HQIC Community of Practice Call

Ready Set Go! Bridging the Gaps to Revolutionize Care Transitions

March 14, 2024

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Introduction

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Centers for Medicare & Medicaid Services

Welcome!

Agenda

- Introduction
- Today's topic: Ready Set Go! Bridging the Gaps to Revolutionize Care Transitions
- Presenters:
  - **Libby Hoy**, PFCCpartners
  - **Glenn Kopelson**, Convergence HQIC Patient Family Partnership Council
- Open discussion
- Closing remarks

As You Listen, Ponder…

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase engagement within your facilities to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 or 90 days?

Meet Your Speakers

Libby Hoy
Founder and CEO
PFCCpartners

Glenn Kopelson
UCLA Patient and Family Advisory Council
Convergence HQIC Patient Family Partnership Council

Ready Set Go! Bridging the Gaps to Revolutionize Care Transitions

Libby Hoy, PFCCpartners

Glenn Kopelson, Convergence Patient Family Partner

March 14, 2024

CONVERGENCE HEALTH CONSULTING

HQIC

PFCCpartners
Patient & Family Centered Care

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CONVERGENCE
HEALTH CONSULTING

ABOUT US

MISSION

Center the inclusive human experience of health. Reinvent through radical collaboration. Be a catalyst for system transformation.

VISION

A health system transformed. One that works **with people** and **through communities** as a partner in their well-being.

VALUES

Equity
A brave space resolving the health challenges of today.

Inclusion
Create belonging for all people and all communities.

Diversity
Differing perspectives are expected and respected.

Collaboration
Equitable and shared decision-making power.

Solution Focused
Acknowledge challenges only to resolve them.

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Definitions

NOUN → **Person-Centered Care**

VERB → **Patient-Family Engagement**

OUTCOMES → **Equity • Better Health Care**
Improved Outcomes • Patient Experience
Integrated Care • Patient Safety

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Convergence HQIC- Funfetti Approach to PFEE

Engage patient family partners (people with lived experience) in all layers of improvement programs.

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Aim: Reduce Readmissions

Key Questions:

What is the root cause of readmissions at your hospital?

Convergence Discovery Tools

Who is experiencing readmissions most?

Stratify your data

What do patients and family caregivers know about readmissions?

Engage patients & family caregivers as partners in improvement

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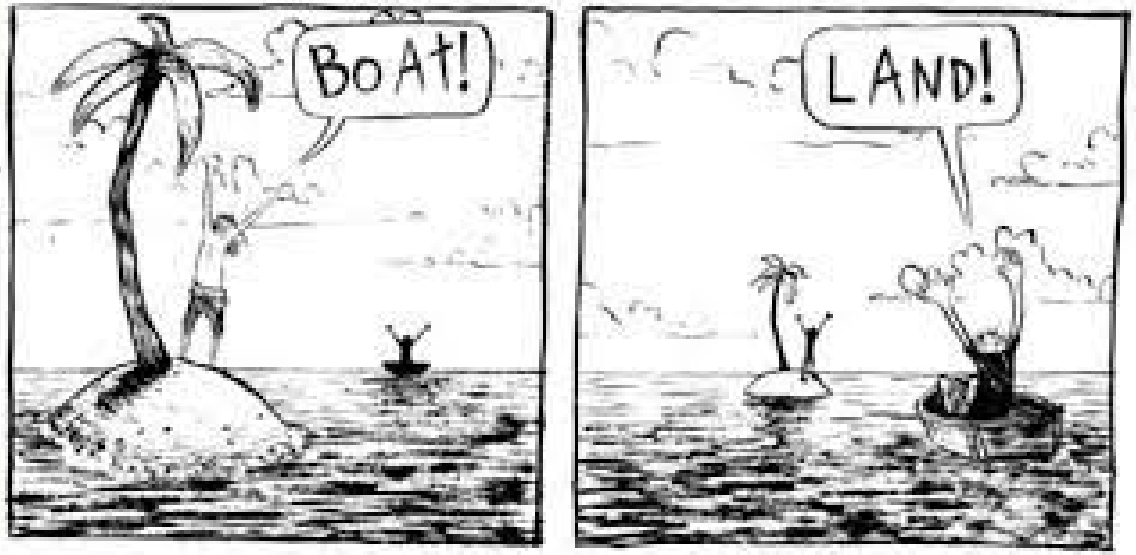
Method



Patient Family Partnership Council

- Brainstorm
- Refinement to categorize activities

Patient Family Partnership Hub

- Response to PFPC brainstorm
- Response to refinement

Hospital Staff

- Respond to refined activities
- Explore underlying processes

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What Causes Readmissions?

