HQIC Community of Practice Call

Readmission Reduction: Transforming into a Care Partner Hospital

Oct. 14, 2021

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
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Hospital Quality Improvement Contractors
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Introduction

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Welcome!

Who's in the Room?

Overview

- **Nancy Landor, RN, MS, CPHQ**
  Senior Director, Strategic Quality Initiatives
  Director, EQIC (HQIC) Healthcare Association of New York State (HANYS)
- **Maria Sacco, RRT, CPHQ**
  Director, Quality Advocacy, Research and Innovation Healthcare Association of New York State (HANYS)
- **Judy Hunter-Eves, RT, CPHQ**
  Director of Quality Management, River Hospital
- Discussion/Q&A

Consider:

How can you leverage the dynamic environment to foster success?

As You Listen….

- Where can you begin with your facility to continue to ensure safety, and a patient-centered approach as you engage care partners?
- What actions can you take in the next 30 days? 90 days?
- What sort of activities do you have underway to impact readmissions?

Meet Your Speakers

Maria Sacco, RRT, CPHQ
Director, Quality Advocacy, Research and Innovation
Healthcare Association of New York State (HANYS)

Nancy Landor, RN, MS, CPHQ,
Senior Director, Strategic Quality Initiatives
Director, EQIC (HQIC) Healthcare Association of New York State (HANYS)

Judy Hunter-Eves, RT, CPHQ
Director of Quality Management,
River Hospital

Transforming into a Care Partner Hospital

The impact on readmissions and patient satisfaction

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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 implementation and evaluation.
- Discuss the model for improvement.

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43 Million people annually serve as a caregiver

Caregivers spend:

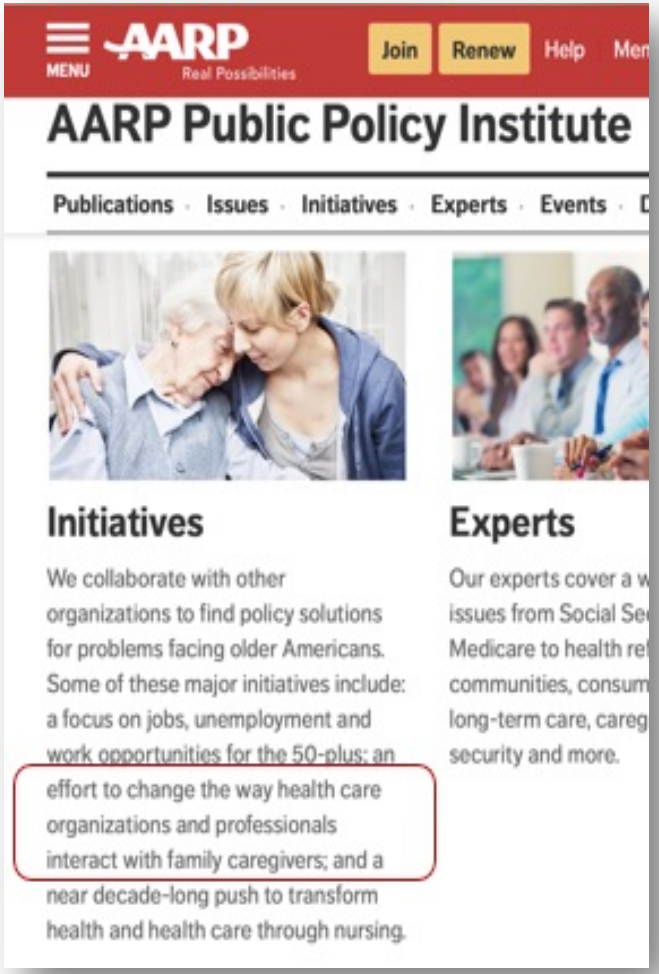
- 13 days/month shopping, food prepping, housekeeping, laundry, transportation, giving meds
- 6 days/PO feeding, dressing, grooming, walking, bathing
- 13 hours researching information, services, coordinating visits, managing finances

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 percent)
- act as an advocate for the care recipient with care providers, community services or government agencies (50 percent)



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.

