



New York State  
Partnership  
for Patients



# Becoming a Care Partner Hospital

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*A strategic initiative of the New York State Partnership for Patients*

Webinar 1  
July 24, 2019



# Agenda

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|---|------------------|
| • Introduction                          | NYSPFP Staff     |
| • Why become a Care Partner Hospital?   | Dr. Amy Boutwell |
| • How to become a Care Partner Hospital | Dr. Amy Boutwell |
| • Step 1: Commit                        |                  |
| • Step 2: Identify                      |                  |
| • Action Steps                          |                  |
| • Questions & Wrap Up                   | NYSPFP Staff     |



## High-Leverage Strategies to Reduce Readmissions

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1. Know your Data & Understand Root Causes
- 2. *Effectively Engage Patients and Care Partners***
3. Reliably & Consistently Deliver Care Transitions

*HIIN Readmission Affinity Group 3/2019*

# Importance of a Care Partner Program

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<https://www.youtube.com/watch?v=Poji5nU12oE>



# Call to Action: Engaging the Patient and Care Partner

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- 20 meetings between October 2018-April 2019 across the state
- 150 Hospitals participated
- 62 Hospitals participated in coaching calls after the in-person sessions with Dr. Boutwell



# Call to Action Work Sessions Momentum

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- Hospitals asked us to help operationalize improving engagement of the patient and care partner
- Build on what hospitals have already accomplished and share how they've done it



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# Why become a Care Partner Hospital?

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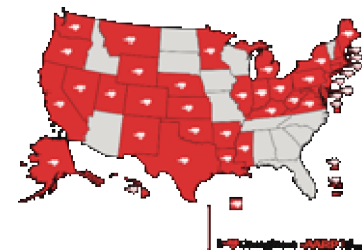
*A brief history of where we've been and where we're going*

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

# The CARE Act

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- Requires hospitals to allow patients to identify a care partner\* and requires hospitals to include the care partner in care planning
- 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
  - Care partners want to understand the care plan, contribute to establishing a plan that will work, and understand how to help



\*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.”





# Our Priorities and Goals

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- Clinical quality
- Patient safety
- HCAHPS
- Readmissions
- Length of stay
- Value-based contracting
- External reputation
- Clinician satisfaction
- Culture of service excellence

**It's the right thing to do!**



# Beyond Compliance to High Value Care

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- The CARE Act requires “compliance”
  - Did you ask the patient if they would like to identify a care partner?
  - If the patient has a care partner, we must notify them of discharge
- Our priorities 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



# Why Don't We?

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- Task oriented
  - The task of “asking” is seen as the job, not the purpose
- Time
  - Perceived as taking too much time to engage CPs
- No standard process
  - Who does it? When?
- Not managed or measured
  - How many patients have CP identified?



## How Could We?

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- Clear role assigned, with redundancy
  - What to do if a CP not identified the first time asked
- Re-work scripting and training on purpose
  - “Caregiver” to “care partner” or “who helps you”
  - Purpose: care partners promote safety/ quality goals
- Place CP name/number on whiteboard
- Ask CP how/when they would like to be updated
- Measure and provide feedback to staff



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# How to become a Care Partner Hospital

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*Collaborative Support, 4 Steps, Tools, Materials*

