

Readmission Care Partnersprint

Include: Care partner is a member
of the healthcare team

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Care Partner Framework

Step 3: Include

Check-in . . . How are you doing?

Step 1: Commit

- ✓ Hospital committed to becoming a Care Partner Hospital
- ✓ Broadly advertising and educating on the program
- ✓ Assessed current status and the who, what, why and when of implementation
- ✓ Developed a high-level process for implementation and began small steps of change

Step 2: Identify

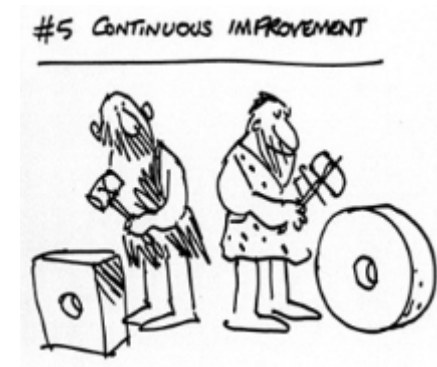
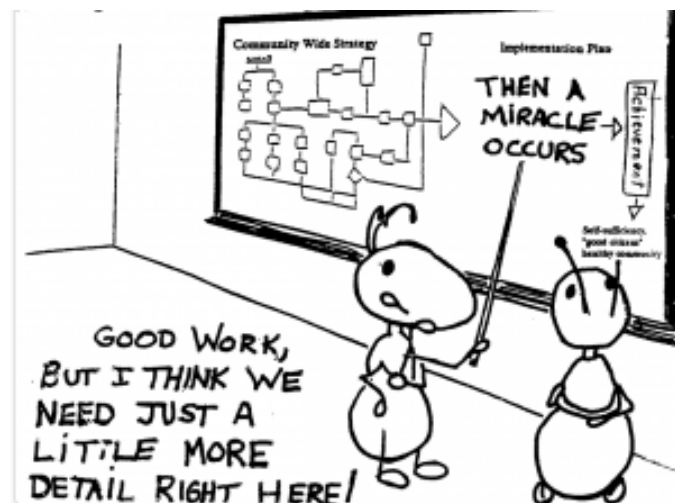
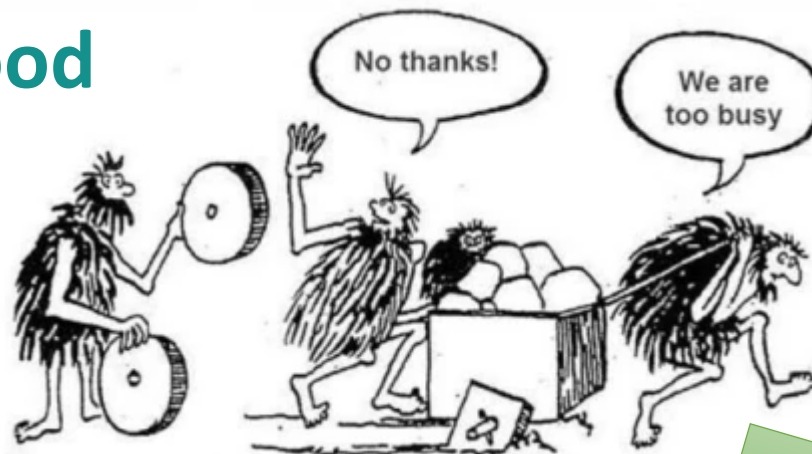
- ✓ Continuing to broadly advertise and educate on the program
- ✓ Implemented patient-designated care partners
- ✓ Care partners are visible: in the EHR, on the white boards, using something like badges or wristbands
- ✓ Measuring compliance with this cycle of change

