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EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

NEWS
April 25, 2024

In this issue

Workgroup updates

Thank you for your continued participation in EQIC's affinity workgroup meetings. Upcoming meeting dates are listed below. All meetings are 1 to 2 p.m.

Focus area	Next meeting
Patient and family engagement	Thursday, April 25
Pressure injuries	Wednesday, May 1
Falls	Thursday, May 16
Readmissions	Tuesday, May 28
Sepsis	Tuesday, June 4
Adverse druge events/opioid prescribing	Wednesday, June 12
Infections	Tuesday, July 9
Health equity	Tuesday, July 16

EQIC events

Don't forget to register for EQIC's QI webinar series; Next session May 29

EQIC encourages hospital team members at all levels to participate in the next two sessions in our 2024 quality improvement webinar series, *Maintaining and sustaining a highly reliable quality improvement strategy.* The May 29 event includes identifying QI opportunities using data analytics and gap analysis.

This series is designed to orient and refresh quality teams on the fundamentals of a strong QI strategy and strengthen the skills and confidence of hospital staff to sustain ongoing patient safety work. Registration provides access to all sessions, and materials from the March 26 kickoff session are available online.

Wednesday, May 29
Session 2 | Closing the gap: Structures, processes and outcomes
1 - 2 p.m.

Wednesday, June 26
Session 3 | Data in action: Ready, set, go!
1 - 2 p.m.

Tools and resources

Guide to strengthening your hospital's surgical care framework

The Telligen HQIC developed a comprehensive educational guide on the surgical continuum of care, including pre-, intra- and post-operative processes. This guide assists hospitals and surgical care teams in examining surgical workflows, identifying practice gaps and implementing best practices to prevent surgical site infections, post-operative pulmonary embolism and/or deep-vein thrombosis. The guide also provides quality improvement recommendations that support the safety and efficacy of pain management for patients within all phases of surgical care.

Education

Patient and family engagement education series

CMS' Five Metrics for Person and Family Engagement provide a framework to engage patients and families in their care. Health Services Advisory Group created a series of 30-minute presentations on how to achieve these metrics, keep patients and families at the center of care and engage staff to form an alliance with patients and families.

This series addresses the criteria to meet these measures and assists your facility in improving your patient and family engagement.

Part 1: Introduction to PFE
Part 2: Achieving patient and family-centered care
Part 3: Preparing for PFE programs
Part 4: Engaging the patient and care partner to prepare for hospital admission
Part 5: Engaging patients and family to prepare for hospital discharge
Part 6: Role of patient and family engagement in readmission prevention
Part 7: How bedside handoff can improve patient outcomes
Part 8: Adverse event transparency: Supporting patients, families and staff

HQIC reliability and resilience learning action series

Convergence Health is hosting the *HQIC Reliability and Resilience Learning Action Series* to educate and activate hospital leaders on the concepts and practices of resilience and high reliability in healthcare.

Featuring live and recorded presentations from hospital quality improvement contractors like EQIC, these sessions are for those interested in deepening their foundational knowledge about the concepts, theories and activities related to resiliency and high-reliability organizations.

Next session: Friday, June 21
Stories from the field: Hospital case studies of reliability and resilience in action at the local level
1 - 2 p.m.

Impact of Implementing a Care Partner program on Hospital-wide Readmission

Maimonides Medical Center

Submitted by:

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Background

Maimonides Medical Center, a 711-bed, community-based, acute care tertiary hospital in Brooklyn, New York, launched its Care Partner program in June 2019 to align with the New York state *Caregiver Advise, Record and Enable Act's* mandate for hospitals to allow patients to designate a caregiver upon admission.

A CP serves as a compassionate companion for patients and can be a family member, friend or individual actively involved in the physical, emotional or logistical aspects of caregiving. Their involvement with daily living activities and healthcare advocacy can enhance a patient's quality of life. Studies have shown improvements in patient outcomes, including readmission reduction and patient satisfaction, when a CP is integrated into care.

After the initial launch of the CP program, unforeseen challenges during the COVID-19 pandemic stalled operations. In late 2022, MMC set out to re-invigorate and refocus the initiative using the EQIC Care Partner "Commit, Identify, Include and Prepare" framework. A multidisciplinary task force spearheaded the work using the Plan Do Study Act quality improvement methodology.

The patient care changes that were made in conjunction with the EQIC framework earned MMC recognition as an EQIC Care Partner Hospital in August 2023.

Approach and collaboration

The journey began with the creation of the multidisciplinary task force comprised of senior leadership, nursing, physician, patient relations, case management, information technology, legal and quality management staff. The task force collaborated to identify areas of opportunity, understand sources of variation, use the PDSA cycle and execute an action plan.

In the "Plan" phase, the task force used process mapping to determine the current state and create a desired future state. In the "Do" phase, the patient relations and admission nurse's initial patient interaction workflow was changed to include electronic health record documentation. This new step captures the identified CP in the Patient Self-Determination Act form and nurse admission note, which also auto-populates into the discharge summary, discharge instructions and clinical summaries. The task force added CP as a learner option in the education record.

MMC customized the HANYS EQIC care partner brochure and included it in patient admission packets and hospital-wide education lectures to leadership, nursing, residents and case management staff. CP program information was also shared in a hospital-wide advertisement via MMC's marketing department.

With each cycle, data checks, communication of ongoing efforts and improvement actions are reported regularly to the multidisciplinary task force, the hospital-wide quality improvement committee and the board of trustees.

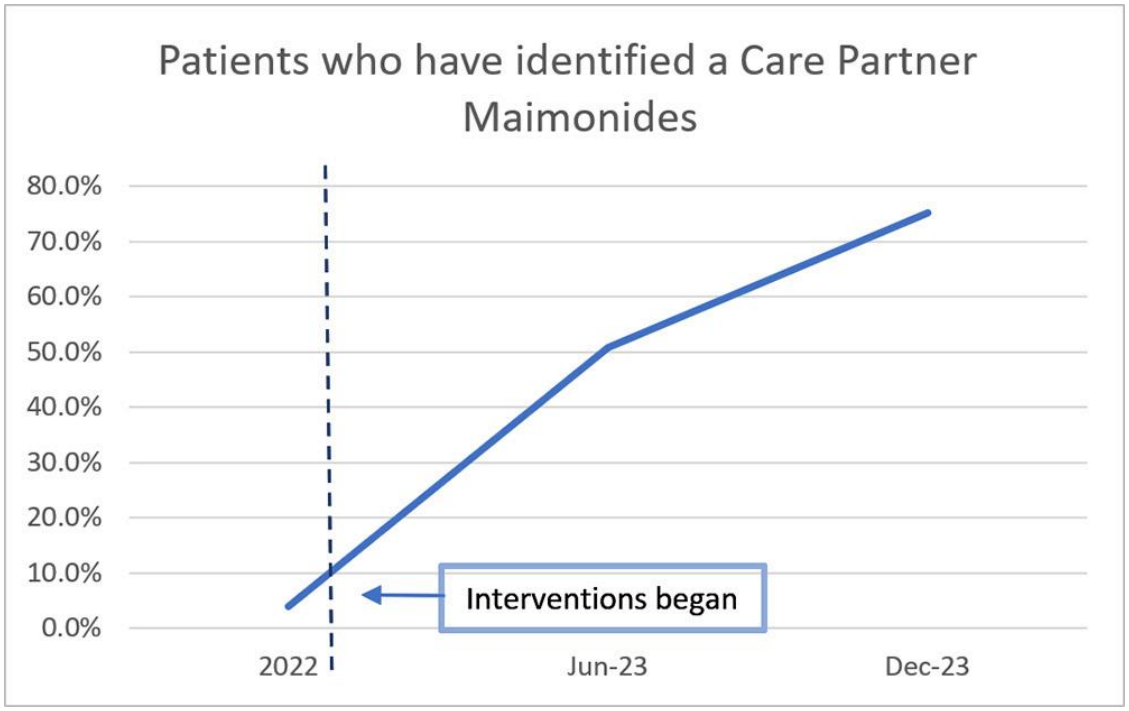
Results and impact
MMC's IT department generates a CP report, which pulls electronic health record data on patients who identify a CP, those who decline and those who defer, and combines these data with the monthly patient readmit report.

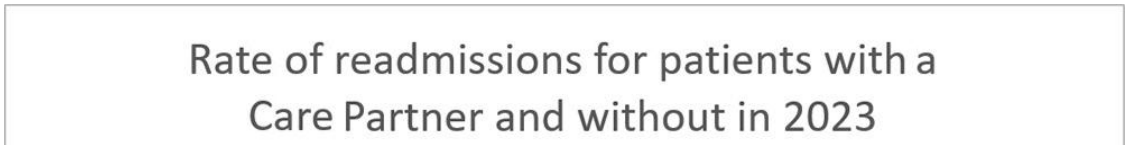
MMC conducted a time series analysis from January through December 2023. During the baseline period in 2022, an average of 3.9% of patients identified a CP. Implementation changes occurred in January 2023, and 50.8% of patients identified a CP in June and 75.2% in December. MMC concluded its 2023 results with a total average of 53.8% of patients identifying CPs, compared to 3.9% the previous year, exceeding the goal of a 20% increase within six months.

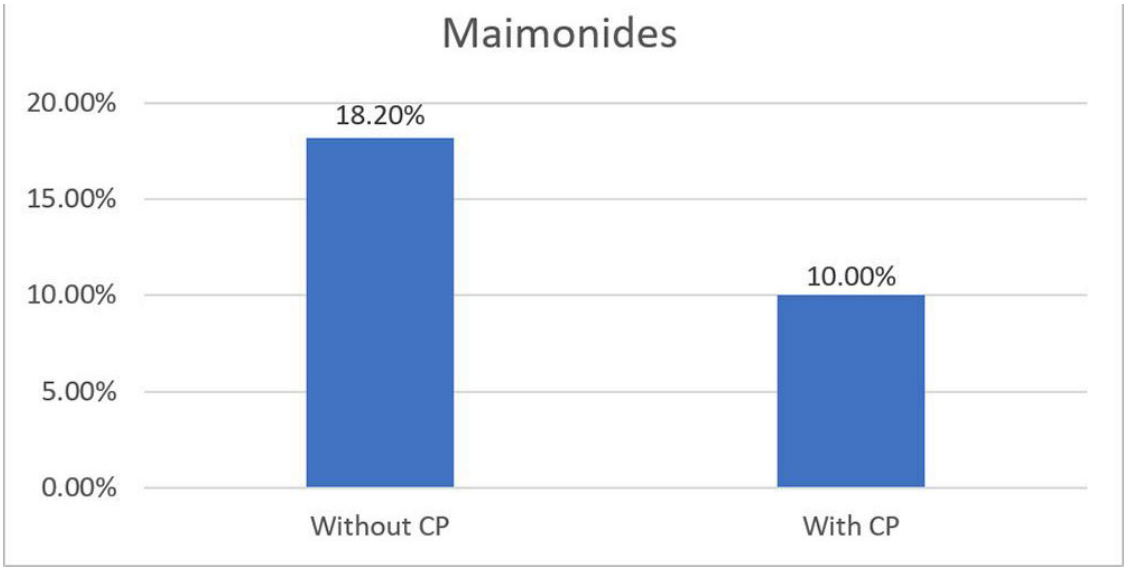
After program implementation, MMC studied the impact of the CP program on its 30-day readmission rate. The team also examined patients with a CP and their Readmission Risk Assessment Score and used the Chi-Squared test to determine if a difference between the observed and expected data was due to chance or a relationship between the variables. The results showed that patients who identified a CP had a significantly lower readmission rate (10.0% compared to 18.2%) than those who did not.

These outcomes underscore the positive influence of CPs on effective communication, collaboration and adherence to treatment plans, with potential implications for broader healthcare improvement. The results also revealed that patients with any risk assessment score who identified a CP had a significantly lower readmission rate than those without a CP (4.9% vs. 10.3% for low risk, 12.7% vs. 23.4% for intermediate risk and 30.9% vs. 49.1%, for high risk). The P-value was <0.001 for all three risk assessment scores.

Care partners not only enhance effective communication and collaboration between the patient and the care team but also positively influence healthcare outcomes by ensuring better adherence to treatment plans and medication regimens. Through this program, MMC showed that patients who identified a CP had a lower 30-day readmission rate than those who did not. MMC's next study will examine the effect of CPs on patient satisfaction. Every attempt will be made to identify a CP for all of MMC's patients and involve them in the plan of care.







Questions?

Please contact Cathleen Wright or your EQIC project manager with any questions.