

Measuring Family Experience of Care Integration to Improve Care Delivery

Thursday, June 15, 2017
10-10:30 a.m. PT, 1-1:30 p.m. ET

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Catalyst Center

Family Voices



INTRODUCTION



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Senior Vice President
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Children's Health

HOUSEKEEPING

- Please enter questions into the GoToWebinar chat box.
- All attendees will be muted for the duration of the webinar.
- Webinar recording and slides will be posted on the Foundation website and shared with all registrants.

PANELISTS



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Pediatric Integrated Care Survey: A New Tool to Measure Family Experience of Care Integration to Improve Care Delivery

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Webinar sponsored by Lucile Packard Foundation for Children's Health, the Catalyst Center, and Family Voices



Boston Children's Hospital



HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Family Experience Measures

- Triple Aim Outcomes¹
 - Patient/Family Experience
 - Patient Outcomes
 - Cost
- Patient/Family Experience Measures
 - Identify gaps in care and care coordination services
 - Data used to drive improvement/intervention

1. <http://www.ihl.org/engage/initiatives/TripleAim>

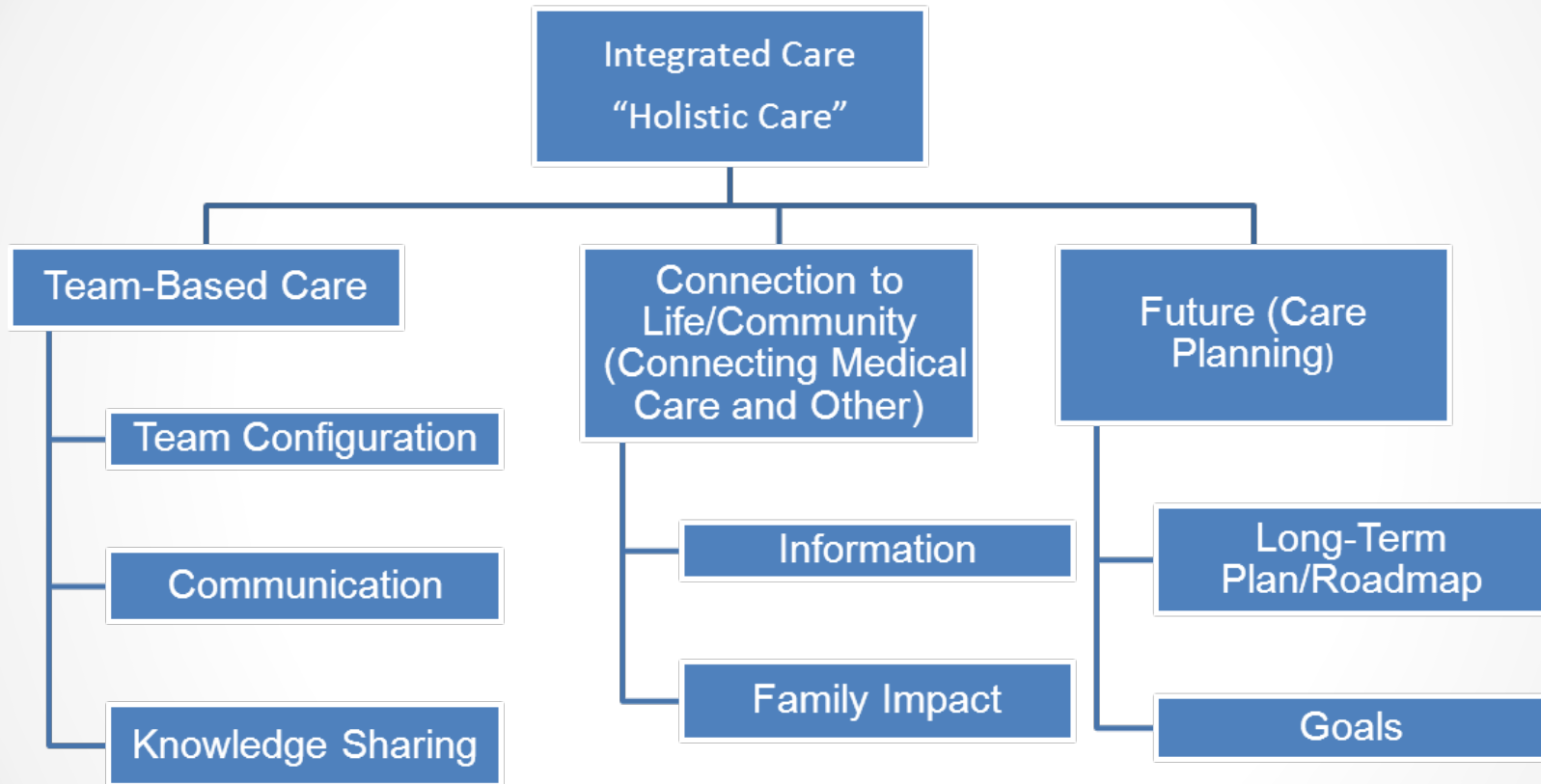


Pediatric Integrated Care Survey (PICS)

- Development of survey funded by Lucile Packard Foundation for Children's Health
- The PICS is:
 - 19 validated experience questions + health care status/utilization & demographic questions
 - Supplementary and topic specific modules
 - Spanish Version is available



Integrated PICS Domains



Ziniel SI, Rosenberg HN, Bach AM, Antonelli RA. Validation of a Parent-Reported Experience Measure of Integrated Care. *Pediatrics*. 2016.



