## Person-Centered Care Pilot Initiative:

# Lessons Learned from Four California Hospitals

Hospital Association of Southern California

**SEPTEMBER 2019**

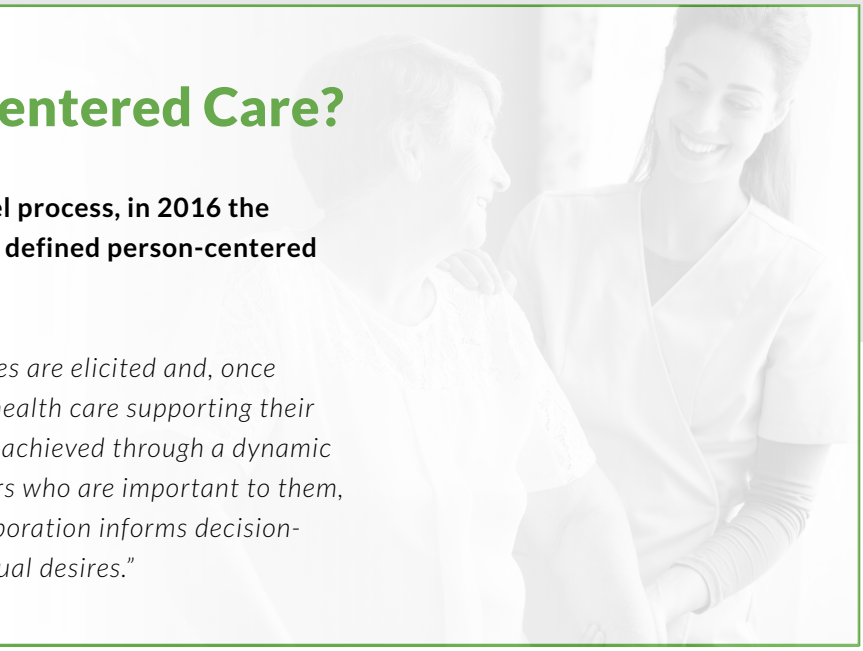
HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA®

# Executive Summary

## What is Person-Centered Care?

**Developed through an expert panel process, in 2016 the American Geriatrics Society (AGS) defined person-centered care as the following:**

*"an individual's values and preferences are elicited and, once expressed, guide all aspects of their health care supporting their realistic health and life goals. PCC is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires."*



Every year, nearly 1,000,000 Medicare beneficiaries are admitted to, and discharged from, hospitals in California. Historically, hospitals have focused on care within their walls, but changes in the environment and payment methods are pushing them to expand their responsibilities to post-discharge outcomes. To that end, person-centered care (PCC) models have demonstrated significant improvements in quality of care, patient satisfaction, and cost effectiveness both within and beyond the realm of the hospital. Establishing effective PCC programs will help hospitals improve the quality of life and better meet the needs of older adults.

Over a three-year period, the Hospital Association of Southern California (HASC) spearheaded the Person-Centered Care Pilot Initiative (Initiative), an effort to help four Southern California hospitals that serve older adults with complex care needs to develop mechanisms that would embed PCC concepts and models across their delivery system post-discharge. The four participating hospitals had a strategic interest in population health and the "Triple Aim" (Better Care, Better Health, and Lower Cost). HASC provided a series of tailored communications, peer-to-peer learning sessions, and technical assistance to the participating hospitals, all of which was guided by a Strategic Planning Group and aided by collaboration with community based organizations, physician advocates, workshop facilitators, and model developers.

Overall, the Initiative provided valuable insights on how hospitals can integrate new concepts into practice through technical assistance and peer-to-peer learning. Each hospital, partnering with post-acute providers and/or community-based organizations learned the following:

- Executive leadership and project accountability to an existing hospital-based committee for continuous support is key to the establishment of a viable intervention.
- Building a strong collaborative, understanding existing processes and designing the model takes a significant amount of time.

## Participating Systems and their Goals

Four hospitals across the southern California landscape participated in the Initiative from April 2016 through March 2019. Summaries of each site are provided below and with full case studies included in this report.

