

# Care Partner Program

---

## CNO, CMO and Executive Huddle



**EQIC**  
EASTERN US QUALITY  
IMPROVEMENT COLLABORATIVE

# Care partner program



Making a commitment to a care partner program entails a formalized process that facilitates and establishes best practices for patient, family and care partner engagement and care delivery.

Support (commitment) from hospital leadership, including the chief nursing officer, chief medical officer, chief executive officer, chief operating officer and board of trustees is essential for implementing and enhancing a care partner program, as it must be promoted as a culture or “way of life” for the entire institution.

Your organization will be a Care Partner hospital.

# What is a care partner?

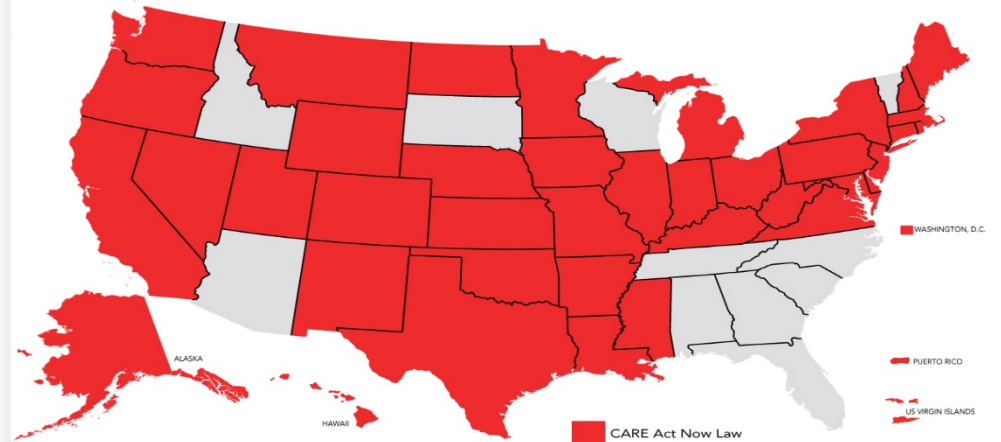
A care partner is someone the patient chooses to help them during and after the hospital stay. The care partner also can help the healthcare team to better understand the patient's needs and preferences and may also participate in the patient's medical care and treatments.

Care partners can be family members, friends, neighbors or paid assistants. The care partner should be available to support the patient both during and after the hospital stay.

Parts of the program are very aligned with many state's CARE ACT promoted by AARP.

## The Caregiver Advise, Record, Enable (CARE) Act

The CARE Act is a commonsense solution that supports family caregivers when their loved ones go into the hospital, and provides for instruction on the medical tasks they will need to perform when their loved ones return home.



**CARE Act goes into effect:**  
Alaska, 1/1/17; Arkansas, 7/22/15; California, 1/1/16; Colorado, 5/8/15; Connecticut, 10/1/15; Delaware, 1/1/17; Hawaii, 7/1/17; Illinois, 1/27/16; Indiana, 1/1/16; Iowa, 7/1/19; Kansas, 7/1/18; Kentucky, 6/29/17; Louisiana, 8/1/16; Maine, 10/15/15; Maryland, 10/1/16; Massachusetts, 11/8/17; Michigan, 7/12/16; Minnesota, 1/1/17; Mississippi, 7/1/15; Missouri, 8/28/18; Montana, 10/1/17; Nebraska, 3/30/16; Nevada, 10/1/15; New Hampshire, 1/1/16; New Jersey, 5/12/15; New Mexico, 6/17/15; New York, 4/23/16; North Dakota, 8/1/19; Ohio, 3/21/17; Oklahoma, 11/5/14; Oregon, 1/1/16; Pennsylvania, 4/20/17; Puerto Rico, 12/31/15; Rhode Island, 3/14/17; Texas, 5/26/17; Utah, 2/10/16; Virgin Islands, 3/30/16; Virginia, 7/1/15; Washington, 6/9/16; Washington, DC, 7/6/16; West Virginia, 6/8/15; Wyoming, 7/1/16.

Updated on 4/10/19

I Caregivers Real Possibilities

# What is a care partner program?

This journey is transformational.

Key Elements are:

- *Identifying* the care partner pre-admission or upon admission.
- *Including* the care partner in all activities during the hospital stay.
- *Preparing* the care partner and the patient for post-discharge care.

The Care Partner Program

- Concrete steps for real changes in patient-centered care.
- Provides ways that the process impacts patient and healthcare team *communication* throughout the hospitalization.
- Tasks translate into compassionate care.

