# *Readmission Care Partner* sprint

## Include: Care partner is a member of the healthcare team

November 18, 2021


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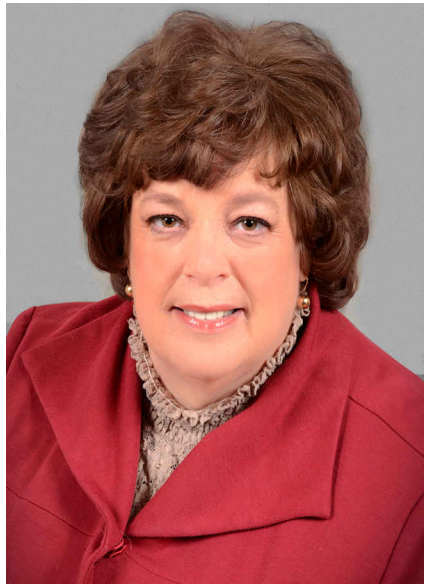
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

# Today's faculty



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# Care Partner Framework
# Step 3: Include

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# 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

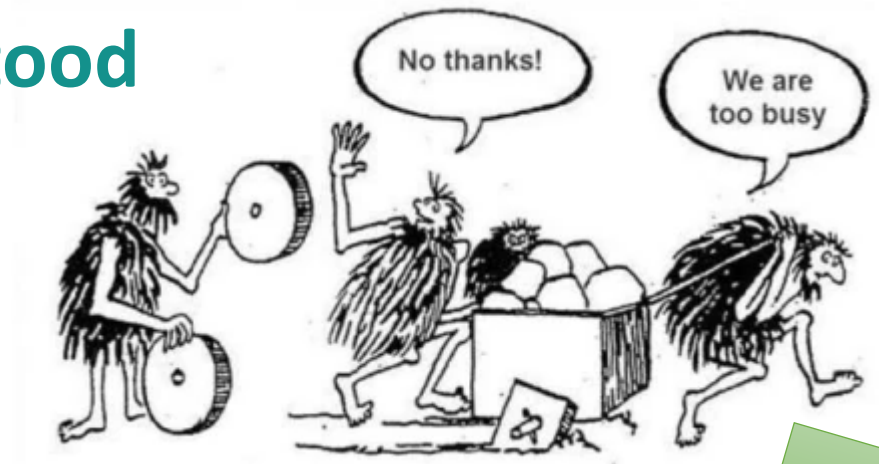
## Step 2: Identify

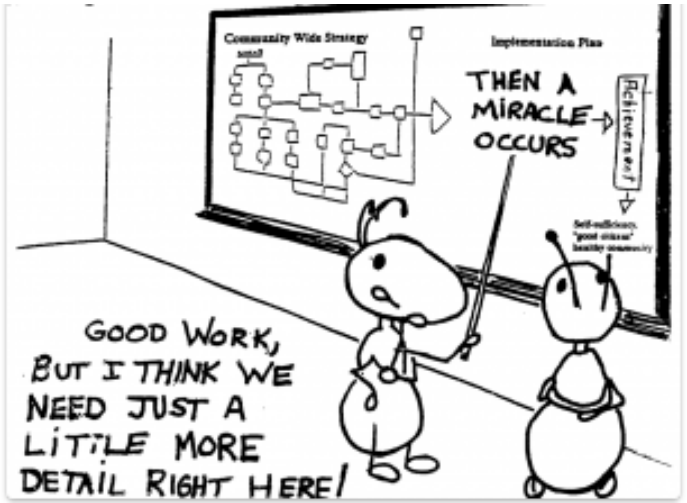
- ✓Continuing to broadly advertise and educate on the program
- ✓Implemented patient-designated care partners
- ✓Care partners are visible: in the EHR, on the white boards, using something like badges or wristbands
- ✓Measuring compliance with this cycle of change

