Transforming into a Care Partner Hospital

The impact on readmissions and patient satisfaction

September 23, 2021

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

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

Transforming into a Care Partner Hospital

Today's faculty

Amy Boutwell, MD, MPP
President of Collaborative Health Strategies

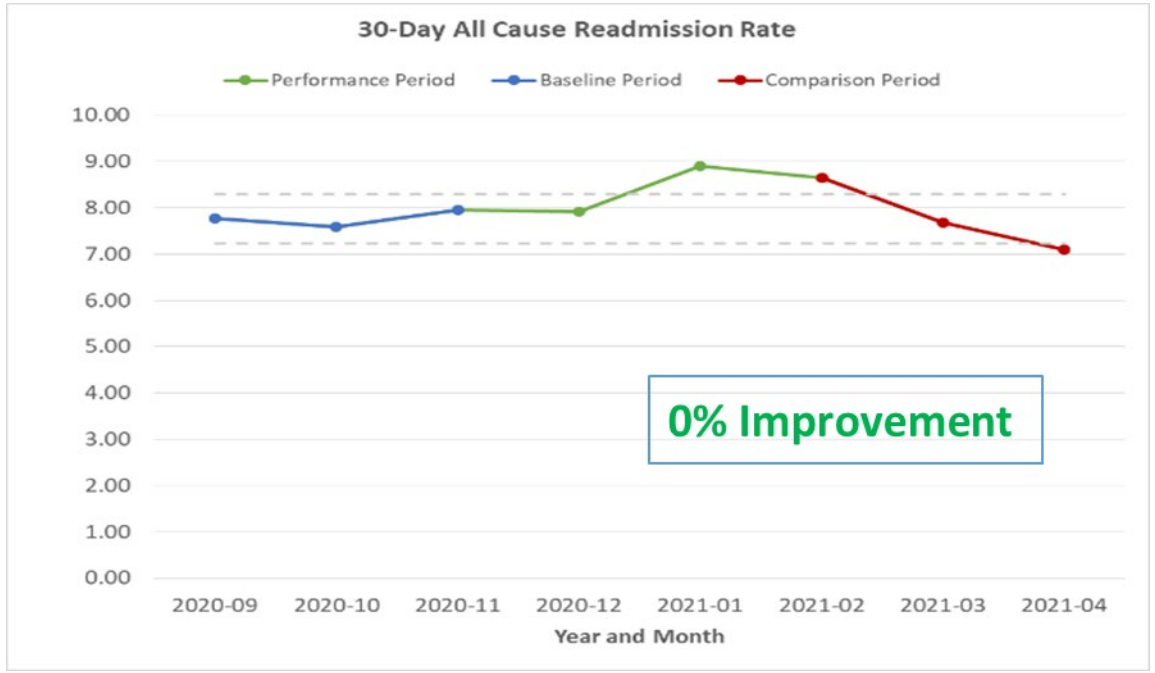
Brenda Chapman BS, RNC
Program Manager, Eastern US Quality Improvement Collaborative, HANYS