Care partner implementation

Hospital Cadence - Understood



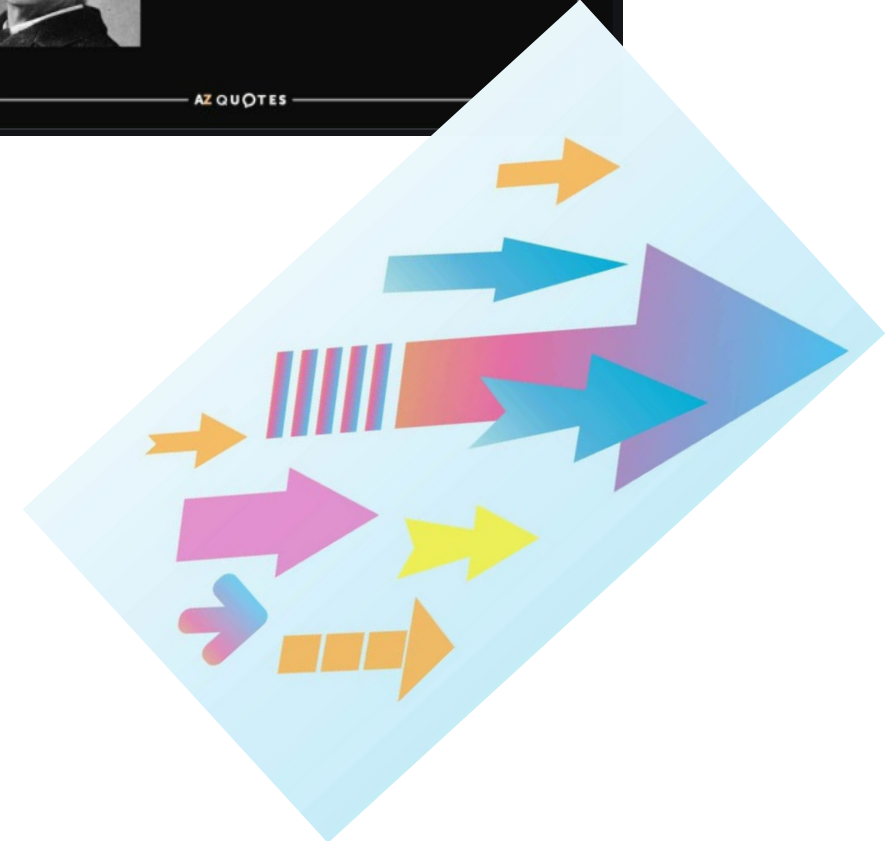
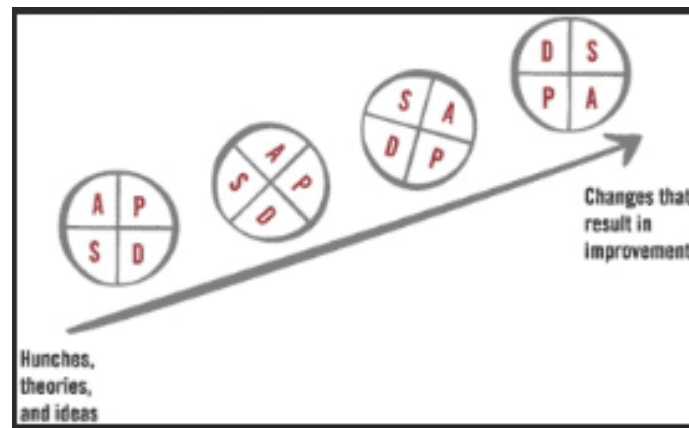
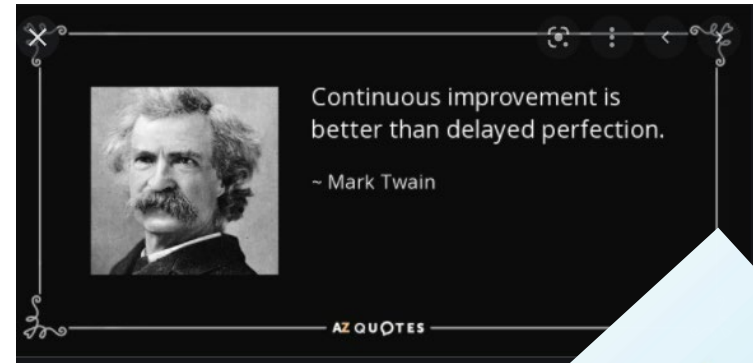
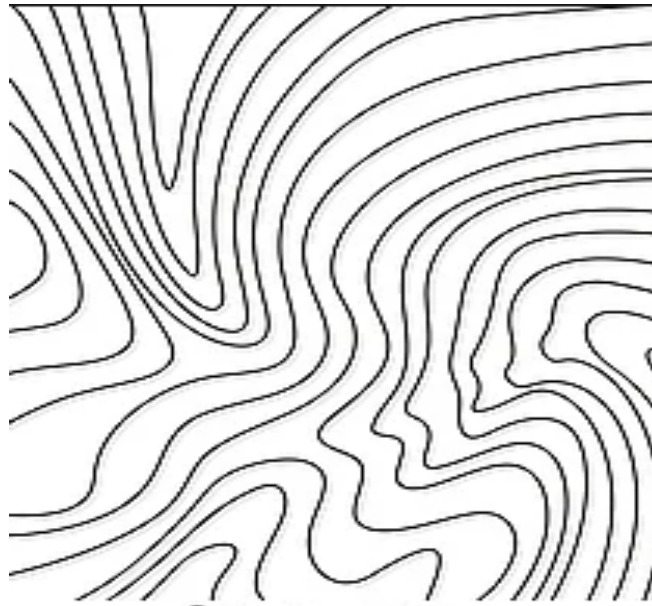
"That's how the clinical team decides which regulations they will follow."



Care partner implementation



Cadence



Michelle Van De Graaff RN, BSN



Michelle Van De Graaff received her BSN from Brigham Young University. She has worked with acute care cardiac patients for 34 years and is the Practice Chair on the Acute Cardiovascular Unit at Intermountain Medical Center. She also sits on the hospital, regional and corporate Nurse Practice Councils, as well as the Systemwide Nursing Research Council for Intermountain. She served for two years in the Peace Corps in the Republic of Kiribati. She is the creator of *Partners in Healing®* in response to a challenge to improve patient care. For twelve years, she has promoted and facilitated the program on a unit, hospital and 23-hospital system-wide basis. Subsequently, she led a research team to learn how the program impacted patient outcomes.

Continue education and awareness

What is a care partner?

Today's Date: _____

Select Specialty Hospital

Our goal is to provide exceptional care at all times.

Room# _____ **Phone #** _____ **Diet** _____

Your Care Team

Charge Nurse _____ Case Manager _____

Nurse _____ Physician _____

Nursing Assistant _____ Family Contact Name & Number _____

Your Plan of Care

What is Important to Me: _____ Today's Goal(s) or Plan: _____

Medication

Last Dose _____ Next Available Dose _____

Pain Goal

0 1 2 3 4 5 6 7 8 9 10

0 No Pain 1 Slight Pain 2 Moderate Pain 3 Severe Pain 4 Worst Pain

CAUTION: Please Call Do Not Fall!

Safety Alerts

Remember to wash them! Hand-washing stops the spread of germs

Fall Risk Do not get out of bed without assistance

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WHAT IS A CARE PARTNER?



FOR PATIENTS:
Why do I need one?

FOR CARE PARTNERS:
What do I do now?

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.

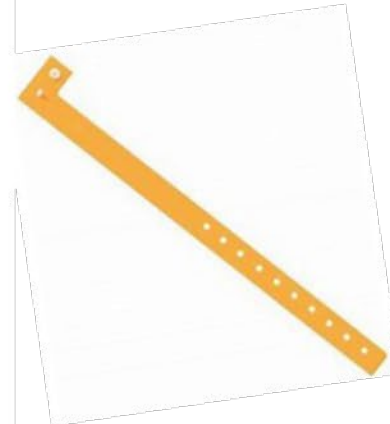
Both the person you select and the hospital staff should know that they are your care partner. Once the hospital staff know who you have selected, they will ensure that your care partner is aware of any changes in the treatment plan and include your care partner in conversations with you regarding your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



Continue education and awareness

Consider social media for public





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®.

Social Media Shareables

Myths and Realities:

In reality families, friends, and caregivers help ensure patients recover by bridging the gap from hospital to home. To learn more about engaging care partners to prevent readmissions, visit nyspfp.org/readmissions

In reality, families, friends, and caregivers are Care Partners - important members of the health care team bridging the gap from hospital to home. To learn more about engaging care partners, visit nyspfp.org/readmissions

MYTHS & REALITIES

CARE PARTNERS IN THE HOSPITAL

✗ Interfere with care

✗ Exhaust the patient

✗ Spread infection

✓ Support more consistent care

✓ Improve patient experience

✓ Promote a safer environment





Learn more about it at
www.nyspfp.org

Insert Logo Here

Benefits:

Hospitals serious about improving quality view families, friends and caregivers as Care Partners - important members of the health care team! To find out more about the benefits of adopting a Care Partner program, visit nyspfp.org/readmissions

Everyone benefits when families, friends and caregivers are included as important members of the health care team. Find out how to become a Care Partner hospital visit nyspfp.org/readmissions.