# Care partner implementation

## Hospital Cadence - Understood


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





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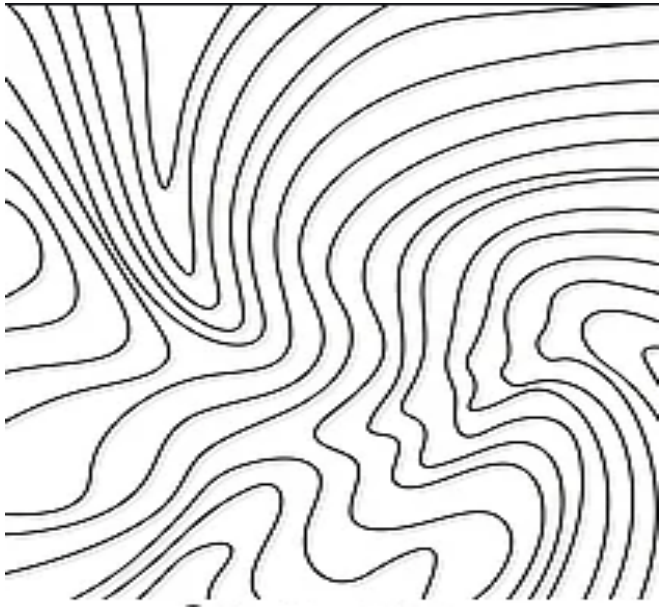
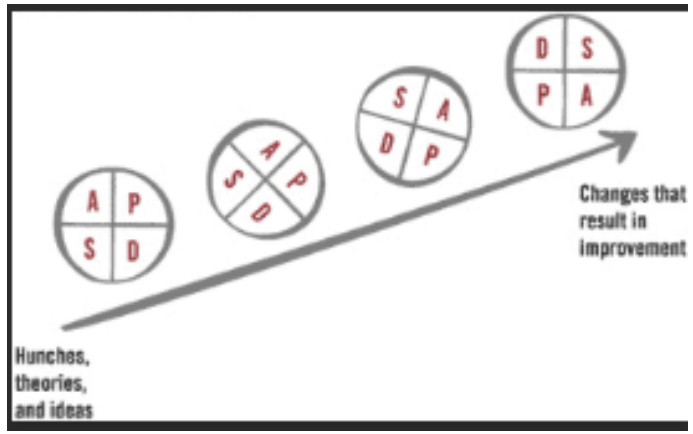
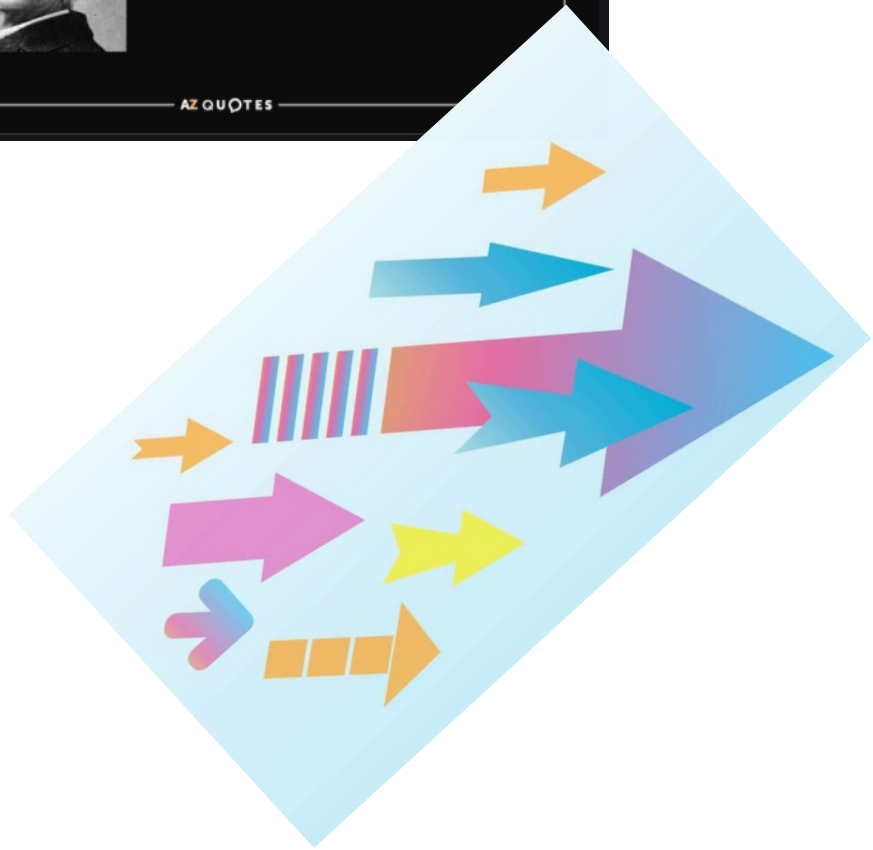
# Care partner implementation

## Cadence







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# 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.