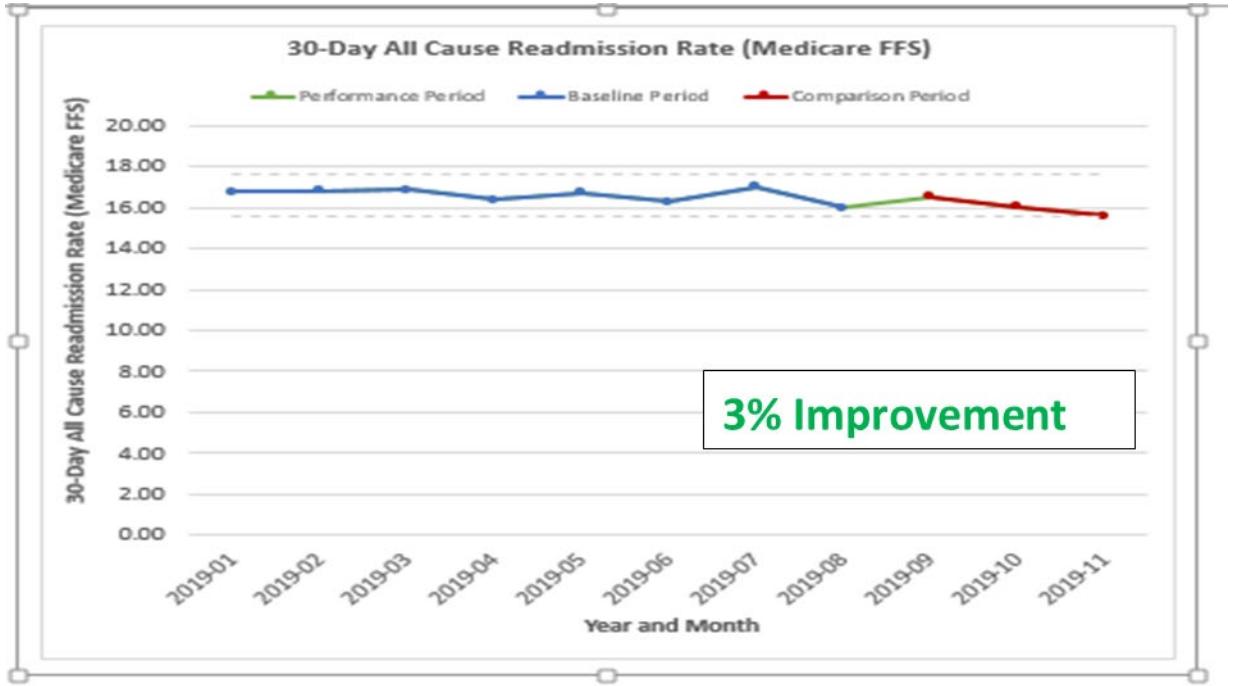
Maria Sacco, RRT, CPHQ
Director, Quality Advocacy, Research and Innovation, HANYS

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

EQIC goal

Goal: Reduce hospital readmission by 5%





EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

