Care Partner Program: Reducing Readmission

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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

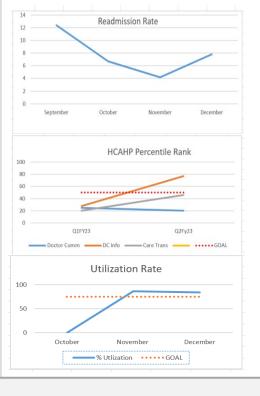
Goals/objectives

- 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.

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- 1. Communication with Doctors- 20th
- 2. Discharge Information- 77th
- 3. 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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