Overview/project description
Utilizing the EQIC Care Partners framework, the team developed a new workflow and process to help patients identify and designate a Care Partner upon admission. Process changes included:

- Adding a question to the Initial Interview in the EMR nursing documentation to identify the Care Partner
- Scripting for staff to follow explaining the Care Partner Program and expectations
- Care Partner information brochure included with each admission packet
- Sharing Care Partner information in the daily Interdisciplinary huddle
- Primary Nurses utilizing the Care Partner as the primary source of communication daily for care plan updates, education, and provider communication

Goals/objectives
1. Reduce Readmission Rates: Decrease to 5%
   - Quarter 1 Fiscal Year 23 Readmission Rate was 8.80%. Our goal was to decrease that rate to 5.00%.

2. Patient Satisfaction HCAHPs: improve to the 50th percentile rank in identified domains
   - Q1FY23 percentile ranks:
     - Communication with Doctors - 25th
     - Discharge Information - 28th
     - Care Transitions - 20th

3. Care Partner Utilization: 75%
   - Once implemented, we had a goal of inpatient admissions who identified a Care Partner of 75%.

Methods/measurements

Results/findings/conclusions
1. Readmission rates decreased to 6.23%, not quite to the goal of 5%, but a decrease of approximately 29% from baseline.
2. Patient Satisfaction scores Q3FY23:
   - Discharge Information met the goal of exceeding 50th percentile rank and Care Transitions increased 130% just below the goal rank. Communication with Doctors however, decreased.
   - Communication with Doctors - 20th
   - Discharge Information - 77th
   - Care Transitions: 46th

3. Utilization Rate: Exceeded goal for 2 months! Will increase goal moving forward.
   - November - 86.8%
   - December - 84.5%

References
All project materials used were from EQIC Care Partner Model Resources.
https://qualityimprovementcollaborative.org/focus_areas/readmissions/tools_resources/

Acknowledgments
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