*Beyond compliance to high value care*

# Hospital priorities and goals

- ✓ Clinical quality
- ✓ Patient safety
- ✓ HCAHPS
- ✓ Reduce readmissions
- ✓ Decrease length of stay
- ✓ Value-based contracting payment
- ✓ External community reputation
- ✓ Clinician workforce satisfaction
- ✓ Deliver care with health equity
- ✓ Culture of safety and service excellence



# 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 and accepts mutually-agreed upon patient care responsibilities during and between episodes of care.*
- **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.*

# Experiential – Medical centers



## University of Pittsburgh Pennsylvania

- Caregiver integration during discharge planning for older adults to reduce resource use: A meta-analysis
  - University of Pittsburgh, Pennsylvania
  - Discharge planning interventions with care partner integration were associated with 25% fewer readmissions at 90 days

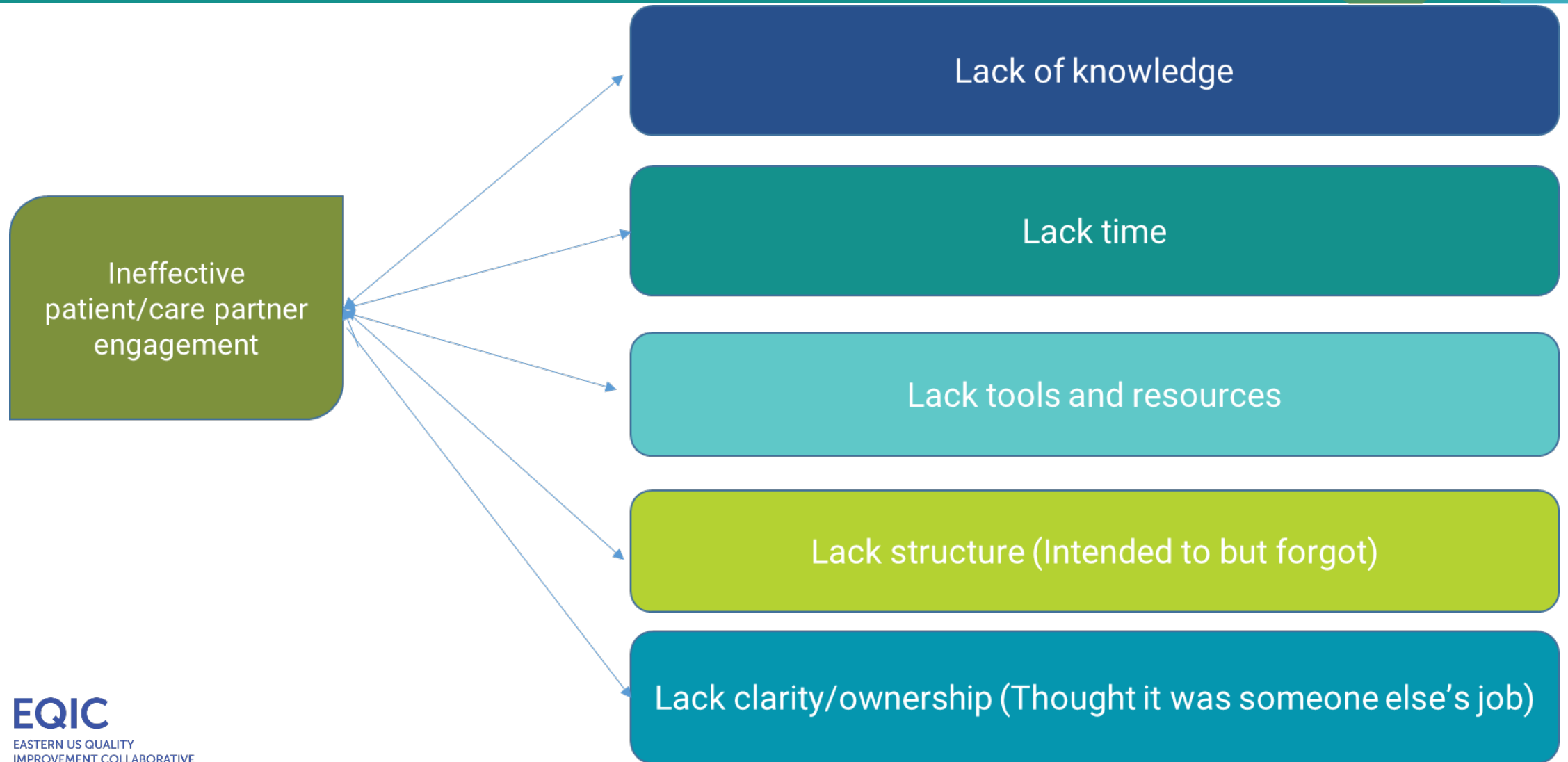
<https://pubmed.ncbi.nlm.nih.gov/28369687/>

