Becoming a Care Partner Hospital

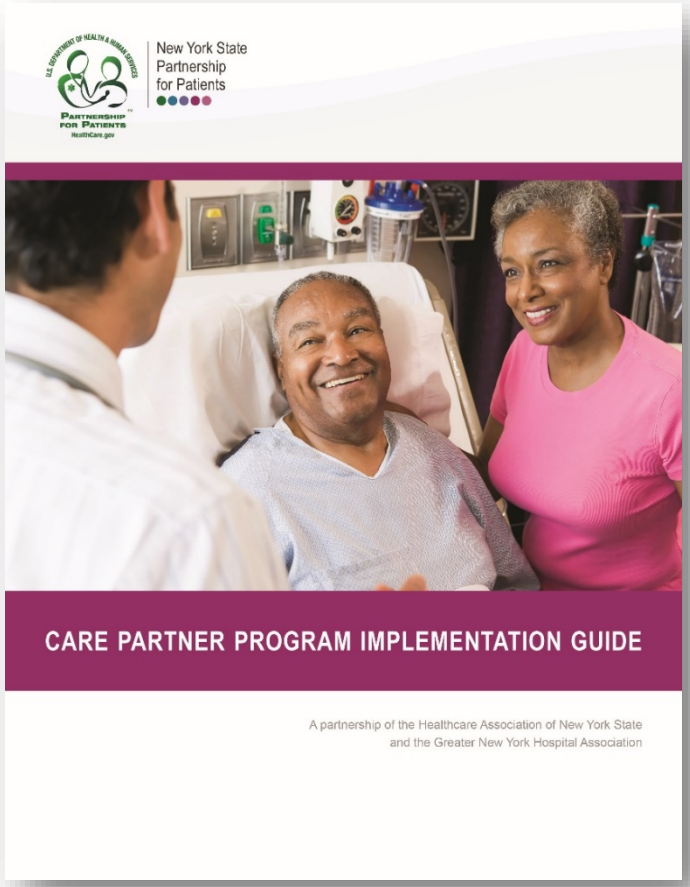
Webinar 3
October 2019

Agenda

- Introduction — NYSPFP Staff
  - 4 Steps to Becoming a Care Partner Hospital
- Step 4: Prepare — Dr. Amy Boutwell
  - Concepts, Practices, Tools
  - Action steps
- Questions & Wrap up — NYSPFP Staff
  - Tools & Materials

4 Steps to Become a Care Partner Hospital

NYSPFP Care Partner Program Materials



NYSPFP Care Partner Collaborative

Call to Action Sessions	Collaborative Developed	Collaborative Webinar 1 "Commit" "Identify"	Collaborative Webinar 2 "Include"	**Collaborative Webinar 3** **"Prepare"**

Becoming a Care Partner Hospital

Step 4: "Prepare"

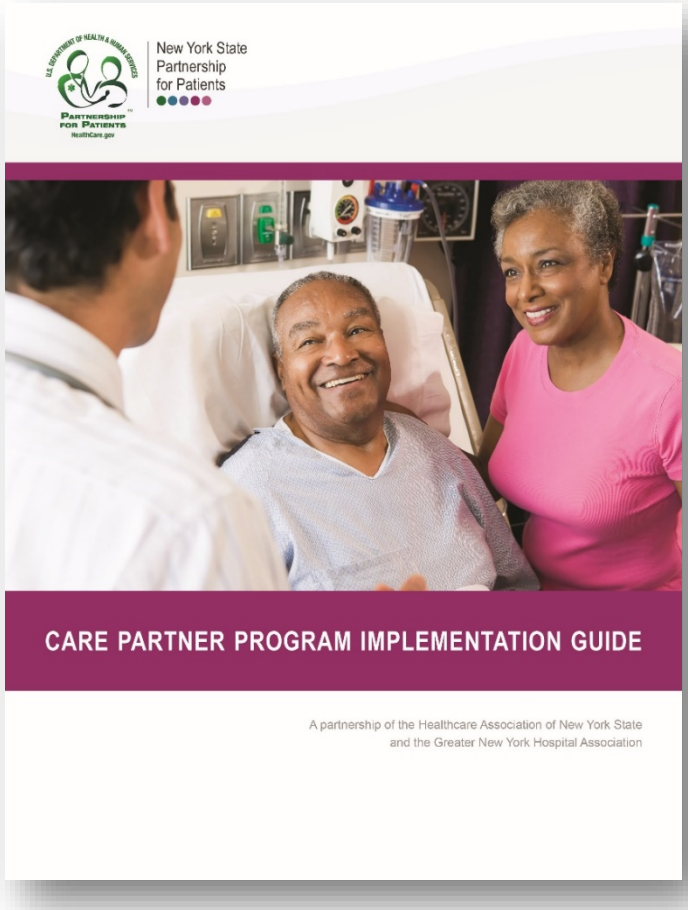
Amy Boutwell, MD, MPP
Advisor, New York State Partnership for Patients
President, Collaborative Healthcare Strategies