Hospital Staff

- Patients are noncompliant
- Patients didn't understand the discharge instructions
- Patients don't have the ability to access medications or mixed-up medications
- Community based healthcare didn't meet the needs of the patient
- Patient refused home health

Patient & Family Caregiver

- My pharmacy doesn't carry the medication I was prescribed
- Home health didn't arrive
- Medical equipment that was ordered didn't arrive
- My insurance doesn't cover the equipment ordered
- I have a question about my medication, but don't know who ordered it
- My discharge instructions were generic
- I was overwhelmed at discharge and didn't understand the instructions, my family caregiver was not present

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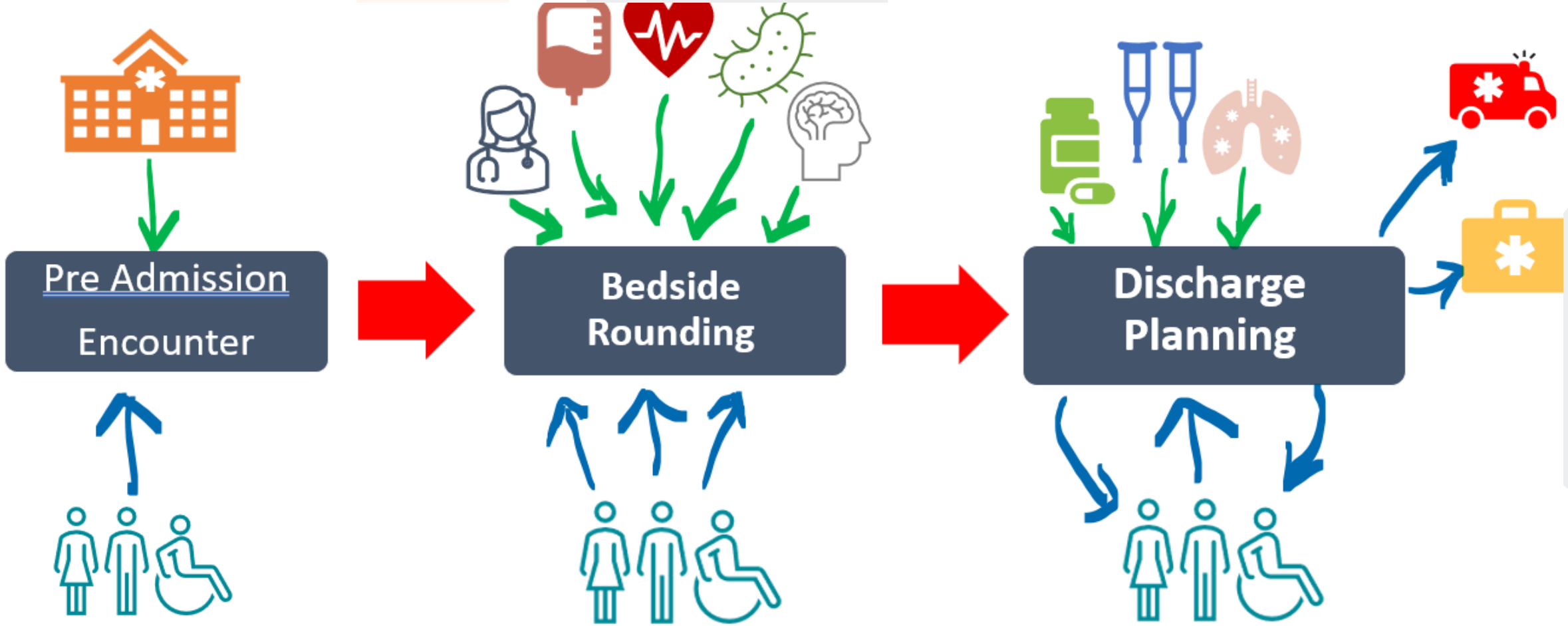
Current Gap

- Anthony identifies as a male who lives with multiple chronic conditions, one of which is Diabetes. At home, Anthony manages his diabetes largely with a Keto diet and insulin. He is proud of the results of his efforts, as indicated by his A1C being within normal limits for years. Anthony has been hospitalized several times for surgeries related to his other chronic conditions. During hospitalization, Anthony loses control of his diabetes maintenance. He does not have access to a keto diet and his blood sugars are not managed well. Multiple times, Anthony has gotten down to 60 and has not had the response needed.

