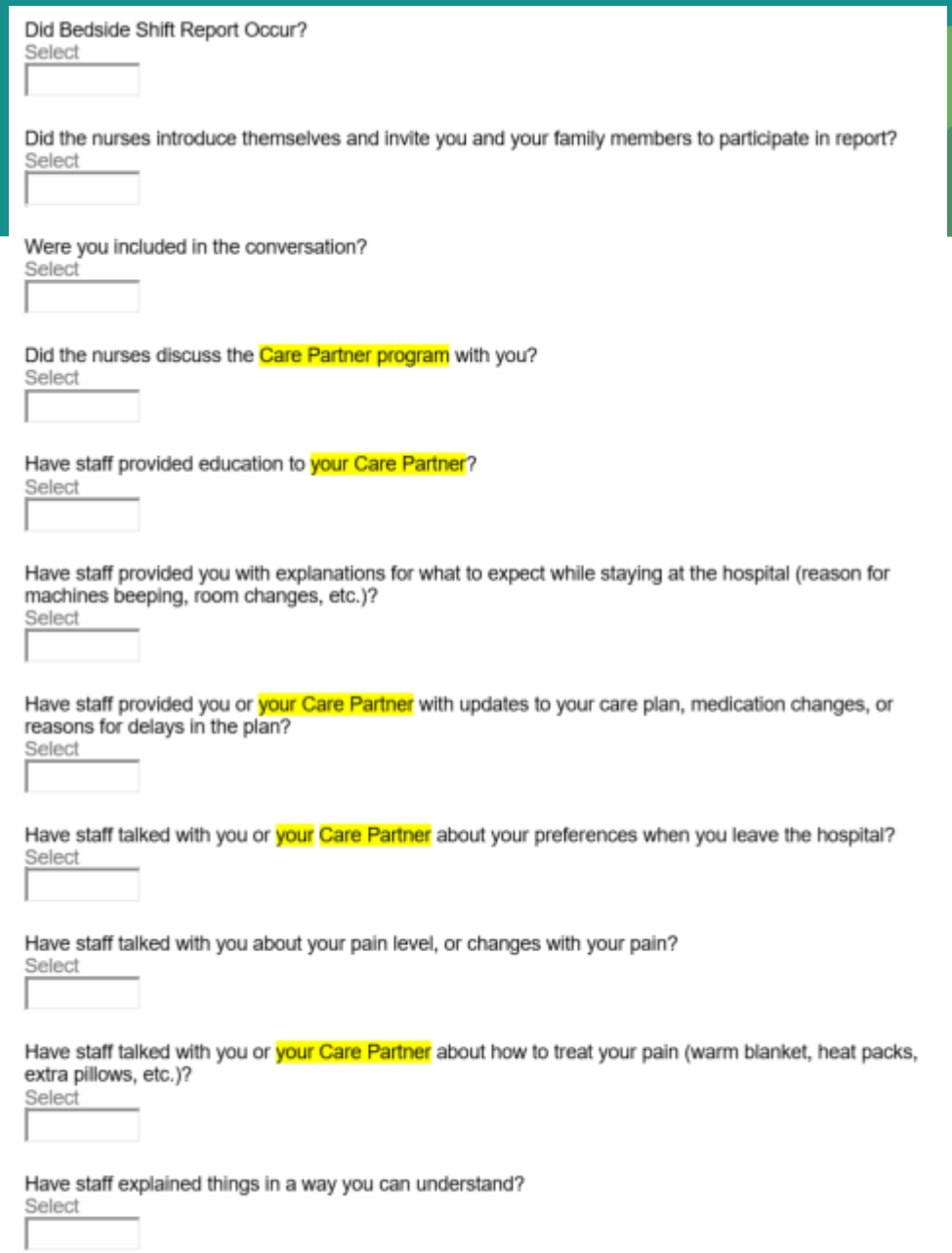
- *We included care partners in: interdisciplinary rounds, bedside shift report, daily care planning, and discharge planning.*

  - *CP is encouraged to participate in interdisciplinary rounds including goal setting*
  - *A note pad is provided to the CP to write down any questions or concerns*
  - *Staff ask the care partner if there are any questions or concerns while rounding*
  - *Communication with the CP during rounds is an interdisciplinary task (e.g., provider, nurse, case manager, social worker) depending the issue or situation*
  - *If not at the bedside, the provider or the nurse calls the CP*

  - ***CPH PFAC** approved the drafts of the rounding questions, brochure, and bracelet before they were finalized*

Communication bundle

- *Use as a rounding tool*
- Completed by leadership or a member of the patient experience team
- Data used to gauge success of implementation
- Comments stating the patients don't know the CP program:
  - revisit with staff barriers and if changes are needed in how we present the information; or
  - if more education is needed for staff.



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Prepare

- *CP participates in discharge planning and preparation*
  - *Both the patient and CP are included in teaching, including what to watch for, and who to call with questions or concerns*
  - *CP is encouraged to share questions or concerns*
- *One set of instructions is given to the patient*
- *The CP is not routinely included in the post-discharge follow-up call*

CP adaptation during COVID and continuing forward

- *Our care partner program started to look different during and since COVID*
  - *IDRs were suspended, visitation was suspended or limited for all patients.*
  - *We continued communicating to care partners and family members via face time and phone calls. We did allow in-person meetings with family/care partners and providers or case managers when necessary.*
- *We are interested in re-energizing our care partner program now that our COVID admissions are on a downward trend*
  - *Our visitation hours have resumed, and we are transitioning from a designated "airborne precaution unit" to a mixed unit. This transition will increase upon our efficiencies in providing quality, safe care by allowing support persons and care partners to be present more often.*
  - *EQIC Sprint participation*

Thank you.

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Questions

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Thank you.

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