New York State Partnership for Patients

Effectively Engaging Patients and Care Partners

Specific, feasible, and meaningful insights and actions of NYSPFP teams

Amy E. Boutwell, MD, MPP
March 20 2019

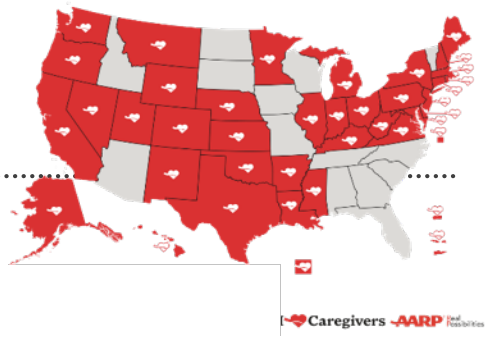
A partnership of the Healthcare Association of New York State and the Greater New York Hospital Association

Agenda

- Welcome
- My 5 Coaching Points
- Your 5 Action Steps
- Our Next Steps Together
- Adjourn

My 5 Coaching Points

Purpose, Pivot, Identify, Engage, Measure



Coaching Point 1: Purpose

Purpose of the CARE Act written by the AARP

- Our patients want us to do better
- Our patients want us to know who their care partner is
- Our patients want us to involve their care partner
- Our patients want us to ask their care partner if they have questions about their care
- Our patients know their care partner is an important part of their recovery, and they want us to understand and value this, too

Coaching Point 2: Pivot

We have an opportunity to pivot:

- From focus on *compliance* with the CARE Act
- To *optimizing the benefits* of effectively engaging care partners:
  - Clinical quality
  - Patient safety
  - HCAHPS
  - Readmissions
  - Length of stay
  - Value-based contracting
  - External reputation
  - Clinician satisfaction
  - Culture of service excellence

Coaching Point 3: Identify

Every hospital has 3 groups of patients:

1. Those who can readily identify a care partner when we ask
2. Those who can't readily identify a care partner, but have one; they just need us to help them think this through a bit
3. Those who don't have a care partner

"Asking the question" works for group 1 but not for groups 2 and 3:

- Group 2 needs us to be proactive: "let's figure out who could help…"
- Group 3 are high risk of readmission: we need to find a "proxy"
- We want to design a system to identify a care partner for all patients
- Goal: high % of all patients have a care partner or proxy identified
- *Note: that is very different from asking the question*

Coaching Point 4: Engage

Once a care partner is identified, consistently engage in care process:

1. Upon identification: speak with (in person, over phone, via email); acknowledge important role, welcome and orient to unit and general schedule of a day, identify their point person and how to ask questions and when to expect updates

2. During admission: daily updates, expand our SOPs to modernize communication – in person, phone, email, text – to more easily connect; tools to prompt questions

3. During discharge planning: focusing on care partner review and input into logistics, self care instructions; use teach back for patient and care partner

4. After discharge: if you conduct post discharge calls, speak with the care partner as well as the patient or speak with the care partner if you can't get a hold of the patient or if the patient can't speak for themselves

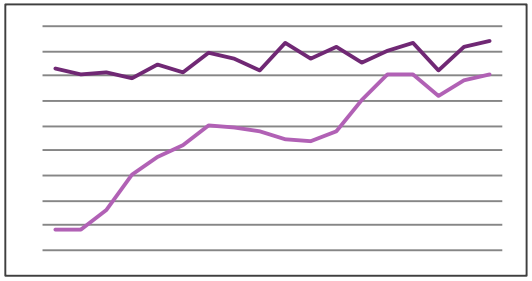
Coaching Point 5: Measure

We can't improve what we don't measure!

~"Some is not a number; soon is not a time"

Percent of admissions with a care partner identified

- Total number of discharges in the past [week, month]
- Total number of discharges with a "Y" indicating they have a care partner
- Look at a prior month, call that your baseline
- Track weekly (if working on a pilot unit) or monthly to demonstrate trend
- Goal: increase the % of patients who have a "Y" for care partner