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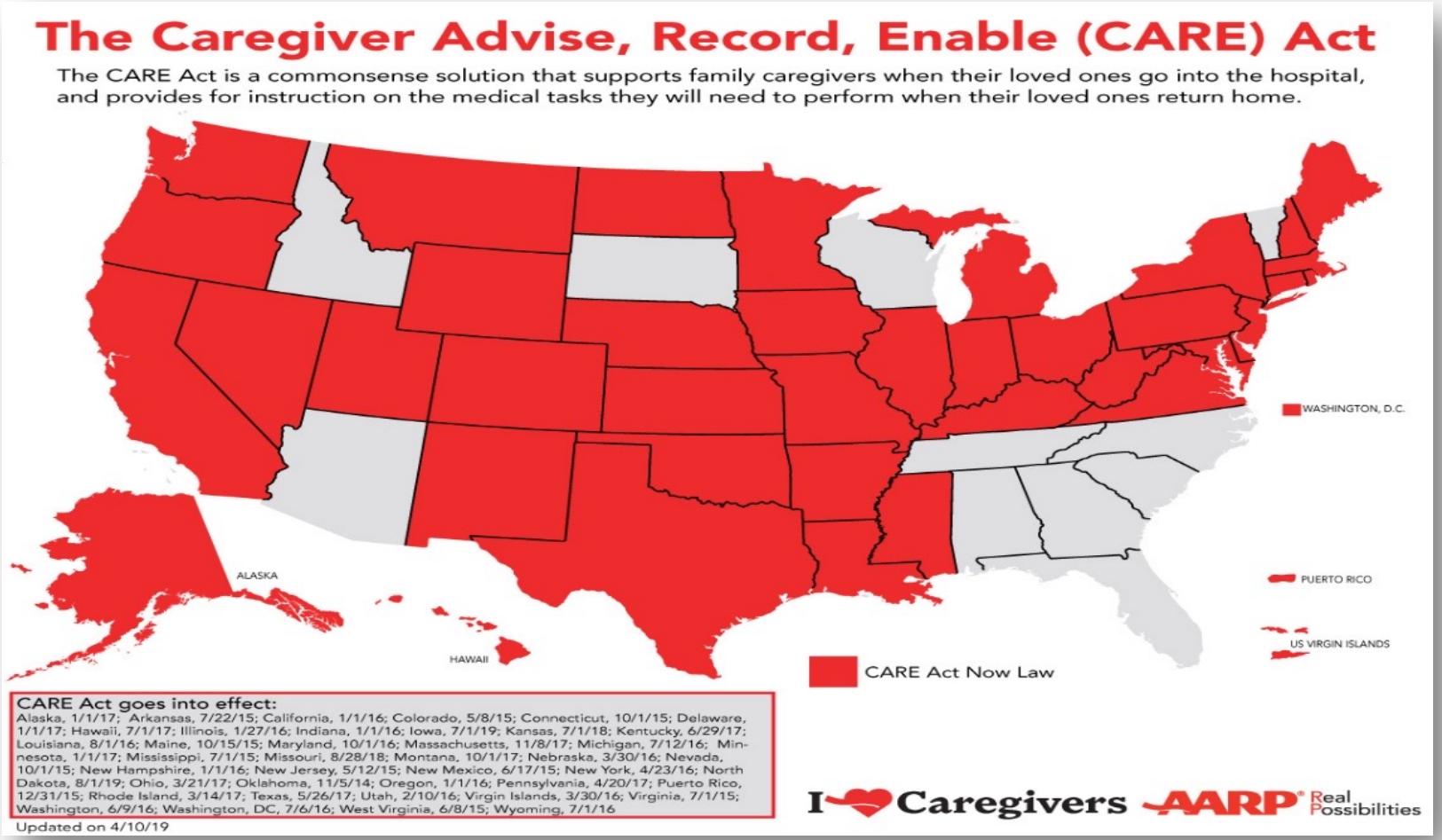
The CARE Act



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Journey

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

***Goal:** Beyond compliance to high value care*

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Join us in implementing a care partner program!

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

It's the right thing to do!

