Becoming a Care Partner Hospital: Commit and Identify

A strategic initiative of the Eastern US Quality Improvement Collaborative





Transforming into a Care Partner Hospital

Today's Faculty



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Agenda

- Introduction
- Why Become a Care Partner Hospital?
- Becoming a Care Partner Hospital
 - Step 1: Commit
 - Step 2: Identify
 - Take Action
- Questions



Strategies to reduce readmissions

Analyze and understand your data

• Empower patients and care partners

Integrate patients and care partners in care transitions



Value of the care partner program





Feedback from hospitals

- Improve engagement of the patient and care partner
- Improve equity of healthcare delivery
- Build on what hospitals have already accomplished

It is a priority - help us operationalize it!



Why become a Care Partner Hospital?



The CARE Act

- Patients want hospital teams:
 - To do better
 - To know who their care partner is
 - To involve their care partner
 - To be a team
 - Have a system to coordinate care
- Care partners want to:
 - Participate in decision making and creating a plan
 - Learn how to help care for the patient

AARP Care Act

Requires hospitals to allow patients to identify a care partner, involve care partner in care and notify care partner of discharge.





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





Beyond compliance to high value care

- The CARE Act legislation requires hospital "compliance"
 - Did you ask the patient if they would like to identify a care partner?
 - Is it documented somewhere?
 - If the patient has a care partner, we must notify them of discharge.

Hospital mission, vision and goals compel us to not only "ask" and "notify," but rather effectively:

Identify - Include - Prepare



This is the foundation for the Care Partner Program

Why don't we?

- Task oriented
 - The task of "asking" is seen as the job, does it meet the intent or principles
- Time
 - Perceived as taking too much time to engage CPs, sometimes getting family involved makes more questions and work for us
- No standard process
 - Who does it? When?
- Not managed or measured
 - How many patients have CP identified? HCAHPS?



How could we?

- Clear role assigned, with redundancy
 - What to do if a CP not identified the first time asked
- Re-work scripting and training on purpose
 - "care partner" or "who helps you"
 - Purpose: care partners promote empowerment, smooth transition of care in and outside the hospital, safety/quality goals
- Place CP name/number on EHR, rounding document and/or whiteboard
- Ask CP how/when they would like to be updated: in-person, phone, email?
- Establish measurements; collect, measure and provide feedback to staff



How to become a Care Partner Hospital



Become a Care Partner Hospital

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
- Identify a proxy care partner in special circumstances
- 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
- · Invite care partner to daily patient rounds and bedside huddles
- . Involve care partner in discussions about the patient's care plan
- · Empower care partner to perform simple patient care activities

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



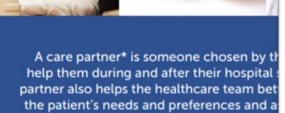


Tools and materials









*The term "care partner" is used to reflect the level of participal provided to the patient throughout their illness and treatment per is promoted by Planetree and the Institute for Patient - and Family

transition home or to post-hospita

Care Partner Program Checklist for Frontline Staff



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	✓ upon registration or admission
patient to speak/share with care partner	* sgott registrator or averageout
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	✓ My Care Transition Plan brochure
means to be a care partner	✓ What is a Care Partner? brochuse

Care Partners

A care partner is someone you choose to help you reach your healthcare goals. The care partner can help you ask questions and generally communicate with the healthcare team on your behalf to make sure your needs are being met.

Care partners can be family members, friends, neighbors or paid help. Once back home, they will help you with daily activities such as shopping, cleaning, managing your medications and appointments, cooking a meal or coordinating services to help support all these activities.

Care partners can also help by giving information — such as your list of medications, health history or home care needs — to your doctor or nurse.

Care partners can listen to doctors, nurses and others for you and make sure you get the information you need and that you understand it.

Insert Hospital Logo



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.

PHONE NUMBER(S):	
CARE PARTNER	
PHONE NUMBER(S):	
FOLLOW-UP APPOINTMENT:	
MY PHARMACY:	
CASE MANAGER:	

Care Partners are SMART* and AWARE

- 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.ibi.org/resources/Pages/Tools/SMARTDischargeProtocol.asp/ (accessed August 20, 2021).

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Care Partner Framework

Step 1: Commit

Commit to becoming a "Care Partner Hospital"





Commit

Making a commitment to a care partner program entails a formalized process that facilitates patient, family and care partner engagement and establishes a standard practice for how care is delivered in your organization.

