Engaging Patients/Residents in Care Coordination Efforts

Nina Hutnyan, MSN,RN, Quality Improvement Specialist
Trish Cruz, RN, MBA, BSN, PHN, Quality Advisor
Lindsay Holland, MHA, Director, Care Coordination
Health Services Advisory Group (HSAG)

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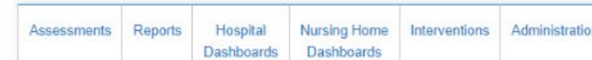
OBJECTIVES

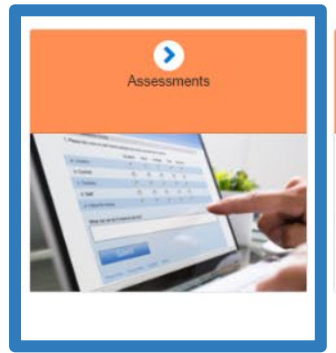
- Define patient/resident engagement as it relates to care coordination.
- Describe how higher levels of patient/ resident involvement lead to better outcomes.
- Discuss practical tips to improve patient/ resident engagement.
- Introduce patient/resident engagement educational tools and resources.

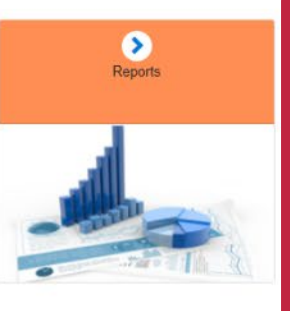
Quality Improvement Innovation Portal (QIIP): Assessments and Data Dashboard

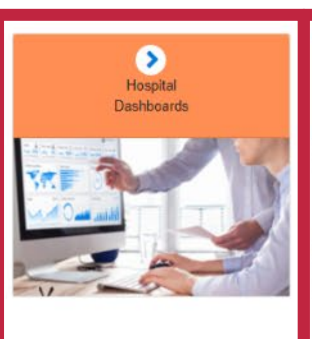


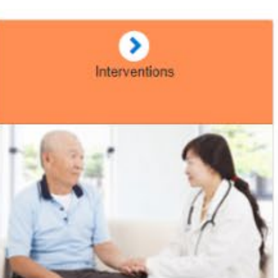
Quality Improvement Innovation Portal

For questions, please contact QIIPSupport@hsag.com.









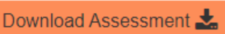
www.hsag.com/qiip-start

QIIP Care Transitions Assessment

Acute Opioids | ED Opioids | Acute ADE | Acute Care Transitions | ED Care Transitions

Care Transitions

Work with your department leadership team to complete the following assessment. Each item relates to care transition elements that should be in place for a program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supported by published evidence and best practices including, but not limited to, The Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered Discharge from the Agency for Healthcare Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine), and the Care Transitions Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each assessment item.



To understand the rationale and references for each question, click here.

A. Medication Management

Item	Not implemented/no plan	Plan to implement/no start date set	Plan to implement/start date set	In place less than 6 months	In place 6 months or more
1. Your facility has a pharmacy representative verifying the patient's pre-admission (current) medication list upon admission. [i] Previous Answer as of: Not Answered	○	○	○	○	○
2. For high-risk medications (anticoagulants, opioids, and diabetic agents), your facility utilizes pharmacists to educate patients, verifying patient comprehension using an evidence-based methodology. [ii] Previous Answer as of: Not Answered	○	○	○	○	○
3. Your facility has a process in place to ensure patients can both access and afford prescribed medications prior to discharge (e.g., Meds-to-Beds, home delivery of meds, for affordability verification). [iii] Previous Answer as of: Not Answered	○	○	○	○	○

B. Discharge Planning

C. Care Continuum

Cancel ✖ Save

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Care Coordination Website

Care coordination is a key priority for the Centers for Medicare & Medicaid (CMS) to improve quality and achieve safer and more effective care. However, gaps in care, such as poor communication and ineffective discharge processes, remain a challenge.To address these gaps, HSAG provides evidence-based tools, strategies, resources, and training needed to improve care coordination.