## Intermountain Healthcare Partners In Healing®

- Clinical outcomes study
  - 465 patients, 200 matched with control patients by surgery, age, attending, time
  - A 2-sided  $p < 0.5$  was considered statistically significant with a study  $p = 0.003$
  - 65% reduction in 30-day all-cause readmissions

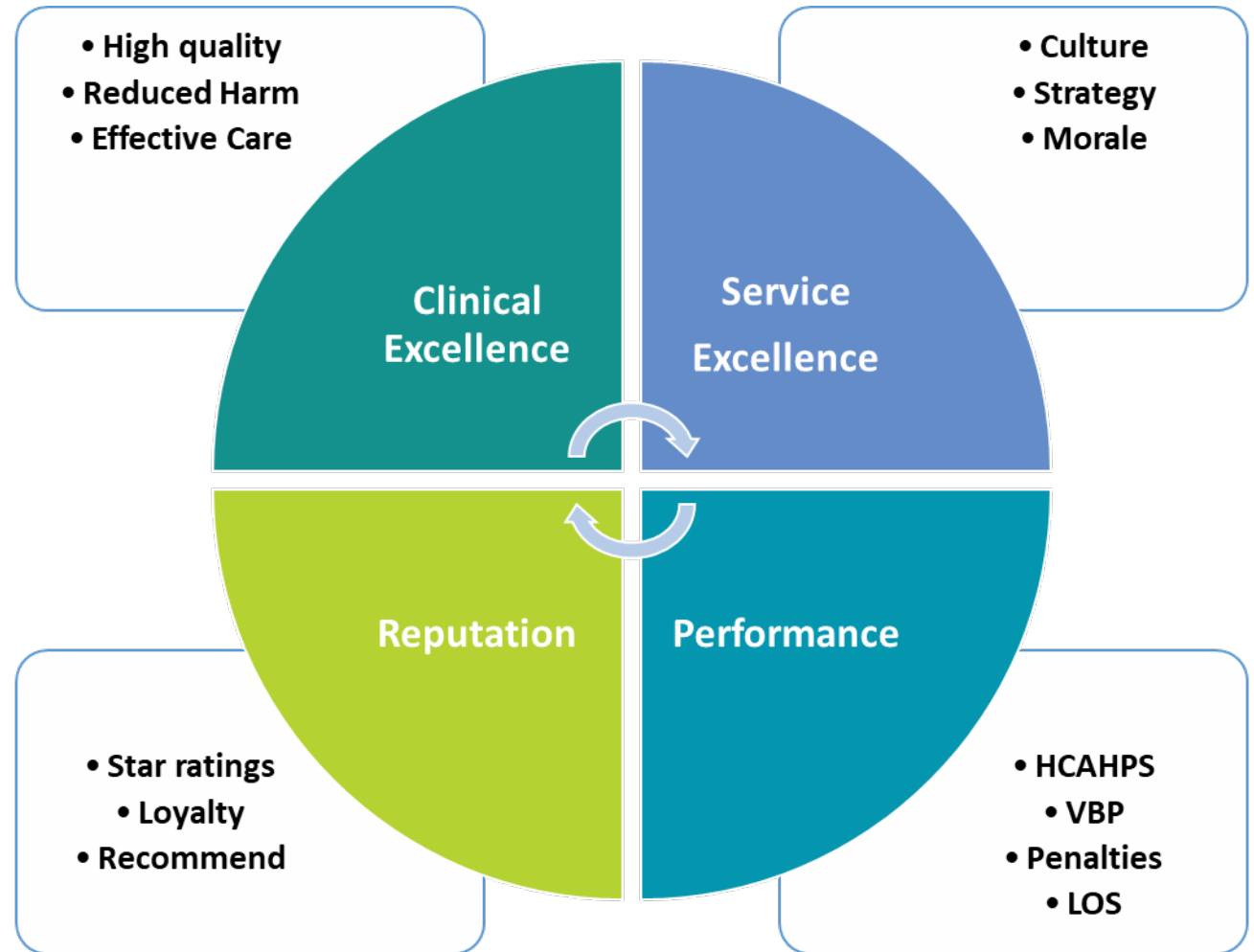
[https://journal.chestnet.org/article/S0012-3692\(17\)32890-8/fulltext](https://journal.chestnet.org/article/S0012-3692(17)32890-8/fulltext)

# Reasons we don't engage the patient & care partner





# Reasons to engage the patient & care partner



# Join us in implementing the care partner program!

- *Service Excellence*
- *Patient Safety*
- *Patient/Workforce Satisfaction*
- *Clinical Excellence*

*It's the right thing to do!*



# Care Partner Sprint Kickoff

## September 23, 2021



- 1 - 2 p.m.
- Featuring Dr. Amy Boutwell
- Register here:  
[https://qualityimprovementcollaborative.org/events/?event\\_id=2172](https://qualityimprovementcollaborative.org/events/?event_id=2172)