Adds value for the patient and care partner



Identify a champion, form a team

Executive Sponsor

CMO, CNO, CQO, chief experience officer

Team Lead

MD, Nurse, QI, patient experience, case manager

- Prioritize work
- Support team
- Increase visibility

Team

- frontline nursing
- medical staff/hospitalist
- quality improvement
- case management
- PFAC representative
- dietician
- home healthcare
- admission department representative
- information technology



The Care Partner Program implementation team should develop "tests of change" to facilitate effective implementation and foster continuous improvement, using process and outcome measures to guide the work.

Team activities

- Use Care Partner Program Implementation Checklist and Care Partner Program Implementation Guide.
- Establish meeting schedule.
- Establish roles and responsibilities.
- Determine measures and establish baseline and goals.
- Evaluate EQIC tools and resources.
- Gather input from staff, PFAC and if available, care partners.
- Design your hospital's Care Partner Program.
- Develop staff education program.
- Promote widely. Begin promoting early, consistently and build on that to get the awareness level and "hospital chatter" energized.



EQIC Care Partner Program tools and resources

Care Partner Program Implementation Checklist

- Will help your team evaluate your current state
- Identify action items
- Care Partner Program Implementation Guide
- Comprehensive resource including explanations, options, tools and resources

Care Partner Program Implementation Checklist



A checklist with strategies that can be implemented to optimize care partner engagement in patient care. Who should use this tool? The care partner program implementation team at your hospital.

How to use the too

- Use the checklist with the EQIC Care Partner Program Implementation Guide to identify and select which strategies to implement to optimize processes at your hospital and enhance care partner engagement in patient care.
- Refer to the Guide for tools and strategies for implementation. Each section of the checklist corresponds to and expands upon a step in the Care Partner Framework (see diagram).



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CARE PARTNER PROGRAM IMPLEMENTATION CHECKLIST

Process steps	Options/ideas	In pl	lace No
Identity an executive sponsor	Select a staff person in a senior leadership role to support, promote and communicate the project goals and the value of a hospital-wide care partner program. Possible personnel for this role may include: • chief medical officer; • chief nursing officer or director; • chief operating officer; • chief quality officer; • vice president or director of case management; or • chief patient experience or engagement officer or director.	0	0
Dedicate a program lead	If the executive sponsor cannot be the team leader, choose a well-respected leader for this role. Consider someone from quality improvement as a facilitator.	0	0
Determine and identify the care partner team	Create a multidisciplinary team to help build the foundation and infrastructure of the care partner program by supporting a culture of patient and family engagement and reducing readmissions. Include the following personnel: • nursing, including frontline nursing staff (consider key unit-based nurse champions); • medical staff/hospitalist; • case management: • patient engagement department staff and potentially patient and family advisory council representative; • admissions department representative; • unit clerk (if you anticipate a role for them); and • information technology.	0	0
Establish a care partner program	Identify how the team will obtain staff input to implement or enhance a care partner program to more effectively engage patients and care partners by using the strategies listed below:	0	0
Team	Immerse the staff (including physicians) in information about the value of the care partner model: - consider starting with one or more pilot sites then spreading: use multidisciplinary task force with identified unit-level physician, nursing champions, unit clerk and direct care clinical staff to promote the program on the units:	0	0
	schedule routine team meetings;	0	0
	identify roles and responsibilities;	0	0
	 determine baseline data, for example: percent of patients who identified a care partner on admission; review patient satisfactions scores/HCAHPS; or review readmission rates. 	0	0
	Create a project plan with clearly defined goals.	0	0

Evaluate EQIC tools and resources

EQIC Care Partner tools

https://qualityimprovementcollaborative.org/focus_areas/readmissions/tools_resources/

- Adopt
- Modify
- Create hospital-unique tools

Consider evaluation of tools and suggestions from your PFAC.



Proposed process and outcome measures

Outcome Measures	Example Process Measures*
Readmission rate	% patients with a CP identified
HCAHPS #20: "my preferences"	% CPs received teach-back
HCAHPS #21: "understand what to do"	% CPs participated in consults
HCAHPS #22: "understand meds"	% CPs involved in discharge
	% CPs satisfied with involvement
	% Satisfied on post-discharge phone call

Establish baseline

https://www.hcahpsonline.org/globalassets/hcahps/survey-instruments/mail/qag-v16.0-materials/updated-materials/2021_survey-instruments_english_mail_updated.pdf



Gather input

- Input from staff, patients and care partners will help you identify opportunities for improvement
 - Patients understand how to help identify a care partner
 - Who will be available to help you once you leave hospital?
 - Do you think it is important to have someone in your life involved in learning about what you are being treated for and what to do to get better once you leave? Why? Why not?
 - How can we more effectively describe what a care partner is and why it is important to have a care partner?
 - Care partners understand how to engage care partner
 - How would you like to be involved/updated day to day?
 - How would you like to be included in discharge planning?