Hospital Care Coordination Toolkit

Nursing Home Care Coordination Toolkit

Access the QIIP

Care Coordination Assessments

Download PDF versions:

- **Acute Care Transitions Assessment**
- **ED Care Transitions Assessment**
- **SNF Care Transitions Assessment**

Care Coordination Quickinars

Care Coordination Resources

- Medication Management
- Health Equity
- Patient Engagement
- Care Coordination Collaboration
- Quality Improvement Tools
- Care Coordination Evidence-Based Models

Hospitals

- **Care Coordination**
  - Hospital Care Coordination Toolkit
- Emergency Preparedness
- Infection Prevention
- Opioid Stewardship
- QIO Events

www.hsag.com/cc-quickinars

Why Care Coordination Is Important

- Has the potential to improve the effectiveness, safety, and efficiency of patient care.
- Health systems can be disjointed, and processes may vary.
- Patients are not always clear regarding referral processes.
- Primary care physicians and specialists often do not receive information about what happened in a visit.
- Physician offices have different processes, and information can be lost.

www.ahrq.gov/ncepcr/care/coordination.html

Care Coordination Ring

Primary Care
Specialty Care (1)
Specialty Care (2)
Inpatient Care
Mental Health Services
Long-Term Care
Medical History
Test Results
Home Care
Informal Caregivers
Patient/ Family Education & Support
Medication/ Pharmacy
Community Resources

Patient/Family Perspective
Healthcare Professional(s) Perspective
System Representative(s) Perspective

Meet patient needs and preferences in the delivery of high-quality, high-value care

www.ahrq.gov/ncepcr/care/coordination/atlas/chapter2.html#fig1

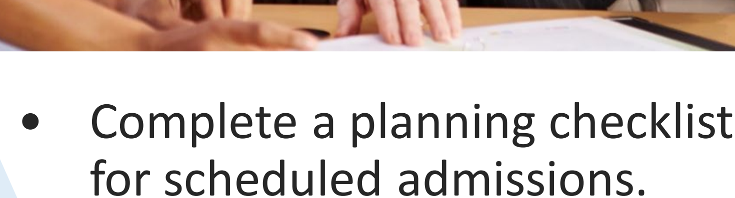
Care Coordination and Patient/Family Engagement (PFE)

Start PFE by Building a Strong Relationship

- Include the family (care partner) when talking with the patient/resident.
- Good communication:
  - Be yourself
  - Be honest
  - Be genuine
  - Show that you care
  - Follow through

PFE in Hospital Care Coordination

- Contributes to safe and quality care.
- Develops a sense of trust.
- Opens dialogue to address concerns and preferences.
- Develops an active partnership with bi-directional conversation.
- Informs and educates patients and care partners.
- Identifies areas for improvement.

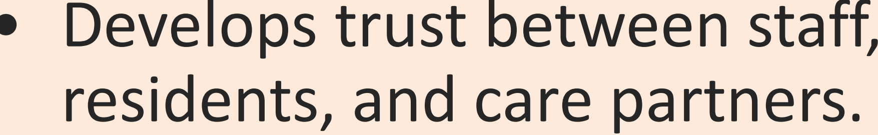


- Complete a planning checklist for scheduled admissions.
  - Develop an individual plan of care.
    - Begin discharge planning before admission.

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Person-and-Family-Engagement

PFE in Nursing Home Care Coordination

- Promotes involvement in activities intended to enhance quality of life, quality of care, best approach to care, and safety for residents.
- Develops trust between staff, residents, and care partners.
- Ensures staff understand and respect resident choices, dignity, and rights to purposeful living.



- Have the resident/family participate in care plan development.
  - Establish which physician will lead and coordinate care.
    - Maintain communication and update on any changes that occur with the primary care provider.