### Community Memorial Health System (Ventura, CA)

The Community Memorial Health System partnered with the Camarillo HealthCare District to target older adults with a primary diagnosis of heart failure or chronic obstructive pulmonary disease, and a secondary diagnosis of dementia. Their goal was to prevent health decline and readmission after a hospital discharge by providing in-home evaluation and follow-up care coordination for individuals without home care agencies or other healthcare entities directing their post-hospital care plan. They accomplished this goal by utilizing social service professionals as "health coaches" who conducted periodic, person-centered assessments on discharged individuals (previously flagged) to develop specialized care plans, addressing what mattered most to their clients.

### Keck Hospital of USC (Los Angeles, CA)

The Keck Hospital of USC partnered with two specialty clinics—Orthopedic and Oncology Services—to implement person-centered approaches targeting clinic patients, pre-procedure for Oncology and post-procedure for Orthopedics. The goals were to improve pre-procedure assessment and case planning for high risk elderly and frail patients undergoing their first round of chemotherapy, and for Orthopedics to gain a better understanding of what mattered most to patients throughout the procedure and how those needs could be better met. For Oncology patients they accomplished this goal by instituting mini-cognition and frailty assessments prior to procedure, and then involving occupational therapists and social workers to help those patients in the time following their procedure. For Orthopedics interviews with patients were conducted after surgery leading to a better understanding of patient experience and person centered goals. These findings were fed back to the Orthopedic teams and adjustments made to pathways of care.

### Adventist Health White Memorial (Los Angeles, CA)

Adventist Health White Memorial partnered with Access.Mobile to reach individuals in their capitated community (including homeless persons). Their goal was to consistently connect with these individuals, typically not revisited after discharge, in order to prevent declines in health. They accomplished this goal by developing a text messaging tool that tailored information and resources offered.

### Eisenhower Health (Rancho Mirage, CA)

Eisenhower Health partnered with an on-site outpatient pulmonary clinic to target individuals with chronic obstructive pulmonary disease. Their goal was to reduce readmission of these individuals by improving coordination between inpatient and outpatient services and providing support for individuals throughout the care process. They accomplished this goal by redesigning communication between the hospital and the outpatient pulmonary clinic through the new electronic health record system, in addition to implementing new processes in both agencies. These new processes included an assessment performed by the pulmonary rehab clinic nurse navigator to learn 'what matters most' to the individual and what their fears and concerns might be, weekly phone calls to patients by a hospital respiratory case manager, revising physician admission and discharge order sets, and educating staff about care coordination and person-centered functional status assessments.

## Conclusions

The Initiative highlighted the value of a variety of approaches to establish PCC inside hospital settings and identified hospital personnel as key players in achieving person-centered goals. Despite implementation challenges, this project accentuated the importance of collaboration: between patient and provider within the hospital, and between hospitals and community organizations. The Initiative was an important first step toward incorporating person-centered approaches system-wide and improving healthcare outcomes.

## About the Hospital Association of Southern California

The Hospital Association of Southern California (HASC), founded in 1923, is a not-for-profit 501(c)(6) regional trade association. HASC is dedicated to effectively advancing the interests of hospitals in Los Angeles, Orange, Riverside, San Bernardino, Santa Barbara and Ventura counties.

## About The SCAN Foundation

The SCAN Foundation is an independent public charity devoted to transforming care for older adults in ways that preserve dignity and encourage independence. We envision a future where high-quality, affordable health care and supports for daily living are delivered on each person's own terms, according to that individual's needs, values, and preferences.

## Acknowledgment and Appreciation of the Advisory Group

A Strategic Planning Group (SPG) was formed at the beginning of the project to help with initial planning and to advise the facilitators throughout the three-year journey. The SPG members were selected for their expertise in various aspects of person-centered care, geriatric medicine, and case management in the continuum. Their commitment, candor, and expertise brought tremendous value to the endeavor.