PICS Example Measures

In the past 12 months, how often did your child's care team members:

Explain things in a way that you could understand?

Know about the advice you got from your child's other care team members?

Follow through with their responsibilities related to your child's care?

Explain to you who was responsible for different parts of your child's care?

Treat you as a full partner in the care of your child?



Implementing PICS

- **PICS can be adapted to reflect the experience of different populations, including children with**
 - medical needs
 - behavioral needs
 - significant social determinant of health risk factors
- **PICS currently deployed:**
 - State/ Community/Family Partner organizations
 - Community-based and academic primary care clinics
 - Subspecialty clinics
 - Liver Transplant
 - Ketogenic Diet Clinic
 - Rett Syndrome Clinic
 - Spina Bifida Clinic
 - Complex Care services
 - Academic medical centers, including research institutions
 - Clinics/State Programs with focus on behavioral health integration
- **PICS results help to set priorities**



How to get started

- Identify population to work with—Start Small!
- Choose target area to prioritize question selection
- Discuss plan for processing data
- We can help!
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Navigate My Care



Rebecca Baum, MD
Chief, Developmental Behavioral
Pediatrics

June 15, 2017

What Is Navigate My Care?

- Our goal
 - Reduce avoidable care
 - Improve the patient/family experience across our health care system
- Informed by
 - Organizational successes and challenges
 - Family feedback

- “One department will say ‘we’re done with you,’ and another will say ‘I don’t think so.’”

- “The providers aren’t talking to each other.”