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPI-Consumer-Factsheet.pdf

Benefits of PFE in Care Coordination

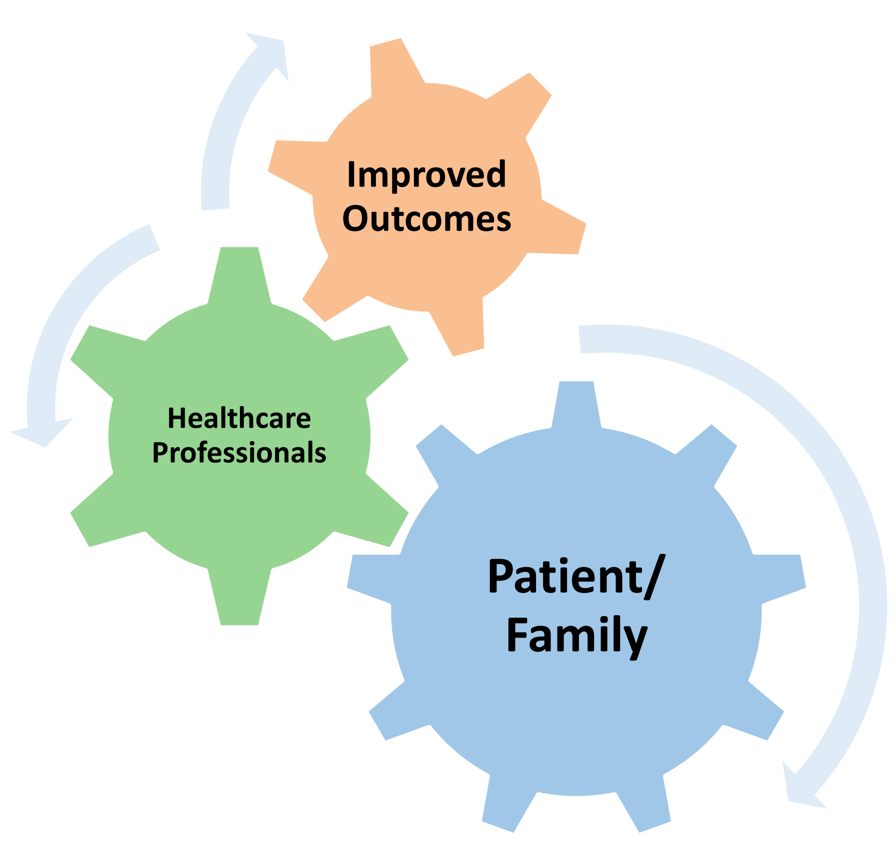
Patients/residents and their care partners:

- Become allies in your efforts to improve quality and safety.
- Become actively engaged in their healthcare with increased knowledge, skills, and confidence.
- Understand the processes necessary to coordinate care.
- Have confidence in the care team and treatment plan.
- Feel empowered, leading to improved compliance.

www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/howtogetstarted/How_PFE_Benefits_Hosp_508.pdf

Practical Tips to Improve PFE

Partner With Patients/Residents and Families



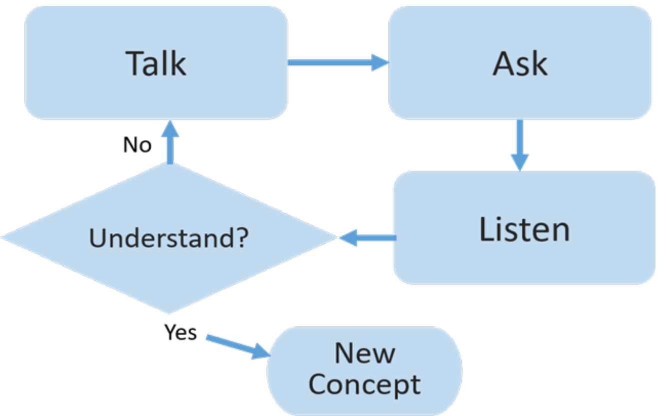
- Agree on a shared outcome or goal.
- All parties contribute something unique to achieve that shared goal.
- Can the patient/resident and family accomplish the plan?
  - Sometimes the plan needs revision.

