Enhancing Hospital Commitment to Patients and Care Partners

March 20, 2019

Agenda

TOPIC	SPEAKER
Introduction	NYSPFP Staff
Effectively Engaging Patients and Care Partners	Amy Boutwell, M.D., M.P.P., Collaborative Healthcare Strategies
Closing and Q&A	NYSPFP Staff

NYSPFP Readmission Reduction Focus - Goal

Reduce hospital preventable readmissions by 12%

NYSPFP Readmission Reduction Focus

What is a Care Partner*?

The term “care partner” highlights a family member, friend, or caregiver as an extension of the health care team and is promoted by the Institute for Patient and Family Centered Care®(IPFCC), Planetree, and Center for Medicare and Medicaid Services (CMS). This term can be used interchangeably with “caregiver” as defined in the Caregiver Advise, Record and Enable (CARE) Act.

*The NYS Department of Health has provided the following clarification: “if different terminology is used to refer to a caregiver as specified in the CARE Act, a clarifying statement in the hospital’s policies and procedures is recommended to clarify intent.”

NYSPFP Readmission Reduction Focus

NYSPFP “CALL TO ACTION: Engaging the Patient and Care Partner in Preventing Readmissions”

- 14 in-person working sessions with approximately 150 hospitals throughout NYS
- Faculty facilitated follow-up coaching sessions with 67 hospitals who are actively working on action plans started during the Call to Action in person working sessions

NYSPFP Readmission Reduction Focus - Aims

- Establish a focus on patient and care partner engagement throughout the hospital stay as a leadership priority
- Employ bedside care redesign to identify and engage care partners throughout the hospital stay
- Move beyond CARE Act compliance to the spirit of the law by hard-wiring engagement of patients and care partners throughout the hospital stay

Dr. Amy Boutwell slide deck

NYSPFP Care Partner Collaborative

Commit—Identify—Include—Prepare

Optimizing Care Partner Engagement

Commit: Become a Care Partner Hospital

- Dedicate a program leader
- Establish a Care Partner program
- Broadly promote the care partner role
- Continuously evaluate and improve the program

Identify: Patients choose their Care Partner

- Support patient to designate a qualified Care Partner
- Introduce care partner to the medical team
- Display name and contact info in highly visible areas
- Provide a visual identifier for Care Partner to wear in the hospital

Optimizing Care Partner Engagement

Include: Care Partner is a member of the health care team

- Orient the Care Partner to the unit environment and routine
- Empower the Care Partner to perform simple patient care activities
- Invite the Care Partner to daily patient rounds and bedside huddles
- Involve the Care Partner in discussions about the patient's care plan

Prepare: Care Partners are prepared for the next transition

- Assess the Care Partner's education needs
- Educate the Care Partners on essential care activities at home
- Allow the Care Partner to demonstrate understanding using teach-back
- Integrate the care partner into discharge planning

National View

Three Foundational Principles to Tackle the Complexities of Readmissions

I. Know Your Data & Understand Root Causes

- Analyze data (quantitative and qualitative) to identify the "who," the "why," and the "risks," to include socio-economic factors.

II. Effectively Engage Patient and Care Partner

- Integrate care partners into the process right away and involve throughout care continuum and at discharge.

III. Reliably & Consistently Deliver Care Transitions

- Ensure your care coordination/transition interventions are being done effectively and consistently.

Opportunity is Now

- Hospitals are penalized for excessive 30-day readmissions rates under the Hospital Readmissions Reduction Program (HRRP).
- Payers are including hospital readmission quality measures to value-based reimbursement programs.
- Customer (Patient and Care Partner) experience scores are linked to care coordination.

Readmission Reduction Programs Need

- Strong Leadership support
- Policy that is executed into practice
- Dedicated staff
- Patient-centered focus
- Time, success begins with 1 – 2 interventions and then spreads.

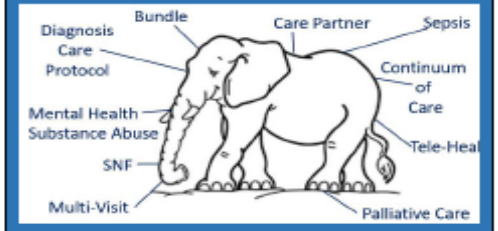
Building the Business Case

- Value-Based models are replacing Fee-For-Service
- Financial Well-Being
- Improve Quality of Care Across the Continuum
- Improve the Customer Experience
- Relieve Staff Stress and Reduce Burden

Many Pieces of the Large Readmissions Elephant

Portfolio of interventions hospials may be working on:

- Diagnosis Care Protocols
- Care Transition Bundles
- Skilled Nursing Facilities
- Tele-Health Services
- Palliative Care Services
- Mental Health
- Substance Abuse
- Multiple Visit Patients (Frequent Flyers)
- Care Partner (Patient and Family) Engagement
- Sepsis Specific Interventions



Next Steps:

- Resources from today's webinar will be available on the NYSPFP website
- The NYSPFP SNF Readmission Reduction toolkit is now also available on the NYSPFP website
- NYSPFP request hospitals contact your NYSPFP Project Manager for more information regarding how to participate in the Care Partner Collaborative

Question & Answers