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
- Identify tools and resources for evaluation
- Discuss the model for improvement

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

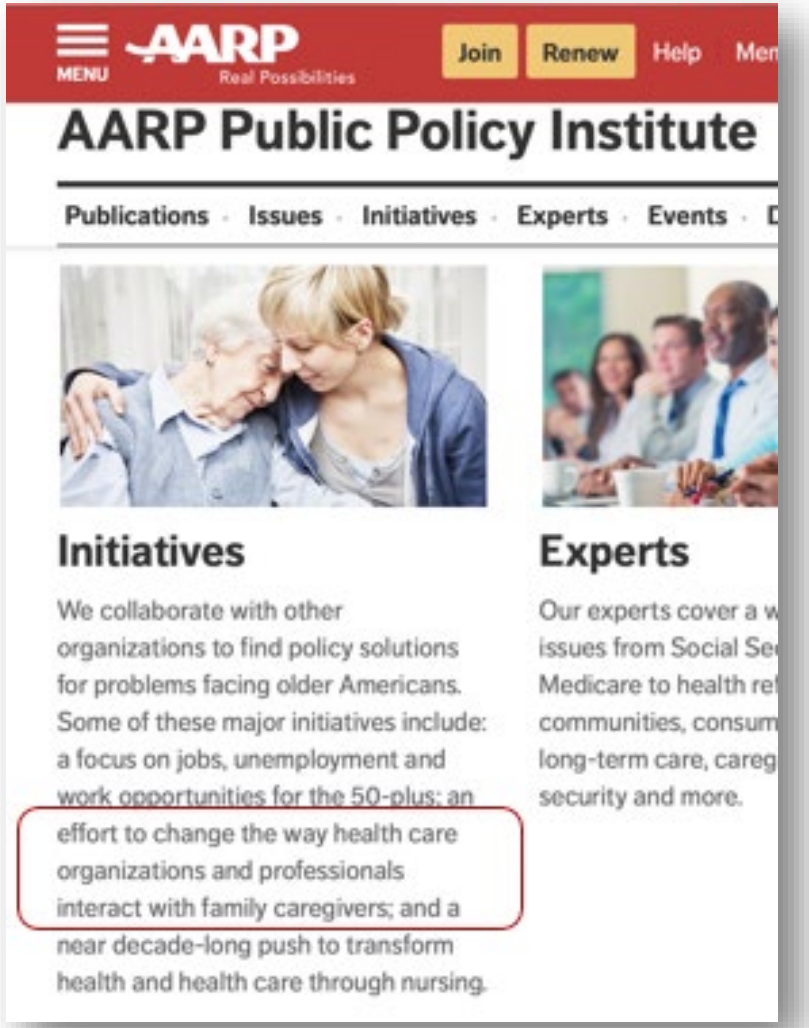
Caregivers report holding significant decision-making authority to:

- 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

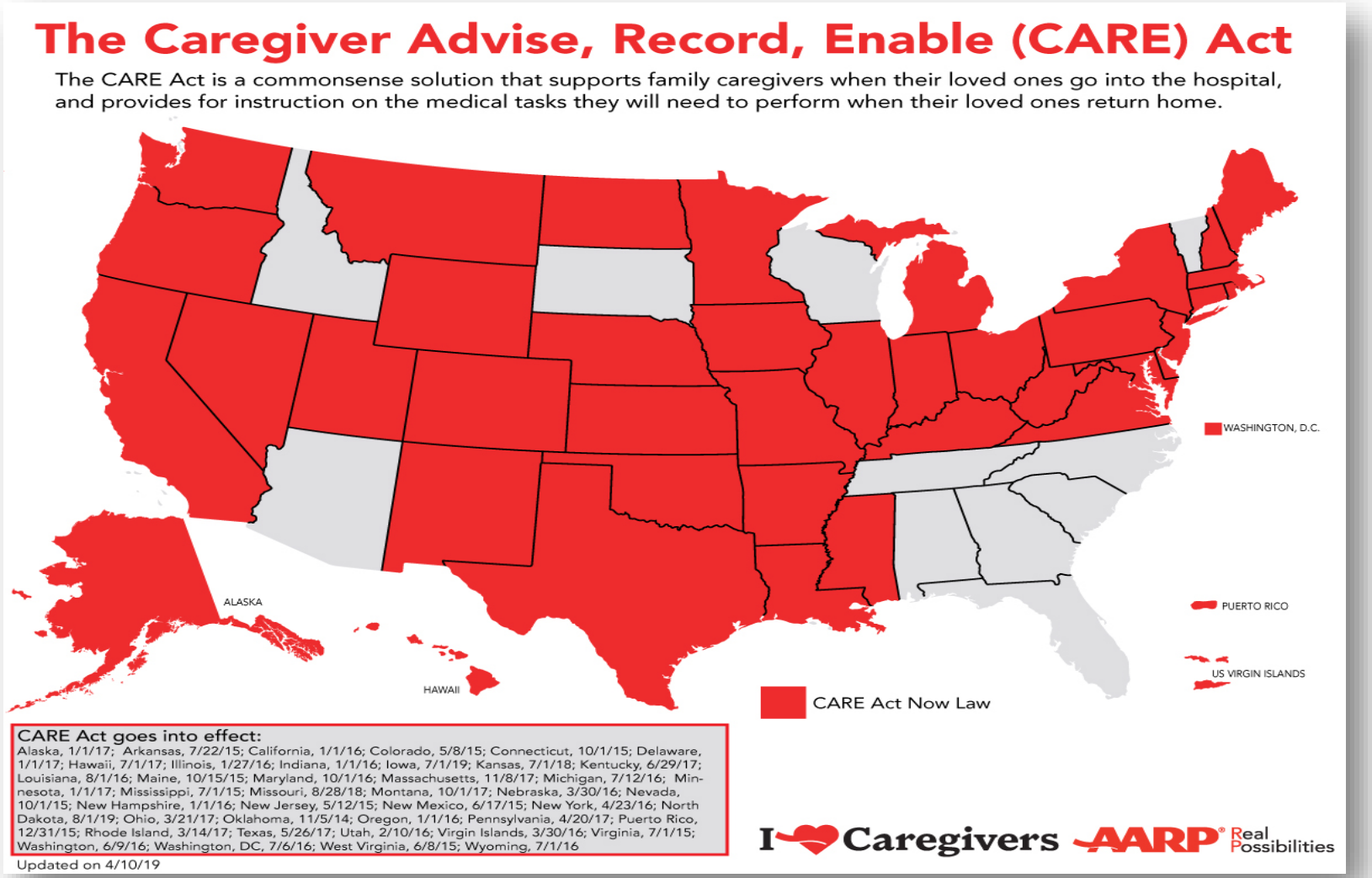
Gallup-Healthways. (2011). Gallup-Healthways Well-Being Index.
AARP and United Health Hospital Fund. (2012). Home Alone: Family Caregivers Providing Complex Chronic Care
National Alliance for Caregiving and AARP. (2015). Caregiving in the U.S.