4-Steps to Becoming a Care Partner Hospital

Commit	Identify	Include	**Prepare**
• Leadership • Input / staff • Input / Pt & CP • Educate staff • Visibility • Measure • Improve	• Re-script the Q • Inform/educate • Dedicated role • Redundancy • Visible, easy • Plan for proxy if no CP ID	• Orient to unit • Point person • Encourage Qs • Share info • How / contact • When / contact • Daily updates • Participate	*Today's topic!*

Concepts

NYSPFP Care Partner Hospital Implementation Guide



Chapter 4: "Prepare"

- **Care Partner is prepared for Transition**
  - Begins at admission, daily updates
  - Participate in discharge planning
- **Assess CP's Educational Needs**
  - Literacy & Health Literacy
  - Language & Culture
- **Integrate CP in discharge planning**
  - Concerns
  - Preferences
  - Readiness for discharge
- **Allow CP to Teach-Back**
  - Disease-specific information
  - Medications, diet
  - Follow up plan
  - What to watch for & who to call
- **Expect & participate in follow up call**

Concepts

Prepare

Transitional Care: Starts at Admission, Continues through Transition to Next Setting

Admission	Hospital Stay	Discharge Planning	Post-Hospital
• Identify the CP • Gather information • Solicit concerns • Anticipate LOS	• Daily updates • Encourage Qs • Include in rounds • Include in teaching • Assess L & HL	• Discuss transition • Describe self-care • Use teach-back • Identify needs • Agree on plan	• Include in f/u call • Ensure CP knows who to call with ?s

Consider :

- Do any of these practices - focused on the CP - occur as standard care in your hospital?
- Which ones?
- How do you know?
- Why are they ”standard” / “consistent”?
- How much more successful do you think our patients’ transitions would be if we did this?
- How much more satisfied would patients / CPs be with the experience of care?

Please chat in your thoughts & observations!

Specific Practices

Use “Identify” and “Include” as an Assessment → Prepare

- Is the patient able to identify a Care Partner?
  - If no, patient is potentially high risk of readmission! We need to work to find a care partner/proxy
- When we “include” the care partner and gather information, do we identify any:
  - Readmission risks, or root causes of prior readmission (if relevant)
  - Language barriers
  - Cultural considerations or health-related beliefs that may impact care
  - Issues with ability to read, understand health-related information (literacy, health literacy)
  - Social needs, stressors in the ”family” unit that may impact care
  - Behavioral health issues
  - Self-care habits, abilities, needs, concerns, challenges
  - Financial, logistical, transportation issues that impact care planning
- This information gathering can start at admission
  - Giving care team more time during the hospitalization to teach, teach-back, coordinate, etc
- Pearl: “Including” the Care Partner in all readmission reviews is best practice

Specific Practices

"Prepare" the CP through Daily Contact

Building on "include" steps……

- Care Partner is encouraged to be involved and ask questions
- Care Partner knows when to expect routine daily updates
- Care Partner has let us know how best to communicate with them (F2F, cell, email)

Leads to "prepare" practices…..

- Care Partner is included in medication teaching (F2F, cell, email)
- Care Partner is included in self-care teaching
- Care Partner is included in transition and post-hospital care plan development
- Care Partner is encouraged to ask questions, express concerns, preferences
- Care Partner's understanding is confirmed through teach-back
- Care Partner's ability to support patient is confirmed through engagement in above

Specific Practices

"Prepare" the CP for Post-Hospital Care

- What are the specific care needs after hospital?
  - Medications
  - Wound/device care
  - Tests, Appointments
  - Post-hospital contact (expect a call) and who to be in touch with questions

- Use teach-back for all of the above!
  - Don't rely on written information from pre-written print-outs
    - (ask your PFAC what they think about those print outs!)