BENEFITS

OF A CARE PARTNER PROGRAM

• Improved patient experience

• Reduced hospital readmissions

• Improved care partner health and wellness

• Safer environment of care

• Reduced time responding to non-emergent requests

• Improved pain management





Learn more about it at
www.nyspfp.org

Framework:

The New York State Partnership for Patients developed an innovative and evidence approach called the Care Partner Framework. To adopt the framework in your hospital visit nyspfp@nyspfp.org.



Essence of Include



- Care partner orientation: to the role, to the unit, to the team
 - Consider brochures, hand-outs, badges/wristbands, etc.
 - Provide unit and staff contact information, as well as ensure you have their phone, email and other contact information.
 - As designated, educate the care partner on using the white board, linen room, kitchen or nutritional items or drinks, family lounge, etc.
 - Huddle time, rounds, meal times, shift reports, etc. and when established, therapy and consultant (nutritionist) times.
- Establish the care partner's preferred communication method
 - Phone, email, white board, preferred language/translator.
 - For huddles, rounds, participation in education, etc.
 - More than one method is fine, especially to ensure their participation in education and teach-back.
 - Scheduled calls or care partner meetings.
- Establish a welcoming and compassionate culture from the start
 - Consider an actual invitation to key items (listed above) on admission.

Care Partner Implementation Guide

Care partner participation

- Include in admission assessments, daily assessments.
- Empower them to **access** unit resources (blankets, ice, etc.).
- Talk about specific opportunities for involvement and general themes:
 - present (can be in person or by phone);
 - invite to all opportunities;
 - should feel comfortable advocating for the patient
 - provide insight or information;
 - share observations;
 - participate in all education, formal and just-in-time; and
 - practice patient care while in the hospital.



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/Tools/Tools/SMART/Discharge/SMART%20Discharge%20Protocol.pdf>
(revised August 20, 2021)

What do you see with a successful care partner program?



- Operationalize – make inclusion the hospital the norm!
- Develop the program from the patient and care partner's "eyes" or how would you want to be included in your loved one's care.
- Nursing, and perhaps unit-specific approaches, should be utilized based on rounds, staffing patterns and other unit practices:
 - rounds or huddles;
 - one essential contact a day approach; or
 - nursing education.
- Work with key departments to set up their approaches and options for the patients and care partners to participate in teaching:
 - physical therapy, occupational therapy, speech therapy;
 - respiratory therapy;
 - nutrition, dietician or CDE;
 - pharmacy; and
 - discharge planning/case management or social work.
- All those areas should "include" spots for documentation of this on their daily care plans or sessions (pre and post intervention).

Each unit or department needs to discuss their process for including the care partner

- If the care partner cannot be present at the bedside or at the visit, how will you ensure the care partner is included?
 - Ideal to teach and communicate with them together: what technology does your hospital have available for telecommunication? iPad, phones, facetime, etc.).
 - Regular telephone can work, ensuring they can hear and we check in on them for questions.
 - Make special appointment for bedside education if there are specific treatments that need to be taught (insulin injection, use of equipment, continue PT exercises, etc.)
 - Use teach-back with care partners as well.
- Keep patient-centered care a top priority, understand how they will want to manage at home.
- Have internal hospital approval and documentation system if care partners can do certain treatments or protocols independently.
- Let care partner know the signs or symptoms of the more common harm events and what to do if they occur.

Include

.....use *Checklist for Frontline Staff*

Use as a guide or for a check and balance



Care Partner Program Checklist for Frontline Staff



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 lab/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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https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/NYSPFP_CarePartner_FLChecklist.pdf

Get care partner involved...