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE



The CARE Act

https://www.aarp.org/caregiving



EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

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

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Goal: Beyond compliance to high value care

Polling question:

What is/are your hospital or hospital system's current priorities?

1. Improve reputation
2. Decrease hospital penalties from value-based purchasing areas, i.e. HAI's, readmission, etc.
3. Improve patient satisfaction
4. Improve staff morale and culture
5. Other

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

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.

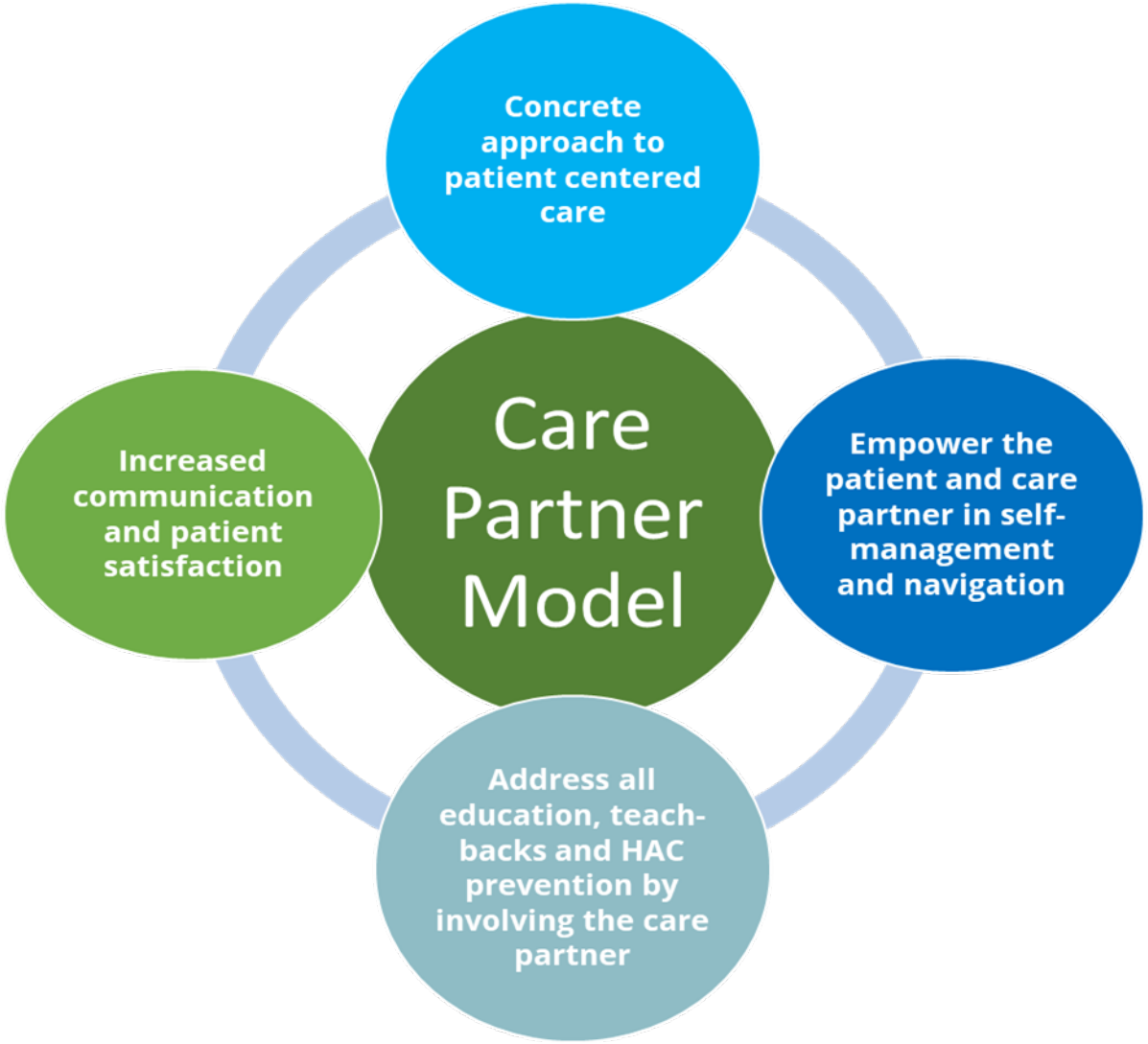
The importance of a care partner

Play video:

The Importance of a Care Partner Program

Patient outcomes

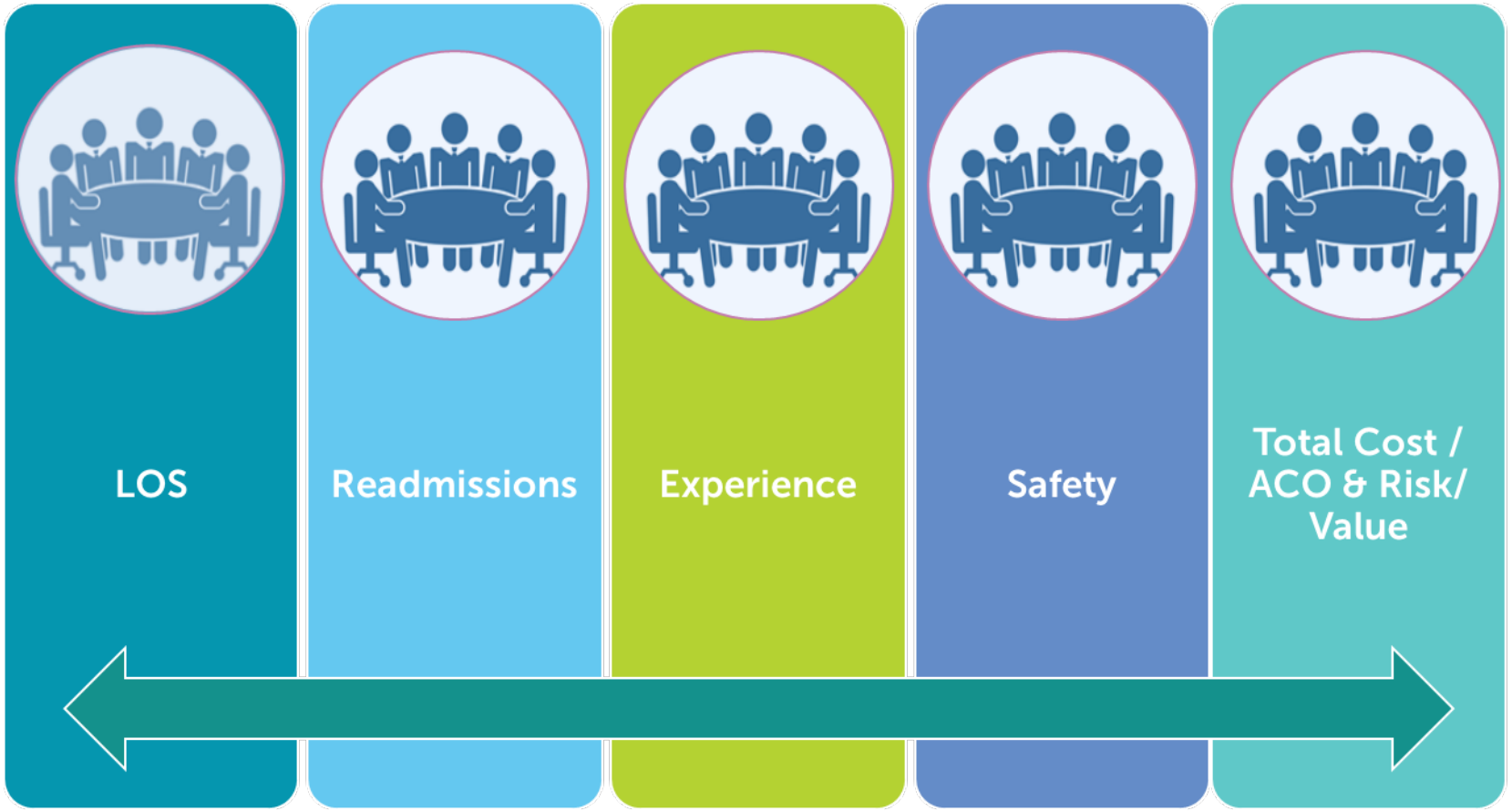
Incredibly impactful Intervention



EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Hospital or system outcomes

Cross-cutting initiative, benefitting multiple current priorities



EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

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

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Reduce health disparities

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

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/

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.

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

What is a care partner?

Care partners can be family members, friends, neighbors, or paid assistants. Whoever the patient chooses should be comfortable discussing the patient's healthcare and also working with the patient to ensure he or she receives care that the patient wants. The care partner should be available to support the patient both during and after the hospital stay.

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

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!

EQIC

Polling question:

- **Who in the audience in the last two years has:**
  - Been a patient in the hospital?
  - Had a person you cared about in a hospital?
  - Held the hand of a patient in the hospital who was alone?

COVID-19 pandemic forced changes

- Limited visitation 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

Polling question:

What did your hospital do during the COVID-19 pandemic to maintain contact and share information with family and care partners?
(choose more than one if applicable)

a. Scheduled care partner/family daily status calls
b. Used technology platforms for patient/care partner visits (facetime, google duo, etc.)
c. Teamed with other staff/departments to assist with communication with family and care partners
d. Other

