Becoming a Care Partner Hospital

A strategic initiative of the New York State Partnership for Patients

Webinar 1
July 24, 2019

Agenda

• 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

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

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

Call to Action: Engaging the Patient and Care Partner

- 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

- 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

Why become a Care Partner Hospital?

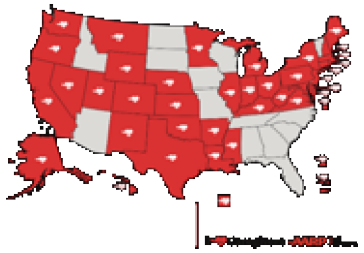
A brief history of where we've been and where we're going

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

The CARE Act

- 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

- 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

- 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?

- 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?

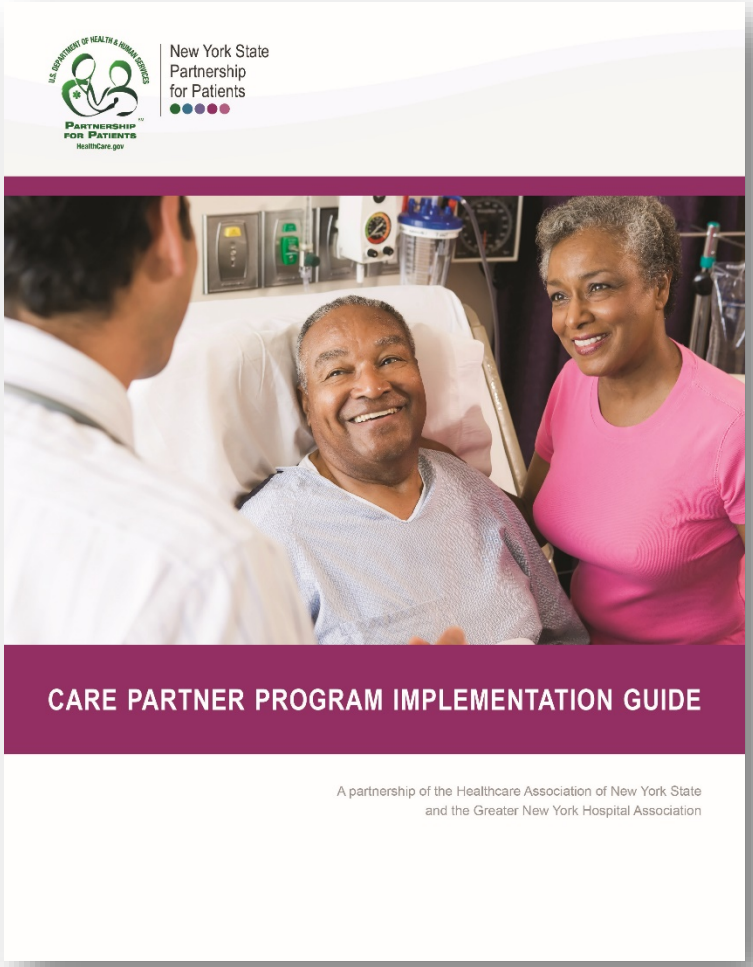
- Clear role assigned, with redundancy
  - What to do if a CP not identified the first time asked
- Re-work scripting and training on purpose
  - “Caregiver” to “care partner” or “who helps you”
  - Purpose: care partners promote safety/ quality goals
- Place CP name/number on whiteboard
- Ask CP how/when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

How to become a Care Partner Hospital

Collaborative Support, 4 Steps, Tools, Materials

Become a Care Partner Hospital

Care Partner Hospital Implementation Guide



Care Partner Hospital Implementation Checklist

New York State Partnership for Patients

Engaging and Optimizing Care Partners
Implementation Checklist
Published: July 2019

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).

CARE PARTNER PROGRAM FRAMEWORK

STEP 1: COMMIT
STEP 2: IDENTIFY
STEP 3: INCLUDE
STEP 4: PREPARE

Proposed Process and Outcome Measures

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

Step 1: Commit

Commit to becoming a "Care Partner Hospital"

Identify Champion, Form a Team

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

- 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

- 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

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

- 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

- 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

Step 2: Identify

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

Actively Support Identification

- 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

- 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

Get Started!

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”

Questions?

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

Contact your NYSPFP Project Manager to enroll or with any questions

Next Steps

- 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