Communication

Transitions and Integration



Self-management and activation

Monitoring, follow up and response

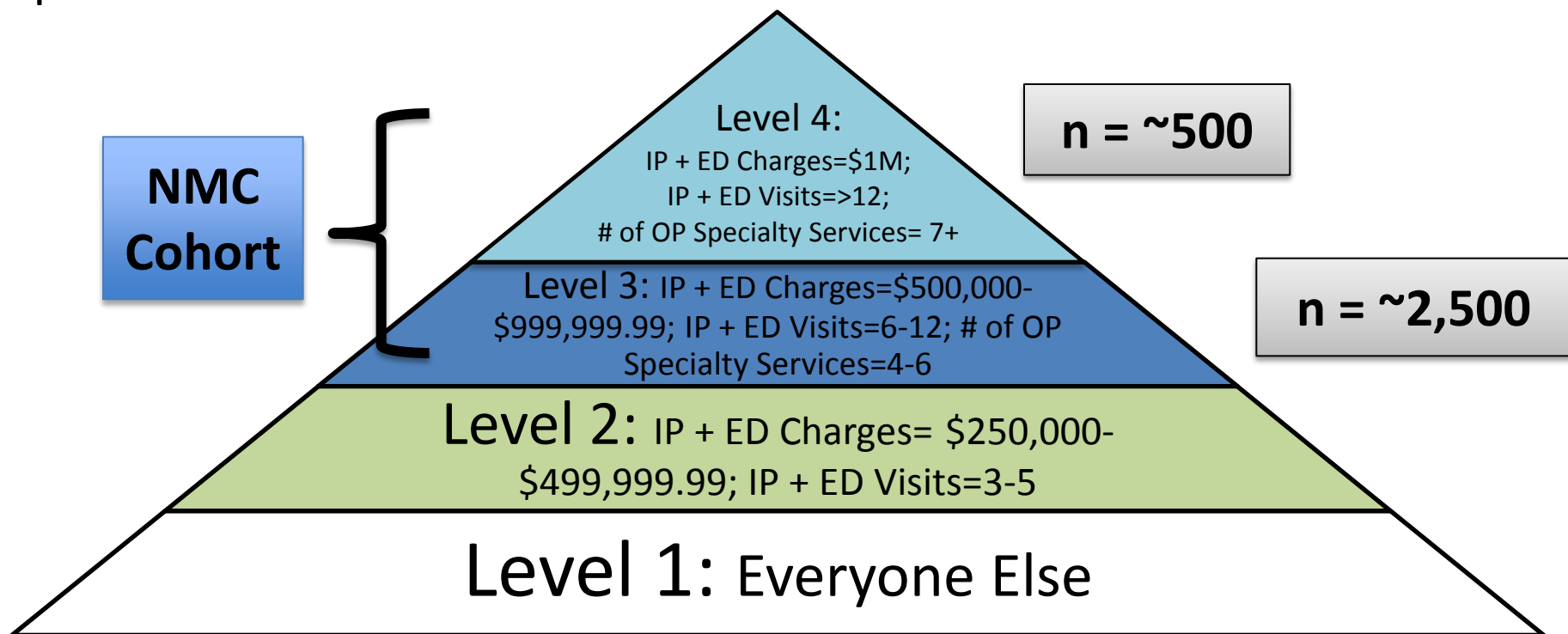


- “I was never told about support groups.”

- “It would be nice to have a social worker call to make sure we got it right.”

The Global Care Coordination

Algorithm is a retrospective model where NCH charges, visits, and specialty clinic utilization are used to stratify patients into levels of care coordination.



All utilization is based on the last 12 rolling months

Navigate My Care

Project Champions: Becky Baum, MD; Kimberly Conkol, RN

Specific Aim

By December 31, 2017, achieve the following amongst medically complex patients*:

- ED visits: 145 (2014) to 125 visits/1000 pts/mo
- Inpatient admissions: 205 (2014) to 175 admits/1000 pts/mo
- Hospital days: 750 (2013-2014) to 650 days/1000 pts/mo
- 7-day readmissions: 16 (2015) to 14 /1000 pts/mo
- 30-day readmissions: 35 (2015) to 30/1000 pts/mo
- ____% ↑ in PICS scores

Strategic Goal

Improve integration and coordination of care for medically complex patients

Key Drivers

Communication

- Interpersonal
- Information transfer

Transitions & Integrated Care

- Specialty ↔ specialty
- Inpatient ↔ outpatient
- Pediatrics → adult
- NCH ↔ non-NCH
- Primary ↔ specialty

Follow-Up, Monitoring, & Response

- Post-discharge follow-up
- Troubleshooting
- Help at home

Self-Management & Activation

- Education resources
- Support systems

Projects/Interventions

Develop “burning platform” (patient stories) to highlight need for NMC interventions

Collaborate with Treat Me With Respect, Diversity & Inclusion and related groups to optimize interpersonal communication for coordination of care

Develop interventions to proactively plan for new CMS Conditions of Participation standard related to discharge planning

Optimize existing care coordination programs

Implement care coord programs in new areas

Optimize physician referral form in Epic

Implement CRG risk stratification

Implement goal-driven, patient-centered (rather than service-centered) Epic care plans

Implement Transitions of Care project & leverage technology resources for post-discharge follow-up (ie automated phone calls and telemedicine)