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
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E Educate me about my home care needs

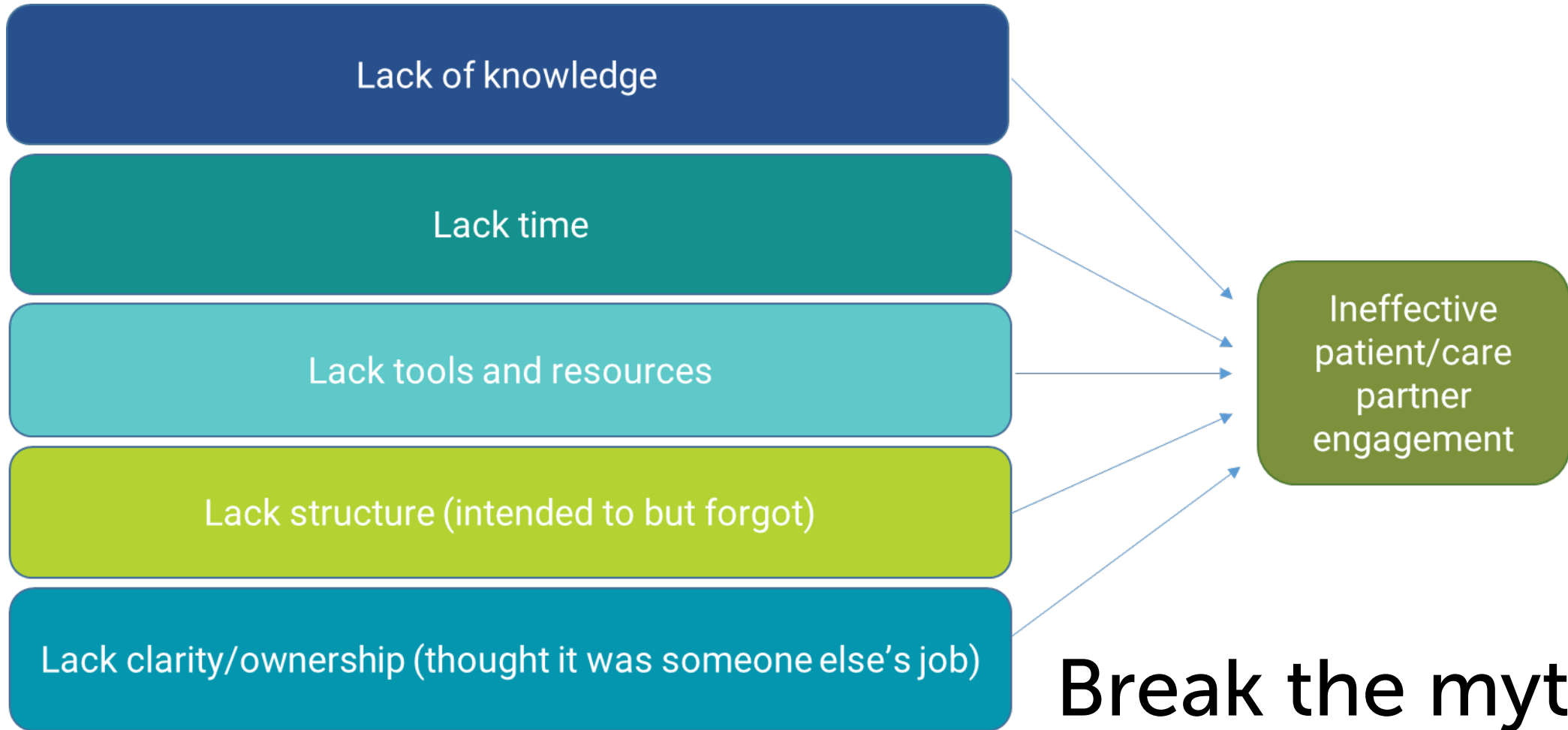
"SMART Discharge Protocol," The Institute for Healthcare Improvement.
<http://www.ihl.org/resources/Pages/Tools/SMARTDischargeProtocol.aspx>
 (accessed August 20, 2021).

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			

Typical reasons staff don't engage care partners



Break the myths!!

Care partner in readmission reduction

- *Promote care partner as the patient navigator through participation in:*
 - Readmission risk assessment
 - Medication reconciliation: admission/prior to discharge/post discharge
 - Education on high risk medication management
 - Bedside rounds/shift to shift huddle communication and planning
 - Use of white boards: care partner contact info and *tentative discharge day*
 - Decision making-goal setting
 - What can the patient and care partner do at home, etc.
 - Self management teaching
 - Practice during hospitalizations, treatments, therapies, etc.
 - Discharge planning
 - Post-discharge care plan with patient and care partner
 - Post-discharge follow up and care coordination
 - Speak to both patient and care partner on follow-up phone call
 - Temporarily or intermittently ask about care partner satisfaction on the follow-up telephone call

Thank you.

Readmission reduction care partner sprint team

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Your hospital project manager



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