Prepare the Patients and Families

- Educate, prepare, and empower patients and families to effectively engage in their health and healthcare.
  - Tailor communication to patients' capacities and needs.
  - Assess patient/family understanding.
  - Use teach-back.

www.air.org/sites/default/files/Roadmap-Patient-Family-Engagement.pdf
Teach-Back Training. www.hsag.com/teach-back

Use Teach-Back

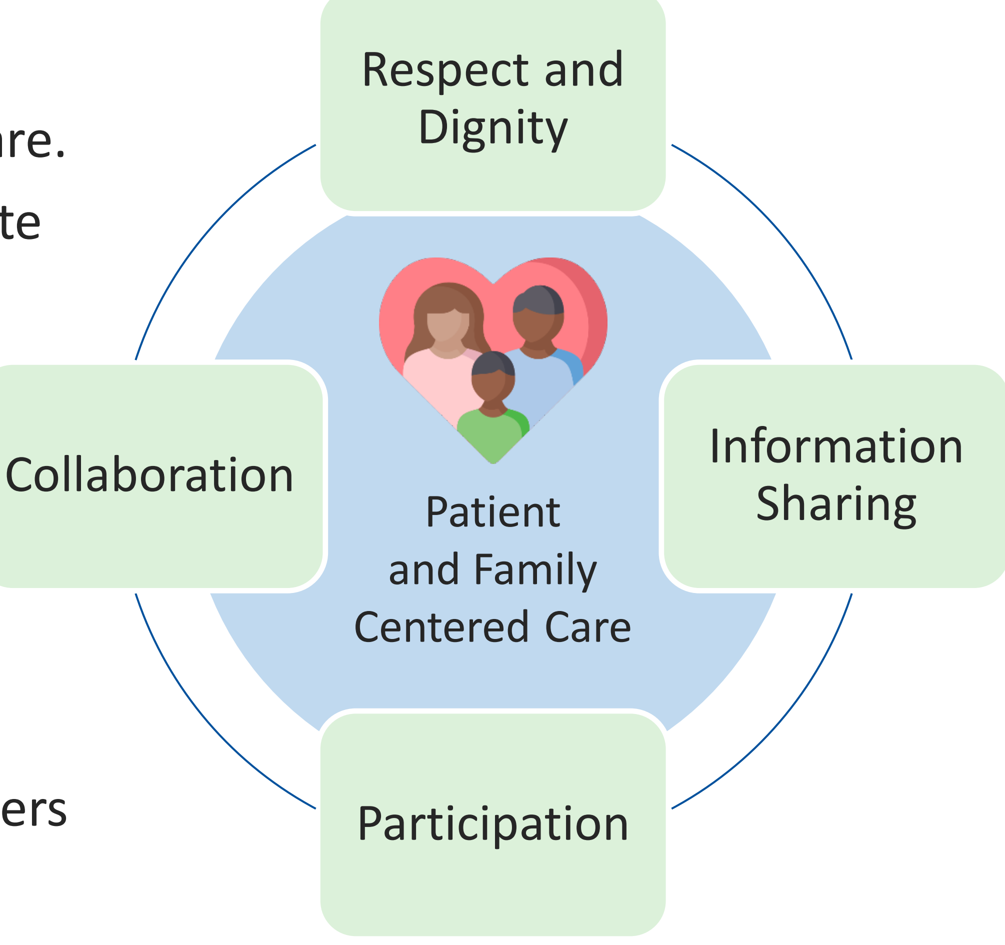


- A way to make sure you explained information clearly.
- Not a quiz for patients.
- A way to check for patient, family, and care partner understanding.
- An evidence-based health literacy intervention that improves patient/provider communication and patient health outcomes.