During COVID-19

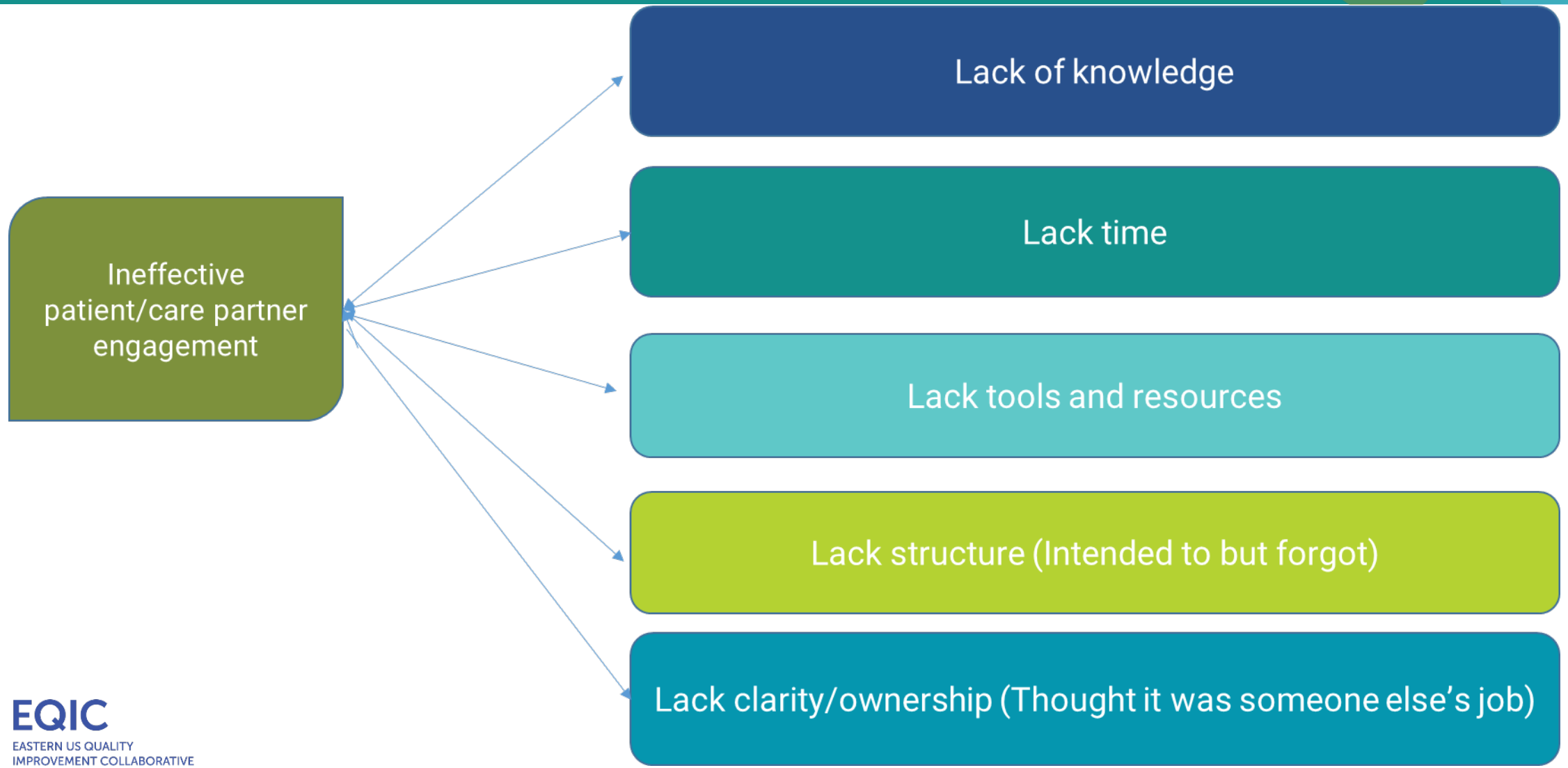
We made sure we stayed connected!

a. Scheduled daily updates with care partner/family
b. Technology deployed for patient care
c. Technology deployed for patient/care partner visitation
d. Staff aware of the fear; prioritized keeping care partners and family involved and informed

Reasons to engage the patient & care partner

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Reasons we don't engage the patient & care partner



EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

From the patient and care partner's perspective

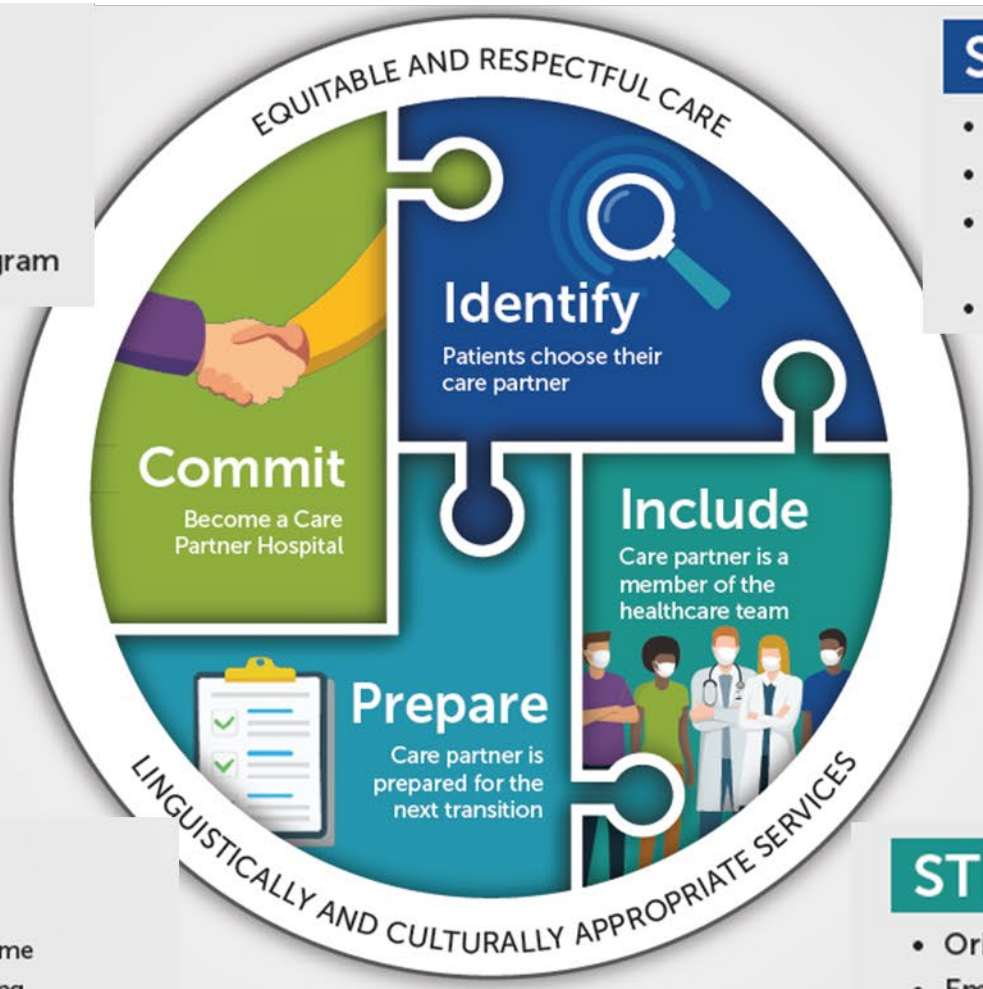
Play video:

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 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

Concrete steps to the care partner program

- Formally engage the patient and their care partner (caregiver, family, friend, etc.) to facilitate a smooth and successful transition home.
- Optimize the care partner model to strengthen and empower post-hospital self-care management.
- Enhance patient-centered care approaches and principles using the fundamental care partner model.
- Enhance the patient and care partner perception and satisfaction with the care.
- Utilize the patient and care partner model to enhance communication, problem solving and all prevention activity during the hospitalization and post discharge.

How to engage the patient & 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

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

EQIC Care Partner syllabus

Readmission Care Partner
Sprint Syllabus

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

To register for the webinars, visit the EQIC Events page. For questions related to this content or to join the care partner sprint listserv, please contact Brenda Chapman (bchapman@hanys.org).

EQIC is pleased to offer its *Readmission Care Partner* sprint, which allows hospitals to engage in an improvement project focused on the development or enhancement of your care partner program. This comprehensive clinical delivery program will support hospitals and systems in operationalizing patient-centered care and the engagement of the patient and care partner throughout the hospital stay and beyond.

Our CMS goals are to reduce readmissions by 5%. Literature is increasingly demonstrating that fully functional care partner programs have a positive impact on reducing readmissions and increasing Hospital Consumer Assessment of Healthcare Providers and System scores.

The care partner programming will be concentrated into a "sprint," which means that we will be using rapid-cycle change principles in order to make a large impact in a short amount of time. Our course will kick off on September 23 with an overview of EQIC's care partner program curriculum.

During the course of the sprint, we will hear from various subject matter experts in implementing the four-step care partner framework of commit, identify, include and prepare.

HQIC

The sprint entails:

- Educational programming from this first session through April 2022
- Office hours
- Homework for teams
- Tools and resources
- Project manager support

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Join us in implementing the care partner program!

- *Service excellence*
- *Patient safety*
- *Patient/Workforce satisfaction*
- *Clinical excellence*

It's the right thing to do!

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Care partner curriculum

Upcoming Events

October 7, 2021:

- **Commit:** Become a care partner hospital, and
- **Identify**: Patients choose their care partner

Hospital follow-up & implementation completed by October 21

October 21, 2021: Optional office hours- Q & A. (SME: Maria Sacco, HANYS)

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Thank you.

Brenda Chapman

bchapman@hanys.org

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE