Person & Family Engagement in Office Practice:
Advancing TCPI, Building on PCMH

Prepared for
COMPASS PTN

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Executive Director
Consumers Advancing Patient Safety

Objectives/Topics

- Describe the theoretical, social and healthcare policy vectors driving new thinking regarding the partnership between providers of care, patients, their families and other community stakeholder,
- Understand and apply the PFE change concepts and tactics in the TCPI change package as well as new office-based PFE interventions in development by AHRQ, the QIN-QIO network and healthcare providers
- Recognize and explore opportunities for PFE in improvement work in office practice and community settings that participants can be in action on now.
Anthony T. Washington Sr.  
12/16/1949 – 08/13/2009

Re-Examining the Patient-Clinician Relationship: An Emergent Partnership Model

Kim Blanton Story

https://www.youtube.com/watch?v=sikdSUnBmos
Re-Examining the Patient-Clinician Relationship: An Emergent Partnership Model

Key Terms

- Patient Activation
- Patient Activation Measures (PAM)
- Patient-Centered Care
- Patient (or Person) & Family Engagement (PFE)
- Patient Satisfaction
- Chronic Care Model
- Shared Decision-Making
- Self-Management
- Systems Approach
- High Reliability Organizations
- Safety Across the Board (SAB)


*Even in an age of hype, calling something “the blockbuster drug of the century” grabs our attention. In this case, the “drug” is actually a concept—patient activation and engagement—that should have formed the heart of health care all along.*

Susan Dentzer, Editor Health Affairs
Re-Examining the Patient-Clinician Relationship: An Emergent Partnership Model

Partnership includes re-evaluating the roles that patients and their families play...

- **with their providers in their own care** and the care of family members or others for whom one is responsible,
- **in designing or improving care processes** in hospitals, physician practices and other healthcare delivery organizations, and
- **in setting social and regulatory policies and priorities**, including healthcare payment policies
Re-Examining the Patient-Clinician Relationship: Major Drivers

1. Growing social consensus about the importance of Patient-Centered Care or more holistically: Person and Family Centered Care

2. Accumulating Research in the Chronic Disease and Patient Centered Medical Home Domains

3. The paradigm shift from reliance on professional responsibility for healthcare outcomes to a Systems Approach for ensuring healthcare safety and quality

Patient Activation = Patient Engagement at the Point of Care

*Health Affairs* 2013, 32(2) 216-222

*Patient Activation is the combination of skills and confidence that equip patients to become actively engaged in their healthcare.*

Judith H. Hibbard, PhD, MPH
Research Professor,
Health Policy Research Group University of Oregon
Many physicians have come to see Patient Activation and Shared Decision-Making as practical ways to be patient-centered. But physicians are now being challenged by CMS and other policymakers and healthcare thought leaders to establish partnership strategies beyond the point of patient care.

**PfP Safety Across the Board Initiative**
*Patients expect more than being protected from 2 or 3 causes of harm (Dennis Wagner, PfP Co-Lead)*

**Four Principles:**
1. Commitment to safety/reliability as a strategic imperative
2. Composite scoring and reporting so improvement work is not just projects & projects
3. Provide big picture that engages all staff, leadership, governance and patients & families we serve
4. Inclusion of PFE and elimination of disparities in safety outcomes
How does the SAB Approach regard Patient Engagement?

Although Systems Approach models emphasize the roles and expertise of physicians & other healthcare professionals, as patients & family caregivers become more engaged, new vistas open up for understanding their contributions to safer, higher quality care.
PFE Environmental Scan of Federal Transformation Efforts

- Partnership from Patients (PfP) Campaigns 1.0, 2.0
  - Frameworks/Roadmaps
  - Metrics
  - Alignment of PFE with outcomes improvement work
- CMS overall PFE strategy, announced at 2015 Quality Conference
  - Signaled the shift from “patient” to “person”
- AHRQ Toolkits
  - Seven Pillars Program
  - CANDOR = Communication and Optimal Resolution
  - Guide to Patient and Family Engagement in Primary Care
- New Quality Improvement Organization (QIN-QIO) Campaign on Medication Self-Management
- Transforming Clinical Practice Initiative (TCPI)

Partnership for Patients (PfP)

Launched in April 2011
- Coordinated by CMS Innovations Center
- Projected Outcomes:
  - 60,000 lives saved, 1.8 million fewer injuries
  - 1.6 million people recover without readmission
  - $35 billion saved ($10 billion to Medicare)
Partnership for Patients: Better Outcomes, Lower Costs

GOALS:

40% Reduction in Preventable Hospital-Acquired Conditions
1.8 Million Fewer Injuries | 60,000 Lives Saved

20% Reduction in 30-Day Readmissions
1.6 Million Patients Recover without Readmission

PfP Participating Hospitals
PFE Metrics, Jul 2013 -- Nov 2014

Kansas Healthcare Collaborative
**Minnesota HEN "Pattern PFE and Campaign Outcomes**

Comparing Minnesota PPR of Low Performers (0-3 PFE) to High Performers (4-5 PFE)

- 2009: 0.987
- 2010: 0.817
- 2011: 0.798
- 2012: 0.631
- 2013: 0.6
- 2014: 0.7
- 2015: 0.8
- 2016: 0.9
- 2017: 1.0
- 2018: 1.1

<table>
<thead>
<tr>
<th>Year</th>
<th>PPR Ratio</th>
</tr>
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<tbody>
<tr>
<td>2009</td>
<td>0.987</td>
</tr>
<tr>
<td>2010</td>
<td>0.817</td>
</tr>
<tr>
<td>2011</td>
<td>0.798</td>
</tr>
<tr>
<td>2012</td>
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<td>1.0</td>
</tr>
<tr>
<td>2018</td>
<td>1.1</td>
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**PFE Contributions to the PfP Campaign**

- **PFE as a provider/user partnership strategy**
  - Patient stories as motivators
  - Patient and family contributions to learning/improvement
- **PFE as a pull strategy to drive demand for improvement**
  - Patient advocate buzz about the PfP Campaign created excitement or change of opinion
  - Outreach to patient advocacy groups reframed PFE as an improvement strategy
  - Engagement of PFAC members in safety work is creating expectation of a new normal in U.S. healthcare system?
- **PFE as a culture change strategy**
  - The conversation changes when the patient is in the room
AHRQ Guide to PFE in Primary Care Research Question

What are effective and potentially generalizable approaches for engaging patients and families to improve patient safety in primary care settings?

AHRQ Environmental Scan

1. Synthesize research in the field
2. Inventory and describe interventions
3. Qualitatively evaluate effectiveness and usability of interventions identified
4. Identify gaps in the field and areas ready for intervention development
Four Key Threats to Patient Safety

- Breakdowns in communication
  - Among patient, provider, practice staff
- Medication management
  - Prescribing, filling, adherence, overuse
- Diagnosis and treatment
  - Decision making, information transfer, missed diagnosis, delayed diagnosis
- Fragmentation and environment of care
  - Care coordination, safety culture, reporting, error identification and management

AHRQ Environmental Scan

Implications for the Guide

- PFE interventions focused primarily on the patient as the agent of change haven’t been measurably successful
- Education alone is unsustainable yet it is the focus of most interventions
- Limited evidence of usability and adoption
- Health equity and literacy are cited as a concern, but not often a focus of interventions
AHRQ Guide Model for Advancing PFE in Primary Care

AHRQ Guide: Recommended Interventions
(= TCPI Tactics?)

1. Family engagement in care
2. Teach back
3. Warm hand-offs
4. Medication safety interventions
   - Patient and family advisory councils
   - Shared decision-making
QIN-QIO Campaign for Meds Management

A Two Phase Campaign

Phase 1. (12 months)
Develop and test successful patient medication self-management programs by 1/1/17 using rapid cycle prototyping

Phase 2. (18 months)
Health coalitions in 50% of counties in US have adopted the evidence-based medication self-management system by 12/18.