American Medical Association (AMA). Health Literacy Video. www.youtube.com/watch?v=BgTuD7l7LG8
Schillinger 2003. jamanetwork.com/journals/jamainternalmedicine/article-abstract/214905
Teach Back Training. www.hsag.com/teach-back

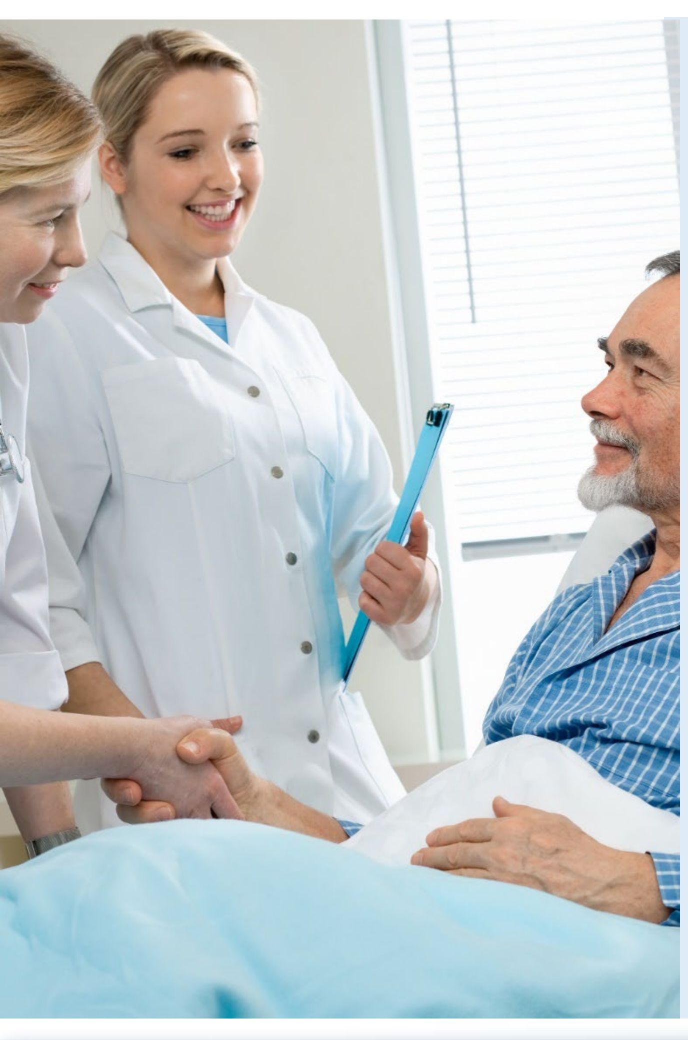
Use the Core Concepts of Patient- and Family-Centered Care

- **Respect and Dignity.** Listen to patient/family choices and incorporate into the delivery of care.
- **Information Sharing.** Communicate timely, complete information so patients/families can effectively participate.
- **Participation.** Encourage patients/families to participate in care and decision-making at the level they choose.
- **Collaboration.** Patients, families, healthcare practitioners, and leaders collaborate on policies and programs.



Institute for Patient-and Family-Centered Care. www.ipfcc.org/about/pfcc.html

Bedside Reporting/Rounding



- Provides a way to transfer information between nurses to prevent medical errors and adverse events.
- Transfer of care is structured and relevant.
- Patients and care partners can make sure transitions in care are safe and effective.
- An effective partnership is developed with the patient and care partner.
- The goal is to improve hospital quality and safety for all patients.

Include patients/families in bedside multidisciplinary rounds whenever possible.

Patient Engagement
Educational Tools and Resources

Hospital and Nursing Home Admissions Flyers

What to Do When You're Admitted to the Hospital

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You have many things to think about when you are admitted to the hospital. Use this checklist to help you keep track of important details regarding your stay and recovery.

