Becoming a Care Partner Hospital: Commit and Identify

A strategic initiative of the
Eastern US Quality Improvement Collaborative

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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

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Value of the care partner program

[Video: Importance of a Care Partner Program]

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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!

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Why become a Care Partner Hospital?

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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

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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

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Become a Care Partner Hospital

Care Partner Framework

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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

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Tools and materials

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Care Partner Framework

Step 1: Commit

Commit to becoming a "Care Partner Hospital"

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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.

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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

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What is this tool?
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 tool:
1. 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.
2. 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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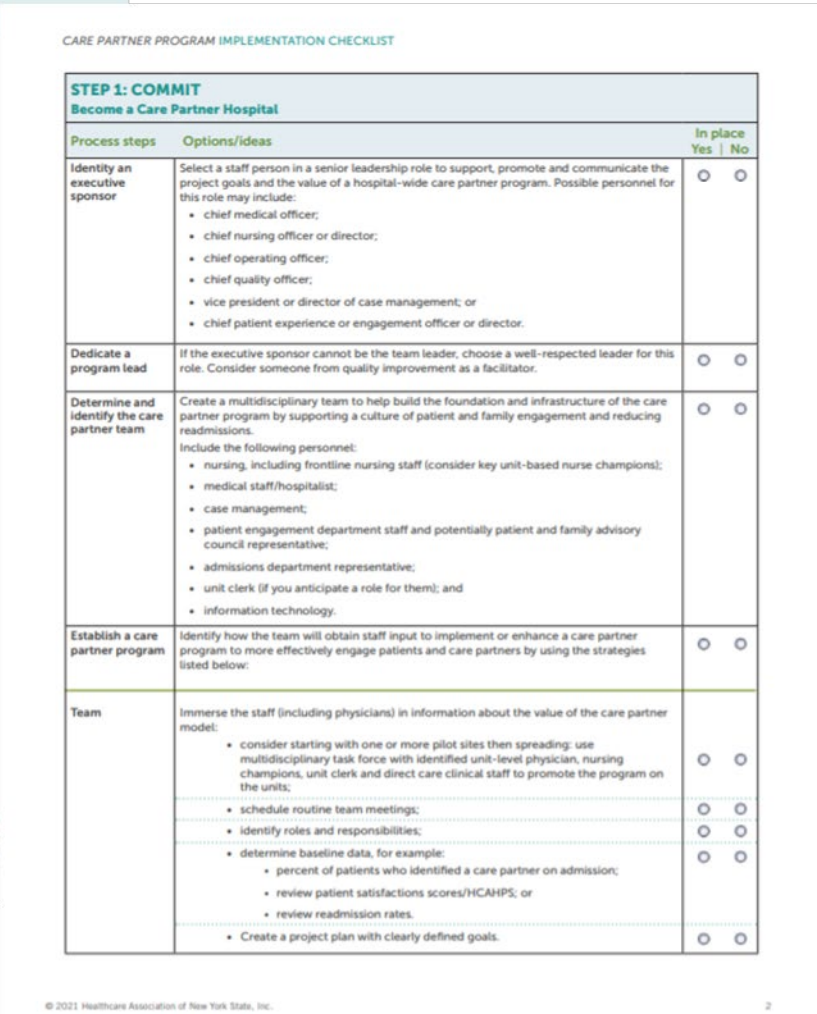

CARE PARTNER PROGRAM IMPLEMENTATION CHECKLIST

STEP 1: COMMIT
Become a Care Partner Hospital

Process steps	Options/ideas	In place Yes | No
Identify 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.	○ ○
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.	○ ○
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.	○ ○
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:	○ ○
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;	○ ○
	• schedule routine team meetings;	○ ○
	• identify roles and responsibilities;	○ ○
	• determine baseline data, for example: ◦ percent of patients who identified a care partner on admission; ◦ review patient satisfactions scores/HCAHPS; or ◦ review readmission rates.	○ ○
	• Create a project plan with clearly defined goals.	○ ○

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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

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* Illustrative; the EQIC staff will work with you to identify feasible, meaningful process measures

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?

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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?

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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

Messaging to staff, patient and care partners via:

- 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, newsprint- how do you communicate with the community now?

Care Partner Framework

Step 2: Identify

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

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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

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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”

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Questions?

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

Contact your EQIC Project Manager with any questions.

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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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