Video: Importance of a Care Partner Program

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Patient outcomes

Incredibly impactful Intervention

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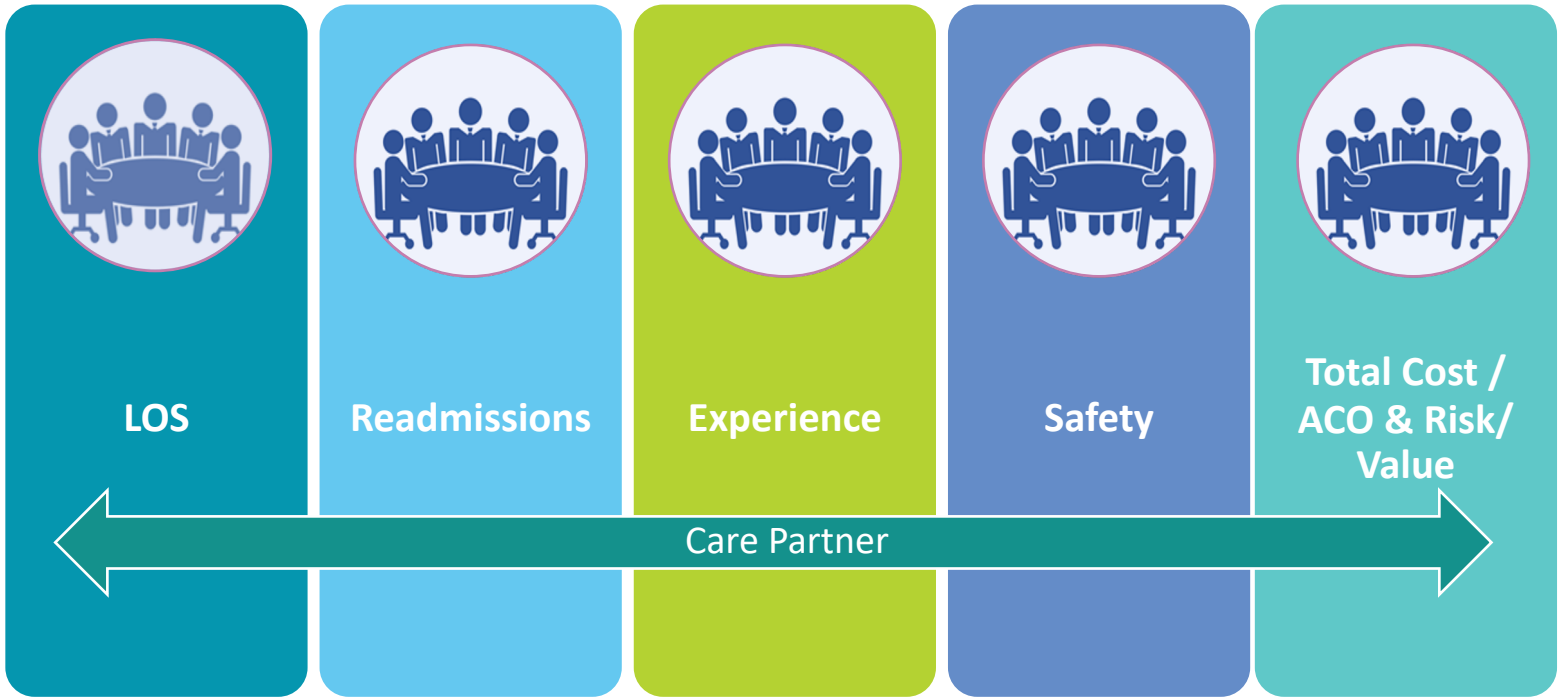
Hospital or system outcomes

Cross-cutting initiative, benefitting multiple current priorities



Ppt. from Dr. A. Boutwell, President, Collaborative Healthcare Strategies

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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.*

Evidence – 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 percent 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 percent reduction in 30-day all-cause readmissions*

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

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Reduce and manage health disparities

Patient and Family Engaged Care: An Essential Element of Health Equity

"improved population health, which is becoming the fundamental premise of healthcare 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/

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During COVID-19

A connection system!

a. Scheduled daily updates with care partner/family

b. Technology deployed for patient care

c. Technology deployed for patient/care partner visitation and communication

d. Staff aware of the fear; prioritized keeping care partners and family involved and informed

- ***Hospitals with care partner programs felt the adjustment was easier for them!***

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What is a Care Partner?

- Someone the patient chooses to help them during and after the hospital stay.
- A 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.

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What is a care partner?

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.

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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!