First Things First

- ☐ Ask hospital staff to explain anything that you may not understand.
- ☐ Tell the nurse* or doctor what you would want to be done if you should stop breathing or your heart should stop (if you have Do Not Resuscitate wishes).
- ☐ Give the nurse a copy of your Advance Directives/Living Will for your chart.
  - If you do not have one, information can be provided.
- ☐ Tell the nurse if you have a specific person who can get information about you during your hospital stay.
- ☐ Tell the nurse if you have a Power of Attorney for your healthcare and who that person is.
- ☐ Make sure all hospital staff are washing or sanitizing their hands when entering and leaving your room.
- ☐ Talk to your doctor and nurse about your plan of care.
  - Discuss what you may need when you are released from the hospital.

Medications

- ☐ Give the nurse an updated list of medications you are taking right now.
- ☐ Tell the nurse if you have any allergies.
- ☐ Tell the nurse if you have trouble getting your medications.
- ☐ If you are given a new medication(s), ask:
  - What it is for.
  - How it will help you.
  - How often you take it.
  - What the side effects are.

The hospital staff person who assists with your admission might be someone other than a nurse or doctor, such as an admissions specialist or case manager.

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What to Do When You're Admitted to a Nursing Home

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...things to think about when you are admitted from a hospital to ... Use this checklist to help you keep track of important details ... stay and recovery.

...First

- ...me staff to explain anything that you may not understand.
- ...g home what you would want to be done if you should stop ...ur heart should stop (if you have Do Not Resuscitate wishes).
- ...nursing home has a copy of your Advance Directives/Living Will.
  - ...t have one, information can be provided.
- ...on's name (family member/Power of Attorney) and contact ...ho can discuss your care and condition.

- ...o review your list of medications you are taking.
- ...f you have any allergies to medications or food.
- ...n a new medication(s), ask:
  - ...r and how it will help you.
  - ...you take it.
  - ...de effects are.

...may not be feeling well, getting you moving as soon as possible will help ...ce of your muscles getting weak and you developing blood clots or bed sores. ...rse:

- ...been getting around prior to being hospitalized and now.
- ...hing to help you walk.
- ...ut of bed and go to the bathroom on your own, or if you should call ...
- ...ut of bed to eat your meals.
- ...ow you can prevent getting blood clots by doing exercises, such as

www.hsag.com/medicare-providers/patients

PFE Measures Checklist

CMS Metrics for Person and Family Engagement (PFE)

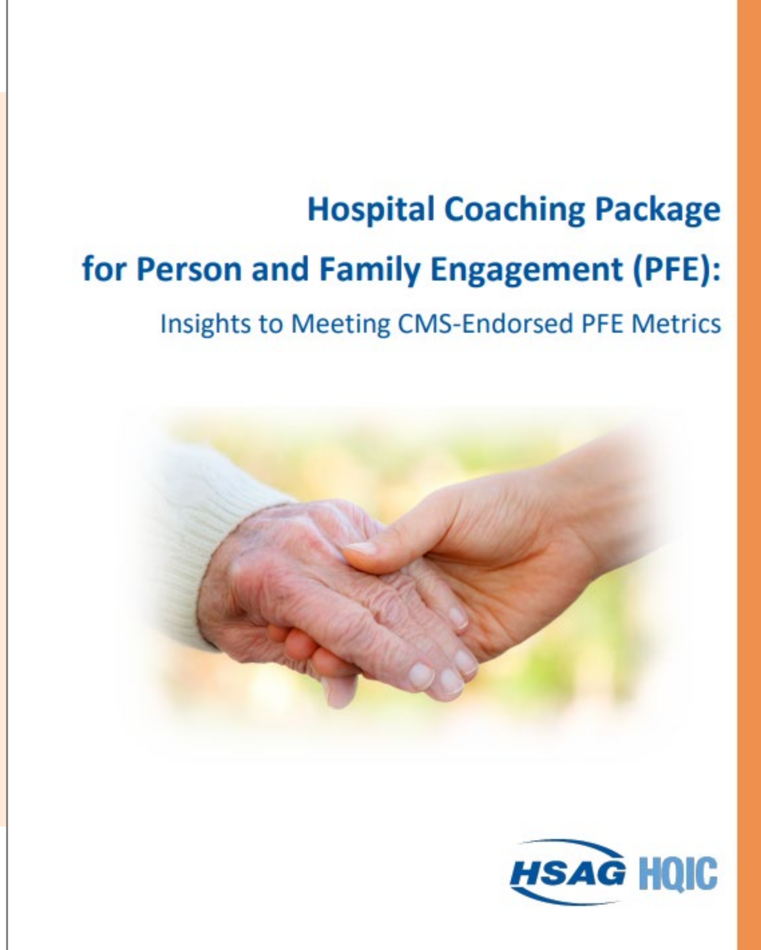
Direct Patient Contact: metrics 1–3; Facility Operations: metrics 4–5