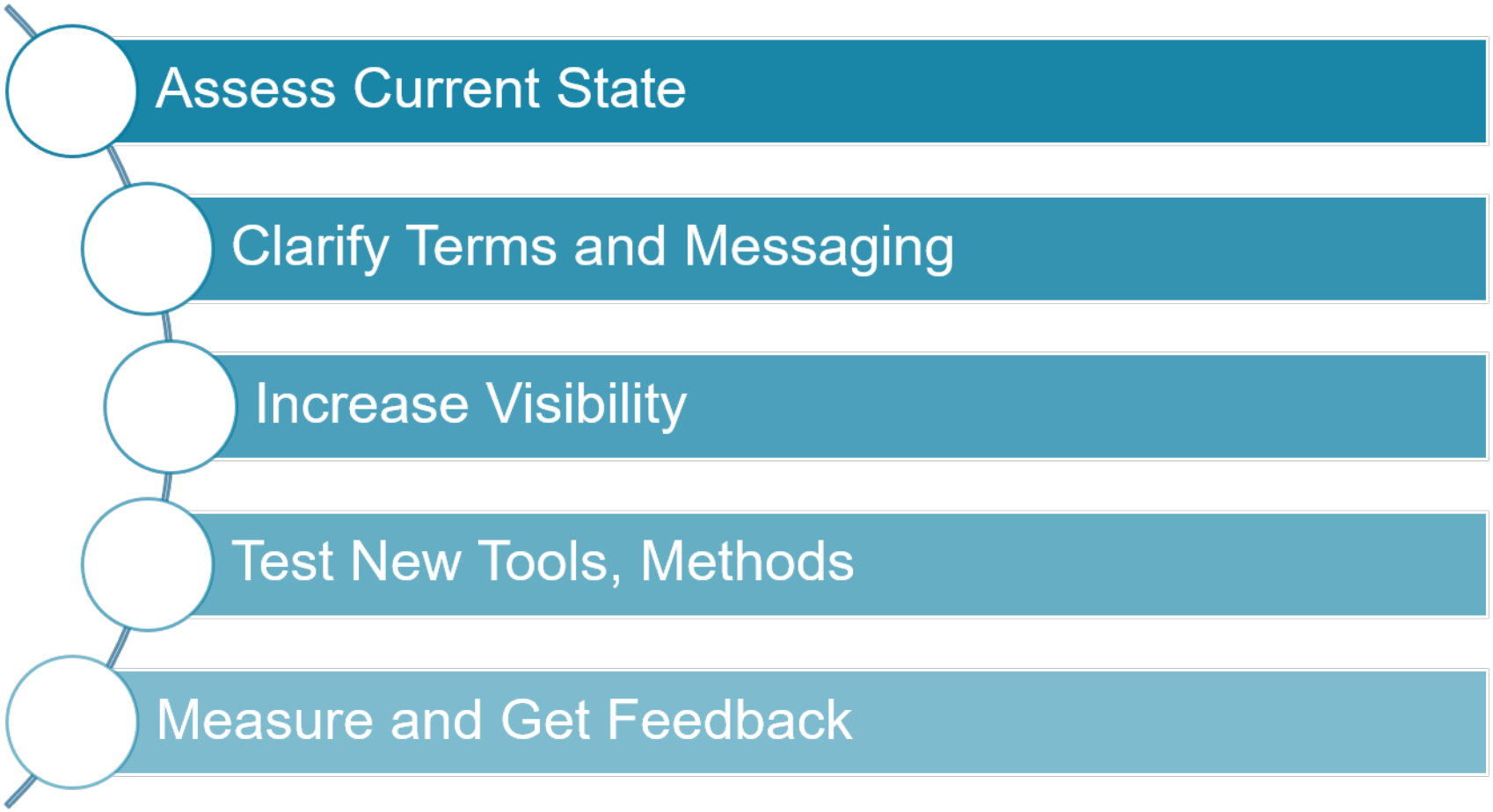


Top Line: all discharges
Bottom Line: "Y" care partner

Your 5 Action Steps

Feasible, meaningful, specific, short-term

Your 5 Action Steps



Action Step 1: Assess Current State

- Analyze current performance
  1. What % of admissions are asked to identify a care partner?
  2. What % of admissions actually (Y) identify a care partner?

- Articulate current process
  - Who asks the patient if they would like to identify a care partner?
  - What “script” / phrasing do we use?
  - Where do we document that information?
  - It is visible to others on the care team?
  - How do we use that information (presence or absence of care partner)
  - How do we engage the care partner? How consistently?
  - What do we do if the patient does not identify a care partner?

Action Step 2: Clarify Terms and Messaging

- Clarify terms (distinction, purpose) for staff
  - Proxy, emergency contact, care partner
  - Example: one team is training clerical staff on new fields in record for care partner through a series of lunch and learns
  - Example: one team provides staff with the “short phrase” description of what a care partner is “a care partner is the person who….”
- Clarify terms (distinction, purpose) for patients
  - Example: several teams are using the “care partner” term from NYSPFP
  - Example: several teams have a ”short phrase” description of a care partner, either in writing or as consistently described by staff
- Key take-away: the term “caregiver” or “care partner” is not sufficiently self evident – we need to use a short phrase to describe

Action Step 3: Increase Visibility

- Teams realize documentation in EMR often is buried → not used
- 2 major approaches: manual and automated
  - Manual
    - When a care partner is identified, write it on the white board
      - This might be during the RN admission assessment; it might be the next day during a PCA, MD, RN, CM, or SW conversation
    - Benefit: we can start this today, one staff person, one patient
    - Benefit: visual cue at the bedside to prompt team to engage care partner
    - Benefit: visual cue to indicate clearly whether or not there is a care partner
  - Automated
    - One team has column on daily patient list indicating if there is a care partner
    - One team has an automated task generated to follow up if no CP identified
    - Several teams are asking IT to place into in more visible location (care coordination, etc)
    - Several teams are asking IT to pull forward care partner name onto discharge paperwork
    - One team is collecting care partner info in clinic, will be available in EMR if/when admitted

Action Step 4: Test New Tools, Methods

- Tools:
  - NYSPFP meal-tray tool: Care Partners are SMART and AWARE
  - Welcome and orientation handout / guide to the unit
  - Allocated space on the whiteboard for care partner name/contact (visual cue)
  - IT tool: perpetuate task to identify care partner until completed

- Methods:
  - Include whether there is a care partner as standard item in IDR; if none, then identify proxy
  - Engage care partner at bedside when team rounds
  - Ask the care partner how they would like to be updated
  - Identify the care partner's primary point of contact on the team
  - Orient the care partner as to when to expect day to day updates
  - Assign role/responsibility to update care partner daily
  - Expand modes of communication with care partner to include phone, text, email
  - Speak with the care partner during the post discharge phone call

Action Step 5: Measure and Get Feedback

- Measure baseline performance
  - % of patients asked if they would like to identify a care partner (Y/N/D)
  - Specifically % of patients who affirmatively identified a care partner (Y)
- Observe current practice
  - Shadow registrar or admitting RN to observe workflow in detail
  - Unit-based walk-rounds to see if care partner name is on white board (%)
- Ask for feedback
  - From patients and care partners on the unit: did you find this tool helpful?
  - From PFAC members: feedback on tools, handouts, materials
  - From staff: testing new tools (handout, whiteboard)
  - From staff: testing new methods (emailing daily updates, CP in IDR rounds)

Our Next Steps Together

Commit – Identify – Include – Prepare