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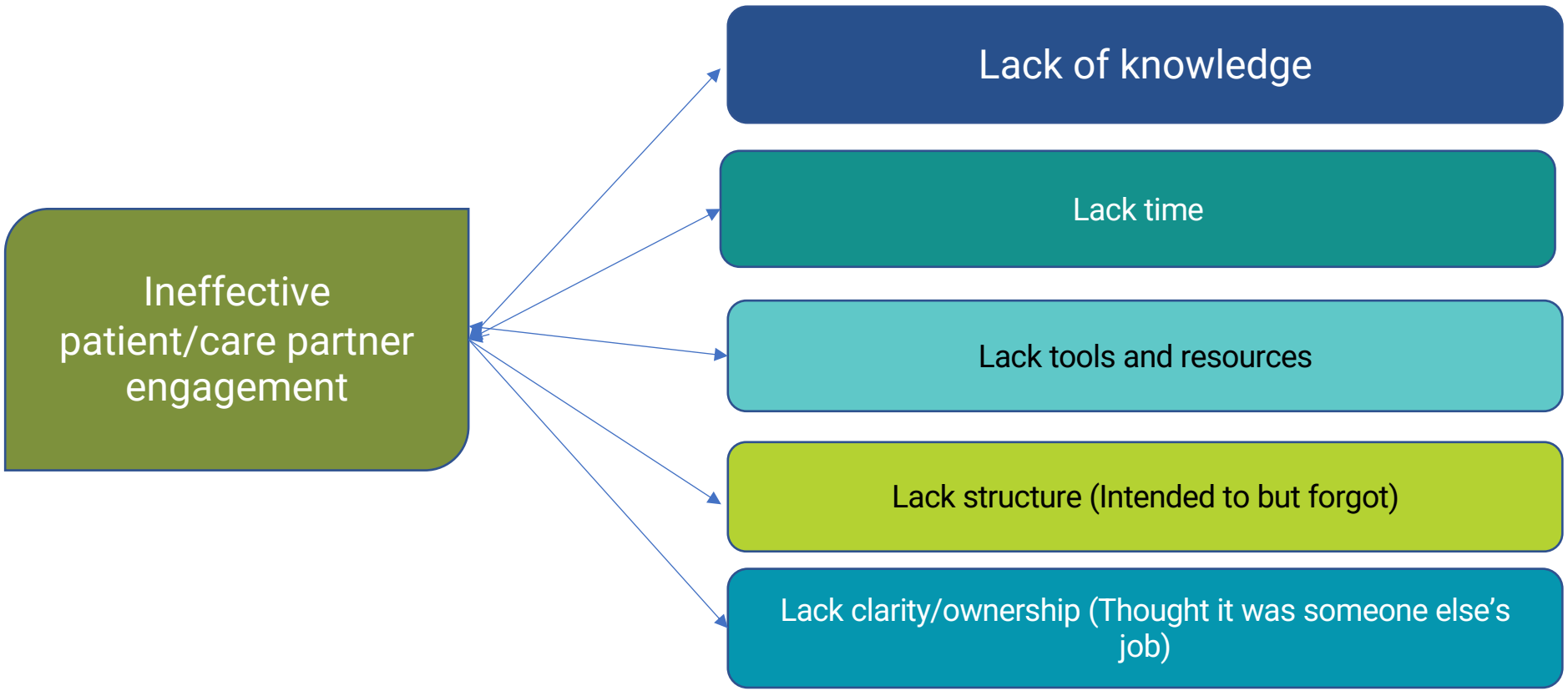
Reasons we don't engage the patient & care partner



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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 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

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

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Readmission Care Partner
Sprint Syllabus

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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.

To register for 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).

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 Sept. 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.

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Calendar	Care Partner Model Objectives	Hospital Follow-up Assignments and Tools

Introduction: Planning and Implementing a Hospital Care Partner Program

Subject matter expert: Amy Boutwell, MD, MPP

Webinar 1 **Thursday, Sept. 23** **1 - 2 p.m.**	**By the end of this session, participants will be able to:** • identify what a care partner program is and why implementing one will benefit your facility; • identify principles and methodology to begin a care partner program; • identify tools and resources for evaluation; and • discuss the model for improvement.	**Following this webinar, participants will:** • define their quality improvement strategy, i.e., PDSA, LEAN-A3, Model for Improvement; • identify multidisciplinary team members; and • begin to strategize on committing to becoming a care partner hospital. **EQIC Tools and Resources:** • How to Use the Toolkit, page 4 of the Care Partner Implementation Guide • Care Partner Implementation Checklist • Care Partner Brochure

Commit: Become a Care Partner Hospital & Identify: Patients Choose Their Care Partner