- When you identify a need during your daily updates and/or teach-back sessions:
  - Follow-up, clarify, repeat; change language/ literacy level
  - Call a consult – nurse educator, pharm/pharm tech, social worker, pall care, etc
  - Bring concerns to inter-disciplinary rounds
  - Hand-off that information, concern to the next relevant provider (ToC, PCP, Home Health, etc)

Tools

NYSPFP Tool: What is a 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 his or her 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 rounds, please feel free to:

- take notes
- ask questions
- tell the team about anything that concerns or confuses 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 looking for specific signs and symptoms of the patient's disease/diagnosis. The medical team will tell you what to look for and who to talk to if you see those signs, 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 both you and the patient are fully comfortable with everything before leaving the hospital.

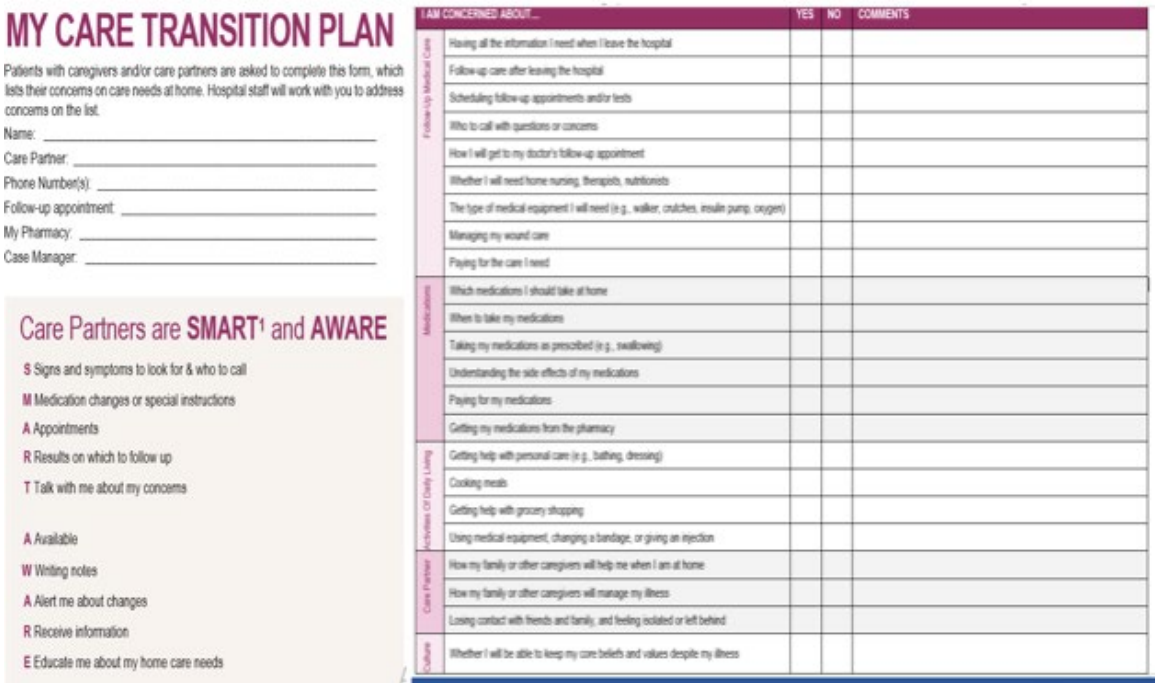
Depending on the patient's needs, tasks may include:

- making and getting to appointments for follow-up care
- remembering how and when to take medication

- Take notes
- Ask questions
- Share concerns
- Be updated
- Learn how to…
- Understand meds
- Know what to look for
- Know who to call
- Know follow up plan
- Know self-care tasks
- Expect our f/u call

Tools

NYSPFP Tool: My Care Transition Plan



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.

