*Readmission Care Partner*

# Sprint Syllabus

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EQIC is pleased to offer its *Readmission Care Partner* sprint, which allows hospitals to engage in an improvement project focused on the development or enhancement of your care partner program. This comprehensive clinical delivery program will support hospitals and systems in operationalizing patient-centered care and the engagement of the patient and care partner throughout the hospital stay and beyond.

**To register for webinars, visit the EQIC Events page. For questions related to this content or to join the care partner sprint listserv, please contact Brenda Chapman (bchapman@hanys.org).**

Our CMS goals are to reduce readmissions by 5%. Literature is increasingly demonstrating that fully functional care partner programs have a positive impact on reducing readmissions and increasing Hospital Consumer Assessment of Healthcare Providers and System scores.

The care partner programming will be concentrated into a "sprint," which means that we will be using rapid-cycle change principles in order to make a large impact in a short amount of time. Our course will kick off on Sept. 23 with an overview of EQIC's care partner program curriculum.

**During the course of the sprint, we will hear from various subject matter experts in implementing the four-step care partner framework of commit, identify, include and prepare.**


HQIC | Hospital Quality Improvement Contractors
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| Calendar | Care Partner Model Objectives | Hospital Follow-up Assignments and Tools |
|---|---|---|
| **Introduction: Planning and Implementing a Hospital Care Partner Program**<br>*Subject matter expert: Amy Boutwell, MD, MPP* | | |
| **Webinar 1**<br><br>**Thursday, Sept. 23**<br>**1 - 2 p.m.** | **By the end of this session, participants will be able to:**<br>• identify what a care partner program is and why implementing one will benefit your facility;<br>• identify principles and methodology to begin a care partner program;<br>• identify tools and resources for evaluation; and<br>• discuss the model for improvement. | **Following this webinar, participants will:**<br>• define their quality improvement strategy, i.e., PDSA, LEAN-A3, Model for Improvement;<br>• identify multidisciplinary team members; and<br>• begin to strategize on committing to becoming a care partner hospital.<br>**EQIC Tools and Resources:**<br>• How to Use the Toolkit, page 4 of the Care Partner Implementation Guide<br>• Care Partner Implementation Checklist<br>• Care Partner Brochure |
| **Commit: Become a Care Partner Hospital & Identify: Patients Choose Their Care Partner**<br>*Subject matter expert: Maria Sacco, RRT, CPHQ* | | |
| **Webinar 2**<br><br>**Thursday, Oct. 7**<br>**1 - 2 p.m.** | **Commit: Become a Care Partner Hospital**<br>**By the end of this session, participants will be able to:**<br>• identify key staff and physician members that should be part of the care partner team;<br>• identify potential QI pilot data elements to be monitored during development of a care partner program; and<br>• discuss insights on gathering feedback from staff, patients and patient and family advisory council. | **Following this webinar, participants will:**<br>• finalize your multidisciplinary team;<br>• dedicate a program lead;<br>• identify unit champions;<br>• determine baseline data;<br>• draft a high-level flow chart as part of a starting point;<br>• gather feedback from your PFAC;<br>• decide on a model to test improvement steps;<br>• build awareness, engagement and excitement with leaders, staff, physicians and nursing:<br>  ○ immerse healthcare team in the value and concepts of becoming a care partner hospital; and<br>• determine how care partners will be identified in your facility i.e., name badge, wrist band, white board, etc.<br>**EQIC Tools and Resources:**<br>• Care Partner Implementation Guide<br>• Care Partner Frontline checklist<br>• Care Partner Framework<br>• Video: Importance of a Care Partner Program<br>• Video: The Power of the Care Partner: The Maria and Don Story<br>• Care Partner Brochure<br>• My Care Transition Brochure (customizable)<br>• Care Partner Poster<br>• Care Partner images |

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| **Webinar 2** *CONTINUED* | **Identify: Patients Choose Their Care Partner**<br><br>**By the end of this session, participants will be able to:**<br>• identify options and determine which staff will have the primary role in identifying the care partner;<br>• adopt scripting for asking patients to identify a care partner;<br>• identify options for documenting and sharing the care partner name and contact information with health-care team; and<br>• discuss options for identifying a care partner proxy when needed.<br><br>**Part I Criteria for certificate:**<br><br>Complete checklist and implement strategies for the care partner model to date. | **Following this webinar, participants will:**<br>• clearly define who on the healthcare team is responsible for identifying the care partner and include redundancy in the process to identify a care partner;<br>• identify proxy care partners for special conditions as needed;<br>• develop or adapt the EQIC script for staff to obtain care partner identification from patient;<br>• distribute written materials describing what it means to be a care partner;<br>• educate the staff to assist the patient with identifying a care partner;<br>• educate the patient and care partner on what it means to be a care partner;<br>• introduce the care partner to the medical team at huddles or rounds; and<br>• notify care partner of rounding times. If unable to be present, coordinate with care partner to participate remotely.<br><br>**EQIC Tools and Resources:**<br>• Care Partner Brochure<br>• My Care Transition Brochure (customizable)<br>• Care Partner Poster<br>• Care Partner images<br>• Sample Staff Script to Help Patient Identify a Care Partner (Care Partner Implementation Guide Appendix F)<br><br>***Complete all hospital follow up and implementation prior to Oct. 21, 2021.*** |

## Office Hours: Q&A

*Subject matter expert: Maria Sacco, RRT, CPHQ*

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| **Webinar 3**<br><br>**Optional Office Hours**<br><br>**Thursday, Oct. 21**<br>**1 - 2 p.m.** | **During this session, participants will be able to:**<br>• enhance planning strategies;<br>• ask questions regarding implementation strategies; and<br>• network with teams to share challenges and successes. | **Following this webinar, participants will:**<br>• review and enhance program implementation using EQIC tools and resources, including their project manager's coaching. |

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| **Include: Care Partner is a Member of the Healthcare Team**<br>Presentation: Partners in Healing®, Michelle Van De Graaff, Intermountain Healthcare<br>*Subject matter expert: Nancy Landor, RN, MS, CPHQ* | | |
| **Webinar 4**<br><br>**Thursday, Nov. 18**<br>**1 - 2 p.m.** | **During this session, participants will be able to:**<br>• identify options for including the patient and care partner as a member of the healthcare team;<br>• discuss what other facilities have done to include care partners; and<br>• define the value of teach-back in preparation for discharge. | **Following this webinar, participants will:**<br>• orient the care partner to the unit;<br>• invite the care partner to participate in rounding and huddles;<br>• designate a team member to be responsible for care partner communication;<br>• review the care partner role with the patient and care partner;<br>• empower the care partner to assist in patient care;<br>• empower the care partner to assist with follow-up appointments;<br>• provide care partner with daily patient updates;<br>• engage care partner in discharge planning; and<br>• include the care partner during education using teach-back.<br>**EQIC Tools and Resources:**<br>• EQIC My Care Transition Brochure (customizable)<br>• EQIC Care Partner Frontline Checklist<br>• Successful Discharge Planning Starts at Admission (Institute for Healthcare Improvement)<br>• Making the transition to Nursing Bedside Shifts Reports (The Joint Commission)<br>***Complete all hospital follow up and implementation prior to Jan. 20, 2022.*** |

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| **Prepare: Care Partner is Prepared for the Next Transition**<br>*Subject matter expert: Brenda Chapman, BS, RNC* | | |
| **Webinar 5**<br><br>**Thursday, Jan. 20, 2022**<br>**1 - 2 p.m.** | **During this session, participants will be able to:**<br>• discuss methods for preparing the patient and care partner for discharge;<br>• discuss the value of post-discharge follow up;<br>• define the value of teach-back prior to discharge; and<br>• have clarity on how to empower the care partner to be an effective post-hospital care navigator for a smooth transition of care. | **Following this webinar, participants will:**<br>• assess care partners' educational needs with consideration of language and health literacy;<br>• prepare the care partner for transitions in care;<br>• provide notice of planned discharge within 24-48 hours in advance;<br>• establish a process to assess care partner knowledge and understanding of patient care needs at home;<br>• establish a process to verify care partner and patient education:<br>  ○ use teach-back to assess patient and care partner understanding;<br>• engage the care partner in the post-discharge follow-up call; and<br>• develop a process to address concerns identified during post-discharge follow-up call.<br>**Tools and Resources:**<br>• Medications at Transitions and Clinical Handoffs toolkit Medication Reconciliation (AHRQ)<br>• Preventing Adverse Drug Events (Medication Reconciliation):Patient and Family Fact Sheet (IHI)<br>• Your Discharge Planning Checklist: For Patients and Their Caregivers Preparing to Leave a Hospital, Nursing Home, or Other Care Setting (CMS)<br>• IDEAL discharge planning overview, process, and checklist (AHRQ) |
| **Office Hours: Preparing for attestation**<br>*Subject matter experts: Maria Sacco, RRT, CPHQ, and Brenda Chapman, BS, RNC* | | |
| **Webinar 6**<br><br>**Optional Office Hours**<br><br>**Thursday, Feb. 17, 2022**<br>**1 - 2 p.m.** | **During this session, participants will be able to:**<br>• ask questions regarding implementation strategies;<br>• troubleshoot and problem-solve program implementation; and<br>• network with teams to share challenges and successes.<br>**Part II Criteria for certificate:**<br>Complete checklist and implement strategies for the care partner model to date. | **Following this webinar, participants will:**<br>• review and enhance program implementation as they prepare to identify as a care partner hospital; and<br>• ensure the implementation checklist has been completed.<br>**EQIC Tools and Resources:**<br>• Care Partner Implementation Checklist<br>***Complete all hospital follow up and implementation prior to March 17, 2022.*** |

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| **Transitions of Care**<br>***Presentation: Care Transitions Collaborative, Gale Grunert, Lewis County Hospital***<br>***Subject matter expert: Brenda Chapman, BS, RNC*** | | |
| **Webinar 7**<br><br>**Thursday, March 17, 2022**<br>**1 - 2 p.m.** | **By the end of this session, participants will be able to:**<br>• define how to identify and collaborate with community-based organizations. | **Following this webinar, participants will:**<br>• familiarize team with community-based organizations who assist in addressing patient needs;<br>• include the patient and care partner in referral process;<br>• work with community organizations where appropriate to identify interventions to meet patients' needs; and<br>• learn about community organizations in your area that can assist in addressing social determinants of health. |
| **Capstone** | | |
| **Webinar 8**<br><br>**Thursday, April 21, 2022**<br>**1 - 2 p.m.** | **In this webinar, we will:**<br>• celebrate program implementation and success stories; and<br>• consider promotion of the care partner program in your hospital. | **Following this webinar, participants will:**<br>• identify your facility as a care partner hospital; and<br>• describe various ways of promoting community awareness of the care partner program. |

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