Subject matter expert: Maria Sacco, RRT, CPHQ

Webinar 2 **Thursday, Oct. 7** **1 - 2 p.m.**	**Commit: Become a Care Partner Hospital** **By the end of this session, participants will be able to:** • identify key staff and physician members that should be part of the care partner team; • identify potential QI pilot data elements to be monitored during development of a care partner program; and • discuss insights on gathering feedback from staff, patients and patient and family advisory council.	**Following this webinar, participants will:** • finalize your multidisciplinary team; • dedicate a program lead; • identify unit champions; • determine baseline data; • draft a high-level flow chart as part of a starting point; • gather feedback from your PFAC; • decide on a model to test improvement steps; • build awareness, engagement and excitement with [illegible] staff, physicians and nursing: ○ immerse healthcare team in the value and components of becoming a care partner [illegible]; • determine how care partners will be identified in your facility i.e., name badge, [illegible] band, [illegible], etc. **EQIC Tools and Resources:** • Care Partner Implementation Guide • Care Partner frontline checklist • Care Partner Framework • Video: Importance of a Care Partner Program • Video: The Power of the Care Partner: The Maria and Don Story • Care Partner Brochure • My Care Transition Brochure (customizable) • Care Partner Poster • Care Partner images

Calendar	Care Partner Model Objectives	Hospital Follow-up Assignments and Tools

Webinar 2 *CONTINUED*	**Identify: Patients Choose Their Care Partner** **By the end of this session, participants will be able to:** • identify options and determine which staff will have the primary role in identifying the care partner; • adopt scripting for asking patients to identify a care partner; • identify options for documenting and sharing the care partner name and contact information with health-care team; and • discuss options for identifying a care partner proxy when needed. **Part I Criteria for certificate:** Complete checklist and implement strategies for the care partner model to date.	**Following this webinar, participants will:** • clearly define who on the healthcare team is responsible for identifying the care partner and include redundancy in the process to identify a care partner; • identify proxy care partners for special conditions as needed; • develop or adapt the EQIC script for staff to obtain care partner identification from patient; • distribute written materials describing what it means to be a care partner; • educate the staff to assist the patient with identifying a care partner; • educate the patient and care partner on what it means to be a care partner; • introduce the care partner to the medical team at huddles or rounds; and • notify care partner of rounding times. If unable to be present, coordinate with care partner to participate remotely. **EQIC Tools and Resources:** • Care Partner Brochure • My Care Transition Brochure (customizable) • Care Partner Poster • Care Partner images • Sample Staff Script to Help Patient Identify a Care Partner (Care Partner Implementation Guide Appendix F) ***Complete all hospital follow up and implementation prior to Oct. 21, 2021.***

Office Hours: Q&A

Subject matter expert: Maria Sacco, RRT, CPHQ

Webinar 3 **Optional Office Hours** **Thursday, Oct. 21** **1 - 2 p.m.**	**During this session, participants will be able to:** • enhance planning strategies; • ask questions regarding implementation strategies; and • network with teams to share challenges and successes.	**Following this webinar, participants will:** • review and enhance program implementation using EQIC tools and resources, including their project manager's coaching.

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Calendar	Care Partner Model Objectives	Hospital Follow-up Assignments and Tools

Include: Care Partner is a Member of the Healthcare Team
Presentation: Partners in Healing®, Michelle Van De Graaff, Intermountain Healthcare
Subject matter expert: Nancy Landor, RN, MS, CPHQ

Webinar 4 **Thursday, Nov. 18** **1 - 2 p.m.**	**During this session, participants will be able to:** • identify options for including the patient and care partner as a member of the healthcare team; • discuss what other facilities have done to include care partners; and • define the value of teach-back in preparation for discharge.	**Following this webinar, participants will:** • orient the care partner to the unit; • invite the care partner to participate in rounding and huddles; • designate a team member to be responsible for care partner communication; • review the care partner role with the patient and care partner; • empower the care partner to assist in patient care; • empower the care partner to assist with follow-up appointments; • provide care partner with daily patient updates; • engage care partner in discharge planning; and • include the care partner during education using teach-back. **EQIC Tools and Resources:** • EQIC My Care Transition Brochure (customizable) • EQIC Care Partner Frontline Checklist • Successful Discharge Planning Starts at Admission (Institute for Healthcare Improvement) • Making the transition to Nursing Bedside Shifts Reports (The Joint Commission) ***Complete all hospital follow up and implementation prior to Jan. 20, 2022.***

Calendar	Care Partner Model Objectives	Hospital Follow-up Assignments and Tools

Prepare: Care Partner is Prepared for the Next Transition
Subject matter expert: Brenda Chapman, BS, RNC