Name: _____

Care Partner: _____

Phone Number(s): _____

Follow-up appointment: _____

My Pharmacy: _____

Case Manager: _____

Care Partners are SMART[1] and AWARE

S Signs and symptoms to look for & 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

I AM CONCERNED ABOUT...		YES	NO	COMMENTS
Follow-Up Medical Care	Having all the information I need when I leave the hospital			
	Follow-up care after leaving the hospital			
	Scheduling follow-up appointments and/or tests			
	Who to call with questions or concerns			
	How I will get to my doctor's follow-up appointment			
	Whether I will need home nursing, therapists, nutritionists			
	The type of medical equipment I will need (e.g., walker, crutches, insulin pump, oxygen)			
	Managing my wound care			
	Paying for the care I need			
Medications	Which medications I should take at home			
	When to take my medications			
	Taking my medications as prescribed (e.g., swallowing)			
	Understanding the side effects of my medications			
	Paying for my medications			
	Getting my medications from the pharmacy			
Activities Of Daily Living	Getting help with personal care (e.g., bathing, dressing)			
	Cooking meals			
	Getting help with grocery shopping			
	Using medical equipment, changing a bandage, or giving an injection			
Care Partner	How my family or other caregivers will help me when I am at home			
	How my family or other caregivers will manage my illness			
	Losing contact with friends and family, and feeling isolated or left behind			
Culture	Whether I will be able to keep my core beliefs and values despite my illness			

- Information
- Follow up care
- Scheduling appointments
- Who to call
- Transportation
- Equipment, supplies
- Wound care
- Medications – how to take
- Medications – how to get, $
- Personal care
- Cooking, errands
- Getting help in general
- Living / recovering from illness
- Coping, emotional impact

Discussion: Making Change

Commit to action in next 30 days

Brainstorm: Prepare

Brainstorm how your organization could better **"prepare" the care partner** for the transition:

Who…	What….
Day-shift bedside RN	[update CP in-person, via phone, email daily]
Evening-shift bedside RN	[backup role to update CP after hours]
Case manager/Discharge Planner	[every meeting includes CP, including by phone/email]
Attending Physician	[encourage questions, elevate role of CP to patient & CP]
Pharmacist / Pharmacy Technician	[include CP in med teaching, including by phone/email]
Nurse Educator	[include CP in teaching, including by phone/email]
Nurse Manager for the Unit	[ensure each RN/CM has ID CP for all patients, daily]
Patient Care Assistant	[ensure CP name on whiteboard or CP tool on meal tray]
Inter-Disciplinary Rounds Participants	[identify "who" will update CP, today]
Nurse Leader/Director of Care Management	[Audit, measure, feedback, coach]
Transitional Care Staff	[ToC staff prepares P & CP to expect post discharge call]
Bundle / ACO Care Management Staff	[CM includes CP in developing post-hospital plan]
PCMH Practice Care Manager	[PCMH calls P after d/c & asks to speak with CP]
Patient Experience Officer	[walk-rounds to observe Identify – Include – Prepare]
Patient Family Advisory Council (PFAC)	[feedback on tools, change ideas]
Other	

Brainstorm: Prepare

Brainstorm 3 tests of change better **"prepare" the care partner** for the transition:

Test of Change 1	Test of Change 2	Test of Change 3
What are we trying to accomplish? [eg Engage CP in Teach Back]	What are we trying to accomplish? [eg Assess CP concerns for discharge]	What are we trying to accomplish? [eg Include CP in follow up phone call]
How will we know test is improvement? [eg Staff confirms/clarifies info with CP]	How will we know test is improvement? [CP concerns are known & addressed]	How will we know test is improvement? [eg Calls are more effective in red. RA]
What change can we make → improve? [eg Day shift RN engages CP in TB]	What change can we make → improve? [eg CM asks CP about concerns]	What change can we make → improve? [Modify f/u call script to include CP]

Chat in your ideas!

From Ideas to Action

- 7 day Action Plan: *What can you do "by Tuesday"?*
  - *Eg 1 RN engages 1 CP in Teach Back*
  - *Eg 1 CM asks CP about d/c concerns*
- 30 day Action Plan: *What can you do "by Thanksgiving"?*
  - *Eg 10 CPs / week receiving Teach Back on 3W pilot unit*
  - *Eg 25 post discharge calls included CP*

Chat in your ideas!

Next Steps

- *Join us! If you haven't enrolled in this collaborative, please do!*
- **The Power of the Care Partner: A Special NYSPFP Event**
  Tuesday, December 3, 2019
  9:30 a.m. – 12: 30 p.m.
- *Contact your NYSPFP Project Manager with questions*

Questions?

Thank you for your commitment to effectively engaging Care Partners

New York State Partnership for Patients Team

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