**Eileen Koons, MSW**
*Director, Huntington Hospital Senior Care Network*

**June Simmons, MSW**
*CEO, Partners in Care Foundation*

**Libby Hoy**
*Founder/CEO, Patient and Family Centered Care Partners*

**Stephen Hoy**
*COO, Patient and Family Centered Care Partners*

**Michael Wasserman, MD**
*Geriatrician President, CALTCM*

**Judy Thomas, JD**
*CEO, Compassionate Care Coalition of California*

**Lindsay Holland**
*Director Care Transitions, Health Services Advisory Group*

**Julie Morath, RN**
*President and CEO, Hospital Quality Institute*

**Boris Kalanj, MSW**
*Director of Culture Care and Experience, Hospital Quality Institute*

**Patricia Blaisdell, FACHE**
*Vice President Continuum of Care, California Hospital Association*

**Julia Slininger, RN**
*Vice President Quality and Patient Safety, Hospital Assn of Southern CA*

**Wendy Gates, LVN**
*Person-Centered Care Project Manager, Hospital Assn of Southern CA*

**Gretchen Alkema, PhD**
*Vice President of Policy and Communications, The SCAN Foundation*

**Rene Seidel, Dipl. Soz. Paed. (FH)**
*Vice President of Programs and Operations, The SCAN Foundation*

**Erin Westphal, MSG**
*Program Officer, The SCAN Foundation*

# Person-Centered Care Case Study

## Adventist Health White Memorial, Los Angeles, CA

White Memorial Medical Center, an inner city general acute care hospital with 277 beds, is part of Adventist Health, a faith-based, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. White Memorial Medical Center's mission is to improve the physical, mental and spiritual health of the community, enhance interactions with patients, providers and employees, and manage people's health to help make care more affordable.

### The Decision to Participate: What "Problem" Needed To Be Solved

Adventist Health White Memorial (AHWM) needed to create sustainable mechanism to reach their large population which is geographically widely spread out to help them access healthcare services. The healthcare team sought to better understand the patient population, including communication preference, content needs, and drivers of health behavior. The goal was to reconnect patients with the managed care system and to improve population health by facilitating access to the appropriate specialty clinics and community partners.

### Partners and Approach

White Memorial Medical Center partnered with Access.Mobile International, a telecommunications company with a behavior science, research, and data analysis division that had the capacity to design a new communication strategy with patients in the hospital's capitated managed care plan. The target population included persons discharged from the hospital, with a focus on high utilizers, homeless persons, and various other demographic groups including those over 65 years of age. SMS text messages were designed and tested that would yield information about reachability, desired health content, and interest in special services. The message was designed with warmth in mind to help recipients feel like the staff at AHWM cared about their well-being. There was an assumption that this population was not "tech savvy", and that a large number would not have cell phones. However, the pilot found high delivery rates, low opt out rates, and significant engagement.

### Challenges Encountered and How These Were Overcome

AHWM encountered two main implementation challenges. The first challenge was getting buy-in from the operations team to try using new technology in this manner, and the second was that SMS texting is not Health Insurance Portability and Accountability Act (HIPAA) compliant, so the undertaking required a complex Information Technology (IT) and corporate approval process. The challenges were mitigated by implementing the project through several phases to progressively monitor the value and applicability of each idea, and by creating "opt-out" and "opt-in" choices as well as a mechanism for recipients to sign an agreement for subsequent contact and content, giving them control over what more (or less) information they would receive.

### Accomplishments

Quantitatively, overall "delivery rate" was confirmed in 70% of the pilot sample, with a slightly lower rate (52%) within the over 65 population. The overall "opt-out" rate was 14%. The specific patient-centered questions about desired content dramatically increased the potential for engagement, education, and improved self-care. The per-member-per-month cost for texting is $0.11 vs. the cost of $30.30 for traditional RN Care Navigator calls which could only reach a very small number of patients

after discharge to learn about their experience and their ongoing needs. No new staff had to be added to manage this process because once the messaging process was designed, the actual text communication could be sent by existing personnel in a matter of seconds. In the first quarter of 2018, there was a 2% decrease in out-of-network claim expense compared to 2017. Since pilot initiation, 492 capitation patients who received the texts have come into AHWM for a visit, including 201 who were new to the hospital.

Qualitatively, a process was created to effectively engage people, including homeless persons, in their care after hospital discharge, where no such mechanism existed before. For the older adults, communication pathways have been increased to reach family and caregivers who can advocate for the needs of the person who was recently discharged when that person cannot. This text message program increased information about social determinants of health, since the message offering information about transportation had a strong response. Lastly, and very gratifying, was the receipt of several favorable "inbound" return messages from persons receiving the pilot texts.