Webinar 5 **Thursday, Jan. 20, 2022** **1 - 2 p.m.**	**During this session, participants will be able to:** • discuss methods for preparing the patient and care partner for discharge; • discuss the value of post-discharge follow up; • define the value of teach-back prior to discharge; and • have clarity on how to empower the care partner to be an effective post-hospital care navigator for a smooth transition of care.	**Following this webinar, participants will:** • assess care partners' educational needs with consideration of language and health literacy; • prepare the care partner for transitions in care; • provide notice of planned discharge within 24-48 hours in advance; • establish a process to assess care partner knowledge and understanding of patient care needs at home; • establish a process to verify care partner and patient education: ○ use teach-back to assess patient and care partner understanding; • engage the care partner in the post-discharge follow-up call; and • develop a process to address concerns identified during post-discharge follow-up call. **Tools and Resources:** • Medications at Transitions and Clinical Handoffs toolkit Medication Reconciliation (AHRQ) • Preventing Adverse Drug Events (Medication Reconciliation):Patient and Family Fact Sheet (IHI) • Your Discharge Planning Checklist: For Patients and Their Caregivers Preparing to Leave a Hospital, Nursing Home, or Other Care Setting (CMS) • IDEAL discharge planning overview, process, and checklist (AHRQ)

Office Hours: Preparing for attestation
Subject matter experts: Maria Sacco, RRT, CPHQ, and Brenda Chapman, BS, RNC

Webinar 6 **Optional Office Hours** **Thursday, Feb. 17, 2022** **1 - 2 p.m.**	**During this session, participants will be able to:** • ask questions regarding implementation strategies; • troubleshoot and problem-solve program implementation; and • network with teams to share challenges and successes. **Part II Criteria for certificate:** Complete checklist and implement strategies for the care partner model to date.	**Following this webinar, participants will:** • review and enhance program implementation as they prepare to identify as a care partner hospital; and • ensure the implementation checklist has been completed. **EQIC Tools and Resources:** • Care Partner Implementation Checklist ***Complete all hospital follow up and implementation prior to March 17, 2022.***

Calendar	Care Partner Model Objectives	Hospital Follow-up Assignments and Tools

Transitions of Care
Presentation: Care Transitions Collaborative, Gale Grunert, Lewis County Hospital
Subject matter expert: Brenda Chapman, BS, RN

Webinar 7 **Thursday, March 17, 2022** **1 - 2 p.m.**	**By the end of this session, participants will be able to:** • define how to identify and collaborate with community-based organizations.	**Following this webinar, participants will:** • familiarize team with community based organizations who assist in addressing patient needs; • include patient and care partner in referral process; • work with community organizations where appropriate to identify interventions to meet patients' needs; and • learn about community organizations in your area that can assist in addressing social determinants of health.

Capstone

Webinar 8 **Thursday, April 21, 2022** **1 - 2 p.m.**	**In this webinar, we will:** • celebrate program implementation and success stories; and • consider promotion of the care partner program in your hospital.	**Following this webinar, participants will:** • identify your facility as a care partner hospital; and • describe various ways of promoting community awareness of the care partner program.

Concrete principles to a 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.