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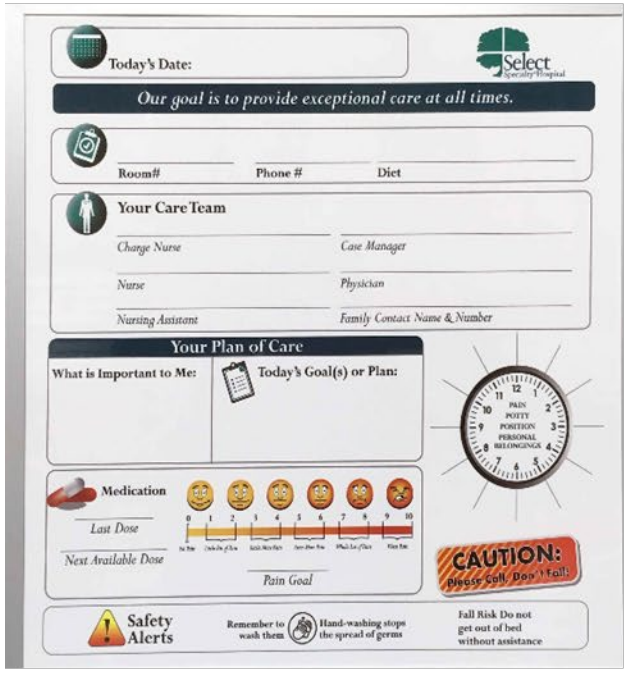
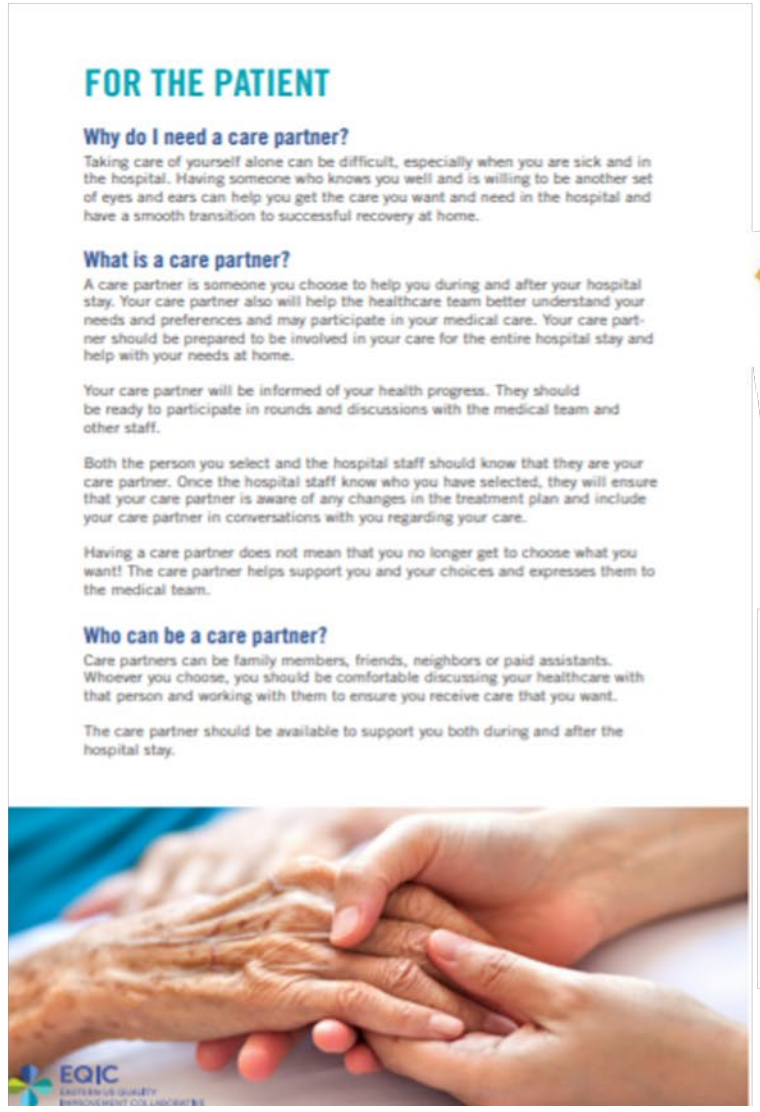
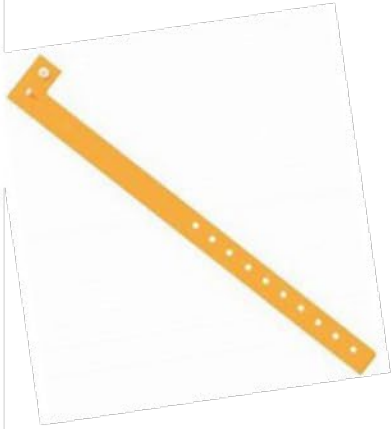
# Continue education and awareness
# What is a care partner?





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# Continue education and awareness
# Consider social media for public


## 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


**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.


**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 hosp 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/Pages/Tools/SMARTDischargeProtocol.aspx (accessed August 20, 2021).