Develop strategies to coordinate appointment scheduling for complex patients

Expand availability of parent mentors

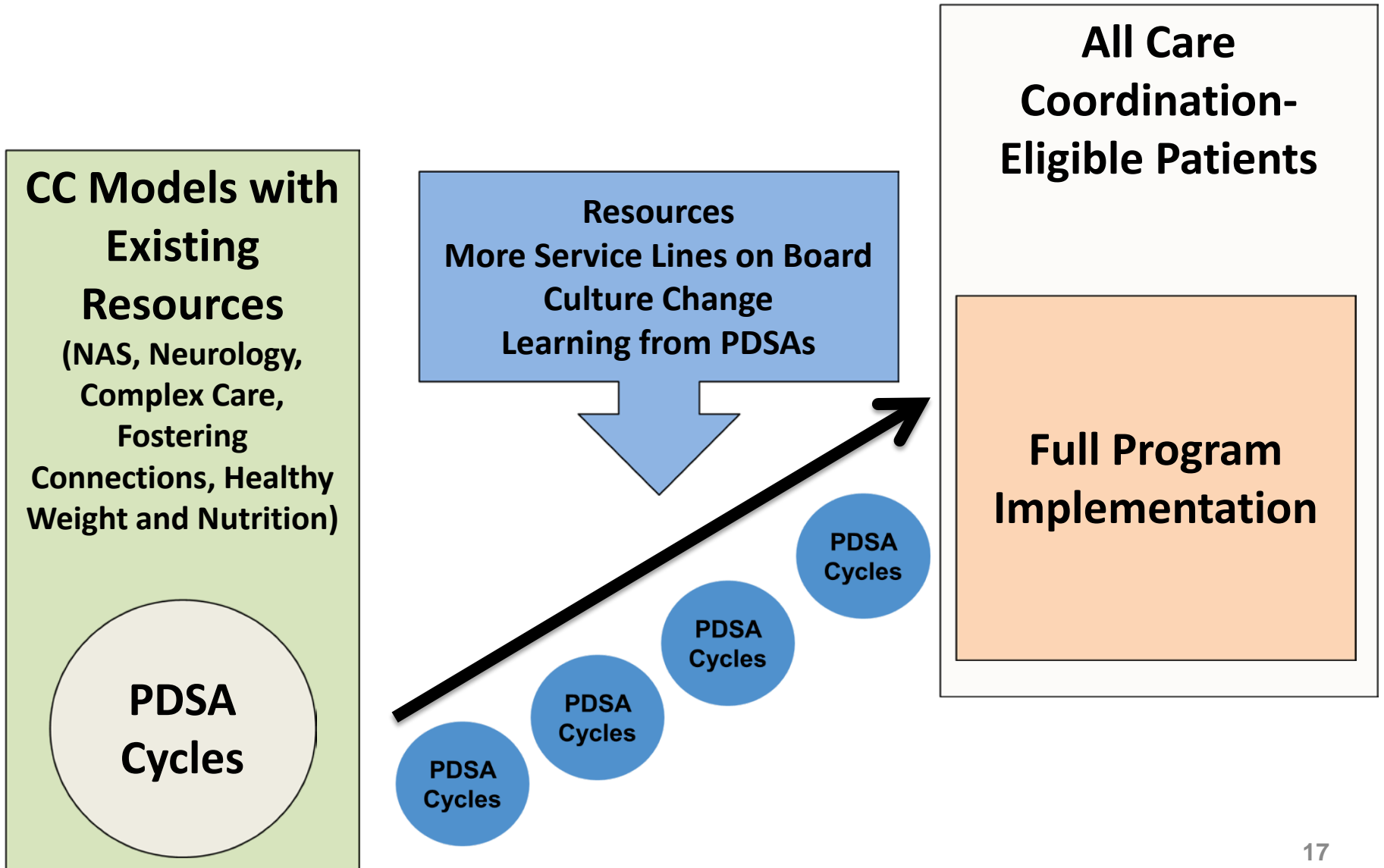
Develop funding plan to continue Complex Care notebook

Implement Daily Goals (whiteboards) for inpatients

	Fully implemented
	Implementation in process
	Planned for a later date

* Patients achieving Level 3 or Level 4 on the NCH Global Care Coordination pyramid

Expanding Care Coordination



Improving the Patient Experience

- PICS questions selected (19 core questions + 6 supplementary questions)
- Sampling strategy
 - 1/4 of patients each quarter with no duplications
- Marketing to assist with mailing (cover letter and survey)

Nationwide Children's Hospital

Patient/Family Centered Quality Strategic Plan

**Keep Us
Well**

Population
health

**Navigate
My Care**

Throughput
Access
Care
Coordination

**Do Not
Harm Me**

Preventable
Harm

**Heal Me
Cure Me**

Outcomes

**Treat Me
w Respect**

Patient
experience



Interprofessional Communication

Questions?

Today's webinar slides and recording will be posted online.

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MORE ON CARE COORDINATION

www.lpfch.org/publications

- A compendium of publications on care coordination

www.lpfch.org/about-us/webinars-conferences-convenings

- Take Action on Care Coordination – webinar materials
- Coordinating Care for Children with Social Complexity – webinar materials
- Care Planning for Children with Special Health Care Needs – webinar materials