Information Sharing



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Enhance touchpoints with patients & family caregivers to create connective tissue to move information across processes:

- Admissions Planning
- Bedside Rounding
- Discharge Process

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Enhance Pre-Admission Encounter

Pre-Admission Planning

+ Invite patient and family caregiver to engage during entire hospitalization journey
+ Add open response items, plan for managing and sharing information such as:

How does the patient manage chronic conditions at home?
How does the patient manage medications at home?
Ask patient five things they want the clinical team to know about them

+Give information about bedside rounds and invite patient & family caregiver in

Purpose, timing, who is involved, what is the patient & family caregiver role

+ Set expectation that discharge planning is a dynamic process that will be discussed daily, with changes and education that aligns with their current condition.

Information Sharing:
Pre-admission planning with patient and family caregiver
Share the same information with the clinical care team

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Bedside Rounding Enhancements

Bedside Rounding

- Clinical team has access to admission planning information open response
- Patient & family caregiver have access to admission planning information and there is an identified process for them to update information
- Introduce all members of the care team, leave cards
- Provide patient access to notes
- Patient insights are captured into note and flagged for specialists
- Daily discussion of medications, patient reported impacts documented
- Daily patient education of current status and treatments
- Daily discussion of patient reported goals of care, connected to discharge planning

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Enhance Discharge Planning

Discharge Planning

- Daily interactive discussion with patient & family caregiver set expectations that discharge is a dynamic process spanning the hospitalization
- Provide contact information of prescribing doctors
- Provide single point of contact for coordination of specialists
- Include details in discharge paperwork specific to the patient
- Remove irrelevant information from discharge paperwork
- Post discharge contact within 24 hours
- Provide a point of contact patient or family caregiver can contact who has access to the medical record
- Provide copy of the medical record in print with discharge

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Ready.Set.Go! Value Statement

- Anthony arrives for his preadmission appointment. He is asked how he manages his diabetes at home. When he describes the critical nature of a keto diet, the information is added to his medical record and flagged for the clinical staff. Anthony also receives information on what bedside rounding is and how he and his family caregiver can participate.
- After surgery, Anthony arrives at the floor and is given a ketogenic diet. His nurse and doctors arrive for rounds and Anthony is prepared to participate, asking questions and providing insights which are captured in the medical record. During the night when his blood sugars come back high, the nurse sees in the notes that this is expected from Anthony and to delay given insulin for a period noted to allow time for him to recover. Anthony's sugars begin to recover and he provides insights to how he is feeling which are added to the medical record.
- During daily rounds, Anthony receives training on wound care and his anticipated barriers are noted and plan made to remove or mitigate barriers. Anthony & his family caregiver are active in these plans throughout. Medications are discussed daily, and Anthony's insights are documented.
- Since elements of the discharge plan have been developed collaboratively during the stay, Anthony recognizes the actual discharge process will likely take most of the day, so he prepares for that.

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Moving Upstream

1. Invite your patients to actively engage
2. Move information, not people
3. Expand current information sharing pathways
4. Define roles
5. Move Patient Story to Strategy
6. Look at the spaces between processes for opportunities