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# 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

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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<br>✓ upon registration or admission to the emergency department or nursing care unit |
| Document care partner information | ✓ in EMR<br>✓ on whiteboard<br>✓ 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<br>✓ 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<br>✓ *What is a Care Partner?* brochure |
| Invite care partner to participate in meaningful interactions | ✓ admission assessment<br>✓ medical and medication history<br>✓ readmission risk assessment<br>✓ daily huddle or rounding |
| Empower care partner to perform simple tasks as defined by hospital | ✓ use of whiteboards<br>✓ care plan and goals of care<br>✓ 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<br>✓ address any concerns identified |
| **Prepare care partner** for post-hospital care | ✓ assess using teach-back to ensure patient and care partner understand:<br>• disease knowledge and management;<br>• proper medication administration and storage;<br>• safety interventions;<br>• food intake/nutrition;<br>✓ signs and symptoms of worsening disease and what to do:<br>• how to assist patient in self-management;<br>• who to call;<br>• where to go; and<br>✓ 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<br>✓ 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<br>✓ review what will be covered on the call with patient and care partner, such as:<br>• check labs/test follow up;<br>• check medication adherence;<br>• clarify follow-up appointment dates and times; and<br>• verify patient has received home care and durable medical services. |

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|---|---|
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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
**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).

| | 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 | | | |

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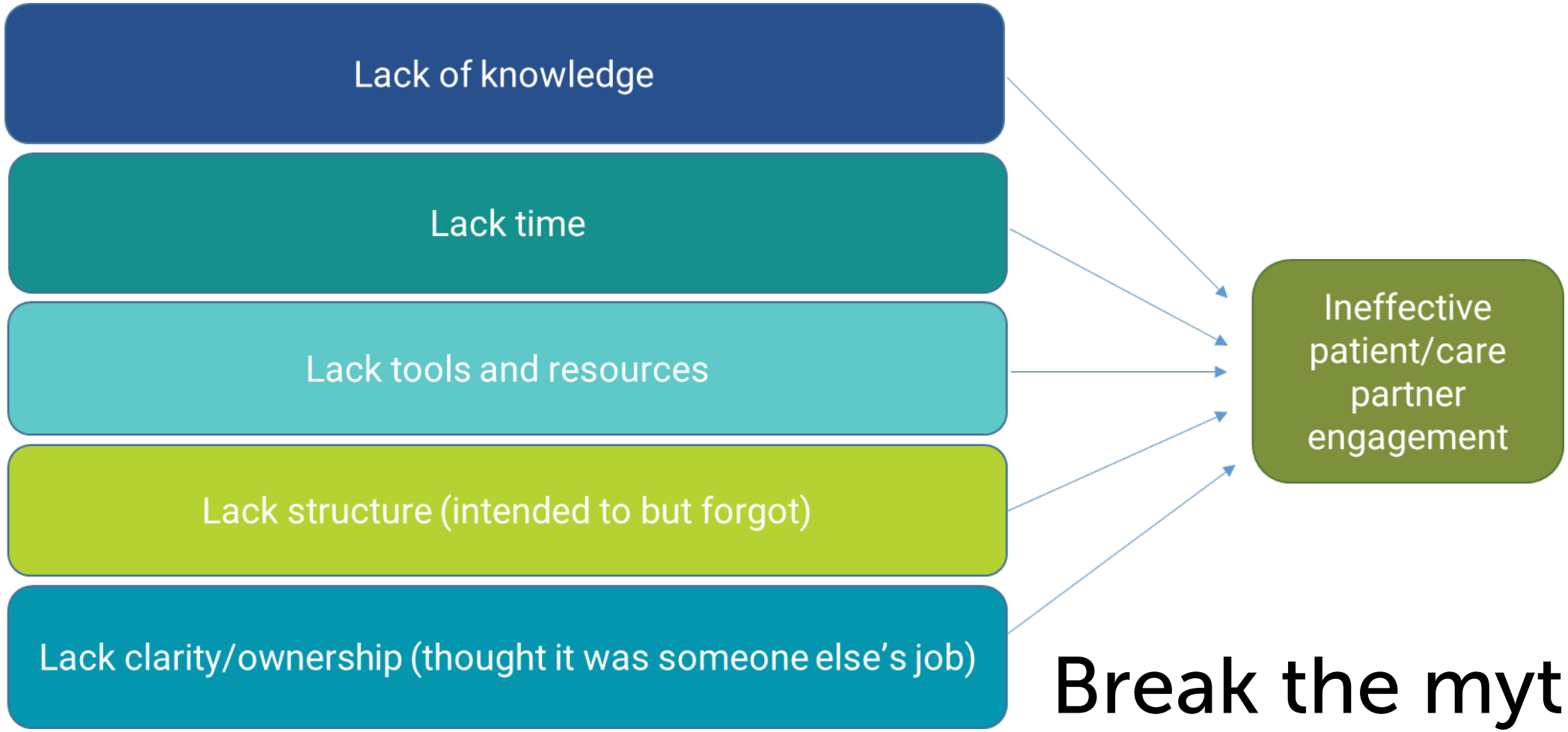
https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/NYSPFP_MyCareTransBrochure.docx

# Typical reasons staff don't engage care partners




Break the myths!!

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# 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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