Impact:
CMS estimates increase in patient at goal, reduce care utilization, reduced total cost of care.

Outcome:
Health coalitions in 50% of counties adopt evidence-based medication self-management system

Medication Self-Management For Patients & Family: A Stable and Resilient 3-Dimensional Structure

Situation Assessment & Community Support
- Community Pharmacist
- Home Health
- Social Services
- ...

Patient and Family

Payer

Physician & Office Staff
### CMM Story Development (to date)

<table>
<thead>
<tr>
<th>Self-Management Of Medication: Cases and Faculty</th>
<th>Medical Condition</th>
<th>Caregiver Situation</th>
<th>Med Self Manager</th>
<th>Scope, Depth of Med Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruce, Connie</td>
<td>Stroke, kidney transplant</td>
<td>Husband, Wife (H/W)</td>
<td>Husband</td>
<td>Personal system manages med flow, effects, &amp; health</td>
</tr>
<tr>
<td>Teresa</td>
<td>Breast cancer</td>
<td>H/W, Neighbor</td>
<td>Neighbor, 1.5 years</td>
<td>Manage flow of meds</td>
</tr>
<tr>
<td>Richard</td>
<td>Heart valve replacement</td>
<td>Individual</td>
<td>Individual</td>
<td>New test process. Manage med level and own health</td>
</tr>
<tr>
<td>Gerry, Kathy</td>
<td>Dementia</td>
<td>Mom, Daughter</td>
<td>Family with assisted living</td>
<td>Created controlled situation. Manage flow of meds</td>
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</tbody>
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### Four Guides in the CMM Change Package

- A. Guide for Physicians
- B. Guide for Payers
- C. Guide for Assessment and Support
- D. Guide for Patients and Families
The TCPI Change Package Structure: Expanded Driver Diagram

Intended Results

<table>
<thead>
<tr>
<th>Practice aims aligned with TCPI goals</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
<th>Change Concepts</th>
<th>Change Tactics</th>
</tr>
</thead>
</table>

Expanded Driver Diagram

Broad concepts that prompt specific change ideas derived from site visits/high performers

Drivers: Essential to Achieving TCPI Aims

<table>
<thead>
<tr>
<th>TCPI AIMS/Goals</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Practice Transformation</td>
<td>Patient and Family-Centered Care Design</td>
<td>1.1 Patient &amp; family engagement</td>
</tr>
<tr>
<td>2) Effective solutions moving to scale</td>
<td>Continuous, Data-Driven Quality Improvement</td>
<td>1.2 Team-based relationships</td>
</tr>
<tr>
<td>3) High Clinical Effectiveness: Practice is effective in bringing all patient segments to their health status goals</td>
<td>Sustainable Business Operations</td>
<td>1.3 Population management</td>
</tr>
<tr>
<td>4) Reduced Avoidable Hospital Use: Rates of readmission and unnecessary admissions for practice’s patients have been reduced</td>
<td></td>
<td>1.4 Practice as a community partner</td>
</tr>
<tr>
<td>5) Reduced Unnecessary Testing &amp; Procedures: Practice demonstrates a reduction in unnecessary testing and in the use of the ED by its patient population</td>
<td></td>
<td>1.5 Coordinated care delivery</td>
</tr>
<tr>
<td>6) Reduced costs: Practice controls its internal costs as well as other elements of total cost of care</td>
<td></td>
<td>1.6 Organized, evidence based care</td>
</tr>
<tr>
<td>7) Documented Value: Practice can articulate its value proposition and increases participation in available value-based payment agreements</td>
<td></td>
<td>1.7 Enhanced Access</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.1 Engaged and committed leadership</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.2 Quality improvement strategy supporting a culture of quality and safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.3 Transparent measurement and monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.4 Optimal use of HIT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.1 Strategic use of practice revenue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2 Staff vitality and joy in work</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3 Capability to analyze and document value</td>
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<tr>
<td></td>
<td></td>
<td>3.4 Efficiency of operation</td>
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Change Tactics… What practice can really do to make the drivers come alive!