Overall, this new process will improve health system literacy, and increase understanding about barriers to care. During the next phase, patients from the diabetes clinic will be provided an 'opt-in' to the texting. The goal will be to improve diabetes adherence and enhance health education. In addition, the same process will be implemented for those at high risk for re-admission, and a community engagement focus on senior wellness.

### Keys to Success

Two main factors fueled the success of this project and continue to pave the way to an expanded reach into the community. The first is that a multidisciplinary cross section of stakeholders and patients were involved in the design and initial testing of the messages. Successive iterations were refined until the "go live" distribution began. The second is that this population health strategy - creating a text message exchange with the patients after hospital discharge - was proven to be an efficient, cost-effective way to reach out to a large population, and target certain demographic segments with selective preventive health reminders, facilitating a partnership for better health.

Many thanks to the hardworking team leaders at Adventist Health White Memorial in Los Angeles County who pursued the vision of this initiative with innovation and shared in collaborative learning:

**Lead**
**Apurva Shah, MPH, MBBS**
*Clinical Performance Improvement at Adventist Health White Memorial*

**Executive Leadership**
**Mara Bryant**
*Operations Executive at Adventist Health White Memorial*

# Person-Centered Care Case Study

## Community Memorial Health System, Ventura CA

Community Memorial Hospital is a non-profit hospital with 242 general acute care beds that is part of the Community Memorial Health System (CMHS).

### The Decision to Participate: What "Problem" Needed To Be Solved

In 2017, CMHS, through their ACO and community needs assessment, identified three critical needs for the populations they serve:

1. Meet the needs of patients who demonstrate difficulty in managing their medical conditions post hospitalization.
2. Design better support for frequent hospital utilizers of both the emergency department and inpatient care.
3. Pay attention to the patient who has complex medical issues as well as complex psychosocial issues. CMHS recognized that patients discharged to the community from an inpatient stay had less of a support system in place to help prevent decline and readmission.

### Partners and Approach

Formed in 2014, the Hospital to Home Alliance of Ventura County (HHAVC) is a unique body of hospitals, skilled nursing facilities, managed care organizations, CMS Quality Improvement Organization, home health agencies, and community-based organizations collaborating to create a new approach toward care. The primary focus of HHAVC members is to improve hospital to home outcomes by improving patient care coordination, cooperation, and communication across the health care continuum. Through the HHAVC, there was an established and successful process of care coordination when a patient was discharged to home health or a skilled nursing facility. The goal of this project was to create a similar process for those discharged to the community.

To meet this goal, CMHS partnered with the Camarillo Health Care District (CHCD), a community-based organization, to provide in-home evaluation and follow up care coordination for persons discharged to home with or without physician orders or plans for traditional home care services.

The target population was older adults with Chronic Obstructive Pulmonary Disease (COPD) and/or Congestive Heart Failure (CHF) who also had a secondary finding of cognitive impairment. CHCD sought to focus specifically on cognitively impaired older adults whose needs may not be adequately addressed in multiple care delivery settings. A process was designed to identify and refer these individuals for follow-up care by CHCD. Health coaches (social services professionals) from CHCD used an assessment which included functional status and quality of life questions to develop and implement care plans for the persons based on what was important to them. Staff monitored care plan implementation and regularly reassessed for improvement in functional status or quality of life.

### Challenges Encountered and How These Were Overcome

CMHS and partners encountered three main implementation challenges. The first challenge was identifying persons who met the pilot criteria during hospitalization and achieving a successful referral, orientation, and transition to the program - from the hospital case manager to the health coach. To achieve a greater response, the pilot criteria were expanded, and hospitalists became involved to change the nature of the conversation with the patient and family to make it more person-centered. They explained the role of the health

coach post hospitalization and conducted an in-person meeting with the health coach prior to discharge.

The second challenge was quantifying the return on investment of the intervention. Although the mathematical and economic factors contained too much variability to fit into an existing formula, one case example showed how much savings could be realized – $119,986.00 in this case – when post-acute care and coordination is focused on a person's expressed needs and social determinants of health.

The third challenge was external in nature, with severe fires and flooding in the County, as well as the disruption caused by the full-scale move into their new hospital building, all during the project period.