PFE METRIC	INTENT	MUST BE IN PLACE TO MEET METRIC	Resources
1 Planning Checklist for Scheduled Admissions	For all scheduled admissions, hospital staff discuss a checklist of items to prepare patients and families for the hospital stay and invite them to be active partners in care.	• Hospital has a planning checklist for patients with scheduled admissions. • Hospital staff discuss the checklist with the patient and family prior to or at admission.	https://www.mnhospitals.org/Portals/0/Documents/patientsafety/Patient%20Family%20Engagement/RoadmapMetric-1-508.pdf; Page 1–9
2 Discharge Planning Checklist	For all inpatient discharges, hospital staff utilize and discuss a checklist to ensure key elements of discharge planning and care transitions are covered to prepare patients and families for discharge and invite them to be active partners in care.	• Hospital has a planning checklist to proactively prepare for discharge. • Hospital staff discuss the checklist with the patient and family to ensure a successful transition of care.	https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf
3 Shift Change Huddles or Bedside Reporting	Include the patient and/or family caregiver in as many conversations about the patient's care as possible throughout the hospital stay.	• On at least one unit, nurse shift change huddles OR clinician reports/rounds occur at the bedside and involve the patient and/or family members in all feasible cases.	https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy3/Strat3_Tool_2_Nurse_Chklst_508.pdf
4 Designated PFE Leader	Hospital has a designated individual (or individuals) with leadership responsibility and accountability for PFE.	• There is a named hospital employee (or employees) responsible for PFE efforts. Such individual(s) can hold either a full-time position or a percentage of time within another position. • Appropriate hospital staff and clinicians can identify the person named as responsible for PFE.	https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/howtogetstarted/Best_Practices_Hosp_Leaders_508.pdf
5 PFAC or Patient/ Family Representative(s) on Hospital Committee	Ensure that a hospital has a formal relationship with patient and family advisors (PFAs) from the local community who provide input and guidance from the patient perspective on hospital operations, policies, procedures, and quality improvement efforts.	• Patient and/or family representatives from the community have been formally named as members of a PFAC or another hospital committee (at least one patient.). • Meetings of the PFAC or another committee with patient and family representatives have been scheduled and conducted.	https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy1/index.html

CMS = Centers for Medicare & Medicaid Services; PFAC = Patient and family advisory council

www.hsag.com/globalassets/hqic/pfemeasureschecklist_v1_508.pdf

Hospital Coaching Package for PFE



- Organizational assessment.
- Benefits, tips, tools, and resources for each of the five PFE measures.

www.hsag.com/globalassets/hqic/hqic_pfemetricscoachingpkg.pdf

Roadmap to Success: Patient and Family Advisory Council (PFAC)

1. Assess leadership engagement and organizational readiness.
2. Create an internal team to design and launch your PFAC.
3. Recruit and select PFAC members.
4. Onboard and orient PFAC members.
5. Implement PFAC projects.
6. Measure PFAC impact and sustainability.

www.hsag.com/globalassets/hqic/hqic_readmission_roadmap_508.pdf

PFE Quickinar Series

Patient & Family Engagement Quickinar Series

Establishing a partnership with patients and families is imperative to improve patient quality and safety. The Centers for Medicare & Medicaid Services (CMS) has developed the 5 Metrics for Person and Family Engagement to provide HQIC facilities a framework to engage patients and families in their care. This begins prior to admission and continues throughout hospitalization until discharge. Discover 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. These short, 30-minute presentations will address the criteria to meet these measures and will assist your facility in improving your patient and family engagement (PFE).

Register for the full PFE Quickinar Series
February 2–July 20, 2023 (Sessions 1–12)
1st and 3rd Thursdays of the month, 1 p.m. ET (12 noon CT | 11: a.m. MT | 10 a.m. PT)
https://bit.ly/pfe-quickinars

1. Intro to PFE
2. Achieving Patient/Family Centered Care
3. Preparing for PFE Programs
4. PFE to Prepare for Hospital Admission
5. PFE to Prepare for Hospital Discharge
6. Role of PFE in Readmission Prevention
7. Bedside Hand Off to Improve Patient Outcomes
8. Adverse Event Transparency
9. Role of the PFE Advisor
10. Selecting/Training/Engaging Advisors
11. PFE in Critical Access & Small Rural Hospitals
12. PFE in Acute Care Hospitals

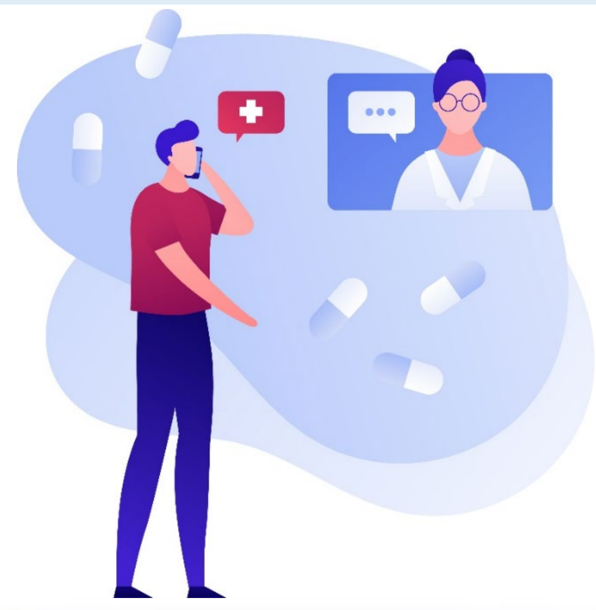
www.hsag.com/pfe-quickinars

Our Next Care Coordination Quickinar

Teach-Back: A Strategy to Improve Care Coordination

Tuesday, July 11, 2023 | 11 a.m. PT

bit.ly/cc-quickinars2



www.hsag.com/cc-quickinars

Care Coordination Quickinar Series Extended

We are extending our series: August 2023–May 2024!

Stay tuned for topics and registration information!

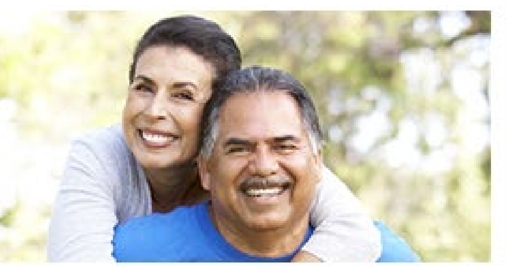
www.hsag.com/cc-quickinars

Questions?

Please Take 5 Seconds and Let Us Know

We want this call to be meaningful to you, so we need your input.

At the end of the webinar, you will be asked **one question** to determine if this call equipped your organization to begin implementing care coordination practices.



Thank you!

Trish Cruz RN, MBA, BSN, PHN
Quality Improvement Specialist
pcruz@hsag.com

Nina Hutnyan, MSN,RN
Quality Improvement Specialist
nhutnyan@hsag.com

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