Other Value	Structure
	Builds Staff Resilience
	More patient connections

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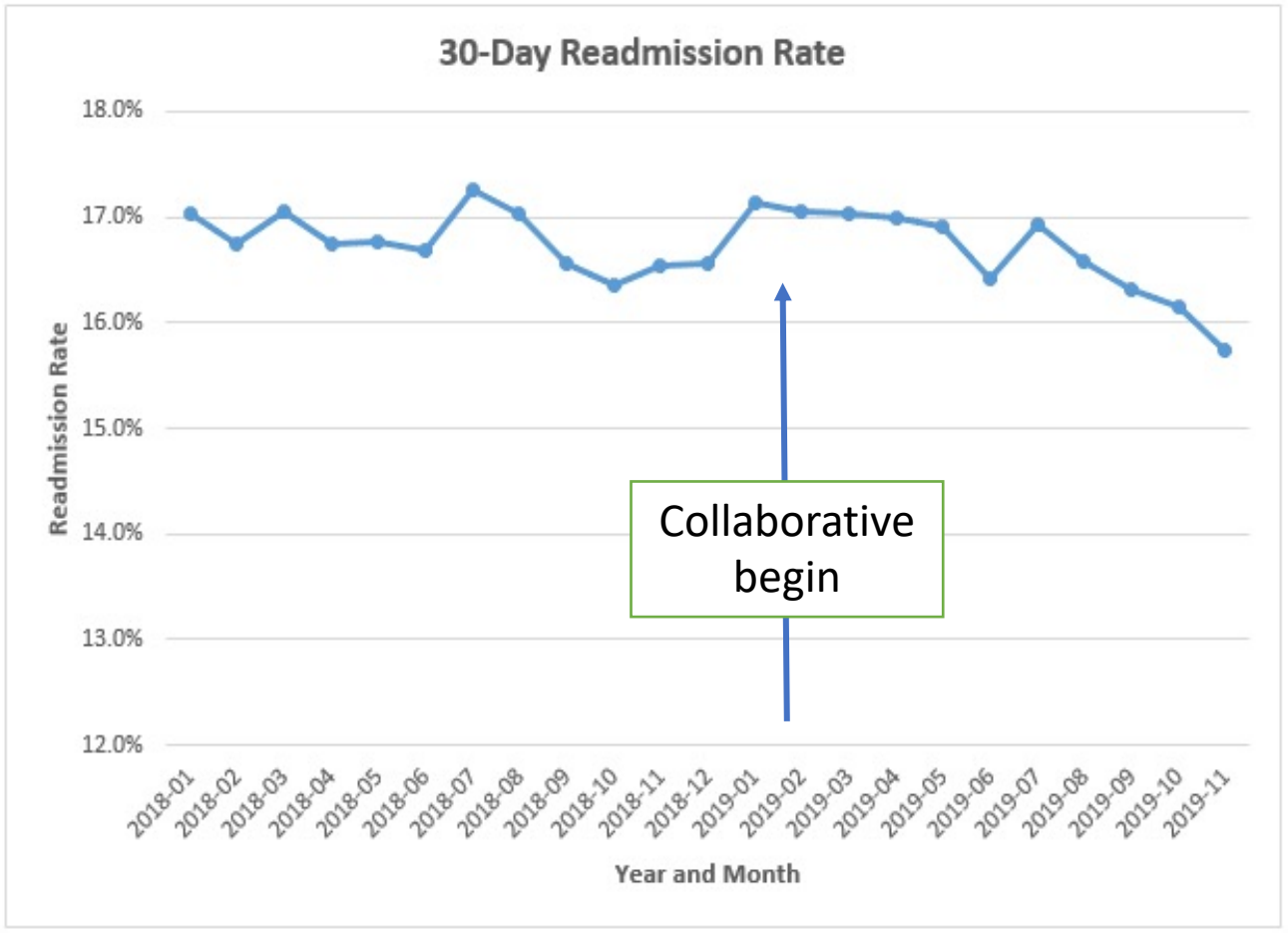
PFP care partner data

- Initiative work began 2019
- PFP program ended Q-I, 2020



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From the patient and care partner's perspective

- Video: The Power of the Care Partner: The Maria and Don Story

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Care partner program

Thank you!

Nancy Landor	nlandor@hanys.org
Dr. Cathleen Wright	cwright@hanys.org
Brenda Chapman	bchapman@hanys.org
Maria Sacco	msacco@hanys.org

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River Hospital

Safe harbor for your health.

Care Partner Program

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River Hospital Care Partner

Alexandria Bay, NY
Thousand Islands Region

- Threatened with closure in 2000, the community came together in support of keeping the hospital local, and through their hard work, including hospital staff, a CON was granted and it was re-born as River Hospital in 2003.
- 24 bed CAH, providing emergency, acute, and sub-acute care services; alos includes outpatient, primary care, specialty services and behavioral health
- Access by boat or car
- Chartis Center: Top 20 CAHs in the country
  - 99th percentile on 50 indicators

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Review of current state

The key first step:

- ✓ Review forms and admission process to determine where the question “who is your care partner” could be integrated.
- ✓ Implement change

Admission Process: Patient Access Staff

- Review of Process:
  - ✓ Patient Access staff, as they are usually the first to ask contact information during the registration process.
  - ✓ Provided education
    - ❖ Patients emergency contact vs or care giver vs **Care Partner**.
  - ✓ Developed and shared a script
  - ✓ Care Partner question was added to the admission electronic form.

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Nursing Staff

- ✓Inpatient nursing staff were the next team to be approached.
- ✓Provided education and scripting to use during their admission process and screening.
- ✓The question was also added to their electronic assessment forms.