### Accomplishments

As a result of the intervention, over 300 persons were engaged in follow-up services and coaching after hospital discharge, 53% of who indicated improved quality of life in subsequent visits, and 86% of whom demonstrated improved or maintained functional status. In addition, assessment and care planning processes for all HHAVC organizations adopted a more person-centered approach to care planning, incorporating three questions into their discussions:

- Are there things you enjoyed doing for yourself that now you cannot do since you were diagnosed with this disease?
- What are your dreams and goals for the future- what would make it a really good day for you? (Things you want to do, people you want to see, goals for your health, etc.)
- What might you be most concerned, afraid, or nervous about, after our discussion today?

### Keys to Success

Two interrelated factors were key to success of this project. The first was the partnership between CMHS and HHAVC. If hospitals do not already have relationships they should build them, starting with post-acute providers in their community. Important components of those relationships include, understanding each other's processes and priorities, alignment of strategic goals, collaboration and flexibility. Second, recognition that including a focus on "what matters most" requires a willingness to address one or more social determinates of health to some degree (i.e., transportation, food insecurity, helping family members participate). Additional partners in the community are often positioned to help with these needs, if they are made aware and invited to collaborate.

At the final interview, one team member summarized:

*"The most important thing was to link the dots for the providers, so that a more person-centered approach could enhance what's already being done. The key is for people to see it as natural, and not as an added burden."*

Many thanks to the hardworking team leaders at Community Memorial Health System in Ventura County who pursued the vision of this initiative with innovation and shared in collaborative learning:

**Lead**
**Bonnie Subira, MSW**
*Manager High Risk Case Management, Ambulatory Medicine at Community Memorial Health System*

**Executive Leadership**
**Cindy DeMotte, MPH, CPHQ, RD**
*Vice President, Quality at Community Memorial Health System*

**Continuum of Care Partner**
**Sue Tatangelo, MAOM**
*Chief Resource Officer at Camarillo Health Care District*

**Lynette Harvey, RN, BSN, CCM**
*Clinical Services Director at Camarillo Health Care District*

# Person-Centered Care Case Study

## Eisenhower Health, Rancho Mirage, CA

Eisenhower Medical Center is a general, acute care, non-profit hospital with 463 beds. It is part of Eisenhower Health, a progressive health care complex that includes the Annenberg Center for Health Sciences, the Barbara Sinatra Children's Center, and outpatient facilities in Palm Springs, Cathedral City, Rancho Mirage and La Quinta. Eisenhower Health exists to serve the changing healthcare needs of their region by providing excellence in patient care with supportive education and research.

### The Decision to Participate: What "Problem" Needed To Be Solved

Eisenhower Medical Center recognized that patients with COPD had a readmission rate of 21% within 30 days of discharge. The pulmonary clinic had previously focused certain efforts on improving care and coordination for patients with COPD after hospitalization but they were not achieving the desired effect. The goal of this project was to reduce readmissions by improving coordination between inpatient and outpatient services and better support persons with COPD in the continuum of care.

### Partners and Approach

Eisenhower Health operates a robust Pulmonary Clinic as an outpatient unit. The clinic works to educate and coach their clients, including those with Chronic Obstructive Pulmonary Disease (COPD) about their condition, to enhance their quality of life and decrease the frequency of inpatient hospitalizations. This is accomplished with a multidisciplinary team at Eisenhower Health that includes physicians, nurses, respiratory case managers, a pulmonary clinic nurse navigator, executives, quality improvement professionals, and EPIC system analysts.

The target population was older adults discharged from the hospital who had a primary diagnosis of COPD and a special focus on those who were diagnosed with Group 3 (severe) and Group 4 (very severe) levels of disease. The hospital and the pulmonary clinic realized they needed to change from working in silos, to coordinating their care and communication. Redesigning processes to work together across the continuum required changes on both sides. New processes originating at the hospital included telephone calls at least weekly for 4-weeks by the hospital respiratory case manager to the patient after discharge and utilizing the new EPIC documentation template that linked inpatient and outpatient communication. Physician admission and discharge order sets were also revised to set the stage for coordination of care in the continuum. New processes originating at the pulmonary clinic included education for pulmonologists & pulmonary clinical staff about coordination of care, improvement of functional status assessments to include a more person-centered discussion, the creation of EPIC COPD documentation templates, and enhanced pulmonary rehabilitation services including a Nurse Navigator intervention for persons with severe COPD.