- Actionable
- Specific
- Customizable to type of practice or practice environment
- Have worked in several practices, but do not necessarily apply to all—why we encourage small scale testing

TCPI PFE National Strategy

Support and Alignment of Change Package
Evolution of PFE Tactics
Align PFE Across Transformation Platforms
Buy-In and Spread Across Consumer Advocacy Networks
PFE Comes Together in Overall TCPI Improvement Process

- Change Package – "Roadmap" to Transformation
- TCPI change package
- Practice Assessment Tool
- Transformation Improvement Assistance
- PAT – Query practices on level of transformation. Repeated every 6 months
- TIA – Process to provide technical assistance to practices. Ongoing, with quarterly roll-up report

Creating Patient Partnerships

- Establish clear measures that track the TCPI Campaign Person and Family Engagement (PFE) progress.
- Organize a diverse set of measures that are clinically relevant and important to both patients and providers.
- Create Campaign-wide buy-in, adoption and full implementation of newly established PFE measures.
Creating Patient Partnerships

1. Practice’s quality improvement infrastructure has patients and family in a proactive policy making and improvement role.

2. Practice provides patients and family with data transparency through the use of technology.

3. Practice leadership stands for Patient and Family Engagement

Creating Patient Partnerships

4. Practice proactively forms community partnerships to create a comprehensive support network for patients and family

5. Practice demonstrates patient and family engagement through advances in health equity and diversity

6. Practice enables self-management of medications by patient and family
Creating Patient Partnerships

1. **Quality role.** Practice’s quality improvement infrastructure has *patients and family* in a proactive policy making and improvement role.

2. **Access to data.** Practice provides *patients and family* with data transparency through the use of technology.

3. **A defining value.** Practice leadership stands for *Patient and Family Engagement*.

Creating Patient Partnerships

4. **Community links.** Practice proactively forms community partnerships to create a comprehensive support network for *patients and family*.

5. **Inclusive.** Practice demonstrates *patient and family engagement* through advances in health equity and diversity.

6. **Self-management.** Practice enables self-management of medications by *patient and family*.
Collaborative Self-Management Support – Practice Core Competencies

http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx

- Emphasize patient’s central role
- Involve family members
- Build a relationship
- Explore patient’s values, preferences, cultural & personal beliefs
- Share information
- Collaboratively set goals
- Use skill building & problem solving to help patient’s identify & overcome challenges
- Follow-up on action plans
- Connect patients with community resources

Challenges to Patient Self-Management

Helping patients with chronic conditions overcome barriers to self-care


Challenges (Examples)
- Physical (disability)
- Psychological (depression, distress)
- Cognitive (health literacy, literacy)
- Economic (health insurance adequacy)
- Social and Cultural (isolation)

Strategies for Overcoming Challenges (Examples)
- Structured Communication (teachback, motivational interviewing)
- Assessment (PAM)
- Enhancing self-efficacy (shared goal setting & action plans)
- Ongoing support (practice follow up, peer support)
Tom Evans, MD: Our “Long Journey” to Partnering with Patients

Stage 1. Working without patient input  “For them but not with them”
Stage 2. Dropping the wall of silence Inviting patients into the improvement work “room”
Stage 3. Listening to patient stories Using their stories to motivate and guide
Stage 4. Engaging patients in our work Showing patients our improvement work, asking for feedback
Stage 5. Partnering with patients Patients bring ideas up and providers listen; providers and users of care jointly make decisions, set priorities.

Transforming your Practice: Leaving in Action

1. Family engagement in care
2. Teach back
3. Warm hand-offs
4. Medication safety interventions
   - Patient and family advisory councils
   - Shared decision-making
   - The evolving Care Team
Leadership, Courage and Fortitude

“Of all the forms of injustice, injustice in health care is the most shocking and inhuman.”

- Martin Luther King Jr.

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