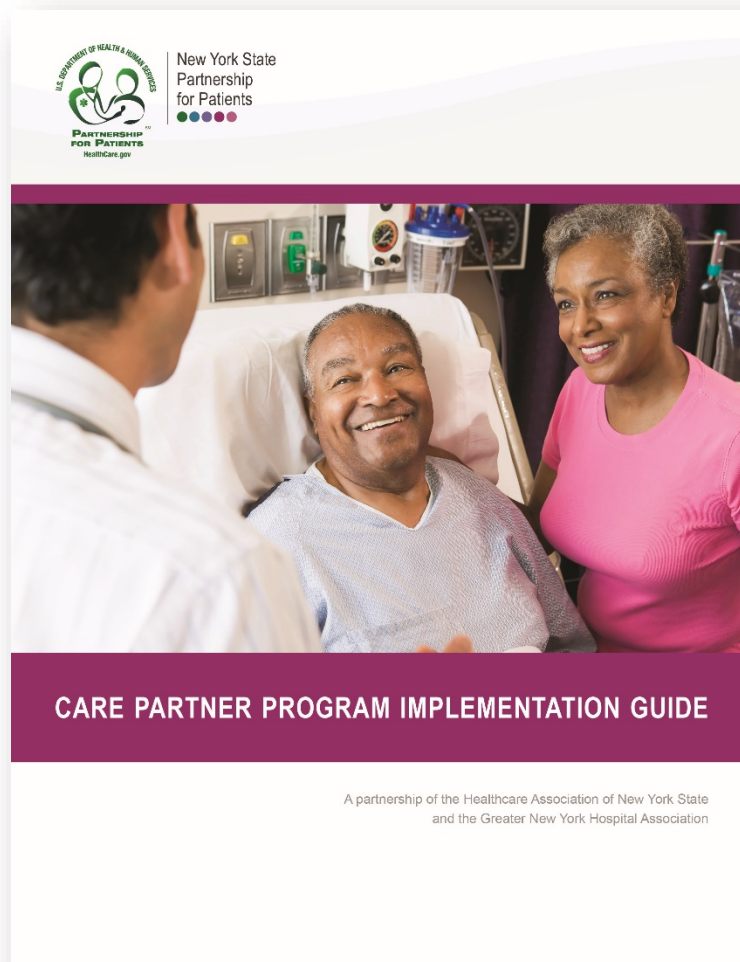
# Become a Care Partner Hospital





# Care Partner Hospital Implementation Guide

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# Care Partner Hospital Implementation Checklist



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## WHAT IS THIS TOOL?

A checklist of 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 NYSPFP *Care Partners 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).

## Engaging and Optimizing Care Partners Implementation Checklist

Published: July 2019







# Proposed Process and Outcome Measures

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Outcome Measures	Example Process Measures*
Readmission rate	% patients with a CP identified
HCAHPS #23: “my preferences”	% CPs received teach back
HCAHPS #24: “understand what to do”	% CPs participated in consults
HCAHPS #25: “understand meds”	% CPs involved in discharge
	% CPs satisfied with involvement

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



# Tools and Materials

Thank you  
for being a  
**CARE  
PARTNER**



Care Partners\* help patients get the care they need at the hospital and at home. The care partner is part of the health care team.



\* The term "care partner" is used intentionally to highlight a family member, friend, caregiver, or an extension of the health care team and is promoted by Planets for the Institute for Patient- and Family-Centered Care.

## NYSPFP My Care Transitions Brochure

### 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.

#### Care Partners are SMART<sup>1</sup> 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

Name: \_\_\_\_\_

Care Partner: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

Follow-up appointment: \_\_\_\_\_

My Pharmacy: \_\_\_\_\_

Case Manager: \_\_\_\_\_

<sup>1</sup> "SMART Discharge Protocol." The Institute for Healthcare Improvement. <http://www.ihi.org/Pages/Tools/SMARTDischargeProtocol.aspx> (accessed July 27, 2017).

I AM CONCERNED ABOUT...	YES	NO	COMMENTS
Hearing all the information I read when I leave the hospital			CARE PARTNERS Taking care of yourself can be difficult at times, especially when you are sick. Sometimes you need help.
Follow-up care after leaving the hospital			Care Partners can be family members, friends, neighbors, or paid help. They will help you with daily activities, such as dressing, going shopping, or cooking a meal.
Scheduling follow-up appointments and/or tests			Care Partners can also help by giving information—such as your list of medications, health history, or home care needs—to your doctor or nurse.
Who to call with questions or concerns			

## What is a CARE PARTNER?

For patients: Why do I need one?  
For care partners: What do I do now?



Engaging and Optimizing Care Partners  
Frontline Checklist

<input checked="" type="checkbox"/>	upon check-in or preadmission testing for elective admission
<input checked="" type="checkbox"/>	upon registration or admission
<input checked="" type="checkbox"/>	in electronic medical record
<input checked="" type="checkbox"/>	on whiteboard

### FOR THE PATIENT

#### Why do I need a care partner?

Taking care of yourself alone can be difficult at times, especially when you are sick and in the hospital. Having another set of eyes and ears can help you get the care you want and need in the hospital and at home afterwards.