### Challenges Encountered and How These Were Overcome

Eisenhower Medical Center encountered three main implementation challenges. The first challenge was identifying the most appropriate individuals at the hospital to participate in the change strategies that would involve care and communication after hospital discharge, while attempting to develop a business case for those interactions. The second was related to the

first, with the hospital team believing that the skill set required for the new interactions would be a social work professional but an attempt to add such a person to the staff was not approved during this pilot. To tackle these two challenges, existing team members at the hospital and at the pulmonary clinic took on expanded roles to perform more person-centered assessments, learn what matters most to the persons they are serving, incorporate that input into the care and coaching plan, and make some connections for other community based services.

Lastly was the parallel timeframe of this project with the implementation of the EPIC electronic medical record system. This required a great deal of the team members' time in addition to their regular clinical work. Although this was considered a "conflicting priority" it was turned into a synergistic opportunity to configure a better communication platform for coordinated care management across the delivery system.

### Accomplishments

As a result of the changes built into the EPIC system and in both inpatient and outpatient processes, Eisenhower Medical Center and the Pulmonary Clinic have coordinated their efforts to reduce readmissions and improve the quality of life of persons with COPD. During this initiative the annualized COPD readmission rate dropped from 21% to 12%. This reduction is attributed to several factors, including early identification of persons with severe COPD, and a more coordinated approach to assessment, coaching, and care given by the physicians, nurses, respiratory therapists, case managers, and pulmonary clinic staff.

### Keys to Success

Two main factors leading to the success of the process changes and to readmission reductions were, first, the collaboration between inpatient hospital staff and the outpatient pulmonary clinic staff. Changing the culture from a "handoff" to a coordinated effort and building a platform for that coordination of care into the EPIC system at the same time ensured that all those involved in the persons' care were communicating with each other effectively. Secondly, the new focus on the *person* ("what matters most" to them) rather than the previous focus on managing the *disease*, changed the dialog and enhanced the relationship between those providing and those receiving care. A shared understanding of the persons' desires, needs, and concerns now drives the care plan. At the conclusion of the project, one team member summarized:

*"Engaging our team, directors, leadership and doctors in this person-centered care project, has given us an opportunity to think about what we are doing on a daily basis, helping persons in our community with COPD to have a better quality of life."*

Many thanks to the hardworking team leaders at Eisenhower Health in Riverside County who pursued the vision of this initiative with innovation and shared in collaborative learning:

**Lead**
**Janet Mirabella, MS, BSN, RN, CPPS**
*Director, Quality Improvement and Patient Safety Officer*

**Executive Leadership**
**Christine Johnstone, MHA, MSN, RN, PHN**
*Vice President, Quality and Process Improvement*

**Continuum of Care Partner**
**Elizabeth A. Smith RN, MS**
*Nurse Navigator, Eisenhower Pulmonary Clinic*

# Person-Centered Care Case Study

## Keck Medicine of USC, Los Angeles, CA

Keck Hospital of University of Southern California (USC) is a 401-bed acute care hospital located in downtown Los Angeles. Keck Hospital is part of the Keck Medicine of USC, which is ranked at #16 nationally in the US News and World Report 2019 Hospital rankings, and has internationally renowned physicians who care for patients at affiliated hospitals and licensed clinics, as well as teach and conduct research at the Keck School of Medicine of USC.

### The Decision to Participate: What "Problem" Needed To Be Solved

Keck Hospital of USC wanted to explore the creation of more person-centered, pre-procedure assessment and post-procedure follow up plans to improve health outcomes. For orthopedic patients, the theory was that optimizing the patient's own expectations and understanding of the care plan would improve the patient experience and reduce postoperative problems. For oncology patients, better understanding of the patients' cognitive function and level of frailty was needed to ensure appropriate discussion about treatment options. The goal of this project was to improve interaction with the patients and their family members so as to better inform and coordinate the care plan between hospital and clinic teams.

### Partners and Approach

This work was facilitated through the Center for Health System Innovation at Keck Medicine of USC (CHSI). The CHSI team partnered with colleagues in Orthopedics and Oncology. The Orthopedic and Oncology Clinics function as a part of Keck Medicine of USC, providing specialty outpatient care and follow up for patients requiring surgical and medical procedures. The Orthopedic Clinic work focused on an existing protocol for hip and knee replacement for older adults over the age of 65, and the Oncology Clinic focused on creating a new protocol for older patients for 'first time' chemotherapy.