FOR PATIENTS:

Why do I need one?

FOR THE PATIENT

Why do I need a care partner Taking care of yourself alone can be the hospital. Having someone who ke of eyes and ears can help you get the

at is a care nartner?

A care partner is someone you choos stay. Your care partner also will help needs and preferences and may part ner should be prepared to be involve help with your needs at home.

Your care partner will be be ready to participate in 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 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 thospital stay.



FOR CARE PARTNERS:
What do I do now?

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 there 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 patients can, looking for specific argis and symptoms related to the patients' disease/diagnosis that should be reported to the medical beam, preparing the patients for discharge and, most importantly, preparing or a smooth transition to managing the patients's care at home. The medical term till you what to look for and who to this for you have concerns, including after that you want to look for and who to this for you have concerns, including after the contract of the patients of the contract of the c

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 learner the hospital.

Depending on the patient's needs, tasks may include:

- making and getting to appointments for follow-up care;
- 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 equipme or other halo.

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!



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Design your Care Partner Program

- Produce your materials
- Determine your goals for care partner engagement throughout the hospital stay:
 - Be specific documented where
 - What is the goal for healthcare team care partner in regards to Identifying, Including and Preparing the care partner
 - What measurements will we monitor and how often?





Educate staff

- Develop education for all clinicians:
 - Roles and responsibilities in the care partner program
 - How to effectively identify and engage care partners
 - Managers reinforce importance routinely, share stories
- Include CP Program information in:
 - New staff orientation
 - Ongoing education and training modules
 - Department and unit communications
- Institute a CP Program Peer Mentor program



Promote care partner role



- Inpatient TV channels
- Screensaver messages to staff
- Posters
- Materials at bedside My Care Transition Brochure,
 What is a Care Partner? Brochure
- Website
- Materials in offices, newsletters, mailings
- Community education programs Radio, newsprinthow do you communicate with the community now?





Care Partner Framework

Step 2: Identify

Support patients in identifying a care partner and make them known!





Actively support identification

- Clarify who asks the patient to identify a CP
 - Who first asks? (Consider ED, registration, admitting RN)
 - Build in redundancy so question is asked again if initial step failed
 - Provide a script for asking the patient-see sample EQIC Script
- PDSA: Do tests of change; get started; then review materials format, wording and terms used – is it clear?
 - Get feedback from staff, patients, care partners
 - Consider more effective scripting (do you have → who helps you)
- Develop a process to help patients identify a proxy if they cannot identify a care partner (these patients are at high risk for readmission)
 - Support patients in feeling comfortable involving a friend/family
 - Be ready to suggest or identify a proxy such as health home, peer navigator, transition of care staff, PCP care manager, office of the aging, etc.

Sample script

"We have learned that patients do better if they have someone participating in their care in the hospital and helping after you go home. Do you have someone who can help you?"

"Is there someone who helps you at home? Someone who you would like to learn about your situation and can help you while you are here and when you leave the hospital?"

"Is there someone you can identify as a care partner while you are in the hospital and when you go home?"

"We will update this person about your care while you are in the hospital, and we will teach them—along with you—to understand your condition and help get you ready to go home and look after you to stay well when you leave the hospital."

Make care partner visible

- This is key for moving from compliance → purpose!
- Where does the CP name/contact go? Healthcare team needs to know who the CP is!
 - Make sure it is visible so it can be used in day-to-day care
 - On the whiteboard, rounding document, huddle board
 - In an easy-to-access place in medical record
 - Identify the care partner with a name badge, wrist band or the like
 - Routinely identify the care partner in daily bedside rounds
 - Collect data based on your measures chosen i.e. % identified





Get started!

Specific steps to take in the next 30 days



30-day action plan

Commit

- Identify a champion, form a team
- Promote care partner role in messaging, materials; educate staff
- Gather staff, PFAC, patient/care partner feedback
- Set up a measurement and management system

Identify

- Support patients in identifying a care partner
- Make the care partner name and contact information visible to the team
- Introduce the care partner to care team
- Identify the care partner with a name badge or similar

Return

- October 21, 2021- Office hours Q & A
- November 18, 2021 webinar "Include"
- January 20, 2021 webinar "Prepare"



Questions?

Thank you for your commitment to becoming a Care Partner Hospital!

Contact your EQIC Project Manager with any questions.



Next steps

- October 21, 2021 Office Hours Q&A
- November 18, 2021 second webinar in our series
 Include: Care partner is a member of the healthcare team
- January 20, 2022 third webinar
 Prepare: Care partner is prepared for the next transition



Thank you.

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