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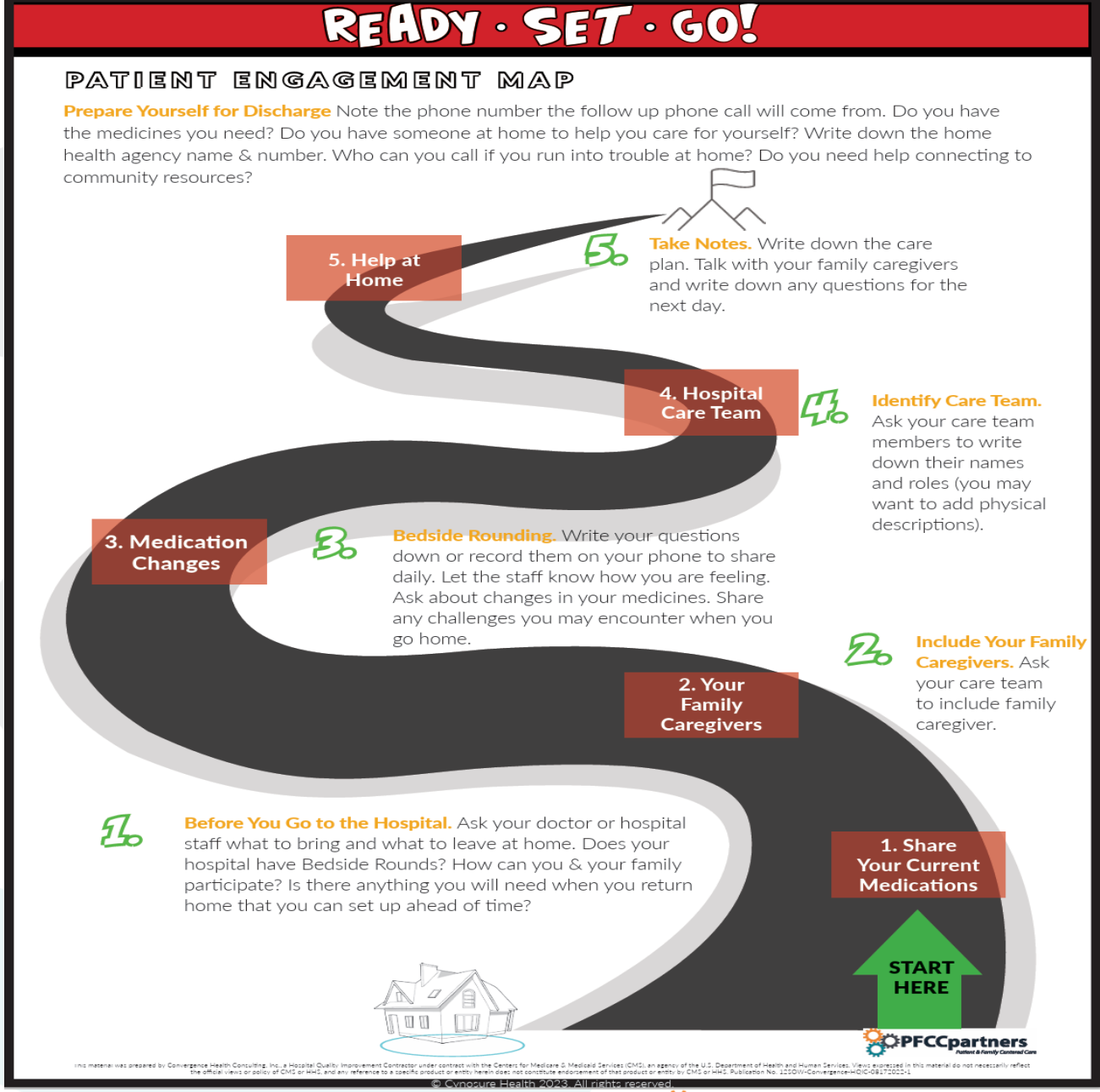
Patient Roadmap

Companion Tool to Support your Patients & Family Caregivers to Engage in their Care



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Resources

- Implementation Guide
  1. Move information not people
  2. Expand current information sharing pathways
  3. Define roles and responsibilities
  4. Listen and talk with your patients and family caregivers
- Mapping a Patient's Journey Tool
- Patient Roadmap

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Libby Hoy, Founder/CEO
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Discussion

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Final Thoughts

Join Us for the Next Community of Practice Call!

Join us for the next
Community of Practice Call on April 11, 2024
from 1:00 – 2:00 p.m. ET

We invite you to register at the following link:
https://zoom.us/webinar/register/WN_ASl_l3p_TEyx_VY_YYFFeA

You will receive a confirmation email with login details.

Thank You!

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We will use the information you provide to improve future events.