Nurse navigators on the Orthopedic team were asked to interview patients once they had returned home following the procedure. They were asked to go through a short questionnaire with the patients, which had been designed by the CHSI team and included questions focused on what mattered most to the patients and how their care could have been improved. The approach of the Oncology Clinic centered on pre-procedure protocol changes to incorporate a brain health exam (mini-cognition test) and frailty assessment for patients who were considering 'new-start' chemotherapy. Discussions about "what mattered most" to these patients and their families, coupled with the results of the mini cognition and frailty assessments, helped the patients in decision-making about whether to proceed with chemotherapy or not.

### Challenges Encountered and How These Were Overcome

Keck Hospital of USC encountered two main implementation challenges. The first challenge was linked to the research approval process at USC for the oncology study, requiring any protocol changes to be approved by an Investigational Review Board (IRB). The team (CHSI and oncology) wanted to obtain IRB approval in order to publish any new findings. Since the anticipated protocol changes were not clinically specific (such as medication or technique changes) and were only a small pilot proposal, after several months of deliberation the IRB did not approve the study. The project was then continued as a quality improvement study rather than a research study, allowing the clinical teams to test out changes that included the "softer science" of interaction with the patients. In the oncology clinic, two physicians participated in the process for improving the person-

centered approach to care by performing the mini-cognition assessment on several of their patients, and incorporating the results into subsequent discussions with the patient and family.

For the orthopedic project, there was some challenge in engaging physician champions to modify their existing protocols, in an already high performing pathway, to include a more person-centered approach. Nursing and case management staff performed interviews, the findings were collated and fed back to the orthopedic teams.

### Accomplishments

A quantitative survey of 46 orthopedic patients found most answering "10 out of 10" for satisfaction and understanding. Several did, however, identify a significant difference between their expectations for "walking after surgery" and the reality of their ability to do so in the early post-operative period. This was very valuable information to the care team. In addition, some patients also commented that they felt confusion around post-operative medications, which led to involving pharmacy and the design of a visual medication prompt. As a result of the learning from the interviews with the orthopedic patients, information exchange with the patients about medications and activity was clarified and became more consistent between the hospital and clinic team members.

With only a few months of active participation in the oncology clinic, the pilot period found 11 oncology patients eligible for the new protocol under study criteria. Of those who were assessed, three opted for hospice care rather than chemotherapy, and the others were poised to engage further in ongoing quality of life evaluation as their treatment continued.

Team-based care that extends across the continuum and including physiotherapists, social workers and occupational therapists has begun to take hold as a direct result of both projects, influencing other initiatives such as Enhanced Recovery After Surgery (ERAS), and in several specialty clinics including Cardiothoracic, Gynecologic, Head and Neck, Spine, Thoracic , and Urological Surgery. An important major project the "Brain Health Initiative" was clearly facilitated by the learning and team, established during the Oncology work.

### Keys to Success

Two main factors contributed to the success of this initiative. The first was improving coordination for 'team-based care" within the clinics, and in collaboration with the hospital. Indeed, improving the understanding between team members, and including the patients and families as members of the team, was a positive outcome in itself. The second was the learnings from the first few patient interviews, asking more open-ended questions, including "what matters most to you". Team members found it gratifying to understand more about their patients - what they understood, what they needed, what they feared – and they became more inspired to expand the population for these person-centered practices and contribute to a better outcome.

Many thanks to the hardworking team leaders at USC Keck Medical Center in Los Angeles County who pursued the vision of this initiative with innovation and shared in collaborative learning:

**Lead**
**Carol Peden, MB ChB, MD, MPH**
*Professor, Department of Anesthesiology, Keck School of Medicine, University of Southern California*

*Executive Director, USC Center for Health System Innovation*

**Veronica Pagan**
*Project Specialist for the Center for Health System Innovation at USC Keck Medical Center*

**Katy Roberts, MS, MBA**
*Senior Quality Analyst for Center for Health System Innovation at USC Keck Medical Center*

HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA®

HASC.ORG