#### 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 to better understand your needs and preferences and may also participate in your medical care. Your care partner should be prepared to get involved in your care for the entire hospital stay and beyond.

Your care partner will be informed of your health progress. He or she should be ready to be present for rounds and discussions with the medical team and other staff on how to help them look after you in the hospital and after discharge.

Both the person you select—and the hospital staff—should know that he or she is your care partner. Once the hospital staff know whom you have selected, they will ensure that your care partner knows about 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 choose what you want! The care partner helps support you and your choices and expresses them to the medical team—for example, when you are too tired or sick to do it yourself.

#### 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 also working with him or her to ensure you receive care that you want.

The care partner should be available to support you both during and after the hospital stay.

### 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 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
- let the team about anything that concerns or confuses you or the patient

If you are not able to attend the rounds, please let the staff how to reach you to let 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



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## Step 1: Commit

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*Commit to becoming a “Care Partner Hospital”*



# Identify Champion, Form a Team

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## Champion

- Prioritize work
- Support team
- Increase visibility
- CXO, CNO, CQO, etc.
- Director CM

## Team

- Unit Manager
- Nurse
- CM
- Physician
- Quality / Analyst
- PFAC member

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.



## Gather Input - 1

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- Input from staff, patients, and care partners will help you identify opportunities for improvement
  - Staff – understand the root causes of “current state” by asking:
    - How do you ask patients if they have a care partner?
    - What do you do with that information?
    - What makes it difficult to identify a care partner?
    - How do you include care partners in day to day care?
    - How do you include care partners in discharge planning?
    - What factors make it difficult to engage care partners?



## Gather Input - 2

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- 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?



# Promote Care Partner Role

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Messaging to staff, patients, and care partners via:

- Posters
- Website
- Screen saver messages to staff
- Materials at bedside
- Materials in offices, newsletters, mailings
- Inpatient TV channels
- Community education programs



## Educate Staff

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- Develop education for all clinicians:
  - Roles and responsibilities in the care partner program
  - How to effectively identify and engage care partners
- Include CP Program information in
  - New staff orientation
  - Ongoing education and training modules
  - Department and unit communications
- Institute a CP Program Peer Mentor program





## Establish Measurement and Management

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- Develop simple measures for small scale tests
  - % of Tuesday's admissions to pilot unit with CP identified
  - % of 1 RN's patients' CP given teach back Wednesday
- Establish measures for new processes
  - % of patients on unit with CP identified on white board
  - % of CPs provided with teach-back
- Establish measures for outcomes
  - % patients with a CP identified
  - Readmission rate
  - HCAHPS #23, 24, 25



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## Step 2: Identify

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*Support patients in identifying a care partner then make them known!*



# Actively Support Identification

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- Clarify who asks the patient to identify a CP
  - Who first asks? (registration, admitting RN?)
  - Build in redundancy so question is asked again if initial step failed
- Review 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 can not identify a care partner
  - 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, etc.



## Make Care Partner Visible

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- This is key for moving from compliance --> purpose!
- Where does the CP name/contact go?
  - Visible! So it can be used in day-to-day care
  - On the whiteboard
  - In an easy-to-access place in record
  - Identify the care partner with a name badge
  - Routinely identify the care partner in daily bedside rounds



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# Get Started!

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*Specific steps to take in next 30 days*



## 30-Day Action Steps

### 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

- ☐ August 14 webinar - "Include"
- ☐ Fall 2019 – In-person sessions
- ☐ November 6 webinar – "Prepare"



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## Questions?

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

*Contact your NYSPFP Project Manager to enroll or with any questions*



## Next Steps

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- Enroll in the NYSPFP Care Partner Collaborative!
- August 14, 2019, second webinar in our series,  
**Include:** Care partner is a member of the healthcare team
- Fall 2019, in-person collaborative networking sessions-  
locations TBD based on who joins the collaborative
- November 6, 2019, third webinar,  
**Prepare:** Care partner is prepared for the next transition

**Contact your NYSPFP Project Manager**

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