We now have two places where the question was asked and documented in the admission process.

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Discharge Planning

- Next step:
  - ✓ Add the question to our Discharge Planning Assessment.
    - ❖ This interview is done within 24 hrs. of admission.
  - ✓ Review the other two assessment already completed prior to interviewing the patient.
    - ❖ Assess patient for understanding of the term care partner
    - ❖ Assist with identification of care partner
  - ✓ Explaining care partner role and preparing for discharge.

We now have three places where the question was asked and documented in the admission process.

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Awareness/Education
Care Partner Campaign

- Posters in elevators and public spaces, explaining what a Care Partner role is.

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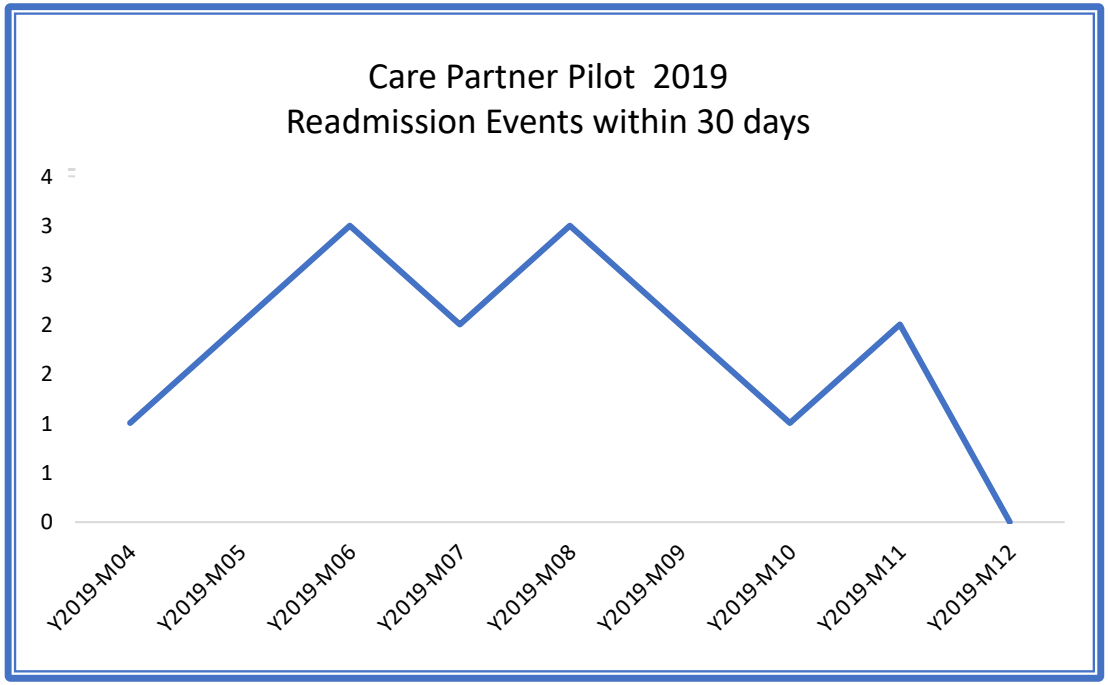
Monitoring the process

QI monitor

Process:

- ✓Review all the areas of documentation to ensure the patient/family is being asked the question
- ✓Documentation reflected in medical record.

Outcome



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Impact

- ✓Uniting the clinical team together with the family members for a true team approach to patient centered care.
- ✓Families and Care Partners feel they are part of the team
- ✓Family members have been given a voice and that their voice is heard.

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Thank you.

Judy Hunter-Eves

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Open Discussion

- Where can you begin with your facility to continue to ensure safety, and a patient-centered approach as you engage care partners?
- What actions can you take in the next 30 days? 90 days?
- What sort of activities do you have underway to impact readmissions?

Final Thoughts

Join Us for the next Community of Practice Call!

Join us for the next
Community of Practice Call on Nov. 18, 2021
from 1:00 – 2:00 PM ET

We invite you to register at the following link:

https://zoom.us/webinar/register/WN_ASl_l3p_TEyx_VY_YYFFeA

You will receive a confirmation email with login details.

Thank You!

Your opinion is valuable to us. Please take a moment to complete the post event assessment here:

https://www.surveymonkey.com/r/10_14_21

We will use the information you provide to improve future events.